



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

November 30, 2018

In Reply Refer To: 001B
FOIA Request: 18-11960-F

Daniel McGrath, Staff Attorney
Austin Evers, Executive Director
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005
foia@americanoversight.org

Dear Mr. McGrath:

This is the Second Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated and received August 23, 2018, and assigned FOIA tracking number **18-11960-F**. You requested: All records reflecting communications (including emails, email attachments, text messages, messages on messaging platforms (such as Slack, GChat or Google Hangouts, Lync, Skype, or WhatsApp), telephone call logs, calendar invitations/entries, meeting notices, meeting agendas, informational material, talking points, any handwritten or electronic notes taken during any oral communications, summaries of any oral communications, or other materials) between any of the individuals listed

- Veterans Affairs Officials
 - Darin Selnick, Senior Advisor to the Secretary
 - Casin Spero, Special Advisor
 - Individuals within the Offices of the Secretary and Deputy Secretary: David Shulkin, Former Secretary, and anyone acting on his behalf
 - Vivieca Wright Simpson, Former Chief of Staff
 - Pete O'Rourke, Former Chief of Staff, Former Acting Secretary, and Senior Advisor to the Secretary; and anyone acting on his behalf
 - Robert Wilkie, Secretary, and anyone acting on his behalf
 - Jacquelyn Hayes-Byrd, Acting Chief of Staff and Deputy Chief of Staff
 - Thomas Bowman, Deputy Secretary, and anyone acting on his behalf
 - Any political appointee* in the immediate Office of the Secretary or Deputy Secretary during the applicable time period not previously listed above
- Outside Recipients
 - Dan Caldwell
 - Nathan Anderson
 - Shannon Hough
 - Pete Hegseth
 - Any email address ending in @cv4a.org or @cvafoundation.org
 - Isaac "Ike" Perlmutter
 - Bruce Moskowitz
 - Marc Sherman
- All email communications between any of the individuals listed in Column A and any external individuals or organizations (i.e., emails with addresses ending in com/.org/.net/.mil/.edu) that mention one or more of the following search terms in the subject line, body of the email, or attachment:
 - a. "Concerned Veterans"
 - b. "Concerned Vets"
 - c. CVA
 - d. CV4A

Please provide all responsive records from January 20, 2017, through the date of the search."

There is substantial overlap between this FOIA request and your prior FOIA request **18-07426-F**, as some redacted records released for your FOIA request **18-07426-F** are also responsive to FOIA request **18-11960-F**.

Reasonable Searches Dated September 6, 2018, September 18, 2018, October 12, 2018, October 16, 2018, October 18, 2018, and November 15, 2018

On September 6, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below ten (10) custodians from January 20, 2017, to September 6, 2018:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) Shulkin, David, former VA Secretary;
- 3) O'Rourke, Peter M., former VA Acting Secretary;
- 4) Bowman, Thomas, former VA Deputy Secretary;
- 5) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 6) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 7) Selnick, Darin, former VA White House Senior Advisor;
- 8) Lukach, Michael, former VA White House Senior Advisor;
- 9) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 10) Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches.

On October 12, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to June 22, 2018. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. These October 12, 2018, and October 16, 2018, searches yielded forty-four (44) pages, which OSVA released redacted as pages Bates-numbered 243-286 to you for FOIA request **18-07426-F**.

On September 18, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Chief of Staff Jacquelyn Hayes-Byrd's emails and calendars from November 8, 2016, to June 22, 2018. OSVA used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. This search yielded two hundred fifty-five (255) pages, which OSVA released redacted as pages Bates-numbered 287-541 to you for FOIA request **18-07426-F**.

On October 18, 2018, the OSVA FOIA office searched through the email boxes and calendars, from January 20, 2017, to June 22, 2018, of: David Shulkin, Thomas Bowman, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded three hundred twenty-eight (328) pages, which OSVA released redacted as pages Bates-numbered 542-813 and 816-871 to you for FOIA request **18-07426-F**.

On November 15, 2018, the OSVA FOIA office searched through the email boxes and calendars from June 23, 2018, to September 6, 2018, of:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) O'Rourke, Peter M., former VA Acting Secretary;
- 3) Bowman, Thomas, former VA Deputy Secretary;
- 4) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 5) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 6) Selnick, Darin, former VA White House Senior Advisor;
- 7) Lukach, Michael, former VA White House Senior Advisor;

- 8) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 9) Spero, Casin D, former VA White House Liaison.

The November 15, 2018, search yielded two pages, which OSVA released redacted as pages Bates-numbered 814-815 for your FOIA request **18-07426-F**.

Partial Initial Agency Decision

Using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms “Concerned Veterans of America,” “CVA,” and “cv4a.org” to search through former VA Secretary David Shulkin’s email boxes for responsive records. The OSVA FOIA Officer also used the same search key terms through the email boxes of the following custodians: Robert Wilkie, Peter O’Rourke, David Shulkin, Thomas Bowman, Jacquelyn Hayes-Byrd, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero.

This Clearwell search yielded approximately four hundred (400) documents totaling approximately five thousand (5,000) pages. OSVA now releases to you one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank). OSVA will release approximately one hundred twenty (120) redacted documents totaling approximately fourteen hundred (1,400) pages to you in the future. After reviewing the three thousand five hundred twenty-four (3,524) pages, OSVA redacts some information with FOIA Exemptions 4, 5, 6, 7(C).

5 U.S.C. § 552(b)(4) exempts from disclosure “trade secrets and commercial or financial information obtained from a person and privileged or confidential.” Redacted information includes voluntary proposal submission verbiage, technical processes, technical approaches, and partnership or subcontracting agreements. The release of this information would likely lead to substantial competitive harm in reverse-engineering of the vendors’ technical approaches, processes, partnership, subcontracting, and business and labor strategies. RMS Indus. v. DOD, No. C-92-1545, slip op. at 7 (N.D. Cal. Nov. 24, 1992) (protecting “descriptions of equipment and the names of contacts, customers, key employees, and subcontractors” because “bidders only submit such information if it will not be released to their competitors”); BDM Corp. v. SBA, 2 Gov’t Disclosure Serv. (P-H) ¶ 81,189, at 81,495 (D.D.C. Mar. 20, 1981) (protecting names of consultants and subcontractors, performance, cost, and equipment information).

5 U.S.C. § 552(b)(5) exempts from disclosure “inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency.” Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials and consultants reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts internal government deliberations, thoughts, opinions, recommendations, and proposed solutions from federal employees and consultants reviewing VA programs in their professional capacities, as well as non-final or draft documents. The information contained in the responsive records is both predecisional and deliberative because it reflects preliminary opinions, proposed solutions, and recommendations, which do not reflect VA’s final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees and consultants to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, proposing changes to, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials and consultants to discuss, opine, recommend or be forthcoming about the agency’s issues which require full and frank assessment. Here, the

disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996).

5 U.S.C. § 552(b)(5) exempts from disclosure “inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency.” Under the attorney-client and work product privileges, the VA redacts portions of records, emails, and communications between VA employees and attorneys analyzing and discussing legal issues for the VA and its employees. The release of this information would impede the ability of VA employees and attorneys to speak openly and frankly about legal issues concerning the VA or its employees. The release of this information would also compromise the legal positions of the VA and its employees.

5 U.S.C. § 552(b)(6) exempts from required disclosure “personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.” FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual’s personal privacy without contributing significantly to the public’s understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal employees and private citizens; we however release the names and VA email addresses of VA Senior Executives. Federal civilian employees and private citizens retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal civilian employees and private citizens whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, except names and VA email addresses of VA Senior Executives, we find that there is no public interest in knowing the names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal civilian employees and private citizens. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public’s understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public’s need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. Releasing even a single VA username reveals the pattern to ascertain VA usernames that VA employees use to log into VA Systems of Records; releasing VA usernames exposes the VA, its employees, and its contractors to potential hacking and information technology security liabilities and risks. “Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed.” Long v. Immigration & Customs Enf’t, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

5 U.S.C. § 552(b)(7)(C) exempts from required disclosure information law enforcement information the disclosure of which "could reasonably be expected to constitute an unwarranted invasion of personal privacy." Redacted information includes names and email addresses of White House employees with security clearances, as well as Redacted information includes names, identities, email addresses, and VA usernames of VA law enforcement employees. The release of this information would risk impersonation of these White House employees with security clearances also working on national security and law enforcement matters, as well as jeopardizing their health and safety and those the White House employees are charged with protecting. The release of this information would risk impersonation of VA law enforcement personnel and jeopardize the health and safety of not only law enforcement personnel, but those persons the VA law enforcement personnel protect including the VA Secretary.

5 U.S.C. § 552(b)(7)(E) exempts from required disclosure information that "would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law." Redacted information includes VA usernames of VA law enforcement employees and shared VA email groups, for which VA law enforcement officials plan their law enforcement operations and protection of VA personnel. The release of this information would compromise the safety of VA law enforcement personnel and VA employees.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:

Name: John Buck

Email Address: vacofoiaservice@va.gov

Office of Government Information Services (OGIS)

Email Address: ogis@nara.gov

Fax: 202-741-5769

Mailing address:

National Archives and Records Administration

8601 Adelphi Road

College Park, MD 20740-6001

FOIA Appeal

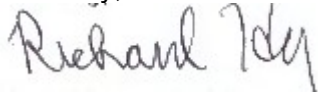
This concludes OSVA's partial IAD to request **18-11960-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Mr. McGrath, Esq., & Mr. Evers
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If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,

A handwritten signature in dark ink, appearing to read "Richard Ha".

Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachments

- Redacted one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank).

(b) (6)

Subject: Meet w/Concerned Veterans of America CVA (b) (6) /Darin Selnick)
Location: SecVA Suite

Start: Wed 6/28/2017 2:15 PM
End: Wed 6/28/2017 2:45 PM

Recurrence: (none)

Categories: Special Events



OWS System: not an Solution for C...	OWS Applikation: Shoulkin.schex	6.2.2.2001/ OWS FBS10003X
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EXECUTIVE BRIEFING SUMMARY

Meeting with Concerned Veterans for America

June 28th, 2017

2:15 – 2:45 PM

SECVA Suite

POINT OF CONTACT: (b) (6) (VSO Liaison)

PURPOSE OF EVENT:

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Decisional | <input type="checkbox"/> Informational | <input type="checkbox"/> Pre-Event |
| <input type="checkbox"/> Remarks | <input checked="" type="checkbox"/> Other | <input type="checkbox"/> Courtesy Call |

ATTENDEES:

CVA

Mark Lucas, Executive Director

Dan Caldwell, Director of Policy

VA

Darin Selnick

Brooks Tucker

John Ulliot

Jake Leinenkugel

(b) (6)

OBJECTIVE:

Meet CVA leadership and understand their priorities; Share your vision and priorities with CVA leadership; Discuss public components of Vets CARE Plan and related issues

BACKGROUND:

- CVA requested to meet with you. They've indicated that while they've seen you briefly at events, they haven't had the chance to sit down and talk to you. The two senior leaders would like to introduce themselves and tell you more about their organization and their priorities.
- They'd also like to discuss how they can work more closely with VA-- in particular the Vets CARE program and the pilots.
- The White House has included CVA in its meetings and they've become more supportive of VA. However, traditional VSO remain skeptical of the organization and don't consider them a VSO

BIOGRAPHY:

(next page)

Mark Lucas is the Executive Director of Concerned Veterans for America. Prior to this, Lucas was a Regional Director of Americans for Prosperity, where he had previously served as the Iowa State Director. Under his leadership, the Iowa chapter of AFP grew to be the highest-performing in the organization in only 2 years.

Mark was the youngest-ever elected City Councilman at the age of 19 in his hometown of Wilton, Iowa. Mid-way through his term he was appointed as the Mayor Pro Tem.

During the 2008 presidential primary, Mark was the State Director of the Americans for Fair Taxation. The National Review said the FairTax campaign was the biggest success story of the 2008 primary season.

Mark has served for over 13 years in the Iowa Army National Guard and is a graduate of the US Army Ranger School. He led an infantry rifle platoon along the Afghanistan-Pakistan border as a platoon leader. He was awarded the Combat Infantry Badge and Bronze Star Medal by distinguishing himself for meritorious service in combat.

He received his Business Management degree from the University of Iowa Tippie College of Business with a certificate in Entrepreneurial Management.

He recently moved to Washington DC with his (b) (6) (b) (6) and (b) (6) (b) (6).

ATTACHMENTS:

1. Press Release: CVA Statement on Choice Testimony
2. Press Release: CVA Statement on Solution to Choice Program

CVA APPLAUDS SHULKIN'S VISION FOR VETERANS HEALTH CARE CHOICE

Arlington, VA – Today the Senate Veterans Affairs Committee (SVAC) held a **hearing** examining the Veterans Choice Program and the future of the Department of Veterans Affairs (VA) care in the community program. VA Secretary Shulkin testified, unveiling a new vision for expanding choice and community care programs, called the Vets Community Access Rewarding Experience (CARE) program, and announcing a new pilot choice program very similar to what CVA has proposed for years.

Concerned Veterans for America (CVA) supports expanding veterans' health choice beyond the current Choice Program. In the bipartisan *Fixing Veterans Health Care Task Force*, CVA proposes the creation of a government-chartered non-profit and veterans insurance program to oversee the distribution of health care benefits to veterans. In this new model, veterans would be fully empowered to decide where and when to seek care outside of the VA.

Concerned Veterans for America (CVA) Policy Director Dan Caldwell issued the following statement:

“We applaud Secretary Shulkin for proposing reforms that will expand choice and for being willing to test new ideas to deliver health care to our veterans. The current Choice Program was meant to be temporary, has been implemented poorly, and offers unacceptably limited health care options. When it doesn't make sense to use the VA for care, veterans should be able to go outside of it. We look forward to working with Secretary Shulkin, this administration, and members of Congress to develop legislation that will achieve a vision of true health care freedom for veterans.

“Unfortunately, some members of the Senate — in particular, Senator Patty Murray — are opposed to even trying new ideas to deliver health care to our veterans. It is disappointing that some in Congress just want to double down on the status quo at the VA.”

In April, the Senate passed and President Trump signed a reauthorization and extension of the **Veterans Choice Act**, which was passed originally in 2014 as a quick fix to the wait list scandal at the VA in Phoenix.

The Veterans Choice Program has been poorly implemented and has not offered the veterans who qualify for it the real choice that the creators of the program envisioned. The “40-mile, 30-day” rule means that, in theory, veterans can only seek care outside the VA if they can't be seen within a month of when they request an appointment or if they can't be seen within a 40-mile radius. Even then, many veterans are still forced to jump through many bureaucratic hoops to access the program.

President Trump and VA Secretary Shulkin have both repeatedly expressed the need to give veterans more choice over their health care. President Trump included choice as part of his 10-point plan to fix the VA while he was on the campaign trail last year.

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CVA STATEMENT ON SOLUTION TO CHOICE PROGRAM

Arlington, VA — This week Department of Veterans Affairs (VA) Secretary Shulkin testified before the Senate that funding for the Veteran Choice Program will likely run out later this year, much sooner than originally expected.

When President Trump reauthorized the Choice Program earlier this year, there were changes made to the program – in particular, making the VA the primary payor for care – which may have led to significantly increased spending. In addition, the increased referrals to the program have been larger than anticipated.

Concerned Veterans for America (CVA) Policy Director Dan Caldwell issued the following statement:

“Elected officials should quickly pass legislation that will allow the VA to move existing funds to the Veteran Choice Program, which they are unable to do under current law. Congress authorized the VA to move funds out of the program in 2015 – a measure we opposed – and they should now allow the VA the same flexibility to move funds back into the program.

“Patching up this flawed program year after year is not a permanent solution to the health care issues facing veterans. A systemic overhaul of the VHA is needed to allow veterans to use their benefits whenever and wherever they want and to remove the VA as the middleman.”

The Choice Program, which was enacted under Veterans’ Access to Care through Choice, Accountability, and Transparency Act, was intended as a temporary solution to the wait list scandal of 2014. The Program was flawed — allowing veterans to only receive care at VA-approved facilities if they meet the “30-day, 40-mile” rule, for example — and has been implemented poorly.

For years, CVA has proposed the creation of a government-chartered non-profit to oversee the distribution of health care benefits at the Department of Veterans Affairs (VA). This entity would empower veterans to use these benefits at his or her own discretion – inside or outside of the VA.

###

(b) (6)

Subject: Meet w/Dan Caldwell, CVA (b) (6)
Location: SecVA Suite

Start: Thu 12/7/2017 2:00 PM
End: Thu 12/7/2017 2:30 PM

Recurrence: (none)

Categories: Special Events



(b) (6)
(b) (6)

DAN CALDWELL



Dan Caldwell was named the Executive Director for Concerned Veterans for America (CVA) in October 2017 and has worked for CVA since 2013.

In 2005, Dan enlisted in the United States Marine Corps as an infantryman. During Basic Training, Dan was selected for the Marine Corps' Presidential Support Program, in which he served as a member of the Marine Security Force at Marine Barracks Washington and the Presidential Retreat at Camp David. Upon completion of his tour at Camp David, Dan was assigned to 2nd Battalion, 1st Marines where he served as an infantry team leader, squad leader, and vehicle commander. Dan deployed to Iraq with 2nd Battalion, 1st Marines in support of Operation Iraqi Freedom and conducted operations in Al Anbar and Ninawa provinces.

Prior to joining CVA in 2013, Dan worked for Congressman David Schweikert (R-AZ) from 2011 to 2013. Dan originally was a constituent caseworker focused on resolving constituents' issues with the Department of Veterans Affairs and Department of Defense and eventually was promoted to Deputy Chief of Staff. Additionally, in 2012, Dan managed the successful re-election campaign of Congressman Schweikert in one of the most intense incumbent versus incumbent races of the 2012 election cycle. Dan also graduated cum laude in 2011 from Arizona State University with degrees in International Studies, Political Science, and Asian History.

(b) (6)

Subject: Meeting w/Sen. Bill Frist & (b) (6) re: VA healthcare
Location: SecVA Suite- VANTS line (b) (6)
Start: Thu 6/29/2017 10:00 AM
End: Thu 6/29/2017 10:45 AM
Recurrence: (none)
Categories: Special Events

w/ (b) (6)

From: DJS
Sent: Thursday, June 01, 2017 4:36 PM
To: Selnick, Darin
Cc: (b) (6)
Subject: RE: Former Senate Majority Leader Dr. Frist

Sure let's set it up

Sent with Good (www.good.com)

-----Original Message-----

From: Selnick, Darin
Sent: Thursday, June 01, 2017 04:32 PM Eastern Standard Time
To: DJS
Cc: (b) (6)
Subject: Former Senate Majority Leader Dr. Frist

I had a long phone conversation with former Senate Majority Leader Dr. Bill Frist last week. Dr. Frist did part-time surgery for over 15 years at the VA Hospital in Nashville. He was also one of the co-chairs of the CVA Fixing Veterans Healthcare Taskforce.

As you know Dr. Frist is a board member for a lot of different types of Healthcare companies and wants to use his expertise and connections to help you and VA healthcare. Below is the follow up email he sent me (b) (5)

One example is Valor Healthcare. VALOR is (b) (5) with 33 CBOCs that see 110,000 veterans each year. As a contract provider (b) (5). I met with their (b) (5)

VA-18-0457-A-000008

(b) (5)

By the way, the OIG did two studies in 2010 and 2011 comparing VA staff CBOC vs. contract CBOC in terms of quality, OIG found (b) (5)

I think Dr. Frist as past Majority leader (b) (5).

(b) (5) is to set up a meeting with you, (b) (6) and myself, with Dr. Frist and (b) (6),
(b) (6) is an Army veteran (b) (6)
Dr. Frist (b) (5)

Let me know if you want to go forward with the meeting with Dr. Frist and I will set it up.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell (b) (6)

From: Darin Selnick [mailto:(b) (6)]

Sent: Tuesday, May 30, 2017 12:11 PM

To: Selnick, Darin

Subject: [EXTERNAL] Fwd: issues discussed

Sent from my iPhone

Begin forwarded message:

From: Bill Frist <(b) (6)>
Date: May 25, 2017 at 12:12:35 PM EDT
To: "(b) (6)" >
Subject: issues discussed

Darin,

Great to catch up and excited about the opportunities to accelerate your and the Secretary's initiatives there.

1. Primary care and access. I have forwarded to you a memo on Valor and hopefully you can discuss (b) (5).
2. Palliative health care. (b) (5) nonhospice, community based palliative care company in the country and is (b) (5) and (b) (5). They are aware of a pilot that the VA has done which apparently was successful and (b) (5) (b) (6) with your smartest person to, again on the innovation and on the service front, (b) (5).
3. Infrastructure: I am on the board of AECOM, the largest design and architecture firm in the country, . The VA is a very important client of AECOM (b) (5) with the agency through several contracts and through the Army Corps of Engineers, which now oversees the major construction projects for the VA. AECOM completed the design for the VA hospital in Orlando and has delivered more than a dozen renovation projects over the last couple of years. (b) (5).
4. Partnerships. I would suggest in the health IT world and mobile technology and communication world, that the VA (b) (5) (b) (6) (b) (5).

Thanks for taking time to discuss these opportunities. And thanks for heling me navigate through the VA to serve our veterans (which I had the privilege of doing every week in the operating room for 15 years!

From: Maurer, Ronald (CLS-House) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6)>
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc: O'Connor, Christopher (SES)
(christopher.o'connor2@va.gov) <christopher.o'connor2@va.gov>;
Tucker, Brooks </o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)> (b) (6)
</o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
(CLS-House) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6)>
Bcc:
Subject: Rep. McMorris Rodgers SEVA meeting packet
Date: Mon Mar 20 2017 15:42:59 CDT
Attachments: Bill Summary and Table.docx
CVA 2017 caring for heroes act.docx
CVA The Reform VA Needs.docx
CVA Website.docx
McMorris Rodgers Wait time is up for VA fix.docx
Mcmorris-Rodgers release draft VA reform legislation.docx
McMorris-Rodgers SECVA Briefing memo.docx
McMorris-Rodgers-Discussion-Draft-VA.pdf
CWEmbed1.xml
Michael Kussman Washington Post opinion.docx
PVA Outraged over caring for our heroes act.docx
Rep. Lamborn caring for heroes act.docx
Rep. McMorris Rodgers, Cathy (CA).doc
VSOs and caring for heroes act.docx

Darin,

Attached are documents OCLA collected or prepared in advance of the Friday meeting with Rep McMorris Rogers. We ask that you specifically look at the SecVA Briefing Memo as we would usually provide background and talking points.

We remain available to assist but wanted to give you enough time to review what has been prepared. The packet includes:

1. SECVA Briefing Memo
2. Rep. McMorris-Rodgers bio
3. Bill Summary and draft bill
4. Related articles/op-eds from members, VSO's and a former

Thank you, Ron

Ron Maurer, Ed.D.

Acting, Deputy Assistant Secretary

Department of Veterans Affairs' Office of Congressional and Legislative Affairs

Owner: Maurer, Ronald (CLS-House) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6)
Filename: Bill Summary and Table.docx
Last Modified: Mon Mar 20 15:42:59 CDT 2017

Veterans Accountable Care Organization (VACO)
Section 101(a) of the bill, creating a new 38 USC 323

Purpose:

(b) (5)

Organization:

(b) (5)

Duties:

(b) (5)

Funding:

(b) (5)

Resources:

(b) (5)

	VetsCare Federal Program	VetsCare Choice Program	VetsCare Senior Program
Authority (bill/USC)	103 (new 38 USC	104 (new 38 USC 2601-2607)	104 (new 38 USC 2611-2612)
Eligibility	(b) (5)		
Scope of Benefits			
Limitations			
Payment Responsibilities/ Forms of support			

Other Provisions:

Section 102(a) of the bill would create a new 38 USC 7309A, "Veterans Health insurance Program," which would (b) (5)

[REDACTED]

Section 105 would allow persons receiving coverage for health insurance support under VetsCare Choice program to (b) (5)

[REDACTED]

Section 106 would require the Veterans Accountable Care Organization to publish on an (b) (5)

[REDACTED]

Section 201 would require the Veterans Accountable Care Organization to (b) (5)

[REDACTED]

Section 401 would amend 5 USC 9001 to make (b) (5)

[REDACTED]

VetsCare Advisory Commission
Section 301 of the bill

Duties:

(b) (5)

Organization:

(b) (5)

Funding:

(b) (5)

Resources:

(b) (5)

Owner: Maurer, Ronald (CLS-House) </o=va/ou=va
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Filename: CVA 2017 caring for heroes act.docx
Last Modified: Mon Mar 20 15:42:59 CDT 2017



Report: 'VA still manipulating wait times'

Concerned Veterans of America pushing for timely health care for veterans

By [Jodi Mohrmann](#) - Managing Editor of special projects

Posted: 6:23 PM, March 06, 2017

Updated: 6:23 PM, March 06, 2017

JACKSONVILLE, Fla. - [Concerned Veterans for America](#) is pointing to a new audit that it says proves VA employees are still manipulating patient wait times, and is pushing for new laws that would give veterans access to timely health care.

Last week, the Department of Veterans Affairs Office of Inspector General released its results of a [new audit](#) confirming widespread wait time inaccuracies at VA medical facilities in North Carolina and Virginia.

The OIG's audit found wait time numbers are "significantly higher" than the numbers reported in the Veterans Health Administration's scheduling system. CVA explains this happened because VA schedulers documented the scheduled appointment time as the "desired appointment time" instead of the "requested appointment time."

As a result, veterans who were eligible for the Choice Program and who could have sought care at a doctor of their choosing, were forced to wait for care at the VA.

Of 15,300 appointments audited, in which veterans should have been added to the Veterans Choice List, OIG estimates VA staff did not identify 90 percent of them to be added to the list.

"The VA has consistently failed at their number one priority: to provide veterans access to timely health care," said CVA Policy Director Dan Caldwell in a statement. "The fact that VA employees across the country are still engaging in inappropriate scheduling practices shows just how dysfunctional the department still is. Accountability and choice reforms at the VA are simply not an option anymore – they are an urgent necessity."

CVA says it is supporting two pieces of legislation to help give military veterans the timely health care they need and deserve.

First is the [Caring for Our Heroes in the 21st Century Act](#). This draft legislation, introduced by Rep. Cathy McMorris Rodgers (R-WA) last year, would empower veterans to seek care inside or outside the VA at their own discretion.

VA-18-0457-A-000019

The second piece of legislation CVA supports is the [2017 VA Accountability First Act](#). The Senate version was introduced last week by Sen. Marco Rubio (R-FL) and the House version was introduced by Rep. Phil Roe (R-TN.) If it passes, it would make it easier to terminate bad VA employees and help bring a new culture of accountability.

In the meantime, CVA is pushing Congress to re-authorize the current Choice Card program this August until more permanent reforms can take hold.

VA OIG's investigations into wait times follows the scandal of wait-time manipulation at the Phoenix VA Health Care System in 2014. After that, VA received numerous allegations from veterans, VA employees and members of Congress of the same thing happening at VA facilities nationwide.

Owner: Maurer, Ronald (CLS-House) </o=va/ou=va
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Filename: CVA The Reform VA Needs.docx
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CONCERNED
VETERANS
FOR AMERICA

CARING FOR OUR HEROES IN THE 21ST CENTURY ACT: THE REFORM VA NEEDS

By Shaun Rieley

06.08.16

Caring for Our Heroes in the 21st Century Act: The Reform VA Needs

Just over two years have passed since it was revealed that numerous veterans died waiting for care on secret VA hospital waiting lists that had been intentionally manipulated, resulting in the resignation of then-VA Secretary Eric Shinseki. In the wake of that scandal, Congress passed the [Veterans Access, Choice, and Accountability Act of 2014](#), which took steps toward providing veterans with access and choice that are the hallmarks of good health care, and toward improving accountability for VA employees.

These reforms were a step in the right direction, but in the years since they were enacted, implementation of the Choice Program has proven less than satisfactory, and it has become clear that the accountability measures have failed to hold accountable many problematic VA employees. This is because the reforms failed to address certain systemic and structural issues in VA that serve to perpetuate a toxic culture which results, all too often, in failure to take care of the veterans that it exists to serve.

In fact, the [independent assessment](#) of VA care, mandated by the Veterans Access, Choice, and Accountability Act, [found](#) that true reform would require “no less than a system-wide reworking.”

Congress will now have the opportunity to bring those changes. U.S. Rep. Cathy McMorris Rodgers (R-WA) has released a [discussion draft](#) of the *Caring for Our Heroes in the 21st Century Act*—legislation which would comprehensively overhaul the Veterans Health Administration.

Rep. McMorris Rodgers’ bill seeks to go to the root of the problems. It restructures VA, shifting the Veterans Health Administration (VHA) to governance by a board of directors, allowing it to be run like a high-performance health care organization, rather than as a government bureaucracy, improving both accountability and access, while allowing the system to right-size itself, which is projected to save money over the long term.

Furthermore, it allows veterans increased choice in both private health care and VA providers. Thus it allows veterans who are satisfied with their care at VA to remain in the system with no cost-sharing, and those who prefer to leverage the resources in their local community can do so, while receiving premium support to help cover costs.

Despite the often-repeated assertion that VA’s problems stem from a lack of money, the VA budget has [grown precipitously](#) over the past decade. Yet, VA’s problems continue. Clearly simply increasing VA’s budget has not appreciably improved outcomes.

VA-18-0457-A-000022

The plan is bold, and real reform is never easy—even when it is clearly needed. But to provide veterans with the best care possible—care that they have earned through their service and sacrifice—we will need to think beyond the tired talking points and failed status quo. Honoring veterans means asking the hard questions and doing the right thing, even when it is difficult.

Owner: Maurer, Ronald (CLS-House) </o=va/ou=va
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FOR AMERICA

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TAKE ACTION PROJECTS EVENTS THE OVERWATCH

THE CARING FOR OUR HEROES IN THE 21ST CENTURY ACT



What can be done to fix the VA?

Real reform for our nations veterans

Give Veterans The Care They Earned



GIVE VETERANS THE CARE THEY EARNED



The VA is failing to keep its promise to veterans across the country. And it's only going to get worse if we don't reform it now.

Fortunately, a real reform plan is under consideration in Congress. Congresswoman Cathy McMorris Rodgers (R-WA) introduced the Caring for Our Heroes in the 21st Century Act.

In order for veterans to get the quality, timely care they truly deserve, Congress must modernize the VA. This legislation is our best hope for giving vets the care they have earned.

Here's what you can do – sign your name to support the Caring for Our Veterans in the 21st Century Act, and tell Congress to give our heroes the health care choice they deserve.

Together, we can give vets and military families more choice, flexibility, and access to medical care.

Owner: Maurer, Ronald (CLS-House) </o=va/ou=va
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Filename: McMorris Rodgers Wait time is up for VA fix.docx
Last Modified: Mon Mar 20 15:42:59 CDT 2017

House GOP conference chair: Wait time is up for VA fix

By Rep. Cathy McMorris Rodgers April 26, 2016

***The Outrage Machine* is regular opinion column by voices from the left and right on Washington.**

Imagine a veterans' hospital with no waiting list to see a doctor.

One where veterans can book their appointments online 24 hours a day, seven days a week.

Where the red carpet is rolled out for our heroes to receive world-class care for their world-class service the very next day — before it's too late.

And where the men and women who accepted the call of duty can choose to continue seeing the doctor they've seen their entire lives.

This is what a common sense, 21st century veterans' health care system should look like. After all, we're talking about the men and women who lay their lives on the line and sacrifice so that we may live free.

To think they could be trapped in a broken system simply because of their service, and not have the same access to quality services available to private citizens, is outrageous.

Unbelievably, as we approach two years since the scandal broke out at the VA with secret wait lists, patients dying waiting for appointments, and an overwhelming feeling of hopelessness, we're finding that our veterans still aren't even coming close to that vision for 21st century care.

In fact, according to recent reports, the situation is even worse.

An audit released last week by the Government Accountability Office (GAO) found that the VA still hasn't fixed the wait times that plagued the system two years ago; schedulers at half the reviewed centers had falsified wait times, and scheduling was done improperly a quarter of the time. An earlier report revealed that as of January, more than 30,000 veterans were waiting longer than one month for health care than they were the year before.

This doesn't mean a 21st century VA isn't possible, but it will require a comprehensive overhaul of the agency we know today, starting with the way health centers schedule appointments, and

continuing until the culture and focus of the agency's bureaucrats places veterans before themselves.

The VA is centered on the status quo and the problems at the agency are deeply rooted at every level of this obsolete government model built for the previous century. And it's failing our veterans.

For example, despite assertions from the agency that several dozen employees lost or would lose their jobs over the manipulated wait times, in reality, only a handful have been fired — not even enough to qualify as a slap on the wrist.

Veterans died while on VA waiting lists, and it is unconscionable that there has been little effort on the part of the agency to reform its own culture, rectify this situation, or hold those responsible accountable.

Delivering timely, quality care for these brave men and women has to be more than just lip service—it has to be a priority.

This means taking seriously the long wait times, insufficient care, and unresponsive management.

It is estimated that 18 percent of VA appointments are wasted due to last-minute cancellations and no-shows. In these instances, VA personnel failed to refill the cancelled appointments.

In June of last year, an internal audit found more than 120,000 veterans waited at least 90 days for appointments for medical care, or they didn't receive appointments at all.

These slots could be filled by the countless other veterans stuck on the wait-list using real-time updates available through existing technology.

The VA recently told Congress that it is putting on hold its overhaul of its scheduling system that was supposed to fix the problem, meaning the agency is still relying on archaic technology systems and phone calls to get the job done.

We can do better.

I believe we should open up the scheduling process to the same technologies being used in doctors' offices by private citizens across the country, which is why I've introduced legislation with Rep. Seth Moulton (D-Mass.) that incorporates self-scheduling so veterans can schedule and confirm medical appointments online and immediately.

But the scheduling system is not enough. Across the board, whether it's how appointments are scheduled, or the quality of health services provided, our veterans should have access to the same technology and services as private patients across the country.

If we don't clean house at the VA and overhaul its culture, we're just biding time until another — potentially worse— scandal surfaces.

Over the coming months, we will focus on legislation that demonstrates to the VA how innovative ideas already being used in the private sector can also work for them to cut back on red tape, stay within budget, and, most importantly, get our veterans the care they earned and need.

The time has run out for the VA to address its issues on its own.

If this administration cannot follow through on the fundamental duty and solemn obligation to serve our veterans with the VA as-is, then it's time to try something different.

No more waiting. No more sitting by the phone hoping that someone follows up.

Self-scheduling is only one example of the endless possibilities for a 21st century VA — one that treats our veterans with dignity and respect, and ensures our heroes' sacrifices don't continue after their tours end.

It just takes the imagination and willpower to make it happen.

A founder of the Congressional Military Family Caucus, Cathy McMorris Rodgers has represented Fairchild Air Force Base in Washington's 5th Congressional District since 2005. McMorris Rodgers is chair of the House Republican Conference.

Owner: Maurer, Ronald (CLS-House) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6)
Filename: Mcmorris-Rodgers release draft VA reform legislation.docx
Last Modified: Mon Mar 20 15:42:59 CDT 2017



Jun 07, 2016 / [Defense/Veterans](#)

MCMORRIS RODGERS RELEASES DRAFT VA REFORM LEGISLATION

Eastern Washington Congresswoman Cathy McMorris Rodgers (WA-05) today released a discussion draft of legislation, the *Caring for our Heroes in the 21st Century Act*, which would modernize the way veterans receive health care.

“Every day I hear from veterans in Eastern Washington who are struggling to work with the VA,” said McMorris Rodgers. “We have a profound obligation to honor the service of our veterans and ensure that our heroes’ sacrifices shouldn’t continue after their tours of duty end. With the never ending wait times and the VA Secretary doubling down on his comparison to Disney, the time has long passed for the VA to make the necessary changes to ensure that our veterans are treated effectively, seen efficiently, and cared for with respect. Veterans should be freed from a system that offers them little or no choice.

“With this draft legislation, my goal is for veterans to have the ability to choose what health care plan best fits their individual needs. This proposal should serve as the starting point for putting veterans in charge of their health care. I look forward to receiving feedback from veterans and the organizations that represent them, so we can ensure veterans receive the health care they deserve and have earned in a timely manner.”

Note: The *Caring for our Heroes in the 21st Act* is a draft document which serves as an opportunity to discuss ideas for introduction in the future. [Click here](#) to read the discussion draft, which has not yet been introduced in the U.S. House of Representatives.

Owner: Maurer, Ronald (CLS-House) </o=va/ou=va
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Filename: McMorris-Rodgers SECVA Briefing memo.docx
Last Modified: Mon Mar 20 15:42:59 CDT 2017

Briefing Memorandum Template

TO: VA Secretary, Dr. David Shulkin

FROM: Chris O'Connor, Acting Assistant Secretary, OCLA

RE: Meeting with Rep. Cathy McMorris-Rodgers (R-WA-05)

DATE: March 24, 2017

TIME: 11:30am in 1314 Longworth H.O.B

CONTACTS: (b) (6) 1 (b) (6)

OVERVIEW

(b) (5)

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

YOUR ROLE

(b) (5)

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

BACKGROUND ON THE CONGRESSWOMAN

(b) (5)

[REDACTED]

[REDACTED]

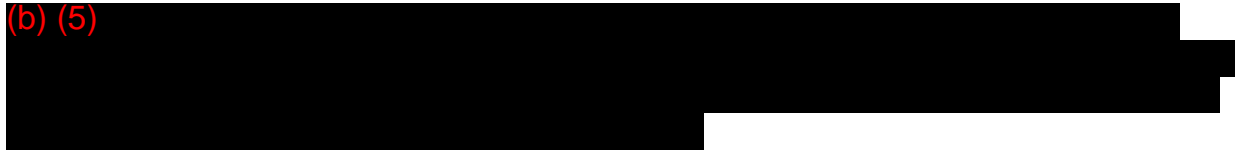
WHAT ELSE DO WE NEED TO KNOW

(b) (5)

[REDACTED]

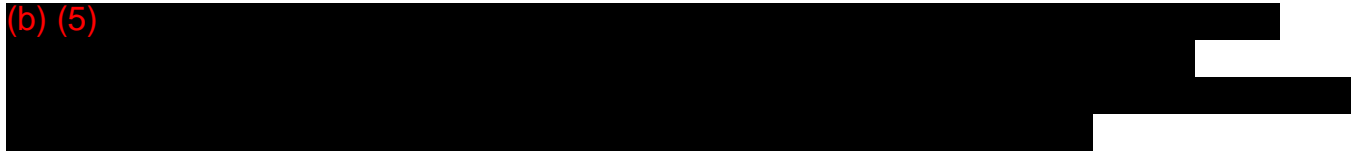
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TALKING POINTS

(b) (5)



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Filename: McMorris-Rodgers-Discussion-Draft-VA.pdf
Last Modified: Mon Mar 20 15:42:59 CDT 2017

[DISCUSSION DRAFT]114TH CONGRESS
2D SESSION**H. R.** _____

To amend title 38, United States Code, to establish the Veterans Accountable Care Organization and to provide veterans access to private health insurance plans, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mrs. MCMORRIS RODGERS introduced the following bill; which was referred to the Committee on _____

DRAFT

A BILL

To amend title 38, United States Code, to establish the Veterans Accountable Care Organization and to provide veterans access to private health insurance plans, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Caring for our Heroes in the 21st Century Act”.

6 (b) TABLE OF CONTENTS.—The table of contents for
7 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—VETERANS ACCOUNTABLE CARE ORGANIZATION AND HEALTH INSURANCE SUPPORT

Sec. 101. Establishment of Veterans Accountable Care Organization.

Sec. 102. Establishment of Veterans Health Insurance Program.

Sec. 103. Designation of existing authorities for hospital care, medical services, and other health care.

Sec. 104. Health insurance support for new veterans and veterans electing health insurance support in lieu of eligibility for hospital care, medical services, and other health care under existing authorities.

Sec. 105. Coordination between VetsCare Choice program and eligibility to make contributions to health savings accounts.

Sec. 106. Publication of health care information.

TITLE II—REALIGNMENT OF MEDICAL CENTERS OF DEPARTMENT OF VETERANS AFFAIRS

Sec. 201. Realignment of medical centers.

Sec. 202. Congressional consideration of Commission report.

TITLE III—IMPLEMENTATION OF HEALTH CARE REFORMS

Sec. 301. VetsCare Advisory Commission.

TITLE IV—LONG-TERM CARE INSURANCE FOR VETERANS

Sec. 401. Veterans' eligibility for long-term care insurance.

TITLE I—VETERANS ACCOUNT- ABLE CARE ORGANIZATION AND HEALTH INSURANCE SUPPORT

SEC. 101. ESTABLISHMENT OF VETERANS ACCOUNTABLE CARE ORGANIZATION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Chapter 3 of title 38, United States Code, is amended by adding at the end the following new section:

1 **“§ 323. Veterans Accountable Care Organization**

2 “(a) ESTABLISHMENT.—(1) There is established the
3 Veterans Accountable Care Organization (in this section
4 referred to as the ‘Corporation’).

5 “(2) The Corporation is a federally chartered cor-
6 poration.

7 “(3) The Corporation shall be incorporated and domi-
8 ciled in the District of Columbia, or another nearby State,
9 as determined by the board of directors of the Corpora-
10 tion.

11 “(4) The Corporation shall be a charitable and non-
12 profit corporation.

13 “(5) Except as otherwise provided, the Corporation
14 shall have perpetual existence.

15 “(b) PURPOSE.—The purpose of the Corporation is
16 to furnish high quality hospital care, medical services, and
17 other health care (excluding nursing home care and domi-
18 ciliary care) to individuals eligible for such care and serv-
19 ices under laws administered by the Secretary.

20 “(c) BOARD OF DIRECTORS.—(1) The powers of the
21 Corporation shall be vested in a Board of Directors that
22 governs the Corporation.

23 “(2) The Board of Directors shall be composed of the
24 following members:

25 “(A) The Secretary of Veterans Affairs.

1 “(A) Two members appointed by the Speaker of
2 the House of Representatives, at least one of whom
3 shall be a veteran.

4 “(B) Two members appointed by the Minority
5 Leader of the House of Representatives, at least one
6 of whom shall be a veteran.

7 “(C) Two members appointed by the Majority
8 Leader of the Senate, at least one of whom shall be
9 a veteran.

10 “(D) Two members appointed by the Minority
11 Leader of the Senate, at least one of whom shall be
12 a veteran.

13 “(E) Two members appointed by the President,
14 at least one of whom shall be veterans.

15 “(3) The President shall designate a member of the
16 Board of Directors to serve as Chairperson of the Board.
17 The Board shall select a Vice Chairperson from among
18 its members.

19 “(4)(A) A member of the Board of Directors shall
20 serve for a term of five years, except that the members
21 first appointed shall be appointed for staggered terms as
22 the President considers appropriate to ensure that the
23 terms of no more than three members expire in the same
24 year.

1 “(B) Any member appointed to fill a vacancy occur-
2 ring before the expiration of the term for which the mem-
3 ber’s predecessor was appointed shall be appointed only
4 for the remainder of that term. A member may serve after
5 the expiration of that member’s term until a successor has
6 taken office. A vacancy on the Board shall not affect its
7 powers, but shall be filled in the same manner in which
8 the original appointment was made.

9 “(C) The term of each member may be renewed for
10 an additional term, except that in no case shall any mem-
11 ber serve more than two consecutive terms exceeding ten
12 years.

13 “(D) During the absence or disability of the Sec-
14 retary of Veterans Affairs or in the event of a vacancy
15 in the office of Secretary, the Acting Secretary of Veterans
16 Affairs shall serve as the member of the Board of Direc-
17 tors specified in paragraph (2)(A).

18 “(d) DUTIES.—In carrying out subsection (b), the
19 Corporation shall—

20 “(1) transfer personnel and assets of the De-
21 partment of Veterans Affairs to the Corporation
22 pursuant to subsection (b) of section 101 of the Car-
23 ing for our Heroes in the 21st Century Act;

24 “(2) establish priorities, milestones, and
25 timelines, in consultation with the Secretary of Vet-

1 erans Affairs, for the termination of functions of the
2 Veterans Health Administration directly related to
3 the furnishing of hospital care, medical services, and
4 other health care (excluding nursing home care and
5 domiciliary care) pursuant to subsection (c) of such
6 section 101;

7 “(3) with respect to centers of excellence relat-
8 ing to service-connected injuries and other medical
9 issues—

10 “(A) continue to administer such centers
11 previously established by the Secretary; and

12 “(B) establish and administer additional
13 such centers as the Board of Directors deter-
14 mines appropriate.

15 “(4) in consultation with the Secretary, carry
16 out such other actions necessary to carry out this
17 section.

18 “(e) POWERS.—The Corporation shall—

19 “(1) appoint employees; and

20 “(2) adopt a Constitution and bylaws consistent
21 with the purpose set forth under subsection (b).

22 “(f) DUTY TO MAINTAIN CORPORATE AND TAX-EX-
23 EMPT STATUS.—(1) The Corporation shall maintain its
24 status as a corporation incorporated under the laws of the

1 District of Columbia or another nearby State, as deter-
2 mined by the Board of Directors.

3 “(2) The Corporation shall maintain its status as an
4 organization exempt from the Internal Revenue Code of
5 1986.

6 “(g) VETERANS ACCOUNTABLE CARE ORGANIZATION
7 FUND.—(1) There is in the Treasury a fund to be known
8 as the Veterans Accountable Care Organization Fund (in
9 this subsection referred to as the ‘Fund’).

10 “(2) Amounts recovered or collected under chapter 26
11 of this title shall be deposited in the Fund.

12 “(3) Amounts in the Fund shall be available, without
13 further appropriation and without fiscal year limitation,
14 to establish and administer centers of excellence described
15 in subsection (d)(3) and for health care or medical services
16 furnished to a veteran at a facility operated by the Cor-
17 poration.”.

18 (2) CLERICAL AMENDMENT.—The table of sec-
19 tions at the beginning of chapter 3 of such title is
20 amended by inserting after the item relating to sec-
21 tion 322 the following new item:

“323. Veterans Accountable Care Organization.”.

22 (b) TRANSFER OF PERSONNEL AND ASSETS.—

23 (1) TRANSFER.—All of the personnel, property,
24 records, and unexpended balances of appropriations,
25 allocations, and other funds employed, used, held,

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1 available, or to be made available in connection with
2 the direct furnishing of hospital care, medical serv-
3 ices, and other health care (excluding nursing home
4 care and domiciliary care) to individuals eligible for
5 such care and services under laws administered by
6 the Secretary of Veterans Affairs are transferred to
7 the Veterans Accountable Care Organization estab-
8 lished under section 323 of title 38, United States
9 Code, as added by subsection (a).

10 (2) REDUCTION IN FORCE.—The Secretary may
11 implement a reduction in force in carrying out para-
12 graph (1).

13 (c) TERMINATION OF FUNCTIONS.—

14 (1) IN GENERAL.—Except as provided by para-
15 graph (2), all of the functions of the Veterans
16 Health Administration directly relating to the fur-
17 nishing of hospital care, medical services, and other
18 health care (excluding nursing home care and domi-
19 ciliary care) to individuals eligible for such care and
20 services under laws administered by the Secretary
21 shall terminate one year after the date of the enact-
22 ment of this Act.

23 (2) EXTENSIONS.—The Secretary of Veterans
24 Affairs may make not more than two 90-day exten-
25 sions to the termination date specified in paragraph

1 (1) if the Secretary notifies Congress of such exten-
2 sions.

3 (3) CERTIFICATION OF TERMINATION DATE.—

4 The Secretary shall certify to Congress the date on
5 which paragraph (1) is carried out.

6 (d) RECOMMENDATIONS FOR STATUTORY AMEND-
7 MENTS.—Not later than 180 days after the date of the
8 enactment of this Act, the Secretary shall submit to Con-
9 gress a report that contains recommendations for tech-
10 nical and conforming amendments to Federal statutes to
11 carry out this Act.

12 **SEC. 102. ESTABLISHMENT OF VETERANS HEALTH INSUR-**
13 **ANCE PROGRAM.**

14 (a) ESTABLISHMENT.—Chapter 73 of title 38,
15 United States Code, is amended by adding at the end the
16 following new section:

17 **“§ 7309A. Veterans Health Insurance Program**

18 “(a) ESTABLISHMENT.—There is established in the
19 Veterans Health Administration the Veterans Health In-
20 surance Program (in this section referred to as the ‘Pro-
21 gram’).

22 “(b) DUTIES.—Under the Program, the Secretary
23 shall administer the provision of health insurance support
24 to veterans under chapter 26 of this title.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 of such title is amended by inserting after the item relating to section 7309 the following new item:

“7309A. Veterans Health Insurance Program.”.

SEC. 103. DESIGNATION OF EXISTING AUTHORITIES FOR HOSPITAL CARE, MEDICAL SERVICES, AND OTHER HEALTH CARE.

(a) DESIGNATION.—Subchapter I of chapter 17 of title 38, United States Code, is amended by inserting after section 1701 the following new section:

“§ 1701A. VetsCare Federal program: designation of authorities for hospital care, medical services, and other health care as program

“(a) IN GENERAL.—Effective as of the date described in section 101(c)(3) of the Caring for our Heroes in the 21st Century Act, the authorities for the provision of hospital care, medical services, and other health care (other than nursing home care and domiciliary care) in subchapter II of this chapter and under any other law administered by the Secretary may be referred to as the ‘VetsCare Federal program’.

“(b) DESIGNATION OF RECIPIENTS.—Effective as of the date described in section 101(c)(3) of the Caring for our Heroes in the 21st Century Act, any eligible individual

VA-18-0457-A-000047

1 who receives hospital care, medical services, and other
2 health care (excluding nursing home care and domiciliary
3 care) in accordance with the authorities referred to in sub-
4 section (a) after such date may be referred to in the re-
5 ceipt of such care or services as participating in the
6 ‘VetsCare Federal program’.

7 “(c) SECONDARY PAYER.—

8 “(1) IN GENERAL.—Notwithstanding any other
9 provision of law, any health plan (including the
10 Medicare program under title XVIII of the Social
11 Security Act (42 U.S.C. 1395 et seq.) or a State
12 plan under title XIX of such Act (42 U.S.C. 1396
13 et seq.) and the TRICARE program under chapter
14 55 of title 10) under which an eligible individual is
15 covered shall be responsible for the payment of costs
16 for any health care received by an eligible individual
17 for a non-service connected disability up to the max-
18 imum amount allowable under such plan before the
19 VetsCare Federal program is responsible for any
20 such costs, if applicable.

21 “(2) NOTIFICATION.—The Secretary of Health
22 and Human Services, the Secretary of Defense, or
23 any other head of a relevant department or agency
24 of the Federal Government shall notify the Secretary
25 of Veterans Affairs of an eligible individual being

1 covered under a health plan described in paragraph
2 (1).

3 “(d) TREATMENT OF EMPLOYER SPONSORED
4 HEALTH PLANS.—

5 “(1) IN GENERAL.—The provisions of section
6 1862(b)(3)(C) of the Social Security Act (42 U.S.C.
7 1395y(b)(3)(C)) shall apply with respect to financial
8 or other incentives for an employee who is an eligible
9 individual not to enroll (or to terminate enrollment)
10 under a health plan that would (in the case of such
11 enrollment) be responsible under subsection (c) for
12 the payment of costs for hospital care, medical serv-
13 ices, or other health care received by the eligible in-
14 dividual for a non-service connected disability in the
15 same manner as such section 1862(b)(3)(C) applies
16 to financial or other incentives for an individual enti-
17 tled to benefits under title XVIII of the Social Secu-
18 rity Act (42 U.S.C. 1395 et seq.) not to enroll (or
19 to terminate enrollment) under a group health plan
20 or a large group health plan which would (in the
21 case of enrollment) be a primary plan (as defined in
22 section 1862(b)(2)(A) of such Act).

23 “(2) REGULATIONS.—The Secretary may by
24 regulation adopt such additional exceptions to the
25 prohibition described in paragraph (1) as the Sec-

1 retary considers appropriate and such paragraph
2 shall be implemented taking into account the adop-
3 tion of such exceptions.

4 “(3) AGREEMENTS.—The Veterans Accountable
5 Care Organization and the Secretary of Health and
6 Human Services may enter into agreements to carry
7 out this subsection. Any such agreement shall pro-
8 vide that any expenses incurred by the Secretary of
9 Health and Human Services pertaining to carrying
10 out this subsection shall be reimbursed by the Vet-
11 erans Accountable Care Organization.

12 “(4) GROUP HEALTH PLAN DEFINED.—In this
13 subsection, the term ‘group health plan’ means a
14 group health plan (as that term is defined in section
15 5000(b)(1) of the Internal Revenue Code of 1986
16 without regard to section 5000(d) of the Internal
17 Revenue Code of 1986).

18 “(e) ELIGIBLE INDIVIDUALS.—An individual is eligi-
19 ble to participate in the VetsCare Federal program if such
20 individual was enrolled in the system of annual patient
21 enrollment established and operated by the Secretary
22 under section 1705(a) of this title as of the date described
23 in section 101(c)(3) of the Caring for our Heroes in the
24 21st Century Act.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1701 the following new item:

“1701A. VetsCare Federal program: designation of authorities for hospital care, medical services, and other health care as program.”.

SEC. 104. HEALTH INSURANCE SUPPORT FOR NEW VETERANS AND VETERANS ELECTING HEALTH INSURANCE SUPPORT IN LIEU OF ELIGIBILITY FOR HOSPITAL CARE, MEDICAL SERVICES, AND OTHER HEALTH CARE UNDER EXISTING AUTHORITIES.

(a) IN GENERAL.—Part II of title 38, United States Code, is amended by inserting after chapter 24 the following new chapter:

“CHAPTER 26—VETERANS INDEPENDENCE IN HEALTH CARE

“SUBCHAPTER I—VETERANS GENERALLY

- “2601. VetsCare Choice program: designation of recipients.
- “2602. Eligibility.
- “2603. Qualifying health insurance.
- “2604. Health insurance support.
- “2605. Treatment of other health plans.
- “2606. Receipt of health care through the Department.
- “2607. Pharmacy benefits.

“SUBCHAPTER II—MEDICARE-ELIGIBLE VETERANS

- “2611. VetsCare Senior program: designation of recipients.
- “2612. Medicare support.

1 **“Subchapter I—Veterans Generally**

2 **“§ 2601. VetsCare Choice program: designation of re-**
3 **ciipients**

4 “(a) IN GENERAL.—The authorities for the provision
5 of health insurance support under this subchapter may be
6 referred to as the ‘VetsCare Choice program’.

7 “(b) DESIGNATION OF RECIPIENTS.—Any veteran
8 who receives health insurance support under this sub-
9 chapter may be referred to in the receipt of support as
10 participating in the ‘VetsCare Choice program’.

11 “(c) RELATIONSHIP TO CARE BY VETERANS AC-
12 COUNTABLE CARE ORGANIZATION.—Health insurance
13 support under this subchapter is in addition to any health
14 care or medical services furnished to a veteran at a facility
15 operated by the Veterans Accountable Care Organization.

16 **“§ 2602. Eligibility**

17 “(a) IN GENERAL.—Except as provided in sub-
18 sections (c) and (d), the following veterans shall be pro-
19 vided health insurance support under this subchapter:

20 “(1) Veterans who first enroll in the system of
21 annual patient enrollment established and operated
22 by the Secretary under section 1705(a) of this title
23 on or after the date described in section 101(c)(3)
24 of the Caring for our Heroes in the 21st Century
25 Act.

1 “(2) Veterans enrolled in such system as of the
2 date described in section 101(c)(3) of the Caring for
3 our Heroes in the 21st Century Act who elect health
4 insurance support under this subchapter in lieu of
5 eligibility for hospital care, medical services, and
6 other health care (excluding nursing home care and
7 domiciliary care) under the VetsCare Federal pro-
8 gram under chapter 17 of this title or any other law
9 administered by the Secretary.

10 “(b) ENROLLMENT.—The Secretary shall admin-
11 ister—

12 “(1) an open enrollment period for the
13 VetsCare Choice program that corresponds to the
14 open enrollment period for the Federal Employees
15 Health Benefits program described in section
16 8905(g); and

17 “(2) special enrollment periods based on quali-
18 fying life events of veterans similar to such events
19 under the Federal Employees Health Benefits Pro-
20 gram, except that the change of priority group shall
21 also be treated as a qualifying life event.

22 “(c) EFFECT OF ELECTION.—While an election
23 under subsection (a)(2) of a veteran described in that sub-
24 section is in effect, the veteran is not eligible for hospital
25 care, medical services, and other health care (excluding

1 nursing home care and domiciliary care) under chapter 17
2 of this title or any other law administered by the Sec-
3 retary.

4 “(d) EXCEPTIONS.—The following veterans are not
5 eligible for health insurance support under this sub-
6 chapter:

7 “(1) Any veteran eligible for care under the
8 Medicare program under title XVIII of the Social
9 Security Act (42 U.S.C. 1395 et seq.).

10 “(2) Any veteran who—

11 “(A) first enrolls in the system of annual
12 patient enrollment established and operated by
13 the Secretary under section 1705(a) of this title
14 on or after the date described in section
15 101(c)(3) of the Caring for our Heroes in the
16 21st Century Act.; and

17 “(B) is in priority group 7 or priority
18 group 8.

19 “(e) COMMENCEMENT OF AVAILABILITY OF SUP-
20 PORT.—Health insurance support under this subchapter
21 shall commence being available as follows:

22 “(1) With respect to veterans in priority group
23 1, 2, or 3, on the first day of the first month that
24 begins on or after the date described in section

1 101(c)(3) of the Caring for our Heroes in the 21st
2 Century Act.

3 “(2) With respect to veterans in a priority
4 group other than 1, 2, or 3, on the first day of the
5 first month that begins on or after the date that is
6 180 days after the commencement date under para-
7 graph (1).

8 “(f) PRIORITY GROUP DEFINED.—In this section,
9 the term ‘priority group’ means the priority groups estab-
10 lished by the Secretary for purposes of the enrollment of
11 veterans in the patient enrollment system under section
12 1705(a) of this title.

13 **“§ 2603. Qualifying health insurance**

14 “Health insurance support may be provided under
15 this subchapter only for health plans that—

16 “(1) include the types of health care authorized
17 under section 1079 of title 10, United States Code;
18 and

19 “(2) provide such additional elements of cov-
20 erage as the Secretary shall prescribe for purposes
21 of this subchapter.

22 **“§ 2604. Health insurance support**

23 “(a) IN GENERAL.—The Secretary shall provide
24 health insurance support to veterans eligible for such sup-
25 port under this subchapter through premium support

1 under subsections (b) and (c), cost-sharing support under
2 subsection (d), and alternative support under subsection
3 (e) by paying or reimbursing such veterans for the costs
4 associated with such health insurance support. The Sec-
5 retary shall make such payments or reimbursements in a
6 manner similar to the manner in which the Centers for
7 Medicare & Medicaid Services make similar payments and
8 reimbursements.

9 “(b) PREMIUM SUPPORT GENERALLY.—The pre-
10 mium support provided by the Secretary under this sub-
11 section is as follows:

12 “(1) TIER 1.—To any veteran with a service-
13 connected disability rated as 100 percent disabling,
14 health insurance support sufficient to provide bene-
15 fits to the veteran under a health plan that are actu-
16 arially equivalent to 100 percent of the full actuarial
17 value of the benefits provided under the health plan.
18 A health plan under this paragraph may be referred
19 to as a ‘Tier 1 Plan’.

20 “(2) TIER 2.—To any veteran in priority group
21 1 not covered by paragraph (1) and any veteran in
22 priority group 2, health insurance support sufficient
23 to provide benefits to the veteran under a health
24 plan that are actuarially equivalent to 90 percent of
25 the full actuarial value of the benefits provided

1 under the health plan. A health plan under this
2 paragraph may be referred to as a ‘Tier 2 Plan’.

3 “(3) TIER 3.—To any veteran in priority group
4 3 or priority group 4, health insurance support suffi-
5 cient to provide benefits to the veteran under a
6 health plan that are actuarially equivalent to 80 per-
7 cent of the full actuarial value of the benefits pro-
8 vided under the health plan. A health plan under
9 this paragraph may be referred to as a ‘Tier 3
10 Plan’.

11 “(4) TIER 4.—To any veteran in priority group
12 5 or priority group 6, health insurance support suffi-
13 cient to provide benefits to the veteran under a
14 health plan that are actuarially equivalent to 70 per-
15 cent of the full actuarial value of the benefits pro-
16 vided under the health plan. A health plan under
17 this paragraph may be referred to as a ‘Tier 4
18 Plan’.

19 “(5) TIER 5.—To any veteran not in a priority
20 group covered by paragraphs (1) through (4) and
21 not ineligible for such support under section
22 2602(d)(2) of this title, health insurance support
23 sufficient to provide benefits to the veteran under a
24 health plan that are actuarially equivalent to 60 per-
25 cent of the full actuarial value of the benefits pro-

1 vided under the health plan. A health plan under
2 this paragraph may be referred to as a ‘Tier 5
3 Plan’.

4 “(c) ADDITIONAL PREMIUM SUPPORT BASED ON
5 NEED.—The premium support provided by the Secretary
6 under this subsection is as follows:

7 “(1) To any veteran with an annual gross
8 household income that is less than 133 percent of
9 the poverty line, health insurance support sufficient
10 to cover any costs of such monthly premium that are
11 more than 2 percent of the monthly gross household
12 income of the veteran.

13 “(2) To any veteran with an annual gross
14 household income that is between 133 percent and
15 150 percent of the poverty line, health insurance
16 support sufficient to cover any costs of such monthly
17 premium that are more than 3 percent of the
18 monthly gross household income of the veteran.

19 “(3) To any veteran with an annual gross
20 household income that is between 150 percent and
21 200 percent of the poverty line, health insurance
22 support sufficient to cover any costs of such monthly
23 premium that are more than 4 percent of the
24 monthly gross household income of the veteran.

1 “(4) To any veteran with an annual gross
2 household income that is between 200 percent and
3 250 percent of the poverty line, health insurance
4 support sufficient to cover any costs of such monthly
5 premium that are more than 6.3 percent of the
6 monthly gross household income of the veteran.

7 “(5) To any veteran with an annual gross
8 household income that is between 250 percent and
9 300 percent of the poverty line, health insurance
10 support sufficient to cover any costs of such monthly
11 premium that are more than 8.05 percent of the
12 monthly gross household income of the veteran.

13 “(6) To any veteran with an annual gross
14 household income that is between 300 percent and
15 400 percent of the poverty line, health insurance
16 support sufficient to cover any costs of such monthly
17 premium that are more than 9.5 percent of the
18 monthly gross household income of the veteran.

19 “(d) COST-SHARING SUPPORT.—The cost-sharing
20 support provided by the Secretary under this subsection
21 is as follows:

22 “(1) To any veteran with an annual gross
23 household income that is less than 150 percent of
24 the poverty line, health insurance support sufficient
25 to cover cost-sharing in order to ensure that the ef-

1 fective minimum actuarial value of the benefits pro-
2 vided under the health plan of the veteran is not less
3 than 94 percent.

4 “(2) To any veteran with an annual gross
5 household income that is between 150 percent and
6 200 percent of the poverty line, health insurance
7 support sufficient to cover cost-sharing in order to
8 ensure that the effective minimum actuarial value of
9 the benefits provided under the health plan of the
10 veteran is not less than 87 percent.

11 “(3) To any veteran with an annual gross
12 household income that is between 200 percent and
13 250 percent of the poverty line, health insurance
14 support sufficient to cover cost-sharing in order to
15 ensure that the effective minimum actuarial value of
16 the benefits provided under the health plan of the
17 veteran is not less than 73 percent.

18 “(e) ALTERNATIVE SUPPORT FOR VETERANS WITH
19 CERTAIN HEALTH INSURANCE.—

20 “(1) IN GENERAL.—Notwithstanding any other
21 provision of this section, upon the election of a vet-
22 eran eligible for health insurance support under this
23 subchapter who obtains a high deductible health
24 plan that includes a health savings account under
25 section 223 of the Internal Revenue Code of 1986,

1 the Secretary shall contribute an amount calculated
2 under paragraph (2) into such health savings ac-
3 count on behalf of the veteran.

4 “(2) AMOUNT CALCULATED.—The amount cal-
5 culated under this paragraph is an amount equal to
6 the difference between—

7 “(A) the amount of health insurance sup-
8 port the veteran would otherwise have received
9 under the subsection of this section applicable
10 to the veteran; and

11 “(B) the amount payable by the veteran in
12 connection with the high deductible health plan
13 described in paragraph (1).

14 “(f) DETERMINATIONS BASED ON COST OF
15 PLANS.—In making determinations under this section
16 with respect to the amount of health insurance support
17 to provide to a veteran, the Secretary shall make such de-
18 terminations based on the costs associated with the sec-
19 ond-least-costly health plan available to the veteran in the
20 area in which the veteran resides.

21 “(g) DEFINITIONS.—In this section:

22 “(1) The term ‘cost-sharing’, in connection with
23 the receipt of health care and treatment under a
24 health plan, means any copayments, deductibles, or
25 other charges imposed, collected, or otherwise re-

1 quired by a health insurance provider or health care
2 provider in connection with the receipt of health care
3 and treatment under such health plan.

4 “(2) The term ‘poverty line’ means the poverty
5 line (as defined in section 673(2) of the Community
6 Services Block Grant Act (42 U.S.C. 9902(2)) appli-
7 cable to a family of the size involved.

8 “(3) The term ‘high deductible health plan’ has
9 the meaning given that term in section 223(c)(2) of
10 the Internal Revenue Code of 1986.

11 “(4) The term ‘priority group’ means the pri-
12 ority groups established by the Secretary for pur-
13 poses of the enrollment of veterans in the patient en-
14 rollment system under section 1705(a) of this title.

15 **“§ 2605. Treatment of other health plans**

16 “(a) SECONDARY PAYER.—

17 “(1) IN GENERAL.—Notwithstanding any other
18 provision of law, any health plan (including a State
19 plan under title XIX of the Social Security Act (42
20 U.S.C. 1396 et seq.) and the TRICARE program
21 under chapter 55 of title 10) under which a veteran
22 is covered that is not a health plan for which health
23 insurance support is provided under this subchapter
24 shall be responsible for the payment of costs for any
25 health care received by an eligible individual for a

1 non-service connected disability up to the maximum
2 amount allowable under such plan before any health
3 plan for which health insurance support is provided
4 under this subchapter is responsible for any such
5 costs, if applicable.

6 “(2) NOTIFICATION.—The Secretary of Health
7 and Human Services, the Secretary of Defense, or
8 any other head of a relevant department or agency
9 of the Federal Government shall notify the Secretary
10 of Veterans Affairs of an eligible individual being
11 covered under a health plan described in paragraph

12 (1).

13 “(b) TREATMENT OF EMPLOYER SPONSORED
14 HEALTH PLANS.—

15 “(1) IN GENERAL.—The provisions of section
16 1862(b)(3)(C) of the Social Security Act (42 U.S.C.
17 1395y(b)(3)(C)) shall apply with respect to financial
18 or other incentives for an employee who is a veteran
19 not to enroll (or to terminate enrollment) under a
20 health plan that is not a health plan for which
21 health insurance support is provided under this sub-
22 chapter and that would (in the case of such enroll-
23 ment) be responsible under subsection (a) for the
24 payment of costs for health care received by the vet-
25 eran in the same manner as such section

1 1862(b)(3)(C) applies to financial or other incentives
2 for an individual entitled to benefits under title
3 XVIII of the Social Security Act (42 U.S.C. 1395 et
4 seq.) not to enroll (or to terminate enrollment)
5 under a group health plan or a large group health
6 plan which would (in the case of enrollment) be a
7 primary plan (as defined in section 1862(b)(2)(A) of
8 such Act).

9 “(2) REGULATIONS.—The Secretary may by
10 regulation adopt such additional exceptions to the
11 prohibition described in paragraph (1) as the Sec-
12 retary considers appropriate and such paragraph
13 shall be implemented taking into account the adop-
14 tion of such exceptions.

15 “(3) AGREEMENTS.—The Secretary of Veterans
16 Affairs and the Secretary of Health and Human
17 Services may enter into agreements to carry out this
18 subsection. Any such agreement shall provide that
19 any expenses incurred by the Secretary of Health
20 and Human Services pertaining to carrying out this
21 subsection shall be reimbursed by the Secretary of
22 Veterans Affairs.

23 “(4) GROUP HEALTH PLAN DEFINED.—In this
24 subsection, the term ‘group health plan’ means a
25 group health plan (as that term is defined in section

1 5000(b)(1) of the Internal Revenue Code of 1986
2 without regard to section 5000(d) of the Internal
3 Revenue Code of 1986).

4 **“§ 2606. Receipt of health care through the Depart-**
5 **ment**

6 “(a) CONTRACTS.—Any health insurance provider
7 that provides a health plan for which health insurance
8 support may be provided under this subchapter or sub-
9 chapter II may enter into a contract with the Veterans
10 Accountable Care Organization under which the medical
11 personnel and facilities of the Veterans Accountable Care
12 Organization may be treated as a designated provider for
13 purposes of such health plan.

14 “(b) COST OF CARE.—The cost, including any copay-
15 ments, of any health care or treatment provided to a vet-
16 eran by the Veterans Accountable Care Organization
17 under a contract under subsection (a) shall be determined
18 by the Veterans Accountable Care Organization.

19 “(c) MECHANISM.—The Board of Directors of the
20 Veterans Accountable Care Organization shall establish a
21 mechanism through which the Veterans Accountable Care
22 Organization enters into contracts with health insurance
23 providers under subsection (a).

1 **“§ 2607. Pharmacy benefits**

2 “A veteran who is enrolled in the VetsCare Choice
3 program or the VetsCare Senior program may fill pre-
4 scriptions at pharmacies of the Department.

5 “SUBCHAPTER II—MEDICARE-ELIGIBLE
6 VETERANS

7 **“§ 2611. VetsCare Senior program: designation of re-
8 cipients**

9 “(a) IN GENERAL.—The authorities for the provision
10 of health insurance support under this subchapter may be
11 referred to as the ‘VetsCare Senior program’.

12 “(b) DESIGNATION OF RECIPIENTS.—Any veteran
13 who receives health insurance support under this sub-
14 chapter may be referred to in the receipt of support as
15 participating in the ‘VetsCare Senior program’.

16 “(c) RELATIONSHIP TO CARE BY VETERANS AC-
17 COUNTABLE CARE ORGANIZATION.—Health insurance
18 support under this subchapter is in addition to any health
19 care or medical services furnished to a veteran at a facility
20 operated by the Veterans Accountable Care Organization.

21 **“§ 2612. Medicare support**

22 “(a) IN GENERAL.—The Secretary shall provide
23 health insurance support to each covered veteran equal to
24 the costs incurred by such veteran for Medicare premiums
25 and cost-sharing under parts A, B, C, and D of title XVIII
26 of the Social Security Act (42 U.S.C. 1395 et seq.) and

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1 for premiums and cost-sharing for medicare supplemental
2 policies under section 1882 of such Act (42 U.S.C.
3 1395ss).

4 “(b) RELATIONSHIP WITH VETSCARE FEDERAL.—
5 Notwithstanding any other provision of law, if a covered
6 veteran is enrolled in the VetsCare Federal program under
7 section 1701A of this title, the Medicare program under
8 title XVIII of the Social Security Act (42 U.S.C. 1395
9 et seq.) (or a medicare supplemental policy under section
10 1882 of such Act (42 U.S.C. 1395ss)) shall be responsible
11 for the payment of costs for any health care received by
12 an eligible individual for a non-service connected disability
13 up to the maximum amount allowable under such program
14 (or supplemental policy) for such health care before the
15 VetsCare Federal program is responsible for any such
16 costs, if applicable.

17 “(c) AVAILABILITY OF PAYMENT OR REIMBURSE-
18 MENT.—

19 “(1) COMMENCEMENT.—Health insurance sup-
20 port under this subchapter shall commence being
21 available as follows:

22 “(A) With respect to covered veterans in
23 priority group 1, 2, or 3, on the first day of the
24 first month that begins on or after the date de-

1 scribed in section 101(c)(3) of the Caring for
2 our Heroes in the 21st Century Act.

3 “(B) With respect to covered veterans in a
4 priority group other than 1, 2, or 3, on the first
5 day of the first month that begins on or after
6 the date that is 180 days after the commence-
7 ment date under paragraph (1).

8 “(2) EXCLUSION OF CERTAIN VETERANS.—A
9 covered veteran is not eligible for health insurance
10 support under this section if such veteran—

11 “(A) first enrolls in the system of annual
12 patient enrollment established and operated by
13 the Secretary under section 1705(a) of this title
14 on or after the date of the enactment of this
15 Act; and

16 “(B) is in priority group 7 or 8.

17 “(d) DEFINITIONS.—In this section:

18 “(1) The term ‘cost-sharing’, in connection with
19 the receipt of health care and treatment under the
20 Medicare program under title XVIII of the Social
21 Security Act (42 U.S.C. 1395 et seq.) or medicare
22 supplemental policies under section 1882 of such Act
23 (42 U.S.C. 1395ss), means any copayments,
24 deductibles, or other charges imposed, collected, or
25 otherwise required by a health insurance provider or

1 health care provider in connection with receipt of
 2 health care and treatment under such program or
 3 supplemental policies.

4 “(2) The term ‘covered veteran’ means a vet-
 5 eran receiving benefits under the Medicare program
 6 under title XVIII of the Social Security Act.

7 “(3) The term ‘priority group’ means the pri-
 8 ority groups established by the Secretary for pur-
 9 poses of the enrollment of veterans in the patient en-
 10 rollment system under section 1705(a) of this title.”.

11 (b) CLERICAL AMENDMENT.—The table of chapters
 12 at the beginning title 38, United States Code, is amended
 13 by inserting after the item relating to chapter 24 the fol-
 14 lowing new item:

“Chapter 26 .Veterans Independence in Health Care 2601”.

15 (c) CONFORMING AMENDMENTS.—

16 (1) MINIMUM ESSENTIAL COVERAGE.—Section
 17 5000A(f)(1)(A)(v) of the Internal Revenue Code of
 18 1986 is amended by striking “or 18” and inserting
 19 “, 18, or 26”.

20 (2) MEDICARE PART B.—

21 (A) NON-APPLICATION OF LATE ENROLL-
 22 MENT PENALTY.—Section 1839(b) of the Social
 23 Security Act (42 U.S.C. 1395r(b)) is amended,
 24 in the second sentence, by inserting “or months
 25 for which the individual can demonstrate that

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1 the individual was enrolled in the VetsCare Sen-
2 ior program under subchapter II of chapter 26
3 of title 38, United States Code” after “an indi-
4 vidual described in section 1837(k)(3)”.

5 (B) SPECIAL ENROLLMENT PERIOD.—Sec-
6 tion 1837 of the Social Security Act (42 U.S.C.
7 1395p) is amended by adding at the end the
8 following new subsection:

9 “(m)(1) In the case of any individual who is enrolled
10 in the VetsCare Senior program under subchapter II of
11 chapter 26 of title 38, United States Code at the time
12 the individual is entitled to part A under section 226 or
13 section 226A and who is eligible to enroll but who has
14 elected not to enroll (or to be deemed enrolled) during the
15 individual’s initial enrollment period, there shall be a spe-
16 cial enrollment period as specified by the Secretary.

17 “(2) In the case of an individual who enrolls during
18 the special enrollment period provided under paragraph
19 (1), the coverage period under this part shall begin on
20 such date specified by the Secretary.

21 “(3) An individual may only enroll during the special
22 enrollment period provided under paragraph (1) one time
23 during the individual’s lifetime.

24 “(4) The Secretary of Veterans Affairs shall collabo-
25 rate with the Secretary of Health and Human Services

1 and the Commissioner of Social Security to provide for
 2 the accurate identification of individuals described in para-
 3 graph (1). The Secretary of Veterans Affairs shall provide
 4 such individuals with notification with respect to this sub-
 5 section. The Secretary of Veterans Affairs shall collabo-
 6 rate with the Secretary of Health and Human Services
 7 and the Commissioner of Social Security to ensure appro-
 8 priate follow up pursuant to any notification provided
 9 under the preceding sentence.”.

10 **SEC. 105. COORDINATION BETWEEN VETSCARE CHOICE**

11 **PROGRAM AND ELIGIBILITY TO MAKE CON-**

12 **TRIBUTIONS TO HEALTH SAVINGS AC-**
 13 **COUNTS.**

14 (a) IN GENERAL.—Section 223(c)(1)(B) of the Inter-
 15 nal Revenue Code of 1986 is amended by striking “and”
 16 at the end of clause (ii), by striking the period at the end
 17 of clause (iii) and inserting “, and”, and by adding at the
 18 end the following new clause:

19 “(iv) coverage for health insurance
 20 support under the VetsCare Choice pro-
 21 gram under subchapter I of chapter 26 of
 22 title 38, United States Code.”.

23 (b) DENIAL OF DEDUCTION FOR AMOUNTS NOT IN-
 24 CLUDIBLE IN GROSS INCOME.—Subsection (b) of section

1 223 of the Internal Revenue Code of 1986 is amended by
2 adding at the end the following new paragraph:

3 “(9) AMOUNTS NOT INCLUDIBLE IN GROSS IN-
4 COME.—No amount paid to a health savings account
5 of an individual shall be taken into account under
6 subsection (a) if (without regard to this section)
7 such amount, when paid to or on behalf of such indi-
8 vidual, is excluded from gross income of the indi-
9 vidual or exempt from taxation under any provision
10 of Federal law.”.

11 (c) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to amounts paid to a health sav-
13 ings account (as defined in section 223(d) of the Internal
14 Revenue Code of 1986) after the date of the enactment
15 of this Act.

16 **SEC. 106. PUBLICATION OF HEALTH CARE INFORMATION.**

17 (a) IN GENERAL.—The Secretary of Veterans Affairs
18 shall make available to the public on an ongoing basis in-
19 formation about the operations of the Veterans Health Ad-
20 ministration in a manner similar to publication of infor-
21 mation under the Medicare Accountable Care Organiza-
22 tion program to better monitor and support continuous
23 improvement in the Veterans Health Administration.

24 (b) ELEMENTS.—The information published under
25 subsection (a) shall include information about the oper-

1 ations of the Veterans Health Administration, including
2 metrics regarding quality, safety, patient experience, time-
3 liness, and cost-effectiveness.

4 **TITLE II—REALIGNMENT OF**
5 **MEDICAL CENTERS OF DE-**
6 **PARTMENT OF VETERANS AF-**
7 **FAIRS**

8 **SEC. 201. REALIGNMENT OF MEDICAL CENTERS.**

9 (a) REALIGNMENT.—

10 (1) IN GENERAL.—Except as provided in sub-
11 section (b), the Veterans Accountable Care Organi-
12 zation shall—

13 (A) close all medical centers recommended
14 for closure by the VetsCare Advisory Commis-
15 sion in each report submitted under section
16 301(b)(2); and

17 (B) realign all medical centers rec-
18 ommended for realignment by the Commission
19 in each such report.

20 (2) MAINTENANCE OF HEALTH CARE SERV-
21 ICES.—In carrying out paragraph (1), the Veterans
22 Accountable Care Organization shall ensure that the
23 availability of health care services for veterans in the
24 area in which a medical center is closed or realigned

1 under paragraph (1) is not decreased as a result of
2 such closure or realignment.

3 (b) CONGRESSIONAL DISAPPROVAL.—

4 (1) IN GENERAL.—The Veterans Accountable
5 Care Organization may not carry out any closure or
6 realignment recommended by the Commission in a
7 report submitted under section 301(b)(2) if a resolu-
8 tion of disapproval is enacted before the earlier of—

9 (A) the end of the 45-day period beginning
10 on the date on which the report is submitted;
11 or

12 (B) the adjournment of Congress sine die
13 for the session during which such report is sub-
14 mitted.

15 (2) CALCULATION OF DAYS.—For purposes of
16 paragraph (1) of this subsection and subsections (a)
17 and (c) of section 202, the days on which either
18 House of Congress is not in session because of an
19 adjournment of more than three days to a day cer-
20 tain shall be excluded in the computation of a pe-
21 riod.

22 (c) RESOLUTION OF DISAPPROVAL DEFINED.—In
23 this section, the term “resolution of disapproval” means
24 a resolution of disapproval under section 202.

1 **SEC. 202. CONGRESSIONAL CONSIDERATION OF COMMIS-**
2 **SION REPORT.**

3 (a) RESOLUTION OF DISAPPROVAL.—For purposes of
4 section 201 and this section, the term “resolution of dis-
5 approval” means only a joint resolution—

6 (1) that is introduced during the 10-day period
7 beginning on the date on which Congress receives
8 the report under section 301(b)(2);

9 (2) that does not have a preamble;

10 (3) the sole matter after the resolving clause of
11 which is as follows: “That Congress disapproves the
12 recommendations of the VetsCare Advisory Commis-
13 sion as submitted to Congress on _____”, with
14 the blank space being filled in with the date on
15 which the report was transmitted to Congress; and

16 (4) the title of which is as follows: “Joint reso-
17 lution disapproving the recommendations of the
18 VetsCare Advisory Commission.”.

19 (b) REFERRAL.—

20 (1) IN THE SENATE.—A resolution of dis-
21 approval introduced in the Senate shall be referred
22 to the Committee on Veterans’ Affairs of the Senate.

23 (2) IN THE HOUSE OF REPRESENTATIVES.—A
24 resolution of disapproval that is introduced in the
25 House of Representatives shall be referred to the

1 Committee on Veterans' Affairs of the House of
2 Representatives.

3 (c) DISCHARGE.—If the committee to which a resolu-
4 tion of disapproval is referred has not reported such reso-
5 lution (or an identical resolution) by the end of the 20-
6 day period beginning on the date on which the Congress
7 receives the report under section 301(b)(2), such com-
8 mittee shall be, at the end of such period, discharged from
9 further consideration of such resolution, and such resolu-
10 tion shall be placed on the appropriate calendar of the
11 House involved.

12 (d) CONSIDERATION.—

13 (1) MOTION TO PROCEED.—On or after the
14 third day after the date on which the committee to
15 which a resolution of disapproval is referred has re-
16 ported, or has been discharged (under subsection
17 (c)) from further consideration of, such a resolution,
18 it is in order (even though a previous motion to the
19 same effect has been disagreed to) for any Member
20 of the respective House to move to proceed to the
21 consideration of the resolution. A Member may make
22 such a motion only on the day after the calendar day
23 on which the Member announces to the House con-
24 cerned the Member's intention to make the motion,
25 except that, in the case of the House of Representa-

1 tives, the motion may be made without such prior
2 announcement if the motion is made by direction of
3 the committee to which the resolution was referred.
4 All points of order against the resolution of dis-
5 approval (and against consideration of the resolu-
6 tion) are waived. The motion is highly privileged in
7 the House of Representatives and is privileged in the
8 Senate and is not debatable. The motion is not sub-
9 ject to amendment, or to a motion to postpone, or
10 to a motion to proceed to the consideration of other
11 business. A motion to reconsider the vote by which
12 the motion is agreed to or disagreed to shall not be
13 in order. If a motion to proceed to the consideration
14 of the resolution of disapproval is agreed to, the re-
15 spective House shall immediately proceed to consid-
16 eration of the resolution of disapproval without in-
17 tervening motion, order, or other business, and the
18 resolution of disapproval shall remain the unfinished
19 business of the respective House until disposed of.

20 (2) FURTHER CONSIDERATION.—Debate on the
21 resolution of disapproval, and on all debatable mo-
22 tions and appeals in connection therewith, shall be
23 limited to not more than two hours, which shall be
24 divided equally between those favoring and those op-
25 posing the resolution of disapproval. An amendment

1 to the resolution of disapproval is not in order. A
2 motion further to limit debate is in order and not
3 debatable. A motion to postpone, or a motion to pro-
4 ceed to the consideration of other business, or a mo-
5 tion to recommit the resolution of disapproval is not
6 in order. A motion to reconsider the vote by which
7 the resolution of disapproval is agreed to or dis-
8 agreed to is not in order.

9 (3) FINAL PASSAGE.—Immediately following
10 the conclusion of the debate on the resolution of dis-
11 approval and a single quorum call at the conclusion
12 of the debate if requested in accordance with the
13 rules of the appropriate House, the vote on final
14 passage of the resolution of disapproval shall occur.

15 (4) APPEALS.—Appeals from the decisions of
16 the Chair relating to the application of the rules of
17 the Senate or the House of Representatives, as the
18 case may be, to the procedure relating to a resolu-
19 tion of disapproval shall be decided without debate.

20 (e) CONSIDERATION BY OTHER HOUSE.—

21 (1) IN GENERAL.—If, before the passage by one
22 House of a resolution of disapproval of that House,
23 that House receives from the other House a resolu-
24 tion of disapproval, the following procedures shall
25 apply:

1 (A) The resolution of disapproval of the
2 other House shall not be referred to a com-
3 mittee and may not be considered in the House
4 receiving it except in the case of final passage
5 as provided in subparagraph (B)(ii).

6 (B) With respect to a resolution of dis-
7 approval of the House receiving the resolu-
8 tion—

9 (i) the procedure in that House shall
10 be the same as if no resolution of dis-
11 approval had been received from the other
12 House; but

13 (ii) the vote on final passage shall be
14 on the resolution of disapproval of the
15 other House.

16 (2) DISPOSITION OF RESOLUTION.—Upon dis-
17 position of the resolution of disapproval received
18 from the other House, it shall no longer be in order
19 to consider the resolution that originated in the re-
20 ceiving House.

21 (f) RULES OF THE SENATE AND HOUSE.—This sec-
22 tion is enacted by Congress—

23 (1) as an exercise of the rulemaking power of
24 the Senate and the House of Representatives, re-
25 spectively, and as such it is deemed a part of the

1 rules of each House, respectively, but applicable only
2 with respect to the procedure to be followed in that
3 House in the case of a resolution of disapproval, and
4 it supersedes other rules only to the extent that it
5 is inconsistent with such rules; and

6 (2) with full recognition of the constitutional
7 right of either House to change the rules (so far as
8 relating to the procedure of that House) at any time,
9 in the same manner, and to the same extent as in
10 the case of any other rule of that House.

11 **TITLE III—IMPLEMENTATION OF** 12 **HEALTH CARE REFORMS**

13 **SEC. 301. VETSCARE ADVISORY COMMISSION.**

14 (a) ESTABLISHMENT OF COMMISSION.—There is es-
15 tablished a permanent independent commission to be
16 known as the “VetsCare Advisory Commission” (in this
17 section referred to as the “Commission”).

18 (b) DUTIES.—

19 (1) POLICIES ON ACCESS TO AND QUALITY OF
20 CARE.—The Commission shall—

21 (A) review the policies of the Veterans Ac-
22 countable Care Organization and the Veterans
23 Health Insurance Program that affect the ac-
24 cess of veterans to health care and the quality
25 of the health care, including with respect to the

1 VetsCare Federal program, the VetsCare
2 Choice program, and the VetsCare Senior pro-
3 gram; and

4 (B) make recommendations to Congress
5 concerning such access and quality policies, in-
6 cluding by identifying cost savings required to
7 offset such recommendations.

8 (2) REALIGNMENT OF MEDICAL CENTERS.—

9 (A) IN GENERAL.—The Commission shall
10 determine the medical centers of the Veterans
11 Accountable Care Organization for which clo-
12 sure or realignment would be feasible and ad-
13 visable.

14 (B) RECOMMENDATIONS.—Not later than
15 180 days after the date of the enactment of the
16 Act, the Commission shall submit to the Presi-
17 dent, the Secretary of Veterans Affairs, and the
18 appropriate congressional committees, such rec-
19 ommendations for closure and realignment of
20 medical centers described in subparagraph (A)
21 as the Commission considers appropriate.

22 (C) MAINTENANCE OF HEALTH CARE
23 SERVICES.—In carrying out the duties of the
24 Commission under this paragraph, the Commis-
25 sion shall ensure that the availability of health

1 care services for veterans in areas in which clo-
2 sure or realignment is recommended under sub-
3 paragraph (B) is not decreased as a result of
4 any such closure or realignment.

5 (c) REPORTS.—

6 (1) ANNUAL REPORTS ON POLICIES.—Not later
7 than March 1, 2018, and each year thereafter, the
8 Commission shall submit to the President, the Sec-
9 retary of Veterans Affairs, and the appropriate con-
10 gressional committees a report on the policies re-
11 viewed under subparagraph (A) of subsection (b)(1),
12 including any recommendations regarding such poli-
13 cies pursuant to subparagraph (B) of such sub-
14 section.

15 (2) ANNUAL REPORTS ON ISSUES.—Not later
16 than June 1, 2018, and each year thereafter, the
17 Commission shall submit to the President, the Sec-
18 retary of Veterans Affairs, and the appropriate con-
19 gressional committees a report containing an exam-
20 ination of issues affecting the health care programs
21 for veterans under title 38, United States Code, in-
22 cluding implications of changes in health care deliv-
23 ery in the United States and in the market for
24 health care services under such programs.

1 (3) REPORT ON IMPLEMENTATION.—Not later
2 than 90 days after the date described in section
3 101(c)(3), the Commission shall submit to the Presi-
4 dent, the Secretary of Veterans Affairs, and the ap-
5 propriate congressional committees a report on the
6 implementation by the Secretary of this Act and the
7 amendments made by this Act.

8 (4) COMMENTS ON CERTAIN SECRETARIAL RE-
9 PORTS.—If the Secretary of Veterans Affairs sub-
10 mits to Congress (or a committee of Congress) a re-
11 port that is required by law and that relates to the
12 provision of health care to veterans pursuant to title
13 38, United States Code, the Secretary shall transmit
14 a copy of the report to the Commission. The Com-
15 mission shall review the report and, not later than
16 six months after the date of the submittal of the
17 Secretary's report to Congress, shall submit to the
18 appropriate congressional committees written com-
19 ments on such report. Such comments may include
20 such recommendations as the Commission deter-
21 mines appropriate.

22 (5) AGENDA AND ADDITIONAL REVIEWS.—The
23 Commission shall consult periodically with the chair-
24 men and ranking minority members of the appro-
25 priate congressional committees regarding the agen-

1 da of the Commission and progress towards achiev-
2 ing the agenda. The Commission may conduct addi-
3 tional reviews, and submit additional reports to the
4 appropriate congressional committees, from time to
5 time on such topics relating to the program under
6 this title as may be requested by such chairmen and
7 members as the Committee determines appropriate.

8 (6) AVAILABILITY OF REPORTS.—Each report
9 submitted by the Commission under this subsection
10 shall be made publicly available.

11 (d) MEMBERSHIP.—

12 (1) NUMBER AND APPOINTMENT.—The Com-
13 mission shall be composed of 15 members appointed
14 by the Comptroller General of the United States, at
15 least six of whom shall be veterans. The Comptroller
16 General shall make the initial appointment of a
17 member not later than 60 days after the date of the
18 enactment of this Act.

19 (2) QUALIFICATIONS.—

20 (A) IN GENERAL.—The membership of the
21 Commission shall include individuals with na-
22 tional recognition for having expertise in health
23 finance and economics, actuarial science, health
24 facility management, health plans and inte-
25 grated delivery systems, reimbursement of

1 health facilities, allopathic and osteopathic med-
2 icine and kinds of medical treatment, and other
3 related fields, who provide a mix of different
4 professionals, broad geographic representation,
5 and a balance between urban and rural rep-
6 resentatives, including individuals described in
7 subparagraph (B);

8 (B) SPECIFIC INDIVIDUALS TO BE AP-
9 POINTED.—Of the members appointed under
10 paragraph (1)—

11 (i) at least one member shall rep-
12 resent an organization recognized by the
13 Secretary of Veterans Affairs for the rep-
14 resentation of veterans under section 5902
15 of title 38, United States Code;

16 (ii) at least one member shall have ex-
17 perience as senior management for a pri-
18 vate integrated health care system with an
19 annual gross revenue of more than
20 \$500,000,000;

21 (iii) at least one member shall be fa-
22 miliar with Federal Government health
23 care systems, including such systems of the
24 Department of Defense, the Indian Health
25 Service, and Federally-qualified health cen-

1 ters (as defined in section 1905(l)(2)(B) of
2 the Social Security Act (42 U.S.C.
3 1396d(l)(2)(B)));

4 (iv) at least one member shall be fa-
5 miliar with the Veterans Health Adminis-
6 tration but shall not be currently employed
7 by the Department of Veterans Affairs;

8 (v) at least one member shall have ex-
9 perience as senior management for a pri-
10 vate health plan with an annual gross rev-
11 enue of more than \$500,000,000; and

12 (vi) at least one member shall have
13 experience as senior management for a pri-
14 vate health care accountable care organiza-
15 tion with an annual gross revenue of more
16 than \$500,000,000.

17 (C) MAJORITY NONPROVIDERS.—Individ-
18 uals who are directly involved in the provision,
19 or management of the delivery, of items and
20 services covered under this Act or the amend-
21 ments made by this Act shall not constitute a
22 majority of the membership of the Commission.

23 (D) ETHICAL DISCLOSURE.—The Comp-
24 troller General shall establish a system for pub-
25 lic disclosure by members of the Commission of

1 financial and other potential conflicts of interest
2 relating to such members.

3 (3) TERMS.—

4 (A) IN GENERAL.—A member of the Com-
5 mission shall serve for a term of three years,
6 except the members first appointed shall be ap-
7 pointed for staggered terms as the Comptroller
8 General considers appropriate to ensure that
9 the terms of no more than five members expire
10 in the same year.

11 (B) VACANCIES.—Any member appointed
12 to fill a vacancy occurring before the expiration
13 of the term for which the member's predecessor
14 was appointed shall be appointed only for the
15 remainder of that term. A member may serve
16 after the expiration of that member's term until
17 a successor has taken office. A vacancy in the
18 Commission shall not affect its powers, but
19 shall be filled in the same manner in which the
20 original appointment was made.

21 (4) CHAIRPERSON AND VICE CHAIRPERSON.—

22 The Comptroller General shall designate a member
23 of the commission, at the time of appointment of the
24 member, to serve as Chairperson of the Commission,
25 except that in the case of vacancy the Comptroller

1 General may designate another member for the re-
2 mainder of that Chairperson's term. The Commis-
3 sion shall select a Vice Chairperson from among its
4 members by a majority vote.

5 (5) COMPENSATION.—

6 (A) IN GENERAL.—Members of the Com-
7 mission shall be compensated at a rate equal to
8 the daily equivalent of the annual rate of basic
9 pay prescribed for level IV of the Executive
10 Schedule under section 5315 of title 5, United
11 States Code, for each day (including travel
12 time) during which such member is engaged in
13 the performance of the duties of the Commis-
14 sion.

15 (B) OFFICERS OR EMPLOYEES OF THE
16 UNITED STATES.—All members of the Commis-
17 sion who are officers or employees of the United
18 States shall serve without compensation in addi-
19 tion to that received for their services as offi-
20 cers or employees of the United States.

21 (C) TRAVEL EXPENSES.—The members of
22 the Commission shall be allowed travel ex-
23 penses, including per diem in lieu of subsist-
24 ence, at rates authorized for employees of agen-
25 cies under subchapter I of chapter 57 of title 5,

1 United States Code, while away from their
2 homes or regular places of business in the per-
3 formance of services for the Commission.

4 (6) MEETINGS.—

5 (A) IN GENERAL.—The Commission shall
6 meet at the call of the Chairperson.

7 (B) INITIAL MEETING.—Not later than 15
8 days after the date on which eight voting mem-
9 bers of the Commission have been appointed,
10 the Commission shall hold its first meeting.

11 (C) QUORUM.—A majority of the members
12 of the Commission shall constitute a quorum.

13 (d) POWERS.—

14 (1) OBTAINING OFFICIAL DATA.—The Commis-
15 sion may secure directly from any Federal agency
16 such information as the Commission considers nec-
17 essary to carry out this section. Upon request of the
18 Chairperson of the Commission, the head of that de-
19 partment or agency shall furnish such information to
20 the Commission on an agreed upon schedule.

21 (2) DATA COLLECTION.—In order to carry out
22 its functions, the Commission shall—

23 (A) use existing information, both pub-
24 lished and unpublished, where possible, collected
25 and assessed either by its own staff or under

1 other arrangements made in accordance with
2 this section;

3 (B) carry out, or award grants or con-
4 tracts for, original research where existing in-
5 formation is inadequate; and

6 (C) adopt procedures allowing any inter-
7 ested party to submit information for the Com-
8 mission's use in making reports and rec-
9 ommendations.

10 (3) ACCESS OF GAO TO INFORMATION.—The
11 Comptroller General shall have unrestricted access
12 to all deliberations, records, and nonproprietary data
13 of the Commission, immediately upon request.

14 (4) PERIODIC AUDIT.—The Commission shall
15 be subject to periodic audit by the Comptroller Gen-
16 eral.

17 (e) PERSONNEL.—

18 (1) STAFF.—

19 (A) IN GENERAL.—The Chairperson of the
20 Commission may, without regard to the civil
21 service laws and regulations, appoint and termi-
22 nate additional personnel as may be necessary
23 to enable the Commission to perform its duties.

24 (B) COMPENSATION.—The Chairperson of
25 the Commission may fix the compensation of

1 personnel without regard to chapter 51 and
2 subchapter III of chapter 53 of title 5, United
3 States Code, relating to classification of posi-
4 tions and General Schedule pay rates, except
5 that the rate of pay for the executive director
6 and other personnel may not exceed the rate
7 payable for level V of the Executive Schedule
8 under section 5316 of such title.

9 (2) DETAIL OF GOVERNMENT EMPLOYEES.—

10 Any Federal Government employee may be detailed
11 to the Commission without reimbursement, and such
12 detail shall be without interruption or loss of civil
13 service status or privilege.

14 (3) PROCUREMENT OF TEMPORARY AND INTER-

15 MITTENT SERVICES.—The Chairperson of the Com-
16 mission may procure temporary and intermittent
17 services under section 3109(b) of title 5, United
18 States Code, at rates for individuals that do not ex-
19 ceed the daily equivalent of the annual rate of basic
20 pay prescribed for level V of the Executive Schedule
21 under section 5316 of such title.

22 (f) BUDGET REQUEST.—The Commission shall sub-
23 mit requests for appropriations in the same manner as the
24 Secretary of Veterans Affairs, but amounts appropriated

1 for the Commission shall be separate from amounts appro-
2 priated for the Secretary.

3 (g) DEFINITIONS.—In this section:

4 (1) The term “appropriate congressional com-
5 mittees” means the Committees on Veterans’ Affairs
6 of the House of Representatives and the Senate.

7 (2) The term “Veterans Accountable Care Or-
8 ganization” means the corporation established by
9 section 323 of title 38, United States Code, as added
10 by section 101;

11 (3) The term “Veterans Health Insurance Pro-
12 gram” means the program established by section
13 7309 of title 38, United States Code, as added by
14 section 102.

15 (4) The term “VetsCare Choice program”
16 means the program established by section 2601 of
17 title 38, United States Code, as added by section
18 104.

19 (5) The term “VetsCare Federal program”
20 means the program established by section 1701A of
21 title 38, United States Code, as added by section
22 103.

23 (6) The term “VetsCare Senior program”
24 means the program established by section 2611 of

1 title 38, United States Code, as added by section
2 104.

3 **TITLE IV—LONG-TERM CARE**
4 **INSURANCE FOR VETERANS**

5 **SEC. 401. VETERANS' ELIGIBILITY FOR LONG-TERM CARE**
6 **INSURANCE.**

7 (a) IN GENERAL.—Section 9001 of title 5, United
8 States Code, is amended—

9 (1) by redesignating paragraphs (5) through
10 (10) as (6) through (11), respectively;

11 (2) by inserting after paragraph (4) the fol-
12 lowing:

13 “(5) VETERAN.—The term ‘veteran’ has the
14 same meaning given the term in section 101(2) of
15 title 38, United States Code.”;

16 (3) in paragraph (6), as so redesignated—

17 (A) in subparagraph (A), by striking “or
18 (4).” and inserting “(4), or (5).”;

19 (B) in subparagraph (B), by striking “(1)
20 or (3).” and inserting “(1), (3), or (5).”;

21 (C) in subparagraph (C), by striking “or
22 (4)” and inserting “(4), or (5)”; and

23 (D) in subparagraph (D), by striking “or
24 (4)” and inserting “(4), or (5)”;

1 (4) in paragraph (7), as so redesignated, by
2 striking “or (5).” and inserting “(5), or (6).”; and

3 (5) in paragraph (11), as so redesignated—

4 (A) in subparagraph (C), by striking
5 “Commerce; and” and inserting “Commerce;”;

6 (B) in subparagraph (D), by striking
7 “Services.” and inserting “Services; and”; and

8 (C) by inserting after subparagraph (D):

9 “(E) with respect to a veteran, the Sec-
10 retary of Veterans Affairs.”.

11 (b) TECHNICAL AND CONFORMING AMENDMENTS.—

12 Title 5, United States Code, is amended as follows:

13 (1) Section 9002 is amended—

14 (A) in subsection (a), by striking “or (5)”
15 and inserting “(5), or (6)”; and

16 (B) in subsection (e)—

17 (i) in paragraph (2), by striking “or
18 (4)” and inserting “(4), or (5)”; and

19 (ii) in paragraph (4), by striking “sec-
20 tion 9001(9)” and inserting “section
21 9001(10)”.

22 (2) Section 9004(d) is amended by inserting
23 after “withheld under subsection (b)” the following:
24 “, who is an enrollee by virtue of being a veteran de-
25 scribed in section 9001(5) of this title,”.

- 1 (3) Section 9008(c) is amended by striking “(3)
2 or (4)” and inserting “(3), (4), or (5)”.

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The Washington Times

Remodeling veterans' health care for the 21st century

The Caring for Our Heroes Act would expand choices of providers

By Michael Kussman - - Tuesday, July 26, 2016

ANALYSIS/OPINION:

From 2007 to 2009, I served as undersecretary for health in the U.S. Department of Veterans Affairs (VA). Overseeing the [Veterans Health Administration \(VHA\)](#), I often saw the best of what our nation offers veterans recovering from the wounds of war in a system staffed by committed health professionals devoted to providing quality care.

Unfortunately, I also witnessed the shortfalls of that same system, where bureaucracy and an outdated institutional model created obstacles, waste and missed opportunities for reform. While we worked diligently to set the [VHA](#) on a sustainable course for the future, it was clear the model was under tremendous strain.

In the seven years since my retirement, the strain has only grown greater as the [VHA](#) struggles to adjust to the changing demands for care among a diverse population of veterans.

The current [VHA](#) — a large, centralized bureaucracy trapped in the policies, procedures and assumptions of the last century — is simply unprepared to respond to the health care needs of today's veterans. What is needed is a plan to transform the [VHA](#) to better meet those needs.

A proposal in Congress, the Caring for Our Heroes in the 21st Century Act, offers a promising way forward that will provide that transformation and ensure veterans have access to the timely, high-quality care they deserve.

This legislative draft by Rep. Cathy McMorris Rodgers, a Washington Republican, would enable critical reforms to the [VHA](#) to better reflect the realities of health care in the 21st century.

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June 08, 2016 20:06 ET

Paralyzed Veterans of America Outraged Over "Caring for Our Heroes in the 21st Century Act"

Draft Bill Pushes Most Catastrophically Injured and Low-Income Veterans Into Private Pay-As-You-Go Health Care

WASHINGTON, DC--(Marketwired - June 08, 2016) - Paralyzed Veterans of America (Paralyzed Veterans) today voiced its shock over a bill drafted by Rep. Cathy McMorris Rogers (R-WA), and supported by Rep. Doug Lamborn (R-CO), that would radically alter the delivery of health care for the most vulnerable American veterans by burdening them with medical costs that they can't bear, for care that in almost every case, is not the best option.

"The premium support model offered in Congresswoman McMorris' bill will put the lives of catastrophically disabled and low-income veterans in jeopardy by forcing them into private sector systems that already face their own waitlist crises and are ill-equipped to provide the specialized care these veterans need," explained Paralyzed Veterans of America Executive Director Sherman Gillums. "Paralyzed Veterans of America is appalled that a member of our U.S. Congress would ignore the choice made by thousands of veterans who prefer VA health care and take the first step toward absolving Congress of its responsibility to resource and oversee a veteran-centric healthcare system."

The "Caring For Our Heroes in the 21st Century Act" purports to reform the VA by establishing a Veterans Accountable Care Organization and Veterans Health Insurance Support that would incentivize veterans to leave the VA system of care. It provides no mechanism to ensure veterans' care is properly coordinated in the private sector, or that veterans receive the most appropriate care. The Act aims to realign the VA medical centers and designates private health care officials for veterans' hospital, emergency and other medical services, but it does not address the capability of the private sector to manage the volume and quality of care that is comparable to the VA system of care they currently rely on.

"Such actions carried out by our legislators suggest a willful ignorance of the struggle our veterans face," continued Gillums. "If this bill becomes law, who will explain to veterans with spinal cord injuries and severe mental health issues that putting them in line for care with the general population, which is outside of the purview of Title 38 and not monitored by Congress, is somehow better for them? As a veteran who underwent rehabilitation in a VA facility and relied on VA healthcare to stay healthy after suffering severe injury, I find it unconscionable."

"To say that Paralyzed Veterans of America's members are astounded by efforts to weaken a VA system that the most vulnerable veterans rely on is an understatement. We agree with those who are tired of hearing story after story of VA's failings, and we fight on the front lines of this issue to ensure changes

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ensue. We also acknowledge that those changes are happening. But this bill would undermine any progress made, and we strongly oppose this proposal and similar recommendations that mirror this effort. It would essentially make VA a non-governmental entity, which is the very definition of privatized care. In essence, it allows the federal government to renege on the obligation it has to care for our wounded and disabled soldiers for the remainder of their lives after service," concluded Gillums.

About Paralyzed Veterans of America:

[Paralyzed Veterans of America](#) is the only congressionally chartered veterans service organization dedicated solely for the benefit and representation of veterans with [spinal cord injury](#) or [disease](#). For 70 years, we have ensured that veterans have received the [benefits](#) earned through their service to our nation; monitored their care in VA spinal cord injury units; and funded [research and education](#) in the search for a cure and improved care for individuals with paralysis.

As a partner for life, Paralyzed Veterans also develops training and career services, works to ensure [accessibility](#) in public buildings and spaces, provides health and rehabilitation opportunities through sports and recreation and advocates for veterans and all people with disabilities. With more than 70 offices and 34 [chapters](#), Paralyzed Veterans serves veterans, their families and their [caregivers](#) in all 50 states, the District of Columbia and Puerto Rico. ([pva.org](#))

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Filename: Rep. Lamborn caring for heroes act.docx
Last Modified: Mon Mar 20 15:42:59 CDT 2017

Focus on Veterans: Caring for Our Heroes in the 21st Century (Part III)

Veterans want a functional VA and high-quality healthcare. My latest piece of legislation gives them that.

June 10, 2016--Congressman Doug Lamborn

I am pleased to work with GOP Conference Chair [Cathy McMorris Rogers](#), along with many of my Republican colleagues, to introduce the *Caring for our Heroes in the 21st Century Act*. This bill responds to the comments and concerns of veterans throughout the country who are dissatisfied with the VA.

This legislation will...

Restructure and Streamline the Veterans Health Organization

In order to best serve veterans, the Veteran's Health Administration's (VHA) health insurance function should be separate from its function as a provider of hospital and clinical care.

The **Veterans Accountable Care Organization (VACO)**, a non-profit government corporation that is fully separate from the VHA, will manage the Department of Veterans Affairs' (VA) brick and mortar health care facilities and delivery of care to our nation's veterans. The **Veterans Health Insurance Program (VHIP)** will administer veterans' health insurance programs within the VHA. An independent entity will have more latitude to reward high performers, fire poor performers, and monitor the quality of overall veteran health care delivery.

Offer Veterans the Same Choice as their Fellow Americans

Today, our veterans are trapped in a system that offers them little to no choice. They deserve the right to choose what health care plan best fits their individual needs. The *Caring for our Heroes in the 21st Century Act* will offer current and newly enrolled veterans choices: VetsCare Federal, VetsCare Choice, and VetsCare Senior.

Currently enrolled veterans who are happy with their health care can choose to remain in the traditional VA system through the **VetsCare Federal** program. Those who are not happy have the option to move to the **VetsCare Choice** program, which will allow veterans to seek private care while providing premium support aligned with a veteran's Priority Group status. Veterans who are deemed 100 percent disabled will receive 100 percent coverage, and those who need further financial assistance can qualify for additional premium and cost-sharing support.

Veterans over the age of 65, or who receive Medicare due to disability, qualify for the **VetsCare Senior** program to help defray the costs of Medicare payments and supplemental coverage (Medigap). All eligible veterans can still receive service-connected care at VACO facilities, regardless of the program they are participating in. This ensures our VACO medical facilities continue to focus on service-connected injuries, illnesses, and diseases to ensure our nation's veterans get the highest quality of specialized care they need.

Veterans will also be eligible to enroll in the Federal Long Term Care Insurance Program, a benefit currently available to VA employees, or apply the equivalent premium support payment to the purchase of alternative, private long-term care insurance.

Realign Vital Infrastructure to Ensure Greatest Benefit

Our current VA medical infrastructure fails to efficiently meet the needs of America's veterans. Some veterans must travel long distances to receive care because access to VA facilities is limited, while in some areas VA facilities are underutilized because of excess capacity. This inefficient distribution results in high fixed costs for the VA, robbing veterans of funds that should be used to provide health care.

The *Caring for our Heroes in the 21st Century Act* will allow the VetsCare Advisory Commission to recommend for closure underutilized VA facilities, to which Congress can object. The realignment will create efficiencies that free funds to be used for providing quality health care instead of maintaining unneeded infrastructure. The Commission must ensure that the availability of health care services for veterans is not decreased in impacted areas.

Ensure Vigilant Oversight by Experts — Not Bureaucrats

The independent VetsCare Advisory Commission, a nonpartisan commission modeled after the Medicare Payment Advisory Commission, will monitor implementation of the law and provide recommendations to Congress and the Department of Veterans Affairs on veterans' health care reforms moving forward. The Commission, which will be comprised of 15 members including health care experts and veterans, is charged with continuously assessing the quality of veterans' health care and recommending legislative proposals for improving such care for consideration by Congress.

This commission will ensure that the policies we implement on behalf of our veterans are not stagnant, and are constantly being improved to keep up with current innovations in the health care community.

I look forward to hearing from veterans about these proposed changes as we refine our draft legislation and continue to hold the VA accountable for misconduct. Veterans should remain our first priority as we bring the Veterans Administration into the 21st century.

Congressman Doug Lamborn represents Colorado's fifth district, home to over 100,000 veterans. He also sits on the House Veterans Affairs Committee and is spearheading efforts to [bring the VA into the 21st Century](#). This article is the third in a three-part series.

Owner: Maurer, Ronald (CLS-House) </o=va/ou=va
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Filename: Rep. McMorris Rodgers, Cathy (CA).doc
Last Modified: Mon Mar 20 15:42:59 CDT 2017

Rep. Cathy McMorris Rodgers (R–Wash.)
5th District, East -- Spokane

Last Updated: March 20, 2017



Residence: Spokane

Born: May 22, 1969; Salem, Ore.

Religion: Christian non-denominational

Family: Husband, Brian Rodgers; two children

Education: Pensacola Christian College, B.A. 1990 (pre-law); U. of Washington, M.B.A. 2002

Military Service: None

Career: State legislative aide; fruit orchard worker

First Elected: 2004 (7th term)

Note: Conference Chairman

Political Highlights: Wash. House, 1994-2004 (minority leader, 2002-03); U.S. House, 2005-present

Committee and Subcommittee Assignments

Energy & Commerce (10th of 31 Republicans)

- Health

Leadership Positions and Party Committee Assignments

Conference Chairman

House National Republican Congressional Committee (ex officio)

House Republican Steering Committee (Conference Chairwoman)

Selected Caucus and Special Organization Memberships

Army Caucus

Congressional Caucus for Women's Issues

Congressional Sportsmen's Caucus

Congressional Wine Caucus

Law Enforcement Caucus

Republican Main Street Partnership

National Guard and Reserve Components Congressional Members Organization

Military Families Caucus

Congressional Neurosciences Caucus

Republican Study Committee (formerly Conservative Action Team)

Rural Health Care Coalition (co-chairwoman)

Western Caucus

Interest

On November 14, 2012 Congresswoman McMorris-Rodgers became the House GOP Conference Chairwoman, the fourth ranking spot in leadership, and the highest ranking Republican woman in Congress.

The wife of a retired Navy officer, she co-chairs the Congressional Military Families Caucus, which she helped found in 2009 to educate Members of the United States Congress and their staff, the Department of Defense, the Armed Forces and the public about the challenges facing our nation's military families.

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Boehner selected her in 2009 to head a Republican task force to come up with a policy on earmarks, which led her to create an online database tracking all earmark requests.

Fairchild Air Force Base, home to much of the Air Force's West Coast tanker fleet is in her district.

VA Issues

VHA Issues:

Caring for our heroes in the 21st Century Act: In June of 2016, the Congresswoman released a discussion draft of the *Caring for Our Heroes in the 21st Century Act*—legislation which would comprehensively (b) (5)

[REDACTED]

Veteran appointment scheduling tool: The Congresswoman was a strong public proponent for the Faster Care for Veterans Act which directs VA to begin

(b) (5)

Congressional Neurosciences Caucus: On March 8, 2017, Dr. J. Wesson Ashford, Director, War Related Illness and Injury Study Center (WRIISC), VA Palo Alto Health Care System; participated in the 6th Annual Brain Mapping Day briefing sponsored by the Congressional Neuroscience Caucus.

VBA Issues:

None

NCA Issues:

None

VA-Related Legislation (Sponsored)

115th Congress

No Bills Introduced

114th Congress

No Bills Introduced

Owner: Maurer, Ronald (CLS-House) </o=va/ou=va
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Filename: VSOs and caring for heroes act.docx
Last Modified: Mon Mar 20 15:42:59 CDT 2017



Veterans Groups Face Off Against ‘Caring For Our Heroes In The 21st Century Act’

By Chuck Yarling -
Jun 28, 2016

U.S. Rep. Cathy McMorris Rodgers (R-WA) has recently drafted a 58-page document entitled, “[Caring For Our Heroes in the 21st Century Act](#)”. The document is a “discussion draft” with a goal to modernize health care for our veterans. Its purpose is to provide an “opportunity to discuss ideas for introduction in the future” as an official bill in the House of Representatives.

Bottom line? The bill is designed to fix many of the deficiencies, problems, and published failures that currently exist within the U.S. Department of Veterans Affairs (VA).

However, in a very short period of time, veterans groups have come out on opposite sides of the bill. Concerned Veterans For America (CVA) is for it; Paralyzed Veterans of America (PVA), the American Legion, and Veterans of Foreign Wars are opposed to it.

John Cooper, Press Secretary for the CVA, published a reasonable [explanation](#) of why the bill is needed as well as describes changes such as restructure of the VA, expansion of veterans health care choices and monitors the future progress of veterans’ health reform. He said the bill

Would offer veterans real choice, enable better access and timely delivery of care, and give VA employees an incentive to pursue accountability. The only question is whether Congress will side with veterans, or whether it will allow special interests and entrenched bureaucrats to determine how we as a nation treat our heroes in this century.

However, Paralyzed Veterans of America came out swinging against it. In a [press release](#) PVA Executive Director Sherman Gillums expressed outrage:

The premium support model offered in Congresswoman McMorris’ bill will put the lives of catastrophically disabled and low-income veterans in jeopardy by forcing them into private sector systems that already face their own waitlist crises and are ill-equipped to provide the specialized care these veterans need.

It provides no mechanism to ensure veterans' care is properly coordinated in the private sector, or that veterans receive the most appropriate care.

The Veterans of Foreign Wars also weighed in on the [issue](#):

Politicians, pundits and politically-motivated organizations are using the national crisis in access to care at the Department of Veterans Affairs as justification to dismantle and privatize the VA health care system, with some even proposing that veterans be charged for their service-connected care. The VFW says no!

And The American Legion [reported](#), “a host of billion-dollar federal contractors, private medical enterprises and cottage-industry opportunists.”

The positions of these three veterans groups opposed to the bill have obvious points: one, they aligned themselves with the current VA healthcare system; and, more importantly, they have provided no alternate solutions to any of the reported problems within the VA.

With all due respect to all opposing veterans groups, it appears they have missed the point: The “Caring For Our Heroes in the 21st Century Act” is a draft of a proposed bill. It has no House of Representatives bill number showing it has not yet been introduced. Its purpose at this point in time is to provide a discussion of a future bill. It seems obvious that these groups should enter the discussion process, express their viewpoints, and resolve their differences.

Regardless of your position on “Caring For Our Heroes in the 21st Century Act”, you should provide your own thoughts about the bill.

Contact your [representative](#) now and provide your input!

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Subject: RE: Meet w/Concerned Veterans of America CVA
Date: Tue Jun 27 2017 11:48:15 CDT
Attachments: 6.27.2017 CVA EBS.docx
CVA Applauds Shulkin.docx
CVA Statement on Solution to Choice Program.docx
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From: (b) (6)
Sent: Tuesday, June 27, 2017 9:45 AM
To: (b) (6) Selnick, Darin
Cc: (b) (6)
Subject: Meet w/Concerned Veterans of America CVA

Good Morning,

Please send any read ahead's for the following meeting schedule with the Secretary on June 28, 2017.

***** Meet w/Concerned Veterans of America CVA

Please let me know if you have any questions.

Sincerely,

(b) (6)

Special Assistant

Office of the Secretary

US Department of Veterans Affairs

Phone: 202.461. (b) (6)

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Last Modified: Tue Jun 27 11:48:15 CDT 2017

EXECUTIVE BRIEFING SUMMARY

Meeting with Concerned Veterans for America

June 28th, 2017

2:15 – 2:45 PM

SECVA Suite

POINT OF CONTACT: (b) (6) (VSO Liaison)

PURPOSE OF EVENT:

Decisional
Remarks

Informational
X Other

Pre-Event
Courtesy Call

ATTENDEES:

CVA

Mark Lucas, Executive Director

Dan Caldwell, Director of Policy

VA

Darin Selnick

Brooks Tucker

John Ulliot

Jake Leinenkugel

(b) (6)

OBJECTIVE:

Meet CVA leadership and understand their priorities; Share your vision and priorities with CVA leadership; Discuss public components of Vets CARE Plan and related issues

BACKGROUND:

CVA requested to meet with you. They've indicated that while they've seen you briefly at events, they haven't had the chance to sit down and talk to you. The two senior leaders would like to introduce themselves and tell you more about their organization and their priorities.

They'd also like to discuss how they can work more closely with VA-- in particular the Vets CARE program and the pilots.

The White House has included CVA in its meetings and they've become more supportive of VA. However, traditional VSO remain skeptical of the organization and don't consider them a VSO

BIOGRAPHY:

(next page)

Mark Lucas is the Executive Director of Concerned Veterans for America. Prior to this, Lucas was a Regional Director of Americans for Prosperity, where he had previously served as the Iowa State Director. Under his leadership, the Iowa chapter of AFP grew to be the highest-performing in the organization in only 2 years.

Mark was the youngest-ever elected City Councilman at the age of 19 in his hometown of Wilton, Iowa. Mid-way through his term he was appointed as the Mayor Pro Tem.

During the 2008 presidential primary, Mark was the State Director of the Americans for Fair Taxation. The National Review said the FairTax campaign was the biggest success story of the 2008 primary season.

Mark has served for over 13 years in the Iowa Army National Guard and is a graduate of the US Army Ranger School. He led an infantry rifle platoon along the Afghanistan-Pakistan border as a platoon leader. He was awarded the Combat Infantry Badge and Bronze Star Medal by distinguishing himself for meritorious service in combat.

He received his Business Management degree from the University of Iowa Tippie College of Business with a certificate in Entrepreneurial Management.

He recently moved to Washington DC with his wife (b) (6) and (b) (6)

ATTACHMENTS:

1. Press Release: CVA Statement on Choice Testimony
2. Press Release: CVA Statement on Solution to Choice Program

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Filename: CVA Applauds Shulkin.docx
Last Modified: Tue Jun 27 11:48:15 CDT 2017

CVA APPLAUDS SHULKIN'S VISION FOR VETERANS HEALTH CARE CHOICE

Arlington, VA – Today the Senate Veterans Affairs Committee (SVAC) held a **hearing** examining the Veterans Choice Program and the future of the Department of Veterans Affairs (VA) care in the community program. VA Secretary Shulkin testified, unveiling a new vision for expanding choice and community care programs, called the Vets Community Access Rewarding Experience (CARE) program, and announcing a new pilot choice program very similar to what CVA has proposed for years.

Concerned Veterans for America (CVA) supports expanding veterans' health choice beyond the current Choice Program. In the bipartisan *Fixing Veterans Health Care Task Force*, CVA proposes the creation of a government-chartered non-profit and veterans insurance program to oversee the distribution of health care benefits to veterans. In this new model, veterans would be fully empowered to decide where and when to seek care outside of the VA.

Concerned Veterans for America (CVA) Policy Director Dan Caldwell issued the following statement:

"We applaud Secretary Shulkin for proposing reforms that will expand choice and for being willing to test new ideas to deliver health care to our veterans. The current Choice Program was meant to be temporary, has been implemented poorly, and offers unacceptably limited health care options. When it doesn't make sense to use the VA for care, veterans should be able to go outside of it. We look forward to working with Secretary Shulkin, this administration, and members of Congress to develop legislation that will achieve a vision of true health care freedom for veterans.

"Unfortunately, some members of the Senate — in particular, Senator Patty Murray — are opposed to even trying new ideas to deliver health care to our veterans. It is disappointing that some in Congress just want to double down on the status quo at the VA."

In April, the Senate passed and President Trump signed a reauthorization and extension of the *Veterans Choice Act*, which was passed originally in 2014 as a quick fix to the wait list scandal at the VA in Phoenix.

The Veterans Choice Program has been poorly implemented and has not offered the veterans who qualify for it the real choice that the creators of the program envisioned. The "40-mile, 30-day" rule means that, in theory, veterans can only seek care outside the VA if they can't be seen within a month of when they request an appointment or if they can't be seen within a 40-mile radius. Even then, many veterans are still forced to jump through many bureaucratic hoops to access the program.

President Trump and VA Secretary Shulkin have both repeatedly expressed the need to give veterans more choice over their health care. President Trump included choice as part of his 10-point plan to fix the VA while he was on the campaign trail last year.

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CVA STATEMENT ON SOLUTION TO CHOICE PROGRAM

Arlington, VA — This week Department of Veterans Affairs (VA) Secretary Shulkin testified before the Senate that funding for the Veteran Choice Program will likely run out later this year, much sooner than originally expected.

When President Trump reauthorized the Choice Program earlier this year, there were changes made to the program – in particular, making the VA the primary payor for care – which may have led to significantly increased spending. In addition, the increased referrals to the program have been larger than anticipated.

Concerned Veterans for America (CVA) Policy Director Dan Caldwell issued the following statement:

“Elected officials should quickly pass legislation that will allow the VA to move existing funds to the Veteran Choice Program, which they are unable to do under current law. Congress authorized the VA to move funds out of the program in 2015 – a measure we opposed – and they should now allow the VA the same flexibility to move funds back into the program.

“Patching up this flawed program year after year is not a permanent solution to the health care issues facing veterans. A systemic overhaul of the VHA is needed to allow veterans to use their benefits whenever and wherever they want and to remove the VA as the middleman.”

The Choice Program, which was enacted under Veterans’ Access to Care through Choice, Accountability, and Transparency Act, was intended as a temporary solution to the wait list scandal of 2014. The Program was flawed — allowing veterans to only receive care at VA-approved facilities if they meet the “30-day, 40-mile” rule, for example — and has been implemented poorly.

For years, CVA has proposed the creation of a government-chartered non-profit to oversee the distribution of health care benefits at the Department

of Veterans Affairs (VA). This entity would empower veterans to use these benefits at his or her own discretion – inside or outside of the VA.

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-0457-A-000122 Attachment 4 of 4)



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Subject: Meet w/Concerned Veterans of America CVA
Date: Tue Jun 27 2017 08:44:57 CDT
Attachments: image001.png

Good Morning,

Please send any read ahead's for the following meeting schedule with the Secretary on June 28, 2017.

***** Meet w/Concerned Veterans of America CVA

Please let me know if you have any questions.

Sincerely,

(b) (6)

Special Assistant

Office of the Secretary

US Department of Veterans Affairs

Phone: 202.461. (b) (6)

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Attachment 1 of 1)
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(b) (6) @vetaff.senate.gov>
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Cc: (b) (6) (Veterans Affairs)
(b) (6) @vetaff.senate.gov>
Bcc:
Subject: [EXTERNAL] FW: CVA Urges Senate to Improve VA Care in the Community Bill
Date: Wed Nov 29 2017 08:18:22 CST
Attachments:

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From: (b) (6) (Isakson)
Sent: Wednesday, November 29, 2017 9:07 AM
To: (b) (6) (Veterans Affairs) <(b) (6) @vetaff.senate.gov>; (b) (6) (Veterans Affairs) <(b) (6) @vetaff.senate.gov>; (b) (6) (Veterans Affairs) <(b) (6) @vetaff.senate.gov>; (b) (6) (Veterans Affairs) <(b) (6) @vetaff.senate.gov>; (b) (6) (Veterans Affairs) <(b) (6) @vetaff.senate.gov>
Cc: (b) (6) (Veterans Affairs) <(b) (6) @vetaff.senate.gov>; (b) (6) (Isakson) <(b) (6) @isakson.senate.gov>; (b) (6) (Isakson) <(b) (6) @isakson.senate.gov>
Subject: FW: CVA Urges Senate to Improve VA Care in the Community Bill

Passing along-

From: CVA - Press [mailto:press@cv4a.org]
Sent: Wednesday, November 29, 2017 9:03 AM
To: (b) (6) (Isakson) <(b) (6) @isakson.senate.gov>
Subject: CVA Urges Senate to Improve VA Care in the Community Bill

For immediate release: November 29, 2017
Contact: press@cv4a.org

CVA Urges Senate to Improve VA Care in the Community Bill

Arlington, VA – Today, the Senate Veterans Affairs Committee (SVAC) is scheduled to mark-up the Caring for our Veterans Act of 2017. The bill would establish a permanent VA community care program and consolidate the Veterans Choice Program with other community care programs.

Concerned Veterans for America (CVA) Executive Director Dan Caldwell issued the following statement:

“Like President Trump and Secretary Shulkin, CVA believes that veterans deserve more control over their health care at the VA. Keeping the VA as the gatekeeper between veterans and outside care will only continue problems that are present in the VA’s current community care and choice programs. The Caring for our Veterans Act of 2017 contains some good elements but needs improvement to ensure that veterans are being empowered with more control over their health care at the VA. CVA strongly encourages the committee to adopt the amendments proposed by Senator Moran that we believe would strengthen this bill. We look forward to working with the Senate to improve this legislation to ensure that veterans can access the care they have earned.”

The Veterans Choice Program, which was enacted under the Veterans’ Access to Care through Choice, Accountability, and Transparency Act, was implemented in response to the wait list scandal of 2014. It was passed as a stop-gap measure and was never intended to be a permanent solution. The Choice Program has faced several issues and failed to give many veterans real choice in their health care. In its current form, the VA Community Care Act does little to improve the restrictions of the current Choice Program.

For years, CVA has advocated for substantial health care reforms at the VA. In CVA’s Fixing Veterans Health Care Taskforce, the group advocates that veterans should have the option to take their earned health care benefits and use them to access care at the VA or in the private sector.

###

If you would rather not receive future communications from Concerned Veterans For America, let us know by [clicking here](#).

Concerned Veterans For America, 2300 Wilson Blvd, Arlington, VA 22201 United States

From: Darin Selnick (b) (6)
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
Cc:
Bcc:
Subject: [EXTERNAL] Choice 2.0
Date: Mon Apr 17 2017 10:14:26 CDT
Attachments: CVA Matrix Taskforce Report to IA to Draft Leg.docx
VHCTF and Sec 201 Comparison Table.docx

Owner: Darin Selnick <(b) (6)>
Filename: CVA Matrix Taskforce Report to IA to Draft Leg.docx
Last Modified: Mon Apr 17 10:14:26 CDT 2017

Key Components/Independent Assessment/Draft Legislation

Key Components	VA Commissioned Independent Assessment	Draft Legislation
(b) (5)		

Key Components	VA Commissioned Independent Assessment	Draft Legislation
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Key Components/Independent Assessment/Draft Legislation

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Key Components	VA Commissioned Independent Assessment	Draft Legislation
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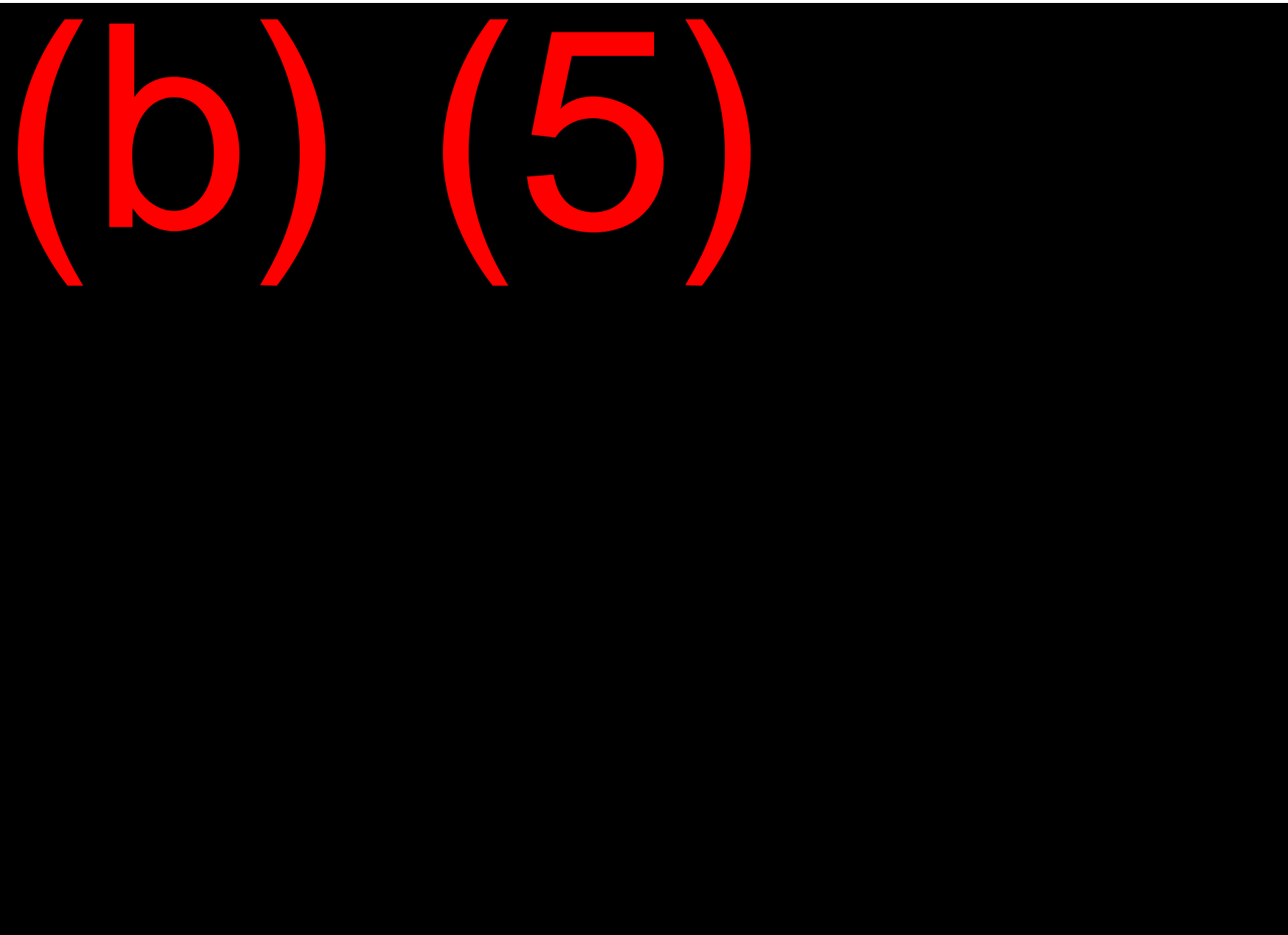
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Filename: VHCTF and Sec 201 Comparison Table.docx
Last Modified: Mon Apr 17 10:14:26 CDT 2017



CONCERNED
VETERANS
FOR AMERICA

Taskforce Report Recommendations Reflect on the Independent Assessment

Fixing Veterans Health Care Taskforce Report	VA Commissioned Independent Assessment
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CONCERNED
VETERANS
FOR AMERICA

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To: (b) (6) (b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 08:40:59 CDT
Attachments:

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

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(571) 344-(b) (6) Cell

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
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Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

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Senior Advisor to the Secretary

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(b) (6) and (b) (6) let me know how else I can be helpful.

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Concerned Veterans for America

C: [602] 999-(b) (6)

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(b) (6)

Boulder Crest Retreat

520.631-(b) (6)

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Date: 7/19/17 2:55 PM (GMT-05:00)
To: (b) (6) (b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

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Thanks again looking forward to catching up.

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Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

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administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 08:51:14 CDT
Attachments:

Darin, a call sound great. Any chance you are free now?

(b) (6)

(571) 344-(b) (6) Cell

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No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

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Boulder Crest Retreat

520.631 (b) (6)

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To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
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Subject: [EXTERNAL] Fwd: Follow Up Meeting
Date: Wed Aug 09 2017 19:42:28 CDT
Attachments:

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Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Wed Aug 09 2017 19:49:40 CDT
Attachments:

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

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Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

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Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 09:56:14 CDT
Attachments:

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
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Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) (b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: Darin Selnick [mailto:(b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Let me check.

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(b) (6)

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(571) 344-(b) (6)

Twitter@ (b) (6)

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Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

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Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (6)

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Best

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(b) (6) and (b) (6)

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I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/19/17 2:55 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

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(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

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From: Dan Caldwell <(b) (6)@cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

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Boulder Crest Retreat

520.631 (b) (6)

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From: Dan Caldwell <(b) (6)@cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

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Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6)@bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

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To: (b) (6) <(b) (6)@bouldercrestretreat.org>
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Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 15:23:34 CDT
Attachments:

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM

To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
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To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
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Twitter@kens2s

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Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

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Boulder Crest Retreat

520.631 (b) (6)

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Boulder Crest Retreat

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Member of the Board of Directors

(b) (6) bouldercrestretreat.org

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520.631, (b) (6)

<image002.jpg>

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From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: Ken Falke
<(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 16:08:04 CDT
Attachments:

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

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Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>

Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: Darin Selnick [mailto:(b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

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Let me check.

Thanks

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Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

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Sent from my iPhone

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Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

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Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

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Best

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(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)cv4a.org>
Date: 7/19/17 2:55 PM (GMT-05:00)
To: (b) (6) <(b) (6)bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)cv4a.org>
Date: 7/17/17 12:50 PM (GMT-05:00)
To: (b) (6) <(b) (6)bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631-(b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6)@bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6)@bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6)@cv4a.org]

Sent: Thursday, July 13, 2017 5:18 PM

To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)@bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
To: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 16:09:38 CDT
Attachments:

How does the morning of the 29th look?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

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Senior Advisor to the Secretary

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Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

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Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

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(b) (6)

(571) 344-(b) (6) Cell

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Twitter@ (b) (6)

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Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

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Concerned Veterans for America

C: [602] 999-(b) (6)

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(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

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To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

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Concerned Veterans for America

C: [602] 999-(b) (6)

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(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

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Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

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To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 16:54:42 CDT
Attachments:

Invite sent. See you then. thanks and have a great day. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, I can do that.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:36 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Could you do lunch on the 5th?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:19 PM

To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM

To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(6)

(571) 344-(b) (6) Cell

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6)

(571) 344-(b) (6) Cell

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Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

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Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
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To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: Darin Selnick [mailto:(b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin

Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: Darin Selnick <(b) (6)>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6)> wrote:

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Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there?
Thanks.

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From: Darin Selnick <(b) (6)>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6)@cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting

experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

Confidentiality:

The information contained in, and attached to, this communication may be confidential, and is intended only for the use of the recipient named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication, or any of its contents, is strictly prohibited. If you have received this communication in error, please re-send this communication to the sender and delete the original message and any copy of it from your computer system. Thank you.

From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631-(b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Wednesday, July 19, 2017 2:54 PM

To: Dan Caldwell <(b) (6) cv4a.org>

Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Monday, July 17, 2017 12:33 PM

To: Dan Caldwell <(b) (6) cv4a.org>

Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6) cv4a.org]
Sent: Thursday, July 13, 2017 5:18 PM
To: (b) (6) <(b) (6) bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 16:36:03 CDT
Attachments:

Could you do lunch on the 5th?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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How does the morning of the 29th look?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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(b) (6) and (b) (6)

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I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999 (b) (6)

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Wednesday, July 19, 2017 2:54 PM

To: Dan Caldwell <(b) (6) cv4a.org>

Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Monday, July 17, 2017 12:33 PM

To: Dan Caldwell <(b) (6) cv4a.org>

Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6)@bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6)@cv4a.org]
Sent: Thursday, July 13, 2017 5:18 PM
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)@bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 16:51:28 CDT
Attachments:

Yes, I can do that.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:36 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Could you do lunch on the 5th?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:19 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: Darin Selnick [mailto:(b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

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From: Darin Selnick <(b) (6)>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

Darin

On Sun, Jul 23, 2017 at 3:24 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there?
Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6)@cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

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(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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Subject: RE: Follow Up Meeting

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(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

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Dan Caldwell

Concerned Veterans for America

C: [602] 999 (b) (6)

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(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/17/17 12:50 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
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Dan Caldwell

Concerned Veterans for America

C: [602] 999 (b) (6)

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To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: Re: Follow Up Meeting

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Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

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Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

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Sent from my iPhone

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Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6)bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6)cv4a.org]
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To: (b) (6) <(b) (6)bouldercrestretreat.org>
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From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 16:12:01 CDT
Attachments:

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
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Hi (b) (6)

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Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
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Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

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(571) 344-(b) (6) Cell

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Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6)

(571) 344-(b) (6) Cell

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Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

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Best

Darin

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Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: Darin Selnick [mailto:(b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

Darin

On Sun, Jul 23, 2017 at 3:24 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there?
Thanks.

(b) (6)

(571) 344-(b) (6) Cell

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From: Darin Selnick <(b) (6)>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344- (b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6) cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6) cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999 (b) (6)

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Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/17/17 12:50 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999 (b) (6)

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Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins.
How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/16/17 9:39 AM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6)@bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6) cv4a.org]
Sent: Thursday, July 13, 2017 5:18 PM
To: (b) (6) <(b) (6) bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

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Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 16:19:09 CDT
Attachments:

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6)

(571) 344-(b) (6) Cell

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Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

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Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

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Twitter@ (b) (6)

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(b) (6)

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(571) 344-(b) (6)

Twitter@ (b) (6)

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Sent from my iPhone

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Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

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(b) (6)

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(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

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Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

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(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

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Thanks again looking forward to catching up.

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Member of the Board of Directors

(b) (6)bouldercrestretreat.org

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<image002.jpg>

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To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 16:15:46 CDT
Attachments:

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(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
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Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

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Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

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Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

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From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

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To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: Darin Selnick [mailto:(b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Let me check.

Thanks

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(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

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Sent from my iPhone

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From: Darin Selnick <(b) (6)>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

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Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(6)

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(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

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Hi (b) (6) and (b) (6)

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Best

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On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6)> cv4a.org> wrote:

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I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/19/17 2:55 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 2:54 PM
To: Dan Caldwell <(b) (6)cv4a.org>
Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6)bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6) cv4a.org]

Sent: Thursday, July 13, 2017 5:18 PM

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 16:31:46 CDT
Attachments:

Should we look at dates after labor Day?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:19 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Concerned Veterans for America

C: [602] 999-(b) (6)

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Boulder Crest Retreat

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Subject: RE: Follow Up Meeting

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Dan Caldwell

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C: [602] 999 (b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 2:54 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/17/17 12:50 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999 (b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/16/17 9:39 AM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6)bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6)bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6)cv4a.org]
Sent: Thursday, July 13, 2017 5:18 PM
To: (b) (6) <(b) (6)bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 16:34:24 CDT
Attachments:

Sure

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:19 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: Darin Selnick [mailto:(b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

Darin

On Sun, Jul 23, 2017 at 3:24 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there?
Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6)> cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/19/17 2:55 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 2:54 PM
To: Dan Caldwell <(b) (6)cv4a.org>
Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

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Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6) cv4a.org]

Sent: Thursday, July 13, 2017 5:18 PM

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

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Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Fri Sep 01 2017 08:06:49 CDT
Attachments:

Darin, hope all is well. Are we still on for Tuesday?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: Thursday, August 10, 2017 at 5:54 PM
To: "Selnick, Darin" <Darin.Selnick@va.gov>
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Invite sent. See you then. thanks and have a great day. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:51 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>

Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, I can do that.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:36 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Could you do lunch on the 5th?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Date: Thursday, August 10, 2017 at 5:19 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

(b) (6)

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www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

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Twitter@ (b) (6)

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Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: Darin Selnick [mailto:(b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

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Let me check.

Thanks

Darin

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Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

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Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there?
Thanks.

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From: Darin Selnick <(b) (6)>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

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Hi (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

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On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6) cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM

To: Dan Caldwell <(b) (6) cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999 (b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 2:54 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/17/17 12:50 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999 (b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/16/17 9:39 AM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6)@bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6)@bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6)@cv4a.org]
Sent: Thursday, July 13, 2017 5:18 PM
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)@bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Fri Sep 01 2017 08:37:57 CDT
Attachments:

Yes, still on for Tuesday. I have moved over to the White House, can we meet nearby at Blackfinn at 1620 I St NW.

Thanks

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Sent: Friday, September 01, 2017 09:07 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, hope all is well. Are we still on for Tuesday?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: Thursday, August 10, 2017 at 5:54 PM
To: "Selnick, Darin" <Darin.Selnick@va.gov>
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Invite sent. See you then. thanks and have a great day. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:51 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, I can do that.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:36 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Could you do lunch on the 5th?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:19 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390- (b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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(b) (6)

(571) 344-(b) (6) Cell

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Twitter@ (b) (6)

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Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

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Senior Advisor to the Secretary

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Subject: Re: Follow Up Meeting

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(b) (6)

(571) 344-(b) (6) Cell

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Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

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(b) (6)

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Dan Caldwell

Concerned Veterans for America

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/19/17 2:55 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

Confidentiality:

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 2:54 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631-(b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/17/17 12:50 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6) cv4a.org]

Sent: Thursday, July 13, 2017 5:18 PM

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)@bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Fri Sep 01 2017 08:41:48 CDT
Attachments:

12pm. Do you want to make reservations?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Friday, September 1, 2017 at 9:37 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, still on for Tuesday. I have moved over to the White House, can we meet nearby at Blackfinn at 1620 I St NW.

Thanks

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Sent: Friday, September 01, 2017 09:07 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, hope all is well. Are we still on for Tuesday?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: Thursday, August 10, 2017 at 5:54 PM
To: "Selnick, Darin" <Darin.Selnick@va.gov>
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Invite sent. See you then. thanks and have a great day. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:51 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, I can do that.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:36 PM

To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Could you do lunch on the 5th?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified,

shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:19 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: Darin Selnick [mailto:(b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

Darin

On Sun, Jul 23, 2017 at 3:24 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there? Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6)@cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Wednesday, July 19, 2017 2:54 PM

To: Dan Caldwell <(b) (6) cv4a.org>

Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999 (b) (6)

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Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6) cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6)bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6) cv4a.org]
Sent: Thursday, July 13, 2017 5:18 PM
To: (b) (6) <(b) (6)bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

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Sent from my iPhone

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Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Fri Sep 01 2017 08:58:24 CDT
Attachments:

OK. Do you want to stick with 12 or do 1130?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Friday, September 1, 2017 at 9:45 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

No reservations needed for Blackfinn.

My new cell is 202-881-(b) (6)

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Sent: Friday, September 01, 2017 09:42 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

12pm. Do you want to make reservations?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>

Date: Friday, September 1, 2017 at 9:37 AM

To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>

Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, still on for Tuesday. I have moved over to the White House, can we meet nearby at Blackfinn at 1620 I St NW.

Thanks

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>

Sent: Friday, September 01, 2017 09:07 AM Eastern Standard Time

To: Selnick, Darin

Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, hope all is well. Are we still on for Tuesday?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: Thursday, August 10, 2017 at 5:54 PM
To: "Selnick, Darin" <Darin.Selnick@va.gov>
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Invite sent. See you then. thanks and have a great day. (b) (6)

(b) (6)

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Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:51 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, I can do that.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:36 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Could you do lunch on the 5th?

(b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

(b) (6)

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To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

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Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (6)

(571) 344- (b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From:"Selnick, Darin" <Darin.Selnick@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From:Darin Selnick [mailto:(b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

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Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6)

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(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

Darin

On Sun, Jul 23, 2017 at 3:24 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there?
Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: Darin Selnick <(b) (6)>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (6)

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(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6)> cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

Confidentiality:

The information contained in, and attached to, this communication may be confidential, and is intended only for the use of the recipient named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication, or any of its contents, is strictly prohibited. If you have received this communication in error, please re-send this communication to the sender and delete the original message and any copy of it from your computer system. Thank you.

From: (b) (6) [mailto:(b) (6)bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6)bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

Confidentiality:

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 2:54 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]

Sent: Monday, July 17, 2017 12:33 PM

To: Dan Caldwell <(b) (6)@cv4a.org>

Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6) cv4a.org]

Sent: Thursday, July 13, 2017 5:18 PM

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Fri Sep 01 2017 08:45:46 CDT
Attachments:

No reservations needed for Blackfinn.

My new cell is 202-881-(b) (6)

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Sent: Friday, September 01, 2017 09:42 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

12pm. Do you want to make reservations?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Friday, September 1, 2017 at 9:37 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, still on for Tuesday. I have moved over to the White House, can we meet nearby at Blackfinn at

1620 I St NW.

Thanks

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) [(b) (6)]@shoulder2shoulderinc.com]
Sent: Friday, September 01, 2017 09:07 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, hope all is well. Are we still on for Tuesday?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: Thursday, August 10, 2017 at 5:54 PM
To: "Selnick, Darin" <Darin.Selnick@va.gov>
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Invite sent. See you then. thanks and have a great day. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:51 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

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From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:36 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

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Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

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Darin

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Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6)

(571) 344- (b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>

Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: Darin Selnick [mailto:(b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated

by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

Darin

On Sun, Jul 23, 2017 at 3:24 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there?
Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6) cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

Confidentiality:

The information contained in, and attached to, this communication may be confidential, and is intended only for the use of the recipient named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication, or any of its contents, is strictly prohibited. If you have received this communication in error, please re-send this communication to the sender and delete the original message and any copy of it from your computer system. Thank you.

From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/19/17 2:55 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

Confidentiality:

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send this communication to the sender and delete the original message and any copy of it from your computer system. Thank you.

From: (b) (6) [mailto:(b) (6)bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 2:54 PM
To: Dan Caldwell <(b) (6)cv4a.org>
Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)cv4a.org>
Date: 7/17/17 12:50 PM (GMT-05:00)
To: (b) (6) <(b) (6)bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999 (b) (6)

Confidentiality:

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only for the use of the recipient named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication, or any of its contents, is strictly prohibited. If you have received this communication in error, please re-send this communication to the sender and delete the original message and any copy of it from your computer system. Thank you.

From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6)@bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6)@bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6)@cv4a.org]
Sent: Thursday, July 13, 2017 5:18 PM
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)@bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Fri Sep 01 2017 09:06:22 CDT
Attachments:

Lets do 1130. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Friday, September 1, 2017 at 10:02 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Either one is fine with me.

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Sent: Friday, September 01, 2017 09:59 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

OK. Do you want to stick with 12 or do 1130?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Friday, September 1, 2017 at 9:45 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

No reservations needed for Blackfinn.

My new cell is 202-881-(b) (6)

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Sent: Friday, September 01, 2017 09:42 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

12pm. Do you want to make reservations?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Friday, September 1, 2017 at 9:37 AM

To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, still on for Tuesday. I have moved over to the White House, can we meet nearby at Blackfinn at 1620 I St NW.

Thanks

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Sent: Friday, September 01, 2017 09:07 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, hope all is well. Are we still on for Tuesday?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

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From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: Thursday, August 10, 2017 at 5:54 PM
To: "Selnick, Darin" <Darin.Selnick@va.gov>
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Invite sent. See you then. thanks and have a great day. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:51 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, I can do that.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:36 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Could you do lunch on the 5th?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:19 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From:"Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From:(b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From:"Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: Darin Selnick [mailto:(b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

Darin

On Sun, Jul 23, 2017 at 3:24 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there?
Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6)> cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

Confidentiality:

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only for the use of the recipient named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication, or any of its contents, is strictly prohibited. If you have received this communication in error, please re-send this communication to the sender and delete the original message and any copy of it from your computer system. Thank you.

From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/19/17 2:55 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999 (b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 2:54 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/17/17 12:50 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999 (b) (6)

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From: (b) (6) [mailto:(b) (6)bouldercrestretreat.org]
Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6)cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6)bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6)bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6)bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6)cv4a.org]
Sent: Thursday, July 13, 2017 5:18 PM
To: (b) (6) <(b) (6)bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Fri Sep 01 2017 09:02:13 CDT
Attachments:

Either one is fine with me.

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Sent: Friday, September 01, 2017 09:59 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

OK. Do you want to stick with 12 or do 1130?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Friday, September 1, 2017 at 9:45 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

No reservations needed for Blackfinn.

My new cell is 202-881-(b) (6)

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) (b) (6)@shoulder2shoulderinc.com]
Sent: Friday, September 01, 2017 09:42 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

12pm. Do you want to make reservations?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Friday, September 1, 2017 at 9:37 AM
To: (b) (6) (b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, still on for Tuesday. I have moved over to the White House, can we meet nearby at Blackfinn at 1620 I St NW.

Thanks

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) (b) (6)@shoulder2shoulderinc.com]
Sent: Friday, September 01, 2017 09:07 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, hope all is well. Are we still on for Tuesday?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: Thursday, August 10, 2017 at 5:54 PM
To: "Selnick, Darin" <Darin.Selnick@va.gov>
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Invite sent. See you then. thanks and have a great day. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:51 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, I can do that.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:36 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Could you do lunch on the 5th?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:19 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]

Sent: Thursday, August 10, 2017 4:24 PM

To: Selnick, Darin

Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>

Date: Thursday, August 10, 2017 at 10:56 AM

To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>

Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM

To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: Darin Selnick [mailto:(b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

Darin

On Sun, Jul 23, 2017 at 3:24 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there? Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>

Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

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Hi (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6)@cv4a.org> wrote:

(b) (6) and (b) (6)

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I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 2:54 PM
To: Dan Caldwell <(b) (6) cv4a.org>
Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999 (b) (6)

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Monday, July 17, 2017 12:33 PM

To: Dan Caldwell <(b) (6) cv4a.org>

Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6)@bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6)@cv4a.org]
Sent: Thursday, July 13, 2017 5:18 PM
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)@bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Fri Sep 01 2017 09:08:11 CDT
Attachments:

Ok, see you then.

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Sent: Friday, September 01, 2017 10:07 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Lets do 1130. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Friday, September 1, 2017 at 10:02 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Either one is fine with me.

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) [(b) (6)]@shoulder2shoulderinc.com]
Sent: Friday, September 01, 2017 09:59 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

OK. Do you want to stick with 12 or do 1130?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Friday, September 1, 2017 at 9:45 AM
To: (b) (6) [(b) (6)]@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

No reservations needed for Blackfinn.

My new cell is 202-881-(b) (6)

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) [(b) (6)]@shoulder2shoulderinc.com]
Sent: Friday, September 01, 2017 09:42 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

12pm. Do you want to make reservations?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>

Date: Friday, September 1, 2017 at 9:37 AM

To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>

Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, still on for Tuesday. I have moved over to the White House, can we meet nearby at Blackfinn at 1620 I St NW.

Thanks

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>

Sent: Friday, September 01, 2017 09:07 AM Eastern Standard Time

To: Selnick, Darin

Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, hope all is well. Are we still on for Tuesday?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: Thursday, August 10, 2017 at 5:54 PM
To: "Selnick, Darin" <Darin.Selnick@va.gov>
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Invite sent. See you then. thanks and have a great day. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:51 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, I can do that.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:36 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Could you do lunch on the 5th?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:19 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (6)

(571) 344- (b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From:"Selnick, Darin" <Darin.Selnick@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From:Darin Selnick [mailto:(b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

Darin

On Sun, Jul 23, 2017 at 3:24 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there?
Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6)> cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

Confidentiality:

The information contained in, and attached to, this communication may be confidential, and is intended only for the use of the recipient named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication, or any of its contents, is strictly prohibited. If you have received this communication in error, please re-send this communication to the sender and delete the original message and any copy of it from your computer system. Thank you.

From: (b) (6) [mailto:(b) (6)bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6)bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

Confidentiality:

The information contained in, and attached to, this communication may be confidential, and is intended only for the use of the recipient named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication, or any of its contents, is strictly prohibited. If you have received this communication in error, please re-send this communication to the sender and delete the original message and any copy of it from your computer system. Thank you.

From: (b) (6) [mailto:(b) (6)bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 2:54 PM
To: Dan Caldwell <(b) (6)cv4a.org>
Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

Confidentiality:

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]

Sent: Monday, July 17, 2017 12:33 PM

To: Dan Caldwell <(b) (6)@cv4a.org>

Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6) cv4a.org]

Sent: Thursday, July 13, 2017 5:18 PM

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Tue Sep 05 2017 10:29:51 CDT
Attachments:

Darin, I am here. I'll get us a table outside. Thx.

(b) (6)
Shoulder 2 Shoulder, Inc
(571) 344-(b) (6)
Twitter@ (b) (6)
www.shoulder2shoulderinc.com
Sent from my iPhone

On Sep 1, 2017, at 10:06 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Lets do 1130. Thanks.

(b) (6)
(571) 344-(b) (6) Cell
www.shoulder2shoulderinc.com
Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Friday, September 1, 2017 at 10:02 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Either one is fine with me.

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) [(b) (6)]@shoulder2shoulderinc.com]
Sent: Friday, September 01, 2017 09:59 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

OK. Do you want to stick with 12 or do 1130?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Friday, September 1, 2017 at 9:45 AM
To: (b) (6) [(b) (6)]@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

No reservations needed for Blackfinn.

My new cell is 202-881-(b) (6)

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) [(b) (6)]@shoulder2shoulderinc.com]
Sent: Friday, September 01, 2017 09:42 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

12pm. Do you want to make reservations?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Friday, September 1, 2017 at 9:37 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, still on for Tuesday. I have moved over to the White House, can we meet nearby at Blackfinn at 1620 I St NW.

Thanks

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Sent: Friday, September 01, 2017 09:07 AM Eastern Standard Time
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, hope all is well. Are we still on for Tuesday?

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: Thursday, August 10, 2017 at 5:54 PM
To: "Selnick, Darin" <Darin.Selnick@va.gov>
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Invite sent. See you then. thanks and have a great day. (b) (6)

(b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:51 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, I can do that.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:36 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Could you do lunch on the 5th?

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Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

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Twitter@ (b) (6)

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To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

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From: "Selnick, Darin" <Darin.Selnick@va.gov>

Date: Thursday, August 10, 2017 at 5:08 PM

To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>

Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]

Sent: Thursday, August 10, 2017 4:24 PM

To: Selnick, Darin

Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390- (b) (6)

From: Darin Selnick [mailto: (b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: Darin Selnick <(b) (6)>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6)

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(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

Darin

On Sun, Jul 23, 2017 at 3:24 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there?
Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: Darin Selnick <(b) (6)>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (6)

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Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6)> cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

Confidentiality:

The information contained in, and attached to, this communication may be confidential, and is intended only for the use of the recipient named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication, or any of its contents, is strictly prohibited. If you have received this communication in error, please re-send this communication to the sender and delete the original message and any copy of it from your computer system. Thank you.

From: (b) (6) [mailto:(b) (6)bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631-(b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 2:54 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631-(b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]

Sent: Monday, July 17, 2017 12:33 PM

To: Dan Caldwell <(b) (6)@cv4a.org>

Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6) cv4a.org]

Sent: Thursday, July 13, 2017 5:18 PM

To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)@bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 16:59:38 CDT
Attachments:

Thanks

Darin

From: (b) (6) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:55 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Invite sent. See you then. thanks and have a great day. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Thursday, August 10, 2017 at 5:51 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

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To: Selnick, Darin
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Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

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To: Selnick, Darin
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Should we look at dates after labor Day?

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Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

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(b) (6)

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Thanks

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Best

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To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <Darin.Selnick@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: Darin Selnick [mailto:(b) (6)]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

Darin

On Sun, Jul 23, 2017 at 3:24 AM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there? Thanks.

(b) (6)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6) <(b) (6)@shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (6)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6)> wrote:

Hi (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6)@cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and Chris is on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

Confidentiality:

The information contained in, and attached to, this communication may be confidential, and is intended only for the use of the recipient named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication, or any of its contents, is strictly prohibited. If you have received this communication in error, please re-send this communication to the sender and delete the original message and any copy of it from your computer system. Thank you.

From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

Confidentiality:

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Wednesday, July 19, 2017 2:54 PM

To: Dan Caldwell <(b) (6) cv4a.org>

Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

Confidentiality:

The information contained in, and attached to, this communication may be confidential, and is intended only for the use of the recipient named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication, or any of its contents, is strictly prohibited. If you have received this communication in error, please re-send this communication to the sender and delete the original message and any copy of it from your computer system. Thank you.

From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Monday, July 17, 2017 12:33 PM

To: Dan Caldwell <(b) (6) cv4a.org>

Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6)bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6)cv4a.org]
Sent: Thursday, July 13, 2017 5:18 PM
To: (b) (6) <(b) (6)bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Fureigh, Brandon </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc: Blackburn, Scott R. </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Wright, Vivieca (Simpson) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6)>
Bcc:
Subject: CVA ad
Date: Thu Apr 13 2017 06:33:26 CDT
Attachments:

Sir,

This was 2.1 in the clips. You can watch the new CVA ad promoting the accountability bill in the senate.

<http://www.washingtonexaminer.com/ads-pressure-senators-to-support-veterans-affairs-bill-allowing-workers-to-be-fired-for-misconduct/article/2620098>

Brandon Fureigh

Senior Advisor, Strategic Engagement

Office of the Secretary

Department of Veterans Affairs

Office: 202-461-(b) (6)

Cell: 202-341-(b) (6)

From: (b) (6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6)>
To: Bowman, Thomas </o=va/ou=exchange
administrative group (fydibohf23spdl)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: FW: [EXTERNAL] Fwd: CVA Applauds Bold VA Health Care Reform Bill
Date: Tue Nov 21 2017 13:45:23 CST
Attachments:

Sent with Good (www.good.com)

From: (b) (6)
Sent: Tuesday, November 21, 2017 11:32:23 AM
To: (b) (6)
Subject: [EXTERNAL] Fwd: CVA Applauds Bold VA Health Care Reform Bill

FYI.

Begin forwarded message:

From: CVA - Press <press@cv4a.org>
Date: November 21, 2017 at 2:29:39 PM EST
To: (b) (6) @mail.house.gov
Subject: CVA Applauds Bold VA Health Care Reform Bill

For immediate release: November 21, 2017
Contact: press@cv4a.org

CVA Applauds Bold VA Health Care Reform Bill

Arlington, VA – Today, Representative Doug Lamborn (R-CO) introduced the Veterans Empowerment Act, a bill that will fundamentally reform the Veterans Health Administration (VHA) and offer all veterans who use the VA the option to access care in the private sector. Concerned Veterans for America (CVA) is urging veterans and concerned citizens across the nation to contact their legislators in support of the new bill.

The bill expands veterans' health care choices by creating a veterans' health insurance program and allowing veterans to use their benefits inside or outside of the VA system. The bill would also establish better oversight of the VA health care system while increasing transparency regarding the VA's performance.

CVA Executive Director Dan Caldwell issued the following statement:

"The seemingly endless stream of stories about veterans receiving delayed or poor-quality health care at the VA demonstrates the current VA medical system is not set up to effectively serve our veterans. Those who put their lives on the line for our country deserve the best health care possible, and the Veterans Empowerment Act would ensure that they receive it.

"We can't leave the VA medical system in its current state and expect results to improve for our veterans. This is a historic opportunity to finally go beyond the failed status quo at the VA and provide veterans with the best care possible. We applaud Rep. Lamborn for introducing this bill and strongly urge Congress to pass it into law."

Since its inception in 2012, CVA has advocated for reforming and fixing the VA. In 2014, CVA launched the VA Accountability Project, which advocated for more accountability for VA employees and more health care choice for veterans. Later that year, CVA convened the bipartisan Fixing Veterans Health Care Taskforce, which in 2015 released the Fixing Veterans Health Care Task Force Report. This report serves as the group's comprehensive proposal for health care reform at the VA.

In 2014, Congress passed the Veterans Access, Choice, and Accountability Act in response to the VA wait list scandal. This bill created the Veterans Choice Program, which only offered limited choice to veterans who satisfied certain requirements. Under the Choice Program, veterans must meet the "40-mile, 30-day" rule, which only allows veterans to seek care outside the VA if they can't be seen within a month of when they request an appointment or if they can't be seen within a 40-mile radius. Even then, many veterans are forced to jump through bureaucratic hoops to access the program, which was poorly implemented and only intended to serve as a temporary measure.

The Choice Program recently faced a budget shortfall and is expected to run out of money again at the beginning of next year unless it is replaced with a more effective and sustainable method of offering veterans at the VA health care choice.

###

If you would rather not receive future communications from Concerned Veterans For America, let us know by clicking [here](#).

Concerned Veterans For America, 2300 Wilson Blvd, Arlington, VA 22201 United States

From: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)>
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)>
Cc: Blackburn, Scott R. </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)> Wright, Vivieca (Simpson) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (5), (b) (6)>
Bcc:
Subject: CVA ad
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Attachments:

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<http://www.washingtonexaminer.com/ads-pressure-senators-to-support-veterans-affairs-bill-allowing-workers-to-be-fired-for-misconduct/article/2620098>

(b) (6)

Senior Advisor, Strategic Engagement

Office of the Secretary

Department of Veterans Affairs

Office: 202-461-(b) (6)

Cell: 202-341-(b) (6)

From: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)>
To: O'Rourke, Peter M. </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)> (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)>
Cc: Hayes-Byrd, Jacquelyn </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)>
Bcc:
Subject: VSO Breakfast Invitees and Seating Chart
Date: Thu Apr 05 2018 10:12:15 CDT
Attachments: Seating Chart 4.6.18 v2.docx
VSO Breakfast Invitees and Agenda v3.docx

(b) (6) (b) (6)

I've attached the updated VSO Breakfast Invite List and Seating Chart per your and the Acting SECVA's guidance this morning. Please advise on any final changes.

Thanks,

(b) (6)

(b) (6) M.B.A.
Acting Special Assistant to the Secretary for VSOs
Office of the Secretary
Department of Veterans Affairs
810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6), (b) (6), (b) (6)
Filename: Seating Chart 4.6.18 v2.docx
Last Modified: Thu Apr 05 10:12:15 CDT 2018

SECVA VSO Breakfast
Friday, March 6, 2018
8:00-9:00am
OBCR

Seating Chart

(b) (6)	(b) (6)
AMVETS	SVA
Brooks Tucker Assistant Secretary, OCLA	(b) (6) WWP
Jim Byrne General Counsel, VA	(b) (6) MOAA
Peter O'Rourke Chief of Staff	(b) (6) Concerned Veterans of America
Acting Secretary Wilkie	(b) (6) DAV
Pamela Powers Senior Advisor, VA	(b) (6) VVA
(b) (6) Special Assistant, VA	(b) (6) PVA
(b) (6) IAVA	(b) (6) Independence Fund

V1

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6), (b) (6), (b) (6)
Filename: VSO Breakfast Invitees and Agenda v3.docx
Last Modified: Thu Apr 05 10:12:15 CDT 2018

Event/Meeting: VSO Breakfast with The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs

Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

VA Invitees:

The Honorable Robert Wilkie, Acting Secretary

Peter O'Rourke, Chief of Staff, Office of the Secretary

Jim Byrne, Office of General Counsel, VA

Brooks Tucker, Assistant Secretary, Office of Congressional and Legislative Affairs, VA

Pamela J. Powers, Senior Advisor to the Acting Secretary, VA

(b) (6) Special Assistant to the Acting Secretary, VA

White House/VSO Invitees:

(b) (6) Legislative Director, The American Legion (TAL)

(b) (6) Executive Director, Disabled American Veterans (DAV)

(b) (6) Executive Director, Paralyzed Veterans of America (PVA)

(b) (6) Executive Director, American Veterans (AMVETS)

(b) (6) Iraq and Afghanistan Veterans of America (IAVA)

(b) (6) Executive Director of Policy and Government Affairs, Vietnam Veterans of America (VVA)

(b) (6) Lieutenant General, U.S. Air Force (Ret), President and CEO Military Officers Association of America (MOAA)

(b) (6) Government and Community Relations Director, Wounded Warrior Project (WWP)

(b) (6) Director of Government Relations, Student Veterans of America (SVA)

(b) (6) Executive Director, Concerned Veterans of America (CVA)

(b) (6) Independence Fund

From: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)
To: (b) (6) </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)
(b) (6) O'Rourke, Peter M. </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6) Hayes-Byrd,
Jacquelyn </o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)
Cc:
Bcc:
Subject: VSO Breakfast Agenda and Seating Chart
Date: Wed Apr 04 2018 15:57:07 CDT
Attachments: Seating Chart 4.6.18 v1.docx
VSO Breakfast Invitees and Agenda v3.docx

(b) (6) (b) (6) (b) (6)

Attached, please find the VSO Breakfast Meeting Agenda and Seating Chart for your review.

Please advise on any suggested edits/changes.

Thanks very much,

(b) (6)

(b) (6) M.B.A.
Acting Special Assistant to the Secretary for VSOs
Office of the Secretary
Department of Veterans Affairs
810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6), (b) (6), (b) (6)
Filename: Seating Chart 4.6.18 v1.docx
Last Modified: Wed Apr 04 15:57:07 CDT 2018

SECVA VSO Breakfast
Friday, March 6, 2018
8:00-9:00am
OBCR

Seating Chart

Brooks Tucker Assistant Secretary, OCLA	(b) (6) VSO Liaison
(b) (6), (b) (7)(C) White House OCLA	Dr. Carolyn Clancy Executive in Charge, VHA
(b) (6), (b) (7)(C) White House Domestic Policy Council	(b) (6) MOAA
(b) (6), (b) (7)(C) White House Office of Public Liaison	(b) (6) Wounded Warrior Project
Peter O'Rourke Chief of Staff	Thomas Bowman Deputy Secretary
Acting Secretary Wilkie	(b) (6) DAV
(b) (6) PVA	(b) (6) VVA
(b) (6) The American Legion	Dr. Lynda Davis Chief Veterans Experience Officer
(b) (6) AMVETS	(b) (6) Concerned Veterans of America
(b) (6) IAVA	(b) (6) Independence Fund
Randy Reeves Under Secretary for Memorial Affairs	Tom Murphy Executive in Charge, VBA

V1

VA-18-0457-A-000521

1544

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6), (b) (6), (b) (6)
Filename: VSO Breakfast Invitees and Agenda v3.docx
Last Modified: Wed Apr 04 15:57:07 CDT 2018

Event/Meeting: VSO Breakfast with The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs

Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

VA Invitees:

The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs
The Honorable Thomas Bowman, Deputy Secretary of Veterans Affairs, Department of Veterans Affairs
Peter O'Rourke, Chief of Staff, Office of the Secretary
Brooks Tucker, Assistant Secretary, Office of Congressional and Legislative Affairs, V
Dr. Lynda Davis, Chief Veterans Experience Officer, VA
Randy Reeves, Under Secretary for Memorial Affairs
Tom Murphy, Executive in Charge for Veterans Benefits Administration
Dr. Carolyn Clancy, Executive in Charge, Veterans Health Administration

White House/VSO Invitees:

(b) (6), (b) (7)(C) White House, Office of Public Liaison
(b) (6), (b) (7)(C) White House, Domestic Policy Council
(b) (6), (b) (7)(C) White House, Office of Congressional and Legislative Affairs
(b) (6) Jr., Director of the Veterans Affairs and Rehabilitation Division, The American Legion (TAL)
(b) (6) Executive Director, Disabled American Veterans (DAV)
(b) (6) Executive Director, Paralyzed Veterans of America (PVA)
(b) (6) Executive Director, American Veterans (AMVETS)
(b) (6) Iraq and Afghanistan Veterans of America (IAVA)
(b) (6) Executive Director of Policy and Government Affairs, Vietnam Veterans of America (VVA)
(b) (6) Lieutenant General, U.S. Air Force (Ret), President and CEO Military Officers Association of America (MOAA)
(b) (6) Government and Community Relations Director, Wounded Warrior Project (WWP)
(b) (6) Director of Government Relations, Student Veterans of America (SVA)
(b) (6) Executive Director, Concerned Veterans of America (CVA)
(b) (6) Independence Fund

Agenda

Welcome/Introductions – The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs
Patient Experience/Medalia Tool/Demo – Dr. Lynda Davis, Chief Veteran Experience Officer, Veteran Experience Office, VA

From: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)
To: (b) (6) </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)
Cc:
Bcc:
Subject: RE: VSO Breakfast Invite List
Date: Wed Apr 04 2018 14:22:14 CDT
Attachments: VSO Breakfast Invitees and Agenda v1.docx

(b) (6) I've attached and included the meeting invite, participant and agenda below. All of the VSOs have been invited and I was in the process of reaching out (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) (b) (6) and (b) (6) per your guidance this afternoon. Please advise if you and Peter have any final edits/changes to the list of attendees prior to finalizing/preparing the seating chart.

Event/Meeting: VSO Breakfast with The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs

Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

VA Invitees:

***** The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs

***** The Honorable Thomas Bowman, Deputy Secretary of Veterans Affairs, Department of Veterans Affairs

***** Peter O'Rourke, Chief of Staff, Office of the Secretary

***** Brooks Tucker, Assistant Secretary, Office of Congressional and Legislative Affairs, VA

***** John Ulyot, Assistant Secretary, Office of Public and Intergovernmental Affairs, VA

***** Dr. Lynda Davis, Chief Veterans Experience Officer, VA

***** (b) (6) Special Assistant to the Secretary for VSOs, VA

White House/VSO Invitees:

***** (b) (6), (b) (7)(C) White House, Office of Public Liaison

***** (b) (6), (b) (7)(C) White House, Domestic Policy Council

***** (b) (6) Jr., Director of the Veterans Affairs and Rehabilitation Division, The American Legion (TAL)

***** (b) (6) Executive Director, Disabled American Veterans (DAV)

***** (b) (6) Executive Director, Paralyzed Veterans of America (PVA)

***** (b) (6) Executive Director, American Veterans (AMVETS)

***** (b) (6) Executive Director of Policy and Government Affairs, Vietnam Veterans of America (VVA)

***** (b) (6) Lieutenant General, U.S. Air Force (Ret), President and CEO Military Officers Association of America (MOAA)

***** (b) (6) Government and Community Relations Director, Wounded Warrior Project (WWP)

***** (b) (6) Director of Government Relations, Student Veterans of America (SVA)

***** (b) (6) Executive Director, Concerned Veterans of America (CVA)

***** (b) (6) Independence Fund

Agenda

***** Welcome/Introductions – The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs

***** Patient Experience/Medalia Tool/Demo – Dr. Lynda Davis, Chief Veteran Experience Officer, Veteran Experience Office, VA

***** Legislation/Policy Update – Brooks Tucker, Assistant Secretary of Congressional and Legislative Affairs, VA

From: (b) (6)
Sent: Wednesday, April 04, 2018 3:01 PM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

Peter wants to talk about he invites before we send.

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:25:45 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

(b) (6) I tried calling but didn't reach (b) (5) (b) (5)

Thanks

(b) (6)

(b) (6) M.B.A.
Acting Special Assistant to the Secretary for VSOs
Office of the Secretary
Department of Veterans Affairs
810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:21:52 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

Shoot, I wanted to (b) (5). No worries, we will adapt.

Who is the Legion sending?

Thanks,

(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:17:28 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

(b) (6) I already sent invites to DAV, Legion, VFW, PVA, AMVETS, VVA WWP, IAVA and MOAA. All have confirmed except for VFW, their principal will be on travel, and the Legion is sending their Director as their principal will be on travel.

Thanks

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810 Vermont Avenue NW Office 1023
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Sent: Wednesday, April 04, 2018 9:12:10 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

Hold on sending invites if you can, if already out that's ok.

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:08:23 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

Thanks (b) (6) - will update the list as well as provide a list of VSO RSVPs by CoB today. Do you have the contact info and/or want to invite (b) (6) (b) (6) (b) (6) and (b) (6)

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810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 8:54:36 AM
To: (b) (6)
Subject: Re: VSO Breakfast Invite List

Peter is going to work on the list of VA employees in attendance so make more room for VSO's, but for the external list, lets start by adding:

(b) (6) CVA

(b) (6) Independence Fund

(b) (6), (b) (7)(C) White House Office of Public Liaison

(b) (6), (b) (7)(C) White House Domestic Policy Council

I'll let you know when we are final.

Thanks!

(b) (6)

From: (b) (6) <(b) (6) va.gov>
Date: Wednesday, April 4, 2018 at 10:06 AM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Subject: VSO Breakfast Invite List

(b) (6) per our discussion, here's the VSO breakfast invite list – please let me know if you and the team have any suggested edits/corrections.

Event/Meeting: VSO Breakfast with Acting Secretary Robert Wilkie

Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

VA Invitees:

- The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs
- The Honorable Thomas Bowman, Deputy Secretary of Veterans Affairs, Department of Veterans Affairs
- Peter O'Rourke, Chief of Staff, Office of the Secretary
- Jacquelyn Hayes-Byrd, Deputy Chief of Staff, Office of the Secretary, Office of the Secretary
- Brooks Tucker, Assistant Secretary, Office of Congressional and Legislative Affairs, VA
- John Ulyot, Assistant Secretary, Office of Public and Intergovernmental Affairs, VA
- Dr. Lynda Davis, Chief Veterans Experience Officer, VA

- Dr. Carolyn Clancy, Executive in Charge, Veterans Health Administration, VA
- Randy Reeves, Under Secretary for Memorial Affairs, VA
- (b) (6) Special Assistant to the Secretary for VSOs, VA

VSO Invitees:

- Ms. (b) (6) Executive Director, The American Legion (TAL)
- Mr. (b) (6) Executive Director, Disabled American Veterans (DAV)
- Mr. (b) (6) Executive Director, Veterans of Foreign Wars (VFW)
- Mr. (b) (6) Executive Director, Paralyzed Veterans of America (PVA)
- Mr. (b) (6) Executive Director, American Veterans (AMVETS)
- Mr. (b) (6) Executive Director of Policy and Government Affairs, Vietnam Veterans of America (VVA)
- Ms. (b) (6) Chief Policy Officer, Iraq and Afghanistan Veterans of America (IAVA)
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- Ms. (b) (6) Government and Community Relations Director, Wounded Warrior Project (WWP)
- Mr. (b) (6) Director of Government Relations, Student Veterans of America (SVA)

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 Office of the Secretary
 Department of Veterans Affairs
 810 Vermont Avenue NW Office 1023
 Washington, DC 20420
 O: 202-461-(b) (6)
 B: 202-684-(b) (6)

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6), (b) (6), (b) (6)
Filename: VSO Breakfast Invitees and Agenda v1.docx
Last Modified: Wed Apr 04 14:22:14 CDT 2018

Event/Meeting: VSO Breakfast with The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs

Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

VA Invitees:

The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs

The Honorable Thomas Bowman, Deputy Secretary of Veterans Affairs, Department of Veterans Affairs

Peter O'Rourke, Chief of Staff, Office of the Secretary

Brooks Tucker, Assistant Secretary, Office of Congressional and Legislative Affairs, VA

John Ulyot, Assistant Secretary, Office of Public and Intergovernmental Affairs, VA

Dr. Lynda Davis, Chief Veterans Experience Officer, VA

(b) (6) Special Assistant to the Secretary for VSOs, VA

White House/VSO Invitees:

(b) (6), (b) (7)(C) White House, Office of Public Liaison

(b) (6), (b) (7)(C) White House, Domestic Policy Council

(b) (6) Jr., Director of the Veterans Affairs and Rehabilitation Division, The American Legion (TAL)

(b) (6) Executive Director, Disabled American Veterans (DAV)

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Welcome/Introductions – The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs

Patient Experience/Medalia Tool/Demo – Dr. Lynda Davis, Chief Veteran Experience Officer, Veteran Experience Office, VA

Legislation/Policy Update – Brooks Tucker, Assistant Secretary of Congressional and Legislative Affairs, VA

From: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)>
To: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)>
Cc:
Bcc:
Subject: Re: VSO Breakfast Invite List
Date: Wed Apr 04 2018 14:42:25 CDT
Attachments: CS EDITS_VSO Breakfast Invitees and Agenda v1.docx

Updates from CoS attached.

Inviting (b) (6), (b) (7)(C) now.

From: (b) (6) <(b) (6)@va.gov>
Date: Wednesday, April 4, 2018 at 3:22 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>
Subject: RE: VSO Breakfast Invite List

(b) (6) I've attached and included the meeting invite, participant and agenda below. All of the VSOs have been invited and I was in the process of reaching out (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) (b) (6) and (b) (6) per your guidance this afternoon. Please advise if you and Peter have any final edits/changes to the list of attendees prior to finalizing/preparing the seating chart.

Event/Meeting: VSO Breakfast with The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs

Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

VA Invitees:

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Subject: RE: VSO Breakfast Invite List

(b) (6) I tried calling but didn't reach IAVA but they've asked about an invite. If you'd like to not invite them, I don't have to send them one.

Thanks

(b) (6)

(b) (6) M.B.A.
Acting Special Assistant to the Secretary for VSOs
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810 Vermont Avenue NW Office 1023
Washington, DC 20420
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B: 202-684-(b) (6)

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I'll let you know when we are final.

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To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>
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Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6), (b) (6), (b) (6)
Filename: CS EDITS_VSO Breakfast Invitees and Agenda v1.docx
Last Modified: Wed Apr 04 14:42:25 CDT 2018

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Peter O'Rourke, Chief of Staff, Office of the Secretary
Brooks Tucker, Assistant Secretary, Office of Congressional and Legislative Affairs, V
Dr. Lynda Davis, Chief Veterans Experience Officer, VA
Randy Reeves, Under Secretary for Memorial Affairs
Tom Murphy, Executive in Charge for Veterans Benefits Administration
Carlyon Clancy, Executive in Charge, Veterans Health Administration

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Agenda

Welcome/Introductions – The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs
Patient Experience/Medalia Tool/Demo – Dr. Lynda Davis, Chief Veteran Experience Officer, Veteran Experience Office, VA

From: (b) (6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (5), (b) (6)>
To: Bowman, Thomas </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)>
Cc:
Bcc:
Subject: FW: [EXTERNAL] Fwd: CVA Applauds Bold VA Health Care Reform Bill
Date: Tue Nov 21 2017 13:45:23 CST
Attachments:

Sent with Good (www.good.com)

From: (b) (6)
Sent: Tuesday, November 21, 2017 11:32:23 AM
To: (b) (6)
Subject: [EXTERNAL] Fwd: CVA Applauds Bold VA Health Care Reform Bill

FYI.

Begin forwarded message:

From: CVA - Press <press@cv4a.org>
Date: November 21, 2017 at 2:29:39 PM EST
To: (b) (6) mail.house.gov>
Subject: CVA Applauds Bold VA Health Care Reform Bill

For immediate release: November 21, 2017
Contact: press@cv4a.org

CVA Applauds Bold VA Health Care Reform Bill

Arlington, VA – Today, Representative Doug Lamborn (R-CO) introduced the Veterans Empowerment Act, a bill that will fundamentally reform the Veterans Health Administration (VHA) and offer all veterans who use the VA the option to access care in the private sector. Concerned Veterans for America (CVA) is urging veterans and concerned citizens across the nation to contact their legislators in support of the new bill.

The bill expands veterans' health care choices by creating a veterans' health insurance program and allowing veterans to use their benefits inside or outside of the VA system. The bill would also establish better oversight of the VA health care system while increasing transparency regarding the VA's performance.

CVA Executive Director Dan Caldwell issued the following statement:

"The seemingly endless stream of stories about veterans receiving delayed or poor-quality health care at the VA demonstrates the current VA medical system is not set up to effectively serve our veterans. Those who put their lives on the line for our country deserve the best health care possible, and the Veterans Empowerment Act would ensure that they receive it.

"We can't leave the VA medical system in its current state and expect results to improve for our veterans. This is a historic opportunity to finally go beyond the failed status quo at the VA and provide veterans with the best care possible. We applaud Rep. Lamborn for introducing this bill and strongly urge Congress to pass it into law."

Since its inception in 2012, CVA has advocated for reforming and fixing the VA. In 2014, CVA launched the VA Accountability Project, which advocated for more accountability for VA employees and more health care choice for veterans. Later that year, CVA convened the bipartisan Fixing Veterans Health Care Taskforce, which in 2015 released the Fixing Veterans Health Care Task Force Report. This report serves as the group's comprehensive proposal for health care reform at the VA.

In 2014, Congress passed the Veterans Access, Choice, and Accountability Act in response to the VA wait list scandal. This bill created the Veterans Choice Program, which only offered limited choice to veterans who satisfied certain requirements. Under the Choice Program, veterans must meet the "40-mile, 30-day" rule, which only allows veterans to seek care outside the VA if they can't be seen within a month of when they request an appointment or if they can't be seen within a 40-mile radius. Even then, many veterans are forced to jump through bureaucratic hoops to access the program, which was poorly implemented and only intended to serve as a temporary measure.

The Choice Program recently faced a budget shortfall and is expected to run out of money again at the beginning of next year unless it is replaced with a more effective and sustainable method of offering veterans at the VA health care choice.

###

If you would rather not receive future communications from Concerned Veterans For America, let us know by clicking [here](#).

Concerned Veterans For America, 2300 Wilson Blvd, Arlington, VA 22201 United States

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED]>
To: O'Rourke, Peter M. </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED]>
Cc:
Bcc:
Subject: FW: [EXTERNAL] Fwd: Keep up the good work...
Date: Wed Jul 05 2017 10:30:50 CDT
Attachments:

Hi Peter

The below email from

[REDACTED]

S/SGT, USAF/USAFR 1972-1978

was forwarded to me. I guess he has tried to get this to you and get the VA OIG to look at it.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-[REDACTED]

From: Darin Selnick [mailto:darin.selnick@[REDACTED]]
Sent: Wednesday, July 05, 2017 10:38 AM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Keep up the good work...

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)@cv4a.org>
Date: July 5, 2017 at 5:39:54 AM MST
To: Darin Selnick <darin.selnick@ (b) (6)>
Subject: FW: Keep up the good work...

Not sure if this is helpful. I don't know anything about this guy.

Best,

(b) (6)

(b) (6)
Executive Director – Concerned Veterans for America
Senior Vice President – Americans for Prosperity
563-607-(b) (6) | Twitter: @ (b) (6) | about.me/ (b) (6)

“Rangers Lead the Way!”

From: (b) (6) <(b) (6)>
Date: Wednesday, July 5, 2017 at 2:13 AM
To: (b) (6) <(b) (6)@cv4a.org>
Cc: (b) (6) <(b) (6)@cv4a.org>
Subject: FW: Keep up the good work...

Hi,

I have yet to get a response. May I schedule a call with someone please?

Thanks,

(b) (6)

E-mail: (b) (6)

From: (b) (6) [mailto:(b) (6)]
Sent: Wednesday, May 31, 2017 4:17 PM
To: (b) (6)@cv4a.org

Cc: (b) (6) cv4a.org
Subject: FW: Keep up the good work...

Hi,

Did you folks receive my email?

Is your organization willing to help Veteran patients who are injured as a result of VA medical malpractice/negligence?

Congressman Bilirakis and I caught VA IG Missal in a lie. The VA does not want to investigate VA doctors.

(b) (6)

From: (b) (6) [mailto:(b) (6)]
Sent: Thursday, May 25, 2017 3:46 PM
To: (b) (6) cv4a.org'
Cc: (b) (6) cv4a.org'
Subject: Keep up the good work...

<http://time.com/4758706/donald-trump-veterans-affair-accountability-whistleblower-office/> "Secretary Shulkin's hands will be tied until Congress passes strong accountability legislation," said (b) (6) executive director of Concerned Veterans for America. Lucas said the office was a "positive first step" but not enough to fix the culture at the VA."

CVA Executive Director Lucas / CVA Deputy Executive Director Anderson: (703) 224-3200

You folks are doing a great job for the Veteran community! On your website, the CVA says, "The VA is failing to keep its promise to veterans and military families across the country. And due to the changing size and nature of the veteran population, the VA culture will only get worse if we don't fix it now." You folks are absolutely right!

Would you please provide contact info for the new VA Office of Accountability and WP Protection? So far, it's a well-kept secret. Unfortunately, Dr. Shulkin is the kind of doctor who refuses to take action against other doctors who are injuring Veteran patients – despite what he tells the national media.

Further, I caught IG Missal lying to Congressman Bilirakis when he claimed in writing that he did not have the authority to investigate the falsification of VA medical records. If you want the details and the evidence (which I have), I will provide it upon request. US Senator Rubio's staff hand delivered my complaint against IG Missal to Dr. Shulkin, yet Dr. Shulkin has refused to confirm receipt and he has refused to act. He is the only VA official who has the authority under the Federal IG Act to 'supervise' IG Missal. Dr. Shulkin knows that IG Missal is refusing to hold offending VA doctors accountable – and he refuses to act.

In addition, I have spoken with the USDOJ. The Tampa US Attorney will not conduct a prosecutorial review unless a federal investigation is conducted first. Since the VA OIG has refused to investigate, the VA doctors who hurt me and the Bay Pines VAMC / VISN-8 officials who buried my complaints will not be held accountable. UN – FREAKIN – BELIEVEABLE!

I just spent a week at the Mayo Clinic in MN. The best doctors in the world thoroughly examined me. They have confirmed the medical problems that the VA doctors refused to acknowledge or treat. A two year delay in receiving any VA medical care because of VA medical malpractice/negligence and criminal fraud (a VA doctor deliberately misrepresented my medical condition/falsified my VA medical records to cover-up the medical malpractice/negligence of his VA peers.) The two year inaction of a number of VA doctors created permanent physical injuries – and a lot of severe, disabling pain. The medical evidence I have recovered is now crystal clear – it establishes VA medical malpractice/negligence and criminal fraud, but Dr. Shulkin refuses to act – and he refuses to provide this Veteran patient the courtesy of an explanation!

VA medical malpractice is at a crisis level – and the VA refuses to respond. If this new VA OAWP refuses to investigate, I would appreciate CVA's help in exposing another VA accountability 'sham' to the Veteran community.

Please confirm receipt.

Thanks,

(b) (6)

S/SGT, USAF/USAFR 1972-1978

FYI:

From: (b) (6) [mailto:(b) (6)]
Sent: Monday, May 15, 2017 11:03 AM
To: Abelardo.Agustines@va.gov
Cc: 'david.shulkin@va.gov'; scott.blackburn@va.gov; baligh.yehia@va.gov; 'peter.orourke@va.gov'; Daigh, John (SES) (OIG) (john.daigh@va.gov); erica.scavella@va.gov; michael.missal@va.gov; 'VHA Client Services Response Team'
Subject: Medical Update - Request for VA OAWP Investigation

To: Dr. Agustines (Bay Pines Healthcare System)

Cc: Dr. Shulkin (VA Secretary) / Peter O'Rourke (VA OAWP) / Dr. John Daigh, Jr (VA A/IG Healthcare Inspections)

US House & US Senate Committees on Veterans Affairs

President Donald Trump via USPS certified mail # 70160750000054090833

Subject: Mayo Clinic Experts Join With USF Health Professors of Neurology (and other Non-VA Neurosurgeons) Confirming Veteran's Neuropathy & Spinal Problems

Veteran's Complaints Of VA Medical Negligence and Fraud (falsification of VA medical records) Are Substantiated - Again! Veteran Asks For A VA OAWP Investigation

Question: When Is Dr. Shulkin Going To Act On A Complaint (delivered to his office by US Senator Rubio's staff) Reporting That VA IG Missal Lied to Congressman Bilirakis?

Dr. Shulkin Has Authority Under The Federal IG Act To Supervise VA IG Missal And Hold Him Accountable For Refusing To Do His Job

Dr. Agustines:

Thank-you for your help! I completed the Mayo Clinic diagnostic tests up in Rochester, MN last week as directed. I met with Dr. Peter J.B. Dyck on Friday, 05/12/17. His father and he are world-renowned neurological experts. After undergoing hours of different kinds of spinal MRI's, extensive NCS/EMG testing, and other neurological tests, Dr. Dyck agreed with other non-VA medical experts who have examined me. He said that I do have a neuropathy, along with cervical and lumbar spine problems which as you know is contrary to the VA's position. Further, Dr. Dyck believes S1 nerve impingement is responsible for my severe SI joint pain.

I'm wondering how many more medical expert opinions I have to secure before Dr. Shulkin stops this VA medical negligence cover-up and acknowledges that several VA officials are, in fact, responsible for acts of medical malpractice/negligence (resulting in permanent physical injuries) and fraud (the deliberate falsification of VA medical records)?

Question: Do you believe Dr. Shulkin to be the kind of doctor who is willing to report other VA doctors who act negligently - injuring a Veteran patient and then falsifying VA medical records in an effort to cover-up the negligence? I'm wondering if he adheres to AMA Policy # 9.031 (shown below). I'm also wondering if he has ever reported a negligent, incompetent, or unethical doctor as the AMA Code of Ethics requires. According to the AMA's Council on Ethical and Judicial Affairs, it states, in part, as follows: "Many of the Council's opinions lay out specific duties and obligations for physicians. Violation of these principles and opinions represents unethical conduct and may justify disciplinary action such as censure, suspension, or expulsion from medical society membership." It has been brought to Dr. Shulkin's attention that several negligent, incompetent, and unethical VA doctors hurt me; however, he has yet to ask for an investigation or report these VA doctors.

Please let me know when all of the Mayo records (Dr. Dyck's office notes, MRI's, and all of the test results) are in my VA medical file so that I may obtain copies. You are shown as the requesting VA doctor, so the records should be sent to your attention. Please request a NVCC consult with Dr. Ryan Glasser for me (the neurosurgeon in Sarasota, FL who did my back surgery) so that surgical options for my cervical and lumbar spine problems may be discussed. It took a Congressional inquiry to get Dr. Glasser the VA approval to remove parts of my lumbar spine in order to resolve painful sciatic nerve root impingement problems – problems the VA doctors said I didn't have. Dr. Glasser established that I do have spinal problems requiring medical care.

Over the past six (6) years, I have been forced to endure an extremely painful challenge - all because of VA medical negligence and fraud. I understand the VA doesn't want to hear this. The VA has done everything possible to bury my complaints, but the best neurological experts in this country have just confirmed what many non-VA medical experts have been telling the VA since March 2012; I do, in fact, have a neuropathy and spinal problems requiring medical care. It's disturbing to note that the VA doctors refuse to agree with these non-VA medical experts. The VA doctors have turned a blind eye to the medical evidence to avoid accountability. Various senior VA officials (including the VA OIG) have refused to investigate because the VA clearly does not want to hold these unethical VA doctors and VA administrators accountable for their misconduct, even though negligence and fraud has resulted in permanent physical injuries to a Veteran patient.

Timely and competent VA medical care back in March 2011 would have prevented the fusing of three vertebrae that has resulted in a reversal of the normal curvature of my cervical spine. VA negligence now requires me to undergo annual RFA surgical procedures for pain management because the VA doctors refuse to approve the recommended cervical surgery. Minimally invasive surgery would have repaired/replaced two herniating/leaking cervical discs thereby preventing the surrounding cervical vertebrae from fusing together. (See the above attachments) Further, it took several Congressional inquiries (and over four years) to secure VA approval for badly needed back surgery to free two lumbar nerve roots from spinal impingement. This was no mistake – the films show the spinal impingement. Dr. Triggs deliberately misrepresented my medical condition to avoid medical malpractice/negligence accountability for his VA peers.

A number of VA doctors have disregarded clear and convincing evidence of neurologic and spinal problems, and they have refused to provide a professional standard of care. Without question, it has been established by a number of respected medical experts that Dr. Triggs did enter false statements in my VA medical record – statements which were found by VA paid medical experts (not my experts) to

be in conflict with his own test results. Dr. Triggs deliberately falsified my records in an effort to cover-up acts of medical negligence that had been committed by other VA doctors. The delay that this unlawful and unethical deception caused resulted in permanent physical injuries. For almost two years, I was deprived from receiving the medical care I was entitled to receive by law. Further, the VA (VAMC and VISN-8 officials re: VA Directive 700 - AIB), the VA OMI, and the VA OIG (including Dr. Daigh, Jr.,) has steadfastly refused to investigate in an apparent effort to protect the offending VA officials. So, there has been no accountability to date.

At my request, Congressman Bilirakis inquired as to why the VA OIG had refused to investigate. IG Missal lied to Congressman Bilirakis in his written response dated 11/04/16 when he said he didn't have the 'authority' to investigate. The Federal IG Act not only gives IG Missal the authority to investigate; it also imposes a duty and a responsibility to investigate. Four months later, IG Missal reversed himself under oath in front of the C-SPAN cameras while testifying at a US House Committee on Veterans Affairs hearing on this 'authority' to investigate issue. IG Missal admitted that he does have the authority to investigate, yet he still refuses to do so – without explanation. This isn't a case of insufficient evidence or IG Missal would have said so. This is all about a VA agenda that betrays the Veteran community's trust by refusing to investigate in order to refrain from holding the offending VA doctors and VA administrators accountable for their misconduct.

Now that it has been established beyond any reasonable doubt that acts of VA medical negligence and fraud have occurred, I renew my request for an investigation to establish accountability. I would appreciate your support. On 05/12/17, Dr. Shulkin publicly announced the establishment of the VA Office of Accountability and Whistleblower Protection. As is detailed in the Executive Order announcing this new VA entity, the Executive Director will:

- *Advise and assist the Secretary in using, as appropriate, all available authorities to discipline or terminate any VA manager or employee who has violated the public's trust and failed to carry out his or her duties on behalf of Veterans.

- *Work closely with relevant VA components to ensure swift and effective resolution of Veterans' complaints of wrongdoing at VA.

- *Work closely with relevant VA components to ensure adequate investigation and correction of wrongdoing throughout the VA, and protect employees who lawfully disclose wrongdoing from retaliation.

VA medical negligence reportedly costs American taxpayers over a hundred million dollars a year in injury awards and that amount is estimated to involve less than 10% of the total number of Veteran patients who are actually harmed as a result of delayed, denied, and negligent VA medical care. Medical negligence is a crisis the VA refuses to address. They reportedly do not have enough doctors to service the Veteran community now, so they are not interested in holding 'bad' doctors accountable.

By copying him via this email, I am asking VA OAWP Director Peter O'Rourke to please investigate my complaint of VA medical negligence and fraud in accordance with CIGIE professional investigative standards. As a retired law enforcement investigator and a former civil judge, the evidence I have recovered proves the allegations of VA misconduct I have reported beyond a reasonable doubt. And, if this new entity refuses to investigate, my complaint will serve to expose another VA 'accountability' sham on the Veteran community.

Since the VA OAR (that was established by former VA Secretary McDonald) proved to be a sad joke,

many injured Veteran patients are anxious to see whether the VA OAWP will act in accordance with its published mission statement. I renew my request to Dr. Shulkin that he ask Mr. O'Rourke to investigate my complaints (in addition to my complaint against IG Missal) in an effort to hold all of the offending VA officials accountable. Should Dr. Shulkin refuse to do so (he reportedly refused to confirm receipt of a complaint I filed with him against IG Missal even though a member of US Senator Rubio's staff hand delivered a copy of my complaint to his office), I will ask President Trump to replace Dr. Shulkin for cause if he continues to bury valid complaints from Veteran patients in an effort to cover-up the misconduct of VA doctors and VA administrators.

In closing, the VA's ongoing efforts to avoid accountability are historic. Former Chairman of the US House Committee on Veterans Affairs Jeff Miller was right when he said, "To see all of the deception and incompetence at the VA with no accountability and no action, it is more than just a shame – it is a national disgrace."

I ask that Dr. Shulkin and Mr. O'Rourke please confirm receipt of this email communication. The VA says they adhere to 'I-CARE' values. Now would be a great time to work together to identify a number of VA officials (including senior officials) who need to be held accountable for what they have done. Again, Veterans remain at risk of harm because there has been no accountability assessed against these unethical VA officials.

Sincerely,

(b) (6)

E-mail: (b) (6)

<https://www.usatoday.com/story/news/politics/2017/04/26/trump-order-va-accountability-whistleblower-office/100939062/>

The office will investigate allegations of misconduct – including retaliation against whistle-blowing employees who reported abuses — and seek to identify systemic barriers that have previously hindered the agencies' top leaders from more adequately addressing such problems in the past, including with disciplinary action. VA Secretary David Shulkin told reporters the new office will report directly to him. "Accountability is an important issue to us at VA and something that we're focusing on to make sure that we have employees who work and are committed to the mission of serving our veterans, and when we find employees that have deviated from these values, we want to make sure that we can move them outside of VA and not have them working at VA," he said, adding that Trump's creation of the office by executive order demonstrates how committed the president is to the issue as well. The VA already has an Office of Accountability Review that was created in 2014 to "ensure leadership accountability for improprieties related to patient scheduling and access to care, whistleblower retaliation, and related

matters that impact public trust in VA.” But Shulkin said that office reports to the agency’s general counsel and is focused on senior VA leaders. The new office will look at all VA employees.

<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion701.page>

Opinion 1.01 - Terminology

The term "ethical" is used in opinions of the Council on Ethical and Judicial Affairs to refer to matters involving (1) moral principles or practices and (2) matters of social policy involving issues of morality in the practice of medicine. The term "unethical" is used to refer to professional conduct which fails to conform to these moral standards or policies.

Many of the Council’s opinions lay out specific duties and obligations for physicians. Violation of these principles and opinions represents unethical conduct and may justify disciplinary action such as censure, suspension, or expulsion from medical society membership.

Opinion 8.021 - Ethical Obligations of Medical Directors

Medical directors acting within the professional sphere, such as when making decisions regarding medical appropriateness, have an overriding ethical obligation to promote professional medical standards. Adherence to professional medical standards includes:

(1) Placing the interests of patients above other considerations, such as personal interests (eg, financial incentives) or employer business interests (eg, profit). This entails applying the plan parameters to each patient equally and engaging in neither discrimination nor favoritism.

Opinion 9.031 - Reporting Impaired, Incompetent, or Unethical Colleagues

Physicians have an ethical obligation to report impaired, incompetent, and/or unethical colleagues in accordance with the legal requirements in each state and assisted by the following guidelines:

Impairment. Physicians’ responsibilities to colleagues who are impaired by a condition that interferes with their ability to engage safely in professional activities include timely intervention to ensure that these colleagues cease practicing and receive appropriate assistance from a physician health program (see Opinion E-9.0305, "Physician Health and Wellness"). Ethically and legally, it may be necessary to report an impaired physician who continues to practice despite reasonable offers of assistance and referral to a hospital or state physician health program. The duty to report under such circumstances, which stems from physicians’ obligation to protect patients against harm, may entail reporting to the licensing authority.

Incompetence. Initial reports of incompetence should be made to the appropriate clinical authority who would be empowered to assess the potential impact on patient welfare and to facilitate remedial action. The hospital peer review body should be notified where appropriate. Incompetence that poses an immediate threat to the health and safety of patients should be reported directly to the state licensing board. Incompetence by physicians without a hospital affiliation should be reported to the local or state medical society and/or the state licensing or disciplinary board.

Unethical conduct. With the exception of incompetence or impairment, unethical behavior should be reported in accordance with the following guidelines and, considering, as necessary, the right to privacy of any patients involved:

Unethical conduct that threatens patient care or welfare should be reported to the appropriate authority for a particular clinical service. Unethical conduct that violates state licensing provisions should be

reported to the state licensing board. It is appropriate to report unethical conduct that potentially violates criminal statutes to law enforcement authorities. All other unethical conduct should be reported to the local or state professional medical organization.

When the inappropriate conduct of a physician continues despite the initial report(s), the reporting physician should report to a higher or additional authority. The person or body receiving the initial report should notify the reporting physician when appropriate action has been taken. Physicians who receive reports of inappropriate behavior, including reports submitted anonymously, have an ethical duty to critically, objectively, and confidentially evaluate the reported information and assure that identified deficiencies are either remedied or further reported to a higher or additional authority. Information regarding reports or investigations of impairment, or of incompetent or unethical behavior should be held in confidence until the matter is resolved.

Opinion 9.04 - Discipline and Medicine

Incompetence, corruption, or dishonest or unethical conduct on the part of members of the medical profession is reprehensible. In addition to posing a real or potential threat to patients, such conduct undermines the public's confidence in the profession. A physician should expose, without fear or loss of favor, incompetent or corrupt, dishonest, or unethical conduct on the part of members of the profession. Questions of such conduct should be reported and reviewed in accordance with Opinion 9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues."

From: (b) (6) @gmail.com [mailto:(b) (6) @gmail.com]
Sent: Tuesday, May 02, 2017 1:53 PM
To: (b) (6) @mail.house.gov; hvac.info@mail.house.gov; (b) (6) @mail.house.gov; (b) (6) @mail.house.gov; (b) (6) @mail.house.gov
Cc: 'david.shulkin@va.gov'; scott.blackburn@va.gov; baligh.yehia@va.gov; (b) (6) @vetaff.senate.gov; (b) (6) t@mail.house.gov; info@johnnyisakson.com; info_sanders@sanders.senate.gov; michael.missal@va.gov; (b) (6) @mail.house.gov; (b) (6) @mail.house.gov; (b) (6) @mail.house.gov; (b) (6) @mail.house.gov; (b) (6) @va.gov; 'VHA Client Services Response Team'; Daigh, John (SES) (OIG) (b) (6) @va.gov; (b) (6), (b) (7)(C) mccain.senate.gov; (b) (6) @rubio.senate.gov; 'Rubio, Casework (Rubio)'; 'casework@rubio.senate.gov'; (b) (6) @legion.org; (b) (6) @legion.org; (b) (6) @usdoj.gov; 'cigie.information@cigie.gov'
Subject: VA medical malpractice/negligence is a crisis the VA won't discuss. Injured Veterans are requesting help!

To: US HCVA Chairman Roe

Cc: US HCVA Vice Chairman Bilirakis

US SCVA Chairman Isakson

US Senator Rubio / US Senator McCain

Medical malpractice costs the VA over a hundred million taxpayer dollars a year! I am a victim of VA medical malpractice/negligence. For almost two years, the VHA said I had no spinal problems requiring medical care, so they denied me the medical care I was entitled to receive by law. Over four years after

I first presented in pain, US Congressman Jolly was able to get the VA to approve badly needed back surgery. A non-VA doctor neurosurgeon removed parts of my lumbar spine to correct a serious nerve root impingement. The impingement was clearly seen on my films by all non-VA doctors. Once I exposed the fact that the VA doctors had acted negligently, they turned a blind eye to the medical evidence and they refused to see what all the non-VA doctors pointed out in my films – clear nerve root impingement problems.

VA medical malpractice is a crisis the VA refuses to address. And, with Dr. Shulkin in charge, it appears he is refusing to hold VA doctors accountable no matter how much evidence a Veteran patient provides showing malpractice. The same criticism goes for IG Missal who lied to Congressman Bilirakis to keep from investigating my complaint of a VA doctor falsifying VA medical records to cover-up acts of VA medical malpractice/negligence. I asked Dr. Shulkin to confirm receipt of a complaint against IG Missal for acting unlawfully and unethically in violation of his oath of office several months ago and to date – Dr. Shulkin has refused to act. So, US Senator Rubio sent a senior policy analyst to hand deliver my complaint to Dr. Shulkin's office – and Dr. Shulkin has still refused to confirm receipt. Veterans know what our elected officials apparently don't know; VA officials lie and lie and lie...

Former Chairman Jeff Miller was right when he said, “To see all of the deception and incompetence at the VA with no accountability and no action, it is more than just a shame – it is a national disgrace.”

Well on April 27, 2017 when this new VA task force activates, I have asked Dr. Shulkin to ensure that my complaints of gross patient abuse/medical malpractice/negligence which have resulted in permanent physical injuries are investigated. How much do you want to bet that this VA task force will refuse to investigate? McDonald's new 'VA Accountability Team' refused to investigate and they had a similar mission. Veterans who have been harmed are asking the US House and US Senate Committees on Veterans Affairs to please ensure that our complaints are professionally investigated in accordance with CIGIE standards.

In my case, several VA paid medical experts (two professors of neurology and a neurosurgeon) reviewed the medical evidence and found that VA Dr. Triggs' not only misdiagnosed my spinal problems; the statements he entered into my VA medical file were found to be false and in conflict with his own test results. Dr. Triggs lied in an effort to cover for his VA peers! My back surgery established serious spinal problems that had to be corrected by surgery. So, I did have spinal problems requiring medical care, yet the VA still has refuses to investigate the VA doctors in question and they refuse to correct my records. The VA (even under a new VA Secretary and a new VA IG) remains in a covert denial mode. They provide great PR soundbites to the media, but the fact that Veteran patients know very well is that VA medical malpractice is a crisis that is harming/killing Veterans – and our most senior VA officials refuse to do anything about it – other than cover it up!

The VA refuses to conduct a professional investigation as it does NOT want to hold offending VA doctors accountable. This is why I am asking our elected officials to please act and for the media to please report on this crisis – please.

Thanks,

(b) (6)

E-mail: (b) (6)

P.S. Here's what they do to VA doctors who report VA misconduct: <http://www.foxnews.com/us/2017/03/30/va-retaliation-against-whistleblower-doctor-kept-in-empty-room.html>

<https://www.stripes.com/>

Vet 'dumbfounded' after VA drops ball on brain mass diagnosis

By JACK ENCARNACAO | The Boston Herald (Tribune News Service) | Published: May 2, 2017

U.S. Marine combat vet Brian Callahan sat in stunned silence. A doctor at Massachusetts General Hospital had just asked him what the Veterans Administration thought about a brain mass he spotted on Callahan's MRIs.

"I looked at him and I said, 'Excuse me?' " said Callahan, who was seeing the growth for the first time on the neuro-endocrinologist's screen. "He just kept pointing at it with a mouse on all the scans. He just kept looking at me going, 'And the VA's never said anything?' He was dumbfounded."

Callahan felt a moment of vindication, then fear, then anger.

"The VA kept telling me that, you know, there's really nothing wrong," he said. "I was like, finally, I'm not crazy. This is something that's really going on ... I was horrified."

The 30-year-old former lance corporal from Dracut had been a machine gunner with 3/8 Marines in Iraq and Afghanistan. He had been rattled by several improvised explosive device blasts, and got a concussion from one. His November 2016 visit to Mass General was the first time the VA's images of his brain were reviewed by a non-VA doctor.

In the six years Callahan had been going to VA hospitals in Jamaica Plain and West Roxbury for treatment of debilitating seizures, he had never been told anything about the mass, which is benign and located between his pituitary gland and ocular nerve. He said the VA docs always chalked up his symptoms to stress, migraines or vertigo, and told him they couldn't see anything amiss on his brain.

Callahan — with a faulty diagnosis and a low disability rating — continued to struggle with the seizures, lost his job at a diesel trucking company and went on Mass Health, through which he ended up at Mass General.

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To: Ulyot, John </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)> Tucker, Brooks </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)> (b) (6) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (5), (b) (6)>
Cc: Wright, Vivieca (Simpson) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (5), (b) (6)>
Bcc:
Subject: FW: [EXTERNAL] CVA Names (b) (6) as New Executive Director - Concerned Veterans for America
Date: Sun Oct 29 2017 16:41:12 CDT
Attachments:

Just FYI

Sent with Good (www.good.com)

From: (b) (6)
Sent: Saturday, October 28, 2017 2:07:49 PM
To: (b) (6)
Subject: [EXTERNAL] CVA Names (b) (6) as New Executive Director - Concerned Veterans for America

[https://cv4a.org/press-release/cva-names-\(b\) \(6\)-new-executive-director/](https://cv4a.org/press-release/cva-names-(b) (6)-new-executive-director/)

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<postmaster@valleysd.org>
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Bcc:
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Date: Sat Jul 08 2017 14:31:34 CDT
Attachments: Good job (1).msg

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(b) (6)

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Diagnostic information for administrators:

Generating server: valleysd.org

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cva.org

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(UTC)

X-MS-Exchange-CrossTenant-Id: b5b01d1f-c135-41ff-8f05-bedb47795b6c

X-MS-Exchange-CrossTenant-FromEntityHeader: Internet

X-MS-Exchange-Transport-CrossTenantHeadersStamped: DM2PR0201MB0735

X-OrganizationHeadersPreserved: DM2PR0201MB0735.namprd02.prod.outlook.com

X-OriginatorOrg: valley.k12.wa.us

X-CrossPremisesHeadersPromoted: vsdexchange.valley.k12.wa.us

X-CrossPremisesHeadersFiltered: vsdexchange.valley.k12.wa.us

Owner: postmaster@valleysd.org <postmaster@valleysd.org>
Filename: Good job (1).msg <extracted>
Last Modified: Sat Jul 08 14:31:34 CDT 2017

Good job (b) (6) [redacted] Item: 87 (Attachment 1 of 1)
To: [redacted]@cva.org
From: DJS
Sent: Sat 7/8/2017 7:31:00 PM
Subject: Good job

I saw your interview and town hall on fox and think you did a really nice job. I think your setting the right tone to keep focus on the important issues but showing the President and I your constructive support for our reforms.

It's not easy as you know- lots of resisters are out there-but like you said im optimistic

David Shulkin

Sent with Good (www.good.com)

From: Ulliyot, John </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)>

To: Alaigh, Poonam, M.D. </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)> Flanz, Meghan Serwin </o=va/ou=va martinsburg/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)> Lapuz, Miguel H. </o=va/ou=visn 10/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)> [REDACTED] </o=va/ou=va martinsburg/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)> Hutton, James </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)> [REDACTED] </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)> Young, Steven W. </o=va/ou=visn 08/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)>

Cc: Leinenkugel, Jake </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)> Wright, Vivieca (Simpson) </o=va/ou=va martinsburg/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)> [REDACTED] </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)> Gruntmeir, Doris </o=va/ou=va martinsburg/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)>

Bcc:

Subject: Re: San Juan former MCD -- call at 1 pm?

Date: Sun May 07 2017 09:56:00 CDT

Attachments: Communications Plan Hamlin San Juan Draft 1 170507.docx

Sent with Good (www.good.com)

-----Original Message-----

From: John Ulliyot [john.[REDACTED] (b) (5), (b) (6)]
Sent: Sunday, May 07, 2017 10:46 AM Eastern Standard Time
To: Ulliyot, John
Subject: [EXTERNAL] Re: San Juan former MCD -- call at 1 pm?

Poonam/Meghan and Team:

Please see the string below from [REDACTED] (b) (5), (b) (6) of OGC — it appears that VA [REDACTED] (b) (5), (b) (6)

[REDACTED]

[REDACTED]

(b) (5)



Can we discuss on a call early this afternoon to decide on a way forward? Does 1 pm work for everyone?

Please let us know and we can circulate a dial-in.

Thanks,

John U.

John Ulliot

Assistant Secretary for Public and Intergovernmental Affairs

U.S. Department of Veterans Affairs

202-461-7500 office

john.ulliot@va.gov

-----Original Message-----

From: Hutton, James

Sent: Saturday, May 06, 2017 08:17 PM Eastern Standard Time

To: (b) (6) (b) (6) Ulliot, John

Cc: (b) (6) Gruntmeir, Doris; Flanz, Meghan Serwin; Young, Steven W.; Lapuz, Miguel H.

Subject: RE: San Juan former MCD

Adding John Ulliot. Please ensure he remains on the email string.

James Hutton
Deputy Assistant Secretary (Acting)
Office of Public Affairs
Department of Veterans Affairs
810 Vermont Ave, NW
Washington, D.C. 20420
Office: 202-461-7558
Email: james.hutton@va.gov
Twitter: @jehutton

From: (b) (6)
Sent: Saturday, May 06, 2017 7:18 PM
To: Hutton, James; (b) (6)
Cc: (b) (6) Gruntmeir, Doris; Flanz, Meghan Serwin; Young, Steven W.; Lapuz, Miguel H.
Subject: RE: San Juan former MCD

Trying to keep everyone on one email string. With regard to communications about this matter, per below, please note that this case is still in active litigation and I strongly recommend that we only (b) (5)

[REDACTED]

(b) (5)

[REDACTED]

[REDACTED]

With regard to OPIA's questions:

(b) (5)

(b) (5)

(b) (6)

(b) (6)

| Deputy Chief Counsel for the Personnel Law Group

U.S. Department of Veterans Affairs (VA) | Office of General Counsel (OGC)

Tel: (202) 461- (b) (6) | Fax: (202) 495- (b) (6) | Email: (b) (6) va.gov

Address: 810 Vermont Avenue, NW, Mail Stop 028, Washington, DC 20420

This e-mail (including any attachments) may contain information that is private, confidential, or protected by attorney-client or other privilege. If you received this e-mail in error, you are notified that any disclosure, copying, distribution, or use of the information contained herein (including any reliance thereon) is strictly prohibited. If you have received this e-mail in error, please notify the sender immediately and destroy the e-mail and any attachments.

From: (b) (6)
Sent: Saturday, May 06, 2017 4:23 PM
To: (b) (6)

Cc: (b) (6) Gruntmeir, Doris; Flanz, Meghan Serwin; Young, Steven W.; Lapuz, Miguel H.
Subject: RE: San Juan former MCD

(b) (5)

Looping in Steve and Dr. LaPuz to avoid two email strings. If you have further questions or want to discuss rational behind some of this (none of which are for publication) we could schedule a call.

(b) (6)

(b) (6) | Deputy Chief Counsel for the Personnel Law Group

U.S. Department of Veterans Affairs (VA) | Office of General Counsel (OGC)

Tel: (202) 461-(b) (6) | Fax: (202) 495-(b) (6) | Email: (b) (6) va.gov

Address: 810 Vermont Avenue, NW, Mail Stop 028, Washington, DC 20420

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From: (b) (6)
Sent: Saturday, May 06, 2017 4:01 PM
To: (b) (6)
Cc: (b) (6) Gruntmeir, Doris; Flanz, Meghan Serwin
Subject: RE: San Juan former MCD

(b) (6)

Thanks for this. I'm not entirely familiar with how the MSRB works. But the VA (b) (6)
(b) (6) ?

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6)
Sent: Saturday, May 06, 2017 03:42 PM Eastern Standard Time
To: (b) (6)
Cc: (b) (6); Gruntmeir, Doris; Flanz, Meghan Serwin
Subject: RE: San Juan former MCD

Hi (b) (6)

DeWayne Hamlin's case is still being actively litigated before the MSPB, which has not yet dismissed this matter until such time as the agency can show that it has (b) (5)

(b) (5)

(b) (5)

(b) (5)

Thanks,

(b) (6)

(b) (6) | Deputy Chief Counsel for the Personnel Law Group

U.S. Department of Veterans Affairs (VA) | Office of General Counsel (OGC)

Tel: (202) 461-(b) (6) | Fax: (202) 495-(b) (6) | Email: (b) (6)@va.gov

Address: 810 Vermont Avenue, NW, Mail Stop 028, Washington, DC 20420

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any disclosure, copying, distribution, or use of the information contained herein (including any reliance thereon) is strictly prohibited. If you have received this e-mail in error, please notify the sender immediately and destroy the e-mail and any attachments.

From: Flanz, Meghan Serwin
Sent: Saturday, May 06, 2017 3:15 PM
To: (b) (6)
Cc: (b) (6); (b) (6) Gruntmeir, Doris
Subject: RE: San Juan former MCD

Amy and (b) (6) (cc'd) have the lead on this matter for OGC. They have a better handle on status than I do.

Meghan Flanz
Interim General Counsel
(202) 461-7661

-----Original Message-----

From: (b) (6)
Sent: Saturday, May 06, 2017 02:24 PM Eastern Standard Time
To: Flanz, Meghan Serwin
Subject: FW: San Juan former MCD

Meghan

Can you help with this?

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6)
Sent: Saturday, May 06, 2017 01:50 PM Eastern Standard Time
To: Lapuz, Miguel H.; (b) (6)
Cc: (b) (6) Liezert, Timothy W.
Subject: RE: San Juan former MCD

(b) (6) spoke with (b) (6) this afternoon. She is working on the (b) (6) ..

Sent with Good (www.good.com)

-----Original Message-----

From: Lapuz, Miguel H.

Sent: Saturday, May 06, 2017 01:09 PM Eastern Standard Time

To: (b) (6)
Cc: (b) (6) Liezert, Timothy W.
Subject: FW: San Juan former MCD

(b) (6)

Can we please have a timeline of events for (b) (6) Thanks

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6)
Sent: Saturday, May 06, 2017 12:26 PM Eastern Standard Time
To: Ulliyot, John; Alaigh, Poonam, M.D.; Lapuz, Miguel H.; (b) (6) Wright, Vivieca (Simpson); Leinenkugel, Jake
Cc: Liezert, Timothy W.; (b) (6) Young, Steven W.; DJS; Hutton, James
Subject: RE: San Juan former MCD

Ok.

We really need info about what happened with the (b) (5)

Steve - can you help?

Gina

Sent with Good (www.good.com)

-----Original Message-----

From: Ulliyot, John
Sent: Saturday, May 06, 2017 11:58 AM Eastern Standard Time
To: Alaigh, Poonam, M.D.; Lapuz, Miguel H.; (b) (6) (b) (6) Wright, Vivieca (Simpson); Leinenkugel, Jake
Cc: Liezert, Timothy W.; (b) (6) Young, Steven W.; DJS; Hutton, James
Subject: RE: San Juan former MCD

Thanks for the heads' up Poonam -- I'm new to this issue, but absolutely agree we need to (b) (5)

(b) (5)

(b) (5)

(b) (5)

(b) (5)

(b) (5)

Please let James and me know if you have any questions or would like to discuss on a brief call today.

Thanks again,

John U.
202-701-0138

Sent with Good (www.good.com)

-----Original Message-----

From: Alaigh, Poonam, M.D.

Sent: Saturday, May 06, 2017 09:52 AM Eastern Standard Time

To: Lapuz, Miguel H.; (b) (6) (b) (6) Ulliyot, John; Wright, Vivieca (Simpson);

Leinenkugel, Jake

Cc: Liezert, Timothy W.; (b) (6) Young, Steven W.; DJS

Subject: RE: San Juan former MCD

Completely agree with (b) (5)

Sent with Good (www.good.com)

-----Original Message-----

From: Lapuz, Miguel H.

Sent: Saturday, May 06, 2017 08:25 AM Eastern Standard Time

To: (b) (6) (b) (6)

Cc: Liezert, Timothy W.; (b) (6) Young, Steven W.; Alaigh, Poonam, M.D.
Subject: San Juan former MCD

Gina,

There was a lot of media interests on Mr. Hamlin's termination. Now that he will be (b) (5)

Thanks

Sent with Good (www.good.com)

Owner: Ulliyot, John </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=[REDACTED]
Filename: Communications Plan Hamlin San Juan Draft 1 170507.docx
Last Modified: Sun May 07 09:56:00 CDT 2017

Communication Plan
Reinstatement of Puerto Rico Medical Center Director
May 6, 2017

Background

DeWayne Hamlin, the director of the San Juan VA Medical Center, was removed from federal service January 20, 2017.

DeWayne Hamlin's case is still being actively litigated before the MSPB, which has not yet dismissed this matter until such time as the agency can show that it has fully restored Mr. Hamlin back to the way he was before the agency took its removal action. Consequently, given the contentious nature of this case, OGC strongly recommends that VA only (b) (5)

[REDACTED]

[REDACTED]

Approach

The VA should be (b) (5)

[REDACTED]

When	Who	What
May 8 – AM	Congressional Notification	VA Media Statement
May 8 – AM	WH Notification	VA Media Statement
May 8 – AM	San Juan Leadership Team	Internal Statement
May 8 – AM	San Juan Employee Notification	All employee email with internal statement
May 8 – AM	VSO Notifications	

Media Statement

(b) (5)

[REDACTED]

[REDACTED]

Internal/employee statement

(b) (5)



Key outlets/key coverage

Benjamin Krause: <http://www.disabledveterans.org/2017/01/24/youre-fired-san-juan-va-director-dewayne-hamlin-terminated/>

Luke Rosiak, Daily Caller: <http://dailycaller.com/2017/01/24/days-into-trump-admin-corrupt-employees-are-already-being-fired-at-the-va/>

USA Today: <https://www.usatoday.com/story/news/nation-now/2016/09/19/va-battles-problem-employees-accountability-accusations/90715048/>

Washington Times: <http://www.washingtontimes.com/news/2014/sep/7/high-ranking-va-official-charged-with-drunken-driv/>

CVA: <https://cv4a.org/vafail-va-offers-record-high-settlement-whistleblower/>

From: (b) (6) </o=va/ou=vha office of
information/cn=recipients/cn=(b) (6), (b) (5)
To: VHA Substantial Interest FOIA
Notification
</o=va/ou=infrastructure/cn=recipients/cn=(b) (6), (b) (5)
Cc:
Bcc:
Subject: VHA Substantial FOIA Notification, Jasper Craven, MuckRock News, 18-04199-F
Date: Fri Feb 16 2018 13:40:25 CST
Attachments: 18-04199-F - Incoming Request.pdf

Attached to this email is a FOIA request received by the VHA FOIA Office on February 14, 2018. The details pertaining to this request are outlined below:

Who: Jasper Craven

Affiliation: MuckRock News

What: All email correspondence between VA officials and officials at the Concerned Veterans For America with email addresses ending in "@cv4a.org" between Jan. 20 and present day. The search terms should include, but are not limited to, "trump" "koch" "accountability" "privatize" "shulkin" "selnick" "VA".

Assigned VHA FOIA Officer: (b) (6)

No further action is required. If anyone has any questions, please feel free to contact me.

Thank you,

(b) (6) RHIA, CHPS, CIPP/G, CHPS

VHA FOIA Officer (10A7)

Information Access & Privacy Office/Health Information Governance

Office of Health Informatics

810 Vermont Avenue, N.W., Washington, D.C. 20420

Office (772) 562-(b) (6) Fax (202) 273-(b) (6)

Owner: (b) (6) </o=va/ou=vha office of information/cn=recipients/cn=(b) (6), (b) (5)
Filename: 18-04199-F - Incoming Request.pdf
Last Modified: Fri Feb 16 13:40:25 CST 2018

RECEIVED DATE
CONTROL #
VHA FOIA OFFICE

14 Feb 2018
18-04199-F

From: 47601-90947708@requests.muckrock.com
To: VACO FOIA Service Inbox
Subject: [EXTERNAL] Freedom of Information Request: All correspondence between CVA + VA
Date: Wednesday, January 10, 2018 1:43:05 PM

January 10, 2018

To Whom It May Concern:

This is a request under the Freedom of Information Act. I hereby request the following records:

All email correspondence between VA officials and officials at the Concerned Veterans For America with email addresses ending in "@cv4a.org" between Jan. 20 and present day. I sent a request earlier for this, and was given tracking number 18-01467-F. I think this request has been closed, as I neglected to properly respond to a request for clarification. If that's the case, please start a new request. But if my last request is live, please tweak. The search terms should include, but are not limited to, "trump" "koch" "accountability" "privatize" "shulkin" "selnick" "VA"

The requested documents will be made available to the general public, and this request is not being made for commercial purposes.

In the event that there are fees, I would be grateful if you would inform me of the total charges in advance of fulfilling my request. I would prefer the request filled electronically, by e-mail attachment if available or CD-ROM if not.

Thank you in advance for your anticipated cooperation in this matter. I look forward to receiving your response to this request within 20 business days, as the statute requires.

Sincerely,

Jasper Craven

Filed via MuckRock.com

E-mail (Preferred): 47601-90947708@requests.muckrock.com

Upload documents directly: https://www.muckrock.com/accounts/agency_login/department-of-veterans-affairs-119/all-correspondence-between-cva-va-47601/?uuid-login=5b66e594-f7d9-44a4-af32-dd2de7623e05&email=vacofoiase%40va.gov#agency-reply

Is this email coming to the wrong contact? Something else wrong? Use the above link to let us know.

For mailed responses, please address (see note):

MuckRock News

DEPT MR 47601

411A Highland Ave

Somerville, MA 02144-2516

PLEASE NOTE: This request is not filed by a MuckRock staff member, but is being sent through MuckRock by the above in order to better track, share, and manage public records requests. Also note that improperly addressed (i.e., with the requester's name rather than

VA-18-0457-A-000580

"MuckRock News" and the department number) requests might be returned as undeliverable.

From: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)
To: (b) (6), (b) (5), (b) (7)(C), (b) (7)(E) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6), (b) (5), (b) (7)(C), (b) (7)(E) >
Cc: (b) (6) </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)
(b) (6)
Bcc:
Subject: Seating Chart 4.6.18 (2)
Date: Thu Apr 05 2018 15:12:09 CDT
Attachments: Seating Chart 4.6.18 (2).docx

(b) (6), (b) (7)(C) :

See updated seating chart – removed (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C) per (b) (6) request.

Thanks

(b) (6)

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6), (b) (6), (b) (6)
Filename: Seating Chart 4.6.18 (2).docx
Last Modified: Thu Apr 05 15:12:09 CDT 2018

SECVA VSO Breakfast
Friday, March 6, 2018
8:00-9:00am
OBCR

Seating Chart

Brooks Tucker Assistant Secretary, OCLA	(b) (6)	SVA
Jim Byrne General Counsel, VA	(b) (6)	WWP
(b) (6), (b) (7)(C) White House Office of Public Liaison	(b) (6)	MOAA
Peter O'Rourke Chief of Staff	(b) (6)	Concerned Veterans of America
Acting Secretary Wilkie	(b) (6)	DAV
Pamela Powers Senior Advisor, VA	(b) (6)	VVA
(b) (6) Special Assistant, VA	(b) (6)	PVA
(b) (6) IAVA	(b) (6)	The American Legion
(b) (6) AMVETS	(b) (6)	Independence Fund

V1

From: David shulkin <drshulkin@[REDACTED]>
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdl)/cn=recipients/cn=[REDACTED]>
Cc:
Bcc:
Subject: [EXTERNAL] Fwd: Pilot project - related to existing telemedicine grant
Date: Mon Jan 29 2018 16:20:30 CST
Attachments: ATT00001.htm
ATT00002.htm
CareSpan Overview.pdf
VRCM-Demo-Proposal.v5.pdf

Sent from my iPhone

Begin forwarded message:

From: [REDACTED] <[REDACTED]@rejuvenan.com>
Date: January 27, 2018 at 10:06:02 AM EST
To: David Shulkin MD <drshulkin@[REDACTED]>
Subject: Pilot project - related to existing telemedicine grant

I hope this finds you well. I recall your last email about the strictures around your being an appointee. This email I think respects that and is about a pilot project that would be cost-free to the VA, although it is related to an existing VA contract.

This pilot would harmonize with

the
VA contract awarded to Care Innovations last year for [REDACTED]

[REDACTED]

[REDACTED]

(b) (4), (b) (5)

(b) (4), (b) (5)

(b) (4), (b) (5)

Please let me know if this program is of interest to you. We would welcome your comments, feedback and support.

With my thanks and best wishes, Michael

(b) (6) (b) (6) CEO, CareSpan USA 303-800-8296 ext (b) (6)

(b) (6) @carespanhealth.com

(b) (6), Ph.D.
Chief Revenue Officer
Rejuvenan Global Health, Inc.
555 Madison Avenue Flr 20 NY NY 10022
917-538-(b) (6) Mobile - best # to call

212-486-8010 Ext (b) (6) (Office)
www.rejuvenan.com

Owner: David shulkin <drshulkin@^{(b) (6)} [REDACTED]>
Filename: ATT00001.htm
Last Modified: Mon Jan 29 16:20:30 CST 2018

Owner: David shulkin <drshulkin@[REDACTED]>
Filename: ATT00002.htm
Last Modified: Mon Jan 29 16:20:30 CST 2018

Owner: David shulkin <drshulkin@^{(b) (6)} [REDACTED]>
Filename: CareSpan Overview.pdf
Last Modified: Mon Jan 29 16:20:30 CST 2018



(b) (5), (b) (4)

Owner: David shulkin <drshulkin@^{(b) (6)} [REDACTED]>
Filename: VRCM-Demo-Proposal.v5.pdf
Last Modified: Mon Jan 29 16:20:30 CST 2018

PROPOSAL:

Integrated Remote Monitoring and Digital Healthcare Services for Elderly, Isolated, At-Risk Veterans

**A Demonstration Program to Improve Medical Care Access,
Care Outcomes, and the Economics of At-Home Care Delivery for Veterans**

Purpose of Veteran Remote Care & Monitoring Program ("VRCM"):

(b) (5), (b) (4)

(b) (5), (b) (4)

Program Objectives:

(b) (5), (b) (4)

Hypothesis—Expected Economic and Health Benefits:

(b) (5), (b) (4)

(b) (5), (b) (4)

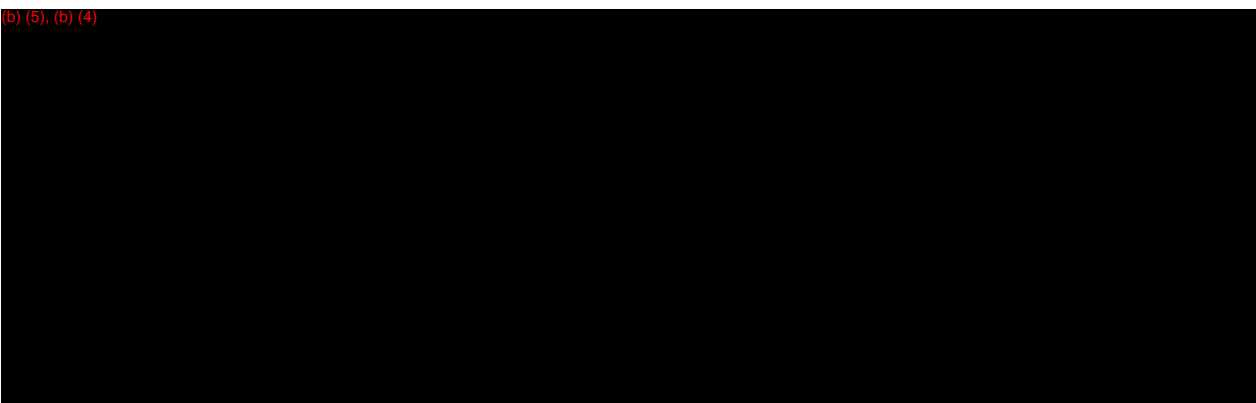
VRCM Demonstration Program

(b) (5), (b) (4)

A large rectangular area of the document is completely redacted with a solid black box.

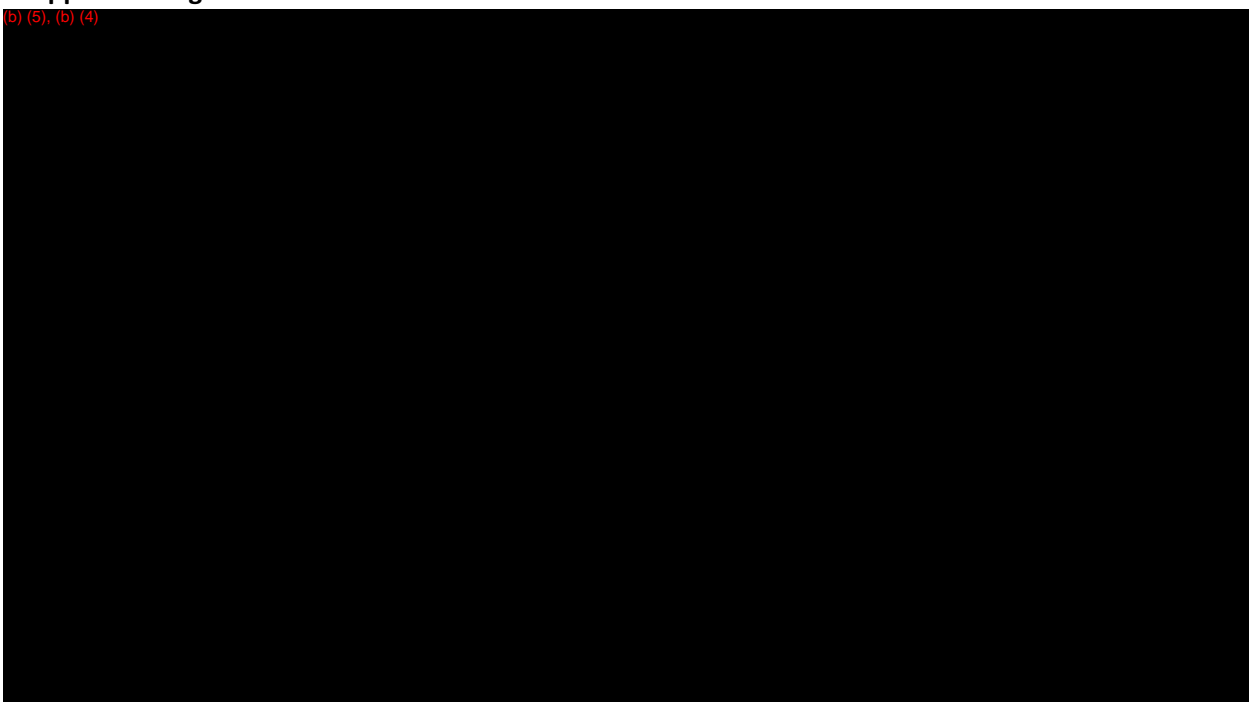
Key Performance Indicators and End Points:

(b) (5), (b) (4)

A large rectangular area of the document is completely redacted with a solid black box.

Supplementing Current VA Initiatives:

(b) (5), (b) (4)

A large rectangular area of the document is completely redacted with a solid black box.

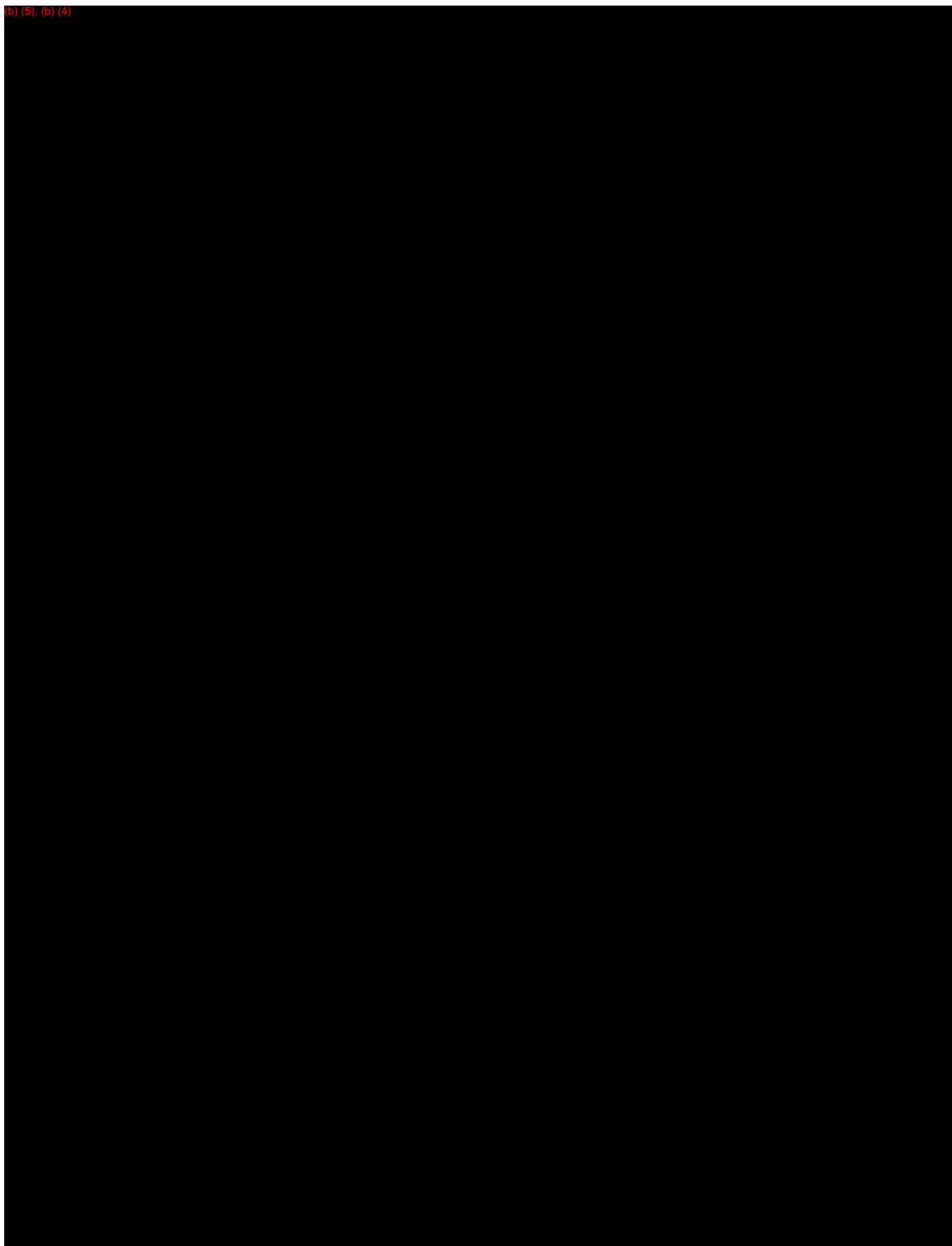
VRCM Demonstration Program Participants:

(b) (5), (b) (4)

A large rectangular area of the document is completely redacted with a solid black box.

VRCM Demonstration Program

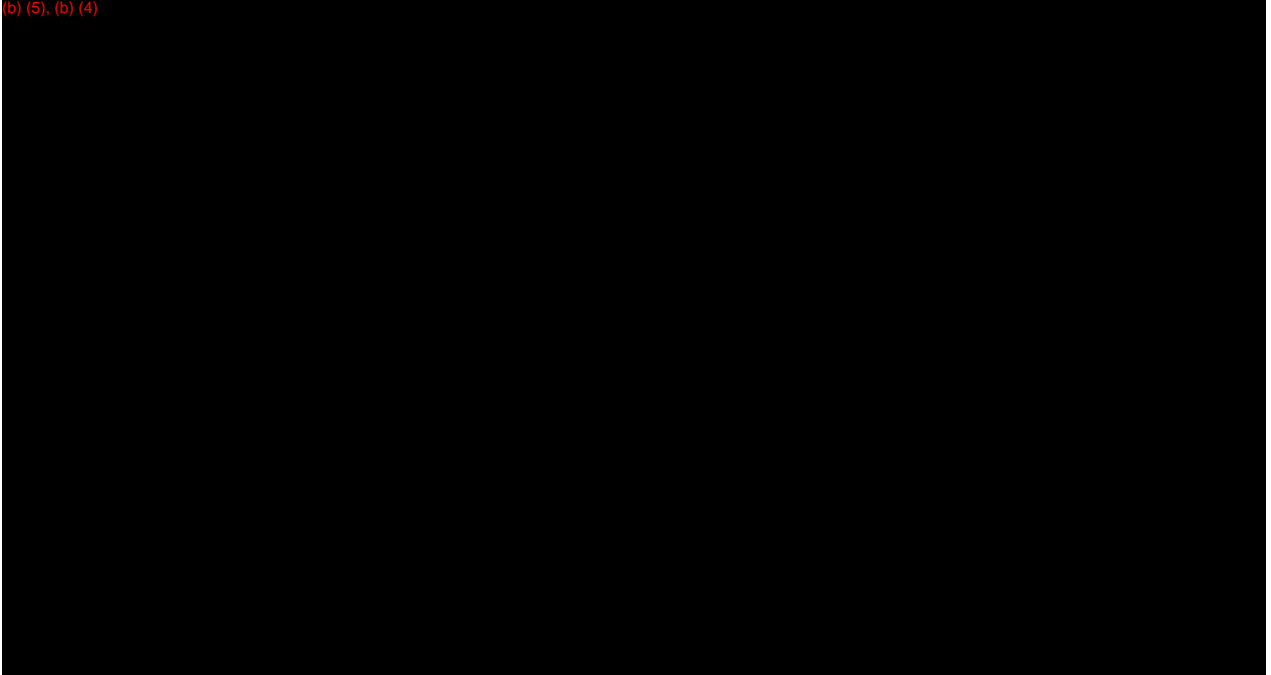
(b) (5), (b) (4)



VRCM Demonstration Program

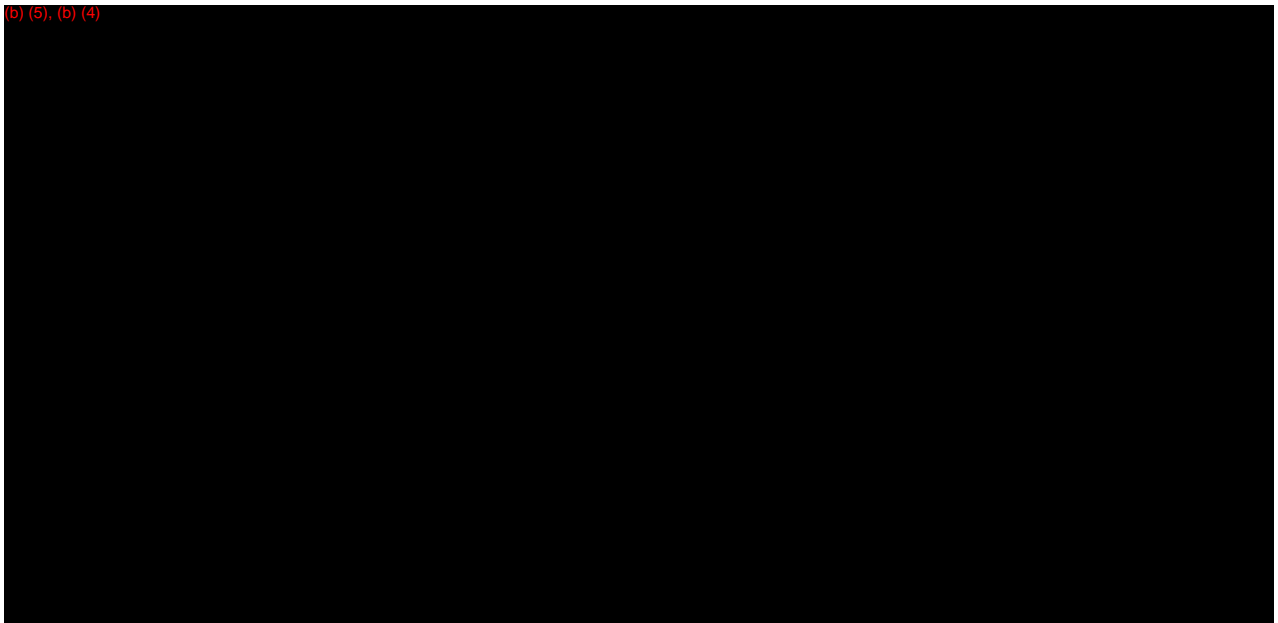
Operating Costs:

(b) (5), (b) (4)



Funding and Program Continuation:

(b) (5), (b) (4)



For More Information:

(b) (6) – CEO
Care Innovations, Inc.
3721 Douglas Blvd., Suite 100
Roseville, CA 95661
Office: 916-548-(b) (6)
(b) (6) [@careinnovations.com](mailto:(b) (6)@careinnovations.com)

(b) (6) (b) (6) – CEO
CareSpan USA, Inc.
7102 La Vista Place, Suite 203
Longmont, Colorado 80503
Office: (303) 800-8296 ext: (b) (6)
(b) (6) [@carespanhealth.com](mailto:(b) (6)@carespanhealth.com)

www.careinnovations.com

www.carespanhealth.com

Reference Links:

Concerned Veterans of America – Video Overview – “Fixing Veterans Healthcare”

<https://cv4a.org/project/taskforce/>

Veterans Affairs Chief Wants Bigger Role for Private Health Care

<https://www.wsj.com/articles/va-secretary-shulkin-wants-bigger-role-for-private-health-care-1511133920>

President Donald Trump has signed an emergency spending bill that will pump more than \$2 billion into a program that allows veterans to receive private medical care at government expense.

<https://www.usnews.com/news/politics/articles/2017-08-12/trump-signs-bill-to-fund-veterans-medical-care-program>

It’s time to end the decades-long sabotage of veteran’s healthcare

<http://thehill.com/opinion/healthcare/361829-its-time-to-end-the-decades-long-sabotage-of-veterans-healthcare>

The Affordable Care Act, VA, and You

<https://www.va.gov/health/aca/Information-For-Tax-Season.asp>

Attached: Fixing Veterans Healthcare Research (Concerned Veterans for America) - <https://cv4a.org/>

From: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)>
To: Wright, Vivieca (Simpson) </o=va/ou=va martinsburg/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)>
Cc:
Bcc:
Subject: FW: [EXTERNAL] Fwd: Pilot project - related to existing telemedicine grant
Date: Mon Jan 29 2018 16:21:11 CST
Attachments: ATT00001.htm
ATT00002.htm
CareSpan Overview.pdf
VRCM-Demo-Proposal.v5.pdf

From: David shulkin
Sent: Monday, January 29, 2018 2:20:30 PM (UTC-08:00) Pacific Time (US & Canada)
To: DJS
Subject: [EXTERNAL] Fwd: Pilot project - related to existing telemedicine grant

Sent from my iPhone

Begin forwarded message:

From: [REDACTED] (b) (5) <[REDACTED] (b) (5)>@rejuvenan.com>
Date: January 27, 2018 at 10:06:02 AM EST
To: David Shulkin MD <drshulkin@[REDACTED] (b) (5)>
Subject: Pilot project - related to existing telemedicine grant

I hope this finds you well. I recall your last email about the strictures around your being an appointee. This email I think respects that and is about a pilot project that would be cost-free to the VA, although it is related to an existing VA contract.

This pilot would harmonize with

the
VA contract awarded to Care Innovations last year fo [REDACTED] (b) (4), (b) (5)

[REDACTED]

(b) (4), (b) (5)

[REDACTED]

[REDACTED]

[REDACTED]

(b) (4), (b) (5)

[REDACTED]

[REDACTED]

[REDACTED]

Please let me know if this program is of interest to you. We would welcome your comments, feedback and support.

With my thanks and best wishes,

(b) (6)

(b) (6) (b) (6) CEO, CareSpan USA 303-800-8296 ext (b) (6)

(b) (6) @carespanhealth.com

(b) (6), Ph.D.
Chief Revenue Officer
Rejuvenan Global Health, Inc.
555 Madison Avenue Flr 20 NY NY 10022
917-538-(b) (6) Mobile - best # to call

212-486-8010 Ext (b) (6) (Office)
www.rejuvenan.com

Owner: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=[REDACTED]
Filename: ATT00001.htm
Last Modified: Mon Jan 29 16:21:11 CST 2018

Owner: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)
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/cn=recipients/cn=[REDACTED]
Filename: VRCM-Demo-Proposal.v5.pdf
Last Modified: Mon Jan 29 16:21:11 CST 2018

PROPOSAL:

Integrated Remote Monitoring and Digital Healthcare Services for Elderly, Isolated, At-Risk Veterans

**A Demonstration Program to Improve Medical Care Access,
Care Outcomes, and the Economics of At-Home Care Delivery for Veterans**

Purpose of Veteran Remote Care & Monitoring Program ("VRCM"):

(b) (4), (b) (5)
[Redacted text block]

[Redacted text block]

Program Objectives:

1. [Redacted]
2. [Redacted]
3. [Redacted]
4. [Redacted]
5. [Redacted]
6. [Redacted]

Hypothesis—Expected Economic and Health Benefits:

(b) (4), (b) (5)
[Redacted text block]

[Redacted text block]

VRCM Demonstration Program

(b) (4), (b) (5)

Key Performance Indicators and End Points:

(b) (4), (b) (5)

Supplementing Current VA Initiatives:

(b) (4), (b) (5)

VRCM Demonstration Program Participants:

• (b) (4), (b) (5)

(b) (4), (b) (5)

(b) (4), (b) (5)

-
-
-
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Patient Cohort and Time-Table

(b) (4), (b) (5)

VRCM Demonstration Program

Operating Costs:

(b) (4), (b) (5)

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] rs.

Funding and Program Continuation:

(b) (4), (b) (5)

[REDACTED]

[REDACTED]

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www.carespanhealth.com

Reference Links:

Concerned Veterans of America – Video Overview – “Fixing Veterans Healthcare”

<https://cv4a.org/project/taskforce/>

Veterans Affairs Chief Wants Bigger Role for Private Health Care

<https://www.wsj.com/articles/va-secretary-shulkin-wants-bigger-role-for-private-health-care-1511133920>

President Donald Trump has signed an emergency spending bill that will pump more than \$2 billion into a program that allows veterans to receive private medical care at government expense.

<https://www.usnews.com/news/politics/articles/2017-08-12/trump-signs-bill-to-fund-veterans-medical-care-program>

It’s time to end the decades-long sabotage of veteran’s healthcare

<http://thehill.com/opinion/healthcare/361829-its-time-to-end-the-decades-long-sabotage-of-veterans-healthcare>

The Affordable Care Act, VA, and You

<https://www.va.gov/health/aca/Information-For-Tax-Season.asp>

Attached: Fixing Veterans Healthcare Research (Concerned Veterans for America) - <https://cv4a.org/>

From: (b) (6) <(b) (6)@cua.edu>
To: Shulkin, David J., MD
</o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (6)>
Cc:
Bcc:
Subject: [EXTERNAL] Winterhaven Follow-up
Date: Mon Jan 29 2018 07:08:39 CST
Attachments: PTSD Contemporary Issue Analysis.doc

Good morning Secretary Shulkin,

Thank you so much for taking a few minutes to speak with me just before leaving the Winterhaven event in DC on Saturday afternoon. It was truly an honor to meet you. I am currently a graduate student at The Catholic University of America studying social work and I have a passion for working with veterans. Last semester in my social welfare policy class, I wrote a paper regarding post-traumatic stress disorder in veterans and much of my research included you as a key player. I have attached the paper here. I have the utmost respect for the work you are doing at the VA and I am excited to see the progress that will be made in the future. I hope you have a great week and thank you again!

Best regards,

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Filename: PTSD Contemporary Issue Analysis.doc
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Post-Traumatic Stress Disorder and Mental Health Concerns in Military Veterans

(b) (6)

The Catholic University of America

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Post-Traumatic Stress Disorder and Mental Health Concerns in Military Veterans

The men and women who have served the United States of America as members of the military put their lives on the line and made endless other sacrifices to defend their country. These brave veterans endured hardships that most civilians cannot begin to imagine. As a result, many returned home from deployments and missions with various mental health issues. One of the most common concerns reported after deployment was post-traumatic stress disorder, also known as PTSD. This remains to be the case today as conflicts in Iraq and Afghanistan continue. The military veterans who struggle with PTSD often have trouble receiving the appropriate care and treatment they need, if they come forward to seek help at all. Numerous incidents have recently proven that the Department of Veterans Affairs (VA), committed to the physical and mental health of military members, has been falling short of expectations and failing to deliver the proper care that veterans require. These members of society need the help of others, such as social workers, to advocate on their behalf because they represent such a small portion of the United States population. Social work as a profession is committed to the health and well being of every individual, including military veterans and service members.

Problem Stream**Statistical Evidence**

Post-traumatic stress disorder has existed within the military as long as soldiers have been fighting in combat. The condition was known as “shell shock”, “soldier’s heart” or “battle fatigue” in previous wars (Abrams, 2017; Shaddad, 2017). It finally gained the name it is known by today in the Vietnam War era and was recognized by the American Psychiatric Association as a diagnosable disorder in 1980 (Abrams, 2017). Regardless of these progressive steps, the military continues to encourage strength and machismo in its members. The ethos of the military

is one in which mental illnesses are shameful weaknesses, moral failings and defects not worthy of a warrior (Abrams, 2017). As Abrams (2017) states, the overall notion is that if the wound is not visible, it does not exist.

According to the Census Bureau, there are approximately 20 million veterans living in the United States today (Williams, 2017). Of these veterans, anywhere from 11-30% are estimated to have experienced PTSD in their lifetime, based on service era (National Center for PTSD, 2016). Approximately 11-20% of veterans who served in Operation Iraqi Freedom and Operation Enduring Freedom have PTSD (National Center for PTSD, 2016). The exact number is difficult to pinpoint because PTSD is challenging to diagnose for a number of reasons. As stated, the stigmatization starts early, highlighting emotions and feelings as weaknesses that should not be discussed. Individuals in the military feel pressured to be strong and resilient and see themselves in a role of providing services to others, not vice versa (Shaddad, 2017). A PTSD diagnosis relies heavily on self-reporting and if men and women are shamed into silence, these numbers will continue to be inaccurately low. Fortunately, society is beginning to view mental health with less stigma and as a result, veterans in need of help are more likely to come forward seeking treatment. Direct combat conflicts in Afghanistan and Iraq are ongoing, which means the number of veterans experiencing PTSD is expected to increase over time.

Causes and Consequences

Post-traumatic stress disorder develops in military members as a result of experiencing an extremely stressful or traumatic event during the war such as combat or a non-war traumatic event such as a terrorist attack, violence, sexual assault or serious injury (Ghaffarzadegan, Ebrahimvandi, & Jalali, 2016). PTSD most often results in military members due to a deployment to a combat zone. One study found that service members deployed to Iraq and

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Afghanistan were more likely to experience symptoms related to both warzone and home front experiences than those who did not deploy (Highland et al., 2015). Symptoms may occur within the first few days after exposure to trauma or they may be delayed for months or years (Government Accountability Office [GAO], 2004). There are four symptoms that individuals experience psychologically as a result of the trauma. These include re-experiencing the event, avoidance of similar stimuli, negative cognition and mood, and increased physical arousal, also known as hyper vigilance, even long after returning to a place of safety (Ghaffarzadegan et al., 2016). These conditions can go unrecognized and unacknowledged by the military, family members and society as a whole, resulting in adverse effects on the service members' moods, thoughts and behaviors (GAO, 2017).

The consequences of this disorder are extensive, severe and far-reaching. PTSD is known to be highly co morbid with other psychological effects or mental illnesses that occur following trauma including depression, anxiety disorders, anger, guilt, shame and violence (Ghaffarzadegan et al., 2016). PTSD is linked to an increased risk for suicide and is more strongly associated with suicide ideation and attempts than any other anxiety disorder (Tanielian & Jaycox, 2008). PTSD increases the risk of substance use disorders because individuals are seeking new methods to cope with the pain (Tanielian & Jaycox, 2008). Individuals suffering are more likely to report being bothered by physical symptoms such as stomach pain, back pain, headaches, dizziness, fainting, shortness of breath, nausea and chest pain (Tanielian & Jaycox, 2008). According to Ghaffarzadegan et al. (2016), PTSD leads to a higher likelihood of losing jobs or being discriminated against in the workplace, social exclusion, lower income, difficulties in renting and obtaining housing, legal difficulties and relationship troubles. The trauma experienced has a negative effect on emotion regulation, leading to a greater risk of anger and

aggression. As a result, PTSD can indirectly affect family members, friends, community members, colleagues and employers (Ghaffarzadegan et al., 2016). The emotional numbing and avoidance aspects of PTSD are associated with poorer parent-child relationships and therefore lead to more severe behavioral and academic problems in children (Tanielian & Jaycox, 2008). Individuals with PTSD are also costly to society because the illness is associated with significant reductions in productivity, a lower probability of working, higher number of missed days at work and lower earnings (Tanielian & Jaycox, 2008). Overall, the symptoms associated with PTSD lead to a reduced functional status and individuals with PTSD report a lower quality of life and wellbeing (Highland et al., 2015; Tanielian & Jaycox, 2008).

While in the military, a troubled mental state can lead to disciplinary infractions, including drug use, insubordination, absence without leave, or criminal behavior, and subsequent separation from the military for misconduct (GAO, 2017). These members are discharged from the military with an “other-than-honorable” label and as a result, they may not be eligible for any VA benefits and services, including health care (GAO, 2017). This topic in particular has led to a strong legislative response to PTSD in the past few years. Between 2004-2005, a number of bills were introduced to legislation with 103 sections regarding PTSD (Purtle, 2014). This occurred as a direct result of service members returning from Iraq and Afghanistan in need of treatment for PTSD. According to Purtle (2014), PTSD policy research is still generally undeveloped but could be a highly powerful tool to prevent and mitigate the effects of the disorder.

From Private Problem to Public Problem

Quite a few notable events have happened over the past few years that brought heightened attention to this issue of veterans’ mental health in what is known as Kingdon’s problem stream. One such event is the protests of National Football League players regarding

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racial inequality in which they kneel during the national anthem. Although it was not the intention of the protests, the acts have caused citizens to begin discussing how military service members and veterans are treated in the United States. Their wellbeing and respect has become recognized as a high priority and the conversation has encouraged many more people to become involved in the rights of veterans. Stephen Curry, a well-known basketball player for the Golden State Warriors, wrote an article on Veteran's Day this year mirroring these sentiments. Curry argued that the debate around national anthem protests needs to be cast aside to make room for a conversation about the actual ways civilians can help veterans (Payne, 2017). Curry proposes real action regarding access to jobs, medical services, both physical and mental, and readjustment to society (Payne, 2017). Hollywood has also joined the discussion regarding military service members and mental health. Various documentaries have discussed PTSD in depth, including Ken Burns' *The Vietnam War*, *Almost Sunrise* and National Geographic's current docuseries, *The Long Road Home*. These sources portray the way in which military members are discouraged from speaking or preparing for the "unseen wounds of war" and provide harrowing statistics. One of which is 90% of 133 mental health clinicians surveyed reported they received no training on the top recommended PTSD treatments (Russell, 2017).

News outlets and social media have played a significant role in bringing the problem to light as well. Multiple events have occurred in recent years that could be considered isolated incidents but the power of the news spread word throughout the country and made the connection to a larger issue. In 2014, a scandal erupted in Phoenix, Arizona when dozens of veterans died waiting to receive care at the local VA medical center (Boyer, 2017). As a result, the VA secretary, Eric Shinseki, was fired. About two years later, a veteran committed suicide in New Jersey by setting himself on fire after his local clinic staff failed to ensure he had adequate

mental health care (Slack, 2017). Most recently, a young man shot and killed 26 people at a church in Sutherland Spring, Texas. The gunman previously served in the Air Force and had a record of mental illness (Marcos, 2017). According to Marcos (2017), he was discharged from the military for bad conduct, making him ineligible to receive any benefits and services from the VA, including mental health care. This means he was also not screened for PTSD or other service-related illnesses upon leaving the military. This particular story drew the attention of a number of congress members and led to renewed discussion about mental health.

Politics Stream

After the Texas church shooting, a significant number of insider participants emerged as key players in the agenda-setting process. Two Republican representatives from the House, Vice Chairman of the House Veterans' Affairs Committee Gus Bilirakis of Florida and Mike Coffman of Colorado, worked on and supported legislation that would improve access to mental health care after discharge from the military (Marcos, 2017). Elizabeth Esty is a member of the House also on the Veterans' Affairs Committee and a representative for Connecticut's 5th District, advocating for a national commitment to veterans to improve mental health care (Esty, 2017). Esty (2017) is fighting to change a culture that discourages veterans from seeking help when they need it. Recently, House Representative Doug Lamborn of Colorado introduced a new bill called the Veterans Empowerment Act (Caldwell, 2017). The Senate is also taking note of the mental health care issue surrounding military veterans. Senator Dean Heller on the Veterans' Affairs Committee has promised to create a bill in the next month that will improve reporting standards at the VA. Democratic Senator Cory Booker and fellow New Jersey Congress members became more deeply involved with the issue following the veteran suicide at the VA medical center (Slack, 2017).

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There are a number of advocacy groups, considered outsiders in the agenda-setting model, speaking up on behalf of veterans including Concerned Veterans for America (CVA) with executive director Mark Lucas, The American Legion, and Vietnam Veterans of America. The American people as a whole seem to be receptive to positive change benefitting veterans and mental health. There is less stigmatization associated with mental illness than in previous years and those affected are more often being encouraged to receive help. There are few competing values in regards to improving mental health care for veterans. It appears to be a topic many want to discuss further, with the primary area of focus as the only difference. Some groups, such as Veterans Cannabis Collective Foundation and Veterans for Medical Cannabis Access, are focused on finding new, unique treatments for veterans with PTSD, including medical marijuana. They argue it eases anxiety, sleeplessness, chronic pain and other PTSD symptoms allowing individuals to function as their old selves again (Associated Press, 2017). However, others claim that medical marijuana masks symptoms and the focus should remain on improving the current treatment system within the VA. The Trump administration is currently the most prominent participant in the political stream and has been making positive changes. According to Boyer (2017), President Donald Trump recently stated, “The veterans have poured out their sweat and blood and tears for this country for so long and it’s time that they are recognized and it’s time that we now take care of them”. President Trump selected David Shulkin as the Secretary of the U.S. Department of Veterans Affairs, which has proved to be a big win for veterans’ mental health care. Shulkin has said his top priorities are to shift more of the VA’s resources into providing services unique to veterans, such as treatments for PTSD and traumatic brain injury, and away from services that veterans can easily obtain from private doctors (Westwood, 2017). This change in administration opened a major window of opportunity

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for policy changes. Both legislators and the American people continue to push for more progress as a new possible war looms on the horizon. Many are hoping for research and methods that would reduce or prevent the risk of PTSD in order to slow the issue in the event that more service members are deployed to new combat zones (Highland et al., 2015).

Policy Stream

As this issue has surfaced more prominently since the events of September 11, 2001 and the subsequent wars in Iraq and Afghanistan, a number of policy ideas have floated through the policy stream. Not many address PTSD directly but the disorder does fall under the mental health umbrella that is at the forefront of policy creation regarding veterans right now. As a direct result of the 2014 VA scandal in Phoenix, the Veterans Access, Choice and Accountability Act of 2014 was developed by the Obama administration. It contains the Veterans Choice Program, which allows veterans to seek assistance using their military benefits from private physicians if they have to wait more than 30 days for an appointment at a VA facility or are located more than 40 miles away from the nearest VA facility (Caldwell, 2017). According to Boyer (2017), this program was set to expire in August 2017 without legislation and with nearly \$1 billion in funding unspent. However, on April 19, 2017, President Trump signed a reauthorization of the original act, known as the Veterans Choice Program Extension and Improvement Act, extending stopgap services for veterans to go outside of the VA for medical care (Boyer, 2017; Shulkin, 2017). According to Hansler (2017), this act also allows the VA to share medical information with non-VA agencies providing medical services to veterans to ensure there are no lapses in treatment and that they are receiving the necessary care.

However, the Veterans Choice Program legislation was intended to be a temporary fix to the issues of receiving adequate service at the VA and many veterans groups are calling for more

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permanent changes. According to Mark Lucas of CVA, Congress needs to simply expand private health care options for veterans and fully empower veterans to decide when and where to get care (Boyer, 2017; Caldwell, 2017). Westwood (2017) claims that David Shulkin supports this notion and has said his plan is to ideally let veterans choose a combination of private and public services. Representative Doug Lamborn from Colorado is taking the steps to accomplish this goal. Towards the end of November, Lamborn introduced the Veterans Empowerment Act as a direct response to falsified patient wait times at the Colorado VA for veterans with PTSD (U.S. Congressman Doug Lamborn, 2017). This act is intended to create a veterans health insurance program that enables veterans to choose to use their benefits either inside or outside of the VA system, without requiring authorization beforehand from the VA (Caldwell, 2017; U.S. Congressman Doug Lamborn, 2017). It also aims to increase oversight and transparency to prevent future cases of abuse and mismanagement (Caldwell, 2017). According to Caldwell (2017), this will allow the VA to concentrate on its original purpose of caring for veterans with service-connected disabilities and veterans are overwhelmingly supportive of such a reform.

Another major piece of legislation recently passed by the House aims to provide mental health care for veterans who received other-than-honorable discharge from the military and as a result, are ineligible for benefits from the VA, including mental health care (Marcos, 2017). According to Marcos (2017), this legislation was authored by Representative Coffman and supported by Representative Bilirakis. The GAO (2017) states that 91,764 service members were separated from the military from 2011 to 2015 due to misconduct charges. Within 2 years prior to separation, 62% of those members were diagnosed with a mental disorder and 16% were diagnosed with PTSD or TBI specifically (GAO, 2017; USA Today, 2017). USA Today (2017) suggests providing more intensive mental screenings to all separating service members and

teaching the individuals to recognize the symptoms of mental illness. The latest proposed bill would cover that recommendation and more. It would ensure the VA provides initial mental health assessments and care services to former service members discharged under other-than-honorable conditions who participated in combat operations or experienced sexual abuse (Marcos, 2017). According to Strassner (2017), veterans with other-than-honorable discharge may also soon be eligible for urgent mental health care from VA facilities if the Senate passes the bill. Most legislators believe these bills are a strong starting point but there is much more work to be done within the VA system. According to Goldsmith (2017), the government must invest in continuing to improve and expand the VA facilities and services to ensure the nation keeps its promise to veterans.

The National Association of Social Workers (NASW) does not have a policy position explicitly discussing mental health in military service members and veterans. However, they do support the population and express this position on their website. The site states that the association is committed to supporting the health and well being of military service members, veterans and their families (National Association of Social Workers [NASW], 2017). It includes various tools and resources available to assist professionals working with this community, including lists of military terms and acronyms, articles on how to assist family members and links to publications on the topic. The NASW also published a set of standards for social work practice with service members, veterans and their families to enhance social workers' awareness of the skills, knowledge, values and sensitivities needed to work effectively with this population (NASW, 2012). This document stresses the importance of taking care of an underserved population that has unique needs and challenges.

Interview

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Ms. Brigit Mancini worked at the Department of Veterans Affairs in Washington, DC and Myrtle Beach for a total of six years during the height of veterans returning from combat in Iraq and Afghanistan. She worked as a substance abuse counselor, a family support counselor and a senior social worker for the Operation Iraqi Freedom/Operation Enduring Freedom Department. She believes that mental health concerns will continue to increase among the veteran population when more come forward for help as a result of the latest conflicts in the Middle East (B. Mancini, personal communication, November 28, 2017). Ms. Mancini identified a wide variety of both causes and consequences for the issue regarding treatment for mental health disorders at the VA. She explained a primary reason for the backup in care as a result of disconnect between the active military system and the VA. A few years ago, the Obama administration decided on a draw down of troops, meaning those who have been in treatment for a while but are not improving are no longer considered “mission ready” and are medically discharged from active duty (B. Mancini, personal communication, November 28, 2017). This leads to a direct surge and burden within VA hospitals and by the time the facilities are approved to hire more staff, there has already been a substantial gap in treatment. As a result of the drastic increase in clients, veterans are often pushed towards group counseling rather than individual counseling, which many prefer and need (B. Mancini, personal communication, November 28, 2017). Ms. Mancini recommends a stronger coordination between the active duty side and the VA system to ensure streamlined care for individuals. A decrease in active service members means an increase in combat era veteran care so hiring an adequate amount of professionals at the VA should come before the draw down of service members, not simultaneously (B. Mancini, personal communication, November 28, 2017). Going forward, Ms. Mancini expressed concerns that staffing will continue to be a problem among VA facilities, hindering the quality of mental

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health care treatment available to veterans. She stated that the various policies recently implemented regarding the VA system give her hope that the issue will continue to be addressed and necessary improvements will be made in the near future (B. Mancini, personal communication, November 28, 2017).

Conclusion

After a thorough analysis of the issue, it is likely that post-traumatic stress disorder, mental illness and the need for mental health care will continue to be a serious issue among veterans over the next few years. As Goldsmith (2017) states, the surge in demand for treatment is directly caused by this generation returning from Iraq and Afghanistan, as well as Vietnam-era veterans growing older. As the topic of mental illness becomes less stigmatized, more service members and veterans will come forward seeking assistance and the country will see a higher demand for treatment. It appears as though the NASW recognizes this trend as well. In the standards specific to the military population published just five years ago, the association recognizes its ability to provide unique services to these individuals. The standards also emphasize the opportunity social workers have to influence other professionals and stakeholders regarding the importance of responding to the needs of these members (NASW, 2012). The hope is that in the future, even more social workers will be well equipped with the appropriate knowledge and training needed to work with service members and veterans to meet the expected rising demand for treatment. Social workers have the compassion, dedication and desire for justice that military service members and veterans need to heal and help tackle their battles long after returning home from war.

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Appendix

Topic Area: Mental Illness in Veterans

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MENTAL HEALTH IN VETERANS

19

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MENTAL HEALTH IN VETERANS

20

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From: (b) (6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6), (b) (5)
To: DJS </o=va/ou=exchange administrative
group (fydibohf23spdl)/cn=recipients/cn=(b) (5), (b) (6)
Cc:
Bcc:
Subject: FW: SECVA Round-table with VSOs
Date: Mon Jun 26 2017 13:26:03 CDT
Attachments: VSO Media Round-Table (Briefing Memorandum Final).docx

Sir – Just wanted to be sure this was on your radar screen for this week in OBCR. Thank you.

(b) (6)

From: (b) (6)
Sent: Monday, June 26, 2017 1:43 PM
To: (b) (6); (b) (6); (b) (6); (b) (6)
Cc: (b) (6); Tallman, Gary; (b) (6)
Subject: RE: SECVA Round-table with VSOs

(b) (6)

As requested. Please let us know if you have any questions.

Best to all

(b) (6)

Owner: (b) (6) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)
Filename: VSO Media Round-Table (Briefing Memorandum Final).docx
Last Modified: Mon Jun 26 13:26:03 CDT 2017

Briefing Memorandum Template

TO: Dr. David Shulkin

FROM: (b) (6) (OPIA)

RE: VSO Media Round-Table

DATE: 29 June, 2017

TIME: 3:00 – 3:45 p.m.

CONTACTS: (b) (6), (b) (6)

OVERVIEW: OPIA will facilitate a round-table media event with you and the communication directors / social media managers of 21 leading Veterans Service Organizations. Each organization produces print and on-line publications for their respective membership.

This forum allows you to speak directly with multiple VSOs about current and future VA initiatives while answering questions on varied topics important to our stakeholders. Your interaction with our VSOs sustains transparency and builds trust as the department undertakes important modernization efforts.

VSOs will share information garnered from this round-table to place images and articles in their print magazines, on-line news programs, and via social media.

The event is on-the-record.

YOUR ROLE: Provide opening comments and field questions from the assembled VSOs.

LOGISTICS: Micheal Migliara will escort you to the Omar Bradley Conference Room and to your seat. John Ulyot will open the forum and introduce you for your opening comments. The question and answer session follows.

AGENDA: 2:55 p.m. – SECVA escorted to OBCR
2:58 p.m. – Opening Remarks
3:00 – 3:30 p.m. – Q/A
3:30 – 3:35 p.m. – SECVA Closing Comments

ABOUT THE ORGANIZATION: See attached list of the participating Veterans Service organizations.

Veterans Service Organizations participating in the media round-table:

American Veterans: (b) (6) ra
Blinded Veterans Associatio (b) (6) son
Catholic War Veterans (b) (6) ne
Commissioned Officers of the US Public Health Servi (b) (6) urrie
Concerned Veterans of America (b) (6) ell
Fleet Reserve Association (b) (6) ski
Gotyour6: (b) (6) (b) (6) ki
Iraqi and Afghanistan Veterans of America (b) (6) cott
Jewish War Veterans: (b) (6) th
Korean War Veterans Associatio (b) (6) her
Legion of Valor: (b) (6) rx
Military Officers Association of Ameri (b) (6) gton
Military Order of the Purple Hear (b) (6) sky
Non Commissioned Officers Associatio (b) (6) wski
Paralyzed Veterans of America (b) (6) lett
The American Legion (b) (6) er
The Mission Continues (b) (6) an
The Retired Enlisted Associatio (b) (6) an
Veterans of Foreign Wars: (b) (6)
Vietnam Veterans of America: (b) (6) r
Wounded Warrior Project: (b) (6) s

From: (b) (6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (5), (b) (6)>
To: Lapuz, Miguel H. </o=va/ou=visn
10/cn=recipients/cn=(b) (5), (b) (6)> Alaigh, Poonam, M.D.
</o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)> Ulliyot, John
</o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)> Flanz, Meghan
Serwin </o=va/ou=va martinsburg/cn=recipients/cn=(b) (5), (b) (6)>
Hutton, James </o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)> (b) (6)
</o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)> Young, Steven
W. </o=va/ou=visn 08/cn=recipients/cn=(b) (5), (b) (6)>
Cc: Leinenkugel, Jake </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)> Wright, Vivieca
(Simpson) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (5), (b) (6)> (b) (6)
</o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)> Gruntmeir, Doris
</o=va/ou=va martinsburg/cn=recipients/cn=(b) (5), (b) (6)>
Bcc:
Subject: RE: San Juan former MCD -- call at 1 pm?
Date: Sun May 07 2017 11:56:13 CDT
Attachments: 05.07 - HC Rev - Communications Plan Hamlin San Juan Draft 1 170507.docx

I added in some (b) (5)

(b) (6)

(b) (6) | Deputy Chief Counsel for the Personnel Law Group

U.S. Department of Veterans Affairs (VA) | Office of General Counsel (OGC)

Tel: (202) 461- (b) (6) | Fax: (202) 495- (b) (6) | Email: (b) (6)@va.gov

Address: 810 Vermont Avenue, NW, Mail Stop 028, Washington, DC 20420

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From: Lapuz, Miguel H.
Sent: Sunday, May 07, 2017 12:41 PM
To: Alaigh, Poonam, M.D.; Ulyot, John; Flanz, Meghan Serwin; (b) (6) Hutton, James;
(b) (6) Young, Steven W.
Cc: Leinenkugel, Jake; Wright, Vivieca (Simpson); (b) (6) Gruntmeir, Doris
Subject: RE: San Juan former MCD -- call at 1 pm?

No worries. I'll pick up the call. Thanks

Sent with Good (www.good.com)

-----Original Message-----

From: Alaigh, Poonam, M.D.
Sent: Sunday, May 07, 2017 11:00 AM Eastern Standard Time
To: Ulyot, John; Flanz, Meghan Serwin; Lapuz, Miguel H.; (b) (6) Hutton, James; (b) (6) Young, Steven W.
Cc: Leinenkugel, Jake; Wright, Vivieca (Simpson); (b) (6) Gruntmeir, Doris
Subject: RE: San Juan former MCD -- call at 1 pm?

I am at a family event at that time but will step away at 1pm to attend- would be good to have Miguel and /or Steve also attend - but we should proceed either ways

Sent with Good (www.good.com)

-----Original Message-----

From: Ulyot, John
Sent: Sunday, May 07, 2017 10:56 AM Eastern Standard Time
To: Alaigh, Poonam, M.D.; Flanz, Meghan Serwin; Lapuz, Miguel H.; (b) (6) Hutton, James;
(b) (6) Young, Steven W.
Cc: Leinenkugel, Jake; Wright, Vivieca (Simpson); (b) (6) Gruntmeir, Doris
Subject: Re: San Juan former MCD -- call at 1 pm?

Sent with Good (www.good.com)

-----Original Message-----

From: John Ulyot [john. (b) (6)]
Sent: Sunday, May 07, 2017 10:46 AM Eastern Standard Time
To: Ulyot, John
Subject: [EXTERNAL] Re: San Juan former MCD -- call at 1 pm?

Poonam/Meghan and Team:

Please see the string below from (b) (6) of OGC — it appears that VA (b) (5)

[REDACTED]

[REDACTED]

(b) (5) [REDACTED]

[REDACTED]

Can we discuss on a call early this afternoon to decide on a way forward? Does 1 pm work for everyone?

Please let us know and we can circulate a dial-in.

Thanks,

John U.

John Ulyot

Assistant Secretary for Public and Intergovernmental Affairs

U.S. Department of Veterans Affairs

202-461-7500 office

john.ullyot@va.gov

-----Original Message-----

From: Hutton, James

Sent: Saturday, May 06, 2017 08:17 PM Eastern Standard Time

To: (b) (6) (b) (6) Ulyot, John

Cc: (b) (6) Gruntmeir, Doris; Flanz, Meghan Serwin; Young, Steven W.; Lapuz, Miguel H.
Subject: RE: San Juan former MCD

Adding John Ulyot. Please ensure he remains on the email string.

James Hutton

Deputy Assistant Secretary (Acting)

Office of Public Affairs

Department of Veterans Affairs

810 Vermont Ave, NW

Washington, D.C. 20420

Office: 202-461-7558

Email: (b) (5), (b) (6) va.gov

Twitter: @jehutton

From: (b) (6)
Sent: Saturday, May 06, 2017 7:18 PM
To: Hutton, James; (b) (6)
Cc: (b) (6) Gruntmeir, Doris; Flanz, Meghan Serwin; Young, Steven W.; Lapuz, Miguel H.
Subject: RE: San Juan former MCD

Trying to keep everyone on one email string. With regard to communications about this matter, per below, please note that this case is still in active litigation and I strongly recommend that we only (b) (5)

[REDACTED]

[REDACTED]

[REDACTED]

With regard to OPIA's questions:

(b) (5)

(b) (5)

(b) (5)

(b) (5)

(b) (5)

(b) (6)

(b) (6) | Deputy Chief Counsel for the Personnel Law Group

U.S. Department of Veterans Affairs (VA) | Office of General Counsel (OGC)

Tel: (202) 461-(b) (6) | Fax: (202) 495-(b) (6) | Email: (b) (6)@va.gov

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immediately and destroy the e-mail and any attachments.

From: (b) (6)
Sent: Saturday, May 06, 2017 4:23 PM
To: (b) (6)
Cc: (b) (6); Gruntmeir, Doris; Flanz, Meghan Serwin; Young, Steven W.; Lapuz, Miguel H.
Subject: RE: San Juan former MCD

(b) (5)

I.

Looping in Steve and Dr. LaPuz to avoid two email strings. If you have further questions or want to discuss rational behind some of this (none of which are for publication) we could schedule a call.

(b) (6)

(b) (6) | Deputy Chief Counsel for the Personnel Law Group

U.S. Department of Veterans Affairs (VA) | Office of General Counsel (OGC)

Tel: (202) 461- (b) (6) | Fax: (202) 495- (b) (6) | Email: (b) (6) va.gov

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From: (b) (6)
Sent: Saturday, May 06, 2017 4:01 PM
To: (b) (6)
Cc: (b) (6); Gruntmeir, Doris; Flanz, Meghan Serwin
Subject: RE: San Juan former MCD

Hansen

Thanks for this. I'm not entirely familiar with how the MSRB works. But the VA (b) (5)

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6)
Sent: Saturday, May 06, 2017 03:42 PM Eastern Standard Time
To: (b) (6)
Cc: (b) (6); Gruntmeir, Doris; Flanz, Meghan Serwin
Subject: RE: San Juan former MCD

Hi Gina,

DeWayne Hamlin's case is still being actively litigated before the MSPB, which has not yet dismissed this matter until such time as the agency can show that it has (b) (5)

(b) (5)

Thanks,

(b) (6)

(b) (6) | Deputy Chief Counsel for the Personnel Law Group

U.S. Department of Veterans Affairs (VA) | Office of General Counsel (OGC)

Tel: (202) 461- (b) (6) | Fax: (202) 495- (b) (6) | Email: (b) (6) va.gov

Address: 810 Vermont Avenue, NW, Mail Stop 028, Washington, DC 20420

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From: Flanz, Meghan Serwin
Sent: Saturday, May 06, 2017 3:15 PM
To: (b) (6)
Cc: (b) (6); (b) (6) Gruntmeir, Doris
Subject: RE: San Juan former MCD

Amy and (b) (6) (cc'd) have the lead on this matter for OGC. They have a better handle on status than I do.

Meghan Flanz
Interim General Counsel
(202) 461-7661

-----Original Message-----

From: (b) (6)
Sent: Saturday, May 06, 2017 02:24 PM Eastern Standard Time
To: Flanz, Meghan Serwin
Subject: FW: San Juan former MCD

Meghan

Can you help with this?

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6)
Sent: Saturday, May 06, 2017 01:50 PM Eastern Standard Time
To: Lapuz, Miguel H.; (b) (6)
Cc: (b) (6) Liezert, Timothy W.
Subject: RE: San Juan former MCD

(b) (6) spoke with (b) (6) this afternoon. She is working on the (b) (5)

Sent with Good (www.good.com)

-----Original Message-----

From: Lapuz, Miguel H.

Sent: Saturday, May 06, 2017 01:09 PM Eastern Standard Time

To: (b) (6)

Cc: (b) (6) Liezert, Timothy W.

Subject: FW: San Juan former MCD

(b) (6)

Can we please have a timeline of events for Gina? Thanks

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6)

Sent: Saturday, May 06, 2017 12:26 PM Eastern Standard Time

To: Ulliyot, John; Alaigh, Poonam, M.D.; Lapuz, Miguel H.; (b) (6) Wright, Vivieca (Simpson); Leinenkugel, Jake

Cc: Liezert, Timothy W.; (b) (6) Young, Steven W.; DJS; Hutton, James

Subject: RE: San Juan former MCD

Ok.

We really need info about what happened with the (b) (5)

Steve - can you help?

Gina

Sent with Good (www.good.com)

-----Original Message-----

From: Ulliyot, John

Sent: Saturday, May 06, 2017 11:58 AM Eastern Standard Time

To: Alaigh, Poonam, M.D.; Lapuz, Miguel H.; (b) (6) (b) (6) Wright, Vivieca (Simpson); Leinenkugel, Jake

Cc: Liezert, Timothy W.; (b) (6) Young, Steven W.; DJS; Hutton, James

Subject: RE: San Juan former MCD

Thanks for the heads' up Poonam -- I'm new to this issue, but absolutely agree we need to (b) (5)

(b) (5)

(b) (5)

(b) (5)

Please let James and me know if you have any questions or would like to discuss on a brief call today.

Thanks again,

John U.
202-701-0138

Sent with Good (www.good.com)

-----Original Message-----

From: Alaigh, Poonam, M.D.

Sent: Saturday, May 06, 2017 09:52 AM Eastern Standard Time

To: Lapuz, Miguel H.; (b) (6) (b) (6) Ulyot, John; Wright, Vivieca (Simpson);
Leinenkugel, Jake

Cc: Liezert, Timothy W.; (b) (6) Young, Steven W.; DJS

Subject: RE: San Juan former MCD

Completely agree with (b) (5)

Sent with Good (www.good.com)

-----Original Message-----

From: Lapuz, Miguel H.

Sent: Saturday, May 06, 2017 08:25 AM Eastern Standard Time

To: (b) (6) (b) (6)

Cc: Liezert, Timothy W.; (b) (6) Young, Steven W.; Alaigh, Poonam, M.D.

Subject: San Juan former MCD

Gina,

There was a lot of media interests on Mr. Hamlin's termination. Now that he will be (b) (6)

Thanks

Sent with Good (www.good.com)

Owner:	(b) (6)	</o=va/ou=va martinsburg/cn=recipients/cn=	(b) (5), (b) (6)
Filename:	05.07 - HC Rev - Communications Plan Hamlin San Juan Draft 1 170507.docx		
Last Modified:	Sun May 07 11:56:13 CDT 2017		

Communication Plan
Reinstatement of Puerto Rico Medical Center Director
May 6, 2017

Background

DeWayne Hamlin, the director of the VA Caribbean Healthcare System, was removed from federal service on January 20, 2017. On Tuesday, May 2, 2017, VA rescinded Mr. Hamlin's removal and has been detailed to the VA Sunshine Healthcare Network office (VISN 8).

Mr. Hamlin, who appealed his removal from the federal service, still has an active litigation before the MSPB, which will only dismiss the matter once the agency can show that it has fully restored Mr. Hamlin back to the way he was before the agency took its removal action. Consequently, given the contentious nature of this case, OGC strongly recommends that VA only (b) (5)

[REDACTED]

Approach

The VA should be (b) (5)

[REDACTED]

When	Who	What
May 8 – AM	Congressional Notification	VA Media Statement
May 8 – AM	WH Notification	VA Media Statement
May 8 – AM	San Juan Leadership Team	Internal Statement
May 8 – AM	San Juan Employee Notification	All employee email with internal statement
May 8 – AM	VSO Notifications	

Media Statement

(b) (5)

[REDACTED]

[REDACTED]

(b) (5)



Internal/employee statement

(b) (5)




Key outlets/key coverage

Benjamin Krause: <http://www.disabledveterans.org/2017/01/24/youre-fired-san-juan-va-director-dewayne-hamlin-terminated/>

Luke Rosiak, Daily Caller: <http://dailycaller.com/2017/01/24/days-into-trump-admin-corrupt-employees-are-already-being-fired-at-the-va/>

USA Today: <https://www.usatoday.com/story/news/nation-now/2016/09/19/va-battles-problem-employees-accountability-accusations/90715048/>

Washington Times: <http://www.washingtontimes.com/news/2014/sep/7/high-ranking-va-official-charged-with-drunken-driv/>

CVA: <https://cv4a.org/vafail-va-offers-record-high-settlement-whistleblower/>

From: Darin Selnick <darin.selnick@[REDACTED]>
To: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED]>
Cc:
Bcc:
Subject: [EXTERNAL] Fwd: Resume
Date: Sun Jul 09 2017 22:16:48 CDT
Attachments: [REDACTED] Resume.pdf

----- Forwarded message -----

From: [REDACTED] <[REDACTED]>
Date: Sun, Jul 9, 2017 at 1:03 PM
Subject: Resume
To: Darin Selnick <darin.selnick@[REDACTED]>

--

[REDACTED]@gmail.com
Phone: 602-909-[REDACTED]

Owner: Darin Selnick <darin.selnick@[REDACTED]>
Filename: CaldwellResume.pdf
Last Modified: Sun Jul 09 22:16:48 CDT 2017

(b) (6)

(b) (6) Cell: 602-909-(b) (6) Email: (b) (6)

Summary

(b) (6)

(b) (6)

Professional Experience

Concerned Veterans for America (CVA) *Arlington, VA*

Oct. 2013 to Present

Vice President for Policy and Communications, Director of Policy

- (b) (6)
-
-
-
-
-
-
-
-
-

Office of Congressman David Schweikert *Scottsdale, AZ/Washington, D.C.*

Mar. 2011 to Oct. 2013

Constituent Services Representative, Campaign Manager, Deputy Chief of Staff

- (b) (6)
-
-
-

United States Marine Corps *Worldwide*
Rifleman, Team Leader, and Squad Leader

Nov. 2005 to Nov. 2009

- (b) (6)
-

Education

Arizona State University

Jan. 2010 to Dec. 2011

- (b) (6)
-

Selected Writings and Interviews

(b) (6)

References

(b) (6)

Further Documentation and References Provided Upon Request

From: Wright, Vivieca (Simpson) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (5), (b) (6)>
To: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)>
Cc: (b) (6) </o=va/ou=visn 10/cn=recipients/cn=(b) (5), (b) (6)> (b) (6)
(b) (6) </o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)>
Bcc:
Subject: RE: CVA in the news
Date: Tue Mar 07 2017 09:21:35 CST
Attachments:

Not what I asked you to do - so let's talk.

-----Original Message-----

From: (b) (6)
Sent: Tuesday, March 07, 2017 09:10 AM Eastern Standard Time
To: Wright, Vivieca (Simpson)
Cc: (b) (6)
Subject: RE: CVA in the news

Vivieca,

I believe you are referring to Sherman Gillums' (PVA) piece titled "The Removal of Senior Officials Will Be The First Big Test For New VA Secretary" written on February 6th. I spoke to Sherman about this article on Friday after you handed it to me and he mentioned that he spoke to Dr Shulkin about this general topic the week he was nominated to be the Secretary. The topic was on Dr Shulkin's radar because Sherman had written a previous piece in December titled "The one problem that will make or break Trump's pick for VA Secretary", which largely covers the same topic-- accountability of mid-level management within the healthcare system. Sherman seemed pleased with the conversation.

The more recent article highlighted two examples (DeWayne Hamlin- Caribbean and Toby Mathew, Overton Brooks) where poor performers were, as Sherman claims, put on administrative leave and allowed to safe harbor in the VISN collecting government pay check while an investigation was taking place. But it focused on the same topic--accountability and responsibly and quickly removing bad actors.

Sherman appreciated me calling and I get the sense that he knows we are looking into this issue. Since

Sherman's ultimate issue is that removal should mean termination, I recommend we respond when we know we have a firm position on Accountability measures as it relates to temporarily removing leaders accused of wrongdoing. However, if you'd like me to prepare a brief note that let's Sherman know the Secretary is aware of the article, is looking into these two cases, and knows the broader issue must be addressed, I'd be happy to do that.

(b) (6)

-----Original Message-----

From: Wright, Vivieca (Simpson)
Sent: Tuesday, March 07, 2017 7:38 AM
To: (b) (6)
Cc: (b) (6)
Subject: RE: CVA in the news

Also, how close are you to crafting the note for the Secretary back to DAV - would like to have this done before he travels this week.

-----Original Message-----

From: (b) (6)
Sent: Tuesday, March 07, 2017 7:13 AM
To: Wright, Vivieca (Simpson)
Cc: (b) (6)
Subject: CVA in the news

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From: Wright, Vivieca (Simpson) </o=va/ou=va
martinsburg/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)>
To: [REDACTED] (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)>
Cc: [REDACTED] (b) (6)
</o=va/ou=visn 10/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)>
Bcc:
Subject: RE: CVA in the news
Date: Tue Mar 07 2017 09:58:04 CST
Attachments:

Sure

-----Original Message-----

From: [REDACTED] (b) (6)
Sent: Tuesday, March 07, 2017 10:54 AM Eastern Standard Time
To: Wright, Vivieca (Simpson)
Cc: [REDACTED] (b) (6)
Subject: RE: CVA in the news

Ma'am,

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Sent: Tuesday, March 07, 2017 10:22 AM
To: [REDACTED] (b) (6)
Cc: [REDACTED] (b) (6), [REDACTED] (b) (6)
Subject: RE: CVA in the news

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Sent: Tuesday, March 07, 2017 09:10 AM Eastern Standard Time
To: Wright, Vivieca (Simpson)
Cc: (b) (6)
Subject: RE: CVA in the news

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Sent: Tuesday, March 07, 2017 7:38 AM

To: (b) (6)

Cc: (b) (6)

Subject: RE: CVA in the news

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Sent: Tuesday, March 07, 2017 7:13 AM

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Cc: (b) (6)

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<http://www.news4jax.com/news/military/report-va-still-manipulating-wait-times>

From: Wright, Vivieca (Simpson) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (5), (b) (6)>
To: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)>
Cc: (b) (6) </o=va/ou=visn 10/cn=recipients/cn=(b) (5), (b) (6)>
Bcc:
Subject: RE: CVA in the news
Date: Tue Mar 07 2017 06:37:53 CST
Attachments:

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Subject: CVA in the news

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From: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)
Cc:
Bcc:
Subject: CVA
Date: Mon Apr 10 2017 10:24:44 CDT
Attachments:

Great meeting with (b) (6) today. Thanks for the connection!

Sent with Good (www.good.com)

From: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)
To: Wright, Vivieca (Simpson) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (5), (b) (6)
Cc: (b) (6) </o=va/ou=visn 10/cn=recipients/cn=(b) (5), (b) (6)
Bcc:
Subject: RE: CVA in the news
Date: Tue Mar 07 2017 08:10:44 CST
Attachments:

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Cc: (b) (6) </o=va/ou=visn 10/cn=recipients/cn=(b) (5), (b) (6)>
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martinsburg/cn=recipients/cn=(b) (6), (b) (5)
To: (b) (6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6), (b) (5)
Cc:
Bcc:
Subject: OPA Regional Summary
Date: Wed Nov 01 2017 14:15:12 CDT
Attachments: Daily Summary 11-01.docx

Regional Office Daily Summary

Wednesday, November 1, 2017

Office of Public Affairs, Field Operations Service

North Atlantic OPA

Media Contacts - Local:

- WBUR (NPR, Boston), WBZ (1030AM, CBS): Arranged for tentative phone interviews for SECVA with WBUR and WBZ. The interviews will cover the upcoming visit to the Edith Nourse Rogers Memorial Veterans Hospital on Saturday, Nov. 4, and topics such as the opioid epidemic, suicide prevention and modernization. (SP)

Facility Developments:

- Philadelphia VAMC: (b) (5)

[REDACTED]

- VA Maine HCS: (b) (5)

[REDACTED]

Southeast OPA

Facility Developments:

- VISN 9 (Nashville); VA Tennessee Valley Healthcare System (Nashville, Tenn. - TVHS): (b) (5)

- National Cemetery Administration, Southeast District (NCA-Southeast); Mountain Home National Cemetery: (b) (5)

- North Florida/South Georgia Veterans Health System (Gainesville, Fla.): (b) (5)

Midwest OPA

Facility Developments:

- 2018 VA National Salute Letter: (b) (5)

- VA National Center for Patient Safety: (b) (5)

- Chillicothe VAMC: (b) (5)

- Milwaukee VAMC: (b) (5)

Continental (North) OPA

Media Contacts – Regional:

- KDVR-TV (FOX Denver): PAS attended interview with Denver VARO PAO regarding VA stand down taking place in Denver tomorrow. PAS will also be on hand to support the event. (EN)

Facility Developments

- Omaha VAMC, Lincoln VARO, Omaha NC, Victory Park Veterans Residence: (b) (5)

- St. Louis VAMC, VISN 15: (b) (5)

- Trip packs: Submitted trip pack for DepSec trip to Denver. (PS, EN)

- Pittsburgh trip: Reviewed training needs with NAD OPA for upcoming Pittsburgh training. Will be presenting Train SMEs and Customer Service. (EB)

- OPIA Calendar: PAS working on this. (EN)

Continental (South) OPA

Media Contacts - Local:

- Open House Media Advisories: Re-distributed media advisories for open houses taking place at Houston National Cemetery, Fort Smith National Cemetery, Jackson VA Medical Center, South Texas VA HCS and Little Rock VA Medical Center. (LS)

Facility Developments:

- Jackson VAMC: (b) (5)

- Oklahoma City VAMC OIG report on the facility is set to publish tomorrow. (b) (5)

- El Paso VA HCS: (b) (5)

ector also wishes to interview with newspaper on this topic and others upon his return on Nov. 6. (JJ)

- Oklahoma City VAMC: (b) (5)

- Shreveport VAMC: (b) (5)

- Phoenix VAMC: (b) (5)

- Central Texas VA HCS: (b) (5)

- VA North Texas HCS: (b) (5)

- Little Rock VAMC: (b) (5)

- Natchez National Cemetery (Mississippi): (b) (5)

- Houston VAMC: (b) (5)

- VBA Leadership Training: (b) (5)

Pacific OPA

Facility Developments:

- Greater Los Angeles HCS: (b) (5)

- Greater Los Angeles HCS: (b) (5)

- Greater Los Angeles HCS: (b) (5)

- Greater Los Angeles HCS: (b) (5)

- Northern California HCS: (b) (5)

(b) (5)

- San Francisco HCS: (b) (5)

- Spokane HCS: (b) (5)

- Greater Los Angeles HCS: (b) (5)

- Central California HCS: (b) (5)

- Southern Oregon Rehab Clinic/White City: (b) (5)

- Pacific Islands HCS: (b) (5)

Owner: (b) (6) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)
Filename: Daily Summary 11-01.docx
Last Modified: Wed Nov 01 14:15:12 CDT 2017

**Regional Office Daily Summary
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- Shreveport VAMC:

(b) (5)

- Phoenix VAMC: (b) (5)

[REDACTED]

- Central Texas VA HCS: (b) (5)

[REDACTED]

- VA North Texas HCS: (b) (5)

[REDACTED]

- Little Rock VAMC: (b) (5)

[REDACTED]

- Natchez National Cemetery (Mississippi): (b) (5)

[REDACTED]

- Houston VAMC: (b) (5)

[REDACTED]

- VBA Leadership Training: (b) (5)

[REDACTED]

Pacific OPA

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- Greater Los Angeles HCS:

(b) (5)

- Greater Los Angeles HCS:

(b) (5)

- Greater Los Angeles HCS:

(b) (5)

- Greater Los Angeles HCS:

(b) (5)

- Northern California HCS:

(b) (5)

- San Francisco HCS:

(b) (5)

- Spokane HCS:

(b) (5)

- Greater Los Angeles HCS:

(b) (5)

- Central California HCS: (b) (5)

- Southern Oregon Rehab Clinic/White City: (b) (5)

- Pacific Islands HCS: (b) (5)

From: Byrne, Jim (OGC) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)>
To: Bowman, Thomas </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)>
Cc:
Bcc:
Subject: FW: Lawsuit - Federal Vacancies Reform Act
Date: Mon Apr 30 2018 13:33:58 CDT
Attachments: Vacancies Reform Act.pdf
Wilkie-DE-1-Complaint.pdf

From: Byrne, Jim (OGC)
Sent: Monday, April 30, 2018 2:34 PM
To: RLW
Subject: Lawsuit - Federal Vacancies Reform Act

Sir,

Please see the attached lawsuit that was filed today in U.S. District Court for the District of Columbia against the VA and you in your personal and official capacities. Plaintiffs are seeking a declaration that

(b) (5)

[REDACTED]

QUESTION: (b) (5)

[REDACTED]

ANSWER: (b) (5)

[REDACTED]

Please let me know if you have any further questions.

Very respectfully,

Jim

James M. Byrne

General Counsel

U.S. Department of Veterans Affairs

(202) 461-4995

Owner: Byrne, Jim (OGC) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (5), (b) (6)
Filename: Vacancies Reform Act.pdf
Last Modified: Mon Apr 30 13:33:58 CDT 2018

**Department of
Veterans Affairs**

Memorandum

Date: April 2, 2018

From: General Counsel

Subj: Vacancies Covered by the Federal Vacancies Reform Act

To: Acting Secretary of Veterans Affairs

QUESTION:

(b) (5)

ANSWER:

(b) (5)

ANALYSIS:

A. Background

1. The Federal Vacancies Reform Act (FVRA), codified at 5 U.S.C. §§ 3345-3349d, sets forth:
 - (a) means for temporarily filling a vacant position that is reserved for an individual who is presidentially-appointed and Senate-confirmed (PAS), in this case the Secretary of Veterans Affairs (Secretary); and
 - (b) the limited time period for which any individual(s) can serve in an "acting" role in a vacant PAS position.
2. The FVRA applies to a PAS position when the individual occupying the position "dies, resigns, or is otherwise unable to perform the functions and duties of the office." 5 U.S.C. § 3345(a).
3. On March 28, 2018, the President announced that Dr. David Shulkin would no longer serve as Secretary of Veterans Affairs and designated you to serve as Acting Secretary. The President also announced that he intended to nominate Admiral Ronny Jackson for the position of Secretary.

4.

(b) (5)

VA-18-0457-A-000688

Vacancies covered by the Federal Vacancies Reform Act

B.	(b) (5)
1.	
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4.	
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Page 3

Vacancies covered by the Federal Vacancies Reform Act

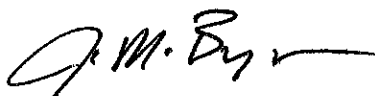
(b) (5)

C	
1	
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D. Conclusion

(b) (5)

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James M. Byrne

Owner: Byrne, Jim (OGC) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (5), (b) (6)
Filename: Wilkie-DE-1-Complaint.pdf
Last Modified: Mon Apr 30 13:33:58 CDT 2018

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

SAMIR HAMEL,
c/o DEMOCRACY FORWARD
FOUNDATION
P.O. Box 34553
Washington, D.C. 20043

and

WILLIAM FISCHER,
c/o DEMOCRACY FORWARD
FOUNDATION
P.O. Box 34553
Washington, D.C. 20043

Plaintiffs,

v.

ROBERT WILKIE,
in his capacity as the person claiming to be
the acting Secretary of Veterans Affairs,
810 Vermont Avenue
Washington, DC 20420

and

U.S. DEPARTMENT OF VETERANS
AFFAIRS,
810 Vermont Avenue
Washington, DC 20420

Defendants.

Case No.

COMPLAINT

1. Plaintiffs Samir Hamel and William Fischer bring this action against Defendants Robert Wilkie, in his capacity as the person claiming to be the acting Secretary of Veterans Affairs, and the U.S. Department of Veterans Affairs (the “Department” or the “VA”), seeking a declaration that Wilkie is not the lawful acting Secretary, and an injunction barring Wilkie and the Department from continuing to represent that Wilkie is the acting Secretary and from taking any action in reliance on Wilkie’s purported authority.

2. According to press reports, the Trump administration and its allies in Congress seek to privatize essential VA services, turning veterans’ health care over to a network of private providers rather than the facilities and physicians that veterans have come to count on. But this case is not about whether privatization is a good idea or a bad idea. This case is about who will make that decision and, more broadly, who possesses the authority to make the many day-to-day decisions regarding veterans’ benefits and care that the Secretary of Veterans Affairs has to make. Specifically, this case is about whether President Trump may circumvent federal statutes and the Constitution to install Wilkie as the acting Secretary of Veterans Affairs, or whether the Deputy Secretary, Thomas G. Bowman, lawfully holds that office instead.

3. The position falls to Deputy Secretary Bowman, not Wilkie, as a matter of law. The VA’s statutory scheme provides that in the event of a vacancy in the Secretary position, the Deputy Secretary shall become acting Secretary. Under the Federal Vacancies Reform Act of 1998 (the “FVRA”), the President may bypass the default order of succession, but only if the previous officeholder dies, resigns, or is otherwise unable to serve in the office—not if the previous officeholder is fired. On March 28, 2018, President Trump unceremoniously fired the Secretary of Veterans Affairs, Dr. David J. Shulkin, by tweet. The President did not, therefore, have legal

authority under the FVRA to fill the vacant Secretary position with an acting officer of his choice. Wilkie's appointment as acting Secretary was unlawful.

4. By disregarding statutory provisions addressing when an individual may be designated to act as an officer in a Senate-confirmed position, the President has also avoided all Congressional checks on his power to fill such positions, and in so doing has violated the Appointments Clause of the Constitution. Nor are Wilkie's new duties as acting Secretary of Veterans Affairs germane to his original duties within the Department of Defense, meaning that he cannot act as Secretary without being specifically appointed to that role.

5. Plaintiffs are veterans who are injured by the President's unlawful appointment of Wilkie, Wilkie's unlawful assumption of authority, and the Department's recognition of it. They receive health care from the VA and are therefore subject to the effects of any decisions Wilkie makes with regard to health care services or other benefits; they are subject to continued, profound uncertainty about how and under what conditions they will receive their benefits; they are deprived of the right to a lawful acting Secretary who will vigorously represent their interests before Congress and the rest of the executive branch; and they face the imminent threat that their health care will be turned over to the private sector.

6. Thus, Plaintiffs respectfully request that the Court declare that Deputy Secretary Bowman is the lawful acting Secretary of Veterans Affairs, and enjoin Wilkie and the Department from continuing to represent that Wilkie is the acting Secretary and from taking any action in reliance on Wilkie's purported authority.

Jurisdiction and Venue

7. The Court has jurisdiction over this action pursuant to 28 U.S.C. § 1331 because Plaintiffs' claims arise under the Constitution and laws of the United States.

8. Venue is proper in this district pursuant to 28 U.S.C. § 1391(e)(1) because Defendants are an agency of the United States and a purported official of the agency sued in his official capacity.

Parties

9. **Plaintiff Samir Hamel** lives with his wife and three children in El Mirage, Arizona. He enlisted in the United States Army Reserve shortly after the September 11th attacks. He served as an Army chaplain until January 2014, when he was honorably discharged. From December 2004 to November 2005, Mr. Hamel deployed to Kuwait, Iraq, and Qatar.

10. Mr. Hamel applied and was enrolled in the VA health care system in 2007. He uses his health benefits on a monthly basis, visiting the Southwest Veterans Affairs Health Care Clinic in Phoenix, Arizona. Mr. Hamel is happy with the health care he has received at the VA; although he has had the option, provided by the VA, to use private service providers, he prefers to use the VA for all of his health care needs, so he can continue to see his own doctor.

11. Mr. Hamel is concerned that the administration will take action to privatize VA health care services. He fears that VA leadership will support and encourage moving veterans like him to private service providers, disrupting his care. If Mr. Hamel could not access VA health care, he would either have to purchase health insurance on the individual market or go without coverage.

12. Mr. Hamel received a home loan through the VA in May 2013 to purchase his current residence. He also used the VA's vocational rehabilitation and employment services to obtain his Masters in Business Administration.

13. **Plaintiff William Fischer** lives in Washington, DC. He served in the United States Marine Corps from March 2001 until he was honorably discharged in March 2009, including a deployment to Fallujah, Iraq in 2004 where he received, among other awards, a Purple Heart.

14. Mr. Fischer is enrolled in the VA health care system. He uses his health benefits for annual check-ups and on a periodic basis as necessary at the Washington, DC VA Medical Center. Mr. Fischer has had a positive experience with the VA. If Mr. Fischer did not have VA health care, he would be forced to rely exclusively on private health coverage.

15. Like Mr. Hamel, Mr. Fischer is concerned about the potential privatization of VA health care services. He fears that privatization would result in worse care for veterans as the VA is set up specifically to meet the needs of veterans and has an institutional expertise unmatched in the private sector.

16. Mr. Fischer also received education assistance through the GI Bill and previously purchased a home using the VA home loan program.

17. As veterans who receive health care and other benefits from the VA, Plaintiffs are injured by the President's unlawful appointment of Wilkie, Wilkie's unlawful assumption of authority, and the VA's acknowledgment of it. They continually receive benefits from the Department pursuant to its regulations, they must comply with the Department's requirements and policies, and any disputes regarding their benefits are resolved by the Secretary and his designees within the Department. They are therefore affected by any decisions Wilkie makes with regard to health care services or other benefits. Beyond these present injuries, Plaintiffs face the imminent threat that their health care will be turned over to the private sector, decreasing their access to health care services and the quality of those services.

18. Because of the dubious legality of Wilkie's appointment as acting Secretary, Plaintiffs are subject to continued, profound uncertainty about how and under what conditions they will receive their benefits. Certainty is essential with respect to medical benefits; Plaintiffs need to know how and whether they can access VA health care services, especially given the possibility

that they could suffer a medical emergency. Plaintiffs are also deprived of the right to a lawful acting Secretary who will vigorously represent their interests before Congress and the rest of the executive branch—and one whose authority is undisputed.

19. **Defendant Robert Wilkie** is the Under Secretary of Defense for Personnel and Readiness and purports to be the acting Secretary of Veterans Affairs. He is sued in his capacity as the person claiming to be the acting Secretary, an official who “is responsible for the proper execution and administration of all laws administered by the Department and for the control, direction, and management of the Department.” 38 U.S.C. § 303.

20. **Defendant Department of Veterans Affairs** is a federal agency headquartered in Washington, DC, charged with “administer[ing] the laws providing benefits and other services to veterans and the dependents and the beneficiaries of veterans.” 38 U.S.C. § 301. The Department is treating Defendant Wilkie as acting Secretary.

The Department Provides Essential Health Care Services and Other Benefits to Veterans Nationwide

21. The Department is the federal agency responsible for ensuring that our collective obligations to those who defended our Nation are fulfilled. As the Supreme Court has recognized, “[t]he solicitude of Congress for veterans is of long standing.” *Henderson ex rel. Henderson v. Shinseki*, 562 U.S. 428, 440 (2011) (quoting *United States v. Oregon*, 366 U.S. 643, 647 (1961)). To that end, the Department administers a complex and extensive benefits system and is charged with fulfilling certain statutory duties and requirements.

22. Of utmost importance, the Department operates a health care system: the Veterans Health Administration (“VHA”). The VHA “provide[s] a complete medical and hospital service for the medical care and treatment of veterans.” 38 U.S.C. § 7301. The VHA “is America’s largest integrated health care system, providing care at 1,240 health care facilities, including 170 medical

centers and 1,061 outpatient sites of care of varying complexity ... , serving 9 million enrolled Veterans each year.”¹ In total, the VA health care system has “an annual budget of approximately \$68 billion.”²

23. Plaintiffs and other veterans receive health benefits by applying to enroll in the VA system in person, by telephone, by mail, or online. Each veteran is assigned to a “priority group,” which determines when he or she will be able to enroll in VA health care and the precise level of benefits they receive. “The enrollment system is based on priority groups to ensure care is available to all enrolled Veterans,” consistent with Congressional budget limitations.³

24. Once veterans have enrolled, they receive a personalized Veterans Health Benefits Handbook that describes their benefits. Those benefits generally include “all the necessary inpatient hospital care and outpatient services to promote, preserve, or restore your health,” including “preventive care, inpatient care, ancillary services, specialty care, and mental health services.”⁴ The handbook informs veterans that “[a]long with your enrollment in the VA health care system comes the assurance that health and treatment services will be available when and where you need them.”⁵ It continues: “You can expect VA’s highly qualified and dedicated health

¹ *Veterans Health Administration*, Dep’t of Veterans Affairs, <https://www.va.gov/health/> (last visited Apr. 27, 2018).

² *About VHA*, Dep’t of Veterans Affairs, <https://www.va.gov/health/aboutVHA.asp> (last visited Apr. 27, 2018).

³ *Priority Groups*, Dep’t of Veterans Affairs, https://www.va.gov/HEALTHBENEFITS/resources/priority_groups.asp (last visited Apr. 27, 2018).

⁴ *Veterans Health Benefits Handbook*, Dep’t of Veterans Affairs 4, https://www.va.gov/HEALTHBENEFITS/vhbh/publications/vhbh_sample_handbook_2014.pdf (last visited Apr. 27, 2018).

⁵ *Id.* at 1.

care professionals to meet your needs, regardless of the treatment program, regardless of the location.”⁶ In other words, the VA emphasizes the reliability and stability of VA care.

25. What distinguishes the care provided by the VA from other forms of health coverage is that the VA generally provides health care directly to enrolled veterans, rather than by contracting with private parties, like a typical private health insurer. Veterans receive a Veteran Health Identification Card which they can use to obtain health care at any VA health facility.⁷ When they see a health care provider, Plaintiffs and other veterans pay a minimal or no co-pay.⁸

26. The VA also provides a number of other benefits to the Nation’s veterans. The Veterans Benefits Administration, under the leadership of the Under Secretary for Benefits and the Secretary, is charged with “the administration of nonmedical benefits programs of the Department which provide assistance to veterans and their dependents and survivors.” 38 U.S.C. § 7701. Among other things, the VA provides disability compensation and a pension for disabled veterans (*id.* §§ 1110, 1131, 1521); life insurance payments (*id.* § 1312); housing assistance for homeless veterans (*id.* § 2011); compensation for burial expenses and designated national cemeteries (*id.* §§ 2302, 2402); educational assistance, commonly referred to as the GI Bill (*id.* § 3461); housing and small business loans (*id.* §§ 3702, 3742); and vocational rehabilitation and training (*id.* § 4102).

27. Currently, the Department lacks either an acting or a permanent Under Secretary for Benefits. The position is staffed by an “Executive in Charge.”⁹

⁶ *Id.*

⁷ *Id.* at 26.

⁸ *Determine Cost of Care*, Dep’t of Veterans Affairs, <https://www.va.gov/HEALTHBENEFITS/cost/index.asp> (last visited Apr. 27, 2018).

⁹ *See Executive Biographies*, Dep’t of Veterans Affairs, <https://www.va.gov/opa/bios/> (last visited Apr. 27, 2018).

**The Secretary Is Responsible for Ensuring Veterans
Get the Health Benefits to Which They Are Entitled**

28. While the Secretary may delegate certain duties to his or her subordinates, it is the Secretary who is ultimately responsible for administering the VA system, for making critical decisions about veterans' benefits, and for advocating on behalf of veterans to other executive branch agencies and officials, to Congress, and to the public at large. Ultimately, the Secretary is charged with achieving "the maximum feasible effectiveness, coordination, and interrelationship of services among all programs and activities affecting veterans," and "shall actively promote the effective implementation, enforcement, and application of all provisions." *Id.* § 523(a).

29. With respect to health coverage, the Secretary is obligated to "furnish hospital and medical services which the Secretary determines to be needed ... to any veteran for a service-connected disability; and ... to any veteran who has a service-connected disability rated at 50 percent or more," and may also furnish nursing home care to certain veterans. *Id.* § 1710(a). To that end, the Secretary must "establish and operate a system of annual patient enrollment," which "manage[s] the enrollment of veterans," as described above. *Id.* § 1705(a).

30. The Secretary is charged with ensuring that the VHA adequately serves the veterans under its care. He or she must "to the extent feasible, design, establish and manage health care programs in such a manner as to promote cost-effective delivery of health care services in the most clinically appropriate setting." *Id.* § 1706(a). And he or she must "establish and conduct a comprehensive program to monitor and evaluate the quality of health care furnished by the Veterans Health Administration." *Id.* § 7311. VA regulations provide that "[p]atients have a right to be treated with dignity in a humane environment," and "have a right to receive, to the extent of eligibility therefor under the law, prompt and appropriate treatment for any physical or emotional disability." 38 C.F.R. § 17.33(a).

31. The Secretary also possesses substantial discretion to extend health care services to those who are not otherwise statutorily entitled to them. For categories of veterans not enumerated in the statute, “the Secretary may, to the extent resources and facilities are available, ... furnish hospital care, medical services, and nursing home care which the Secretary determines to be needed.” 38 U.S.C. § 1710(a)(3). The Secretary can also provide medical care to the survivors and dependents of certain veterans. *Id.* § 1781(a). And the Secretary may provide benefits where an “administrative error” results in non-payment (*id.* § 503(a)), or where a beneficiary suffers loss in reliance on an erroneous decision (*id.* § 503(b)).

32. To fulfill his or her statutory duties, the Secretary has a number of statutory powers. The Secretary can promulgate rules (*id.* § 501); reorganize the Department’s functions (*id.* § 510); decide all questions of law and fact related to benefits determinations (*id.* § 511); delegate functions to his or her subordinates (*id.* § 512); and settle tort claims against the Department (*id.* § 515). The Secretary may also “enter into contracts or agreements with private or public agencies or persons” for “necessary services ... as the Secretary may consider practicable.” *Id.* § 513; *see also id.* §§ 1703 (authorizing the Secretary to enter into contracts for “hospital care and medical services”); 8102 (authorizing the Secretary to acquire medical facilities).

33. As part of his or her duties with regard to ensuring the provision of health care services to veterans, the Secretary has specific statutory obligations to staff the Office of the Under Secretary for Health.

34. The Under Secretary for Health is “the head of, and is directly responsible to the Secretary for the operation of, the Veterans Health Administration.” *Id.* § 305(b). He or she is charged with numerous responsibilities for administering the VHA, including decisionmaking on what types of medical services to outsource from the VHA. *See, e.g.*, 38 C.F.R. §§ 17.52, 17.142.

As such, the Under Secretary for Health directs the administration of the entire VHA and, together with the Secretary, is ultimately responsible for the treatment and care of all veterans like Plaintiffs who receive medical care from the VA.

35. The Under Secretary for Health’s qualifications are set forth by statute: he or she “shall be appointed without regard to political affiliation or activity and solely--

(A) on the basis of demonstrated ability in the medical profession, in health-care administration and policy formulation, or in health-care fiscal management; and
(B) on the basis of substantial experience in connection with the programs of the Veterans Health Administration or programs of similar content and scope.

38 U.S.C. § 305(a)(2).

36. The Secretary is responsible for establishing a commission to recommend individuals to the President for appointment to the Under Secretary for Health position. 38 U.S.C. § 305(c)(1). The membership of this commission must include veteran and medical provider representatives, among others. *Id.* § 305(c)(2). The commission must recommend at least three individuals for appointment, who the Secretary shall forward to the President with any comments he or she considers appropriate. *Id.* § 305(c)(3).

37. The Under Secretary for Health position has been vacant since October 7, 2017, and there is no current nomination for the position.¹⁰ The VHA currently is run by an “Executive in Charge” with the authority to perform the functions and duties of the Under Secretary for Health.¹¹ The Executive in Charge cannot perform non-delegable duties of this position without being appointed as acting Under Secretary, or otherwise complying with succession requirements.

¹⁰ See, e.g., Nikki Wentling, *Chief of VA Health System Steps Down*, Stars & Stripes (Oct. 6, 2017), <https://www.stripes.com/news/chief-of-va-health-system-steps-down-1.491395>; Nominations, S. Comm. on Veterans’ Affairs, <https://www.veterans.senate.gov/nominations> (last visited Apr. 27, 2018).

¹¹ Carolyn Clancy, MD, Dep’t of Veterans Affairs, <https://www.va.gov/directory/guide/manager.asp?pnun=30310> (last visited Apr. 27, 2018).

38. The Secretary is responsible for taking action to fill the Under Secretary for Health position.

39. The Secretary is also responsible for the appointment of numerous positions within the Department, including leadership positions in the Office for the Under Secretary for Health. *See* 38 U.S.C. § 7306(a), (c). These positions are required by statute to meet certain medical qualifications, such as being a qualified doctor of medicine for the Deputy Under Secretary for Health position and a qualified doctor of medicine or of dental surgery or dental medicine for various Medical Director positions. *Id.* § 7306(a). Several of the appointments must be made upon recommendation of the Under Secretary for Health. *Id.* § 7306(c).

40. Several of the leadership positions in the Office of the Under Secretary for Health are empty or staffed by individuals serving in an acting capacity. For example, the Assistant Deputy Under Secretary for Health for Organizational Integration position is vacant. Other key positions, such as the Deputy Under Secretary for Health for Community Care and the Deputy Under Secretary for Health for Policy and Services have acting officials, not permanent appointments.¹²

41. The Secretary is responsible for taking action to fill these important positions with permanent appointees. 38 U.S.C. § 7306.

The Secretary Is Responsible for Representing Veterans' Interests to Congress

42. The Secretary is also responsible for representing the interests of veterans to Congress, both through regular testimony and through written submissions.

¹² *Key Staff, Veterans Health Administration, Dep't of Veterans Affairs*, <https://www.va.gov/directory/guide/keystaff.cfm?id=2001> (last visited Apr. 27, 2018).

43. For example, since the start of this calendar year, the Secretary has testified in support of the Department's budget request¹³ and on the progress of implementing 2017 VA Reform Legislation, including with respect to implementing electronic medical records.¹⁴

44. The Secretary also has regular obligations to submit written reports to Congress.

45. Among these responsibilities, the Secretary is responsible for reporting to Congress on the recommendations of numerous advisory committees related to veterans' concerns. These include six statutorily required advisory committees, as well as non-statutory advisory committees. Their topics include: Former Prisoners of War (38 U.S.C. § 541), Women Veterans (*id.* § 542), Prosthetics and Special-Disabilities Programs (*id.* § 543), Minority Veterans (*id.* § 544), the Readjustment of Veterans (*id.* § 545), and Disability Compensation (*id.* § 546).

46. In general, the authorizing statutes for these advisory committees require the Secretary to appoint the members of the committees; to, on a regular basis, consult with and seek advice of the committee with respect to the subject matter of the committee; and to submit periodic reports by the committees to Congress with any comments concerning the report that the Secretary considers appropriate.

47. At least one such reporting period is imminent. The Advisory Committee on the Readjustment of Veterans' annual report was due to the Secretary by March 31. *See id.* § 545(c)(1). The Secretary has 90 days to transmit to the Committees on Veterans' Affairs of the Senate and

¹³ *Statement of the Hon. David J. Shulkin, MD*, S. Comm. on Veterans' Affairs (Mar. 21, 2018), <https://www.veterans.senate.gov/imo/media/doc/VA%20Shulkin%20Testimony%2003.21.2018.pdf>.

¹⁴ *Statement of the Hon. David J. Shulkin, MD*, S. Comm. on Veterans' Affairs (Jan. 17, 2018), <https://www.veterans.senate.gov/imo/media/doc/Shulkin%20VA%20Testimony%2001.17.2018.pdf>.

House of Representatives a copy of the report, together with any comments and recommendations concerning the report that the Secretary considers appropriate. *See id.* § 545(c)(2).

48. In the past this Advisory Committee has made specific recommendations on the administration of healthcare by VHA. Among these is a recommendation it has made over the course of multiple reports for VHA to implement strategies and policies to enhance coordination of care for individual veteran clients between Vet Center and VA medical center providers. The Committee called for “clear and precise directives from VHA” leadership.¹⁵ The Advisory Committee has also made recommendations related to veteran access to mental health care providers familiar with military culture and combat-theater experience and specific veteran suicide prevention efforts.¹⁶ Similar recommendations should now be before the Acting Secretary to review, and report along with recommendations to Congress.

**The Administration’s Plans to Dismantle the Veterans Health Administration,
Privatize Veterans’ Health Care, and Strip Veterans’ Benefits**

49. As explained above, the Department is charged with ensuring that veterans receive stable, predictable, high-quality health care. However, President Trump and his administration have long supported the privatization of the VA—a decision that would threaten Plaintiffs and other veterans’ health care and increase the cost of providing health care services.

50. During his campaign, then-candidate Trump and other campaign officials advocated for policies that would direct veterans toward private health care providers rather than the VA. Trump’s plan would have generally allowed “veterans to choose a doctor outside the VA

¹⁵ *Advisory Committee of the Readjustment of Veterans, Eighteenth Annual Report*, Dep’t of Veterans Affairs (Feb. 2017), <https://www.va.gov/ADVISORY/Reports/ReportReadjustFeb2017.pdf>.

¹⁶ *Id.*

system,” who would be reimbursed by the VA.¹⁷ In May 2016, one of his senior advisors gave comments that indicated that Trump “would likely push VA health care toward privatization and might move for it to become more of an insurance provider like Medicare rather than an integrated hospital system.”¹⁸ And in a July 2016 speech in Virginia Beach, Trump himself argued that “[v]eterans should be guaranteed the right to choose their doctor and clinics, whether at a VA facility or at a private medical center,” describing the VA as “corrupt and inefficient.”¹⁹

51. Since his election, President Trump has continued to support privatization. During the transition, Trump openly “consider[ed] changing the department to allow some veterans to bypass the VA health-care system completely and get care exclusively from private-sector hospitals and clinics”—a step “which many veterans groups argue is the first step toward privatization.”²⁰ Toward the end of 2017, Trump proposed to eliminate eligibility requirements for the use of private health coverage, which would transfer a greater share of funding from the VA to private providers.²¹ The administration has also suggested that it would consider merging parts

¹⁷ Quil Lawrence, *Is Donald Trump Proposing Privatizing the VA?*, NPR (July 13, 2016), <https://www.npr.org/2016/07/13/485782407/is-trump-proposing-privatizing-the-va>.

¹⁸ Ben Kesling, *Donald Trump Adviser Signals Plan to Change Veterans’ Health Care*, Wall St. J. (May 12, 2016), <https://www.wsj.com/articles/donald-trump-adviser-signals-plan-to-change-veterans-health-care-1463064129>.

¹⁹ See, e.g., Nathaniel Weixel, *VA Privatization Fight Could Erupt in Confirmation Hearing*, The Hill (Apr. 11, 2018), <http://thehill.com/policy/healthcare/382555-va-privatization-fight-could-erupt-in-confirmation-hearing>.

²⁰ Ben Kesling, *Donald Trump Considers Moving VA Toward Privatization*, Wall St. J. (Dec. 28, 2016), <https://www.wsj.com/articles/trump-considering-moving-va-toward-privatization-1482974260>.

²¹ Eric Katz, *Trump Administration’s Plan to Expand Private Care for Vets Sparks Fight Over VA’s Future*, Gov’t Exec. (Oct. 17, 2017), <https://www.govexec.com/management/2017/10/trump-administrations-plan-expand-private-care-vets-begins-fight-over-vas-future/141842/>.

of the VA with Tricare, the military's privately administered health care program for troops, families, and retirees.²²

52. "Groups like the Koch brothers-backed Concerned Veterans for America" ("CVA") have driven the privatization agenda by "pushing to loosen current restrictions on veterans receiving private-sector care."²³ CVA, which "stands virtually alone among veterans' groups in its commitment to vastly expanded private options for veterans," "seems to have the Trump administration's ear."²⁴ Indeed, President Trump's most recent plan for the VA closely "resembled the CVA's priorities," with six proposals that "drew directly on CVA ideas."²⁵

53. CVA and other proponents of privatization have also pushed the administration to hire friendly voices for critical positions in the federal government. "Darin Selnick, a former senior advisor to the Koch-funded group," served "as the veterans affairs adviser for the White House's Domestic Policy Council."²⁶ Selnick was "pushed out of the [Department] last year after butting heads with Shulkin over privatization of veterans health services."²⁷ Just days before President

²² Leo Shane III, *White House Officials Looking Into Merging VA and Tricare Health Services*, Army Times (Nov. 17, 2017), <https://www.armytimes.com/veterans/2017/11/17/white-house-officials-looking-into-merging-va-and-tricare-health-services/>.

²³ Weixel, *supra*.

²⁴ Josh Keefe, *Is the VA Being Privatized? This Koch-Backed Group Says It Just Wants "Choice" but Veterans Aren't So Sure*, Newsweek (Apr. 5, 2018), <http://www.newsweek.com/koch-brothers-backed-group-could-determine-future-va-870693>.

²⁵ Isaac Arnsdorf, *Inside the Trump Administration's Internal War Over the VA*, Politico Mag. (Feb. 16, 2018), <https://www.politico.com/magazine/story/2018/02/16/trump-veterans-affairs-va-david-shulkin-217013>.

²⁶ Nicholas Fandos & Dave Philipps, *In Battle Over Future of Veterans' Care, Moderation Wins, for Now*, N.Y. Times (Mar. 6, 2018), <https://www.nytimes.com/2018/03/06/us/politics/veterans-affairs-shulkin-koch-brothers.html>.

²⁷ Lorraine Woellert, *Shulkin Critic Leaves White House to Return to VA*, Politico (Mar. 26, 2018), <https://www.politico.com/story/2018/03/26/shulkin-va-white-house-486776>.

Trump fired former Secretary Shulkin, however, Selnick returned to a post at the VA.²⁸ President Trump also considered Fox News host Pete Hegseth, the former executive director of CVA, as a potential replacement for Shulkin, as well as Rick Perry, the current Secretary of Energy, who has said that he “supports moving more veterans’ care to the private sector.”²⁹ And President Trump has also leaned on Jeff Miller, a former member of Congress allied with CVA—and now a lobbyist—as his “point man on veterans policy.”³⁰

54. Privatization would imperil Plaintiffs’ and other veterans’ essential health care. A 2016 study by RAND found that the “[q]uality of care delivered by VA is generally equal to or better than care delivered in the private sector.”³¹ Another 2016 RAND study, based on a meta-analysis of 69 articles, confirmed that “[s]tudies of safety and effectiveness indicated generally favorable performance by VA facilities compared to non-VA facilities.”³² That study confirmed a 2010 report from the Department itself, which reviewed 55 studies and concluded that “the available literature suggests that the care provided in the VA compares favorably to non-VA care systems, albeit with some caveats.”³³

²⁸ *Id.*

²⁹ Lisa Rein, *Trump Eyes ‘Fox & Friends’ Personality Pete Hegseth to Take Over Veterans Affairs*, Wash. Post (Mar. 15, 2018), https://www.washingtonpost.com/politics/trump-eyes-fox-and-friends-personality-pete-hegseth-to-take-over-veterans-affairs/2018/03/15/f8d03ef6-284e-11e8-b79d-f3d931db7f68_story.html; Kaitlan Collins et al., *Trump Eyes Rick Perry to Replace VA Secretary*, CNN (Mar. 18, 2018), <https://www.cnn.com/2018/03/13/politics/rick-perry-david-shulkin-veterans-affairs/index.html>.

³⁰ Arnsdorf, *supra*.

³¹ Carrie M. Farmer et al., *Balancing Demand and Supply for Veterans’ Health Care*, Rand Health Q. (June 20, 2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5158276/>.

³² Claire O’Hanlon et al., *Comparing VA and Non-VA Quality of Care: A Systematic Review*, 32 J. Gen. Internal Med. 105, 118 (2016).

³³ Health Servs. Research & Dev. Serv., *Comparison of Quality of Care in VA and Non-VA Settings: A Systematic Review*, Dep’t of Veterans Affairs, at vi (Sept. 2010), <https://www.hsrd.research.va.gov/publications/esp/quality.pdf>.

55. Moreover, the Department “has developed singular expertise on the medical needs of veterans,”³⁴ in subjects like severe trauma, rare diseases, amputations, burns, exposure to toxic substances like Agent Orange, physical therapy, anxiety, post-traumatic stress disorder, and other service-related ailments. “VHA’s behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled.”³⁵ Because of its unique competencies, the VA “provides highly integrated treatment specific to the needs of veterans—care that is typically not available at any price to patients outside the VA system.”³⁶

56. Privatization would be more expensive to boot. “Policymakers in both parties argue that offering veterans unrestricted choice between the public veterans health care system and private medical providers would be too expensive and lead to the dismantling of the Veterans Affairs system.”³⁷ The nonpartisan Congressional Budget Office has found that “the structure of VHA and published studies suggest that VHA care has been cheaper than care provided by the private sector.”³⁸ Services provided by the VA in the past “would have cost about 21 percent more if those services had been delivered through the private sector.”³⁹ For these reasons, the Committee for a Responsible Federal Budget estimated that Trump’s 2016 campaign “plan to reform the

³⁴ Daniel Marans, *Veterans Groups Worry VA Chief’s Ouster Sets the Stage for Privatization*, HuffPost (Mar. 29, 2018), https://www.huffingtonpost.com/entry/veterans-group-worry-david-shulkin-ouster-va-privatization_us_5abd6b70e4b0a47437a9b663.

³⁵ *Final Report*, Comm’n on Care 22 (June 30, 2016), https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf.

³⁶ Phillip Longman & Suzanne Gordon, *VA Health Care: A System Worth Saving*, Am. Legion, <https://www.legion.org/publications/238801/longman-gordon-report-va-healthcare-system-worth-saving> (last visited Apr. 27, 2018).

³⁷ Fandos & Philipps, *supra*.

³⁸ *Comparing the Costs of the Veterans’ Health Care System with Private-Sector Costs*, Cong. Budget Office 1 (Dec. 2014), https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/49763-VA_Healthcare_Costs.pdf.

³⁹ *Id.* at 5.

veterans affairs system and increase veterans' access to private doctors would cost about \$500 billion" over the next ten years.⁴⁰

57. Most veterans oppose privatization. One survey found that "the vast majority of veterans (87%) believe the federal government should provide a health care system dedicated to the needs of ill, injured and wounded veterans," despite the VA's flaws.⁴¹ Another found that veterans overwhelmingly reject the idea that "the VA health care system should be dismantled by creating a subsidy-based private health insurance for veterans, shutdown completely and outsourced to the private sector, or limited to only serving service-connected conditions."⁴²

The President Fires Secretary Shulkin

58. On February 14, 2017, the Senate confirmed Dr. David J. Shulkin to serve as Secretary of Veterans Affairs by a 100 to 0 vote—the only cabinet secretary in this administration to be confirmed unanimously.⁴³

59. During his tenure, former Secretary Shulkin promised to prevent privatization of VA health services, noting in one statement that: "Many of VA's services cannot be replicated in the private sector. In addition to providing some of the best quality overall health care in the country, VA delivers world class services in polytrauma, spinal cord injury and rehabilitation,

⁴⁰ *Promises and Price Tags: A Fiscal Guide to the 2016 Election*, Comm. for a Responsible Fed. Budget 5 (2016), http://www.crfb.org/sites/default/files/CRFB_Promises_and_Price_Tags.pdf.

⁴¹ *The DAV Veterans Pulse Survey*, Disabled Am. Veterans (Nov. 11, 2015), <https://www.dav.org/wp-content/uploads/DAV-Pulse-Report-Final.pdf>.

⁴² *Our Care 2017: A Report Evaluating Veterans Health Care*, Veterans of Foreign Wars (Mar. 2017), <https://www.vfw.org/-/media/vfwsite/files/advocacy/vfw-our-care-2017--executive-summary.pdf?la=en>.

⁴³ Wilson Andrews, *How Each Senator Voted on Trump's Cabinet and Administration Nominees*, N.Y. Times, https://www.nytimes.com/interactive/2017/01/31/us/politics/trump-cabinet-confirmation-votes.html?_r=0&mtref=en.wikipedia.org (last updated May 11, 2017).

prosthetics and orthotics, traumatic brain injury, post-traumatic stress treatments and other behavioral health programs.”⁴⁴

60. Just over a year after his confirmation, on March 28, 2018, President Trump fired former Secretary Shulkin.⁴⁵

61. That morning, former Secretary Shulkin spoke to the President, who “made no mention of the fact that he was about terminate [him].”⁴⁶ Several hours later, however, the President’s Chief of Staff, John Kelly, called Shulkin to inform him that the President intended to fire him.⁴⁷

62. President Trump then “announced Shulkin’s ouster in a tweet.”⁴⁸ Specifically, President Trump tweeted that he intended to nominate Dr. Ronny L. Jackson as the new Secretary of Veterans Affairs, but was “thankful for Dr. David Shulkin’s service to our country and to our

⁴⁴ David Shulkin, *Veterans Affairs Secretary - VA Health Care Will Not Be Privatized on Our Watch*, USA Today (July 24, 2017) <https://www.usatoday.com/story/opinion/2017/07/24/veterans-health-care-will-not-be-privatized-david-shulkin-column/499417001/>.

⁴⁵ See, e.g., Nicholas Fandos & Maggie Haberman, *Veterans Affairs Secretary Is Latest to Go as Trump Shakes Up Cabinet*, N.Y. Times (Mar. 28, 2018), <https://www.nytimes.com/2018/03/28/us/politics/david-shulkin-veterans-affairs-trump.html>; Amanda Macias, *David Shulkin, Fired By Trump, Warns that Privatizing the Veterans Affairs Department Will Hurt Veterans*, CNBC (Mar. 29, 2018), <https://www.cnbc.com/2018/03/29/david-shulkin-fired-by-trump-warns-against-privatizing-the-va.html>; Hope Yen & Zeke Miller, *Trump Fires Veterans Affairs Secretary Shulkin*, Time (Mar. 28, 2018), <http://time.com/5219737/trump-fires-veterans-affairs-secretary-david-shulkin-admiral-ronny-jackson/>.

⁴⁶ Rebecca Morin, *Shulkin: Trump Didn’t Mention Firing in Call Hours Before He Was Fired*, Politico (Mar. 29, 2018), <https://www.politico.com/story/2018/03/29/trump-shulkin-firing-tweet-call-492412>.

⁴⁷ *Id.*

⁴⁸ Todd Shields, *Trump’s Outgoing Veterans Affairs Secretary Blasts ‘Toxic’ Washington*, Bloomberg (Mar. 29, 2018), <https://www.bloomberg.com/news/articles/2018-03-28/trump-ousts-shulkin-as-veterans-affairs-chief-in-latest-shakeup>.

GREAT VETERANS!”⁴⁹ When asked “if he was essentially fired via the tweet from the president, Shulkin responded: ‘Yes.’”⁵⁰

63. Notwithstanding these public reports, the administration soon began to insist that former Secretary Shulkin had resigned. On March 31, Spokeswoman Lindsey Walters explained that “Secretary Shulkin resigned from his position as Secretary of the Department of Veterans Affairs.”⁵¹ This assertion has been “strongly disputed” by “a person familiar with Shulkin’s dismissal ... [who] not[ed] that he did not submit a resignation letter.”⁵²

64. By April 2, the administration changed its explanation again. White House communications aide Mercedes Schlapp stated that Kelly “called Shulkin and gave him the opportunity to resign.”⁵³ When pressed on whether that meant Shulkin had been fired, Schlapp clarified that “General Kelly offered him the opportunity to resign. At this point, the president said it was time to move on in terms of Veterans Affairs. He thanks Secretary Shulkin for his service.”⁵⁴

65. Former Secretary Shulkin’s dismissal was preceded by months of plotting by administration officials, motivated by disagreements about “how far and how fast to privatize

⁴⁹ Donald J. Trump (@realDonaldTrump), Twitter (Mar. 28, 2017, 2:31 PM), <https://twitter.com/realDonaldTrump/status/979108653377703936> [hereinafter “Trump Tweet”].

⁵⁰ Meagan Vazquez, *Shulkin Says He Was Fired Via Trump Tweet*, CNN (Apr. 2, 2018), <https://edition.cnn.com/2018/04/02/politics/shulkin-tweet-fired-cnntv/index.html>.

⁵¹ Andrew Restuccia, *Did Shulkin Get Fired or Resign? This Is Why It Matters*, Politico (Mar. 31, 2018), <https://www.politico.com/story/2018/03/31/did-shulkin-get-fired-or-resign-veterans-492877>.

⁵² *Id.*

⁵³ Juana Summers, *Shulkin Says He Was Fired. The White House Said He Resigned. Here’s Why It Matters*, CNN (Apr. 2, 2018), <https://www.cnn.com/2018/04/02/politics/shulkin-trump-resigned-fired/index.html>.

⁵⁴ Andrew Restuccia, *White House Appears to Shift Explanation on Whether Shulkin Resigned or Was Fired*, Politico (Apr. 2, 2018), <https://www.politico.com/story/2018/04/02/shulkin-resign-or-fire-495074>.

health care for veterans, a long-sought goal for conservatives like the Koch brothers.”⁵⁵ “[T]he president’s appointees have felt betrayed by what they see as backtracking at the department on access to privately provided health care,” and in December “quietly bypassed the secretary to advance legislation that would open the way for more privately provided health care for veterans.”⁵⁶ In other words, “[t]he fight over the leadership of the department is part of a long-running battle over how to deliver health care to the nation’s veterans.”⁵⁷

66. In an editorial published the day he was fired, former Secretary Shulkin attributed his dismissal to “advocates within the administration for privatizing V.A. health services,” who “saw [him] as an obstacle to privatization who had to be removed.”⁵⁸ Specifically, Shulkin believed that “privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans.”⁵⁹ In Shulkin’s view, “[t]he private sector, already struggling to provide adequate access to care in many communities, is ill-prepared to handle the number and complexity of patients that would come from closing or downsizing V.A. hospitals and clinic.”⁶⁰

⁵⁵ Fandos & Haberman, *supra*.

⁵⁶ Dave Philipps & Nicholas Fandos, *Intrigue at V.A. as Secretary Says He Is Being Forced Out*, N.Y. Times, Feb. 15, 2018, <https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html>.

⁵⁷ *Id.*

⁵⁸ David J. Shulkin, *Privatizing the V.A. Will Hurt Veterans*, N.Y. Times, Mar. 28, 2018, <https://www.nytimes.com/2018/03/28/opinion/shulkin-veterans-affairs-privatization.html>.

⁵⁹ *Id.*

⁶⁰ *Id.* Former Secretary Shulkin repeated his account in an interview with NPR, asserting that “political forces in the Trump administration want to privatize the VA – and that he was standing in the way.” Laurel Wamsley & Scott Neuman, *Fired VA Secretary Says White House Muzzled Him*, NPR (Mar. 29, 2018), <https://www.npr.org/sections/thetwo-way/2018/03/29/597866101/fired-va-secretary-says-white-house-muzzled-him>. According to Shulkin, “[t]here are many political appointees in the VA that believe that we are moving in the wrong direction or weren’t moving fast enough toward privatizing the VA.” *Id.* And he told MSNBC that “[t]here was clear

67. President Trump himself even admitted that he fired Shulkin to accelerate the privatization of the VA, claiming in a speech on March 30 that “[w]e made changes because we want them taken care of, we want them to have choice so that they can run to a private doctor and take care of it, and it’s going to get done.”⁶¹

68. More recently, “[i]n a private meeting ... with major veterans groups,” Chief of Staff Kelly, who delivered the news to former Secretary Shulkin that he had been fired, “repeatedly said that the decision to remove Shulkin was President Donald Trump’s,” thereby “contradict[ing] the White House’s claims about David Shulkin’s departure.”⁶²

69. In nominating Shulkin’s proposed replacement, Dr. Ronny Jackson, the White House did not say that Shulkin resigned—as the White House typically does when nominating a new official to replace an official who resigned.⁶³ Dr. Jackson has since withdrawn his nomination to serve as Secretary of Veterans Affairs, and no new nomination has been announced or submitted to the Senate by the President.⁶⁴

evidence ... that the political appointees inside the VA were working against me and my leadership team because they felt that we were trying to strengthen the VA rather than moving towards privatization.” Phil Helsel, *Fired VA Head Shulkin Says Political Appointees Were Focused on Privatization*, NBC News (Mar. 29, 2018), <https://www.nbcnews.com/politics/politics-news/fired-va-head-shulkin-says-political-appointees-were-focused-privatization-n861351>.

⁶¹ Donovan Slack, *Donald Trump Says David Shulkin Out of Sync with Agenda on Private Sector Veterans Care*, USA Today (Mar. 29, 2018), <https://www.usatoday.com/story/news/politics/onpolitics/2018/03/29/donald-trump-firing-va-secretary-says-he-fired-david-shulkin-give-veterans-choice-private-sector-car/470598002/>.

⁶² Isaac Arnsdorf, *White House Chief of Staff Contradicts White House Claim on VA Shakeup*, ProPublica (Apr. 16, 2018), <https://www.propublica.org/article/david-shulkin-white-house-chief-of-staff-contradicts-white-house-claim-on-va-shakeup>.

⁶³ *One Nomination Sent to the Senate Today*, White House (Apr. 16, 2018), <https://www.whitehouse.gov/presidential-actions/one-nomination-sent-senate-today-5/>.

⁶⁴ Cristiano Lima, *Ronny Jackson Withdraws as Veterans Affairs Secretary Nominee*, Politico (Apr. 26, 2018), <https://www.politico.com/story/2018/04/26/ronny-jackson-withdraws-as-veterans-affairs-secretary-nominee-555110>.

The President Unlawfully Chooses Wilkie Over Deputy Secretary Bowman

70. Federal law presumptively mandates that “the Deputy Secretary shall be Acting Secretary of Veterans Affairs ... in the event of a vacancy in the office of Secretary” (38 U.S.C. § 304), which results in the current Deputy Secretary of Veterans Affairs, Thomas Bowman, serving as the lawful acting Secretary. Before his appointment as Deputy Secretary, Bowman had a lengthy career in VA leadership positions and other policy roles related to veterans’ affairs.⁶⁵

71. Bypassing the legal succession requirements, President Trump appointed Wilkie—the Under Secretary of Defense for Personnel and Readiness—to serve as acting Secretary of Veterans Affairs (again by tweet).⁶⁶ Wilkie purports to serve as acting Secretary, and the Department recognizes him as the Secretary.⁶⁷ He also continues to serve in his original position within the Department of Defense. Aside from his current position as acting Secretary, Wilkie has never served in the Department of Veterans Affairs and has instead spent most of his career in various offices at the Department of Defense.⁶⁸

72. The President appears to have bypassed Deputy Secretary Bowman due to Bowman’s opposition to privatization of VA health services. In an email sent in December 2017, the President’s senior advisor on veterans affairs, Jake Leinenkugel, proposed that the administration replace Bowman with himself, and former Secretary Shulkin with a “strong

⁶⁵ See *Thomas G. Bowman, Deputy Secretary of Veterans Affairs*, Dep’t of Veterans Affairs, https://www.va.gov/opa/bios/bio_bowman.asp (last visited Apr. 27, 2018).

⁶⁶ See Trump Tweet, *supra*.

⁶⁷ See *Secretary of Veterans Affairs*, Dep’t of Defense, <https://www.va.gov/opa/bios/secva.asp> (last visited Apr. 27, 2018).

⁶⁸ See *id.*

political candidate,” as retaliation for their positions on privatization.⁶⁹ Leinenkugel described Bowman as an “obstructionist[]” opposed to the administration’s privatization agenda.⁷⁰

73. Then, in February 2018, the Washington Post reported that the administration again sought to fire Deputy Secretary Bowman, who “was said to be at odds with the administration’s plan to expand health care access for veterans through private producers,” as a “warning shot” to former Secretary Shulkin.⁷¹ “Bowman had pushed back on broad privatization efforts, leading Trump to berate him in an Oval Office meeting for his lack of loyalty.”⁷²

Wilkie Takes Control of the Department

74. To date, Wilkie has taken action in reliance on his purported authority as acting Secretary.

75. As of April 27, 2018, the Department had issued five final rules, nine proposed rules, and twenty-nine notices in the few weeks since Wilkie took office, and apparently in reliance on Wilkie’s authority as acting Secretary. The four final rules include rules amending the rating schedule that addresses gynecological conditions and disorders of the breast, amending the rating schedule that addresses eye disabilities, and amending acquisition regulations—rules that affect

⁶⁹ See Fandos & Philipps, *supra*.

⁷⁰ Lisa Rein et al., *VA Chief Fights for His Political Future Amid Internal Strife and Allegations of Subterfuge*, Wash. Post (Feb. 15, 2018), https://www.washingtonpost.com/politics/va-chief-fights-for-his-political-future-amid-internal-strife-and-allegations-of-subterfuge/2018/02/15/e0c5ca2e-1278-11e8-9570-29c9830535e5_story.html.

⁷¹ Emily Wax-Thibodeaux et al., *White House Targets VA’s Deputy Secretary As ‘A Warning Shot’ to Agency’s Leader*, Wash. Post (Feb. 8, 2018), https://www.washingtonpost.com/amphtml/world/national-security/white-house-targets-vas-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html.

⁷² Woellert et al., *Trump’s VA Pick Blindsides Staff, Deepens Agency Disarray*, Politico (Mar. 29, 2018), <https://www.politico.com/story/2018/03/29/trumps-veterans-pick-agency-451219>; see also Fandos & Haberman, *supra* (“The officials ... came to consider Dr. Shulkin and his top deputy as obstacles.”).

how and whether veterans will receive necessary health care—as well as a rule that affects which veterans are eligible for Supplemental Service-Disabled Veterans’ Insurance.⁷³ Five additional rules are currently pending review at the Office of Information and Regulatory Affairs, including a rule pertaining to “Expanded Access to Non-VA Care Through the Veterans Choice Program.”⁷⁴ The Department has also issued guidance regarding staffing, pay administration, histopathology technicians, licensed professional mental health counselors, and Congressional relations.⁷⁵

76. Similarly, as of April 27, 2018, the Department had approved 390 contracts since Wilkie took office.⁷⁶ At the same time, the dubious legality of Wilkie’s appointment has called the Department’s authority to enter contracts into question, including a recent contract regarding the Department’s medical records system which was negotiated but not finalized by former Secretary Shulkin.⁷⁷

77. Because Wilkie is not authorized to enter into these contracts, the availability of the services and materials provided pursuant to them could be jeopardized at any time. Moreover, the Department could be subjected to conflicting and overlapping obligations, draining the Department’s resources and reducing its ability to provide care to Plaintiffs and other veterans.

⁷³ *Veterans Affairs Department*, Fed. Register, <https://www.federalregister.gov/agencies/veterans-affairs-department> (last visited Apr. 27, 2018)

⁷⁴ *List of Regulatory Actions Currently Under Review*, Office of Info. & Regulatory Affairs, <https://www.reginfo.gov/public/jsp/EO/eoDashboard.jsp> (last visited Apr. 27, 2018).

⁷⁵ *VA Publications*, Dep’t of Veterans Affairs, https://www.va.gov/vapubs/Search_action.cfm?formno=&tkey=&dType=0&SortBy=issue&sort=desc&oid=0 (last visited Apr. 27, 2018).

⁷⁶ *Opportunities*, Fed. Bus. Opportunities, <https://www.fbo.gov/index?> (advanced search with “Department of Veterans Affairs” as the agency and a contract award date between March 28 and April 27, 2018) (last visited Apr. 27, 2018).

⁷⁷ Leo Shane III, *Ambitious VA Medical Records Overhaul in Jeopardy After Department Shakeup*, Army Times (Apr. 19, 2018), <https://www.armytimes.com/veterans/2018/04/19/ambitious-va-medical-records-overhaul-in-jeopardy-after-department-shakeup/>.

This problem will only increase with time, as Wilkie takes or approves more and more actions that are subject to invalidation. As a result, Plaintiffs' and other veterans' health care is and will continue to be in imminent danger.

78. Wilkie has used his platform as acting Secretary to advocate on behalf of reforms that would push the VA toward privatization. On April 9, purporting to speak for "America's veterans," he issued a statement urging Congress to pass a bill expanding the VA Choice program, which "allow[s] Veterans to seek care in the private sector."⁷⁸

79. Senior staffers have also left the Department, or have been reassigned within the Department, since Wilkie took office. For example, Scott Blackburn, the acting Executive in Charge for the Office of Information and Technology, left the Department on April 17.⁷⁹

80. In a statement, VA Press Secretary Curt Cashour described the departed officials as "employees who were wedded to the status quo and not on board with this administration's policies or pace of change."⁸⁰ According to Cashour, the VA's leadership "is now firmly aligned with President Trump and his priorities," "speaking with one voice to Veterans, employees and outside stakeholders, such as Congress and veterans service organizations," and "working closely with the White House to implement the president's priorities for VA."⁸¹ Those priorities include "work[ing] with Congress to get community care reform legislation passed" that would increase

⁷⁸ *Statement by Acting VA Secretary Robert Wilkie – Congress Must Pass Choice Bill Now to Give Best Care Options to Our Veterans*, Dep't of Veterans Affairs (Apr. 9, 2018), <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4036>.

⁷⁹ Jessie Bur, *Veterans Affairs CIO Scott Blackburn Resigns*, Fed. Times (Apr. 18, 2018), <https://www.federaltimes.com/management/leadership/2018/04/17/veterans-affairs-cio-scott-blackburn-resigns/>.

⁸⁰ *Statement by VA Press Secretary Curt Cashour on VA's Near-Term Priorities Under Acting Secretary Robert Wilkie*, Dep't of Veterans Affairs (Apr. 25, 2018).

⁸¹ *Id.*

access to private health care providers, as well as “finaliz[ing] a decision on the department’s electronic health record (EHR) modernization.”⁸²

81. Until another nominee is selected by the President and confirmed by the Senate, which could take months, Wilkie will likely continue to serve as acting Secretary.

First Claim

Wilkie’s Appointment Violates the Federal Vacancies Reform Act, 5 U.S.C. § 3345 *et seq.*, and the Administrative Procedure Act, 5 U.S.C. § 706

82. Plaintiffs incorporate the foregoing paragraphs as if set forth fully herein.

83. Under the Federal Vacancies Reform Act of 1998, the President “may direct a person who serves in an office for which appointment is required to be made by the President, by and with the advice and consent of the Senate, to perform the functions and duties of the vacant office temporarily in an acting capacity.” 5 U.S.C. § 3345(a).

84. However, the President’s power under the Act is limited; he may do so only if the previous officeholder “dies, resigns, or is otherwise unable to perform the functions and duties of the office.” *Id.* The statute does not permit the President to fill the vacancy if the previous officeholder is removed from office or merely because the office is vacant, regardless of the reason for the vacancy.

85. Former Secretary Shulkin did not “die” or “resign.” Nor was he “unable to perform the functions and duties of the office.” He was ready and willing to continue serving as Secretary of Veterans Affairs. Instead, he was fired by the President.

86. Congress passed the FVRA to eliminate the “threat to the Senate’s advice and consent power” posed by permitting the President to appoint acting officials at will. *N.L.R.B. v.*

⁸² *Id.*

SW Gen., Inc., 137 S. Ct. 929, 936 (2017). The President’s appointment of Wilkie in violation of the terms of the FVRA circumvents Congress’s power over the appointment process entirely.

87. “Unless the President designates another officer of the Government” using his power under the FVRA, which President Trump did not lawfully exercise, “the Deputy Secretary shall be Acting Secretary of Veterans Affairs ... in the event of a vacancy in the office of Secretary.” 38 U.S.C. § 304. Thus, Deputy Secretary Bowman, not Wilkie, is the current acting Secretary of Veterans Affairs, with all of the duties and powers inherent in the office.

88. Because Wilkie is not the lawful acting Secretary, any action that he takes “shall have no force or effect,” and “may not be ratified” by a subsequent Secretary. 5 U.S.C. § 3348(d).

89. The President’s appointment of Wilkie to serve as acting Secretary, Wilkie’s continued representation that he is the acting Secretary of Veterans Affairs, the Department’s recognition that he currently serves in that office, and any actions taken by Wilkie pursuant to his purported authority as acting Secretary are therefore unlawful, violating the FVRA, 5 U.S.C. § 3345 *et seq.*, the Department’s order of succession statute, 38 U.S.C. § 304, and the Administrative Procedure Act, 5 U.S.C. § 706.

Second Claim

Wilkie’s Appointment Violates the Appointments Clause of the Constitution, art. II, § 2, cl. 2

90. Plaintiffs incorporate the foregoing paragraphs as if set forth fully herein.

91. The Appointments Clause mandates that the President “shall nominate, and by and with the Advice and Consent of the Senate, shall appoint Ambassadors, other public Ministers and Consules, Judges of the Supreme Court, and all other Officers of the United States.” U.S. Const. art. II, § 2, cl. 2.

92. Specifically, the Secretary of Veterans Affairs “is the head of the Department” of Veterans Affairs “and is appointed by the President, by and with the advice and consent of the Senate.” 38 U.S.C. § 303.

93. By directing Wilkie to serve as the acting Secretary of Veterans Affairs, the President appointed him to that office within the meaning of the Appointments Clause and Section 303 of Title 38 of the U.S. Code.

94. However, Wilkie was neither nominated by the President nor confirmed by the Senate to serve in that position. Nor did the President lawfully appoint him to that office in an acting capacity under the terms of the FVRA, in derogation of the process established by Congress to protect its authority under the Appointments Clause. Wilkie’s appointment as acting Secretary therefore violates the Appointments Clause.

95. Wilkie’s new duties as acting Secretary of Veterans Affairs—which involve overseeing a massive, complex bureaucracy that provides services to individual veterans—are not germane to his duties as an Under Secretary of Defense, in which he serves in an entirely different federal agency with a different statutory and regulatory mandate. *Cf. Weiss v. United States*, 510 U.S. 163, 172-76 (1994)

96. The President’s appointment of Wilkie to serve as acting Secretary, Wilkie’s continued representation that he is the acting Secretary, the Department’s recognition that he currently serves in that office, and any actions taken by Wilkie pursuant to his purported authority as acting Secretary violate the Appointments Clause and are therefore void.

Third Claim

Plaintiffs Are Entitled to a Declaratory Judgment Under 28 U.S.C. § 2201

97. Plaintiffs incorporate the foregoing paragraphs as if set forth fully herein.

98. Under Section 2201 of Title 28 of the United States Code, “[i]n a case of actual controversy within its jurisdiction, ... any court of the United States, upon the filing of an appropriate pleading, may declare the rights and other legal relations of any interested party seeking such declaration.”

99. There is an actual controversy between Plaintiffs and Defendants regarding Wilkie’s purported authority as acting Secretary of Veterans Affairs. His unlawful appointment calls into question the lawfulness of any actions he has taken or will take while purporting to serve as acting Secretary, and thereby creates profound uncertainty over the standards and procedures by which veterans, including Plaintiffs, will receive the benefits to which they are entitled under federal law.

100. Any cutbacks in or additional requirements for obtaining veterans’ benefits are presumed unlawful and subject to challenge if enacted under Wilkie’s leadership. In particular, any actions the Department might take under Wilkie’s authority to privatize veterans’ health care, including new rules and agency guidance, contracts with third party service providers, and changes to the procedures and manuals that govern veterans’ receipt of health care, would be unlawful.

101. However, many of these changes may well take place without formal rulemaking or other public process which allow Plaintiffs and other veterans to voice their concerns and challenge unlawful action—or even to learn that such action has taken place. Wilkie’s assertion of authority to act in these innumerable ways subjects Plaintiffs to an ongoing risk of imminent harm, as their health care and other benefits could be altered at any time and without other remedy.

102. Conversely, any benefits that Plaintiffs and other veterans might receive while Wilkie purports to serve as acting Secretary, especially any benefits received or anticipated as a consequence of Wilkie’s actions and policies, could be subject to challenge and recoupment by the

Department or third parties if Wilkie's tenure is later found to be unlawful. *See* 38 U.S.C. § 5316.⁸³ Instead of receiving, free and clear, the benefits statutorily owed to them by the Department, Plaintiffs' benefits are subject to a cloud of uncertainty that decreases their value and harms Plaintiffs.

103. A declaration as to the lawful leadership of the VA is essential to resolve the uncertainty and confusion that currently surrounds the relationship between veterans and the Department.

Prayer for Relief

WHEREFORE, Plaintiffs respectfully request that the Court:

1. declare that pursuant to 38 U.S.C. § 304, Deputy Secretary Bowman is the lawful acting Secretary of Veterans Affairs, and further declare that Wilkie's appointment to that position was unlawful and that any actions taken in reliance on Wilkie's purported authority are unlawful and void;
 2. enjoin Wilkie from continuing to represent that he is the acting Secretary of Veterans Affairs, the Department from recognizing that he currently serves in that office, and both Wilkie and the Department from taking any action in reliance on Wilkie's purported authority as acting Secretary of Veterans Affairs;
 3. award Plaintiffs their attorneys' fees, costs, and other disbursements in this action;
- and

⁸³ *Cf.* James Clark, *The VA Takes Back Millions in Benefits from Disabled Vets and Can't Explain Why*, Task & Purpose (May 11, 2017), <https://taskandpurpose.com/va-congress-separation-disability-pay-recoupment/> (discussing recoupment of separation pay before payment of disability benefits).

4. grant Plaintiffs such other relief as the Court deems just and proper.

Dated: April 30, 2018

Respectfully submitted,

/s/ John T. Lewis

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From: (b) (6) </o=va/ou=exchange
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Cc:
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Subject: VSO Reception Tomorrow
Date: Wed Sep 27 2017 14:35:22 CDT
Attachments: 2017 09-28 Forever GI Bill Celebration SECVA Cards_BF.DOCX
Reception Hosted by SECVA Guest List ao 092717 1030am.docx

Mr. Blackburn,

According to (b) (6) the Secretary is scheduled to give remarks at 6:30pm, but he noted the event would be informal.

I have attached the SecVA remarks as well as the guest list.

(b) (6)

(b) (6)

Office of the Assistant Secretary for
Information and Technology
Department of Veterans Affairs
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DRAFT 1
GI Forever Bill Celebration
September 28, 2017

OPENING

Welcome everyone.
{Acknowledge Post 9-11
Organizations; Big 6 VSOs;
Congressional Staff}

I am glad all of you could
join us today to celebrate
the success we have had
over the past 9 months.

Together we have passed,
and the President has
signed key pieces of
legislation:

1
VA-18-0457-A-000728

- **Accountability**
- **Extension of Choice**
- **Appeals Reform**
- **And of course the GI Forever Bill**

None of this would have been possible without the support of each organization, and the members of Congress represented here today.

I want to thank each one of you and your organizations for all you have done and continue to do for our nation's Veterans.

FOREVER GI BILL

The GI Bill is one of the most important pieces of legislation ever produced in this country.

There have been updates over the years – the Montgomery GI Bill in 1984 and the post-9/11 GI Bill in 2008.

And now, thanks to you, we have the Forever GI Bill.

VA-18-0457-A-000730³

This allows Veterans to access educational benefits throughout their lives, and restores benefits for Veterans hurt by school shutdowns.

It provides benefits to Purple Heart recipients whose injuries forced them to leave military service.

And for those killed in the line of duty - it allows their benefits to be transferred to an eligible dependent.

4
VA-18-0457-A-000731

This is expanding our ability to support Veterans in getting an education, and preparing them for rapidly evolving job market after active-duty service.

After leaving service, most Veterans and their families look for ways to continue to serve and contribute to the security and prosperity of our country.

The Forever GI Bill makes it easier for them to do so.

Sometimes, at VA, we are focused on the work right in front of us that we don't take the time to acknowledge the collective work of the groups here today.

This Bill shows what we can do when we work together.

THE ROAD AHEAD

Though we are clearly making progress, we still have a long way to go.

Just last week we held our annual senior leader business meeting here in DC – bringing together over 600 of our Senior Leaders across the organization.

During that meeting we hosted a panel so that our leaders could hear about the challenges we face directly from Veterans.

One thing that stood out to me was hearing from a Veteran, a Post 9-11 Veteran, about her experiences trying to schedule a medical appointment online.

7
VA-18-0457-A-000734

{EXPOUND}

Clearly, we have a long way to go to make it easier for Veterans to access the benefits available to them.

But together, we can make a difference and build a VA that Veterans deserve.

CLOSING

I know that if we continue working closely together, we will succeed in modernizing VA.

**Thank you all again for
your commitment and hard
work. And congratulations
for passing such an
important piece of
legislation.**

**I look forward to the work
ahead!**

9
VA-18-0457-A-000736

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (5), (b) (6)
Filename: Reception Hosted by SECVA Guest List ao 092717 1030am.docx
Last Modified: Wed Sep 27 14:35:22 CDT 2017

Reception Hosted by SECVA
Thursday, September 28, 2017 – 5:30-7:30pm
Secretary's Suite

Acceptances – 67

Category	Last Name	First Name	Honorific	Title
Host	Shulkin	David J.	T.H.	Secretary of Veterans Affairs
VA Leadership	Bowman	Thomas G.	T.H.	Deputy Secretary of Veterans Affairs
VA Leadership	Wright Simpson	Vivieca	Ms.	Chief of Staff of Veterans Affairs
VA Leadership	Alaigh	Poonam	Dr.	Acting Under Secretary for Health
VA Leadership	Murphy	Thomas J.	Mr.	Acting Under Secretary for Benefits
VA Leadership	Ulyot	John	T.H.	Assistant Secretary for Public and Intergovernmental Affairs
VA Leadership	Shelby	Peter J.	T.H.	Assistant Secretary for Human Resources and Administration
VA Leadership	Tucker	Brooks D.	T.H.	Assistant Secretary for Congressional and Legislative Affairs
VA Leadership	Byrne	James M.	T.H.	General Counsel
VA Leadership	Loren	Donald P.	T.H.	Assistant Secretary for Operations, Security, and Preparedness
VA Leadership	Murray	Edward	Mr.	Acting Assistant Secretary for Management and Interim Chief Financial Officer
VA Leadership	Tran	Dat P.	Mr.	Acting Assistant Secretary for Enterprise Integration
VA Leadership	Davis	Lynda C.	Dr.	Chief Veterans Experience Officer
VA Leadership	Leinenkugel	Thomas (Jake) J.	Mr.	Senior White House Advisor
VA Leadership	Selnick	Darin	Mr.	Senior Advisor to the Secretary
VA Leadership	O'Rourke	Peter	Mr.	Executive Director, Office of Accountability Whistleblower Protection
VA	(b) (6)		Mr.	Deputy Assistant Secretary, Office of Congressional and Legislative Affairs
VA			Mr.	Office of the Secretary
VA			Ms.	Office of the Secretary
VA			Mr.	VSO Liaison, Office of the Secretary
VA			Mr.	VSO Liaison, Veterans Health Administration
VA			Mr.	Office of the Secretary, Staff Assistant
VA			Mr.	Director, Education Service, Veterans Benefits Administration
Congress-Staff	(b) (6)		Mr.	Staff Director, SVAC Majority
Congress-Staff			Mr.	Staff Director, HVAC Minority
Congress-Staff			Mr.	Staff Director, SAC Majority
Congress-Staff			Mr.	Deputy Staff Director, SVAC Majority
Post 9/11 Veteran Employee			Mr.	Guest of Mr. Brooks Tucker
Post 9/11 Veteran Employee			Mr.	Guest of Mr. Peter Shelby
Post 9/11 Veteran Employee			Mr.	Guest of Mr. Thomas Murphy
Post 9/11 Veteran Employee			Mr.	Guest of Dr. Poonam Alaigh
Post 9/11 Veteran Employee			Mr.	Guest of Mr. Edward Murray
Post 9/11 Veteran Employee			Mr.	Guest of Mr. Peter O'Rourke
Post 9/11 Veteran Employee			Mr.	Guest of Mr. Dat Tran
Post 9/11 Veteran Employee			Mr.	Guest of Mr. Donald Loren
VSO			Ms.	Legislative Director, Got Your Six (GY6)

VSO	(b) (6)	Mr.	Executive Director, Disabled American Veterans
VSO		Ms.	Senior Vice President of Government, Wounded Warrior Project
VSO		Mr.	Director of Legislative and Military Policy, Enlisted Association of the National Guard of the United States (EANGUS)
VSO		Mr.	Executive Director, Global War on Terror Memorial Foundation
VSO		Mr.	Founder & Executive Director, Veterans in Global Leadership
VSO		Ms.	Government and Community Relations Director, Wounded Warrior Project
VSO		Mr.	Policy Director, Concerned Veterans for America (CVA)
VSO		Mr.	Executive Director, AMVETS
VSO		Ms.	Deputy Finance Manager, Team Rubicon
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VSO		Mr.	Executive Vice President, Student Veterans of America (SVA)
VSO		Mr.	Communications Director, Got Your Six (GY6)
VSO		Ms.	Travis Manion Foundation
VSO		Mr.	Executive Director for Policy & Government Affairs, Vietnam Veterans of America (VVA)

Pending – 12

Category	Last Name	First Name	Honorific	Title
Congress-House	(b) (6)		T.H.	Chairman, Committee on Veterans' Affairs
Congress-Senate			T.H.	Senator, Sponsor of Choice Funding
Congress-Senate			T.H.	Chairman, Subcommittee on Military Construction, Veterans Affairs and Related Agencies, Committee on Appropriations
Congress-Senate			T.H.	Ranking Member, Committee on Veterans' Affairs
Congress-Staff			Mr.	Senator Dean Heller Chief of Staff
Congress-Staff			Ms.	Clerk, SAC Minority
Congress-Staff			Mr.	Representative Dina Titus Chief of Staff
Congress-Staff			Ms.	Staff Director, HAC Majority
Congress-Staff			Mr.	Staff Director, HVAC Majority
Congress-Staff			Mr.	Staff Assistant, HAC Minority
VSO			Ms.	Executive Director, Tragedy Assistance Program for Survivors (TAPS)
VSO			Mr.	Legislative Director, Veterans of Foreign Wars (VFW)

Regrets – 27

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VA Leadership	Missal	Michael J.	T.H.	Inspector General
VA Leadership	Thomas II	Rob C.	Mr.	Acting Assistant Secretary for Information and Technology and Acting Chief Information Officer
VA Leadership	Spickler	David	Mr.	Acting Chairman, Board of Veterans' Appeals
VA Leadership	Fiotes	Stella S.	Ms.	Principal Executive Director for Acquisition, Logistics, and Construction
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Congress-Senate			T.H.	Senator, Sponsor of Appeals Modernization
Congress-House			T.H.	Chairman, Subcommittee on Military Construction, Veterans Affairs and Related Agencies
Congress-House			T.H.	Ranking Member, Committee on Veterans Affairs
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Congress-Staff			Mr.	Staff Director, SVAC Minority
VSO			Mr.	President & CEO, MOAA
VSO			Mr.	Vice President of Communications, Student Veterans of America (SVA)
VSO			Mr.	Legal Director, Wounded Warrior Project
VSO			Ms.	Government and Community Relations Specialist, Wounded Warrior Project
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VSO	(b) (6)		Mr.	Executive Director, Veterans of Foreign Wars (VFW)
VSO			Mr.	Enlisted Association of the National Guard of the United States (EANGUS)

From: Blackburn, Scott R. </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED]>
To: [REDACTED] </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED]>
Cc:
Bcc:
Subject: FW: VSO Reception Tomorrow
Date: Wed Sep 27 2017 14:44:44 CDT
Attachments: 2017 09-28 Forever GI Bill Celebration SECVA Cards_BF.DOCX
Reception Hosted by SECVA Guest List ao 092717 1030am.docx

The remarks don't mention [REDACTED]

From: [REDACTED]
Sent: Wednesday, September 27, 2017 3:35 PM
To: Blackburn, Scott R.
Subject: VSO Reception Tomorrow

Mr. Blackburn,

According to [REDACTED] the Secretary is scheduled to give [REDACTED] at 6:30pm, but he noted the event would be informal.

I have attached the SecVA [REDACTED] as well as the guest list.

[REDACTED]

[REDACTED]

Office of the Assistant Secretary for
Information and Technology
Department of Veterans Affairs
810 Vermont Ave NW

Washington, DC 20420

Desk: 202-461-(b) (6)

Mobile: 202-631-(b) (6)

OI&T Front Office Main Line: 202-461-6910

Owner: Blackburn, Scott R. </o=va/ou=exchange administrative group (fydibohf23spdl)
/cn=recipients/cn=[REDACTED]
Filename: 2017 09-28 Forever GI Bill Celebration SECVA Cards_BF.DOCX
Last Modified: Wed Sep 27 14:44:44 CDT 2017

DRAFT 1
GI Forever Bill Celebration
September 28, 2017

OPENING

Welcome everyone.
{Acknowledge Post 9-11
Organizations; Big 6 VSOs;
Congressional Staff}

I am glad all of you could
join us today to celebrate
the success we have had
over the past 9 months.

Together we have passed,
and the President has
signed key pieces of
legislation:

1
VA-18-0457-A-000745

- **Accountability**
- **Extension of Choice**
- **Appeals Reform**
- **And of course the GI Forever Bill**

None of this would have been possible without the support of each organization, and the members of Congress represented here today.

I want to thank each one of you and your organizations for all you have done and continue to do for our nation's Veterans.

VA-18-0457-A-000740²

FOREVER GI BILL

The GI Bill is one of the most important pieces of legislation ever produced in this country.

There have been updates over the years – the Montgomery GI Bill in 1984 and the post-9/11 GI Bill in 2008.

And now, thanks to you, we have the Forever GI Bill.

VA-18-0457-A-000747³

This allows Veterans to access educational benefits throughout their lives, and restores benefits for Veterans hurt by school shutdowns.

It provides benefits to Purple Heart recipients whose injuries forced them to leave military service.

And for those killed in the line of duty - it allows their benefits to be transferred to an eligible dependent.

VA-18-0457-A-000748⁴

This is expanding our ability to support Veterans in getting an education, and preparing them for rapidly evolving job market after active-duty service.

After leaving service, most Veterans and their families look for ways to continue to serve and contribute to the security and prosperity of our country.

The Forever GI Bill makes it easier for them to do so.

Sometimes, at VA, we are focused on the work right in front of us that we don't take the time to acknowledge the collective work of the groups here today.

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THE ROAD AHEAD

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7
VA-18-0457-A-000751

{EXPOUND}

Clearly, we have a long way to go to make it easier for Veterans to access the benefits available to them.

But together, we can make a difference and build a VA that Veterans deserve.

CLOSING

I know that if we continue working closely together, we will succeed in modernizing VA.

**Thank you all again for
your commitment and hard
work. And congratulations
for passing such an
important piece of
legislation.**

**I look forward to the work
ahead!**

VA-18-0457-A-000753⁹

Owner: Blackburn, Scott R. </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=[REDACTED]
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VA Leadership	Murphy	Thomas J.	Mr.	Acting Under Secretary for Benefits
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VA Leadership	Tucker	Brooks D.	T.H.	Assistant Secretary for Congressional and Legislative Affairs
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VA Leadership	Loren	Donald P.	T.H.	Assistant Secretary for Operations, Security, and Preparedness
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VA Leadership	Tran	Dat P.	Mr.	Acting Assistant Secretary for Enterprise Integration
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To: (b) (6), (b) (7)(C) EOP/WHO
(b) (6), (b) (7)(C) @who.eop.gov>
Cc:
Bcc:
Subject: Wrap of of Jackson Clips - 29MAR - 12APR
Date: Thu Apr 12 2018 13:57:13 CDT
Attachments: Jackson Clips - ongoing list - FINAL[1].docx

See attached.

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6), (b) (6), (b) (6)
Filename: Jackson Clips - ongoing list - FINAL[1].docx
Last Modified: Thu Apr 12 13:57:13 CDT 2018



Jackson News Clips

March 29 – April 12, 2018

1 - Washington Post (AP): [Trump's VA pick draws concern over thin management record](#)

(29 March, Hope Yen and Calvin Woodward, 43.9M uvm; Washington, DC)

President Donald Trump's selection of his White House doctor to run the massive Department of Veterans Affairs triggered concern Thursday among lawmakers and veterans groups about whether he has the experience to manage an agency paralyzed over Trump's push to expand private care. Ronny Jackson, a Navy rear admiral entrusted with the health of the past three presidents, is a lifelong physician whose positions on privatizing operations in the second largest federal department...

[Hyperlink to Above](#)

2 - Washington Post: [Trump's pick to head veterans department faces skepticism over his experience](#)

(29 March, Lisa Rein, Seung Min Kim, Emily Wax-Thibodeaux, and Josh Dawsey, 43.9M uvm; Washington, DC)

The White House was thrown on the defensive Thursday over President Trump's choice to lead the Department of Veterans -Affairs, forcing officials to fend off mounting skepticism that Ronny L. Jackson has the experience to run the government's second-largest agency. Trump announced by tweet late Wednesday that the White House physician would succeed ousted secretary David Shulkin, surprising veterans groups and lawmakers...

[Hyperlink to Above](#)

3 - Wall Street Journal: [Lawmakers Respond Cautiously to Little-Known VA Pick Ronny Jackson - Key senators on panel say they don't know enough about White House doctor to form an opinion about his ability to lead a vast bureaucracy](#)

(29 March, Louise Radnofsky and Peter Nicholas, 43.6M uvm; New York, NY)

Capitol Hill lawmakers reacted guardedly to President Donald Trump's nomination of the White House physician to head the Department of Veterans Affairs, with key members noting that they know little about him. Dr. Ronny Jackson, a U.S. Navy rear admiral who has served as a White House physician during the past three administrations, is slated to succeed Secretary David Shulkin, who was ousted Wednesday.

[Hyperlink to Above](#)

4 - USA Today (Video): [6 big things the new Veterans Affairs chief will have to address](#)

(29 March, Donovan Slack and Dennis Wagner, 36.8M uvm; McLean, VA)

On the front lines at the Department of Veterans Affairs — in the agency's 1,240 hospitals and clinics — it doesn't much matter these days who holds the secretary's job in Washington. David Shulkin, who was fired Wednesday, was the third VA secretary in four years. If President Trump's nominee to lead the agency, physician and Navy Rear Adm. Ronny Jackson, is confirmed, he will be the fourth.

[Hyperlink to Above](#)

5 - Politico: [Trump's VA pick blindsides staff, deepens agency disarray - 'He's got a department that's in turmoil,' a former VA secretary said. 'It's in crisis.'](#) (29 March, Lorraine Woellert, Eliana Johnson and Connor O'Brien, 23.9M uvm; Arlington, VA)

The timing of President Donald Trump's announcement to name Rear Admiral Ronny Jackson to lead Veterans Affairs was a snap decision that surprised his own chief of staff and knocked the government's second-largest agency, already bedeviled by scandal, deeper into disarray. White House chief of staff John Kelly had spoken with David Shulkin by phone Wednesday morning, reassuring the now-former VA secretary that he wouldn't be fired by tweet that afternoon.

[Hyperlink to Above](#)

6 - Task & Purpose: [What's In Store For The Next VA Chief? Let's Break It Down](#) (29 March, James Clark, 102k uvm; New York, NY)

It's been an awkwardly long time coming, but as of yesterday afternoon embattled Veterans Affairs secretary David Shulkin is out of a job. The news comes after a month and a half of uncertainty that began when a scathing inspector general report detailed "serious derelictions" in expensing a Europe trip last summer. And then there were all the accusations and counter accusations of political infighting and rumors of possible replacements — at least all that is over:

[Hyperlink to Above](#)

7 - Washington Post: [Opinions - Surprise: Trump's newest Cabinet nominee has no relevant experience](#) (29 March, Eugene Robinson, 43.9M uvm; Washington, DC)

You can't make this stuff up: President Trump has announced he will nominate a medical doctor who has no discernible management experience to run the second-largest agency in the federal government. Can presidents be sued for malpractice? The man Trump has named to become secretary of veterans affairs, Ronny L. Jackson, happens to be the president's personal doctor.

[Hyperlink to Above](#)

8 - Washington Post (The Fix): [Who is Trump's new Veterans Affairs pick, Ronny Jackson?](#) (29 March, Aaron Blake, 43.9M uvm; Washington, DC)

The seemingly never-ending parade of staff changes in the Trump administration continued apace Wednesday, with the president announcing that Veterans Affairs Secretary David Shulkin is out and that White House physician Ronny L. Jackson will replace him. Jackson's name will be familiar to political watchers across the country for one main reason: He's the physician who delivered what some felt to be a suspiciously rosy picture of Trump's health in January.

[Hyperlink to Above](#)

9 - FOX News: [Ronny Jackson picked by Trump to lead the VA: What to know about the president's physician](#) (29 March, Kaitlyn Schallhorn, 32.5M uvm; New York, NY)

President Trump gave Dr. Ronny Jackson a clean bill of health in March — to run the Department of Veterans Affairs. A Navy rear admiral, Jackson is the president's personal physician who rose to prominence after he addressed the press from the White House briefing room in January to discuss Trump's health.

[Hyperlink to Above](#)

10 - FOX News (Video): [John Brennan: Trump's nomination for VA secretary is 'terribly misguided'](#) (29 March, Nicole Darrah, 32.5M uvm; New York, NY)

Former CIA Director John Brennan once again took a shot at President Trump on Twitter Thursday, saying he believes the decision to nominate Adm. Ronny Jackson to run the Department of Veterans Affairs is "terribly misguided." "I personally know and greatly respect Ronny Jackson....as a terrific doctor and Navy officer," Brennan tweeted. "However, he has neither the experience nor the credentials to run the very large and complex VA.

[Hyperlink to Above](#)

11 - New York Times: [Op-ed - Ronny Jackson's Disturbing Lack of Independence](#) (29 March, Norman L. Eisen and Bandy X. Lee, 30M uvm; New York, NY)

In announcing Dr. Ronny Jackson, the White House physician, as his choice to be the new secretary for veterans affairs, President Trump has taken his latest misstep in what has been the worst presidential personnel process in modern history. We take no pleasure in saying so, including because one of us (Mr. Eisen) worked with Dr. Jackson in the White House, was even treated by him...

[Hyperlink to Above](#)

12 - ABC News (Video): [Veterans groups respond cautiously to VA secretary nomination](#) (29 March, Sarah Kolinovsky, 24.2M uvm; New York, NY)

Despite his active duty status as a Navy rear admiral (lower half) and his medical experience, veterans service organizations are responding cautiously to the nomination of Dr. Ronny Jackson for secretary of Veterans Affairs, with some expressing concern about his lack of managerial experience or what his views are on reforming the VA.

[Hyperlink to Above](#)

13 - The Atlantic: [The Doctor Who Suddenly Got Nine Million Patients - For a position that demands high-level policy expertise, President Trump appointed his personal physician, Ronny Jackson.](#) (29 March, James Hamblin, 23.9M uvm; Washington, DC)

Nine million veterans will soon be under the care of the emergency-physician rear admiral Ronny Jackson, pending confirmation of his appointment Wednesday to lead the U.S. Department of Veterans Affairs. This seemingly mundane appointment—a doctor and naval officer with years of experience as White House physician under both Trump and Obama...

[Hyperlink to Above](#)

14 - The Hill: [White House: Trump has 'full confidence' in presidential physician to lead VA](#) (29 March, Max Greenwood, 11.9M uvm; Washington, DC)

President Trump has "full confidence" in White House physician Ronny Jackson's ability to head the Veterans Affairs (VA) Department, a spokeswoman for the White House said Thursday, despite reported concerns from some aides. "As I said earlier, the president has full confidence in Adm. Jackson," White House deputy press secretary Lindsay Walters told reporters.

[Hyperlink to Above](#)

15 - The Hill: [GOP, vet groups react with caution to Trump VA pick](#) (29 March, Rebecca Kheel, 11.9M uvm; Washington, DC)

Senators and influential veterans groups are withholding judgment on President Trump's pick to lead the Department of Veterans Affairs (VA), a Navy doctor with no experience leading a federal bureaucracy. Both the Republican chairman and the Democratic ranking member of the Senate Veterans Affairs Committee said only that they look forward to meeting Rear Adm. Ronny Jackson. Several veterans groups expressed some concern about Jackson's qualifications...

[Hyperlink to Above](#)

16 - Military.com: [Others Considered for VA Job Before Trump Picked His Personal Doctor](#) (29 March, Richard Sisk, 9M uvm; San Francisco, CA)

Rear Adm. Ronny L. Jackson, the personal physician to President Donald Trump, was not his first choice to replace fired VA Secretary Dr. David Shulkin, the White House said Thursday. "The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary," White House deputy press secretary Lindsay Walters told reporters.

[Hyperlink to Above](#)

17 - Government Executive: [Lawmakers, Veterans Groups and Former Officials Worry VA Nominee Is Not 'Up to the Job'](#) (29 March, Eric Katz, 870k uvm; Washington, DC)

With David Shulkin now ousted from the Veterans Affairs Department, all eyes are on President Trump's nominated replacement to see where he comes down on the most pressing issue at VA: How large a role should the private sector play in providing health care to veterans? One problem for observers and stakeholders in the veteran community is Trump's pick, Dr. Ronny Jackson, has very little experience in public policy or veterans issues...

[Hyperlink to Above](#)

18 - PBS: [Who is Ronny Jackson, Trump's pick to lead the Department of Veterans Affairs?](#) (30 March, Gretchen Frazee, 22M uvm; Arlington, VA)

Rear Admiral Ronny Jackson has garnered almost universal praise for his skills as a military physician and his character. But his appointment to lead the Department of Veterans Affairs is proving divisive as critics point to his lack of experience managing a large organization.

[Hyperlink to Above](#)

19 - NPR (Morning Edition, Audio): [Trump Pick For VA Secretary May Get Additional Scrutiny](#) (30 March, 22M uvm; Washington, DC)

Noel King talks to Democratic Sen. Richard Blumenthal about President Trump's decision to fire VA Secretary David Shulkin, and the confirmation process of the president's pick to replace him.

[Hyperlink to Above](#)

20 - MSNBC (Video): [Reines: 'There's never been a no vote against a VA nominee, this might be the time to change that record'](#) (30 March, 11.8M uvm; New York, NY)

In yet another White House personnel shakeup, President Trump ousts Secretary of Veterans Affairs David Shulkin and appoints his personal doctor Ronny Jackson. Philippe Reines, former adviser to then-Secretary of State Hillary Clinton, and Shermichael Singleton, former Deputy Chief of Staff for the Department of Housing and Urban Development, discuss with Kristen Welker whether the president's new appointee is qualified for the position.

[Hyperlink to Above](#)

21 - The Hill: [Trump VA pick hesitated to take job: report](#) (30 March, Max Greenwood, 11.8M uvm; Washington, DC)

White House physician Ronny Jackson initially hesitated at the suggestion that he be nominated to lead the Department of Veterans Affairs, The Washington Post reported Thursday. Jackson was reportedly shocked when Trump tapped him for the top job at the nation's second largest government agency, the Post reported, citing senior White House officials.

[Hyperlink to Above](#)

22 - New York Daily News: [A novice in the VA OR: Dr. Ronny Jackson is a very puzzling choice to lead a Veterans Affairs turnaround](#) (31 March, 26.1M uvm; New York, NY)

The 20 million-plus veterans of the U.S. Armed Forces served this country with the eminently deserved expectation that their country would serve them. Now even as the heart of that trust, the VA health care system, recovers from deadly delays in getting patients care, and after summarily dispatching his first head of the U.S. Department of Veterans Affairs, David Shulkin, President Trump inflicts risky experimental treatment, nominating as the new chief a doctor who has never come close to the operating room of managing a large organization — never mind one with nearly 378,800 employees.

[Hyperlink to Above](#)

23 - NPR (All Things Considered, Audio): [Veteran Congressman On Trump's New VA Secretary Nominee](#) (31 March, 22M uvm; Washington, DC)

President Trump has picked Rear Adm. Ronny Jackson to be secretary of Veterans Affairs. Veteran and Rep. Mike Coffman (R-Colo.) tells NPR's Michel Martin why he supports the new leadership.

[Hyperlink to Above](#)

24 - The Washington Post (Video): [Does Trump believe in the value of expertise, or does he disdain it?](#) (31 March, Dan Balz, 43.9M uvm; Washington, DC)

The shake-up at the Department of Veterans Affairs — out with Secretary David Shulkin and potentially in with White House physician Ronny L. Jackson — is being portrayed, correctly, as President Trump surrounding himself with Cabinet officials with whom he feels personally comfortable. A broader question arises, however, over the extent to which this president prizes or disparages expertise.

[Hyperlink to Above](#)

25 - Politico Magazine: [When Our President Put His Doctor in Charge of Everything](#) (31 March, Marius Stan and Vladimir Tismaneanu, 23.9M uvm; Arlington, VA)

No one knows more about leaders' bodies than their personal physicians. Notoriously, Joseph Stalin mistrusted the Kremlin doctors, whom he suspected of trying to poison him and the other Soviet magnates. In February 1953, a month before Stalin passed away, they were arrested and horribly tortured. The ones still left alive were too terrified to treat him as he lay dying in March.

[Hyperlink to Above](#)

26 - CBS News (Face the Nation, Video): [Sen. Bernie Sanders on "Face the Nation," April 1, 2018](#) (1 April, 26M uvm; New York, NY)

President Trump announced the ouster of David Shulkin as secretary of Veterans Affairs this week, nominating longtime White House physician Adm. Ronny Jackson as his replacement. Shulkin had come under withering criticism from lawmakers on Capitol Hill over his travel expenses and a blistering inspector general's report on conditions at the VA.

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27 - CBS News (Video): [Sen. Bernie Sanders says privatizing the VA a "very, very bad idea"](#) (1 April, Emily Tillett, 26M uvm; New York, NY)

Sen. Bernie Sanders, I-Vermont, says that he thinks it's too early to tell what President Trump's pick to take over leadership at the embattled Department of Veterans Affairs "stands for," but cautioned that privatizing the VA to be a "very, very bad idea." Former VA Secretary Shulkin became the latest member of Mr. Trump's cabinet to be terminated last week. The president announced that he was replacing Shulkin in a series of tweets, and said he would nominate Adm. Ronny Jackson, who had been serving as the president's doctor, to replace him.

[Hyperlink to Above](#)

28 - Politico: [Sanders: 'We know nothing' about Trump's VA pick](#) (1 April, Connor O'Brien, 23.9M uvm; Arlington, VA)

Sen. Bernie Sanders wouldn't commit to supporting President Donald Trump's pick to lead the Department of Veterans Affairs, Rear Adm. Ronny Jackson, on Sunday. In an interview on CBS' "Face the Nation," the Vermont independent noted that Jackson, Trump's personal physician, is a virtual unknown on veterans issues. He also expressed concerns the Trump administration is pushing to privatize the nearly \$200 billion bureaucracy...

[Hyperlink to Above](#)

29 - The Hill: [Sanders: I will work against any VA nominee backing privatization](#) (1 April, Mallory Shelbourne, 11.9M uvm; Washington, DC)

Sen. Bernie Sanders (I-Vt.) said Sunday he will work against any Veterans Affairs (VA) nominee who supports privatizing the agency. "I will do everything I can as a member of the veterans committee not to approve any nominee who is not going to strengthen the VA and who will oppose privatization," Sanders told CNN's "State of the Union."

[Hyperlink to Above](#)

30 - Miami Herald: [Trump's doc shouldn't be a slam dunk to lead Veterans Affairs](#) (1 April, Editorial Board, 8.9M uvm; Miami, FL)

The U.S. Department of Veterans Affairs has enough problems. It doesn't need one in the form of a leader who, very possibly, has no idea what he's doing. In yet another nomination made under President Trump's "You'll do — for now" philosophy of hiring the "very best people," White House physician Ronny Jackson is up for the vital job of secretary of Veterans Affairs.

[Hyperlink to Above](#)

31 - Washington Examiner: [Bernie Sanders: Ronny Jackson will bend to pressure to privatize the VA](#) (1 April, Kyle Feldscher, 4.8M uvm; Washington, DC)

Sen. Bernie Sanders, I-Vt., said he thinks Dr. Ronny Jackson will likely be tasked with privatizing the U.S. Department of Veterans Affairs due to his lack of experience manning a large organization. Sanders said on CNN's "State of the Union" Jackson, the White House physician and a rear admiral in the U.S. Navy, doesn't know much about heading a large bureaucracy.

[Hyperlink to Above](#)

32 - Newsday: [Senate should be wary of Dept. of Veterans Affairs nominee](#) (1 April, Editorial Board, 3.2M uvm; Melville, NY)

Caring for our nation's military veterans was one of Donald Trump's most consistent promises on the presidential campaign trail, and certainly one of his least controversial. Getting veterans the care they need is a nonpartisan priority. But the increased quality of care Trump promised hasn't come. Facilities on Long Island and in many other communities are falling apart. The Department of Veterans Affairs is increasingly being exposed as dangerous and dysfunctional.

[Hyperlink to Above](#)

33 - Las Vegas Sun: [Heller's dilemma: Side with Trump or veterans on VA pick](#) (1 April, Editorial Board, 1.5M uvm; Las Vegas, NV)

Assuming Donald Trump follows through in nominating Dr. Ronny Jackson to lead the Department of Veterans Affairs, Sen. Dean Heller will soon face an ugly consequence for becoming a team player for the president. For Heller, Jackson's confirmation offers a lose-lose proposition. Either he votes against Jackson and runs the risk of getting dinged by Trump before the midterm elections, or he votes for Jackson and alienates veterans groups that have raised concerns about the White House doctor's qualifications for the position.

[Hyperlink to Above](#)

34 - Times Union: [Editorial: VA pick insults veterans](#) (1 April, Editorial Board, 1.5M uvm; Albany, NY)

The health and welfare of millions of veterans rest on what feels more like a casting call. Donald Trump has long promoted himself as a champion of military veterans, but when he finally had a chance last week as president to demonstrate that they were more than political props for him, he failed miserably. In the same cavalier way in which he has appointed so many people who have turned out to be disasters in their jobs...

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35 - Montana Standard: [For pity's sake, don't privatize Veterans Affairs](#) (1 April, Editorial Board, 202k uvm; Butte, MT)

Just when it was starting to look like Montana's veterans could expect a little more stability from the federal agency charged with providing their health care, another major shakeup at the Department of Veterans Affairs has placed the future of their care in doubt. Of course, the VA has long stood on shaky ground. However, the current push toward privatization, if successful, could completely erode the foundations of this critical agency and leave millions of veterans...

[Hyperlink to Above](#)

36 - Washington Examiner: [Ron Johnson: Trump 'deserves' a VA secretary who agrees with him on policy](#) (1 April, Naomi Lim, 4.8M uvm; Washington, DC)

Sen. Ron Johnson, R-Wi., agreed Sunday President Trump was right to fire former Veterans Affairs Secretary David Shulkin. "Well, I think the IG report's pretty troubling," Johnson told NBC, referring to VA inspector general Michael Missal's finding that Shulkin improperly used taxpayer dollars for a trip to Europe with his wife in July.

[Hyperlink to Above](#)

37 - U.S. News & World Report (AP): [Shulkin Says He Has 'Comfort' With Potential Successor at VA](#) (2 April, Hope Yen, 24M uvm; Washington, DC)

Former Veterans Affairs Secretary David Shulkin downplayed concerns about his potential successor's lack of managerial experience Monday, saying the key for improving the VA will be surrounding White House doctor Ronny Jackson with a good team "because no one person can do this alone." Shulkin and the White House have engaged in a highly public campaign surrounding his departure from the VA last week. Shulkin said he was fired.

[Hyperlink to Above](#)

38 - Military Times: [White House doctor could face the most contentious VA confirmation process ever](#) (2 April, Leo Shane III, 2.1M uvm; Springfield, VA)

Ronny Jackson's nomination to become the next Veterans Affairs secretary could become the most contentious confirmation process since the department was founded 30 years ago. But that's also a fairly low bar. Since the department was elevated to a Cabinet-level post back in 1988, no senator has ever voted against a VA secretary pick.

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39 - The Vindicator: [Trump's choice to lead VA raises questions on intent](#) (3 April, Editorial Board, 193k uvm; Youngstown, OH)

The physician who gave President Donald J. Trump a squeaky clean bill of health could soon lead the Department of Veterans Affairs, even though he lacks the experience to manage an enormous agency that has long been steeped in controversy. Trump's nomination of Rear Admiral Ronny Jackson, the White House physician since President George W. Bush's administration, has raised eyebrows on Capitol Hill and triggered concerns among veterans service organizations.

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40 - Washington Post: [Perspective - I've seen what a mess Veterans Affairs is. Ronny L. Jackson can't fix it. Trump's new pick to lead the cabinet is a fine doctor. That doesn't mean he can handle a massive, dysfunctional bureaucracy.](#) (2 April, Mikki Kendal, 43.9M uvm; Washington, DC)

The mission of the Department of Veterans Affairs was laid down in the wake of the Civil War, in a promise by President Abraham Lincoln to care for the men who fought, as well as their widows and orphans. The scope of that promise has broadened as women have enlisted. It is the only department that focuses exclusively on caring for veterans and their families in times of crisis spawned by injury, illness and death, a mission most Americans would agree is vital, if not sacred.

[Hyperlink to Above](#)

41 - Fierce Healthcare: [5 things to know about Ronny Jackson, Trump's pick to replace Shulkin at the VA](#) (2 April, Paige Minemyer, 141k uvm; Washington, DC)

President Donald Trump fired David Shulkin as Department of Veterans Affairs secretary last week and tapped White House physician Ronny Jackson as Shulkin's replacement. Trump praised Jackson as "highly respected" in his Twitter announcement, and White House Press Secretary Sarah Huckabee Sanders echoed the sentiment in a tweet of her own, saying that he and other cabinet nominees should be confirmed "without delay."

[Hyperlink to Above](#)

42 - Aiken Standard: [Column: Surprise: Trump's newest cabinet nominee has no relevant experience](#) (2 April, Eugene Robinson, 68k uvm; Aiken, SC)

You can't make this stuff up: President Trump has announced he will nominate a medical doctor who has no discernible management experience to run the second-largest agency in the federal government. Can presidents be sued for malpractice? The man Trump has named to become secretary of veterans affairs, Dr. Ronny Jackson, happens to be the president's personal physician.

[Hyperlink to Above](#)

43 - Truthout: [Trump's New VA Pick Appears Poised to Rubber-Stamp Privatization of Veterans Affairs](#) (3 April, Michael Corcoran, 422k uvm; Chicago, IL)

For the last year, Veterans Affairs Secretary David Shulkin insisted the VA would not be privatized on his watch. Now, thanks to a Koch-supported coup at the top of the second-largest department in government, his watch has ended -- and the battle over privatization persists. For years the Koch brothers have been hovering around the Department of Veterans Affairs and its \$186 billion budget like vultures surrounding a carcass.

[Hyperlink to Above](#)

44 - We Are The Mighty: [No one was ready for President Trump's next VA secretary](#) (3 April, Ben Brimelow, 3.6M uvm; New York, NY)

Questions have emerged about the managerial ability of White House physician Admiral Ronny L. Jackson, President Donald's Trump pick to run the Department of Veterans Affairs, the federal government's second-largest agency. If confirmed, Jackson would replace David Shulkin as the secretary of veterans affairs. Trump announced his decision to fire Shulkin on March 28, 2018.

[Hyperlink to Above](#)

45 - MedPage Today: [Jackson's Nomination to Run VA Brings Questions, Lack of management experience cited as major issue](#) (3 April, Joyce Frieden, 1.5M uvm; New York, NY)

Reaction to President Trump's nomination of White House physician Ronny Jackson, MD, as Secretary of Veterans Affairs (VA) has leaned toward the negative, with most people questioning whether Jackson has the experience needed to run the vast department. "I am deeply concerned about the nominee," Joe Chenelly, executive director of AMVETS, a veterans service organization, said in a press release.

[Hyperlink to Above](#)

46 - KWTX (CBS-10): [Waco: Chris Kyle's family hopes new secretary will change VA culture](#) (3 April, John Carroll, 315k uvm; Waco, TX)

The brother and father of slain American Sniper Chris Kyle say they hope that Texas born and reared Navy Rear Adm. Ronny L. Jackson, whom the president has nominated as the next secretary of veterans affairs will change the culture in the VA to get veterans help more quickly. "Our veterans are not being taken care of here in America, no way, absolutely not," Kyle's father, Wayne said.

[Hyperlink to Above](#)

47 - Creators Syndicate: [Marching Orders for Trump's New VA Secretary](#) (4 April, Betsy McCaughey, 318k uvm; Hermosa Beach, CA)

Since President Trump ousted Veterans Affairs Secretary David Shulkin, the question reverberating in Washington is whether Trump's new pick, Rear Adm. Ronny Jackson, is capable of heading a department with 360,000 employees and 9 million vets under its care. Senate Democrats carp he lacks experience running "a complex organization."

[Hyperlink to Above](#)

48 - Hawaii Tribune-Herald: [Senate should be wary of Veterans Affairs nominee](#) (4 April, 135k uvm; Hilo, HI)

Caring for our nation's military veterans was one of Donald Trump's most consistent promises on the presidential campaign trail, and certainly one of his least controversial. Getting veterans the care they need is a nonpartisan priority. But the increased quality of care Trump promised hasn't come.

[Hyperlink to Above](#)

49 - WUSF (NPR-89.7, Audio): [For Veterans Groups, Questions Surround Trump's VA Nominee](#) (6 April, Carson Frame, 197k uvm; Tampa, FL)

Some veterans groups say they're uncertain about the future of care at the Department of Veterans Affairs, after President Trump ousted Secretary David Shulkin and nominated White House physician Ronny Jackson to head the agency.

[Hyperlink to Above](#)

50 - Lubbock Avalanche-Journal: [Levelland native talks about nomination as head of VA](#) (7 April, Karen Michael, 194k uvm; Lubbock, TX)

Levelland native Dr. Ronny Jackson -- the rear admiral who is President Donald Trump's nominee as secretary of the Department of Veterans Affairs -- knows he will someday be a veteran and his sons will be veterans.

[Hyperlink to Above](#)

51 - Tampa Bay Times: [Editorial: For the sake of Tampa Bay veterans, Senate should scrutinize Trump's VA pick](#) (7 April, 4.8M uvm; Saint Petersburg, FL)

President Donald Trump's decision to fire Veterans Affairs Secretary David Shulkin and to replace him with presidential physician Dr. Ronny Jackson has outsized ramifications for the Tampa Bay area, given the large number of veterans here and the expansive and unique role that two major VA health centers play on both sides of the bay. Whether Jackson is the right

person for the job, or whether this amounts to yet another glaring example of gross cronyism in the Trump White House, remains to be seen.

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52 - Washington Post: [Ronny Jackson, Trump's pick for Veterans Affairs, may pass up \\$1 million to join the Cabinet](#) (8 April, Andrew deGrandpre, 43.9M uvm; Washington, DC)
President Trump's controversial nomination of Ronny L. Jackson to head the Department of Veterans Affairs has grown further complicated by the Navy physician's pending military promotion, which he could be forced to pass up — along with an estimated \$1 million in future retirement income — if confirmed for the Cabinet post.

[Hyperlink to Above](#)

53 - USA Today (Video): [VA pick Ronny Jackson: 'I've got what it takes' to lead the troubled agency](#) (8 April, Donovan Slack, 36.8M uvm; McLean, VA)
President Trump's pick to lead the Department of Veterans Affairs is dismissing concerns that he lacks the experience necessary to take over the massive agency, which has more than 300,000 employees and 1,200 medical facilities. Ronny Jackson, a Navy rear admiral, has been a White House physician since 2006 but has little executive management experience.

[Hyperlink to Above](#)

54 - CNN (Video): [Trump's VA pick says he's 'got what it takes' to be secretary](#) (8 April, Devan Cole, 29.8M uvm; Atlanta, GA)
Ronny Jackson, President Donald Trump's physician and pick for secretary of the Department of Veterans Affairs, said in his first interview since being nominated that he's "got what it takes" to lead the department. In a Sunday profile of Jackson in the Lubbock Avalanche-Journal, a newspaper located near Jackson's hometown of Levelland, Texas, the White House doctor said: "I've been in leadership school for 23 years now."

[Hyperlink to Above](#)

55 - The Hill: [Trump VA nominee: 'I think I've got what it takes'](#) (8 April Mallory Shelbourne, 11.9M uvm; Washington, DC)
President Trump's nominee to take over the Department of Veterans Affairs (VA) said in a new interview that he has "what it takes" to lead the agency. "You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions," Rear Adm. Ronny Jackson, who currently serves as the White House physician, told the Lubbock Avalanche-Journal.

[Hyperlink to Above](#)

56 - The Hill: [Senate braces for showdown over Trump's nominees](#) (8 April, Jordain Carney, 11.9M uvm; Washington, DC)
The Senate is barreling toward a showdown over President Trump's latest Cabinet shuffle, with three critical departments looking for new leaders and more that could follow. Republicans are preparing for a weeks-long battle as they try to confirm CIA Director Mike Pompeo to be secretary of State and CIA deputy director Gina Haspel to succeed him.

[Hyperlink to Above](#)

57 - Washington Examiner: [VA pick Ronny Jackson: 'I've got what it takes'](#) (8 April, Kelly Cohen, 4.8M uvm; Washington, DC)

The man picked by President Trump to take over as head of the Department of Veterans Affairs says he's "got what it takes" to lead the troubled agency. "I think I've got what it takes, and you know, I don't buy into that argument [that I lack experience] at all," Ronny Jackson said in a profile of him published in the Lubbock Avalanche-Journal on Sunday.

[Hyperlink to Above](#)

58 - The Hill: [Senate uncertain how to proceed on dual Trump nominations for White House physician: report](#) (8 April, Brett Samuels, 11.9M uvm; Washington, DC)

Some lawmakers are unsure how to proceed with President Trump's pick for Veterans Affairs secretary because he also has a pending military promotion, The Washington Post reported Sunday. Trump nominated Rear Adm. Ronny Jackson to be promoted from a one-star admiral to a two-star admiral just days before the president ousted Veterans Affairs Secretary David Shulkin. Trump named Jackson as Shulkin's replacement, pending Senate confirmation.

[Hyperlink to Above](#)

59 - Military Times: [VA secretary nominee brushes off criticism over inexperience](#) (9 April, Leo Shane III, 2.1M uvm; Springfield, VA)

President Donald Trump's pick to take over the Department of Veterans Affairs downplayed his management inexperience in his first public interview since his nomination, saying his time in the military has honed his leadership skills. Dr. Ronny Jackson, who has served as White House physician since 2006, told the Lubbock Avalanche-Journal of Texas, his hometown newspaper...

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60 - ConnectingVets: [IAVA hopes VA Secretary nominee is the right choice](#) (9 April, Eric Dehm, 24k uvm; New York, NY)

The maelstrom continues to swirl atop the Department of Veterans Affairs. Shulkin is out, Wilkie is the acting secretary and Rear Admiral Ronny Jackson came out of left field as President Trump's nominee to permanently fill the position. It's been a wild few weeks in regards to veteran issues on Capitol Hill...

[Hyperlink to Above](#)

61 - ConnectingVets: [VA pick Ronny Jackson says he's up for the job](#) (9 April, Matt Saintsing, 24k uvm; New York, NY)

President Donald Trump's pick to lead VA wants veterans to know he's up to the task and is dismissing fears he's not qualified to lead the second largest government agency, one with more than 300,000 employees. Randy Jackson certainly has the medical chops as a Navy doctor, but veterans groups were largely caught off guard when Trump tweeted his intent to nominate him as Secretary of Veterans Affairs.

[Hyperlink to Above](#)

62 - Becker's Hospital Review: [How a military promotion could complicate Dr. Ronny Jackson's VA nomination](#) (9 April, Leo Vartorella, 441k uvm; Glencoe, IL)

President Donald Trump's nomination of White House physician Ronny Jackson, MD, to lead the Department of Veterans Affairs has been complicated by his simultaneous promotion to two-star admiral, according to The Washington Post. President Trump nominated Dr. Jackson for the promotion in late March, but he cannot stay on active duty and also direct the VA.

[Hyperlink to Above](#)

63 - Task & Purpose: [Trump's VA Pick Faces A Dilemma Most Troops Would Love To Have](#) (9 April, Adam Weinstein, 102k uvm; New York, NY)

I'm about to suggest something that would've been unthinkable to me as an E-3: Put yourself in the admiral's shoes. You're 23 years into a terrific career as a naval physician. For 12 of that, you've been the president's doctor, administering checkups to three very different POTUSes — high-stakes business, sure, but you've been doing it longer than most service members do anything.

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64 - Washington Post: [Senate Republicans express concerns about Trump's choice to lead Veterans Affairs](#) (11 April, Seung Min Kim, 43.9M uvm; Washington, DC)

Ronny L. Jackson, President Trump's choice to lead the Department of Veterans Affairs, is facing mounting skepticism from Senate Republicans over whether he has the management experience to lead the nation's second-largest bureaucracy. The comments from several GOP senators, particularly those with influence on veterans' issues, signal Jackson will have to work overtime to convince not just Democrats but Trump's own party that he is qualified...

[Hyperlink to Above](#)

65 - The Hill: [VA privatization fight could erupt in confirmation hearing](#) (11 April, Nathaniel Weixel, 11.9M uvm; Washington, DC)

Long-simmering tensions about privatizing the Department of Veterans Affairs (VA) could erupt into a confirmation battle over President Trump's pick to lead the department. Trump's decision to oust former VA Secretary David Shulkin late last month and replace him with White House physician Ronny Jackson stoked speculation that the White House wants to allow veterans more access to private-sector health-care providers.

[Hyperlink to Above](#)

66 - American Thinker: [VA privatization debate could derail new secretary's confirmation](#) (11 April, Rick Moran, 4.8M uvm; El Cerrito, CA)

When Donald Trump fired his secretary of Veterans Affairs, David Shulkin, and named his personal physician, Rear Admiral Ronny Jackson, to replace him, red flags went up on Capitol Hill and among some veterans groups who oppose privatizing the V.A. Indeed, in a parting shot to his detractors within the administration, Shulkin wrote an op-ed in the New York Times warning against forces inside the White House that want to privatize the entire agency.

[Hyperlink to Above](#)

67 - Herald-Tribune (Creators Syndicate): [McCaughey: Marching orders for Trump's new VA secretary](#) (11 April, Betsy McCaughey, 871k uvm; Sarasota, FL)

Since President Donald Trump ousted Veterans Affairs Secretary David Shulkin, the question reverberating in Washington is whether Trump's new pick, Rear Adm. Ronny Jackson, is

capable of heading a department with 360,000 employees and 9 million vets under its care. Senate Democrats carp he lacks experience running “a complex organization.”

[Hyperlink to Above](#)

68 - Fayetteville Observer: [Our View: Does VA nominee have the right stuff?](#) (11 April, Editorial Board, 439k uvm; Fayetteville, NC)

We hope Robert Wilkie enjoys the challenge of running the Department of Veterans Affairs, because he may have the job for a bit longer than his “acting secretary” title might indicate. Storm clouds are already gathering for President Trump’s nominee for the permanent position, Navy Rear Adm. Ronny Jackson.

[Hyperlink to Above](#)

Full Stories

1 - Washington Post (AP): [Trump’s VA pick draws concern over thin management record](#) (29 March, Hope Yen and Calvin Woodward, 43.9M uvm; Washington, DC)

President Donald Trump’s selection of his White House doctor to run the massive Department of Veterans Affairs triggered concern Thursday among lawmakers and veterans groups about whether he has the experience to manage an agency paralyzed over Trump’s push to expand private care.

Ronny Jackson, a Navy rear admiral entrusted with the health of the past three presidents, is a lifelong physician whose positions on privatizing operations in the second largest federal department and addressing ballooning health care costs are unknown. First named to the top White House post by President Barack Obama, he would be new to running a big bureaucracy if given leadership over a department of 360,000 employees serving 9 million veterans.

In a statement, Trump praised Jackson as “highly trained and qualified.” But representatives of veterans aren’t sold on the choice, or on Trump’s decision a day earlier to fire VA Secretary David Shulkin.

“There is little that we know about Dr. Ronny Jackson’s vision and qualifications,” said Paul Rieckhoff, founder and CEO of Iraq and Afghanistan Veterans of America. “Our concern is whether President Trump was more interested in picking a secretary who would be politically loyal rather than someone who can work across the aisle to fix long standing problems of bureaucratic delay.”

Similar doubts were expressed by Veterans of Foreign Wars, which praised Jackson’s military background in a statement but pointed to a nominee biography devoid of “any experience working with the VA or with veterans, or managing any organization of size, much less one as multifaceted as the Department of Veterans Affairs.” AMVETS echoed such sentiments.

“We look forward to a rigorous confirmation hearing,” Rieckhoff said.

Montana Sen. Jon Tester, top Democrat on the panel that will consider the nomination, said he had yet to determine if Jackson “is up to the job.”

It’s not clear from Jackson’s military service record how much, if any, management experience he has. His military assignments did not appear to include supervision over a large department or unit. His Navy biography says he deployed to Iraq with a Marine unit and served as the emergency physician in charge of resuscitative medicine for a trauma platoon.

Jackson joined the White House medical team in 2006 and is perhaps best known for his appearance before the press corps in January, announcing the results of Trump’s first physical in a performance that showed he was quick-witted and unfailingly complimentary of Trump.

Marveling at the 71-year-old president’s good health, Jackson opined, “It’s just the way God made him.”

A White House official said Shulkin himself had recommended Jackson for an undersecretary position at the VA in the fall, and Trump ultimately decided he was more comfortable with Jackson than with other top candidates. The official was not authorized to discuss personnel matters and spoke on condition of anonymity.

If confirmed by the Senate, Jackson would face immediate crises, like a multi-billion dollar revamp of electronic medical records now in limbo that members of Congress fear will prove too costly and wasteful, and a budget shortfall in the coming weeks in its private-sector Veterans Choice program.

Trump is seeking an aggressive expansion of the Choice program to make it easier for veterans to see private doctors outside the VA system at government expense, but proposals are stalled in Congress following a failed effort last week.

“We’re going to have real choice,” Trump said in Ohio. “That’s why I made some changes, because I wasn’t happy with it.”

Jackson’s nomination comes as Trump’s new Cabinet nominees begin to pile up in the Senate. That is certain to stir weeks of confirmation battles this spring when senators, especially those running for re-election, may prefer to shift focus away from the changes at the White House.

None of the nominees, including the president’s new picks for secretary of state and CIA director, is expected to sail to easy confirmation. The GOP-led Senate is narrowly divided 51-49 and Democrats — and some Republicans — are preparing to ask tough questions. Even though Congress has an otherwise slim legislative agenda before campaign season, prolonged confirmation fights could jam up the Senate and influence the election.

Pending Jackson’s confirmation, Robert Wilkie, a former Pentagon undersecretary for personnel and readiness, is serving as the acting head of the VA.

Lawmakers said they needed to learn more about Jackson’s record.

Republican Sen. Johnny Isakson of Georgia, chairman of the Senate Veterans Affairs Committee that will review the nomination, declined to indicate his support. He stressed that he looked forward to “meeting Admiral Jackson and learning more about him.” Isakson, a

moderate, has expressed skepticism in the past toward nominees who expressed strong views in favor of privatization.

Sen. Bernie Sanders, independent of Vermont and a former chairman of the panel, cautioned that Jackson would not be approved if he supported privatizing the VA. “Our job is to strengthen the VA in order to provide high-quality care to our veterans, not dismember it,” he said.

Shulkin, a physician and the lone Obama administration holdover in Trump’s Cabinet, was unceremoniously fired late Wednesday by Trump in a tweet. Shulkin had enjoyed support from Trump for much of his first year in the administration but support eroded last month after a bruising ethics scandal and political infighting at VA.

Dan Caldwell, executive director of the conservative Concerned Veterans for America, said the group is keeping an “open mind” about Jackson’s nomination. Some of the names that had been in circulation for the post had previous ties to the group, which supports giving veterans greater access to private doctors outside the VA system.

“We’d like to hear more about his positions to reform and fix the VA,” Caldwell said. “He has a very distinguished service record and it would be unfair to outright dismiss him — you have to be very professional to reach his rank.”

A native of Levelland, Texas, Jackson, 50, graduated from Texas A&M with a degree in marine biology, then from medical school at the University of Texas Medical Branch.

He headed to the Navy, then in 2005 joined a 2nd Marines regiment. Jackson was deployed to Iraq as the physician in charge of resuscitative medicine for a trauma platoon, according to the White House.

Ned Price, a National Security Council spokesman under Obama, described the doctor as “the guy you always want to be around” because he’s affable and funny. But Price said it was difficult to believe the nomination was unrelated to the “glowing assessment” of Trump’s health that the doctor had provided.

Associated Press writers Jill Colvin, Lisa Mascaro, Lolita Baldor, Zeke Miller, Jonathan Lemire, Catherine Lucey and Darlene Superville contributed to this report.

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2 - Washington Post: [Trump’s pick to head veterans department faces skepticism over his experience](#) (29 March, Lisa Rein, Seung Min Kim, Emily Wax-Thibodeaux, and Josh Dawsey, 43.9M uvm; Washington, DC)

The White House was thrown on the defensive Thursday over President Trump’s choice to lead the Department of Veterans -Affairs, forcing officials to fend off mounting skepticism that Ronny L. Jackson has the experience to run the government’s second-largest agency.

Trump announced by tweet late Wednesday that the White House physician would succeed ousted secretary David Shulkin, surprising veterans groups and lawmakers, who were not

notified beforehand and scrambled to learn the policy views of someone whose positions on the chronic challenges facing VA are unknown.

Jackson is a career naval officer who was an emergency trauma doctor in Iraq before spending the past 12 years as a White House physician. But his résumé lacks the type of management experience usually expected from the leader of an agency that employs 360,000 people, has a \$186 billion annual budget and is dedicated to serving the complex needs of the country's veterans.

"It's great that he served in Iraq and he's our generation. But it doesn't appear that he's had assignments that suggest he could take on the magnitude of this job, and this makes Jackson a -surprising pick," said Paul Rieckhoff, chief executive of Iraq and Afghanistan Veterans of America.

Jackson was taken aback by his nomination, said senior White House officials, who spoke on the condition of anonymity to discuss internal deliberations. After aides gauged his interest in recent days, he hesitated to take on such a big job. But the president continued to push and told his senior staff Monday that the doctor was his top choice. A senior White House official described an informal interview process, without the extensive vetting that typically accompanies a Cabinet selection.

Navy Rear Adm. Ronny L. Jackson, the lead White House doctor, said on Jan. 16 that President Trump's "overall health is excellent." (Bastien Inzaurrealde/The Washington Post)

"The President has full confidence in Dr. Jackson's abilities to give our veterans the care they've earned," spokesman Raj Shah said.

The White House planned to announce Wednesday that Shulkin would leave the administration and be replaced on an interim basis by Robert Wilkie, undersecretary for defense personnel and readiness at the Defense Department, until a nominee was found.

But Trump preempted the plan when he tweeted that he intended to nominate Jackson, administration officials said.

The active-duty rear admiral had been a behind-the-scenes figure while serving the past three administrations as a White House physician, but he moved into the spotlight in January when he delivered a glowing assessment of Trump's physical and mental health to reporters, which aides said endeared him to the president.

The White House on Thursday defended Trump's choice of Jackson, saying his hands-on experience as a doctor would serve him well as Veterans Affairs secretary.

"He knows what soldiers need on the battlefield and what they need when they come home as veterans," deputy White House press secretary Lindsay Walters told reporters aboard Air Force One en route to Cleveland, where Trump delivered a speech on his infrastructure plan. "The president has full confidence in his pick and trusts he will be able to give veterans the care they deserve."

Key congressional Republicans publicly took a cautious approach to the nomination.

“We are doing our homework on Dr. Jackson,” said Amanda Maddox, spokeswoman for Sen. Johnny Isakson (R-Ga.), chairman of the Senate Veterans’ Affairs Committee, which will hold Jackson’s nomination hearing. Trump called Isakson after announcing that he had picked the doctor to replace Shulkin, she said.

“His name was never floated around,” Maddox said, “so we are doing our due diligence.”

Trump’s decision to upend VA’s leadership comes as Senate Republicans were already worried about other potentially difficult nominations in the months leading up to midterm elections, when they want to focus their message on the recently passed tax cuts rather than deal with more upheaval in the administration.

“Any time Republicans are not selling the tax bill over the next seven months is a missed opportunity,” said GOP strategist Brian Walsh, a former spokesman for the National Republican Senatorial Committee. “I will say Senate Republicans are a little more insulated by the nature of the seats that are up. But there’s no question that these are unhelpful distractions.”

The stack of Trump nominees includes Gina Haspel, who was picked this month to be the director of the Central Intelligence Agency and is facing opposition from members of both parties because of her ties to the agency’s past use of brutal interrogation measures on terrorism suspects, which critics say amounted to torture.

Senate Republicans have told White House officials in recent days that the process of confirming CIA Director Mike Pompeo to replace Rex Tillerson as secretary of state is going to be challenging even though he is expected to be approved, according to two people briefed on the discussions. Democratic senators said privately when Pompeo was tapped to replace Tillerson that they expect far fewer Democrats to back him than the 14 who voted for him to lead the CIA.

Senior Senate Republicans have privately expressed frustration over the personnel battles that have raged since the beginning of Trump’s presidency and recently told the White House that they did not want to have to consider a series of nominees this year, according to aides and officials who have heard the complaints.

The move to dismiss Shulkin — as well as the lack of communication about Jackson — only fueled concerns on Capitol Hill that the administration was not doing enough to help Congress defend or even respond to the president’s rush of personnel changes.

Jackson’s policy views are unknown, particularly on the most pressing issue facing VA: how much access veterans should have to private doctors outside the system at government expense. Shulkin’s moderate views on the subject, which were at odds with many administration officials, helped end his tenure.

VA secretary is one of Washington’s most unforgiving jobs even for someone with extensive management experience. Shulkin, also a physician, had run large hospital systems — including VA’s — before taking the job. His predecessor, Robert McDonald, was a chief executive of Procter & Gamble. The secretary before him was a decorated retired Army general, Eric K. Shinseki, who was forced out after managers in the far-flung health system were found to have fudged waitlists for veterans’ medical appointments.

As recently as February, Jackson was a candidate to run VA's health-care arm, the Veterans Health Administration, the country's largest health-care system, with 1,200 hospitals and medical clinics. On the day of his interview, he told a selection panel that the president was unwilling to let him leave his White House job, according to two people familiar with the discussion.

The panel interviewed him informally anyway, asking him how he would drive change in such a large organization but not about his views on policy. One person who sits on the panel, and who spoke on the condition of anonymity because its proceedings are confidential, said they didn't think Jackson had the requisite skills to transition from overseeing a team of about 20 doctors, nurses and physician assistants in the White House medical office to overseeing the health administration.

"I don't remember him coming in trying to convince us he had the experience to do the job. He did not inflate his qualifications," this person said. "The tone was, 'Maybe I don't have the same kind of experience as others who came before me in the job.'"

Jackson's former colleagues in the Obama White House, who have publicly praised him in the past, said his nomination caught them off guard as they swapped text messages to ask how an extremely likable but unlikely candidate could end up running VA in the Trump administration.

"I've seen him managing a staff of a couple dozen, which he did to perfection," said Ned Price, a National Security Council spokesman under Obama who recalled that he was treated by Jackson for a toe injury in the Philippines.

"But how that would translate to managing the second-largest department in federal government I have no idea," Price said. "He has competence and integrity. I don't think he's going to fly around the world first-class or be buying thousands of dollars in furniture. But can he run VA? Anyone's guess is as good as mine."

Colleagues described the schedule of the White House physician as grueling, with continual foreign and domestic travel, always at the president's side.

Some Democrats warned that if Jackson embraced the idea of privatizing more of VA's health coverage, his nomination would be met with stiff resistance.

"I will carefully review Dr. Jackson's qualifications to determine whether he has the best interests of our Veterans at heart or whether he, like many in the Trump administration, wants to push VA down the dangerous path of privatization," Sen. Tammy Duckworth (D-Ill.), a wounded Iraq veteran, said in a statement.

At the American Legion, the country's largest veterans organization, senior officials were putting together ideas to help Jackson acquaint himself with the agency and its challenges.

"He's going to have a huge learning curve," Executive Director Verna Jones said, "but we stand ready to assist and educate him."

Robert Costa and Julie Tate contributed to this report.

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3 - Wall Street Journal: [Lawmakers Respond Cautiously to Little-Known VA Pick Ronny Jackson - Key senators on panel say they don't know enough about White House doctor to form an opinion about his ability to lead a vast bureaucracy](#) (29 March, Louise Radnofsky and Peter Nicholas, 43.6M uvm; New York, NY)

Capitol Hill lawmakers reacted guardedly to President Donald Trump's nomination of the White House physician to head the Department of Veterans Affairs, with key members noting that they know little about him.

Dr. Ronny Jackson, a U.S. Navy rear admiral who has served as a White House physician during the past three administrations, is slated to succeed Secretary David Shulkin, who was ousted Wednesday. Mr. Trump indicated on Thursday that he removed Dr. Shulkin because change at the agency was coming too slowly. The secretary had also been the subject of a travel-expenses scandal.

The lead Republican and Democratic senators who will decide whether to confirm Dr. Jackson said they didn't yet know enough to form an opinion about his ability to lead a bureaucracy of 370,000 employees. The department, which is the second-biggest government agency, is also still recovering from a 2014 scandal in which employees were found to have falsified records to hide delays in patient care.

"I look forward to meeting Adm. Jackson and learning more about him," said Sen. Johnny Isakson (R., Ga.), chairman of the Committee on Veterans' Affairs, which will vote on confirmation.

Sen. Jon Tester of Montana, the top Democrat on the panel, offered a near-identical sentiment, adding that he is looking forward to "seeing if he is up to the job."

Veterans service organizations and some other lawmakers have expressed skepticism about Dr. Jackson, raising concern over the propriety of an active-duty military officer holding a political appointment, and saying his biography showed scant experience at running a bureaucracy on the scale he would inherit.

"He's more of a hands-on physician—not a lot of desk time in terms of administrative leadership," said Rep. Mike Coffman (R., Colo.), a member of the House Veterans' Affairs Committee who was among Dr. Shulkin's harshest critics.

It's unclear how Dr. Jackson would address the issue of his active military status, including whether he would seek to relinquish it before securing confirmation to the new job.

Dr. Jackson's confirmation will come as senators are debating legislation that would increase veterans' ability to seek non-government medical care. Congress is approaching an early June deadline to agree to new funds for the existing system allowing some veterans to go outside the VA for care, or to create a new policy allowing all veterans to participate.

"I made some changes, because I wasn't happy with the speed with which our veterans were taken care of," Mr. Trump said Thursday in a speech in Ohio. "We want them to have choice so that they can run to a private doctor and take care of it."

The White House informed Mr. Isakson's committee of the leadership change in a courtesy call Wednesday; a timeline for proceeding with the nomination, or preliminary introduction meetings,

wasn't discussed, a spokeswoman said. Mr. Isakson and Dr. Jackson spoke by phone Thursday afternoon, in an informal introduction, the spokeswoman said.

Past and present White House officials have praised Dr. Jackson as a steady force, deft in caring for different presidents and cabinet members. They said they found him friendly, bright and knowledgeable about medicine, including on issues specifically affecting veterans.

"If you're not calmly decisive, the job of White House physician ain't for you," said Paul Winfree, a former deputy director of Mr. Trump's Domestic Policy Council.

Dr. Jackson has been sought out for management positions before, though on a significantly smaller scale. Toward the end of the Obama administration, he was invited to interview by the Cleveland Clinic for an international posting managing a handful of people because of his affability, versatility and experience with VIPs, a person familiar with the interview said.

The federal agency Dr. Jackson would inherit is notoriously riven with competing power centers, and has now churned through three secretaries in four years.

Dr. Shulkin came directly from a health-care management background into the Obama administration when he took over the VA. He stayed on for Mr. Trump and initially received high reviews. He lost credibility recently when the VA inspector general found that, during a trip to Europe, he improperly accepted Wimbledon tennis tickets, misspent thousands of dollars of taxpayer money on his wife's airfare and improperly used a department employee as a "personal travel concierge."

Dr. Shulkin denied wrongdoing. He repaid the \$4,312 cost of his wife's airfare and then sent the U.S. Treasury a check equal to the amount of the tennis tickets.

Mr. Trump's advisers had openly explored possible successors for Dr. Shulkin in recent weeks, including having conversations with potential candidates, people familiar with the matter had said.

Still, the nomination of Dr. Jackson stunned some White House aides, who hadn't known the president was even considering his physician for the role.

It became clearer Thursday that Mr. Trump had been thinking about moving Dr. Jackson to the VA for months. Last fall, Dr. Shulkin recommended that Dr. Jackson take an undersecretary job at the department, a White House official said. At that time, Dr. Jackson and the president discussed plans for improving the VA—talks that set in motion the announcement on Thursday.

Lindsay Walters, a White House spokeswoman, on Thursday said the White House believed Dr. Jackson had "bipartisan respect."

"The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary," she added. "The president has full confidence in his pick and trusts he will be able to give veterans the care they deserve."

Some lawmakers expressed dismay over the treatment and departure of Dr. Shulkin, which could linger into the new confirmation process. "By once again choosing chaos over consistent leadership, Donald Trump is hurting veterans around the country," said Illinois Democratic Sen. Tammy Duckworth, who is a retired U.S. Army lieutenant colonel.

—Kristina Peterson and Ben Kesling contributed to this article.

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4 - USA Today (Video): [6 big things the new Veterans Affairs chief will have to address](#)

(29 March, Donovan Slack and Dennis Wagner, 36.8M uvm; McLean, VA)

On the front lines at the Department of Veterans Affairs — in the agency's 1,240 hospitals and clinics — it doesn't much matter these days who holds the secretary's job in Washington.

David Shulkin, who was fired Wednesday, was the third VA secretary in four years. If President Trump's nominee to lead the agency, physician and Navy Rear Adm. Ronny Jackson, is confirmed, he will be the fourth.

Each has sought to fix the department, laying out visions and priorities — Shulkin's top priority was "access," making sure veterans get appointments when they need them. His predecessor, former Procter and Gamble CEO Bob McDonald, focused on staffing, training and veteran-centered customer service.

But year after year, critical deficiencies remain and veterans are bearing the brunt of the failures. Here are some key, seemingly intractable shortfalls that continue to plague the system — and that Jackson will face if confirmed.

Veterans are still waiting

The furor over VA health care exploded in 2014 when whistle-blowers in Arizona divulged that thousands of patients were backlogged at the Phoenix veterans hospital, and some of them had died awaiting care. VA investigators soon determined that medical center administrators knew about the crisis, yet put out fraudulent wait-time data to collect bonus pay.

The problems weren't just in Phoenix. A USA TODAY investigation in 2016 found supervisors instructed employees to falsify patient wait times at VA medical facilities in at least seven states. And employees at 40 VA medical facilities in 19 states and Puerto Rico regularly "zeroed out" veteran wait times.

A few weeks after Shulkin was sworn in last year, the VA inspector general released a report finding widespread inaccuracies in scheduling records at a dozen hospitals in North Carolina and Virginia. The records vastly understated how long veterans were waiting for appointments and prevented as many as 13,000 from getting VA-funded care in the private sector — an option they were entitled to if they waited longer than 30 days. At the time, Shulkin said the findings were based on outdated rules and that he had instituted new regulations to prevent such problems in the future.

But just two weeks ago, another inspector general investigation found the problems continued.

Looking at 64 VA hospitals and clinics in a swath of states from Kentucky to Illinois, investigators found scheduling staff entered the wrong dates in the system in more than 5,000 cases. That masked how long veterans were actually waiting for specialty care and mental health appointments.

They estimated 2,500 of those waited longer than a month, but the scheduling system falsely showed only 1,300 waited that long. Even in the cases accurately reflected in the system, they concluded, most weren't offered the chance to get care in the private sector.

"VA data continues to be a high-risk area," wrote Larry Reinkemeyer, VA assistant inspector general for audits and evaluations.

Quality of care

The VA's lowest performing hospitals remained at the bottom of the pack on the agency's own internal quality measures for two years in a row.

The VA regularly scores its medical centers based on dozens of quality factors, including death and infection rates, instances of avoidable complications and wait times. The agency uses a five-star scale with one being the worst and five being the best.

The rankings compare VA hospitals against each other but the number of one-star hospitals is not constant. Medical centers in that bracket can be elevated to two stars based on quality-of-care factors.

Among the facilities who received only one star in both 2015 and 2016 were the VA hospital in Phoenix and another in Memphis, Tenn. One Memphis employee dubbed the facility a "house of horrors" when USA TODAY obtained internal documents revealing reported threats to patient safety soared in recent years from 700 to more than 1,000.

One veteran had to have his leg amputated after a VA provider there left a piece of plastic tubing in a critical blood vessel during a procedure.

On a number of patient safety factors, the VA overall on average scores better than the private sector on many key patient-safety measures, including instances of avoidable death, respiratory failure, and infection. But there are vast disparities among VA hospitals, according to VA data collected from October 2015 to March 2017.

The death rate for surgical patients with treatable complications ranged from zero at the VA hospital in Sacramento, Calif., to more than 20% in Miami; Columbia, Mo.; and Washington, D.C. In Long Beach, Calif., it was 29%. That's more than double the private sector average of 14%, according to Medicare data.

Bureaucratic breakdowns

In Washington, the VA inspector general issued a rare emergency report last year saying that patients were in imminent danger at the hospital. The facility had dirty sterile storage areas and was regularly running out of critical supplies needed for surgeries and other procedures, including patches to seal blood vessels and tubes for kidney dialysis.

Shulkin quickly removed the hospital director there and sent teams from headquarters to try to fix the problems. But an inspector general report released this month found that VA officials at every level — local, regional and national — knew about the problems for years but didn't fix them.

Investigators found “a culture of complacency and a sense of futility pervaded offices at multiple levels.”

“In interviews, leaders frequently abrogated individual responsibility and deflected blame to others,” the investigation report says. “Despite the many warnings and ongoing indicators of serious problems, leaders failed to engage in meaningful interventions of effective remediation.”

Morale at the agency has taken a beating amid the constant drumbeat of crises. Employees ranked it as the second to worst agency to work for among large departments last year. The only department scoring lower was Homeland Security.

The inspector general singled out frontline workers at the Washington hospital, saying they went to great lengths to make do and they may be the only reason no patients were actually harmed.

“The OIG did not find evidence of adverse clinical outcomes, a condition that is largely attributable to front-line care providers who were committed to providing the best possible care by borrowing supplies, improvising, or personally ensuring patients received what they needed,” the investigation report said.

Vetting failures

The VA has had persistent difficulties recruiting and keeping enough medical care providers to meet veterans needs.

In 2015, one in six critical VA jobs — intake workers, doctors, nurses and assistants — were unfilled, a USA TODAY investigation found. Though the agency has made headway, there are still shortfalls.

In some cases, that has created an incentive to hire medical care providers with problem records that may have prevented them from getting jobs in the private sector.

A VA hospital in Oklahoma knowingly hired a psychiatrist sanctioned for sexual misconduct who went on to sleep with a VA patient, according to internal documents obtained by USA TODAY. A Louisiana VA clinic hired a psychologist with felony convictions. The VA ended up firing him after they determined he was a “direct threat to others” and the VA’s mission.

The Iowa City VA hospital knowingly hired John Henry Schneider last year, a neurosurgeon who had racked up more than a dozen malpractice claims in two states and had his license revoked in one.

After USA TODAY revealed the case in December, the VA forced him out and discovered that conflicting VA policies allowed its hospitals to illegally hire doctors with revoked licenses for 15 years. Shulkin ordered the policies rewritten but with the current process, that could take up to two years.

In a report released Monday, the inspector general found vetting failures go beyond medical providers. Investigators determined that the VA did not conduct required background checks on more than 6,000 employees and managers failed to properly document and oversee background checks.

“As a result, VA cannot reliably attest to the suitability of its largest workforce, exposing veterans and employees to individuals who have not been properly vetted,” the report said. “Unless internal controls and data are improved, VA and the public lack assurance that VHA has a workforce suitable for serving our nation’s veterans.”

Hiding shoddy care

The agency has failed for years to ensure medical care providers found to have provided poor care are reported to state licensing boards or to a national database created to prevent them from crossing state lines and endangering other patients.

In one case in Maine revealed in a USA TODAY investigation, the VA found a podiatrist had harmed 88 patients but didn’t report him to the national database and took years to report him to state boards. By the time the VA told his patients, one of them, U.S. Army veteran April Wood, had decided to have her leg amputated after two failed surgeries by the podiatrist.

The investigation found VA hospitals also signed secret settlement deals with dozens of doctors, nurses and health care workers in recent years that included promises to conceal serious mistakes — from inappropriate relationships and breakdowns in supervision to dangerous medical errors — even after forcing them out of the VA.

In response to the story last fall, Shulkin required increasing vetting of future such deals and he ordered policies on reporting to state boards and the national database rewritten. Again, five months later, the new policies still are not in place and could take months or years more.

Politics

Jackson, Trump's pick to be the new secretary, has no experience running a huge government agency, and dealing with veterans’ health care challenges will require deft politics and bureaucratic acumen.

His predecessor, Shulkin, was ousted despite being well regarded in Congress and assured of job security by Trump.

Now, a White House physician and former Navy admiral faces not just a plethora of VA maladies, but partisan politics and special interests that bitterly disagree on the cures.

The most perilous and important controversy involves decisions on privatizing veterans’ healthcare.

Powerful unions and veteran service organizations, such as the American Legion, oppose a radical change, and they are supported by most Democrats on Capitol Hill. But Republicans and key advocacy groups, such as Concerned Veterans for America, are demanding a system that would let veterans decide whether they go to the VA for care, or get private treatment subsidized by the government.

On Thursday, Trump suggested that Shulkin was dismissed because he was not aggressive enough in promoting the private-care option.

The existing Choice Program, which ate up billions of dollars and had to be re-funded, promises to be even more expensive if expanded. And those costs already have included tens of millions of dollars in improper payments to contractors.

Veteran enrollment for healthcare has skyrocketed, and Congress continues to expand benefits for those already in the system, with care for Agent Orange victims and high-cost medications for hepatitis patients. Bringing in enough funding to meet that demand also requires political aplomb.

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5 - Politico: [Trump's VA pick blindsides staff, deepens agency disarray - 'He's got a department that's in turmoil,' a former VA secretary said. 'It's in crisis.'](#) (29 March, Lorraine Woellert, Eliana Johnson and Connor O'Brien, 23.9M uvm; Arlington, VA)

The timing of President Donald Trump's announcement to name Rear Admiral Ronny Jackson to lead Veterans Affairs was a snap decision that surprised his own chief of staff and knocked the government's second-largest agency, already bedeviled by scandal, deeper into disarray.

White House chief of staff John Kelly had spoken with David Shulkin by phone Wednesday morning, reassuring the now-former VA secretary that he wouldn't be fired by tweet that afternoon. Hours later, Kelly had to phone Shulkin again telling him plans had changed.

Trump declared Jackson's nomination on Twitter at 5:31 p.m. The tweet was big news — not just to the public, but to some senior aides, according to one White House official.

The chaos — by now a typical part of the president's management style — has for months upended Kelly's attempts to ensure that an unorthodox White House adheres to traditional processes. But while White House aides are left unpacking the day's events, the drama at the VA is just beginning.

Deputy Secretary Thomas Bowman, a Trump appointee who is the agency's No. 2, is widely expected to leave soon, either by choice or by force. Kelly and other aides wanted Bowman gone before Shulkin left to avoid installing the deputy at the helm, even temporarily. Bowman had pushed back on broad privatization efforts, leading Trump to berate him in an Oval Office meeting for his lack of loyalty.

Trump got around the Bowman problem by naming Robert Wilkie, an undersecretary at the Department of Defense, to the temporary job. A Capitol Hill veteran and member of Trump's transition team, Wilkie is a former senior adviser to Sen. Thom Tillis (R-N.C.), who supports expanding service members' access to private doctors.

"He's got a department that's in turmoil. It's in crisis. There's warfare there," said Anthony Principi, who led the agency under former President George W. Bush. "And you have an acting secretary who doesn't know the VA."

But if and when Bowman departs, Wilkie will be left with a shallow bench at an agency already paralyzed by political mistrust, some veterans' advocates say. The VA's health and benefit agencies — which administer tens of billions of dollars in health programs, pensions, survivor

benefits and other forms of assistance to some 9 million service members — have been without Senate-confirmed officials since the Obama administration.

Veterans Affairs is the second-largest federal agency, behind only the Department of Defense, with 377,000 employees. And it has proven unwieldy even when led by highly decorated, experienced administrators such as Eric Shinseki, a retired four-star Army general who resigned during the Obama administration amid a scandal over lengthy wait times and faulty scheduling practices for medical appointments.

Shinseki was followed by Bob McDonald, an Army veteran and former Procter & Gamble CEO. Shulkin, McDonald's successor, was the first non-veteran to lead the VA.

As recently as two weeks ago, the Trump White House was still making overtures to potential candidates for the top job, according to a person with direct knowledge of the inquiries. Trump reportedly agonized over the decision, changing his mind several times, a senior administration official said.

“Instead of going through the paces to convince the best possible person to take this job, they’re going with the person who’s still on active duty in the Navy and can’t say no to the commander in chief,” said one Obama White House aide, who spoke highly of Jackson as a doctor and individual. “You could look at it as them giving up trying to find a competent commander or manager to fix the problems.”

Shulkin had come under fire after a VA inspector general's report accused him of improperly accepting tickets to the Wimbledon tennis tournament and using his agency staff to arrange a sightseeing tour of Denmark and England. He repaid the VA for the trip. The longtime hospital administrator, who was engaged in open warfare with conservatives in the department intent on privatizing the VA, contended he was set up.

Veterans' groups remained loyal to Shulkin, whom they saw as their best line of defense of against privatization. During his campaign, Trump made promises that veterans would be allowed to seek medical treatment outside the VA's system, statements taken by some to mean a step toward handing the system to commercial companies to manage.

Jackson, while well-liked by both Republicans and Democrats, is a cipher on privatization and other policy issues. With no agency experience to speak of, veterans suspect he could be installed as a figurehead, leaving lower-level appointees to steer the agency toward privatization.

“He’s a blank slate. Nobody knows really anything about his competency or capacity for this job,” said Paul Rieckhoff, CEO of Iraq and Afghanistan Veterans of America. “We especially know that being a veteran doesn’t qualify you to run the VA any more than being a soldier qualifies you to run the DoD.”

Principi urged Jackson to move quickly on his own agenda.

“The new secretary, really, if he wants to accomplish anything, has to hit the deck running and has to bring in some very, very good people,” he said. “I hope and pray he’s a success. Because if he’s not, American veterans are going to be the losers.”

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6 - Task & Purpose: [What's In Store For The Next VA Chief? Let's Break It Down](#) (29 March, James Clark, 102k uvm; New York, NY)

It's been an awkwardly long time coming, but as of yesterday afternoon embattled Veterans Affairs secretary David Shulkin is out of a job. The news comes after a month and a half of uncertainty that began when a scathing inspector general report detailed "serious derelictions" in expensing a Europe trip last summer. And then there were all the accusations and counter accusations of political infighting and rumors of possible replacements — at least all that is over:

Rear Adm. Ronny Jackson, the president's appointed White House physician, who drew national attention when he complimented President Trump on his "incredibly good genes," has been tapped to lead the Department of Veterans Affairs — pending approval by the Senate. Given that this leadership post has been described as "one of the most difficult jobs in government" — which has stymied generals, CEOs and health care executives — we thought it was time to give you a rundown of what's in store for the next officeholder, by the numbers:

More than 1,243 health care facilities. These Veterans Health Administration facilities include 170 VA Medical Centers, and 1,063 outpatient sites — making it the largest health care system in the United States.

9,000,000 veterans.. That's the number who receive medical care from VA, and many of these patients are older and suffer from multiple traumas and injuries that require specialized care: amputations, traumatic brain injuries, post-traumatic stress disorder, military sexual trauma, and as of 2013, half of all VA patients suffer from chronic pain, to name just a few. And as many as 2 million patients receive in-facility care, according to an American Legion statement.

20,000,000 veterans in the United States... we think. There could be far more veterans than we realize, since an individual's military history isn't tracked by the census bureau, which is a concern since the VA relies on headcount of its target population to get a feel for the size and scope of the services it needs to provide.

\$10,000,000,000 contract for Electronic Health Records. A long-term plan to modernize the VA's health records system could be jeopardy, with Shulkin's dismissal coming just as the VA was set to finalize the acquisition of a new electronic health record system.

2nd largest federal agency. The only one bigger is the Department of Defense.

\$186,000,000,000 budget for fiscal year 2018.

360,000 employees spread across three separate administrations within the department; the Veterans Health Administration, Veterans Benefit Administration, and the National Cemetery Administration.

23 years active duty. Jackson's Navy career began in 1995, and includes postings as an instructor, diving medical officer, diving safety officer, from Panama City, Florida Sigonella, Italy, to Norfolk, Virginia. By 2005 he deployed to Taqaddum, Iraq as part of a Surgical Shock Trauma platoon.

3 presidents. While still in Iraq in 2006, Jackson was selected as a White House physician and served as the supervising physician for the Camp David Presidential Retreat under the George W. Bush administration. Later he led the White House Medical Unit as its director and was the appointed White House physician for Presidents Barack Obama and Donald Trump.

Soon to be 7 VA secretaries in 4 years. The department has been beset by turmoil and scandal. Eric Shinseki resigned from his post as VA chief following the 2014 wait-list scandal the department. Since then, the VA has gone through three sitting secretaries, and is on its third acting secretary, with Robert Wilkie, previously the Pentagon's undersecretary of personnel and readiness, now tasked as the interim chief until Shulkin's replacement is approved by the Senate.

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7 - Washington Post: [Opinions - Surprise: Trump's newest Cabinet nominee has no relevant experience](#) (29 March, Eugene Robinson, 43.9M uvm; Washington, DC)

You can't make this stuff up: President Trump has announced he will nominate a medical doctor who has no discernible management experience to run the second-largest agency in the federal government.

Can presidents be sued for malpractice?

The man Trump has named to become secretary of veterans affairs, Ronny L. Jackson , happens to be the president's personal doctor. More to the point, given Trump's perpetual hunger for sycophancy, is the fact that Jackson showered the president with hyperbolic Dear-Leader-style praise during a widely viewed television appearance in January.

Trump has "incredibly good genes," the White House physician said in describing a examination he had given the president. Trump's overall health is "excellent." His "cardiac assessment" put him "in the excellent range." If his diet were a bit better, "he might live to be 200 years old." In any event, "I think he will remain fit for duty for the remainder of this term and even for the remainder of another term if he's elected."

That is an unusual way to describe a 71-year-old man whose height was reported as a generous 6 feet 3 inches , and weight at an eyebrow-raising 239 pounds, which classifies him as overweight — but conveniently one pound short of obese. Jackson's are odd words characterizing a man whose cheeseburger-laden diet my doctor would describe as suicidal and whose coronary calcium scan results, according to many other physicians, indicate some degree of heart disease and a clearly elevated risk of heart attack.

I assume Jackson has been more, shall we say, plain-spoken with the president about his health than he was with the public. But am I suggesting that flattery, rather than merit, is what makes him Trump's choice to replace ousted VA Secretary David Shulkin? Absolutely, because no other explanation makes sense.

Pliability may also be playing a role. In a New York Times op-ed, Shulkin wrote that he believed he was being sacked because he opposed a push by the Trump administration "to put VA health care in the hands of the private sector."

Shulkin is a physician, but before he took over VA, he also had experience running hospitals. With no comparable administrative background, Jackson — if confirmed by the Senate — would take over a sprawling agency with about 360,000 employees, a \$186 billion budget and responsibility for providing medical care to 9 million veterans who deserve better, faster service than they now receive.

Shulkin was one of several high-ranking Trump appointees under fire for lavish spending on the taxpayers' dime. He was also a holdover from the Obama administration, and even though the job is perhaps the least partisan in the Cabinet, that prior association clashed with Trump's bratty determination to oppose everything President Barack Obama supported and support everything he opposed.

But Shulkin, by most accounts, had stabilized VA's vast system of hospitals and health clinics. What he refused to do was support the notion of privatizing veterans' health care — an idea pushed by some of the political appointees the White House had installed under him.

"I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans," Shulkin wrote in his Times op-ed. "The private sector . . . is ill-prepared to handle the number and complexity of patients that would come from closing or downsizing VA hospitals and clinics, particularly when it comes to the mental health needs of people scarred by the horrors of war."

Shulkin wrote that "in recent months" the political environment in Washington had become "toxic, chaotic, disrespectful and subversive," making it impossible for him to do his job. "It should not be this hard to serve your country," he wrote.

But it should be hard to get a job running any organization as big, complex and vital as the Department of Veterans Affairs. Perhaps Jackson has an innate genius for management that awaits only the opportunity to flower. If not, Trump will be doing a grave disservice to men and women who are owed the nation's thanks and gratitude.

I can't say I'm surprised. Trump put neurosurgeon Ben Carson in charge of the Department of Housing and Urban Development, despite Carson having zero experience in housing policy. He put Betsy DeVos in charge of the Department of Education, despite her apparent unfamiliarity with actual schools. He put politician Rick Perry in charge of the Department of Energy, which Perry wanted to eliminate until he learned what the agency does.

Perry actually said that during his confirmation hearing. One doesn't know whether to laugh or cry.

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8 - Washington Post (The Fix): [Who is Trump's new Veterans Affairs pick, Ronny Jackson?](#) (29 March, Aaron Blake, 43.9M uvm; Washington, DC)

The seemingly never-ending parade of staff changes in the Trump administration continued apace Wednesday, with the president announcing that Veterans Affairs Secretary David Shulkin is out and that White House physician Ronny L. Jackson will replace him.

Jackson's name will be familiar to political watchers across the country for one main reason: He's the physician who delivered what some felt to be a suspiciously rosy picture of Trump's health in January. But he's an interesting pick for a whole host of other reasons.

For one, Jackson is something of a nonpartisan pick. Like Shulkin, he served in the Obama administration, where he was also President Barack Obama's White House physician. A native of Texas and a graduate of Texas A&M and University of Texas Medical Branch, he's a rear admiral in the U.S. Navy who has spent decades practicing medicine in the military. Jackson was nominated for a promotion to rear admiral (upper half) as recently as last week, which would give him his second star. According to his Navy biography, he was deployed to Iraq in the mid 2000s to head up an emergency medical unit tasked with resuscitating troops.

While there, he was chosen to join President George W. Bush's White House as a physician. In 2013, Obama promoted him to the top job in the West Wing. Trump elected to keep him on. In that role, Jackson oversees not just Trump's health, but also that of the first family and White House staff and guests. He mostly stayed behind the scenes but made headlines after treating a girl who got bit by one of the Obamas' dogs in January 2017.

Navy Rear Adm. Ronny L. Jackson, the lead White House doctor, said on Jan. 16 that President Trump's "overall health is excellent." (Bastien Inzaurrealde/The Washington Post)

Jackson reached his highest degree of notoriety in January, when he delivered a promised review of Trump's health. Trump, who at 70 was the oldest newly elected president ever, is known to eschew exercise and dine on fast food. There have also been persistent questions — especially among his critics — about his mental health. And Trump's medical reviews during the campaign were both ridiculously hyperbolic — claiming he would be the most healthy president ever — and omitted key pieces of information, including a hair-loss drug Trump takes.

Jackson's review played up a cognitive test Trump had passed that seeks out early signs of dementia and other kinds of mental deterioration. He said Trump had "incredible genes" and (seemingly) joked that if Trump's diet had been better he might live to be 200 years old. He denied Trump had heart disease even as the data suggested he might. He listed Trump's weight at 239 pounds, which left Trump exactly one pound shy of the definition of "obese" and spawned a whole host of dubious reactions. (Call it the "girther" movement.)

The whole thing earned Jackson a send-up during the cold open of "Saturday Night Live."

Despite the ridicule, members of the Obama administration vigorously defended Jackson as a patriot and an honest man.

If nothing else, Jackson's ascension seems to reinforce that the best way to get ahead in the Trump administration is to say nice things about him. Some defended Jackson's credentials, but that review will likely be a topic at his confirmation hearings.

Perhaps the main reason Jackson is a somewhat controversial pick, though, is his lack of management experience. VA has been a department beset by scandals in recent years — including before Shulkin — and has proved a logistical and bureaucratic nightmare. Jackson has headed up medical units in the White House and Iraq, but he has never dealt with anything close to the scale of what he's set to take on. It may be the toughest Cabinet job in the entire administration, in fact.

Trump, though, as he often does, has gone with a nontraditional pick who said things he liked on television.

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9 - FOX News: [Ronny Jackson picked by Trump to lead the VA: What to know about the president's physician](#) (29 March, Kaitlyn Schallhorn, 32.5M uvm; New York, NY)

President Trump gave Dr. Ronny Jackson a clean bill of health in March – to run the Department of Veterans Affairs.

A Navy rear admiral, Jackson is the president's personal physician who rose to prominence after he addressed the press from the White House briefing room in January to discuss Trump's health. While Jackson said the president needs to lose some weight, he said the physical exam he conducted showed overall that Trump was in good physical and mental health.

Trump fired Secretary David Shulkin on March 28, and Robert Wilkie is serving as interim secretary until Jackson is confirmed.

He has a marine biology degree

From Texas, Jackson, 50, graduated from Texas A&M University in 1991 with a degree in marine biology, according to his Navy biography. He graduated from the University of Texas Medical Branch with his medical degree in 1995.

That same year, Jackson joined the Portsmouth Naval Medical Center – located just outside Chesapeake, Virginia – which kicked off his active duty military career. It was there that he finished an internship in transitional medicine.

Later, he would return to the naval center to complete his residency in emergency medicine, graduating at the top of his class in 2004.

Jackson is a veteran

Jackson was deployed to Iraq after he joined the 2nd Marines in 2005, according to his Navy biography.

He served as the emergency medicine physician in charge of resuscitative medicine for a forward deployed Surgical Shock Trauma Platoon.

He's been a White House physician since Bush

While still in Iraq, Jackson was tapped as a White House physician in 2006. He has overseen the physicians for Camp David presidential retreats, led the White House Medical Unit and directed the executive health care for the Cabinet and senior staff members, according to his biography.

It was former President Barack Obama who selected Jackson to fill the position of physician to the president.

The Associated Press contributed to this report.

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10 - FOX News (Video): [John Brennan: Trump's nomination for VA secretary is 'terribly misguided'](#) (29 March, Nicole Darrah, 32.5M uvm; New York, NY)

Former CIA Director John Brennan once again took a shot at President Trump on Twitter Thursday, saying he believes the decision to nominate Adm. Ronny Jackson to run the Department of Veterans Affairs is "terribly misguided."

"I personally know and greatly respect Ronny Jackson....as a terrific doctor and Navy officer," Brennan tweeted. "However, he has neither the experience nor the credentials to run the very large and complex VA. This is a terribly misguided nomination that will hurt both a good man and our veterans."

Trump announced via Twitter Wednesday his intention to replace current VA Secretary David Shulkin with Jackson, a 50-year-old Navy rear admiral who has served as personal physician to the president since 2013, when he was appointed by former President Obama, after being tapped to serve as a White House doctor in 2006.

Jackson's also a veteran. He was deployed to Iraq after he joined the 2nd Marines in 2005, according to his Navy biography.

Jackson's nomination triggered some concern among lawmakers and veterans groups about his experience to manage a federal agency, but Trump praised the lifelong doctor as "highly trained and qualified."

Trump decided to oust Shulkin from his Cabinet after he served just over a year in office. An internal VA watchdog found last month that Shulkin improperly accepted Wimbledon tennis tickets and that his then-chief of staff had doctored emails to justify his wife traveling to Europe with him at taxpayer's expense.

The swipe from Brennan, now an analyst for NBC News and MSNBC, isn't the first he's made against Trump.

Just last week, he suggested that the Russians "may have something" against the president, and days prior to that in response to former FBI official Andrew McCabe's firing: "When the full extent of your venality, moral turpitude, and political corruption becomes known, you will take your rightful place as a disgraced demagogue in the dustbin of history."

Fox News' Kaitlyn Schallhorn and Elizabeth Llorente, along with The Associated Press, contributed to this report.

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11 - New York Times: [Op-ed - Ronny Jackson's Disturbing Lack of Independence](#) (29 March, Norman L. Eisen and Bandy X. Lee, 30M uvm; New York, NY)

In announcing Dr. Ronny Jackson, the White House physician, as his choice to be the new secretary for veterans affairs, President Trump has taken his latest misstep in what has been the worst presidential personnel process in modern history.

We take no pleasure in saying so, including because one of us (Mr. Eisen) worked with Dr. Jackson in the White House, was even treated by him, and can testify that he is a very capable physician. But that good opinion of Dr. Jackson, which was widely held in the Obama administration, by no means qualifies him to run one of the largest, most complex and troubled cabinet agencies in the federal government.

Indeed, the very affability of Dr. Jackson's approach when it comes to his current presidential patient is perhaps his greatest disqualification, followed closely by his lack of relevant management experience and the apparent absence of a normal pre-nomination personnel vetting.

Dr. Jackson's January examination of President Trump, and subsequent news conference, give us great pause because they evinced a disturbing lack of independence — one of the most important qualities in a cabinet member. Dr. Jackson startled observers by not only finding the president healthy, but declaring he would remain so in the future. The doctor even looked into his crystal ball to predict good health for a second term, a pronouncement extending seven years into the future and so more fit for a fortuneteller than a scientist.

Some expert observers also felt Dr. Jackson may have understated the president's heart disease, and even fudged the president's height (his driver's license says 6 feet 2 inches; Dr. Jackson reported 6 feet 3 inches) because the lower number would have forced the doctor to admit his patient was obese. When asked why he had such glowing things to say about the president's health when Mr. Trump gorges on McDonalds, guzzles diet Coke, and seldom exercises, Dr. Jackson said: "Some people have just great genes. I told the president that if he had a healthier diet over the last 20 years, he might live to be 200 years old."

That is hardly the objectivity that America needs from its cabinet members. But Dr. Jackson's worst failing was his purported examination of the president's psychological fitness, resulting in his pronouncement that "the president is mentally very, very sharp." The examination came at a time when there was widespread public discussion about the president's mental state, driven by reporting about some of the president's startling behind-the-scenes behavior. The scrutiny was so intense that the president himself asked Dr. Jackson for testing.

But the test that Dr. Jackson administered was not fit for his conclusion. It was a short examination known as the Montreal Cognitive Assessment, which is generally used as a screen for Alzheimer's and similar symptoms. One of us (Dr. Lee) is a mental health professional who has expertise in these examinations, and would never have utilized this narrow test under these circumstances. It is the equivalent of pronouncing a patient cancer-free because she has a good complexion.

A full history should have been taken and a standardized battery of tests given, such as the Minnesota Multiphasic Personality Inventory. Among the other, more appropriate tests that should also have been considered are the Wisconsin Card Sorting Test, the California Verbal Learning Test and the Stroop Test. The MoCA examination was simply not sufficient under the circumstances to support Dr. Jackson's declaration that he had "absolutely no concerns" about the president's cognitive ability or neurological functions.

All of this matters because, if Dr. Jackson cannot be trusted to act independently when it comes to the president's mental and physical health, we cannot be confident that he will do so when it comes to the fitness of the Department of Veterans Affairs. The department has the sacred charge of repaying our soldiers for their service by providing them with health care and other support. If Dr. Jackson tells the president — and the country — what Mr. Trump wants to hear about his own health, how can we trust him to honestly and rigorously diagnose the ailments of the V.A., and to treat them appropriately?

Having a candid V.A. secretary is all the more important because the department faces profound challenges. Since 2014, it has dealt with a pattern of negligent treatment at hospitals operated by one of its agencies, the Veterans Health Administration. Outgoing Secretary David Shulkin revealed yesterday that he had fought Trump administration proposals to privatize services provided by the V.A. — a move that could undermine the quality of health care provided to our veterans. Dr. Jackson's treatment of the president does not inspire confidence that he will take on the V.A.'s problems with the brutal honesty that the job demands.

Dr. Jackson's nomination is also undermined by the fact that although he is a medical professional, he lacks the management experience that the job demands. The V.A. secretary is responsible for a department that provides health care services to over nine million individuals. While Dr. Jackson has served his country with distinction, both in Iraq and as the White House physician, managing a relatively small medical team is not preparation for leading a vast and sprawling bureaucracy. The V.A. is one of the most complex health care management jobs in the world, and ideally would be run by someone with experience operating hospital systems or health businesses or enterprises, and large ones.

The nomination fits a pattern of cronyism, with the president appointing those of dubious qualifications to patronage jobs across the administration. The president's former golf caddy is now the White House social media director. A contractor married to one of the Trump's former household staff members now has a job at the Environmental Protection Agency. And a longtime friend of the Trump family who has been involved in planning golf tournaments and Eric Trump's wedding is the head of the New York and New Jersey office of the Department of Housing and Urban Development. And now he has appointed his White House doctor to oversee the health care of millions of veterans.

Finally, in addition to concerns about independence and qualifications, it appears that Dr. Jackson had not undergone the normal vetting process for White House presidential personnel. Reportedly, the tweet-from-the-hip nomination of Dr. Jackson by the president surprised even his own advisers. That suggests that Dr. Jackson has not in fact received the careful review that is normally completed before such an announcement.

One of us worked (just down the hall from Dr. Jackson, actually) on vetting hundreds of senior administration officials. Very presentable and capable individuals — sometimes even those with existing security clearances — are sometimes disqualified by the rigorous personnel investigations that are normally undertaken for cabinet positions. Such cabinet-level vets complement but are more thorough than a typical pre-existing security clearance, and can uncover conflicts, misdeeds or other disqualifying information.

We are not suggesting that vetting will uncover anything improper, but caution is warranted, since many of Mr. Trump's nominees have had unprecedented conflicts and other issues.

Norman L. Eisen (@NormEisen) is a senior fellow at the Brookings Institution and was President Obama's ethics czar from 2009 to 2011. Bandy X.Lee is a forensic psychiatrist at the Yale School of Medicine and a project leader for the World Health Organization.

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12 - ABC News (Video): [Veterans groups respond cautiously to VA secretary nomination](#)
(29 March, Sarah Kolinovsky, 24.2M uvm; New York, NY)

Despite his active duty status as a Navy rear admiral (lower half) and his medical experience, veterans service organizations are responding cautiously to the nomination of Dr. Ronny Jackson for secretary of Veterans Affairs, with some expressing concern about his lack of managerial experience or what his views are on reforming the VA.

Jackson has served as White House Physician in the past three administrations and in January gave President Donald Trump a glowing health review. Recently, Trump nominated Jackson to receive a second star, promoting him to the rank of full rear admiral. Jackson has deployed to Iraq as an emergency medicine physician in charge of resuscitative medicine for a forward-deployed Surgical Shock Trauma Platoon.

Iraq and Afghanistan Veterans of America, an organization serving the post-9/11 generation of veterans, say it looks "forward to learning more about Dr. Ronny Jackson's vision and qualifications." The statement underscores the fact that Jackson lacks significant managerial experience as he is poised to lead the government's second largest agency, which cares for more than nine million veterans and has an annual budget of nearly \$200 billion.

"Nobody really knows who is he. Is he an empty vessel? Does he have strong views on privatization, or reforming the VA?" asked IAVA CEO and Founder Paul Rieckhoff during an appearance on CNN Thursday morning. "So the confirmation hearings are going to be really really important. The Senate, House, time for you guys to step up and grill this guy and find out if he is qualified to not only run the agency but care for our veterans in a time of war."

IAVA welcomed the news that "finally puts an end to weeks of painful speculation that was negatively impacting VA and veterans nationwide," referring to media reports that President Trump had lost confidence in Secretary Shulkin. IAVA pointed out that in a recent survey, only 24% of the organization's members approved of the job Shulkin was doing.

Veterans of Foreign Wars (VFW) echoed IAVA's hesitation about Jackson's experience. "The VFW will be closely monitoring the Senate confirmation process, because what Dr. Jackson's bio does not reflect is any experience working with the VA or with veterans, or managing any organization of size, much less one as multifaceted as the Department of Veterans Affairs," VFW Director of Communications Joe Davis said in a statement.

The conservative group Concerned Veterans for America expressed more optimism about the change, saying in a statement "We are hopeful that this change will end the recent distractions at the VA and put the focus back on advancing policy that will ensure veterans get the health care and other benefits they have earned. The Trump administration has made great progress over the last year reforming and fixing the VA, however, there is still much work to be done."

The American Legion declined to comment directly on Jackson's qualifications. Instead, the group highlighted their intention to work "directly with the President through this transition and going forward, and providing him an increased level of advice and feedback on the issues important to America's veterans."

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13 - The Atlantic: [The Doctor Who Suddenly Got Nine Million Patients - For a position that demands high-level policy expertise, President Trump appointed his personal physician, Ronny Jackson.](#) (29 March, James Hamblin, 23.9M uvm; Washington, DC)

Nine million veterans will soon be under the care of the emergency-physician rear admiral Ronny Jackson, pending confirmation of his appointment Wednesday to lead the U.S. Department of Veterans Affairs.

This seemingly mundane appointment—a doctor and naval officer with years of experience as White House physician under both Trump and Obama—is of great consequence. It comes at a time when the VA is in need of a politically savvy expert on health-care administration, budgeting, and resource allocation, as the system is on the brink of major changes that bear on national security. The system has proven to require a leader who can thread multiple bureaucratic needles with his or her eyes closed. Jackson does not clearly fit this bill.

The VA is the second-largest federal department, overseeing 1,243 health-care facilities including 170 hospitals, which tend to be a ghostly network of dim, mid-century structures that bear the scars of serving as constant political battlefields. They tend to have bad food and no marble and bizarre gift shops that I've seen sell knives and cured meats. Yet VA hospitals seem to underscore the waste of the glitz of five-star-hospital-style academic medical centers. The system punches above its weight in the quality and safety of care it delivers compared to most of the private health-care industry.

While it is crucial to have experienced veterans and physicians in the upper echelons of a system like this, the work is mostly about politics and economics. Jackson is not an expert in policy, and he lacks work experience in health-care administration or management. His chief credential is that he is a physician. I'm also a physician, and—ask anyone—I'm wholly unqualified to lead a hospital system, much less to lead the one most crucial to our national security.

Even as a doctor, Jackson's judgment has been dubious at times. The press conference in January where he extolled President Trump's soundness of mind suggested allegiance to the president above the public or the profession: "I've found no reason whatsoever to think that the president has any issues whatsoever with his thought process," Jackson said, after having administered a 10-minute test for dementia in which the president was asked to do basic math, identify zoo animals, and draw a clock. (A useful and good test, the results of which were, I've argued, overstated in the context of widespread physician concern over the president's soundness of mind.)

Professional bearing intact, Jackson also said that the borderline-obese (BMI 29.9), 71-year-old president—who does not exercise and eats McDonald's to excess (Filet-o-Fish, no less) and is known for angry outbursts and drinks around 144 ounces of Diet Coke per day and barely sleeps—is in "very good health, excellent health." He speculated that the president would

remain fit for service until the end of a second term and said he told Trump that “if he had a healthier diet over the last 20 years, he might live to be 200 years old.”

As David Axelrod, former adviser to President Obama and now the director of the University of Chicago Institute of Politics, responded publicly to the appointment: “Dr. Jackson is a good and honorable person, [a] fine doctor and career military, but you do get the sense that this [appointment] has as much to do with his boffo press conference on the president’s physical [exam] as anything else.”

Trump has become known for proximity-based, loyalty-based promotions made with apparent haste. Jackson may simply have been the only doctor in Trump’s field of view. With doctors Oz and Phil being televisually obligated, and Harold Bornstein all the way up in New York ... who else is there?

Though if the move was deliberate to a policy end, it was a savvy move from the perspective of those who would like to see the VA privatized. There has been a creeping movement to privatize elements of the VA system, backed by the Koch brothers, among others. At a policy level, the concept is worthy of consideration and debate. Some experts argue that certain elements being privatized could improve quality and decrease costs.

But that doesn’t seem to be what’s happening. The outgoing VA secretary David Shulkin made this clear on Thursday in an op-ed in The New York Times. He argued that some public-private cooperation had been fruitful: “We have expanded access to health care by reducing wait times, increasing productivity, and working more closely with the private sector.” But he also warned that the push toward complete privatization was not being undertaken in good faith. Shulkin writes:

It seems that these successes within the department have intensified the ambitions of people who want to put VA health care in the hands of the private sector. I believe differences in philosophy deserve robust debate, and solutions should be determined based on the merits of the arguments. The advocates within the administration for privatizing VA health services, however, reject this approach. They saw me as an obstacle to privatization who had to be removed. That is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans.

With Shulkin out of the way, the next secretary of the VA would need to approach the job with strong moral bearing and willingness to resist political expedience for the sake of improving the system. Without this force, special interests could sway the system toward privatization at a cost to taxpayers and veterans.

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14 - The Hill: [White House: Trump has 'full confidence' in presidential physician to lead VA](#) (29 March, Max Greenwood, 11.9M uvm; Washington, DC)

President Trump has “full confidence” in White House physician Ronny Jackson’s ability to head the Veterans Affairs (VA) Department, a spokeswoman for the White House said Thursday, despite reported concerns from some aides.

"As I said earlier, the president has full confidence in Adm. Jackson," White House deputy press secretary Lindsay Walters told reporters.

"The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary and ultimately decided that his health care experience, his distinguished career in the medical profession, was something that would be beneficial at the VA," she continued.

"At the end of the day, as I said earlier, the status quo was not working. We need somebody who understands the health care system," she said.

Trump continued a spate of shake-ups in his Cabinet on Wednesday by dismissing VA Secretary David Shulkin and tapping Jackson, a rear admiral in the Navy and the current White House physician, for the role.

The New York Times reported Wednesday that some White House aides had privately expressed concern about the decision to nominate Jackson for the VA's top job, because of his lack of experience managing a large organization.

At the same time, some aides acknowledged that Trump's relationship with Jackson carried more weight in making the decision than the physician's prior experience, the Times reported. Jackson gave Trump his first physical in office earlier this year.

Walters told reporters Thursday that Jackson "has bipartisan respect" in Congress, and said his experience in the Navy gives him an insight into "what soldiers need on the battlefield and what they need when they come home as veterans."

She also said the decision to oust Shulkin and nominate Jackson was in no way part of an effort to privatize veterans' health care, as Shulkin had implied in an op-ed he wrote the day after his ouster.

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15 - The Hill: [GOP, vet groups react with caution to Trump VA pick](#) (29 March, Rebecca Kheel, 11.9M uvm; Washington, DC)

Senators and influential veterans groups are withholding judgment on President Trump's pick to lead the Department of Veterans Affairs (VA), a Navy doctor with no experience leading a federal bureaucracy.

Both the Republican chairman and the Democratic ranking member of the Senate Veterans Affairs Committee said only that they look forward to meeting Rear Adm. Ronny Jackson. Several veterans groups expressed some concern about Jackson's qualifications, but did not immediately oppose him, saying that questions need to be answered during the confirmation process.

"We look forward to understanding more about the qualifications of Admiral Ronny L. Jackson, MD to helm the VA during this critical time," Carl Blake, executive director of Paralyzed Veterans of America, said in a statement. "The VA has a broad mission and the secretary must be someone who is eminently qualified to lead the nation's second largest cabinet agency."

VA-18-0457-A-000799

On Wednesday night, Trump announced on Twitter that he'd tapped Jackson to replace David Shulkin, who fell out of the president's good graces after turmoil over the direction of private health care for veterans and a scathing inspector general report accusing him of misusing taxpayer dollars on a trip to Europe.

Shulkin's firing was expected, but Jackson was not among the names circulating as possible replacements.

Statements from lawmakers and veterans groups poured in Wednesday night, heavily praising Shulkin for his service at the department.

When it came to Jackson, though, the statements were generally shorter and more neutral.

"I look forward to meeting Admiral Jackson and learning more about him," Senate Veterans Affairs Chairman Johnny Isakson (R-Ga.) said in a statement.

In a separate statement, committee ranking member Sen. Jon Tester (D-Mont.) likewise said he looks "forward to meeting Admiral Jackson soon and seeing if he is up to the job."

Jackson was first thrust into the public spotlight when he gave Trump a clean bill of health in January during a lengthy and unusual press briefing at the White House.

Jackson told reporters that a cognitive test showed "no reason whatsoever to think the president has any issues whatsoever with his thought processes." He also proclaimed Trump's "overall health is excellent," crediting the president's "good genes" despite a well-known penchant for fast food and lack of exercise.

Jackson has served as a White House physician since 2006 and was promoted by former President Obama in 2013 to become the physician to the president.

Just last week, Trump nominated Jackson for a promotion in rank from rear admiral (lower half) to rear admiral. Jackson is expected to retire from active duty if confirmed.

A Texas native who received his doctorate of medicine from the University of Texas Medical Branch, Jackson started his naval career in 1995 at the Portsmouth Naval Medical Center in Virginia, according to his Navy biography.

In 2005, Jackson deployed as part of the Surgical Shock Trauma Platoon in Taqaddum, Iraq. There, he served as the emergency physician in charge of resuscitative medicine.

His bio lists several awards, including the Defense Superior Service Medal, the Legion of Merit, the Navy/Marine Corps Commendation Medal and the Navy/Marine Corps Achievement Medal.

But it makes no mention of any work on veterans issues.

Still, the White House says Trump has "full confidence" in Jackson, adding he believes the department needs someone who understands health care.

If confirmed, Jackson would take the helm at the government's second largest bureaucracy at a time when the VA is still regaining trust after a 2014 scandal over long and falsified wait times for veterans seeking health care.

In addition to overseeing 1,700 health-care sites serving almost 9 million veterans annually, the doctor would be in charge of benefits delivery, 360,000 employees and a nearly \$200-billion budget.

Jackson would also come in during a raging debate over legislation to expand a program known as Choice that provides private health care to some veterans -- a concern seen as central to Shulkin's undoing.

At issue is how much to expand the program. Veterans groups and Democrats fear the White House wants to essentially privatize veterans health care, which they warn would not be able to address the unique challenges veterans face.

Jackson's position on the issue is unknown, though the White House said Thursday in response to accusations made by Shulkin that "there are no discussions about privatizing" the VA.

Veterans service organizations, which are congressionally chartered and hold substantial sway over veterans issues in Congress, raised questions about Jackson's qualifications.

AMVETS listed several questions for Jackson, including how someone who's never held a command is qualified to lead a massive bureaucracy and what his qualifications are to address issues outside of health care including claims, appeals, benefits and cemetery affairs.

"I am deeply concerned about the nominee," AMVETS Executive Director Joe Chenelly said in a statement. "Veterans' lives depend on this decision, and the Trump administration needs to substantiate that this active-duty Navy officer is qualified to run a \$200 billion bureaucracy, the second largest agency in the government."

Disabled American Veterans (DAV) said they look forward to "learning more about the qualifications and views" of Jackson and expressed concern about a leadership vacuum.

"At a time of critical negotiations over the future of veterans healthcare reform, VA today has no secretary, no under secretary of health or benefits, and the named acting secretary has no background in health care and no apparent experience working in or with the department," DAV Commander Delphine Metcalf-Foster said in a statement, referring to acting Secretary Robert Wilkie, who comes from the Pentagon.

"We certainly expect the next secretary to continue the path set by VA, Congress and veterans organizations in recent years to strengthen the VA healthcare system while ensuring that all enrolled veterans have timely access to quality care, whenever and wherever they need it."

Still, Vietnam Veterans of America (VVA) said Jackson will understand veterans' needs.

"We are pleased that he is a combat veteran with firsthand knowledge of the trauma of war, and as such, will understand what our veterans need," VVA National President John Rowan said in a statement.

VA secretaries typically receive strong bipartisan support in their confirmation. Shulkin was confirmed unanimously, as was his predecessor Bob McDonald. The secretary before that, Eric Shinseki, was confirmed by voice vote.

Nominees only need a simple majority to be confirmed. But Republicans only have a two-seat advantage over Democrats in the Senate, and one Republican, Sen. John McCain (Ariz.), has not voted in months as he receives cancer treatment in his home state.

Republicans on the Senate Veterans Affairs Committee appeared inclined to support Jackson.

"I look forward to working with Dr. Ronny Jackson on modernizing and reforming the VA, fixing the VA Choice Program, and implementing the major reforms that Congress has passed over the last year," Sen. Thom Tillis (R-N.C.) said in a statement.

Sen. Jerry Moran (R-Kan.), who in January accused Shulkin of "double-talk" in negotiating on Choice, said the VA secretary needs to focus on changing the department's bureaucracy.

"Rear Admiral Jackson has a career in service and I look forward to discussing his plans for the VA to make certain veterans receive access to care they deserve," Moran said in a statement.

Committee Democrats, meanwhile, promised close scrutiny of Jackson's qualifications and his position on privatization.

"I will seriously scrutinize the president's nominee, Ronny Jackson, because our nation's veterans deserve the best," Sen. Richard Blumenthal (D-Conn.) said in a statement.

Sen. Bernie Sanders (I-Vt.), who caucuses with Democrats, was more blunt.

"The Senate Committee on Veterans Affairs should not approve any nominee for secretary who supports the privatization of the VA," he said in a statement.

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16 - Military.com: [Others Considered for VA Job Before Trump Picked His Personal Doctor](#) (29 March, Richard Sisk, 9M uvm; San Francisco, CA)

Rear Adm. Ronny L. Jackson, the personal physician to President Donald Trump, was not his first choice to replace fired VA Secretary Dr. David Shulkin, the White House said Thursday.

"The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary," White House deputy press secretary Lindsay Walters told reporters.

She said Trump "ultimately decided that his [Jackson's] health care experience, his distinguished career in the medical profession, was something that would be beneficial at the VA."

Walters added that Trump "has full confidence in Admiral Jackson" to fulfill the demanding job at the Department of Veterans Affairs despite his lack of experience in running large organizations.

Walters did not name the others who were considered to head the VA, but they reportedly included Toby Cosgrove, former head of the \$8 billion Cleveland Clinic health care system, and Pete Hegseth, an Army National Guard veteran of Iraq, former head of the advocacy group Concerned Veterans of America and co-host of the weekend "Fox & Friends" program.

Cosgrove, a Vietnam veteran, was among those invited in 2016 to Trump's Mar-a-Lago estate in Florida to be interviewed for the VA post before Trump settled on Shulkin, a holdover from the Obama administration.

Others who were under consideration as VA secretary included former Rep. Jeff Miller, R-Florida, who had been chairman of the House Veterans Affairs Committee; retired Army Lt. Gen. Keith Kellogg; Michael Kussman, a former VA undersecretary of health; and Leo Mackay Jr., a former VA deputy secretary who is now senior vice president at Lockheed Martin Corp., The Associated Press reported.

The surprise announcement of his nomination Wednesday afternoon, his status as a relative unknown on Capitol Hill, and the ongoing turmoil at the VA indicate Jackson will have little in the way of a honeymoon period if he is confirmed by the Senate.

Shulkin wasn't even out the door when Jackson faced a barrage of conflicting demands from the White House, Congress and the major Veterans Service Organizations (VSOs).

The immediate concern is the upcoming decision by the VA to award a contract that could run up to \$10 billion and is aimed at finally giving the agency electronic health records. There are also the perennial disagreements on what to do about benefits, wait times, suicides, PTSD, corruption, caregivers and the crumbling infrastructure at VA hospitals.

However, at the top of Jackson's to-do list is reaching a final resolution on the extension and expansion of the Veterans Choice Program, which allows vets to opt for private health care.

Proponents, including Trump, see Choice as guaranteeing that vets get the best health care available; opponents, including the VSOs, see overreliance on Choice as threatening the core mission of VA as the primary provider and payer for the care of nine million vets annually.

In leaving, Shulkin sidestepped the scandal over his travel expenses. He portrayed himself as the victim of palace intrigues hatched by White House political appointees advocating the full "privatization" of VA health care.

In an op-ed for The New York Times, Shulkin wrote that the political appointees, at the White House and within the VA, "saw me as an obstacle to privatization who had to be removed."

"That is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans," he said.

In testimony to the House Veterans Affairs Committee earlier this month, Shulkin warned that the Choice program could run out of money as early as June.

Sen. Johnny Isakson, R-Georgia, chairman of the Senate Veterans Affairs Committee, had co-sponsored a bill that would have extended Choice while keeping the decision on whether vets could go to private doctors within the VA, but the bill was not included in the \$1.3 billion omnibus spending package signed by Trump last week.

Isakson has pledged to renew his efforts on Choice when Congress returns after the Easter recess. In a statement Thursday, he also hinted at the conflicts with the White House by heaping praise on Shulkin and pointing to improvements at the VA in the past year.

Shulkin "has made a tremendous impact toward improving the lives of veterans," Isakson said. "He has been instrumental in all that we have accomplished in the last year, and I thank Dr. Shulkin for his dedicated service to our country and our veterans."

As for Jackson's nomination, Isakson said, "I look forward to meeting Admiral Jackson and learning more about him."

If confirmed by the Senate, Jackson, who has little administrative experience and none in running an organization such as the VA, could be expected to rely on the insider knowledge of the No. 2 at the agency, Deputy VA Secretary Thomas Bowman. The VA, the largest healthcare system in the United States, has 370,000 employees and a budget of nearly \$200 billion.

However, Bowman, a retired Marine colonel and military attorney, has already been targeted for removal by Jake Leinenkugel, a former brewery company executive and now a senior White House adviser on veterans issues.

In December, Leinenkugel wrote in an email to Camilo Sandoval, a political appointee at the VA, that they should lobby for the ousters of both Shulkin and Bowman. The email was first reported by The Washington Post and later obtained by Military.com.

Isakson and the VSOs came to the defense of Bowman, a long-time former staffer on the Senate Veterans Affairs Committee.

"Tom Bowman is a veteran and a patriot, a public servant and a good man," Isakson said in a statement. "If this is true, it will be a mistake, and I am deeply disappointed in the president. Veterans will suffer because of this decision if it's true."

The VSOs have partly blamed the moves against Shulkin and Bowman, and the efforts at privatization, on the work of the advocacy group Concerned Veterans for America, which is funded by the conservative Koch brothers organization.

In a statement, CVA's executive director, Dan Caldwell, said that Shulkin "made significant headway in reforming the department, but ultimately became a distraction from the important task of improving health care for our veterans."

Without mentioning Choice, Caldwell said, "Congress needs to continue work with the president to pass legislation that will give veterans more health care options and better access to care through the VA."

In a statement, Sen. John McCain, R-Arizona, chairman of the Senate Armed Services Committee, said of Choice that "much more work remains to improve the Veterans Choice Program and ensure our nation's heroes have access to the best possible services."

"Let me be very clear: none of us committed to reform wants to privatize care. We simply believe the VA must put the needs of veterans first, and ensure they receive timely, quality and uncompromised health care, whether that's in the VA or in the community," McCain said.

Sen. Jack Reed, D-Rhode Island, ranking member of the Senate Armed Services Committee, said, "I admire Dr. Jackson's service to the nation, but I don't know if he is the right person to lead the VA."

"One thing is clear -- the Trump administration seems to devolve further into turmoil by the day," Reed said. "I hope the level of dysfunction that has engulfed other parts of the administration does not impact the care that our veterans receive."

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17 - Government Executive: [Lawmakers, Veterans Groups and Former Officials Worry VA Nominee Is Not 'Up to the Job'](#) (29 March, Eric Katz, 870k uvm; Washington, DC)

With David Shulkin now ousted from the Veterans Affairs Department, all eyes are on President Trump's nominated replacement to see where he comes down on the most pressing issue at VA: How large a role should the private sector play in providing health care to veterans?

One problem for observers and stakeholders in the veteran community is Trump's pick, Dr. Ronny Jackson, has very little experience in public policy or veterans issues. Veterans service organizations and lawmakers were effusive in their praise of Shulkin, while expressing disappointment in his firing and noting the new relationships they would have to now forge.

"I don't know if he ever set foot in a VA [facility]," Louis Celli, the national VA director at American Legion, a group that represents more than 2 million veterans, said of Jackson. By the time the secretary designate is fully able to understand all the issues facing the department, Celli said, "this administration could be over."

As VA secretary, Jackson would be responsible for managing 370,000 employees spread across 3,000 facilities. Administering veterans disability benefits, education subsidies and cemeteries number among the department's dozens of lines of business. Still, its responsibility to provide health care to veterans is by far its biggest operation—the Veterans Health Administration runs the largest hospital network in the country—and is what led Jackson, a physician, to get the job.

Trump "ultimately decided that his health care experience, his distinguished career in the medical profession was something that would be beneficial at the VA," Lindsay Walters, a White House spokeswoman, told reporters Thursday. "At the end of the day . . . the status quo was not working. We need somebody who understands the health care system."

While Jackson has served as White House physician since 2006 and the president's personal doctor since 2013, his background is atypical for VA secretaries. While Shulkin was the first to helm the department without himself being a veteran, he had served at VA as an undersecretary as head of the Veterans Health Administration. He had previously led multiple private medical centers and health systems. His predecessor was Bob McDonald, who came from the private sector but whose nomination was met with plaudits because of his experience leading the Fortune 50 company Procter & Gamble. McDonald replaced Eric Shinseki, who had previously served as chief of staff of the Army.

In a New York Times op-ed published after his firing, Shulkin warned that his political enemies from within the Trump administration pushed him out not due to the scandals surrounding him but because of ideological differences about the future of VA.

"I have been falsely accused of things by people who wanted me out of the way," Shulkin said. "But despite these politically based attacks on me and my family's character, I am proud of my record and know that I acted with the utmost integrity. Unfortunately, none of that mattered."

Shulkin added that the environment surrounding him became "so toxic, chaotic, disrespectful and subversive" that he could no longer accomplish his job. He said his opponents within the department, whom he repeatedly vowed to oust, were fighting to privatize VA health care and saw him as a barrier in achieving that goal.

"They saw me as an obstacle to privatization who had to be removed," Shulkin said. "That is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans."

Opponents of privatization, including Shulkin, nearly all veterans service organizations and key lawmakers on both sides of the aisle on Capitol Hill, could breathe at least a momentary sigh of relief when Trump announced Jackson as his nominee to be the next VA secretary. Jackson is in many ways an unknown, but is not associated with any previous push to minimize the government's role in providing veterans health care as were some of the other candidates Trump was reportedly considering.

"I am deeply concerned about the nominee," said Joe Chenelly, executive director of AMVETS, another congressionally chartered veterans service organization. "Veterans' lives depend on this decision, and the Trump administration needs to substantiate that this active-duty Navy officer is qualified to run a \$200 billion bureaucracy, the second largest agency in the government."

AMVETS added it was pleased Jackson had a medical background, but noted VA is "more than healthcare."

"What qualifications does the president's nominee have to address claims, appeals, benefits and cemetery affairs?" the group asked.

Celli noted that even McDonald, a veteran who came to the department with vast managerial experience, took a while to fully "wrap his arms around the entire mission of what VA was" and was therefore only able to make a significant impact in two or three areas of VA's operation.

President Obama was wise to recognize he needed a veteran who had also run a large company with a big budget and many employees, much like VA itself, McDonald told Government Executive.

"That intersection is very small and I think [Obama] recognized that," McDonald said. "While Adm. Ronny must be a great doctor, the question the Senate will need to address is does he have sufficient management experience."

Even Shulkin seemed to suggest the job requires a large learning curve.

"No one is naturally prepared to take on a task like this," Shulkin told NPR on Thursday. Jackson would not be met with political leadership at the department to help guide him through

the ins and outs of its medical network, as Trump has yet to nominate an undersecretary to head VHA.

"Given the state of the VA today, the most important thing is the leadership experience of a very large organization," McDonald said. Having medical experience would only be the third top priority, McDonald said, after being a veteran.

Several groups expressed concern over the fate of reforms VA had already initiated under Shulkin. The now former secretary was in the process of realigning the department's regions, or Veterans Integrated Service Networks, and the larger structure of the department. He had worked with oversight committees in Congress on a proposal to consolidate existing programs giving veterans access to private sector care on the government's dime and easing veterans access to such programs, while maintaining a tight balance with those who tend to have a knee-jerk reaction against any reform that could be construed as VA privatization. The existing Veterans Choice Program is expected to run out of funding this summer. He had won approval for his plan to shutter underutilized facilities and had already help shepherd measures to expedite firing of problematic employees and reform the disability appeals process through Congress and into law.

"I have enjoyed getting to know Secretary Shulkin, and I'm glad to call David a friend," said Rep. Phil Roe, R-Tenn., who chairs the House Veterans Affairs Committee. "I think he's done a fantastic job and I hate to see him go."

Roe pledged to work with Jackson and build "a strong relationship with him also." Roe's counterparts in the Senate made clear they would not automatically grant their approval, as will be necessary for his confirmation.

"I look forward to meeting Admiral Jackson and learning more about him," Sen. Johnny Isakson, chairman of the Senate VA committee, said after praising Shulkin for the "tremendous impact" he made during his tenure.

Sen. Jon Tester, D-Mont., was even more non-committal.

"Moving forward, the VA needs a strong leader at the top who will listen to veterans, strengthen the VA and work with Congress to implement bipartisan reform," Tester said. "I look forward to meeting Rear Adm. Jackson soon and seeing if he is up to the job."

McDonald suggested Trump's selection could mark a departure from the path on which he and Shulkin put the department, which the former secretary said he formulated after hundreds of visits around the country to listen to VA beneficiaries.

"Veterans don't want the privatization of the VA," McDonald. "I hope President Trump is listening to veterans."

The American Legion's Celli speculated that Trump's choice of Jackson was a matter of happenstance rather than qualification. His selection was not as "draconian" as he and many had feared, Celli said, but it still appeared as if Jackson got the nod because he was "someone with military experience who [Trump] just happened to know." Celli was at least pleased that Jackson's demeanor and medical abilities were "above reproach," but said he would still have to prove himself beyond that to earn the support of the veteran community.

“Great, he’s a nice guy,” Celli said. “There’s a lot of nice guys out there.”

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18 - PBS: [Who is Ronny Jackson, Trump’s pick to lead the Department of Veterans Affairs?](#) (30 March, Gretchen Frazee, 22M uvm; Arlington, VA)

Rear Admiral Ronny Jackson has garnered almost universal praise for his skills as a military physician and his character. But his appointment to lead the Department of Veterans Affairs is proving divisive as critics point to his lack of experience managing a large organization.

On Wednesday, President Donald Trump named Jackson, the top White House physician, to replace David Shulkin, a holdover from the Obama administration, as secretary of Veterans Affairs.

The nomination immediately sparked criticism over Jackson’s limited management experience. The Department of Veterans Affairs has a \$182 billion budget and hundreds of medical facilities and offices across the country. The agency has 385,233 employees, a spokesperson for the agency said.

“I personally know and greatly respect Ronny Jackson ... as a terrific doctor and Navy officer,” former CIA Director John Brennan tweeted Thursday. “However, he has neither the experience nor the credentials to run the very large and complex VA. This is a terribly misguided nomination that will hurt both a good man and our veterans.”

Others defended Jackson, citing his decades-long career as a military physician and ability to perform in high stress situations and coordinate large operations.

“Ronny Jackson will be just damn fine in management skills,” said Dan Bongino, a former Secret Service special agent who worked with Jackson on the presidential protective division from 2006 to 2011. Bongino has since run for political office as a Republican and been a conservative commentator on numerous television programs.

Jackson has served under three presidents, which gives him bipartisan appeal. Both Democrats and Republicans say he is a superb doctor.

Trained in emergency medicine in the U.S. Navy, Jackson was appointed as a White House physician in 2006 under President George W. Bush. In 2013, President Barack Obama appointed him as physician to the president. He now serves in that same role under Trump.

Jackson is not well known outside of Washington, but he attracted national attention recently after conducting Trump’s medical exam, when he gave the president a glowing assessment at a press conference.

“The president’s overall health is excellent,” Jackson said at the time. “His cardiac performance during his physical exam was very good. He continues to enjoy the significant long-term cardiac and overall health benefits that come from a lifetime of abstinence from tobacco and alcohol.”

Jackson put the president at 6-foot-3 and 239 pounds, sparking widespread memes and photo comparisons to famous athletes online that poked fun at whether those numbers were accurate.

Yet those who have worked with Jackson say Americans should look past that episode and focus on his years of experience coordinating advance medical teams for presidential visits abroad.

As part of his job at the White House, Jackson helped create a contingency plan in case of a medical emergency so the president could receive the best treatment as quickly as possible.

The job has required coordinating with the Secret Service, foreign government leaders, and hundreds of medical staff to determine the closest medical facilities in locations where the president traveled, what their treatment specialties were, and whether they had access to things like a helicopter landing pad, for example.

“Quite literally the president’s life is in his hands,” Bongino said.

It is a high-stress environment, according to Jonathan Wackrow, another Secret Service agent who served under the Obama administration from 2009 to 2014. The president’s physician must handle the presidential family’s medical needs, the everyday stresses of the White House, political influences and constant travel.

“What Dr. Jackson has always done is put his head down and move forward,” Wackrow said. “He is going to take on this challenge like he has everything else in his career.”

Jackson graduated from Texas A&M University in 1991 with a bachelor’s degree in marine biology. He attended medical school at the University of Texas Medical Branch.

After graduating he became an instructor at the Naval Diving and Salvage Training Center in Panama City, Florida. He went on to serve as a diving medical officer for an explosive ordnance disposal unit in Sigonella, Italy, and a diving safety officer at the Naval Safety Center in Norfolk, Virginia.

He later served as an emergency medicine physician in Iraq before joining the White House.

If he is confirmed by the Senate, Jackson would be the first Veterans Affairs secretary to have served in either the Iraq or Afghanistan wars — an experience that will likely resonate with the more than 2.7 million soldiers who have been deployed to the countries since 2001.

“It means he will relate with the people who he is serving,” said Melissa Bryant, the chief policy officer for the advocacy group Iraq and Afghanistan Veterans of America. “But it doesn’t necessarily translate into managing the bureaucracy.”

Even those who support Shulkin’s resignation said Jackson will have a steep learning curve.

“The VA is a very complicated and complex medical system. There is a lot that anybody will need to learn about it,” said Dan Caldwell, the policy director for Concerned Veterans for America, an advocacy group funded by the conservative billionaire Koch brothers.

There are also questions about whether Jackson would be required to retire from the military or be granted a waiver from Congress because active members of the military are generally barred from holding civilian office.

And for all his military and experience, Johnson is still a largely unknown quantity in the larger veterans community.

At the fore of many veterans group's minds is whether Jackson might privatize more agency services. In a New York Times op-ed after he was fired by Trump, Shulkin warned that the department has "become entangled in a brutal power struggle," with political appointees seeking to "privatize veteran health care," a point he echoed in an interview Wednesday with the PBS NewsHour. Shulkin, who has been under fire for an inspector general report that suggested he misused government funds during a trip to Europe, added the chaos surrounding that debate played a role in his ouster.

When he was asked by the NewsHour's Judy Woodruff whether Jackson might push for more privatization, Shulkin said he had not discussed the issue with his successor.

"But I certainly hope he's going to continue the work that I've been doing to move the department to transform it in a better way," Shulkin said of Jackson. "I will certainly do everything I can to help Dr. Jackson succeed in that role," he added.

Shulkin is one of several top administration officials dismissed by Trump in recent weeks. The president has also recently ousted Rex Tillerson as secretary of state, and nominated CIA Director Mike Pompeo as his replacement. He also picked John Bolton, a former U.S. ambassador to the United Nations, to replace National Security Adviser H.R. McMaster. Bolton, unlike Shulkin and Pompeo, do not require Senate confirmation.

Veterans advocates said they would follow Jackson's confirmation process closely. If he does get the Senate's stamp of approval, Caldwell argued, Jackson would have one major advantage: he has the trust of President Trump, at least for now.

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19 - NPR (Morning Edition, Audio): [Trump Pick For VA Secretary May Get Additional Scrutiny](#) (30 March, 22M uvm; Washington, DC)

Noel King talks to Democratic Sen. Richard Blumenthal about President Trump's decision to fire VA Secretary David Shulkin, and the confirmation process of the president's pick to replace him.

Transcript:

NOEL KING, HOST:

President Trump has nominated White House physician Ronny Jackson to replace David Shulkin as the secretary of Veterans Affairs. But Doctor Jackson will still need to be confirmed by the Senate. One man who will help decide whether Jackson gets the job is Connecticut Democrat Richard Blumenthal. He's on the Senate committee for veterans affairs (ph), and he was also a reservist in the Marines in the 1970s. Good morning, Senator.

RICHARD BLUMENTHAL: Good morning to you. Thank you for having me.

KING: We're glad to have you. Before we move on to Ronny Jackson, I want to quickly get your take on the firing of Dr. Shulkin. What's your understanding of why he was let go?

BLUMENTHAL: I take the president at his word - that he was dissatisfied with his performance. But he contributed a lot to the VA at very difficult times. And I think that Dr. Jackson is going to face a buzz saw of skepticism and scrutiny about his management expertise and ability to face exactly the challenges that Dr. Shulkin eventually found unsurmountable (ph).

KING: We'll talk about that buzz saw in a second. But we did talk to Dr. Shulkin on MORNING EDITION yesterday, and he suggested that one issue behind his being let go may have been his views on privatization at the VA. Let me have you listen to him for a sec.

(SOUNDBITE OF ARCHIVED BROADCAST)

DAVID SHULKIN: It's essential for national security and for the country that we honor our commitment by having a strong VA. I was not against reforming VA, but I was against privatization. Do you think his use played a role in his dismissal?

BLUMENTHAL: There is no question that a segment and maybe a dominant part of the Trump administration is looking to privatize the VA health care system. Dr. Shulkin resisted it and rightly so. I have no question that his opposition to privatization played a role in his dismissal. And it will play a role in the confirmation hearings that Dr. Jackson face because he's going to have to state unequivocally and clearly that he, too, opposes privatization for his nomination to be confirmed in my view.

KING: Will you ask him during the confirmation hearing if he does?

BLUMENTHAL: I will not only ask him to state his views, I will eventually demand, respectfully, but still very directly that he commit that he will sustain and, in fact, improve the current VA health care system rather than abandoning it, in effect, to a privatized system that relies on private providers rather than the VA facilities. There is a role for private providers when the wait are too long or the length of time and distance are too large. But the VA health care facility serves, very well, many veterans needs. And it should be improved to be a first-rate, world-class system rather than gradually reduced and abandoned.

KING: Dr. Jackson is a career military doctor. He also served as a personal doctor to President Obama. But the VA is a very big bureaucracy. Do you have specific concerns about his ability to lead such a large organization?

BLUMENTHAL: You know, the VA is kind of like the Mount Everest of public management challenges. It is the second largest agency in the government. It's a sprawling bureaucracy of 360,000 people with a budget of 186 billion. And it will present a challenge. And I have very strong questions about Dr. Jackson's expertise and experience to lead that kind of very, very challenging management bureaucracy.

KING: Questions that you will get to put to him. Senator Richard Blumenthal, Democrat of Connecticut, thank you so much.

BLUMENTHAL: Thank you.

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20 - MSNBC (Video): [Reines: 'There's never been a no vote against a VA nominee, this might be the time to change that record'](#) (30 March, 11.8M uvm; New York, NY)

In yet another White House personnel shakeup, President Trump ousts Secretary of Veterans Affairs David Shulkin and appoints his personal doctor Ronny Jackson. Philippe Reines, former adviser to then-Secretary of State Hillary Clinton, and Shermichael Singleton, former Deputy Chief of Staff for the Department of Housing and Urban Development, discuss with Kristen Welker whether the president's new appointee is qualified for the position. The panel also joins Ari Melber, host of MSNBC's The Beat, to weigh in on the breaking news of a federal judge denying Stormy Daniels' motion to depose Trump.

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21 - The Hill: [Trump VA pick hesitated to take job: report](#) (30 March, Max Greenwood, 11.8M uvm; Washington, DC)

White House physician Ronny Jackson initially hesitated at the suggestion that he be nominated to lead the Department of Veterans Affairs, The Washington Post reported Thursday.

Jackson was reportedly shocked when Trump tapped him for the top job at the nation's second largest government agency, the Post reported, citing senior White House officials.

The sources said that when aides initially gauged Jackson's interest, he hesitated. But Trump continued to push for the nomination, insisting that the White House physician was his top choice.

One senior White House official described the interview process to the Post as very informal and without the extensive vetting typical for a Cabinet appointment.

The choice of Jackson has prompted concern among some White House aides, who have privately expressed unease about Jackson's lack of experience managing a large organization.

The New York Times reported Wednesday that some aides acknowledged that Trump's personal relationship with Jackson carried more weight in the decision to nominate him to the VA job than the doctor's professional experience.

Jackson performed Trump's first physical exam since taking office in January, and assured reporters of the president's good health in an hourlong press briefing shortly after that.

The White House has insisted that Trump has full confidence in Jackson's ability to lead the VA, and has pointed to his experience in the Navy as a valuable asset.

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22 - New York Daily News: [A novice in the VA OR: Dr. Ronny Jackson is a very puzzling choice to lead a Veterans Affairs turnaround](#) (31 March, 26.1M uvm; New York, NY)

The 20 million-plus veterans of the U.S. Armed Forces served this country with the eminently deserved expectation that their country would serve them.

Now even as the heart of that trust, the VA health care system, recovers from deadly delays in getting patients care, and after summarily dispatching his first head of the U.S. Department of Veterans Affairs, David Shulkin, President Trump inflicts risky experimental treatment, nominating as the new chief a doctor who has never come close to the operating room of managing a large organization — never mind one with nearly 378,800 employees.

The distinguished career of Rear Admiral Ronny Jackson, a medical doctor, has put him everywhere from the Iraq battlefield to the deep sea, demonstrating impressive courage and resourcefulness, starting from humble roots in Texas.

In recent years he has served as the White House physician, in which capacity he pronounced Donald J. Trump to be in excellent health. His team of 58 or so medical pros treats a few thousand executive employees, including cabinet members and senior staff.

No doubt Trump is fond of Jackson, and Jackson in no position to decline the demand of his commander-in-chief. So it must fall to the Senate to make full use of its confirmation powers to press Jackson on the hows, whys and wherefores of delivering complex services across more than 1,200 facilities.

This, after the VA's inspector general laid at Shulkin's feet alarming failures that ranged from inventory mismanagement to costly accounting laxity to misapplication of anesthesia. And Shulkin was an experienced hospital administrator who once ran New York City's own Beth Israel.

If Jackson cannot prove himself poised to do any better, he should not get the job.

Congress must also stay alert to forces eager to meddle with VA's core mission and services by putting vets' health care in the hands of for-profit businesses, a possibility Shulkin warned of after his firing in an extraordinary New York Times Op-Ed.

"I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits," he wrote, "even if it undermines care for veterans."

To the extent private players can deliver better services for less money, go for it. Indeed, greater freedom to visit private physicians was a breakthrough in solving the VA's patient-care crisis.

But Shulkin's dark prognosis casts doubt that improving the VA's own services is part of the plan. A Department of Veterans Affairs that fails to put veterans first, middle and last will be unworthy of the name.

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23 - NPR (All Things Considered, Audio): [Veteran Congressman On Trump's New VA Secretary Nominee](#) (31 March, 22M uvm; Washington, DC)

President Trump has picked Rear Adm. Ronny Jackson to be secretary of Veterans Affairs. Veteran and Rep. Mike Coffman (R-Colo.) tells NPR's Michel Martin why he supports the new leadership.

MICHEL MARTIN, HOST:

We're going to start the program today with the recent shakeup at the Department of Veterans Affairs. President Trump nominated Rear Admiral Ronny Jackson, the top White House physician, to replace Dr. David Shulkin as secretary of the Department of Veterans Affairs. It's a huge and complex job overseeing medical facilities around the country, hundreds of thousands of employees, not to mention programs that distribute hundreds of millions of dollars in benefits to veterans and beneficiaries. Jackson will need to be confirmed by the Senate before he officially steps into the job.

Needless to say, no one veteran can speak for all veterans, but we thought we'd like to hear from one of the military veterans serving in Congress, so we called Republican Congressman Mike Coffman. He represents Colorado's 6th District. He serves on the House Armed Services Committee, and he's with us now from Aurora. Congressman, thanks so much for joining us.

MIKE COFFMAN: Thanks for having me.

MARTIN: You served in both the Army and the Marine Corps. So if I may, thank you for that. So I understand that you have expressed the frustration that the incumbent of that position, whoever it is, needs to clean house. The question is, does Dr. Jackson have the kind of experience leading a large, complex organization to not just clean house but then to fix the house? Do you think he has that experience?

COFFMAN: Well, no matter how good he is, no matter what experiences he has, if he's not going clean the house, the VA will not change. It did not change under Secretary Shulkin. It did not change under Secretary McDonald. It did not change under Secretary Shinseki before then because none of them took the actions to clean house at the top. And I think that he clearly needs a strong deputy secretary who has a lot of administrative skills in terms of managing an organization that is over half the size of the United States Army.

MARTIN: Some of the veterans organizations, and frankly, some members of Congress, suspect that the real agenda here is to move faster toward privatization. Do you think that that's true?

COFFMAN: No. I know Secretary Shulkin had raised that issue. But, no, I think it's going to be the preservation of the Choice Act, which essentially states if a veteran lives a certain distance away from a VA facility or if a veteran can't get an appointment wait time within a reasonable period of time that that veteran have access to community providers that augment the capacity of the VA health care system. That program is temporary. Now we want to reauthorize it and make it permanent, make it work. It's not working very well. But that's not privatization. I think that that's just a red herring.

MARTIN: I'm wondering if you have any sense of what the Senate's posture is toward this nomination. Do you have any sense of - what are you hearing?

COFFMAN: I think he needs - in order to be confirmed, I believe he's going to have to dispel this notion of privatization. He certainly can be supportive of augmenting the Department of Veterans Affairs with community providers under the Choice program. But if he does do what Secretary Shulkin says he will do, which I don't believe he will do, he will not be confirmed.

MARTIN: Before we let you go, Congressman, it's an election year. There's a Democrat running against you, Jason Crow, who is also a veteran. A number of veterans are, you know, running this year. I wonder if you feel that that kind of interest in running for office among veterans might be part of the thing that creates a change here?

COFFMAN: Well, I think that it's good that we have veterans running and serving in Congress, either it's on the veterans committee or on the Armed Services Committee. I think there are a deficit of veterans serving on those committees that are entrusted to make very key policy decisions. And I think that that's the individual to understand those issues is another veteran.

MARTIN: That's Congressman Mike Coffman, Republican of Colorado, who represents the 6th Congressional District in Colorado. He was kind enough to join us from Aurora. Congressman, thanks so much for speaking with us today.

COFFMAN: Oh, thanks so much for having me.

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24 - The Washington Post (Video): [Does Trump believe in the value of expertise, or does he disdain it?](#) (31 March, Dan Balz, 43.9M uvm; Washington, DC)

The shake-up at the Department of Veterans Affairs — out with Secretary David Shulkin and potentially in with White House physician Ronny L. Jackson — is being portrayed, correctly, as President Trump surrounding himself with Cabinet officials with whom he feels personally comfortable. A broader question arises, however, over the extent to which this president prizes or disparages expertise.

Defenders of the president can point to his national security team to rebut suggestions that he resists recruiting people with experience and expertise to advise him. Though he has run through more than his share of foreign policy advisers, one reality is that they have mostly brought either military, business or relevant congressional experience to their positions.

That was certainly true of his early team: Defense Secretary Jim Mattis, national security adviser H.R. McMaster, Secretary of State Rex Tillerson, CIA Director Mike Pompeo and Homeland Security Secretary John F. Kelly, who has since become White House chief of staff. McMaster and Tillerson are on their way out, however, with Pompeo nominated for State and John Bolton selected as the president's third national security adviser.

Bolton comes to the job with many critics, who see him as far too hawkish at such a dangerous time internationally. But he is no novice when it comes to the issues, nor is he a stranger to the inner workings of government and the bureaucracy. For Pompeo's replacement, Trump has picked CIA Deputy Director Gina Haspel, a career intelligence official. She could face a challenging confirmation process but nonetheless has strong support from former intelligence community officials for her capabilities and experience.

The domestic side of Trump's Cabinet is another story. Shulkin was a holdover from the Obama administration and early on was praised — even singled out — by Trump for his leadership of an agency long plagued by scandal and inefficiencies. Though he had the background to run the agency, he leaves under a cloud of his own making — the misuse of taxpayer money that drew

a rebuke from the department's inspector general. In his final weeks, he ran a divided agency bunkered in his office, as portrayed vividly by The Washington Post's Lisa Rein. Shulkin is among several Trump Cabinet officers who have faced ethical questions.

Trump concluded a change was needed and looked no farther than inside his own White House, tapping Jackson, even though the White House physician has had no experience running a big operation, let alone something as complicated and dysfunctional as VA. What counted in the decision seemed to be Jackson's compelling performance briefing reporters about the president's physical examination.

Look beyond VA.

Ben Carson was one of the world's foremost pediatric neurosurgeons before he entered politics, and he had a compelling personal story of rising from the inner city of Detroit to the highest ranks of medicine. But he had never served in government, nor did he have specific credentials to oversee the Housing and Urban Development Department. His main qualification seems to have been running against and later endorsing Trump.

Carson has made little substantive mark at HUD, though he has recently been caught up in the embarrassment of having a \$31,000 dining set ordered for his private office. Testifying before Congress, Carson declined to accept full responsibility for the purchase, saying he had left redecorating to his wife and others and "dismissed myself from the issues." Days later, he took responsibility.

At the Education Department, Secretary Betsy DeVos arrived on a mission — to build up charter schools and to push for school choice and school vouchers, while reducing the federal government's role in education — issues she championed as a Republican activist and philanthropist in Michigan. She has no experience in the classroom, nor has she overseen a local school district or served in a state government education position, the backgrounds of recent education secretaries.

That DeVos was a polarizing choice was not a surprise, given the policies she believes in and her political advocacy before coming to Washington. Her lack of preparation about the status of public education and schools was displayed most recently on national television earlier this year when she was interviewed on CBS's "60 Minutes" and repeatedly could not answer questions from correspondent Lesley Stahl.

Others in the administration — Environmental Protection Agency head Scott Pruitt the most prominent — reject the overwhelming scientific consensus about climate change.

Expertise isn't everything. Vietnam showed how even the so-called best and brightest could lead the country astray. It was then-House speaker Sam Rayburn (D-Tex.) — who after hearing then-vice president Lyndon B. Johnson rave about the brains and credentials of the Cabinet assembled by President John F. Kennedy — reportedly said, "Well, Lyndon, they may be every bit as intelligent as you say, but I'd feel a whole lot better if just one of them had run for sheriff, once."

Rayburn's instincts proved tragically correct, showing that brains alone weren't sufficient for those in positions of responsibility and that both an absence of hubris and a connection to everyday Americans were vital to the careful exercise of power. But he also understood, as one

of the strongest House speakers in history, that to be successful, he needed an intimate understanding of the institution and the people he was leading.

In today's political climate, skepticism of expertise is widespread.

During a television interview ahead of the Brexit vote, Michael Gove, a British Conservative Party official, was read a list of domestic and foreign leaders, including then-president Barack Obama, who were uniformly warning that leaving the European Union would have dire consequences for the United Kingdom.

"I think the people in this country have had enough of experts with organizations with acronyms saying that they know what is best and getting it consistently wrong," Gove famously replied.

He was proved right when the British public voted narrowly to leave the E.U., a vote that foreshadowed the even bigger earthquake months later in the 2016 U.S. presidential election, when Trump defeated Hillary Clinton, the embodiment of the country's political and cultural elite.

Trump played on those anti-expertise sentiments as a candidate, appealing to voters to reject the establishment's policies and leadership, and instead to trust themselves and especially him, a political novice. He carried that viewpoint to an extreme when, at the Republican National Convention, he declared, "I alone can fix it."

Trump's presidency continues as an extension of that pronouncement, with the nation's leader increasingly trusting in himself rather than those around him on critical decisions. Some — not all, but some — of his personnel choices underscore the related belief, that expertise or relevant experience is overrated, perhaps even a handicap. It is an experiment, to say the least, and a risky one at that.

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25 - Politico Magazine: [When Our President Put His Doctor in Charge of Everything](#) (31 March, Marius Stan and Vladimir Tismaneanu, 23.9M uvm; Arlington, VA)

No one knows more about leaders' bodies than their personal physicians. Notoriously, Joseph Stalin mistrusted the Kremlin doctors, whom he suspected of trying to poison him and the other Soviet magnates. In February 1953, a month before Stalin passed away, they were arrested and horribly tortured. The ones still left alive were too terrified to treat him as he lay dying in March.

An avowed Stalinist, the late Romanian dictator Nicolae Ceausescu held a different vision for his medical entourage. Not only did he trust his doctors, he also made one of them—professor Theodor Burgele—the country's minister of health. Even by the standards of Romanian dictatorships, this was new. So as U.S. President Donald Trump taps the White House physician to head the Department of Veterans Affairs, a vast and sprawling bureaucracy, he might want to brush up on some recent Romanian history.

It's not that Burgele, the former rector of the respected Bucharest Institute of Medicine and Pharmacy (the country's top medical school), was not a capable person. He was, but his administrative experience was limited to a small-size bureaucracy. He was said to be an excellent urologist, a decent person and a respected professor. As a surgeon, he was highly regarded. But the Ministry of Health was a different business. What Ceausescu wanted to

emphasize with such an appointment was that human life was a state affair and that he, as the supreme leader, could sweep aside any past criteria of administrative competence. According to our sources, Dr. Burghela was quite reluctant to accept the ministerial job, but no one in the Securitate-controlled regime could say NO to Ceausescu without facing unpleasant consequences. So, Burghela said yes and served between 1972 and 1975. During this period, he reluctantly complied with Ceausescu's increasingly erratic orders and eventually, he resigned.

Another telltale case was Dr. Iulian Mincu, Ceausescu's last personal doctor, whom he entrusted with designing the notorious Rational Nourishment Program, a set of draconian policies imposed in the 1980s to justify starvation in the name of medical progress. Ersatz food (adulterated oil made from unrefined soy, fake cheese fluffed up with flour, dregs of meat like chicken claws, fake coffee called "Nechezol," and so on) proclaimed superior to natural products. In the meantime, the regime could export food for hard currency. For instance, one ration card for one person in the city of Gala i, eastern Romania, from the late 1980s contained: Bread—300gr/daily; poultry—1 kilo/month; pork or beef—500gr/month, or meat cans from Czechoslovakia or the Soviet Union as replacements; other meat products (salami, sausages, usually made of soy)—800gr/month; salted cheese—500gr/each trimester; butter—100gr/month; oil—750ml/month; sugar—1 kilo/month; corn flour—1 kilo/month; flour—1 kilo/each semester; eggs—8 to 12/month; and a supplement for hard workers, meaning 300 more grams monthly for diverse products.

In spite of his dismal record—including a deliberate concealment of HIV and AIDS data in the 1980s—Dr. Mincu was resurrected after the Romanian December 1989 revolution as Minister of Health under the reign of Ceausescu's authoritarian successor, Ion Iliescu. During a research interview in 2007 conducted by one of this article's authors (Marius Stan), Mincu stood by his bizarre food ideas and denied any wrongdoing.

One of the lessons from these two Romanian stories is that expertise matters decisively. Another is that proximity to the leader (even if he or she is democratically elected, as Trump was) does not qualify one for running huge bureaucracies in need of urgent overhaul. Managing complex organizations is a skill in its own right. Putting someone unqualified in charge of a massive system such as the Romanian Ministry of Health could lead to amateurism, improvisation and, eventually, mission failure. In our case, it did—twice.

This seems to be the case right now in Washington: A person with impressive credentials in terms of running small medical units, Dr. Ronny Jackson, has suddenly been catapulted to the top of a government agency dealing with veteran affairs—thanks in no small measure, it seems, to his robust defense of Trump's personal health. Yet taking the president's blood pressure or even performing surgery, the Romanian case suggests, has nothing to do with being in charge of major institutions that affect the lives of millions. Ceausescu was certain that personal loyalty to him was the most important quality of any top official. He shared this illusion with most of the last century's dictators. Is this now a litmus test for promotion in the Trump administration? At the end of the Ceausescu regime, the Romanian health system was a complete disaster. Intrahospital infections and scarcity of medical drugs were rampant. Doctors' salaries were miserable and, in order to increase their incomes, many expected to be paid with Kent cigarettes, whiskey, and other coveted goods. As a result of the restrictive reproductive health policies enforced under the 25-year Ceausescu dictatorship, Romania ended the 1980s with the highest recorded maternal mortality of any country in Europe—159 deaths per 100,000 live births in 1989.

One can only hope America's veterans will fare better. For Ceausescu, such promotions meant an assertion of his autocratic ruling style. Like Italy's Benito Mussolini, he saw himself as the successor to Roman emperors. And, as we know, Caligula could appoint anyone to any position, even the Roman Senate. On the other hand, no one is ever better placed than a personal doctor to subvert the tyrant's glorious self-image with a few well-placed details—see Li Zhisui's devastating critique of Mao Zedong as a manipulative egomaniac who boasted about his unorthodox sexual appetites. Dare we quote William Gladstone's suddenly apt admonition? "The disease of an evil conscience is beyond the practice of all the physicians of all the countries in the world."

Marius Stan is research director of the Hannah Arendt Center at the University of Bucharest. Vladimir Tismaneanu is professor of politics at the University of Maryland, College Park. They have a co-authored book coming out from Cambridge University Press in May 2018, Romania Confronts its Communist Past. Democracy, Memory, and Moral Justice.

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26 - CBS News (Face the Nation, Video): [Sen. Bernie Sanders on "Face the Nation," April 1, 2018](#) (1 April, 26M uvm; New York, NY)

President Trump announced the ouster of David Shulkin as secretary of Veterans Affairs this week, nominating longtime White House physician Adm. Ronny Jackson as his replacement. Shulkin had come under withering criticism from lawmakers on Capitol Hill over his travel expenses and a blistering inspector general's report on conditions at the VA.

Sen. Bernie Sanders, an independent from Vermont, is the ranking member of the Senate Budget Committee and former chairman of the Senate Committee on Veterans Affairs. He joined us to discuss the reforming the VA, Jackson's nomination and more.

The following is a transcript of the interview with Sanders that aired Sunday, April 1, 2018, on "Face the Nation."

MARGARET BRENNAN: We turn now to Vermont independent Senator Bernie Sanders who sits on the Senate Veterans Affairs Committee. He joins us from Burlington in his home state this morning. Senator the VA is the largest health care system in this country. Will you support Dr. Ronnie Jackson as the nominee?

SEN. BERNIE SANDERS: Well we know nothing about what Dr. Jackson stands for and what his vision is for the VA. But Margaret this is what I will tell you. What concerns me very much is that right now in Washington we have a family called the Koch brothers, third wealthiest family in America a family that is prepared with a few of their other billionaire friends to spend four hundred million dollars on the coming elections. They are now the most powerful political force in America, stronger than the Democratic National Committee or the Republican National Committee. Their view has been we have got to privatize, privatize and privatize. And what Dr. Shulkin, who Trump just fired this week has told us is that the reason for his firing is that he resisted privatization of the Veterans Administration. Now I work very closely with the major veterans organizations, the American Legion, VFW, DAV Vietnam vets all of the veterans organizations. And what they say is they want to strengthen the VA not dismember it, not privatize it. So we will see what Dr. Jackson has to say.

BRENNAN: Well the White House says at this time they have no intent to privatize the VA. Do you know what the Trump administration policy is?

SANDERS: Yeah of course I do. They have been putting more and more money into the private sector with VA money. I do not believe them on that issue. I think they are listening to the Koch brothers and I think that that is a very, very bad idea. If you listen to veterans all across this country as I do they will tell you sure there are problems with the VA but by and large once they get into the system they are proud of the quality that the - quality care that the VA provides in fact the American Legion has just come out with a publication which vigorously opposes privatization. So I do believe that the Trump administration no matter what they are now saying I think they are working on behalf of the Koch brothers, look these are the guys, Koch brothers who want to privatize everything. You have a Trump administration that in their budget, the Trump budget proposed 500 billion dollar cuts in Medicare. Trillion dollar cuts in Medicaid. You have a Secretary of Education who doesn't believe in public education a head of the EPA.

BRENNAN: Sir on the issue of the VA you did last year vote for a bill that allowed at least more leeway for veterans and their doctors -

SANDERS: Right.

BRENNAN: - to decide whether they wanted to opt in for private care. So it sounds like you are open to some private sector option here.

SANDERS: Well there has always been private sector option if you live in a rural community you don't want 75, 80 year old veterans to travel two hours to get a physical examination. If there is a VA facility in the country that is not treating veterans in a timely manner of course you want to allow veterans to go to the private sector. That is the case now that has always been the case. But what the Koch brothers want and what I feared the Trump administration wants is to rip that wide open and to take many. We got a 200 billion dollar veterans budget.

BRENNAN: Yeah.

SANDERS: There are special corporate interests that want a big chunk of that money. We must not allow that to happen.

BRENNAN: Senator we have to take a quick break and we'll talk to you on the other side of it. We'll be right back.

SANDERS: Thank you.

(COMMERCIAL BREAK)

BRENNAN: Welcome back to "Face the Nation." I'm Margaret Brennan. We're back now with Vermont independent Senator Bernie Sanders who is going to be asking some tough questions of that next nominee to be the VA secretary, Senator. The VA says the average wait time at some facilities can be as long as 100 days. President says he's not happy with the speed of reform there. What is the source of this problem?

SANDERS: Well look the VA is the largest integrated health care system in the country. And as I said previously if you asked the veterans organizations they by and large think the VA is providing good quality care. You know Margaret there is a lot of attention paid to the VA

because it's a government agency. But I've got news for you. People all over this country when they want to get to a doctor or they need hospital care they don't get in the very next day. So I am sure that there are some VA facilities where the waiting time is too long. That has got to be addressed. There are other VA facilities for example I know here in Vermont that if you are dealing with a psychiatric crisis, an emotional crisis you get in that day that's pretty good. So the VA does a lot of good things. It has problems. We have got to improve the VA. But I think we've got to listen to the veterans of this country and not privatize it.

BRENNAN: Senator you also sit on the Environment Committee and you've been a harsh critic of EPA Administrator Scott Pruitt. He's facing a number of questions about ethics and these new reports that he rented a residence here in Washington partly owned by the wife of a top energy lobbyist whose firm did business with the EPA. Do you think your committee should hold hearings on this?

SANDERS: I do. But I think the issue goes well beyond that problem. The issue goes to the fact that the vast majority of people in this country understand that climate change is real. It is already doing devastating problems throughout our nation and throughout the world and yet we have a president and a head of the EPA who do not even recognize the reality of climate change let alone the need to transform our energy system away from fossil fuel to energy efficiency and sustainable energy. So you got a guy who's head of the EPA now who is nothing more than a front man for the fossil fuel industry and that is a very serious problem and the Congress has got to stand up and oppose that line of policy.

BRENNAN: I imagine you oppose the lowering of emission standards that the administration is expected to announce this week.

SANDERS: Well, of course. I mean what we have got to do is understand that we have over the last number of years made success against air pollution and against water pollution. We have made some success in transforming our energy system and the idea to go back and listen to the short term needs of the coal industry or the oil industry makes no sense to me at all. Look, here is the truth. What the scientific community is telling us is that climate change is one of the great environmental crises facing this planet and if we don't get a handle on that we're going to be leaving this planet - a planet to our kids, that is not healthy or habitable. We've got to address that. The Trump administration is moving in exactly the wrong direction.

BRENNAN: Sir you have been critical of the Israeli government's decision to use lethal force against Palestinian demonstrators killing 15 wounding over 700. The Trump administration has stopped short of calling on Israel for restraint. Should they explicitly do so.

SANDERS: Yes they should look, Gaza as I think everybody knows is a humanitarian disaster. The unemployment rate there is beyond comprehension. And there is just enormous unrest. What the function of the United States government should be right now is to sit down with the Israelis sit down with the Palestinians and figure out how, we can rebuild Gaza and also to tell the Israelis that when you've got tens and tens of thousands of people protesting, they cannot overreact and the idea of 15 or so people being killed and hundreds being wounded is - is to me unacceptable.

BRENNAN: We should note the Palestinian Authority already did boycott a meeting at the White House recently to talk about rebuilding Gaza. Senator thank you so much for your time.

We'll be right back with our political panel.

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27 - CBS News (Video): [Sen. Bernie Sanders says privatizing the VA a "very, very bad idea"](#) (1 April, Emily Tillett, 26M uvm; New York, NY)

Sen. Bernie Sanders, I-Vermont, says that he thinks it's too early to tell what President Trump's pick to take over leadership at the embattled Department of Veterans Affairs "stands for," but cautioned that privatizing the VA to be a "very, very bad idea."

Former VA Secretary Shulkin became the latest member of Mr. Trump's cabinet to be terminated last week. The president announced that he was replacing Shulkin in a series of tweets, and said he would nominate Adm. Ronny Jackson, who had been serving as the president's doctor, to replace him.

"I work very closely with the major veterans organizations, the American Legion, VFW, DAV, Vietnam vets, all of the veterans organizations. And what they say is they want to strengthen the VA, not dismember it, not privatize it. So we will see what Dr. Jackson has to say," said Sanders.

Transcript: Sen. Bernie Sanders on "Face the Nation," April 1, 2018

Shulkin came under fire for a series of blunders including reported insurgencies inside his own department and improper use of travel expenses. The former secretary said he was ousted over internal and administration disputes over privatizing the VA.

"Privatization leading to the dismantling of the department's extensive health care system is a terrible idea. The department's understanding of service-related health problems, its groundbreaking research and its special ability to work with military veterans cannot be easily replicated in the private sector," Shulkin wrote in an op-ed for the New York Times last week.

Sanders agreed, saying that while the VA has problems that need to be addressed, "We've got to listen to the veterans of this country and not privatize it."

"If you listen to veterans all across this country as I do they will tell you sure there are problems with the VA but by and large once they get into the system they are proud of the quality care that the VA provides."

He added, "There is a lot of attention paid to the VA because it's a government agency. But I've got news for you. People all over this country, when they want to get to a doctor or they need hospital care, they don't get in the very next day. So I am sure that there are some VA facilities where the waiting time is too long. That has got to be addressed. There are other VA facilities -- for example, I know here in Vermont that if you are dealing with a psychiatric crisis, an emotional crisis you, get in that day. That's pretty good."

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28 - Politico: [Sanders: 'We know nothing' about Trump's VA pick](#) (1 April, Connor O'Brien, 23.9M uvm; Arlington, VA)

Sen. Bernie Sanders wouldn't commit to supporting President Donald Trump's pick to lead the Department of Veterans Affairs, Rear Adm. Ronny Jackson, on Sunday.

In an interview on CBS' "Face the Nation," the Vermont independent noted that Jackson, Trump's personal physician, is a virtual unknown on veterans issues. He also expressed concerns the Trump administration is pushing to privatize the nearly \$200 billion bureaucracy, citing the conservative agenda of the influential donors Charles and David Koch.

"We know nothing about what Dr. Jackson stands for and what his vision is for the VA," Sanders said.

Trump replaced VA Secretary David Shulkin last week after months of criticism over reports he misused government travel. Shulkin has since said he was forced out for pushing back against efforts to privatize veterans services.

Jackson's nomination came as a surprise. And the pick has raised questions about his qualifications to manage the myriad health services and benefits provided by VA and whether the administration is indeed pressing to privatize more veterans services.

"I do believe that the Trump administration, no matter what they are now saying, I think they are working on behalf of the Koch brothers," Sanders said, adding they "want to privatize everything."

"They have been putting more and more money into the private sector with VA money. I do not believe them on that issue," he added. "I think they are listening to the Koch brothers and I think that that is a very, very bad idea."

While he helped negotiate additional funding for veterans to access private medical care, Sanders, a former Senate Veterans' Affairs chairman, has said beefing up VA's budget and health services should be the priority.

"The VA does a lot of good things. It has problems. We have got to improve the VA," Sanders said. "But I think we've got to listen to the veterans of this country and not privatize it."

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29 - The Hill: [Sanders: I will work against any VA nominee backing privatization](#) (1 April, Mallory Shelbourne, 11.9M uvm; Washington, DC)

Sen. Bernie Sanders (I-Vt.) said Sunday he will work against any Veterans Affairs (VA) nominee who supports privatizing the agency.

"I will do everything I can as a member of the veterans committee not to approve any nominee who is not going to strengthen the VA and who will oppose privatization," Sanders told CNN's "State of the Union."

The comments from Sanders come after Trump announced Rear Adm. Ronny Jackson, who currently serves as the presidential physician, would replace David Shulkin as the Secretary of Veterans Affairs.

Shulkin penned an op-ed in The New York Times opposing the privatization of the agency after his exit and saying there are officials within the administration pushing for it.

Sanders, a member of the Senate Veterans' Affairs Committee, said veterans' organizations argue the agency should be strengthened rather than privatized. He also blamed billionaire brothers Charles and David Koch, arguing their influence over the Trump administration is what's pushing privatization.

"So what you're looking at under the leadership of the Koch brothers, is a massive effort to privatize agencies of the United States government and give them over to private corporations," said Sanders. "That is what the removal of Shulkin is all about."

The Koch brothers did not contribute to Trump's presidential campaign, breaking with years of donations to Republican candidates.

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30 - Miami Herald: [Trump's doc shouldn't be a slam dunk to lead Veterans Affairs](#) (1 April, Editorial Board, 8.9M uvm; Miami, FL)

The U.S. Department of Veterans Affairs has enough problems. It doesn't need one in the form of a leader who, very possibly, has no idea what he's doing.

In yet another nomination made under President Trump's "You'll do — for now" philosophy of hiring the "very best people," White House physician Ronny Jackson is up for the vital job of secretary of Veterans Affairs.

If confirmed by the Senate, Jackson will replace David Shulkin, a rare and respected Obama administration holdover who sullied his tenure by not only misusing taxpayers' funds to take a swell trip to London and Copenhagen. His wife's expenses were also paid for by the government. A bit of business, indeed, was done — meetings and such — but then there was the shopping, the castle tours and tickets to the Wimbledon tennis finals, free of charge, in violation of rules that ban gifts to government employees.

Shulkin defended the trip, blamed the media — in this case the Washington Post, which broke the story — and worst of all, lied about it. In addition, he enlisted colleagues to assist in the coverup. According to a VA inspector general's report, Vivieca Wright Simpson, Shulkin's chief of staff, rejiggered documents to make it seem as if Shulkin had received an award in Copenhagen. He didn't. In fact, no such award existed.

Simpson, ahem, has retired. Last week, Shulkin was out, rightly.

In Miami alone, the Veterans Administration's medical facilities do not always measure up, failing the people who have put their lives on the line for this country through military service, but putting those lives in danger again when they need that care back home. In February, an

investigation confirmed discrepancies in HIV test results when some veterans were also tested by an outside lab.

Last fall, an inspection found the public cafeteria in Miami's VA healthcare system egregiously unsanitary — pest droppings, unrefrigerated foods and the like. Though hospitalized vets were not served meals from this cafeteria, the point is that no one should be exposed to the dangers of unclean conditions. And that's just in one region. The VA is the second-largest department in the federal government, with almost 400,000 employees and more than 1,200 health-care facilities.

President Trump nominated Jackson to replace Shulkin. Jackson's credentials as a medical doctor are solid. His ability to run this consistently challenged system? Not so much in evidence. In fact, there is little in his professional background that shows he has what it takes to ensure the VA can truly serve its clients. This is one more nomination that should not be rubber-stamped.

The Senate, if it truly cares for the nation's veterans, will ask Jackson the tough, uncomfortable questions and say No if he's deemed deficient.

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31 - Washington Examiner: [Bernie Sanders: Ronny Jackson will bend to pressure to privatize the VA](#) (1 April, Kyle Feldscher, 4.8M uvm; Washington, DC)

Sen. Bernie Sanders, I-Vt., said he thinks Dr. Ronny Jackson will likely be tasked with privatizing the U.S. Department of Veterans Affairs due to his lack of experience manning a large organization.

Sanders said on CNN's "State of the Union" Jackson, the White House physician and a rear admiral in the U.S. Navy, doesn't know much about heading a large bureaucracy. If he's the one Trump picked to replace David Shulkin, ousted on Wednesday, Sanders said, then he must be in favor of privatization.

"He has no experience in this area but I would strongly suspect that if you get rid of Shulkin, who opposed privatization, and you put in Dr. Jackson, that is what his mission will be," Sanders said.

Sanders, an independent who caucuses with the Democrats, said one only needs to look at the past decisions of the Trump administration to know what the end result will be.

Sanders said the Koch brothers, powerful Republican donors, are going to push for privatization and the administration will likely accede.

"What the Koch brothers believe is not just that we have to privatize the Veterans administration, they want to privatize Medicare, and the Trump administration had a \$500 billion cut in Medicare," he said. "They want to privatize Medicaid. They had a trillion-dollar cut in Medicaid. They're beginning to go after Social Security."

"We have a secretary of education who does not believe in public education. A secretary of the environment, EPA, who does not believe in environmental protection. So, what you're looking at

under the leadership of the Koch brothers is a massive effort to privatize agency of the U.S. government and give them over to private corporations.”

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32 - Newsday: [Senate should be wary of Dept. of Veterans Affairs nominee](#) (1 April, Editorial Board, 3.2M uvm; Melville, NY)

Caring for our nation’s military veterans was one of Donald Trump’s most consistent promises on the presidential campaign trail, and certainly one of his least controversial. Getting veterans the care they need is a nonpartisan priority.

But the increased quality of care Trump promised hasn’t come.

Facilities on Long Island and in many other communities are falling apart. The Department of Veterans Affairs is increasingly being exposed as dangerous and dysfunctional. Last week, as was expected, Trump fired the secretary of veterans affairs, David Shulkin, who could never rise above his ethical violations and his shoddy leadership. His designated replacement is Navy Rear Adm. Ronny Jackson, the White House physician for the past three administrations who garnered praise from Trump for performing well during a news conference about the results of the president’s physical exam.

While Jackson is highly regarded as a physician, his resume does not include a shred of evidence that he can lead the government’s second-largest bureaucracy (it has a \$186 billion budget) and probably its most dysfunctional. This might be the toughest management job in Washington.

Before the Senate confirms Jackson, it must elicit his views on further privatization of medical care, which other Trump appointees are recklessly pushing as a way to dismantle the agency instead of providing improved service. And unless the Senate can ensure that Jackson can overcome his lack of management experience and create a solid plan for building a leadership team that can improve care, it should reject his nomination.

Here on Long Island, the problems are increasingly daunting, and care for our veterans is suffering. Last month, we learned that the Northport VA Medical Center was again forced to stop performing surgeries when a faulty air conditioner forced the hospital to close all five of its operating rooms. The shutdown went on for about a week, and 18 surgeries had to be rescheduled while the \$58,000 repair was performed.

That’s only the latest breakdown at the Northport facility, where surgeries were halted for four months in 2016 when another air-conditioning system failure sent metal fragments flying into the air, threatening to contaminate patients with open wounds. Another cooling system problem a year earlier led to pipe ruptures and a \$12 million repair. And in January, Northport had to close its 42-bed veterans homeless shelter after the heat failed.

A recent report estimated the cost of Northport’s repair and renovation to be \$273 million. Long Island’s 130,000 veterans rely heavily on the facility, which has traditionally maintained a top reputation. Its quality cannot be allowed to decline.

If Jackson is confirmed, Trump, who has a warm personal relationship with his nominee, must make sure their communications remain constant. Jackson will need the president's full support to get the VA running properly and all of its facilities up to par, including Northport.

We owe these veterans. There can be no reneging. — The editorial board

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33 - Las Vegas Sun: [Heller's dilemma: Side with Trump or veterans on VA pick](#) (1 April, Editorial Board, 1.5M uvm; Las Vegas, NV)

Assuming Donald Trump follows through in nominating Dr. Ronny Jackson to lead the Department of Veterans Affairs, Sen. Dean Heller will soon face an ugly consequence for becoming a team player for the president.

For Heller, Jackson's confirmation offers a lose-lose proposition. Either he votes against Jackson and runs the risk of getting dinged by Trump before the midterm elections, or he votes for Jackson and alienates veterans groups that have raised concerns about the White House doctor's qualifications for the position.

Granted, Jackson deserves a fair confirmation hearing, and maybe during his testimony he'll be able to convince Americans that he's the perfect person for the job.

But that's an enormous maybe, given Jackson's razor-thin resume for the job.

The biggest organization Jackson has overseen numbers in the several dozens. The VA employs 360,000 people, has a \$186 billion budget and is the second-largest entity in the federal government, ranking only behind the Pentagon.

This is an organization that was once led by the former CEO of Procter & Gamble, a former member of the U.S. House and a former high-ranking official with the Disabled Veterans of America, among others.

Jackson's qualifications appear to be that he served in the Navy and is apparently a fine doctor. Trump reportedly also likes how Jackson looks and thought he did a nice job in handling the January news conference in which he reported the results of Trump's physical examination.

But where Trump saw greatness, others saw a toady whose glowing remarks about Trump seemed like they could have been copied from Kim Jong Un's physician.

Jackson described a man who is noticeably overweight, disdains vigorous exercise and regularly gorges on fast food as being in "excellent" health, and went as far as to say that if Trump had eaten more healthily during the last several years he might "live to be 200." He predicted that Trump would be fine throughout this term and even through a second term. "It's just the way God made him," Jackson said.

This may sound like satire, but for veterans groups it's no joke. It's potentially a life-and-death matter, as advocates have raised concerns that the Trump administration is angling toward privatizing the VA's health services. Privatization, they believe, would erode the quality of care and lead to higher costs.

The outgoing VA secretary, David Shulkin, fueled advocates' concerns in saying the Trump administration saw him as "an obstacle to privatization who had to be removed." The White House responded by saying Shulkin's ouster was not an indication that the administration was moving toward privatization.

But considering that conservatives like the Koch brothers are pushing for the change, veterans advocates are justifiably uneasy.

For Heller, the nomination process comes at an inopportune time politically. Although Trump cleared a path for Heller to the general election by encouraging Danny Tarkanian to seek a House seat instead of opposing Heller, Heller will be heavily targeted by Democrats in the general election and can scarcely risk alienating Trump's base.

Heller has already faced Trump's wrath. After he initially voted not to repeal the Affordable Care Act, Trump "joked" that Heller would come around if he wanted to "remain a senator." Heller did so, and he has been subjugating himself to Trump ever since.

If the Jackson nomination plays out as expected and the doctor proves to be as bad as a nominee as he looks on paper, Nevada's veterans will be watching him closely to see who he cares more about — the nation's 21 million veterans or Trump.

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34 - **Times Union:** [Editorial: VA pick insults veterans](#) (1 April, Editorial Board, 1.5M uvm; Albany, NY)

THE ISSUE:

The president picks his White House doctor to run the second largest federal agency.

THE STAKES:

The health and welfare of millions of veterans rest on what feels more like a casting call.

Donald Trump has long promoted himself as a champion of military veterans, but when he finally had a chance last week as president to demonstrate that they were more than political props for him, he failed miserably.

In the same cavalier way in which he has appointed so many people who have turned out to be disasters in their jobs, Mr. Trump named his White House physician as secretary of veterans affairs. He thus thrust a man with no experience running a big bureaucracy to the helm of the second-largest federal agency. If the Senate goes along with this, Dr. Ronny L. Jackson, a Navy rear admiral, would go from monitoring the president's health to overseeing a department of more than 366,000 employees.

By all accounts, Dr. Jackson is a nice guy. But this is as absurd as taking a pleasant cashier off the register to be CEO of McDonalds, or plucking a friendly delivery boy off his route to run FedEx.

Dr. Jackson's main qualification to head a department bigger than any branch of the military or the Department of Homeland Security seems to be his talking up of the president's health in January, when he credited Mr. Trump with what he assumed must be "incredibly good genes." Mr. Trump could hardly have been more bombastic himself.

All this might be delightfully surprising in a reality TV show sort of way were the stakes not so high. The VA's mission is not one to take lightly. It's responsible for the health care of more than 9 million veterans served by its 145 hospitals, 300 vet centers, and more than 1,200 outpatient sites. It also handles disability and education benefits, home loans, life insurance, pensions and vocational rehabilitation for millions of vets. Choosing a leader for it should not be treated like a casting call.

Dr. Jackson would succeed David J. Shulkin, who was trying to reform a department in need of modernization and marred by scandal over long waiting lists. Dr. Shulkin, however, had a scandal of his own stemming from his overseas travel, giving Mr. Trump a ready excuse to fire him.

There are concerns that this is part of a conservative small-government quest to end the VA as veterans have known it and privatize its work. A lack of competence at the top would no doubt bolster the case for a radical overhaul. That, however, is not something that should be done in haste or on ideological whim any more than the pick for the secretary of veterans affairs should be the last person to check the president's vitals.

Mr. Trump, who never served in the military thanks to five deferments, may see this all as part of the chaos on which he seems to thrive, and which has left his administration with more high-level turnover in 14 months than some presidents have had in entire terms. But the veterans he claims to cherish don't need what passes for excitement in Mr. Trump's life. They've had quite enough, thank you. That's the message the Senate should send back to Mr. Trump if he doesn't rethink this ridiculous appointment.

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35 - Montana Standard: [For pity's sake, don't privatize Veterans Affairs](#) (1 April, Editorial Board, 202k uvm; Butte, MT)

Just when it was starting to look like Montana's veterans could expect a little more stability from the federal agency charged with providing their health care, another major shakeup at the Department of Veterans Affairs has placed the future of their care in doubt.

Of course, the VA has long stood on shaky ground. However, the current push toward privatization, if successful, could completely erode the foundations of this critical agency and leave millions of veterans — and tens of thousands of Montanans — without the support they earned in service to our country.

The VA's experiment with privatization through the Veterans Choice Program provides a good example of the potential risk. The program was created in 2014 in response to audits that found many veterans faced long waiting periods before they could see a physician. Some even died while they were waiting for an appointment, and some VA employees fudged the data to make it appear they had met the official 14-day target.

Congress passed the Veterans Choice bill to fix the problem by creating a new program that would allow veterans who live more than 40 miles away from the nearest VA clinic to see health care providers in their own community. Obviously, this held a lot of appeal for veterans in rural states like Montana. But U.S. Sen. Jon Tester, D-Montana, a ranking member of the Senate Veterans' Affairs Committee, favors scrapping the program and replacing it with a different system.

The bill provided roughly \$2 billion to hire more physicians and nurses, build more facilities and expand services for underserved populations, such as women and those seeking mental health care. Unfortunately, from its inception, Veterans Choice has relied on third-party administrators to manage the program, and their track record has shown a lot of room for improvement. One of the health insurance companies awarded a major contract, Health Net, was severely chastised just last month in a letter from Tester and Sen. Mike Crapo, R-Idaho.

"Our home state providers deserve better than the miserable customer service provided to them by Health Net, who appears to be devoting even less attention to the Choice Program as its expiration nears," wrote the two senators, who also noted providers' complaints that the company has not paid them on time, and when they attempt to collect their payments, Health Net either puts them on hold or ignores them altogether.

In March 2016, Health Net was acquired by an even larger company, the publicly traded Centene Corporation, for a reported \$6.8 billion. Any hopes that the acquisition would lead to improved services were soon dashed when, last year, a whistleblower alerted authorities to Health Net's complete failure to schedule appointments for some veterans in New Hampshire, some of whom had to wait for longer than six months to schedule an appointment despite the fact that they suffered from life-threatening conditions.

That scandal, among others, helped prompt President Donald Trump to sign an executive order providing better protections for whistleblowers within the agency and establishing a more streamlined system of accountability.

Montana is still working through its own whistleblower scandal. A dentist with the Montana Veterans Affairs Health Care System in Billings, Kelly Hale, reported that veterans faced long wait times due to problems with the clinic's management. The report was confirmed through an internal investigation that found problems dating back to mid-2016. After the investigation, the head of dental services, Robert Bourne, resigned but was rehired on a fee basis so he could continue providing dental services.

The Montana VA then put Hale through a misconduct review and tried to terminate his employment. That action is on hold while the Merit System Protection Board weighs whether it was taken in retaliation for Hale's whistleblowing. Meanwhile, Hale remains a paid staff member but is not allowed to see patients, meaning that for many months in 2017, patients were referred to the nearest VA dental clinic — in Sheridan, Wyoming. This past February, the VA finally hired another dentist, but Hale's case is still pending.

Also in February, the Montana VA issued a press release explaining how it is working to overcome an ongoing shortage of primary care providers. In Montana, the system is required to have about 37 full-time-equivalent positions, but only about 34.5 were filled at last count. Further, providers accounting for 5.5 of those positions have announced they are either leaving or reducing their hours.

The VA responded by explaining that it has already scheduled 8.5 to be filled by the end of May, which would bring it above the 37-position threshold. It is actively recruiting to fill vacant positions in Billings and Helena, and will rely on temporary relief from other providers to meet any other needs throughout its network of 15 facilities in Montana.

Last month, the Montana VA learned it will at last be able to move forward with expansion plans at several of these clinics, including the expansion and upgrade of facilities in Missoula and construction of new sites in Butte, Helena and Fort Harrison.

The exact construction costs are not yet known, but it's likely to cost many millions of dollars. The investment is worth every penny — so long as every one of those pennies goes to providing the best possible care to veterans. Money spent on anything else is money wasted.

In fact, recognition of this value — that private profit off the backs of our veterans is wrong — may have been why former Veterans Affairs Secretary David Shulkin was fired last week. President Trump has already announced that he would like to replace Shulkin with White House physician Ronny L. Jackson.

Shulkin said he suspects he was targeted by supporters of privatization. It likely also had something to do with allegations of ethics violations. An internal investigation found that Shulkin accepted tickets to Wimbledon, and that he not only brought his wife with him on a trip to Europe at taxpayer expense, he directed his chief of staff to go back and change emails in an attempt to justify it. Shulkin denies these accusations.

Nevertheless, his apparent abuse of public dollars for private benefit was soundly criticized, even by his most loyal supporters. It's a lesson that ought to resound throughout the agency.

The VA is still struggling to overcome major problems. Whoever eventually replaces Shulkin must have the depth of experience and expertise to tackle these problems, and the wisdom to avoid creating new ones — and that includes the misguided push to privatize the VA.

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36 - Washington Examiner: [Ron Johnson: Trump 'deserves' a VA secretary who agrees with him on policy](#) (1 April, Naomi Lim, 4.8M uvm; Washington, DC)

Sen. Ron Johnson, R-Wi., agreed Sunday President Trump was right to fire former Veterans Affairs Secretary David Shulkin.

"Well, I think the IG report's pretty troubling," Johnson told NBC, referring to VA inspector general Michael Missal's finding that Shulkin improperly used taxpayer dollars for a trip to Europe with his wife in July.

"Presidents do deserve and have advisers that actually agree with them on policies. And apparently, there were some policy disputes," Johnson continued in reference to alleged disagreements between Trump and Shulkin over the direction of the VA, particularly regarding whether aspects of the department be privatized.

But Johnson added he would not have dismissed Shulkin via social media.

"The president does need to understand the effect it has on attracting other people," he said.

Trump announced Shulkin's departure on Twitter Wednesday, adding that Navy Rear Adm. Ronny Jackson, who has served as White House physician for former Presidents George W. Bush, Barack Obama, as well as Trump, would be nominated to replace Shulkin.

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37 - U.S. News & World Report (AP): [Shulkin Says He Has 'Comfort' With Potential Successor at VA](#) (2 April, Hope Yen, 24M uvm; Washington, DC)

Former Veterans Affairs Secretary David Shulkin downplayed concerns about his potential successor's lack of managerial experience Monday, saying the key for improving the VA will be surrounding White House doctor Ronny Jackson with a good team "because no one person can do this alone."

Shulkin and the White House have engaged in a highly public campaign surrounding his departure from the VA last week. Shulkin said he was fired. The White House said he resigned.

On Monday, Shulkin told CNN there was no reason he would resign. He said he had been given a heads-up on his ouster by Chief of Staff John Kelly moments before President Donald Trump tweeted it.

Shulkin said he supports the person President Donald Trump selected to replace him.

"I have comfort because I know Dr. Jackson," Shulkin said. "Dr. Jackson is a very honorable man who wants to do the right thing."

Shulkin's comments represented a different tone from the fractious back-and-forth Sunday when the White House hit back at Shulkin for claiming that he was fired from his job and that he was only informed about it shortly before President Donald Trump tweeted about his replacement.

The Trump administration says he left his job willingly amid a bruising ethics scandal and mounting rebellion within the agency.

On Sunday, chagrined by Shulkin's public statements blaming his ouster on unfair "political forces" in the Trump administration, the White House circulated a "talking points" memo to some veterans groups in a bid to discredit him.

The three-page memo, obtained by The Associated Press, points out seven "lies" that it said Shulkin had spread. They include statements in which he minimizes a VA watchdog report in February that concluded he violated ethics rules by accepting free Wimbledon tennis tickets. The VA inspector general has previously found Shulkin made misleading statements about the trip to investigators and the news media.

In television interviews earlier Sunday, Shulkin said he had not submitted a resignation letter, or planned to, and was only told of Trump's decision to replace him shortly before the Twitter announcement. He said he had spoken to Trump by phone earlier that day about VA improvements, with no mention of his job status, and was scheduled to meet with the president the next morning.

"I came to run the Department of Veterans Affairs because I'm committed to veterans," Shulkin said. "And I would not resign because I'm committed to making sure this job was seen through to the very end."

Last week, Trump named Defense Department official Robert Wilkie to the acting position, bypassing Shulkin's deputy secretary, Tom Bowman. Bowman has come under criticism for being too moderate to push Trump's agenda.

Under federal law, a president has wide authority to temporarily fill a federal agency job if someone "dies, resigns, or is otherwise unable to perform the functions and duties of the office." There is no mention of a president having that authority if the person is fired. Still, it's unclear if courts would seek to draw a legal distinction between a firing and a forced resignation, if that is indeed what happened to Shulkin.

The day after announcing he was replacing Shulkin, Trump told a rally in Richfield, Ohio, that he had been dissatisfied with efforts to improve the VA. Shulkin had enjoyed Trump's support for much of his first year in the administration, but that eroded in February after mounting ethics questions and political infighting at the VA.

Wilkie, now listed on the VA website as acting secretary, took over Shulkin's duties last week.

The back and forth over the circumstances behind Shulkin's departure — and what it could mean for Wilkie's status — comes as the nomination of Jackson is drawing concern among lawmakers and veterans groups. They worry the Navy rear admiral and lifelong physician lacks the experience to manage an enormous agency paralyzed over Trump's push to expand private care.

Trump's new Cabinet nominees also are beginning to pile up in the Senate, likely leading to weeks of confirmation battles and other delays in the run-up to congressional midterm elections in November. That could mean an extended reign for an acting VA secretary.

Shulkin's dismissal comes amid a broader shakeup of top Trump administration officials and accusations of excessive spending by Cabinet officials. Also currently under fire are Environmental Protection Agency Administrator Scott Pruitt, Interior Secretary Ryan Zinke and Housing and Urban Development Secretary Ben Carson.

Shulkin had agreed to reimburse the government more than \$4,000 after the VA's internal watchdog concluded last month that he had improperly accepted Wimbledon tennis tickets and that his then-chief of staff had doctored emails to justify his wife traveling to Europe with him at taxpayer expense. Shulkin also blamed internal drama at the agency on a half-dozen or so rebellious political appointees, insisting he had White House backing to fire them.

Associated Press writer Darlene Superville contributed from Palm Beach, Florida.

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38 - Military Times: [White House doctor could face the most contentious VA confirmation process ever](#) (2 April, Leo Shane III, 2.1M uvm; Springfield, VA)

Ronny Jackson's nomination to become the next Veterans Affairs secretary could become the most contentious confirmation process since the department was founded 30 years ago.

But that's also a fairly low bar.

Since the department was elevated to a Cabinet-level post back in 1988, no senator has ever voted against a VA secretary pick. All of the confirmations have been unanimous or near-unanimous votes (with a handful of lawmakers absent), or procedural votes where no opposition was formally recorded.

That includes former VA Secretary David Shulkin, confirmed by a 100-0 vote in February 2017. His total support from the Senate was frequently touted by President Donald Trump in public appearances, including one just a few weeks before Shulkin was fired by the president over social media on March 28.

In fact, no nominee for a confirmable department post over the last 30 years — totaling more than 150 individuals — has ever received a vote of opposition from the Senate, underscoring the non-partisan nature of VA work.

Rear Adm. Ronny Jackson, the White House physician, is a relative unknown in the veterans community.

By: Leo Shane III

That means even a single vote against Jackson's confirmation could send a message of irreversible political division on the once seemingly untouchable approach to the department issues.

Jackson, who retired from the Navy last week as a rear admiral with 23 years of service, was a surprise nominee for the post. He's an Iraq War veteran who served under three presidents as the top White House medical officer, and is best known for giving Trump a clear bill of health in January.

But little is known about his familiarity with the department, which boasts a budget this fiscal year of more than \$186 billion and a staff of more than 370,000 employees. Senate Democrats have openly questioned the pick, and hinted he may not receive the same support as past nominees.

"I admire Dr. Jackson's service to the nation, but I don't know if he is the right person to lead the VA," Sen. Jack Reed, D-R.I., and ranking member on the Senate Armed Services Committee, said in a statement last week. "The VA is a large and intricate agency that requires steadfast leadership and an understanding of how to run a complex organization."

Sen. Tammy Duckworth, D-Ill., is a combat-wounded Iraq War veteran and a frequent critic of the Trump administration. Like Reed, she promised to "carefully review Dr. Jackson's qualifications to determine whether he has the best interests of our veterans at heart."

But she also accused Trump of wanting “to push VA down the dangerous path of privatization” and warned that “the next VA secretary must be able to protect the department from becoming consumed by partisan politics.”

Former Senate Veterans’ Affairs Committee Chairman Bernie Sanders, I-Vt., similarly said the Senate “should not approve any nominee for secretary who supports the privatization of the VA,” a charge which he has also leveled at Trump. The current top Democrat on the committee, Montana Sen. Jon Tester, said simply that he is “looking forward to meeting Admiral Jackson soon and seeing if he is up to the job.”

Few Republicans in the chamber have offered strong praise for Jackson thus far, though none have offered serious public concerns, either.

No timetable has been set for the confirmation hearings. Senate officials still have not received the formal nominating paperwork from the White House, which will start the background check and confirmation process.

That work typically takes between one and two months. Senate leaders have said they hope to move quickly on the work to ensure a vote on Jackson’s nomination before the summer.

Confirmation votes by the Senate on VA secretary nominees

David Shulkin, 100-0 (Feb. 13, 2017)
Bob McDonald, 97-0 (July 29, 2014)
Eric Shinseki, voice vote (Jan. 20, 2009)
James Peake, voice vote (Dec. 14, 2007)
John Nicholson, voice vote (April 11, 2003)
Anthony Principi, 100-0 (Jan. 23, 2001)
Togo West Jr., voice vote (April 28, 1998)
Jesse Brown, unanimous consent (Jan. 23, 1993)
Edward Derwinski, 94-0 (March 2, 1989)

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39 - The Vindicator: [Trump’s choice to lead VA raises questions on intent](#) (3 April, Editorial Board, 193k uvm; Youngstown, OH)

The physician who gave President Donald J. Trump a squeaky clean bill of health could soon lead the Department of Veterans Affairs, even though he lacks the experience to manage an enormous agency that has long been steeped in controversy.

Trump’s nomination of Rear Admiral Ronny Jackson, the White House physician since President George W. Bush’s administration, has raised eyebrows on Capitol Hill and triggered concerns among veterans service organizations.

There is nothing in Dr. Jackson’s background to suggest he could lead a government agency with a \$200 billion budget and a staff of 370,000 spread across 3,000 facilities.

While providing health care to veterans is the main focus of the VA – the Veterans Health Administration operates the largest hospital network in the U.S. – there are other important services veterans depend on.

Disability benefits, education subsidies and cemeteries are just a few of the numerous programs available to the men and women who served this country.

The VA is second only to the Department of Homeland Security in terms of its budget and its importance.

That is why Trump's nomination of Dr. Jackson is so troubling. It seems that he is being rewarded for saying the president is in "excellent health" and "fit for duty."

Jackson claimed Trump had "incredible genes" that kept him healthy despite his well-documented affinity for fast food and abhorrence of exercise.

"It's called genetics. I don't know," the doctor said at one point. "Some people have just great genes. I told the president that if he had a healthier diet over the last 20 years, he might live to be 200 years old. I just don't know."

He added, "It's just the way God made him."

It is no secret that the billionaire real- estate developer from New York City expects to be showered with high praise from those around him and does not like to be second-guessed.

Secretary fired

Indeed, his nomination of Jackson to be secretary of the Department of Veteran Affairs came in the wake of his firing of David Shulkin, who was cool to the idea of privatizing some of the health-care services.

Shulkin, who is not a veteran but had served at VA as head of the Veterans Health Administration, was popular with veterans service organizations and lawmakers.

In an opinion piece published in the New York Times after his firing, Shulkin sought to set the record straight by saying he had been fired and had not resigned, as the White House claimed.

"I have been falsely accused of things by people who wanted me out of the way," the former secretary of the VA wrote. "But despite these politically based attacks on me and my family's character, I am proud of my record and know that I acted with utmost integrity. Unfortunately, none of that mattered."

As for the campaign by some Trump insiders to privatize the delivery of health care, Shulkin wrote:

"They saw me as an obstacle to privatization who had to be removed. This is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans."

That goes to the heart of the matter and must be the focus of confirmation hearings in Congress.

The website Government Executive Management quoted Joe Chenelly, executive director of AMVETS, as saying, "I am deeply concerned about the nominee. Veterans' lives depend on this decision, and the Trump administration needs to substantiate that this active-duty Navy officer is qualified to run a \$200 billion bureaucracy, the second largest agency in government."

AMVETS also has this question that members of Congress should pursue when they meet with Jackson:

"What qualifications does the president's nominee have to address claims, appeals, benefits and cemetery affairs?"

Throughout the 2016 presidential campaign and since he took office in January 2017, Trump has claimed to be the greatest advocate for the military and veterans this country has ever had.

Yet, the Republican president did not hesitate to get rid of an individual who enjoyed wide support among veterans. Indeed, Shulkin's popularity stems from the fact that he has put in place programs and initiatives that address past problems with the delivery of services, especially health care.

Given the conflicting reports regarding the VA secretary's departure, we believe President Trump should tell the American people if he wants health-care services to be privatized.

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40 - Washington Post: [Perspective - I've seen what a mess Veterans Affairs is. Ronny L. Jackson can't fix it. Trump's new pick to lead the cabinet is a fine doctor. That doesn't mean he can handle a massive, dysfunctional bureaucracy.](#) (2 April, Mikki Kendal, 43.9M uvm; Washington, DC)

The mission of the Department of Veterans Affairs was laid down in the wake of the Civil War, in a promise by President Abraham Lincoln to care for the men who fought, as well as their widows and orphans. The scope of that promise has broadened as women have enlisted. It is the only department that focuses exclusively on caring for veterans and their families in times of crisis spawned by injury, illness and death, a mission most Americans would agree is vital, if not sacred.

Yet every administration going back decades has failed to appoint a leader capable of guiding the agency to fulfill its mission. Ronny L. Jackson, President Trump's pick to lead the department after Secretary David Shulkin was fired, will continue that legacy. And veterans will continue to pay for it.

Whether the problem was covering up shoddy health care or questionable hiring practices, there is no question that Shulkin was ill-equipped for the position. His predecessor, Bob McDonald, did not adequately address staffing problems and wait times that were present before and during his tenure, and still remain. During the quality-of-care scandal at Walter Reed Army Medical Center, President George W. Bush appointed three men to the role of Veterans Affairs secretary. Since the position was created in 1989, 16 leaders have been appointed or stepped in as acting secretary, and the department continues to fail veterans.

I'm a veteran and former employee of the department. Although I enjoyed some aspects of my work as a veterans services representative, I'm the first to admit that VA is deeply dysfunctional. The reasons are well documented and myriad: chronic understaffing, limited investment in infrastructure, an ever-changing array of guidelines for who is eligible for benefits, and what those benefits consist of from year to year. It's a complicated system prone to backlogs that can run more than two years deep — in part because of the administrative issues that arise when management and funding don't match need.

Jackson is an experienced physician and a rear admiral with an awareness of the medical concerns of military members and their families. He's certainly qualified to work for a VA facility, and quite possibly qualified to run a medical department, with the support of a good staff.

What he lacks experience in is responding to the concerns of veterans. Hospitals don't run on doctors alone. Doctors don't direct cleaning schedules, seek donors, or do dozens of other things that make their work possible.

Veterans Affairs isn't just hospitals treating injuries. It's compensation and pensions, it's mental health care, rehab, and programs to house homeless veterans. It is a massive department with a staff of almost 378,000 people, a small city of workers that serves about 22 million veterans and their families. In raw numbers, that means every staff member has 58 veterans relying on them to do their jobs. In actual numbers, it means that every veterans services representative can have a caseload in the hundreds. It's a hard job, made worse when the people making decisions about policy have no idea what the population being served needs, or how to provide it. And it's just one aspect of the multistep process required to help veterans build a new life.

Cases are often far more complicated than they appear. A veteran who is chronically unemployed can't simply be referred to a job program. A VSR needs to examine the reasons for unemployment. That might mean compensation for depression or for post-traumatic stress disorder, drawing on VA benefits. On the medical side, that means a referral to therapy, possibly a program for substance abuse if the veteran is self-medicating. If the unemployment has led to homelessness, housing assistance is needed through the HUD VASH, which brings in yet another side of the department. And this would be just one case handled by one representative.

Is it possible to learn? Absolutely. To be a good VSR, you need two months of classes, at eight hours a day. Then you need at least six months of supervised on-the-job training. It is a lot of paperwork and memorization and asking questions about conditions you may have never imagined were possible for one person to face. It's complex work on the best day with all the training and experience. Jackson has no training in so much as building a file. He lacks experience in managing a large staff, directing any federal department, or even directing troops at this scale. He doesn't understand the work or the people who do it, and that's not how effective leadership models are built in any industry.

Jackson's only apparent qualification, besides a medical degree, is being able to stand in front of a lectern and respond to reporters. He has that in common with Ben Carson, another doctor who was appointed to a Cabinet position and who has not generated anything but scandals and subpar policy decisions. In the parade of failed appointees under this administration, Jackson is almost the least objectionable, if you ignore the effect his inexperience will have on a system that is not adequately serve a vulnerable population.

I was a good soldier. I'm a successful writer. But I wasn't especially good at being a VSR, and ultimately I recognized that my talents could be put to better use elsewhere. One can only hope

that after Jackson gets past feeling flattered by the attention, he'll set aside his ego long enough to recognize that he isn't qualified to lead this department at this time. Veterans deserve better.

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41 - Fierce Healthcare: [5 things to know about Ronny Jackson, Trump's pick to replace Shulkin at the VA](#) (2 April, Paige Minemyer, 141k uvm; Washington, DC)

President Donald Trump fired David Shulkin as Department of Veterans Affairs secretary last week and tapped White House physician Ronny Jackson as Shulkin's replacement.

Trump praised Jackson as "highly respected" in his Twitter announcement, and White House Press Secretary Sarah Huckabee Sanders echoed the sentiment in a tweet of her own, saying that he and other cabinet nominees should be confirmed "without delay."

However, veterans' groups expressed concern about Jackson's lack of experience in managing government agencies, let alone one the size of the VA. A former VA official told Politico that his "first reaction" to the announcement was "OMG."

"[Jackson] has no experience," the official told the publication. "The VA is the hardest department to manage because it is so political."

Jackson's experience—or lack thereof—will certainly be a point of contention in his confirmation hearings. Here are a few more facts to know about Trump's pick to head the VA:

1. He has served in three presidential administrations.

Jackson first joined the White House medical staff in 2006 during the Bush administration, according to his Navy biography, and has directed the Executive Health Care for the President's Cabinet and Senior Staff. He was named Physician to the President by President Barack Obama in 2008, a role he continued under Trump.

Jackson has also served as physician supervisor for the Camp David presidential retreat.

2. Jackson is still an active duty soldier.

Jackson was serving in Iraq as an emergency physician and specializing in resuscitating troops when he was notified that he would be joining the White House Medical Unit. He began active duty naval service in 1995, according to his biography.

The White House announced on March 23 that it had nominated Jackson for a promotion to rear admiral (upper half), which would make him a two-star admiral, CNN reported.

3. He caught Trump's eye after announcing the results of the president's physical in January.

The president was impressed with Jackson's performance at a January press conference where he revealed the results of Trump's annual physical, CBS News reported. A source told CBS that Trump is also personally fond of Jackson.

At the press conference, Jackson answered reporters' questions about Trump's health for more than an hour, saying that if the president had maintained a healthier diet over the past 20 years, "he might live to be 200 years old."

4. His stance on key VA issues is an unknown.

Where Jackson stands on crucial issues at the agency he could soon command is not publicly known, according to Politico. This extends to privatizing the department's health system. Shulkin said that his opposition to VA privatization is the main reason he was pushed out.

Jackson does have Trump's ear, though. Richard Tubb, M.D., the longest-tenured White House physician and Jackson's mentor, told CBS that White House doctors have been "figuratively Velcro-ed" to Trump since he won the election.

"On Jan. 20, 2017, Dr. Jackson became that Velcro," Tubb said.

5. Shulkin has praised his potential replacement

Following his ouster, Shulkin didn't mince words about what it was like at the VA, writing in a New York Times op-ed last week that "the environment in Washington has turned so toxic, chaotic, disrespectful and subversive" that he struggled to accomplish his goals at the agency.

However, he told ABC News that Jackson, despite his lack of experience, should be able to build a team around him that will allow him to succeed at the VA if he's confirmed. Shulkin told CNN that Jackson is a friend, and that he "will do everything that I can" to help him in the transition.

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42 - Aiken Standard: [Column: Surprise: Trump's newest cabinet nominee has no relevant experience](#) (2 April, Eugene Robinson, 68k uvm; Aiken, SC)

You can't make this stuff up: President Trump has announced he will nominate a medical doctor who has no discernible management experience to run the second-largest agency in the federal government.

Can presidents be sued for malpractice?

The man Trump has named to become secretary of veterans affairs, Dr. Ronny Jackson, happens to be the president's personal physician. More to the point, given Trump's perpetual hunger for sycophancy, is the fact that Jackson showered the president with hyperbolic Dear-Leader-style praise during a widely viewed television appearance in January.

Trump has "incredibly good genes," Jackson said in describing the physical examination he had given the president. Trump's overall health is "excellent." His "cardiac assessment" put him "in the excellent range." If his diet had been a bit better, "he might live to be 200 years old." In any event, "I think he will remain fit for duty for the remainder of this term and even for the remainder of another term if he's elected."

That is an unusual way to describe a 71-year-old man whose height was reported as a generous 6 feet 3 inches and weight at an eyebrow-raising 239 pounds, which classifies him as overweight – but conveniently just one pound short of obese. Jackson's are odd words for a man whose cheeseburger-laden diet my doctor would describe as suicidal and whose coronary calcium scan results, according to many other physicians, indicate some degree of heart disease and a clearly elevated risk of heart attack.

I assume Jackson has been more, shall we say, plain-spoken with the president about his health than he was with the public. But am I suggesting that flattery, rather than merit, is what makes him Trump's choice to replace ousted VA Secretary David Shulkin? Absolutely, because no other explanation makes sense.

Pliability may also be playing a role. In a New York Times op-ed, Shulkin wrote that he believed he was being sacked because he opposed a push by the Trump administration "to put VA health care in the hands of the private sector."

Shulkin is also a physician, but before he took over at the VA he had experience running hospitals. With no comparable administrative background, Jackson – if confirmed by the Senate – would take over a sprawling agency with 360,000 employees, a \$186 billion budget and responsibility for providing medical care to 9 million veterans who deserve better, faster service than they now receive.

Shulkin was one of several high-ranking Trump appointees under fire for lavish spending on the taxpayers' dime. He was also a holdover from the Obama administration, and even though the job is perhaps the least partisan in the cabinet, that prior association clashed with Trump's bratty determination to oppose everything Obama supported and support everything he opposed.

But Shulkin, by most accounts, had stabilized the VA's vast system of hospitals and health clinics. What he refused to do was support the notion of privatizing veterans' health care – an idea pushed by some of the political appointees the White House had installed under him.

"I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans," Shulkin wrote in his op-ed. "The private sector ... is ill-prepared to handle the number and complexity of patients that would come from closing or downsizing VA hospitals and clinics, particularly when it comes to the mental health needs of people scarred by the horrors of war."

Shulkin wrote that "in recent months" the political environment in Washington has become "toxic, chaotic, disrespectful and subversive," making it impossible for him to do his job. "It should not be this hard to serve your country," he wrote.

But it should be hard to get a job running any organization as big, complex and vital as the Department of Veterans Affairs. Perhaps Jackson has an innate genius for management that awaits only the opportunity to flower. If not, Trump will be doing a grave disservice to men and women who are owed the nation's thanks and gratitude.

I can't say I'm surprised. Trump put neurosurgeon Ben Carson in charge of the Department of Housing and Urban Development, despite Carson having zero experience in housing policy. He put Betsy DeVos in charge of the Department of Education, despite her apparent unfamiliarity with actual schools. He put politician Rick Perry in charge of the Department of Energy, which Perry wanted to eliminate until he learned what the agency does.

Perry actually said that at his confirmation hearing. One doesn't know whether to laugh or cry.

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43 - Truthout: [Trump's New VA Pick Appears Poised to Rubber-Stamp Privatization of Veterans Affairs](#) (3 April, Michael Corcoran, 422k uvm; Chicago, IL)

For the last year, Veterans Affairs Secretary David Shulkin insisted the VA would not be privatized on his watch. Now, thanks to a Koch-supported coup at the top of the second-largest department in government, his watch has ended -- and the battle over privatization persists.

For years the Koch brothers have been hovering around the Department of Veterans Affairs and its \$186 billion budget like vultures surrounding a carcass. The billionaires have been pushing a radical legislative agenda, using the front group Concerned Veterans for America. Their goal is to dismantle the Veterans Health Administration (VHA) -- the only system of socialized medicine in the United States -- to the benefit of for-profit providers.

So, one can only imagine the glee felt in the Kochs' offices on Thursday when the president finally sent Shulkin packing. The VA Chief had retained the support of most Veterans Service Organizations (VSOs), which generally are opposed to privatization of the VHA, but it was not enough to save his job. This is a strong indicator of the Kochs' influence over the Trump administration on veterans' issues.

Experts and advocates now fear that Ronny Jackson, the White House doctor and Trump's pick to replace Shulkin, will rubber-stamp the Koch agenda. "I think [Jackson] will be a puppet that will put the VHA and the VA on a starvation diet," said Suzanne Gordon, a journalist and author who covers the VA, in an interview with Democracy Now.

Among the legislation the Kochs are pushing is the Veterans Community Care and Access Act (S.2184, which was introduced by Sens. John McCain and Jerry Moran), the Veteran Empowerment Act (HR.4457, introduced by Rep. Doug Lamborn), which seek to privatize much of the VHA, and the Vet Protection Act (HR.1461), which would weaken the rights of VA employees.

Passing this legislative agenda would radically remake the VA in the Kochs' image. Can anyone stop it from happening?

Privatization of VA Enters Mainstream Debate

Shulkin's firing brought one silver lining for those seeking to preserve the VHA. The drama surrounding the firing -- and the curveball appointment of Trump's physician to replace him -- has elevated the issue of the privatization of the VHA into the national debate.

Shulkin did not go quietly after his dismissal. He penned an op-ed in The New York Times and appeared on shows like "Meet the Press" to pointedly explain why he was removed.

"They saw me as an obstacle to privatization who had to be removed," Shulkin wrote in the Times. "That is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans.

"His ringing defense of the VA in the New York Times is very important for people to read. I'm sad that [he] didn't articulate that kind of defense earlier," Gordon said. "But the fact that he's [speaking out on privatization] now is really to be commended."

Shulkin's language was not very different from that of Sen. Bernie Sanders, who said at a news conference in Vermont, "The firing of Shulkin has everything to do with the administration's desire to privatize the VA, and I think that that is a disastrous idea."

This has led to a rare public discussion of VA privatization -- and the role of the Koch brothers in advancing the cause -- in the dominant media. Jackson's confirmation hearings could provide more chances to educate the public about the Koch's war on the VHA. Democratic opponents will have a chance to step up and confront Jackson on these privatization efforts in public.

The fact that Trump chose his own White House doctor to replace Shulkin only adds to the media's interest in the pick. It seems likely that the process of replacing Shulkin will take place with a much wider audience than it would have if Trump had made a less controversial decision.

"We know nothing about what Dr. Jackson stands for and what his vision is for the VA," Sanders said of Jackson on CBS's Face the Nation.

Koch-Approved Legislation: Exploitation of Choice

This mysterious physician, however, may well end up running the largest health care system in the United States.

So, what do the Kochs have planned for the new VA chief? They do not make you search hard for these answers. In Concerned Veterans for America's statement responding to Shulkin's firing, they celebrate that the "distractions" are over and quickly pivot to their legislative agenda.

"Concerned Veterans for America's grassroots leaders flew in from around the country earlier this month and held nearly 100 meetings with legislative leaders to discuss the group's policy agenda," the statement reads.

It then lists its legislative agenda. The top two bills it is pushing would, to varying degrees, fundamentally alter the VHA through privatization: the Veterans Community Care and Access Act (S.2184) and the Veterans Empowerment Act (HR.4457), which is sponsored by Rep. Doug Lamborn, a Republican from Colorado.

These two pieces of legislation must be considered in the context of the 2014 VA Scandal, when VA employees were accused of falsifying records about long wait times. After the wait-time scandal, a bipartisan agreement called Veteran Choice Act of 2014, allowed veterans who do not live near a VA clinic, or are subject to long wait times, to seek care at a private provider.

There was no real opposition to this plan, which created the Veteran Choice Program, and it was supposed to be an emergency measure. "This particular program was authorized as a temporary fix in the midst of a crisis," said Allison Jaslow, executive director of Iraq and Afghanistan Veterans of America, in an interview with The Atlantic. "We always viewed it as an experiment."

This experiment, however, has turned into the primary means by which the GOP is trying to privatize the VA. The program was set to expire this year, but Trump extended it in April and

December 2017. Now GOP legislation, supported by the Koch brothers, would, as Nikki Wentling of the Stars and Stripes reported, "overhaul the controversial Choice program and create a network of community medical providers that veterans could use at taxpayers' expense."

The more radical of the Kochs' two bills is Lamborn's legislation, which was introduced in November. The Veterans' Empowerment Act, as Wentling describes, "mirrors a proposal from the conservative group, Concerned Veterans for America, which is part of the Koch brothers' political network, to create a government-chartered organization to operate a new veterans health insurance system."

The bill drew immediate resistance from opponents of privatization, such as the Veterans of Foreign Wars (VFW). "We hope that it has absolutely no chance of becoming law," said Carlos Fuentes, legislative director for the VFW, in response to Lamborn's bill.

The Kochs, who, according to The Wall Street Journal, are spending millions to influence this debate, praised the bill. In an op-ed for The Hill, Dan Caldwell, executive director of Concerned Veterans for America, said the bill would "truly expand veterans' health care choice in an effective and sustainable way."

The Veterans Community Care and Access Act (S.2184, which is sometimes called McCain-Moran) is similar to the Lamborn bill but not quite as militant. Unlike with the Lamborn act, under McCain-Moran the VA is maintained "as a gatekeeper to private-sector treatment," Wentling reports, whereas the VA can be bypassed entirely under the Veterans Empowerment Act.

"The bill would require the VA to use objective data on healthcare demand to set standards for access and quality, and to identify and bridge gaps in veterans' care -- whether in VA or community facilities," according to a press release from Moran about the bill.

"It is as if they want the VA staff to serve as billers for the private sector," Gordon told Truthout.

The McCain-Moran legislation goes well beyond the accommodations made for rural veterans as envisioned by the Choice program. Some estimate that "McCain-style privatization" could triple the cost of veterans' care to almost \$450 billion a year.

Both the Lamborn and McCain-Moran bills also overlook the possibility that the private sector is not ready for the specific health needs of veterans, according to a Rand Report published in March, which studied New York State providers. The report found that private providers knew "little about the military or veterans" and are "not routinely screening for conditions common among veterans," among other critiques.

"These bills have lots of nice words, about empowerment, or choice, but what those bills do is hurt veterans," said William Attig, executive director of the Union Veterans Council, AFL-CIO, in an interview with Truthout. "There is a lot of money for some to make by farming out services to the private sector, but what the VHA needs is to be fully funded, not privatized."

The Kochs' attack on the VA is also an attack on federal employees and public-sector unions. Their legislative agenda includes the Vet Protection Act (HR.1461), which makes it easier to fire employees and tries to weaken public sector unions.

Concerned Veterans for America says the bill would involve monitoring "the amount of time VA employees can devote to union activities during work hours and ensure clinicians are doing the work the VA hired them to do -- care for patients."

The law is an attack on the collective bargaining rights of federal employees at the VA, according to the National Federation of Federal Employees.

"This legislation does not help veterans or taxpayers. Rather, it serves only to weaken federal employee unions," the union said in response to the proposal.

The Fight Ahead

These big legislative efforts are ongoing, as are other acts of "stealth privatization," such as hiring freezes, and plans laid out in the Trump VA budget, which undermine the VA without an act of Congress. These practices are likely to continue.

From a wider-angle lens, the goal of the Koch brothers is not just to pass these bills to dismantle the VHA, but to undermine the very idea of government-run health care.

However, while the Kochs have enormous resources invested in their effort to dismantle the VA, there is organized resistance from most Veterans Service Organizations, as well as from progressives like Bernie Sanders, who seek to defend government-run health care on principle.

With the Koch brothers' role in trying to privatize the VHA now a matter of national debate, the best way to maximize opposition to their agenda is to make sure the US public knows who is most hurt by it: veterans.

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44 - We Are The Mighty: [No one was ready for President Trump's next VA secretary](#) (3 April, Ben Brimelow, 3.6M uvm; New York, NY)

Questions have emerged about the managerial ability of White House physician Admiral Ronny L. Jackson, President Donald's Trump pick to run the Department of Veterans Affairs, the federal government's second-largest agency.

If confirmed, Jackson would replace David Shulkin as the secretary of veterans affairs. Trump announced his decision to fire Shulkin on March 28, 2018.

Though Jackson has an impressive resume as a career naval officer who served as an emergency trauma doctor in Iraq, as well as a White House physician for the 12 years, he seems to lack any management experience.

Considering the VA has 360,000 employees and a \$186 billion annual budget, that has some people worried.

"It's great that he served in Iraq and he's our generation. But it doesn't appear that he's had assignments that suggest he could take on the magnitude of this job, and this makes Jackson a -surprising pick," Paul Reckhorn, the chief executive of Iraq and Afghanistan Veterans of America, told the Washington Post.

Shulkin had managed several hospitals before, including some that were part of the VA, and almost all of his predecessors were either high ranking managers in the private sector, or military leaders.

Senior White House officials told the Washington Post that Jackson "was taken aback by his nomination," and was reportedly hesitant to take the position. One official described an "informal interview" process, without the traditional Cabinet-level vetting.

The White House had reportedly planned to announce that Shulkin would leave on March 28, 2018, with an interim director to run the department until a permanent head could be found. Trump apparently changed that plan when he tweeted that Jackson was his pick to lead the VA.

Virtually nothing at all is known about Jackson's views on the issues that currently face the VA, like Trump's views on privatization of elements of the VA.

"We are doing our homework on Dr. Jackson," Amanda Maddox, a spokeswoman for the chairman of the Senate Veterans' Affairs Committee, Sen. Johnny Isakson, told the Washington Post.

"His name was never floated around," Maddox said, "so we are doing our due diligence."

It is unclear if Democrats will support Jackson's nomination. Senator Tammy Duckworth of Illinois, an Iraq veteran who lost both of her legs when the helicopter she was co-piloting was shot down, released a statement saying that she would "carefully review" his qualifications.

"The next VA Secretary must be able to protect the department from becoming consumed by partisan politics," Duckworth said.

"I hope Dr. Jackson is someone who is willing and able to do that by continuing the important tradition of VA Secretaries working in a bipartisan manner."

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45 - MedPage Today: [Jackson's Nomination to Run VA Brings Questions, Lack of management experience cited as major issue](#) (3 April, Joyce Frieden, 1.5M uvm; New York, NY)

Reaction to President Trump's nomination of White House physician Ronny Jackson, MD, as Secretary of Veterans Affairs (VA) has leaned toward the negative, with most people questioning whether Jackson has the experience needed to run the vast department.

"I am deeply concerned about the nominee," Joe Chenelly, executive director of AMVETS, a veterans service organization, said in a press release. "Veterans' lives depend on this decision, and the Trump administration needs to substantiate that this active-duty Navy officer is qualified to run a \$200-billion bureaucracy, the second largest agency in the government."

Chenelly posed several questions that he said needed to be answered about Jackson, including:

"Is it appropriate for an active-duty military officer to run a federal agency?"

"With an official bio that does not seem to contain any indication that he's held a command, is the president's nominee fully prepared to lead such a massive bureaucracy?"

"While we are pleased this nominee has a medical background, the VA is much more than healthcare. What qualifications does the president's nominee have to address claims, appeals, benefits, and cemetery affairs?"

Michael Carome, MD, director of Public Citizen's Health Research Group, was even more blunt. "Dr. Jackson appears to lack the type of management experience that the VA secretary position demands," he wrote in an email to MedPage Today. "There are undoubtedly dozens of other individuals who would be more qualified, but many are likely unwilling to serve under President Trump."

But not everyone agreed. "The questions ... raised about his [lack of] experience in managing a large bureaucracy [are] relevant, but there is a lot of precedence about having the deputy secretary being the main management person," said Gail Wilensky, PhD, senior fellow at Project HOPE, in Bethesda, Md. "The bigger question is, do you know what you know and know what you don't know?"

If Jackson doesn't have management experience, "he needs to understand the importance of working as a team with regard to the skill sets he doesn't have, and if he understands that, most potential problems are relatively easily resolved."

Mike Haynie, PhD, director of the Institute for Veterans and Military Families at Syracuse University, said that while Jackson's background will become clearer during the nomination process, the change in leadership also raises other issues.

"The conversation should be much greater than just about Dr. Jackson," he said in an email. "What is missing is the larger issue of the other key vacancies across the agency – to include the Undersecretary for Health and Undersecretary for Benefits. These are key leadership roles, and the absence of leaders in these roles will further complicate Dr. Jackson's transition."

Jackson, a rear admiral in the Navy, has served as White House physician since 2006, according to his official bio. He has served as an instructor at a naval diving and salvage training center as well as an emergency physician in Iraq before being selected for the White House post. He has served as director of the White House medical unit but there is no other reference in his biography of having run a larger organization.

President Trump announced on Twitter on March 28th that he would be nominating Jackson to replace Shulkin, although there is some dispute over whether Shulkin was fired or he resigned. Shulkin maintains he was fired while the White House says he resigned. The Trump administration and Shulkin were at odds over whether the VA should become more privatized.

Privatization would hurt the agency, said Eugene Gu, MD, a surgery resident at the VA medical center in Nashville, Tenn., who has been speaking out on the issue. "Privatizing means veterans are shipped off to a small private hospital in whatever community they're in," he said in a phone interview. "They're not going to get the same level of integrated care ... What they should be focusing on is giving veterans the best care that they deserve, which means investing more money into [this] single-payer nationally integrated health system."

Right now, privatization is being used as a crutch to avoid fixing problems within VA facilities, he continued. For example, Gu said that at the hospital he works at, broken sterilization equipment is not being fixed because, under the current Choice program allowing veterans to go outside the VA for care, staff can just send surgery patients elsewhere.

"How can you have a hospital without completely working sterilizing system? That should be a scandal," said Gu. Although it's true that the hospital can send surgery patients elsewhere, "that delays their care. If we didn't have [the] Choice [program] they would have been working around the clock to fix the sterilizer and we would have clean tools to operate on patients ... Relying on [Choice] is a disservice to veterans."

Haynie urged going slow on expanding privatization. "A wholesale dismantling of the VA healthcare system is not in the best interest of veterans, or American medical education," he said. "The administration has made it clear they want to see more choice for veterans when it comes to their healthcare, but it is important to expand choice in a way that preserves the core integrity of the VA healthcare system."

Although Jackson would be new to the VA, no one should assume he will be a pushover for those who want to increase privatization, Wilensky said. "Most of the flag officer-level people I've met in the military are not so easy to manipulate.... He has spent his adult life in the military, where they rely on government-funded healthcare."

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46 - KWTX (CBS-10): [Waco: Chris Kyle's family hopes new secretary will change VA culture](#) (3 April, John Carroll, 315k uvm; Waco, TX)

The brother and father of slain American Sniper Chris Kyle say they hope that Texas born and reared Navy Rear Adm. Ronny L. Jackson, whom the president has nominated as the next secretary of veterans affairs will change the culture in the VA to get veterans help more quickly.

"Our veterans are not being taken care of here in America, no way, absolutely not," Kyle's father, Wayne said.

"We're hopeful that somebody has been placed there that understands our veterans and understands what they are going through," he said.

Kyle's sons Chris and Jeff both served overseas in foreign wars.

Chris, known as the American Sniper, was shot and killed at a gun range five years ago in Erath County while attempting to help a troubled vet.

President Donald Trump has been moving to privatize some healthcare for veterans, saying he wants them to get the help they need.

"We need to address it immediately. Get them the care that they need and get the problem resolved," the elder Kyle says.

"I hate to say this, but to me the VA has up until now been like a revolving drug dispensary. These young men and women have become addicted to prescription drugs and they become like zombies."

Jackson is a Texas native, a 1991 graduate of Texas A&M University and a 1995 graduate of the University of Texas Medical Branch.

On the subject of school safety, both Kyle and his son Jeff believe veterans could be one answer to making campuses safer for students.

Jeff Kyle says schools should hire two to three Veterans per campus to guard the students.

"Making sure that their mental health is checked out, there's plenty of guys, men and women, both out there that are well trained and ready to standby and you know do what is necessary to protect these kids."

His father Wayne agrees.

"I just feel like we could make better use of our veterans if there are unemployed then put them to work."

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47 - Creators Syndicate: [Marching Orders for Trump's New VA Secretary](#) (4 April, Betsy McCaughey, 318k uvm; Hermosa Beach, CA)

Since President Trump ousted Veterans Affairs Secretary David Shulkin, the question reverberating in Washington is whether Trump's new pick, Rear Adm. Ronny Jackson, is capable of heading a department with 360,000 employees and 9 million vets under its care. Senate Democrats carp he lacks experience running "a complex organization."

Experience is overrated. President Obama's VA Secretary, Robert McDonald, failed miserably, despite having run Procter & Gamble. Vets died on phony wait lists on McDonald's watch.

Jackson's last combat role was with a surgical shock trauma unit in Iraq. Sounds like good preparation for battling the killer VA bureaucracy.

Jackson also shares Trump's vision of putting vets in the driver's seat about their own medical care. Here's what Jackson can learn from his predecessors' failures.

Lesson 1: Make vets the priority, not protecting the VA bureaucracy. Shulkin refused to do that.

Trump has pledged to fix the Veterans Choice Program so vets can see private doctors when they decide it's necessary. VCP was created in 2014 after revelations that sick vets were dying on wait lists at VA hospitals. VCP is supposed to allow vets to get private care if they live far from a VA facility or have waited too long. But VCP's red tape makes seeing an outside doctor almost impossible. That's deliberate. Senator Bernie Sanders, who co-authored VCP legislation, relies on union campaign contributions and will do just about anything to protect union jobs at the VA. Keeping vets trapped at the VA with no alternatives is a job protection racket.

Shulkin was part of that racket, too. He misled Trump and Congress with double talk about reforming VCP "in a way that will work for veterans and work for VA." But protecting VA bureaucracy shouldn't be a consideration, when vets' lives are at stake.

Shulkin showed his true colors when Congress passed last month's big spending package. Trump and congressional Republicans had pushed hard to include VA reforms helping vets see outside doctors.

But the key person to sell this to Congress was Shulkin, and he equivocated, allowing Democrats to block its passage. It was a setback for Trump and vets. No wonder Shulkin was canned days later — not because of flimsy travel expense abuse allegations.

Lesson 2: Cut wait times in half at the VA.

Shulkin claimed success in reducing waits, but that's questionable. VA bureaucrats are still fudging the numbers, according to the inspector general.

Here's a remedy. A whopping 47 percent of VA health care users are 65 or older. They need angioplasty and bypass surgery like other seniors. They use the VA to avoid Medicare's out-of-pocket expenses, because their median annual income is only \$24,000. Picking up their co-pays would cost very little and encourage them to use Medicare instead of the VA Bingo, and it would cut VA wait times by nearly half, making room for younger vets to get combat-related care only the VA can provide.

Lesson 3: Don't count on VA bureaucrats to fess up when things go wrong. Jackson should use unannounced audits to uncover dangerous conditions at medical facilities, instead of trusting officials to report them up the chain of command.

An inspector general report last month exposed "a breakdown of core services" at medical centers under Shulkin's command. At the Washington, D.C., facility, under Shulkin's nose, patients were needlessly overexposed to anesthesia due to inventory mismanagement. After patients were put under, surgeons sometimes discovered they were out of equipment and had to race across the street to borrow it from another hospital or reschedule the procedure. Shulkin claims he could "not recall" ever being notified of such problems. He expected to be notified?

Pundits are predicting a confirmation battle. The smart money should be on Jackson. He's combat tested. Disregard the partisan drivel about his lack of experience running a big organization. It's coming from the same people who had no problem making a community organizer the president.

Betsy McCaughey is a senior fellow at the London Center for Policy Research and a former lieutenant governor of New York State.

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48 - Hawaii Tribune-Herald: [Senate should be wary of Veterans Affairs nominee](#) (4 April, 135k uvm; Hilo, HI)

Caring for our nation's military veterans was one of Donald Trump's most consistent promises on the presidential campaign trail, and certainly one of his least controversial. Getting veterans the care they need is a nonpartisan priority.

But the increased quality of care Trump promised hasn't come.

Facilities on Long Island and in many other communities are falling apart. The Department of Veterans Affairs is increasingly being exposed as dangerous and dysfunctional. Last week, as was expected, Trump fired the secretary of veterans affairs, David Shulkin, who could never rise above his ethical violations and his shoddy leadership. His designated replacement is Navy Rear Adm. Ronny Jackson, the White House physician for the past three administrations who garnered praise from Trump for performing well during a news conference about the results of the president's physical exam.

While Jackson is highly regarded as a physician, his resume does not include a shred of evidence that he can lead the government's second-largest bureaucracy (it has a \$186 billion budget) and probably its most dysfunctional. This might be the toughest management job in Washington.

Before the Senate confirms Jackson, it must elicit his views on further privatization of medical care, which other Trump appointees are recklessly pushing as a way to dismantle the agency instead of providing improved service. And unless the Senate can ensure that Jackson can overcome his lack of management experience and create a solid plan for building a leadership team that can improve care, it should reject his nomination.

On Long Island, the problems are increasingly daunting, and care for veterans is suffering. Last month, it was learned that the Northport VA Medical Center again was forced to stop performing surgeries when a faulty air conditioner forced the hospital to close all five of its operating rooms. The shutdown went on for about a week, and 18 surgeries had to be rescheduled while the \$58,000 repair was performed.

That's only the latest breakdown at the Northport facility, where surgeries were halted for four months in 2016 when another air-conditioning system failure sent metal fragments flying into the air, threatening to contaminate patients with open wounds. Another cooling system problem a year earlier led to pipe ruptures and a \$12 million repair. And in January, Northport had to close its 42-bed veterans homeless shelter after the heat failed.

A recent report estimated the cost of Northport's repair and renovation to be \$273 million. Long Island's 130,000 veterans rely heavily on the facility, which has traditionally maintained a top reputation. Its quality cannot be allowed to decline.

If Jackson is confirmed, Trump, who has a warm personal relationship with his nominee, must make sure their communications remain constant. Jackson will need the president's full support to get the VA running properly and all of its facilities up to par.

We owe these veterans. There can be no reneging.

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49 - WUSF (NPR-89.7, Audio): [For Veterans Groups, Questions Surround Trump's VA Nominee](#) (6 April, Carson Frame, 197k uvm; Tampa, FL)

Some veterans groups say they're uncertain about the future of care at the Department of Veterans Affairs, after President Trump ousted Secretary David Shulkin and nominated White House physician Ronny Jackson to head the agency.

Navy Rear Admiral Ronny Jackson has served as a White House physician during the last three presidential administrations, starting with George W. Bush.

It's typically a low-profile position, but Jackson had a rare moment in the media spotlight in January, when he appeared in the White House briefing room to release the results of President Trump's annual physical.

"All clinical data indicates that the President is currently very healthy, and that he will remain so for the duration of his presidency," Jackson declared. "I told the President that if he'd had a healthier diet over the last 20 years that he might live to be 200 years old."

Some observers speculate that Jackson's glowing report on President Trump's health played a role in the President's decision to nominate him as Secretary the Department of Veterans Affairs. President Trump ousted Secretary David Shulkin after a turbulent 14 months in the position.

"I think that Donald Trump was enamored by having Ronny Jackson go out and say something like that before the press corps," said Will Fischer at the left-leaning political action committee VoteVets. "And it was that moment that I think Ronny Jackson probably became Donald Trump's new VA secretary."

A native Texan, Jackson joined the active duty Navy in 1995 after finishing medical school at the University of Texas Medical Branch in Galveston. He went on to graduate from the Navy's Undersea Medical Officer program, and specialized in resuscitating troops during the Iraq war in 2005 and 2006.

But Fischer suspects that his nomination may be part of a larger push to privatize the VA.

"There is a coordinated effort being led by Donald Trump and others to destroy and privatize our VA healthcare system," Fischer said.

Other veterans groups are taking more of a "wait and see" attitude and asking a lot of questions.

"We were surprised," said American Legion Executive Director Verna Jones. "He seemed to have just come out of nowhere."

The VA is one of the largest healthcare systems in the world, with a budget of almost 200 billion dollars and around 350 thousand employees. Jones says Jackson will have a lot on his plate, and that the American Legion will try to support him.

"There are 20 million veterans in the United States and nine million are enrolled in the VA," Jones said. "So the new secretary's going to have to come in and manage all of that."

He also would take over the agency at a tumultuous time. President Trump ousted Shulkin after about 13 months on the job. Shulkin called the Washington environment "toxic, chaotic, disrespectful and subversive."

Richard Delgado of the San Antonio Coalition for Veterans and Families said Jackson's military experience is appealing in such an environment and could help him get a handle on the VA.

"With him being an admiral, that also shows his leadership style and the type of person that he is," Delgado said. "You don't make admiral just willy nilly."

Outside San Antonio's Audie Murphy Memorial VA hospital, Army veteran Melissa Cervantes was caught off guard by news that the VA would be getting a different leader

"I felt like Shulkin had more experience," Cervantes said. "I don't know anything about this one coming in."

Cervantes said she worries the change will affect quality of care for her and her husband, who's also a veteran.

"Everyone has different plans, agendas," Cervantes said. "You never know what the new person coming in is going to do, whether they care about veterans or not."

A White House official told CNN that Jackson will resign his commission and retire from active duty if he's confirmed as VA Secretary. In the interim, Robert Wilkie, the Undersecretary of Defense for Personnel and Readiness, will be the acting VA secretary.

This story was produced by the American Homefront Project, a public media collaboration that reports on American military life and veterans. Funding comes from the Corporation for Public Broadcasting and the Bob Woodruff Foundation.

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50 - Lubbock Avalanche-Journal: [Levelland native talks about nomination as head of VA](#)
(7 April, Karen Michael, 194k uvm; Lubbock, TX)

Levelland native Dr. Ronny Jackson -- the rear admiral who is President Donald Trump's nominee as secretary of the Department of Veterans Affairs -- knows he will someday be a veteran and his sons will be veterans.

"I'm going to be a vet one day soon. If I do get confirmed, I won't stay on active duty, I'll be a vet right away," Jackson said Thursday in a phone interview with the Avalanche-Journal, the first interview he did after being nominated.

Jackson, currently the physician to the president, noted that it's in his best interest and his children's best interest to do what is right for veterans. He is also a United States Navy rear admiral.

"I've been overseas, and I've been deployed in combat zones with Marines and soldiers and airmen and sailors, and I've seen first-hand what they go through, the injuries and the things they come home with. I've seen how that happens, and how devastating it is to them and their families. I just want to make sure that we do our part as a country and we let them know that we appreciate that and we take care of them," Jackson said.

Veterans are like anyone else -- they don't see themselves as entitled or eligible for anything that normal people don't expect, the VA nominee said. Veterans just want good quality care and they want to know that they have access to care.

"We owe the vets the absolute best care that's available out there," Jackson said.

The naval officer was appointed as a White House physician under President George W. Bush, whom he calls "Bush 43" to distinguish him from his father, President George H.W. Bush, whom Jackson calls "Bush 41". He served as First Lady Laura Bush's personal physician, and also spent a lot of time at the Bush ranch in Texas with the family.

"I was the first lady's assigned physician. I traveled everywhere she went," Jackson said. "She and I got along really well, as did President Bush and I, because we were all from Texas. Obviously I grew up just due north from where they grew up."

He continued as a White House physician under President Barack Obama, when several of the physicians who had seniority at the time left for a variety of reasons.

"I kind of got catapulted toward the top of the docs who were currently there, as far as seniority goes," Jackson said, noting that he was the deputy director of the White House medical unit for about a year before becoming director. Then Obama appointed him as his personal physician.

As a personal physician to the president, Jackson does not wait in his office for the president to have a medical problem.

"I take care of basically the entire White House compound. I oversee all of the care here," Jackson said, adding that over 18 acres, that's about 7,000 people.

"We do urgent care here, anybody who is injured or they are sick, they come see us. We do a lot of travel medicine, because, of course, we have a lot of travelers here, so immunizations and travel preparation, we do all of that," Jackson said. "And we do, basically, a lot of primary care as well, and I take care of and end up being a primary-care provider for most of the senior folks in the White House who work in the East Wing and the West Wing, the president's senior staff and cabinet members."

When Obama left in 2017, Jackson said he was ready to retire because he had 20-plus years in the military and a new administration was coming into the White House.

"Typically, anyone who's in an appointed spot in one administration, they won't carry on to the next administration, especially when it changes from one party to the other," he said.

"I made a lot of good relationships in the Bush 43 administration, and some of the people that were working on the Trump transition had been a part of the Bush 43 administration, and they knew me," Jackson said. "They talked to President Trump about it, and I talked about it with him, and he just immediately appointed me as his physician as well."

Some national critics have acknowledged that Jackson is a great doctor while also questioning his experience in management, particularly of a large agency like the VA.

"I've been in leadership school for 23 years now. ... And I've been able to rise to the level of an admiral, a flag officer in the Navy. I didn't just stumble into that. So I've gotten a lot of leadership

background, I've got a lot of leadership experience as a Navy officer, and I've got a lot of day-to-day leadership experience," he said. "You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions.

"I think I've got what it takes, and you know, I don't buy into that argument at all."

Despite his assertion that he didn't stumble into the VA nomination, Jackson said much of his life has been serendipitous.

When he started college, he never dreamed of going to medical school or becoming a doctor.

After taking classes at South Plains College and going on to Texas A&M in Galveston to pursue a degree in marine biology, Jackson found himself with a problem common to college students: he needed money. He applied for a job at the University of Texas medical school in Galveston as an autopsy assistant and found it interesting.

"It sounds a little bit gross, but you know, it was pretty educational. They would teach me a lot of stuff about different disease processes as we were doing an autopsy. That's what got me interested in medical school," Jackson said.

His mother, Norma, also told the A-J in a Jan. 26 story that her son had never wanted to be a doctor.

"He was fixing to graduate, and he called me and his daddy, and told us he had decided he wanted to be a doctor. And we thought, 'What in the world?' But anyway, he made a doctor, and we're glad for that," Norma Jackson said.

He didn't have any plans of joining the military, either, but didn't have money for medical school. Once he was admitted, he called a Navy recruiter who had told him to call back once he was admitted to a medical school, and he learned about a program in which he could be a Navy diver and a doctor.

"I really liked diving, so I signed on," he said.

He never dreamed of becoming a White House physician, but he was nominated by his specialty leader, who is responsible for all emergency medicine doctors in the Navy.

"I didn't even know the job existed," Jackson said. "I just got an email out of nowhere saying that I'd been nominated for a job at the White House. Luckily, it was on an old email account that I wasn't checking very often, but I saw it before the deadline, but only shortly before the deadline, maybe just four or five days."

He scrambled to get an application package in.

"I kind of cut a lot of corners," Jackson said.

But a few months later, he got an email out of the blue, and this one said he was one of three physicians selected for an interview. Unfortunately, it was 2005 and he was stationed in Iraq.

"Once again, I thought that was it -- this is where the road stops because I wasn't going to be able to be back in D.C. for an interview, because I was once again in the middle of the desert," Jackson said. But his supervisor wanted him to succeed.

That supervisor was Lt. Gen. John E. Wissler, who had been a military aide to Bush 41. Wissler summoned him to his office and told him to pack his bags for a flight on a transport plane full of broken helicopters back to the United States.

After a crazy few days in Washington D.C. , had to get a new suit because he'd lost 40 pounds in Iraq, and interviewed for three days at the White House. He got the job that launched him on an unthinkable trajectory to possibly get a seat on the president's cabinet.

"I really haven't planned my life out real meticulously. I've just kind of tried to enjoy what I'm doing and do a good job, and one thing has led to another," Jackson said.

Looking back at growing up in Levelland, Jackson said: It was an experience that I appreciate now more as I've gotten older and I've lived all over the world. Levelland and that part of West Texas is just a special place with people that are like nowhere else in the world," Jackson said. "It instilled a lot of small town values with me that I've carried with me throughout my career. So you know, I can't say enough good things about West Texas. I'm proud to be a West Texan."

Jackson said he misses the people of Levelland, but not the sand storms and weather extremes. He remembers Levelland as a place that had only two restaurants: The Spot and The Chat 'n' Chew. He preferred The Spot, he said.

"It's grown a little bit," he said.

Those West Texas values probably led him into the Navy.

"My parents, they didn't really have the money to fork over and help me pay for med school," Jackson said. "My mom and dad kind of instilled in me, and I think a lot of other people when I was growing up in Levelland were the same way, they didn't like to spend money they didn't have."

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51 - Tampa Bay Times: [Editorial: For the sake of Tampa Bay veterans, Senate should scrutinize Trump's VA pick](#) (7 April, 4.8M uvm; Saint Petersburg, FL)

President Donald Trump's decision to fire Veterans Affairs Secretary David Shulkin and to replace him with presidential physician Dr. Ronny Jackson has outsized ramifications for the Tampa Bay area, given the large number of veterans here and the expansive and unique role that two major VA health centers play on both sides of the bay. Whether Jackson is the right person for the job, or whether this amounts to yet another glaring example of gross cronyism in the Trump White House, remains to be seen. But the Senate needs to use the confirmation process to explore not only Jackson's management ability but his vision for a health system that despite all its faults delivers critical care for millions of Americans.

Shulkin was an Obama-era holdover and his firing was no surprise, coming after a critical report in February by the VA inspector general's office that faulted him for improperly accepting

Wimbledon tickets during an official trip to Europe last summer. Shulkin needs to answer for his conduct, but his bigger offense may have been to slow-walk the administration's efforts to privatize VA health care services. While Shulkin agreed to explore limited privatization in some service areas and markets, he also recognized that the VA delivered a unique level of care to a specialized patient base. He was widely lauded in his tenure for improving accountability in the VA's entrenched bureaucracy and for moving to modernize the VA's delivery of care.

Jackson has won admirers for his service under two presidents prior to Trump as White House physician and for his distinguished career in emergency medicine. His service with a trauma unit in Iraq certainly makes him familiar with and sensitive to the VA's patient profile and the vital role the agency plays in caring for wounded warriors. But what appears to have propelled him to a Cabinet nominee was Jackson's televised appearance this year strongly hailing Trump's physical condition. Having the president's confidence is invaluable. But it should reflect core competence in a nominee, not merely fealty to any single president.

Jackson's lack of management experience is an obvious concern for anyone hoping to lead the nation's largest integrated health care system. With more than 1,700 hospitals and other health care facilities, and nearly 40,000 providers, the VA is the second-largest federal department, and there is nothing automatic about delivering quality, responsive services to 20 million veterans. The VA has rebounded from the recent scandals of secret waiting lists, but its bureaucratic culture still protects many incompetent leaders and outdated practices that harm its quality of care. And that in turn has colored the VA's public narrative. For all its faults, the VA has been recognized in recent years for outperforming non-VA facilities in outpatient services. And in the most recent survey of customer satisfaction, released in February, VA patients rated their experience higher than did those who were treated in private hospitals.

The next secretary needs to recognize the unique role the VA plays in treating complex cases that involve the intersection of blunt physical trauma and post-traumatic stress. The next leader needs to recognize the challenge of meeting the evolving patient profile, as older veterans require more care and as younger ones cope with regaining physical and emotional skills necessary to get back into civilian life.

The agency also needs to plan for the special needs that veteran-heavy states like Florida — which ranks third in the nation's veteran population, with 1.6 million — are facing. With 200,000 veterans in Pinellas and Hillsborough counties alone, the VA needs to continue investing in a modern health care delivery system. The Senate should press Jackson on how he would fulfill this mission and examine his commitment to put the interests of veterans ahead of any political agenda by this administration.

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52 - Washington Post: [Ronny Jackson, Trump's pick for Veterans Affairs, may pass up \\$1 million to join the Cabinet](#) (8 April, Andrew deGrandpre, 43.9M uvm; Washington, DC)

President Trump's controversial nomination of Ronny L. Jackson to head the Department of Veterans Affairs has grown further complicated by the Navy physician's pending military promotion, which he could be forced to pass up — along with an estimated \$1 million in future retirement income — if confirmed for the Cabinet post.

Jackson, a one-star admiral and the president's White House doctor, was nominated by Trump for promotion to be a two-star admiral in the days leading up to VA Secretary David Shulkin's

departure late last month. The White House has said Jackson intends to remain on active duty until the Senate confirms him to become VA secretary, at which point he would retire from the service. A Navy spokesman said there's been no change in the admiral's duty status.

The dual nominations and a lack of clarity from the White House have left lawmakers flummoxed about how to proceed, said a Senate aide who spoke on the condition of anonymity to offer a candid assessment of Jackson's unusual circumstances. The situation is symptomatic of broader frustration on Capitol Hill, particularly among Senate Republicans, with the administration's contentious personnel moves. They have complained that the time and effort required to consider multiple Cabinet nominations — the top jobs at VA, the State Department and CIA all are pending — is an unwanted distraction during a challenging midterm election cycle.

"This whole situation is very much out of the norm," the Senate aide said. "There's some question here whether [Jackson's] flag officer nomination will move forward given his VA nomination. It's all TBD, because he can't serve in both positions concurrently, so it wouldn't make sense for the Senate to move the nominations concurrently."

The timing most likely is coincidental, as the military evaluates those eligible for promotion months before their nominations are sent to Congress.

[VA's acting secretary takes over: 'I don't think he has any idea what he's gotten himself into']

The White House did not respond to questions seeking clarity on whether it intends to deconflict Jackson's two nominations, if the admiral has discussed his pending promotion with Trump or if it's the president's goal for Jackson to be promoted before he joins the Cabinet.

The dilemma adds another dimension to Trump's surprising announcement that he had chosen Jackson, whose flattering assessment of the president's health was met with skepticism earlier this year, to lead the government's second-largest agency — and arguably its most challenged. His nomination stunned lawmakers, advocacy groups and former White House colleagues dubious of his qualifications or suspicious of Trump's desire to expand a program that enables veterans to seek medical care outside the VA network.

In an interview published over the weekend by the *Avalanche-Journal* in Lubbock, Tex., Jackson, a Texas native, pushed back against his critics and suggested that his military experience has prepared him for the challenges he would face leading such a sprawling and complex bureaucracy.

"I've been in leadership school for 23 years now," he told the newspaper, "... and I've been able to rise to the level of an admiral, a flag officer in the Navy. I didn't just stumble into that. So I've gotten a lot of leadership background, I've got a lot of leadership experience as a Navy officer, and I've got a lot of day-to-day leadership experience. You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life-and-death decisions.

"I think I've got what it takes, and you know, I don't buy into that argument at all."

Jackson is well liked inside the White House, where he's worked for the past 12 years, and he is respected by those who know him and have been in his care. Trump is said to have marveled at Jackson's January appearance in the White House briefing room, where he praised the

president's physical wellness and cognitive acuity. Before settling in Washington, Jackson was deployed to Iraq, where he led an emergency trauma unit responsible for treating troops grievously wounded during one of the war's most violent stretches.

He was surprised, however, by the president's offer to run VA, White House officials have said, and initially questioned whether, as a career Navy officer with limited managerial experience, he's an optimal candidate to lead an agency of more than 360,000 employees.

By all accounts, "he's an extremely sharp officer and a terrific doc," said Barry McCaffrey, a retired Army general who served as President Bill Clinton's drug czar. "If he retired from the military with two stars and went back to civilian life, he would have career prospects for sure. But after 12 years in the White House . . . the only qualification he has [to run VA] is the confidence of the president.

"I think it's 50-50 he is confirmed. And if he's confirmed, I have great empathy. Why would he succeed? The answer is: Because the president put him there."

Jackson's political views and his positions on key policy questions have not surfaced publicly, though he told the *Avalanche-Journal* that military veterans "want to know that they have access" to medical care.

"We owe the vets the absolute best care that's available out there," he said. It's unclear whether Jackson was weighing in specifically on the administration's drive to outsource more medical services. There is deepening concern among those who oppose that effort that the admiral won't stand up to those closest to Trump who have proposed the most aggressive measures. As such, it is believed Jackson will face a difficult confirmation.

Separately, a move to VA could entail financial sacrifice. As a Cabinet secretary, Jackson would earn a salary of \$210,000, though a pay freeze has the rate locked at \$200,000 through the end of this year. That's up significantly from the \$150,000 he earns as a one-star admiral and the \$170,000 he would make as a two-star, according to current Defense Department pay tables. But as a senior officer living in Washington, he also rates thousands of dollars annually in housing allowance plus other special incentive pay the military makes available to medical professionals.

In the long term, a higher rank would qualify Jackson for a more generous pension, which is determined in part by a service member's final pay grade and years of service. Assuming Jackson lives to age 90, the difference before taxes is \$6.4 million versus \$5.3 million, according to estimates based on the Defense Department's retirement pay calculator.

Specialists with First Command Financial Services, which offers financial planning and advice for the military community, independently verified these results at The Washington Post's request but cautioned that other variables could influence Jackson's decision-making in forgoing the promotion in favor of joining Trump's Cabinet.

For instance, he would probably boost his future marketability and earning power in the private sector if he can demonstrate success while running VA. Chief executives of major medical networks can command sizable salaries, and Jackson, 50, though of age to retire from the military, is at the outset of his prime earning years.

There's also the satisfaction that comes from working in service to the nation -and for those who've sacrificed on its behalf, said Arnold Punaro, a retired Marine general who also spent many years on the staff of the Senate Armed Services Committee, overseeing, among other matters, the promotion confirmation process.

"It's been my experience," Punaro said, "that senior military officers — like Admiral Jackson — aren't motivated by money. They're motivated by service. They're motivated by mission."

Senate leaders have not set a date for Jackson's confirmation hearing or a vote on his nomination for promotion.

This article was updated to include Jackson's comments to the Lubbock Avalanche-Journal.

Eric Yoder contributed to this report.

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53 - USA Today (Video): [VA pick Ronny Jackson: 'I've got what it takes' to lead the troubled agency](#) (8 April, Donovan Slack, 36.8M uvm; McLean, VA)

President Trump's pick to lead the Department of Veterans Affairs is dismissing concerns that he lacks the experience necessary to take over the massive agency, which has more than 300,000 employees and 1,200 medical facilities.

Ronny Jackson, a Navy rear admiral, has been a White House physician since 2006 but has little executive management experience.

"You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions," he told the Lubbock Avalanche-Journal in his first interview since Trump announced his intent to nominate Jackson March 28. "I think I've got what it takes, and you know, I don't buy into that argument at all."

"Dr. Ronny," as colleagues call him, rose to national prominence in January when he conducted a White House press conference after giving the president a check up and mental acuity exam and proclaimed Trump's "overall health is excellent." But little has been publicly reported beyond his official bio on the Pentagon website.

For that reason, some lawmakers and veterans' groups have said they are withholding judgment on his nomination to be VA secretary.

"Dr. Jackson's bio does not reflect any experience working with the VA or with veterans, or managing any organization of size, much less one as multifaceted as the Department of Veterans Affairs, so the VFW will be closely monitoring his Senate confirmation process," the Veterans of Foreign Wars said in a statement.

Trump announced his intent to nominate Jackson in a tweet March 28. At the same time he fired David Shulkin from the secretary's post, saying he wasn't happy with the pace of improvements to the VA and wanted veterans to have more options for private care.

Shulkin wrote in an op-ed at the time that he believed he was removed because he refused to privatize the agency. He told USA TODAY that he believes Jackson can do the job if he builds the right team around himself.

Jackson, in his interview with the Lubbock Avalanche-Journal, did not outline his views on giving veterans more options to get VA-sponsored health care in the private sector. But he said, "We owe the vets the absolute best care that's available out there."

"I've been overseas, and I've been deployed in combat zones with Marines and soldiers and airmen and sailors, and I've seen first-hand what they go through, the injuries and the things they come home with," Jackson said.

"I've seen how that happens, and how devastating it is to them and their families. I just want to make sure that we do our part as a country and we let them know that we appreciate that and we take care of them."

The VA has been buffeted by scandal since 2014, when news reports revealed veterans had died waiting for appointments in Phoenix while schedulers kept secret wait lists masking how long they were waiting.

Since then, USA TODAY has reported on poor quality of care, misdiagnoses, supply shortages and failures in hiring and firing medical providers, among other problems that still plague the VA.

If confirmed, Jackson will be the fourth VA secretary in four years.

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54 - CNN (Video): [Trump's VA pick says he's 'got what it takes' to be secretary](#) (8 April, Devan Cole, 29.8M uvm; Atlanta, GA)

Ronny Jackson, President Donald Trump's physician and pick for secretary of the Department of Veterans Affairs, said in his first interview since being nominated that he's "got what it takes" to lead the department.

In a Sunday profile of Jackson in the Lubbock Avalanche-Journal, a newspaper located near Jackson's hometown of Levelland, Texas, the White House doctor said: "I've been in leadership school for 23 years now. ... And I've been able to rise to the level of an admiral, a flag officer in the Navy. I didn't just stumble into that. So I've gotten a lot of leadership background."

"You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions," Jackson told the paper.

Jackson, whom Trump picked to be the VA's next secretary last month, first worked in the White House under President George W. Bush, where he was assigned to care for first lady Laura Bush. After Bush left office, then-President Barack Obama appointed Jackson as his own physician, and he maintained the role under Trump.

Jackson, a rear admiral, told the paper that former Bush employees who were on the Trump transition team helped him keep his job under Trump.

"Some of the people that were working on the Trump transition had been a part of the Bush 43 administration, and they knew me," Jackson told the paper. "They talked to President Trump about it, and I talked about it with him, and he just immediately appointed me as his physician as well."

If confirmed, Jackson said he "won't stay on active duty, I'll be a vet right away." His predecessor, who was dismissed by Trump last month, was not a veteran, which was widely noted after he was nominated in 2017.

According to the paper, Jackson noted in his interview that it's in "his best interest and his children's best interest to do what is right for veterans."

"We owe the vets the absolute best care that's available out there," Jackson said.

CNN's Kevin Liptak contributed to this report.

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55 - The Hill: [Trump VA nominee: 'I think I've got what it takes'](#) (8 April Mallory Shelbourne, 11.9M uvm; Washington, DC)

President Trump's nominee to take over the Department of Veterans Affairs (VA) said in a new interview that he has "what it takes" to lead the agency.

"You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions," Rear Adm. Ronny Jackson, who currently serves as the White House physician, told the Lubbock Avalanche-Journal.

"I think I've got what it takes, and you know, I don't buy into that argument at all."

Trump announced Jackson as his choice to serve as the new VA secretary late last month in a tweet, in which he also announced the departure of embattled Secretary David Shulkin.

"I am pleased to announce that I intend to nominate highly respected Admiral Ronny L. Jackson, MD, as the new Secretary of Veterans Affairs," Trump wrote on Twitter on March 28.

"In the interim, Hon. Robert Wilkie of [the Department of Defense] will serve as Acting Secretary. I am thankful for Dr. David Shulkin's service to our country and to our GREAT VETERANS!"

Shulkin later claimed he did not resign from the position, though the White House maintains he stepped down from his post.

Senators have said they look forward to hearing from Jackson as he goes through the confirmation process.

Jackson told the Texas newspaper that veterans deserve "the absolute best care that's available out there."

"I just want to make sure that we do our part as a country and we let them know that we appreciate that and we take care of them," he told the Journal.

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56 - The Hill: [Senate braces for showdown over Trump's nominees](#) (8 April, Jordain Carney, 11.9M uvm; Washington, DC)

The Senate is barreling toward a showdown over President Trump's latest Cabinet shuffle, with three critical departments looking for new leaders and more that could follow.

Republicans are preparing for a weeks-long battle as they try to confirm CIA Director Mike Pompeo to be secretary of State and CIA deputy director Gina Haspel to succeed him.

Haspel's nomination in particular is controversial, and the GOP has little margin for error given Sen. Rand Paul's (R-Ky.) opposition to both of Trump's picks.

"I mean that's going to take a lot of floor time," Sen. John Thune (R-S.D.), the No. 3 Senate Republican, told The Hill. "Who knows how long and how much the Democrats are going to want to weigh in with some of those. But it will for sure be time consuming. That's not going away."

Senators also will need to consider Ronny Jackson, the top White House physician, to replace David Shulkin as Department of Veterans Affairs secretary.

GOP senators have largely remained mum over Jackson's nomination, which has come under scrutiny given the physician's lack of experience in running a large bureaucratic organization.

"I've never met him, don't know him. And what I do know does suggest that he needs to demonstrate that he has the qualifications, the capabilities despite the lack of experience," Sen. Jerry Moran (R-Kansas), a member of the Senate Veterans Affairs Committee, told NPR.

Nominations need just a simple majority to clear the Senate. But with a fragile 51-seat grip on the chamber, Republicans have no room for error.

Democrats haven't signaled if they will unanimously vote against the three nominees.

The White House, GOP leadership and outside groups are expected to pressure red and purple state Democrats up for reelection to vote for Trump's picks, and there's reason to think some Democrats could see reason to vote for one or more of the nominees.

Haspel is seen as facing a more challenging confirmation battle than Pompeo, as several key Republican senators remain on the fence.

Sen. John McCain (R-Ariz.), who has been absent from Washington for months as he battles brain cancer, wants Haspel to detail her views and involvement on Bush-era "enhanced interrogation techniques," which are now widely viewed as torture, saying the issue is critical to the Senate's consideration of her nomination.

Director of National Intelligence Dan Coats would not commit to fully declassifying all information on Haspel's involvement in the techniques but said "every effort will be made to fully explain exactly what her role was and what wasn't."

Outside groups and advocates are already gearing up for an intense fight.

Dozens of former Pompeo staffers released a letter on Friday urging support for his nomination. The letter said that Pompeo had "never shied away from speaking the truth" and that his "leadership at State will empower American diplomacy, strengthen America's influence and make the world a better place."

Progressive and human rights groups want the Senate to reject Haspel's nomination over her role in interrogations at a so-called black site prison and the destruction of videotapes documenting the waterboarding sessions of an al Qaeda suspect there.

Several Democratic senators—including Sen. Ron Wyden (D-Ore.), a member of the Senate Intelligence Committee—have already come out against her.

The Senate Intelligence Committee hasn't yet scheduled a hearing date for Haspel.

Pompeo is scheduled to testify before the Senate Foreign Relations Committee on Thursday. Aides to several Democratic senators on the panel noted their bosses are also expected to meet privately with him.

The fight comes as Republicans and Democrats bicker over the length of time it has taken to consider Trump nominees.

Under the rules, senators can force up to 30 hours of post-cloture debate time, eating up days of Senate floor time. It has taken Trump's nominees an average of 84 days to be confirmed, according to a tracker from The Washington Post and the Partnership for Public Service.

Changing the rules to speed up votes for Trump's nominees has been under discussion among Senate Republicans for roughly a year.

GOP Sen. James Lankford's (Okla.) proposal would cut down debate time from 30 hours to eight hours for most nominations once they've overcome an initial hurdle that shows they have the simple majority to pass. Most Cabinet-level nominations would not qualify for the shorter debate time under Lankford's proposal.

A GOP aide told The Hill that the proposal could see movement in the Rules Committee in May. Sen. Roy Blunt (R-Mo.), the next chairman of the committee, predicted the proposal will get a vote, adding that "Republicans have every right to be offended by the way the rules have been abused."

Republicans are putting the fight over Trump's nominees at the center of their messaging heading into the 2018 election.

"Even if we were to lose the House and be stymied legislatively, we could still approve appointments, which is a huge part of what we do," Majority Leader Mitch McConnell (R-Ky.) told the Kentucky Today editorial board.

It's unlikely that the current slate of confirmation fights will be the final Cabinet shakeup senators face amid speculation that several officials—including EPA Administrator Scott Pruitt, Attorney General Jeff Sessions and Housing and Urban Development Secretary Ben Carson—could be next on the chopping block.

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57 - Washington Examiner: [VA pick Ronny Jackson: 'I've got what it takes'](#) (8 April, Kelly Cohen, 4.8M uvm; Washington, DC)

The man picked by President Trump to take over as head of the Department of Veterans Affairs says he's "got what it takes" to lead the troubled agency.

"I think I've got what it takes, and you know, I don't buy into that argument [that I lack experience] at all," Ronny Jackson said in a profile of him published in the Lubbock Avalanche-Journal on Sunday.

The Texas native was appointed to be the doctor to the president by former President Barack Obama in 2013, and retained by President Trump. Last month, Trump announced he planned to replace David Shulkin with Jackson as the VA secretary.

"I've been in leadership school for 23 years now. ... And I've been able to rise to the level of an admiral, a flag officer in the Navy. I didn't just stumble into that. So I've gotten a lot of leadership background, I've got a lot of leadership experience as a Navy officer, and I've got a lot of day-to-day leadership experience," Jackson told the newspaper.

He added: "You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions."

Jackson, a Navy rear admiral, first worked in the White House under former President George W. Bush. He told the paper that former Bush employees who were on Trump's presidential transition team helped him remain in his role in the Trump administration.

"Some of the people that were working on the Trump transition had been a part of the Bush 43 administration, and they knew me," Jackson explained. "They talked to President Trump about it, and I talked about it with him, and he just immediately appointed me as his physician as well."

Jackson also said he "won't stay on active duty" and will "be a vet right away."

"I've been overseas, and I've been deployed in combat zones with Marines and soldiers and airmen and sailors, and I've seen first-hand what they go through, the injuries and the things they come home with. I've seen how that happens, and how devastating it is to them and their families. I just want to make sure that we do our part as a country and we let them know that we appreciate that and we take care of them," he said.

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58 - The Hill: [Senate uncertain how to proceed on dual Trump nominations for White House physician: report](#) (8 April, Brett Samuels, 11.9M uvm; Washington, DC)

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Some lawmakers are unsure how to proceed with President Trump's pick for Veterans Affairs secretary because he also has a pending military promotion, The Washington Post reported Sunday.

Trump nominated Rear Adm. Ronny Jackson to be promoted from a one-star admiral to a two-star admiral just days before the president ousted Veterans Affairs Secretary David Shulkin. Trump named Jackson as Shulkin's replacement, pending Senate confirmation.

However, the timing of the two nominations has created confusion on how to proceed, The Washington Post reported. To lead the VA, Jackson may be forced to give up his military promotion and roughly \$1 million in future pension earnings.

The White House has said Jackson will remain on active duty until he is confirmed to run the VA. However, the White House did not respond to inquiries from the Post about whether it will address Jackson's conflicting nominations.

Jackson, who has served as the presidential physician since 2013, has drawn criticism from outside groups and some lawmakers who worry he does not have the managerial experience to run an operation as large as the VA.

The White House brushed aside those concerns, saying Trump has "full confidence" in Jackson to replace Shulkin.

Shulkin was fired amid intense scrutiny after an inspector general report found he spent most of his time during a trip to Europe last summer sightseeing rather than conducting official business and improperly accepted tickets to a Wimbledon tennis match as a gift.

Following his ouster, Shulkin defended his tenure, speculated he was pushed out because he opposed privatization and railed against the "toxic" atmosphere in Washington.

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59 - Military Times: [VA secretary nominee brushes off criticism over inexperience](#) (9 April, Leo Shane III, 2.1M uvm; Springfield, VA)

President Donald Trump's pick to take over the Department of Veterans Affairs downplayed his management inexperience in his first public interview since his nomination, saying his time in the military has honed his leadership skills.

Dr. Ronny Jackson, who has served as White House physician since 2006, told the Lubbock Avalanche-Journal of Texas, his hometown newspaper, that he has heard the criticism concerning his ability to take over the nearly \$200 billion department with 385,000-plus employees.

But he remains undeterred.

"I've been in leadership school for 23 years now ... and I've been able to rise to the level of an admiral, a flag officer in the Navy," he said. "I didn't just stumble into that. So I've gotten a lot of

leadership background, I've got a lot of leadership experience as a Navy officer, and I've got a lot of day-to-day leadership experience

"You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions."

Jackson was a surprise pick as the next VA secretary, following the dismissal of David Shulkin from the role last month.

He is an Iraq war veteran who deployed as an emergency medicine physician with the Surgical Shock Trauma Platoon in Taqaddum, Iraq, in 2005. He served as the White House doctor for Trump and also former presidents George W. Bush and Barack Obama, directing health care for not only the commander in chief but their senior staff and Cabinet officials.

Jackson told the *Avalanche-Journal* he had planned to retire from the military after Obama's presidency ended, but Trump convinced him to stay on staff. Now, he's poised to make the move from leading a small medical staff at the White House to a Cabinet secretary post.

He acknowledged it's a promotion he never expected.

"I really haven't planned my life out real meticulously," he told the paper. "I've just kind of tried to enjoy what I'm doing and do a good job, and one thing has led to another."

Jackson still has not retired from the military, but White House officials said he intends to do so as his confirmation process progresses. Active duty military officers cannot serve in Cabinet roles.

Although not a veteran yet himself, Jackson said he is familiar with the needs of his fellow service members and is focused on delivering "the absolute best care" to them.

"I've been overseas, and I've been deployed in combat zones with Marines and soldiers and airmen and sailors, and I've seen first-hand what they go through, the injuries and the things they come home with," he said.

"I've seen how that happens, and how devastating it is to them and their families. I just want to make sure that we do our part as a country, and we let them know that we appreciate that and we take care of them."

No timetable has been set for Jackson's confirmation hearings.

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60 - ConnectingVets: [IAVA hopes VA Secretary nominee is the right choice](#) (9 April, Eric Dehm, 24k uvm; New York, NY)

The maelstrom continues to swirl atop the Department of Veterans Affairs. Shulkin is out, Wilkie is the acting secretary and Rear Admiral Ronny Jackson came out of left field as President Trump's nominee to permanently fill the position.

It's been a wild few weeks in regards to veteran issues on Capitol Hill, and Iraq and Afghanistan Veterans of America (IAVA) has been closely watching as it has all unfolded. Chief Policy

Officer Melissa Bryant says the organization has concerns over recent events, but maintains hope that it will all work out in the best interests of veterans.

During an appearance on the Morning Briefing, Bryant said the upcoming hearings on Admiral Jackson's nomination should shed quite a bit of light on the nominee's qualifications, and his vision for the future of the VA. At this point, Bryant believes it unfair to reach any conclusion on Jackson as there's simply not enough information available on him and until his thoughts on important matters like privatization are known, IAVA will maintain a "wait and see" approach to the presidential physician's nomination.

Bryant's full interview, focusing on the VA and other issues like the omnibus spending bill and IAVA's "Big 6" legislative items is available below.

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61 - **ConnectingVets:** [VA pick Ronny Jackson says he's up for the job](#) (9 April, Matt Saintsing, 24k uvm; New York, NY)

President Donald Trump's pick to lead VA wants veterans to know he's up to the task and is dismissing fears he's not qualified to lead the second largest government agency, one with more than 300,000 employees.

Randy Jackson certainly has the medical chops as a Navy doctor, but veterans groups were largely caught off guard when Trump tweeted his intent to nominate him as Secretary of Veterans Affairs. In his first media appearance since Trump nominated him, Jackson says he's more than just a Naval officer.

"You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions," Jackson told the Lubbock Avalanche-Journal.

"I think I've got what it takes, and you know, I don't buy into that argument at all."

Trump announced his intent to nominate Jackson March 28 in a tweet, citing his displeasure with the slow pace of improvements under David Shulkin's tenure.

Shulkin penned an op-ed the day after he was fired taking to task what he calls the administration's attempt to privatize the agency. However, Shulkin told USA TODAY that he believes Jackson can do the job, but he has to build the right team around himself.

In his interview with the Avalanche-Journal, Jackson didn't outline any policy or his views on how best to give veterans care. He did say, however, that "we owe the vets the absolute best care that's available out there."

"I've been overseas, and I've been deployed in combat zones with Marines and soldiers and airmen and sailors, and I've seen first-hand what they go through, the injuries and the things they come home with," said Jackson.

The VA has been beleaguered by scandals since 2014, when it was revealed veterans had died while waiting for appointments at a VA clinic in Phoenix, Ariz.

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If confirmed, Jackson will be the fourth Secretary of Veterans Affairs in four years.

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62 - Becker's Hospital Review: [How a military promotion could complicate Dr. Ronny Jackson's VA nomination](#) (9 April, Leo Vartorella, 441k uvm; Glencoe, IL)

President Donald Trump's nomination of White House physician Ronny Jackson, MD, to lead the Department of Veterans Affairs has been complicated by his simultaneous promotion to two-star admiral, according to The Washington Post.

President Trump nominated Dr. Jackson for the promotion in late March, but he cannot stay on active duty and also direct the VA. A Senate aide told The Washington Post that lawmakers are confused on how to proceed with the dual nomination tasks. Dr. Jackson will retire from active duty upon assuming the role of VA secretary, but he stands to gain nearly \$1 million in pension benefits if the Senate confirms his promotion before retiring.

"This whole situation is very much out of the norm," the unnamed Senate aide told The Washington Post. "There's some question here whether [Dr. Jackson's] flag officer nomination will move forward given his VA nomination. It's all [to be determined], because he can't serve in both positions concurrently, so it wouldn't make sense for the Senate to move the nominations concurrently."

Dr. Jackson's nomination has faced criticism over his lack of formal management experience, but he believes his military career has adequately prepared him for the job's responsibilities.

"I've been in leadership school for 23 years now," Dr. Jackson told the Lubbock Avalanche-Journal, ". . . and I've been able to rise to the level of an admiral, a flag officer in the Navy. I didn't just stumble into that. So I've gotten a lot of leadership background, I've got a lot of leadership experience as a Navy officer, and I've got a lot of day-to-day leadership experience. You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life-and-death decisions."

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63 - Task & Purpose: [Trump's VA Pick Faces A Dilemma Most Troops Would Love To Have](#) (9 April, Adam Weinstein, 102k uvm; New York, NY)

I'm about to suggest something that would've been unthinkable to me as an E-3: Put yourself in the admiral's shoes.

You're 23 years into a terrific career as a naval physician. For 12 of that, you've been the president's doctor, administering checkups to three very different POTUSes — high-stakes business, sure, but you've been doing it longer than most service members do anything.

You've got a star on your shoulder, and you've just been selected to collect a second one... along with a nice bump to \$14,268.30 in base monthly pay — which would also add a welcome

boost to your already-rich retirement pension, whenever you feel like actually retiring. You're a spry 50, so no need to worry about that just now.

But then a president asks you to do a daunting job you have no hard experience for: joining his Cabinet to run the Department of Veterans Affairs, the nation's second-largest publicly funded institution. You'll face a tough Senate confirmation. If confirmed, you'll enter a snake's nest of competing interests and ponderous bureaucracies, where your standing with the POTUS who hired you is in doubt from day to day.

Also, you'll have to forgo that second star and retire from the only organization that's employed you since med school. Like, now.

Such is the dilemma that Rear Adm. (lower half) Ronny Jackson, U.S. Navy, faces this week, as he prepares for Senate hearings about his nomination to run VA.

Jackson, a highly respected physician, first garnered headlines when he declared after President Donald Trump's first physical that the portly POTUS "might live to be 200 years old... He has incredibly good genes, and it's just the way God made him." Whatever else may have transpired between Jackson and Trump since then, the boss evidently has the impression that Jackson's got the right stuff to run 1,250 hospitals and clinics serving 9 million veterans across the U.S.

We should have such problems, you say: Take the extra star and the \$171,000 admiral's salary, or get out with an annual retirement of more than \$50,000 to take a prestigious six-figure job working directly for the president of the United States?

Of course, there's a lot more to it than money. Here are three reasons Jackson isn't living the dream, so much as facing a nightmare:

His choice isn't really a choice.

You're an active duty military officer, and the president asked you point blank to do a thing that is neither illegal nor immoral. Could you really say no? Perhaps, but most officers wouldn't, even if they hated the proposal. And though he's all in, it's not at all clear where Jackson really stands on his job offer; White House sources tell the Washington Post that the admiral "initially questioned whether, as a career Navy officer with limited managerial experience, he's an optimal candidate to lead an agency of more than 360,000 employees."

He's being set up for failure.

Lately, Jackson's been expressing enthusiasm about the job Trump offered him. "I've been able to rise to the level of an admiral, a flag officer in the Navy. I didn't just stumble into that," he told a hometown paper when asked what qualified him to run VA. "I think I've got what it takes." That's undoubtedly true! But far more politically savvy hospital administrators and CEO types — like David Shulkin and Robert McDonald — have been smashed by the daily grind of nervous veterans' groups, rattled civil servants, and strident political lobbyists who cloy the VA secretary on a daily basis. The uniform provided Jackson a modicum of safety: Tell your truth and take your orders. (Not that it did Lt. Gen. H.R. McMaster any good.) Now you're a civilian, and you going to have to bring bad news the president's way — with a lot more at stake than another star.

He's probably not gonna make it that far.

Nominating a sitting flag officer to run VA is largely unprecedented — Gen. Omar Bradley did it after World War II, until pro-privatization vets' groups pushed him out in 1946 — and nominating a flag officer with a promotion pending before the Senate has caused a bunch of procedural problems that the Trump administration doesn't seem to care about, leaving “lawmakers flummoxed about how to proceed,” one Senate aide suggested to the Washington Post. “There's some question here whether [Jackson's] flag officer nomination will move forward given his VA nomination. It's all TBD, because he can't serve in both positions concurrently, so it wouldn't make sense for the Senate to move the nominations concurrently.” Senators are already expected to squeeze Jackson hard, on television, on his qualifications and preparations for a Cabinet post. The pending promotion just gives them another reason to question whether the VA post is the best use of Jackson's talents — and whether the White House that tapped him has its crap together.

In the end, this grunt's dream — which prestigious six-figure gig to take? — is a career officer's nightmare: Jackson could avoid an iffy nomination and a thankless job while collecting a \$25,000-a-year promotion... but that would require him to say “No, sir” to a president. So far, Jackson's doing what you'd expect a career officer to do: trying to polish this turd. For his sake and the sake of vets all over America, here's hoping that shit will keep a shine for a while.

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64 - Washington Post: [Senate Republicans express concerns about Trump's choice to lead Veterans Affairs](#) (11 April, Seung Min Kim, 43.9M uvm; Washington, DC)

Ronny L. Jackson, President Trump's choice to lead the Department of Veterans Affairs, is facing mounting skepticism from Senate Republicans over whether he has the management experience to lead the nation's second-largest bureaucracy.

The comments from several GOP senators, particularly those with influence on veterans' issues, signal Jackson will have to work overtime to convince not just Democrats but Trump's own party that he is qualified to oversee the beleaguered agency. That challenge comes at a time when Senate Republicans are already juggling other controversial nominations that will consume much of the political oxygen on Capitol Hill.

Jackson has served three administrations under both parties as the White House physician yet has little management experience on his résumé as he gears up to take over a sprawling agency of 360,000 workers and deal with the vexing challenges of providing health care and benefits to military veterans. Republicans say they know little to nothing about Jackson and are quickly studying up as they prepare for one-on-one meetings with the nominee.

“Certainly, I do have concerns about his experience, as far as managing people,” said Sen. John Boozman (R-Ark.), who sits on the Senate Committee on Veterans' Affairs, which will vet Jackson's nomination. “There is some concern about whether he's been in a position to lead an organization like that.”

Sen. Jerry Moran (R-Kan.), another committee member, also expressed worries about Jackson.

White House physician Ronny L. Jackson is facing questions about whether he has the right experience to lead the Department of Veterans Affairs. (Jabin Botsford/The Washington Post)

"The VA is a difficult place to manage, regardless of what your background experience is. I want to know more about how he believes that he's capable of fulfilling those responsibilities, and I have a wide array of questions in regard to his experience and background," Moran said. "I need to be convinced that he can make a difference at a department in which the culture and the upper echelons of its leadership need to have somebody who can take charge."

At best, Jackson is getting a tepid reaction from Senate Republicans, many of whom had praised his ousted predecessor, David Shulkin, even if they occasionally clashed with him over policy. Democrats were also vocal supporters of Shulkin, the sole Cabinet holdover from the Obama administration and who was the rare Trump-appointed official who sailed through the Senate with no objections.

A White House spokesman did not return a request for comment Tuesday on the Senate Republicans' concerns surrounding Jackson's qualifications. But the White House has defended Jackson's credentials in the past, and the physician himself laid out his leadership background in an interview with a local newspaper in Texas published over the weekend.

"I've been in leadership school for 23 years now. . . . And I've been able to rise to the level of an admiral, a flag officer in the Navy. I didn't just stumble into that," he told the Lubbock Avalanche-Journal.

He added: "I think I've got what it takes, and you know, I don't buy into that argument at all."

Democrats are also questioning whether Jackson can handle oversight of the massive bureaucracy, which is second only to the Pentagon in size. And they're making it clear that Jackson's nomination will be intertwined with the broader fight about whether veterans should have more access to private doctors at taxpayers' expense.

Shulkin had worked with senators on a bipartisan compromise that would largely keep VA in control if veterans can obtain private health care, while removing some restrictions. But the White House has pushed for a more aggressive turn toward privatization, which has alarmed Democrats and some veterans' groups who worry about outsourcing so much of veterans' care.

Sen. Patty Murray (D-Wash.) said she wants to hear from Jackson that he is "unequivocally opposed to privatization."

"This is also a concern across the board, from all sides and from the veterans organizations that want to see a VA that was promised to them," Murray said. "We don't want to send the millions of veterans out into a system where the doctors meeting them may not be qualified."

Compounding the challenges for the Trump administration is that Jackson is just one of a handful of Cabinet vacancies that the Senate is suddenly facing after a recent wave of dismissals and resignations.

Republicans are scrambling to quickly install Mike Pompeo as secretary of state. His nomination to be CIA director was supported by 15 members of the Senate Democratic Caucus last year, but he will face a much more sharply partisan confirmation battle to become the nation's chief diplomat. Gina Haspel's nomination to succeed Pompeo at the CIA will be a greater challenge for the administration, with both Democrats and Republicans raising questions about her involvement in the agency's "enhanced interrogation" program, which critics say is tantamount to torture.

Both nominees are already facing opposition from Sen. Rand Paul (R-Ky.). Pompeo's confirmation hearing is scheduled for Thursday. Haspel's paperwork has yet to be submitted to the Senate and a hearing is not on the books. Jackson's hearing has yet to be scheduled.

Senators are also carefully watching the controversies surrounding Scott Pruitt, the embattled administrator of the Environmental Protection Agency, which would be another challenging vacancy to fill in an election year.

Republican lawmakers are much more eager to focus on touting their legislative accomplishments, such as the recently passed tax law, rather than grueling confirmation battles that will only ignite partisan tensions in the Senate.

"The confirmations, they're important," Moran said. "But it is very difficult for us to deal with other issues, any things that are pending, that are important to the country when we're consumed with confirmations, and confirmations that are ones that we had confirmed within the last year or so. And so it reduces the time in which we have to pursue other important issues for the country."

"It would be good to have consistency [among the Cabinet secretaries] to develop the relationships on Capitol Hill," said Sen. Mike Rounds (R-S.D.). "I think today, that is lacking with this administration."

Senate Republicans and the White House have hammered Democrats, most recently this week, for stalling key administration nominees. But by adding more Cabinet-level picks to the Senate's to-do list, the administration is only further delaying consideration of those lower-level picks.

The White House keeps a list of nominees that ranks each of them by priority, according to one GOP official familiar with the tally. Once Cabinet-level nominations are moved to the top, it moves other picks down, potentially for months, the official said.

Sen. Jon Tester (Mont.), the top Democrat on the veterans' committee, said he urged Jackson to submit his paperwork to the Senate soon so a review of his qualifications can begin.

"I think both the management experience as well as his view on where he wants to take VA is really going to be important," Tester said. "I'm very concerned about VA right now."

When asked if he believes Jackson is qualified to run the agency, Sen. Johnny Isakson (R-Ga.), who chairs the veterans' committee, said, "I don't know enough to know anything."

"I'm a blank slate," said Isakson, who has spoken on the phone with Jackson. Senate Majority Leader Mitch McConnell (R-Ky.) has yet to comment on Jackson's nomination.

Sen. Thom Tillis (R-N.C.), a member of the veterans' committee, also said he has yet to make a judgment on whether Jackson is qualified. Sen. Dan Sullivan (R-Alaska), a fellow committee member, said he wants to question Jackson about "his experience, or lack thereof, on the management side."

"That's the most difficult, frustrating bureaucracy in Washington," Sullivan said. "I think most people would absolutely agree with that."

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65 - The Hill: [VA privatization fight could erupt in confirmation hearing](#) (11 April, Nathaniel Weixel, 11.9M uvm; Washington, DC)

Long-simmering tensions about privatizing the Department of Veterans Affairs (VA) could erupt into a confirmation battle over President Trump's pick to lead the department.

Trump's decision to oust former VA Secretary David Shulkin late last month and replace him with White House physician Ronny Jackson stoked speculation that the White House wants to allow veterans more access to private-sector health-care providers.

In an op-ed published in The New York Times just hours after he was removed, Shulkin blamed his ouster on forces within the administration that he said are pushing hard for privatization "The advocates within the administration for privatizing VA health services ... saw me as an obstacle to privatization who had to be removed," Shulkin wrote.

Dismantling the department's health-care system "is a terrible idea," Shulkin wrote, adding that the private sector "is ill-prepared to handle the number and complexity of patients that would come from closing or downsizing VA hospitals and clinics."

Groups like the Koch brothers-backed Concerned Veterans for America (CVA) are pushing to loosen current restrictions on veterans receiving private-sector care.

Democrats and veterans' advocates are concerned that the White House is taking those calls for privatizing the VA system seriously, but the VA denied last week that there is any push to privatize its health system.

"There is no effort underway to privatize VA, and to suggest otherwise is completely false and a red herring designed to distract and avoid honest debate on the real issues surrounding veterans' health care," the agency said in a statement.

Democrats and veterans' advocacy groups have been wary of Republican efforts to privatize the VA since before Trump took office.

In a 2016 campaign rally in Virginia Beach, Trump called the VA corrupt and inefficient.

"Veterans should be guaranteed the right to choose their doctor and clinics, whether at a VA facility or at a private medical center," Trump said. "We must extend this right to all veterans."

Senate Democrats and veterans groups have not yet drawn any hard lines against Jackson, partly because they said they don't know what his positions are.

Verna Jones, the executive director of the American Legion, said she would have to sit down and speak with Jackson before passing judgment on his nomination.

"It seems like people are putting the cart before the horse. Jackson hasn't had a confirmation and none of us know his views," Jones said. "To be clear, the Legion opposes privatization. How all this ties into Jackson — we owe it to him to wait and see."

Jackson is an active-duty Navy admiral who has worked as the White House physician for three presidents. Lawmakers have expressed skepticism over whether Jackson, who doesn't have experience working with the VA or managing a health-care organization, has the qualifications to run the agency.

Senate Democrats on the Veterans' Affairs Committee said they also don't know where Jackson stands on privatization. Still, they don't trust the administration's motives and are gearing up for a fight.

Sen. Jon Tester (D-Mont.), the ranking Democrat on the committee, told The Hill he has only had a brief phone call with Jackson since Trump nominated him for the position.

"There are two areas of concern ... one is privatization and the other is management. So that's what we're going to focus on," Tester said.

"Our job is to strengthen the VA in order to provide high-quality care to our veterans, not dismember it," Sen. Bernie Sanders (I-Vt.) said in a statement. "The Senate Committee on Veterans Affairs should not approve any nominee for secretary who supports the privatization of the VA."

Sen. Richard Blumenthal (D-Conn.) told The Hill privatization is a "serious concern" that he hopes to address with Jackson.

A spokeswoman for the VA committee said a hearing would be scheduled as soon as Jackson submits his paperwork and finishes a background check.

Jackson's nomination could also spotlight legislation that is intended to make it easier for veterans to get care outside the VA system without completely privatizing the system.

The legislation from Tester and Senate Veterans' Affairs Committee Chairman Johnny Isakson (R-Ga.) has backing from major veterans groups such as the American Legion and Veterans of Foreign Wars.

The bill would overhaul VA Choice, a temporary program that allows veterans to seek care outside the VA network — but only in cases where they have to wait more than 30 days for an appointment or drive more than 40 miles to a facility.

It would eliminate the waiting period and distance requirements and allow veterans to seek community care outside the VA if veterans and their providers agree it's the best method of treatment.

But the Koch-backed CVA has lobbied hard against it, because they think it doesn't loosen regulations enough.

Opposition has also come from the left. House Democrats blocked the bill from being included in the omnibus funding bill that passed last month because they think it moves the VA too far toward privatization.

A Senate VA committee aide said Isakson has spoken to Majority Leader Mitch McConnell (R-Ky.), and hopes to bring the bill to the floor for a stand-alone vote in the next few weeks.

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66 - American Thinker: [VA privatization debate could derail new secretary's confirmation](#)
(11 April, Rick Moran, 4.8M uvm; El Cerrito, CA)

When Donald Trump fired his secretary of Veterans Affairs, David Shulkin, and named his personal physician, Rear Admiral Ronny Jackson, to replace him, red flags went up on Capitol Hill and among some veterans groups who oppose privatizing the V.A.

Indeed, in a parting shot to his detractors within the administration, Shulkin wrote an op-ed in the New York Times warning against forces inside the White House that want to privatize the entire agency.

The Hill:

In an op-ed published in the New York Times just hours after he was removed, Shulkin blamed his ouster on forces within the administration that he said are pushing hard for privatization[.]

"The advocates within the administration for privatizing V.A. health services ... saw me as an obstacle to privatization who had to be removed," Shulkin wrote.

Dismantling the department's health care system "is a terrible idea," Shulkin wrote, adding that the private sector "is ill-prepared to handle the number and complexity of patients that would come from closing or downsizing V.A. hospitals and clinics."

Groups like the Koch brothers-backed Concerned Veterans for America (CVA) are pushing to loosen current restrictions on veterans receiving private sector care.

Very few veterans groups want to eliminate the V.A. or downsize it. But it's a convenient red herring for liberal groups and Democrats in Congress to bash Trump:

"There is no effort underway to privatize VA, and to suggest otherwise is completely false and a red herring designed to distract and avoid honest debate on the real issues surrounding veterans' health care," the agency said in a statement.

Democrats and veterans' advocacy groups have been wary of Republican efforts to privatize the VA since before Trump took office.

In a 2016 campaign rally in Virginia Beach, Trump called the VA corrupt and inefficient.

"Veterans should be guaranteed the right to choose their doctor and clinics, whether at a VA facility or at a private medical center," Trump said. "We must extend this right to all veterans."

Senate Democrats and veterans groups have not yet drawn any hard lines in the sand [sic – a line in the sand...? –DJB] against Jackson, partly because they said they don't know what his positions are.

Verna Jones, the executive director of the American Legion, said she would have to sit down and speak with Jackson before passing judgment on his nomination.

"It seems like people are putting the cart before the horse. Jackson hasn't had a confirmation and none of us know his views," Jones said. "To be clear, the Legion opposes privatization. How all this ties into Jackson – we owe it to him to wait and see."

That's a rare sentiment in these partisan times. But Democrats will also look to diminish Jackson by claiming he is unqualified to lead such a large agency:

Jackson is an active-duty Navy admiral who has worked as the White House physician for three presidents. Lawmakers have expressed skepticism over whether Jackson, who doesn't have experience working with the VA or managing a health care organization, has the qualifications to run the agency.

Senate Democrats on the Veterans' Affairs Committee said they also don't know where Jackson stands on privatization. Still, they don't trust the administration's motives and are gearing up for a fight.

AT contributor Ed Timperlake, a former V.A. assistant secretary, weighed in on Jackson's qualifications:

The selection of Admiral Jackson is being attacked on the issue of his lack of significant command qualifications. In fact, Jackson's immediate experience will ultimately prove to be a boon for the VA. Navy doctors are trained professionals for big-deal thinking. I would never typecast a Navy doctor with the rank of Admiral as someone who doesn't understand how to take command of an organization the size of the VA.

As for privatization of the V.A., it's not going to happen. Every major veterans group is opposed to privatizing the agency, and most Republicans oppose it, too. But the scandals in recent years involving unacceptable wait times for veterans who need care have begun the process of much needed reforms that include some care being supplied in certain circumstances by the private health care industry. As Mr. Timperlake points out, there may be issues with timely payments by the government to private providers, which he recommends an agency-wide audit to discover. But with so many returning veterans from Iraq, Afghanistan, and other combat zones who have serious health issues, it seems that an expansion of choices for veterans is logical and necessary.

How this impacts Jackson's confirmation isn't clear, except that Democrats will seek any opportunity to damage the president, and the Jackson nomination is setting up to give them exactly what they want.

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67 - Herald-Tribune (Creators Syndicate): [McCaughey: Marching orders for Trump's new VA secretary](#) (11 April, Betsy McCaughey, 871k uvm; Sarasota, FL)

Since President Donald Trump ousted Veterans Affairs Secretary David Shulkin, the question reverberating in Washington is whether Trump's new pick, Rear Adm. Ronny Jackson, is capable of heading a department with 360,000 employees and 9 million vets under its care.

Senate Democrats carp he lacks experience running “a complex organization.”

Experience is overrated. President Barack Obama’s VA Secretary, Robert McDonald, failed miserably, despite having run Procter & Gamble. Vets died on phony wait lists on McDonald’s watch.

Jackson’s last combat role was with a surgical shock trauma unit in Iraq. Sounds like good preparation for battling the killer VA bureaucracy.

Jackson also shares Trump’s vision of putting vets in the driver’s seat about their own medical care. Here’s what Jackson can learn from his predecessors’ failures.

Lesson 1: Make vets the priority, not protecting the VA bureaucracy. Shulkin refused to do that. Trump has pledged to fix the Veterans Choice Program so vets can see private doctors when they decide it’s necessary. VCP was created in 2014 after revelations that sick vets were dying on wait lists at VA hospitals. VCP is supposed to allow vets to get private care if they live far from a VA facility or have waited too long. But VCP’s red tape makes seeing an outside doctor almost impossible. That’s deliberate. Sen. Bernie Sanders, who co-authored VCP legislation, relies on union campaign contributions and will do just about anything to protect union jobs at the VA. Keeping vets trapped at the VA with no alternatives is a job-protection racket.

Shulkin was part of that racket, too. He misled Trump and Congress with double talk about reforming VCP “in a way that will work for veterans and work for VA.” But protecting VA bureaucracy shouldn’t be a consideration, when vets’ lives are at stake.

Shulkin showed his true colors when Congress passed last month’s big spending package. Trump and congressional Republicans had pushed hard to include VA reforms helping vets see outside doctors.

But the key person to sell this to Congress was Shulkin, and he equivocated, allowing Democrats to block its passage. It was a setback for Trump and vets. No wonder Shulkin was canned days later -- not because of flimsy travel expense abuse allegations.

Lesson 2: Cut wait times in half at the VA.

Shulkin claimed success in reducing waits, but that’s questionable. VA bureaucrats are still fudging the numbers, according to the inspector general.

Here’s a remedy. A whopping 47 percent of VA health care users are 65 or older. They need angioplasty and bypass surgery like other seniors. They use the VA to avoid Medicare’s out-of-pocket expenses, because their median annual income is only \$24,000. Picking up their co-pays would cost very little and encourage them to use Medicare instead of the VA Bingo, and it would cut VA wait times by nearly half, making room for younger vets to get combat-related care only the VA can provide.

Lesson 3: Don’t count on VA bureaucrats to fess up when things go wrong. Jackson should use unannounced audits to uncover dangerous conditions at medical facilities, instead of trusting officials to report them up the chain of command.

An inspector general report last month exposed “a breakdown of core services” at medical centers under Shulkin’s command. At the Washington, D.C., facility, under Shulkin’s nose,

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patients were needlessly overexposed to anesthesia due to inventory mismanagement. After patients were put under, surgeons sometimes discovered they were out of equipment and had to race across the street to borrow it from another hospital or reschedule the procedure. Shulkin claims he could “not recall” ever being notified of such problems. He expected to be notified?

Pundits are predicting a confirmation battle. The smart money should be on Jackson. He’s combat-tested. Disregard the partisan drivel about his lack of experience running a big organization. It’s coming from the same people who had no problem making a community organizer the president.

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68 - Fayetteville Observer: [Our View: Does VA nominee have the right stuff?](#) (11 April, Editorial Board, 439k uvm; Fayetteville, NC)

We hope Robert Wilkie enjoys the challenge of running the Department of Veterans Affairs, because he may have the job for a bit longer than his “acting secretary” title might indicate. Storm clouds are already gathering for President Trump’s nominee for the permanent position, Navy Rear Adm. Ronny Jackson.

Storm clouds, and rough seas, may be appropriate for the man whose unconventional route to the nomination was primarily hitting it off with the commander in chief while serving as his personal physician.

His path to becoming a flag officer certainly involved command responsibilities at times, and he’s by all descriptions an excellent physician, dedicated to medicine, and he clearly sees the need for providing great care for the nation’s veterans.

But we don’t see anything that prepares him to run the federal government’s second-largest bureaucracy, supervising more than 360,000 workers spread across the country in an unwieldy bureaucracy, providing health care and benefits to veterans.

Members of the Senate Committee on Veterans Affairs, which will hold hearings on his nomination, are keptical. That includes the committee’s Republican members. One of them, Sen. Jerry Moran of Kansas, told The Washington Post that, “The VA is a difficult place to manage, regardless of what your background experience is. I want to know more about how he believes that he’s capable of fulfilling those responsibilities and I have a wide array of questions in regard to his experience and background.” Moran added that, “I need to be convinced that he can make a difference at a department in which the culture and the upper echelons of its leadership need to have somebody who can take charge.”

That was the undoing of former VA Secretary David Shulkin, a physician with a resume that included running big hospital systems. Shulkin was the sole cabinet holdover from the Obama administration and as recently as last summer, the president said he was the last member of his cabinet who’d hear the Trump trademark, “You’re fired.” Six months later, that’s exactly what Shulkin heard after he was caught in the nasty crossfire of VA bureaucrats trying to thwart him, and of others determined to privatize many VA services. Shulkin stood with most national veterans groups in opposing privatization. But other high-ranking VA leaders succeeded in undermining him and it was clear that he was losing control of the organization.

Asked about his lack of large-scale management experience in a GateH Gouse Media interview, Jackson said, "I've been in leadership school for 23 years now. ... And I've been able to rise to the level of admiral, a flag officer in the Navy." Jackson added that, "You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life-and-death decisions. I think I've got what it takes, and you know, I don't buy into that argument at all."

Maybe Jackson should talk with Ben Carson, the brilliant pediatric neurosurgeon who has had a rough first year trying to manage the Department of Housing and Urban Development. He's told several interviewers lately that brain surgery was a lot easier than what he's trying to do now.

Meanwhile, acting VA chief Wilkie, a Fayetteville native and veteran of military service and several management tours at the Defense Department, is settling in at VA headquarters. The Post reported that he sent out a video to all VA staffers, urging them to communicate openly. He emphasized the VA's mission of caring for our veterans. "Being with you today is the culmination of a lifetime of watching those who have borne the battle." We hope he's able to stay out of the management warfare that did in David Shulkin, but the battle over privatization is likely to continue. And the country needs a permanent VA secretary who can take control, lead the agency and solve its problems.

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Cc:
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Subject: FW: Jackson Clips compilation March 29- April 12
Date: Thu Apr 12 2018 13:55:50 CDT
Attachments: image001.jpg
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Jackson Clips - ongoing list - FINAL.docx

fyi

James Hutton
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From: [REDACTED] (b) (6)
Sent: Thursday, April 12, 2018 2:47 PM
To: Hutton, James
Cc: [REDACTED] (b) (6); [REDACTED] (b) (6)
Subject: Jackson Clips compilation March 29- April 12

James,

Attached is the Adm. Jackson clips compilation from March 29 – April 12 (68 stories thus far).

Thanks,

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Office of Public Affairs

U.S. Department of Veterans Affairs

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Jackson News Clips

March 29 – April 12, 2018

1 - Washington Post (AP): [Trump's VA pick draws concern over thin management record](#)

(29 March, Hope Yen and Calvin Woodward, 43.9M uvm; Washington, DC)

President Donald Trump's selection of his White House doctor to run the massive Department of Veterans Affairs triggered concern Thursday among lawmakers and veterans groups about whether he has the experience to manage an agency paralyzed over Trump's push to expand private care. Ronny Jackson, a Navy rear admiral entrusted with the health of the past three presidents, is a lifelong physician whose positions on privatizing operations in the second largest federal department...

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2 - Washington Post: [Trump's pick to head veterans department faces skepticism over his experience](#)

(29 March, Lisa Rein, Seung Min Kim, Emily Wax-Thibodeaux, and Josh Dawsey, 43.9M uvm; Washington, DC)

The White House was thrown on the defensive Thursday over President Trump's choice to lead the Department of Veterans -Affairs, forcing officials to fend off mounting skepticism that Ronny L. Jackson has the experience to run the government's second-largest agency. Trump announced by tweet late Wednesday that the White House physician would succeed ousted secretary David Shulkin, surprising veterans groups and lawmakers...

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3 - Wall Street Journal: [Lawmakers Respond Cautiously to Little-Known VA Pick Ronny Jackson - Key senators on panel say they don't know enough about White House doctor to form an opinion about his ability to lead a vast bureaucracy](#)

(29 March, Louise Radnofsky and Peter Nicholas, 43.6M uvm; New York, NY)

Capitol Hill lawmakers reacted guardedly to President Donald Trump's nomination of the White House physician to head the Department of Veterans Affairs, with key members noting that they know little about him. Dr. Ronny Jackson, a U.S. Navy rear admiral who has served as a White House physician during the past three administrations, is slated to succeed Secretary David Shulkin, who was ousted Wednesday.

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4 - USA Today (Video): [6 big things the new Veterans Affairs chief will have to address](#)

(29 March, Donovan Slack and Dennis Wagner, 36.8M uvm; McLean, VA)

On the front lines at the Department of Veterans Affairs — in the agency's 1,240 hospitals and clinics — it doesn't much matter these days who holds the secretary's job in Washington. David Shulkin, who was fired Wednesday, was the third VA secretary in four years. If President Trump's nominee to lead the agency, physician and Navy Rear Adm. Ronny Jackson, is confirmed, he will be the fourth.

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5 - Politico: [Trump's VA pick blindsides staff, deepens agency disarray - 'He's got a department that's in turmoil,' a former VA secretary said. 'It's in crisis.'](#) (29 March, Lorraine Woellert, Eliana Johnson and Connor O'Brien, 23.9M uvm; Arlington, VA)

The timing of President Donald Trump's announcement to name Rear Admiral Ronny Jackson to lead Veterans Affairs was a snap decision that surprised his own chief of staff and knocked the government's second-largest agency, already bedeviled by scandal, deeper into disarray. White House chief of staff John Kelly had spoken with David Shulkin by phone Wednesday morning, reassuring the now-former VA secretary that he wouldn't be fired by tweet that afternoon.

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6 - Task & Purpose: [What's In Store For The Next VA Chief? Let's Break It Down](#) (29 March, James Clark, 102k uvm; New York, NY)

It's been an awkwardly long time coming, but as of yesterday afternoon embattled Veterans Affairs secretary David Shulkin is out of a job. The news comes after a month and a half of uncertainty that began when a scathing inspector general report detailed "serious derelictions" in expensing a Europe trip last summer. And then there were all the accusations and counter accusations of political infighting and rumors of possible replacements — at least all that is over:

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7 - Washington Post: [Opinions - Surprise: Trump's newest Cabinet nominee has no relevant experience](#) (29 March, Eugene Robinson, 43.9M uvm; Washington, DC)

You can't make this stuff up: President Trump has announced he will nominate a medical doctor who has no discernible management experience to run the second-largest agency in the federal government. Can presidents be sued for malpractice? The man Trump has named to become secretary of veterans affairs, Ronny L. Jackson, happens to be the president's personal doctor.

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8 - Washington Post (The Fix): [Who is Trump's new Veterans Affairs pick, Ronny Jackson?](#) (29 March, Aaron Blake, 43.9M uvm; Washington, DC)

The seemingly never-ending parade of staff changes in the Trump administration continued apace Wednesday, with the president announcing that Veterans Affairs Secretary David Shulkin is out and that White House physician Ronny L. Jackson will replace him. Jackson's name will be familiar to political watchers across the country for one main reason: He's the physician who delivered what some felt to be a suspiciously rosy picture of Trump's health in January.

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9 - FOX News: [Ronny Jackson picked by Trump to lead the VA: What to know about the president's physician](#) (29 March, Kaitlyn Schallhorn, 32.5M uvm; New York, NY)

President Trump gave Dr. Ronny Jackson a clean bill of health in March — to run the Department of Veterans Affairs. A Navy rear admiral, Jackson is the president's personal physician who rose to prominence after he addressed the press from the White House briefing room in January to discuss Trump's health.

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10 - FOX News (Video): [John Brennan: Trump's nomination for VA secretary is 'terribly misguided'](#) (29 March, Nicole Darrah, 32.5M uvm; New York, NY)

Former CIA Director John Brennan once again took a shot at President Trump on Twitter Thursday, saying he believes the decision to nominate Adm. Ronny Jackson to run the Department of Veterans Affairs is "terribly misguided." "I personally know and greatly respect Ronny Jackson....as a terrific doctor and Navy officer," Brennan tweeted. "However, he has neither the experience nor the credentials to run the very large and complex VA.

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11 - New York Times: [Op-ed - Ronny Jackson's Disturbing Lack of Independence](#) (29 March, Norman L. Eisen and Bandy X. Lee, 30M uvm; New York, NY)

In announcing Dr. Ronny Jackson, the White House physician, as his choice to be the new secretary for veterans affairs, President Trump has taken his latest misstep in what has been the worst presidential personnel process in modern history. We take no pleasure in saying so, including because one of us (Mr. Eisen) worked with Dr. Jackson in the White House, was even treated by him...

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12 - ABC News (Video): [Veterans groups respond cautiously to VA secretary nomination](#) (29 March, Sarah Kolinovsky, 24.2M uvm; New York, NY)

Despite his active duty status as a Navy rear admiral (lower half) and his medical experience, veterans service organizations are responding cautiously to the nomination of Dr. Ronny Jackson for secretary of Veterans Affairs, with some expressing concern about his lack of managerial experience or what his views are on reforming the VA.

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13 - The Atlantic: [The Doctor Who Suddenly Got Nine Million Patients - For a position that demands high-level policy expertise, President Trump appointed his personal physician, Ronny Jackson.](#) (29 March, James Hamblin, 23.9M uvm; Washington, DC)

Nine million veterans will soon be under the care of the emergency-physician rear admiral Ronny Jackson, pending confirmation of his appointment Wednesday to lead the U.S. Department of Veterans Affairs. This seemingly mundane appointment—a doctor and naval officer with years of experience as White House physician under both Trump and Obama...

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14 - The Hill: [White House: Trump has 'full confidence' in presidential physician to lead VA](#) (29 March, Max Greenwood, 11.9M uvm; Washington, DC)

President Trump has "full confidence" in White House physician Ronny Jackson's ability to head the Veterans Affairs (VA) Department, a spokeswoman for the White House said Thursday, despite reported concerns from some aides. "As I said earlier, the president has full confidence in Adm. Jackson," White House deputy press secretary Lindsay Walters told reporters.

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15 - The Hill: [GOP, vet groups react with caution to Trump VA pick](#) (29 March, Rebecca Kheel, 11.9M uvm; Washington, DC)

Senators and influential veterans groups are withholding judgment on President Trump's pick to lead the Department of Veterans Affairs (VA), a Navy doctor with no experience leading a federal bureaucracy. Both the Republican chairman and the Democratic ranking member of the Senate Veterans Affairs Committee said only that they look forward to meeting Rear Adm. Ronny Jackson. Several veterans groups expressed some concern about Jackson's qualifications...

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16 - Military.com: [Others Considered for VA Job Before Trump Picked His Personal Doctor](#) (29 March, Richard Sisk, 9M uvm; San Francisco, CA)

Rear Adm. Ronny L. Jackson, the personal physician to President Donald Trump, was not his first choice to replace fired VA Secretary Dr. David Shulkin, the White House said Thursday. "The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary," White House deputy press secretary Lindsay Walters told reporters.

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17 - Government Executive: [Lawmakers, Veterans Groups and Former Officials Worry VA Nominee Is Not 'Up to the Job'](#) (29 March, Eric Katz, 870k uvm; Washington, DC)

With David Shulkin now ousted from the Veterans Affairs Department, all eyes are on President Trump's nominated replacement to see where he comes down on the most pressing issue at VA: How large a role should the private sector play in providing health care to veterans? One problem for observers and stakeholders in the veteran community is Trump's pick, Dr. Ronny Jackson, has very little experience in public policy or veterans issues...

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18 - PBS: [Who is Ronny Jackson, Trump's pick to lead the Department of Veterans Affairs?](#) (30 March, Gretchen Frazee, 22M uvm; Arlington, VA)

Rear Admiral Ronny Jackson has garnered almost universal praise for his skills as a military physician and his character. But his appointment to lead the Department of Veterans Affairs is proving divisive as critics point to his lack of experience managing a large organization.

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19 - NPR (Morning Edition, Audio): [Trump Pick For VA Secretary May Get Additional Scrutiny](#) (30 March, 22M uvm; Washington, DC)

Noel King talks to Democratic Sen. Richard Blumenthal about President Trump's decision to fire VA Secretary David Shulkin, and the confirmation process of the president's pick to replace him.

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20 - MSNBC (Video): [Reines: 'There's never been a no vote against a VA nominee, this might be the time to change that record'](#) (30 March, 11.8M uvm; New York, NY)

In yet another White House personnel shakeup, President Trump ousts Secretary of Veterans Affairs David Shulkin and appoints his personal doctor Ronny Jackson. Philippe Reines, former adviser to then-Secretary of State Hillary Clinton, and Shermichael Singleton, former Deputy Chief of Staff for the Department of Housing and Urban Development, discuss with Kristen Welker whether the president's new appointee is qualified for the position.

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21 - The Hill: [Trump VA pick hesitated to take job: report](#) (30 March, Max Greenwood, 11.8M uvm; Washington, DC)

White House physician Ronny Jackson initially hesitated at the suggestion that he be nominated to lead the Department of Veterans Affairs, The Washington Post reported Thursday. Jackson was reportedly shocked when Trump tapped him for the top job at the nation's second largest government agency, the Post reported, citing senior White House officials.

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22 - New York Daily News: [A novice in the VA OR: Dr. Ronny Jackson is a very puzzling choice to lead a Veterans Affairs turnaround](#) (31 March, 26.1M uvm; New York, NY)

The 20 million-plus veterans of the U.S. Armed Forces served this country with the eminently deserved expectation that their country would serve them. Now even as the heart of that trust, the VA health care system, recovers from deadly delays in getting patients care, and after summarily dispatching his first head of the U.S. Department of Veterans Affairs, David Shulkin, President Trump inflicts risky experimental treatment, nominating as the new chief a doctor who has never come close to the operating room of managing a large organization — never mind one with nearly 378,800 employees.

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23 - NPR (All Things Considered, Audio): [Veteran Congressman On Trump's New VA Secretary Nominee](#) (31 March, 22M uvm; Washington, DC)

President Trump has picked Rear Adm. Ronny Jackson to be secretary of Veterans Affairs. Veteran and Rep. Mike Coffman (R-Colo.) tells NPR's Michel Martin why he supports the new leadership.

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24 - The Washington Post (Video): [Does Trump believe in the value of expertise, or does he disdain it?](#) (31 March, Dan Balz, 43.9M uvm; Washington, DC)

The shake-up at the Department of Veterans Affairs — out with Secretary David Shulkin and potentially in with White House physician Ronny L. Jackson — is being portrayed, correctly, as President Trump surrounding himself with Cabinet officials with whom he feels personally comfortable. A broader question arises, however, over the extent to which this president prizes or disparages expertise.

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25 - Politico Magazine: [When Our President Put His Doctor in Charge of Everything](#) (31 March, Marius Stan and Vladimir Tismaneanu, 23.9M uvm; Arlington, VA)

No one knows more about leaders' bodies than their personal physicians. Notoriously, Joseph Stalin mistrusted the Kremlin doctors, whom he suspected of trying to poison him and the other Soviet magnates. In February 1953, a month before Stalin passed away, they were arrested and horribly tortured. The ones still left alive were too terrified to treat him as he lay dying in March.

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26 - CBS News (Face the Nation, Video): [Sen. Bernie Sanders on "Face the Nation," April 1, 2018](#) (1 April, 26M uvm; New York, NY)

President Trump announced the ouster of David Shulkin as secretary of Veterans Affairs this week, nominating longtime White House physician Adm. Ronny Jackson as his replacement. Shulkin had come under withering criticism from lawmakers on Capitol Hill over his travel expenses and a blistering inspector general's report on conditions at the VA.

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27 - CBS News (Video): [Sen. Bernie Sanders says privatizing the VA a "very, very bad idea"](#) (1 April, Emily Tillett, 26M uvm; New York, NY)

Sen. Bernie Sanders, I-Vermont, says that he thinks it's too early to tell what President Trump's pick to take over leadership at the embattled Department of Veterans Affairs "stands for," but cautioned that privatizing the VA to be a "very, very bad idea." Former VA Secretary Shulkin became the latest member of Mr. Trump's cabinet to be terminated last week. The president announced that he was replacing Shulkin in a series of tweets, and said he would nominate Adm. Ronny Jackson, who had been serving as the president's doctor, to replace him.

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28 - Politico: [Sanders: 'We know nothing' about Trump's VA pick](#) (1 April, Connor O'Brien, 23.9M uvm; Arlington, VA)

Sen. Bernie Sanders wouldn't commit to supporting President Donald Trump's pick to lead the Department of Veterans Affairs, Rear Adm. Ronny Jackson, on Sunday. In an interview on CBS' "Face the Nation," the Vermont independent noted that Jackson, Trump's personal physician, is a virtual unknown on veterans issues. He also expressed concerns the Trump administration is pushing to privatize the nearly \$200 billion bureaucracy...

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29 - The Hill: [Sanders: I will work against any VA nominee backing privatization](#) (1 April, Mallory Shelbourne, 11.9M uvm; Washington, DC)

Sen. Bernie Sanders (I-Vt.) said Sunday he will work against any Veterans Affairs (VA) nominee who supports privatizing the agency. "I will do everything I can as a member of the veterans committee not to approve any nominee who is not going to strengthen the VA and who will oppose privatization," Sanders told CNN's "State of the Union."

[Hyperlink to Above](#)

30 - Miami Herald: [Trump's doc shouldn't be a slam dunk to lead Veterans Affairs](#) (1 April, Editorial Board, 8.9M uvm; Miami, FL)

The U.S. Department of Veterans Affairs has enough problems. It doesn't need one in the form of a leader who, very possibly, has no idea what he's doing. In yet another nomination made under President Trump's "You'll do — for now" philosophy of hiring the "very best people," White House physician Ronny Jackson is up for the vital job of secretary of Veterans Affairs.

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31 - Washington Examiner: [Bernie Sanders: Ronny Jackson will bend to pressure to privatize the VA](#) (1 April, Kyle Feldscher, 4.8M uvm; Washington, DC)

Sen. Bernie Sanders, I-Vt., said he thinks Dr. Ronny Jackson will likely be tasked with privatizing the U.S. Department of Veterans Affairs due to his lack of experience manning a large organization. Sanders said on CNN's "State of the Union" Jackson, the White House physician and a rear admiral in the U.S. Navy, doesn't know much about heading a large bureaucracy.

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32 - Newsday: [Senate should be wary of Dept. of Veterans Affairs nominee](#) (1 April, Editorial Board, 3.2M uvm; Melville, NY)

Caring for our nation's military veterans was one of Donald Trump's most consistent promises on the presidential campaign trail, and certainly one of his least controversial. Getting veterans the care they need is a nonpartisan priority. But the increased quality of care Trump promised hasn't come. Facilities on Long Island and in many other communities are falling apart. The Department of Veterans Affairs is increasingly being exposed as dangerous and dysfunctional.

[Hyperlink to Above](#)

33 - Las Vegas Sun: [Heller's dilemma: Side with Trump or veterans on VA pick](#) (1 April, Editorial Board, 1.5M uvm; Las Vegas, NV)

Assuming Donald Trump follows through in nominating Dr. Ronny Jackson to lead the Department of Veterans Affairs, Sen. Dean Heller will soon face an ugly consequence for becoming a team player for the president. For Heller, Jackson's confirmation offers a lose-lose proposition. Either he votes against Jackson and runs the risk of getting dinged by Trump before the midterm elections, or he votes for Jackson and alienates veterans groups that have raised concerned about the White House doctor's qualifications for the position.

[Hyperlink to Above](#)

34 - Times Union: [Editorial: VA pick insults veterans](#) (1 April, Editorial Board, 1.5M uvm; Albany, NY)

The health and welfare of millions of veterans rest on what feels more like a casting call. Donald Trump has long promoted himself as a champion of military veterans, but when he finally had a chance last week as president to demonstrate that they were more than political props for him, he failed miserably. In the same cavalier way in which he has appointed so many people who have turned out to be disasters in their jobs...

[Hyperlink to Above](#)

35 - Montana Standard: [For pity's sake, don't privatize Veterans Affairs](#) (1 April, Editorial Board, 202k uvm; Butte, MT)

Just when it was starting to look like Montana's veterans could expect a little more stability from the federal agency charged with providing their health care, another major shakeup at the Department of Veterans Affairs has placed the future of their care in doubt. Of course, the VA has long stood on shaky ground. However, the current push toward privatization, if successful, could completely erode the foundations of this critical agency and leave millions of veterans...

[Hyperlink to Above](#)

36 - Washington Examiner: [Ron Johnson: Trump 'deserves' a VA secretary who agrees with him on policy](#) (1 April, Naomi Lim, 4.8M uvm; Washington, DC)

Sen. Ron Johnson, R-Wi., agreed Sunday President Trump was right to fire former Veterans Affairs Secretary David Shulkin. "Well, I think the IG report's pretty troubling," Johnson told NBC, referring to VA inspector general Michael Missal's finding that Shulkin improperly used taxpayer dollars for a trip to Europe with his wife in July.

[Hyperlink to Above](#)

37 - U.S. News & World Report (AP): [Shulkin Says He Has 'Comfort' With Potential Successor at VA](#) (2 April, Hope Yen, 24M uvm; Washington, DC)

Former Veterans Affairs Secretary David Shulkin downplayed concerns about his potential successor's lack of managerial experience Monday, saying the key for improving the VA will be surrounding White House doctor Ronny Jackson with a good team "because no one person can do this alone." Shulkin and the White House have engaged in a highly public campaign surrounding his departure from the VA last week. Shulkin said he was fired.

[Hyperlink to Above](#)

38 - Military Times: [White House doctor could face the most contentious VA confirmation process ever](#) (2 April, Leo Shane III, 2.1M uvm; Springfield, VA)

Ronny Jackson's nomination to become the next Veterans Affairs secretary could become the most contentious confirmation process since the department was founded 30 years ago. But that's also a fairly low bar. Since the department was elevated to a Cabinet-level post back in 1988, no senator has ever voted against a VA secretary pick.

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39 - The Vindicator: [Trump's choice to lead VA raises questions on intent](#) (3 April, Editorial Board, 193k uvm; Youngstown, OH)

The physician who gave President Donald J. Trump a squeaky clean bill of health could soon lead the Department of Veterans Affairs, even though he lacks the experience to manage an enormous agency that has long been steeped in controversy. Trump's nomination of Rear Admiral Ronny Jackson, the White House physician since President George W. Bush's administration, has raised eyebrows on Capitol Hill and triggered concerns among veterans service organizations.

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40 - Washington Post: [Perspective - I've seen what a mess Veterans Affairs is. Ronny L. Jackson can't fix it. Trump's new pick to lead the cabinet is a fine doctor. That doesn't mean he can handle a massive, dysfunctional bureaucracy.](#) (2 April, Mikki Kendal, 43.9M uvm; Washington, DC)

The mission of the Department of Veterans Affairs was laid down in the wake of the Civil War, in a promise by President Abraham Lincoln to care for the men who fought, as well as their widows and orphans. The scope of that promise has broadened as women have enlisted. It is the only department that focuses exclusively on caring for veterans and their families in times of crisis spawned by injury, illness and death, a mission most Americans would agree is vital, if not sacred.

[Hyperlink to Above](#)

41 - Fierce Healthcare: [5 things to know about Ronny Jackson, Trump's pick to replace Shulkin at the VA](#) (2 April, Paige Minemyer, 141k uvm; Washington, DC)

President Donald Trump fired David Shulkin as Department of Veterans Affairs secretary last week and tapped White House physician Ronny Jackson as Shulkin's replacement. Trump praised Jackson as "highly respected" in his Twitter announcement, and White House Press Secretary Sarah Huckabee Sanders echoed the sentiment in a tweet of her own, saying that he and other cabinet nominees should be confirmed "without delay."

[Hyperlink to Above](#)

42 - Aiken Standard: [Column: Surprise: Trump's newest cabinet nominee has no relevant experience](#) (2 April, Eugene Robinson, 68k uvm; Aiken, SC)

You can't make this stuff up: President Trump has announced he will nominate a medical doctor who has no discernible management experience to run the second-largest agency in the federal government. Can presidents be sued for malpractice? The man Trump has named to become secretary of veterans affairs, Dr. Ronny Jackson, happens to be the president's personal physician.

[Hyperlink to Above](#)

43 - Truthout: [Trump's New VA Pick Appears Poised to Rubber-Stamp Privatization of Veterans Affairs](#) (3 April, Michael Corcoran, 422k uvm; Chicago, IL)

For the last year, Veterans Affairs Secretary David Shulkin insisted the VA would not be privatized on his watch. Now, thanks to a Koch-supported coup at the top of the second-largest department in government, his watch has ended -- and the battle over privatization persists. For years the Koch brothers have been hovering around the Department of Veterans Affairs and its \$186 billion budget like vultures surrounding a carcass.

[Hyperlink to Above](#)

44 - We Are The Mighty: [No one was ready for President Trump's next VA secretary](#) (3 April, Ben Brimelow, 3.6M uvm; New York, NY)

Questions have emerged about the managerial ability of White House physician Admiral Ronny L. Jackson, President Donald's Trump pick to run the Department of Veterans Affairs, the federal government's second-largest agency. If confirmed, Jackson would replace David Shulkin as the secretary of veterans affairs. Trump announced his decision to fire Shulkin on March 28, 2018.

[Hyperlink to Above](#)

45 - MedPage Today: [Jackson's Nomination to Run VA Brings Questions, Lack of management experience cited as major issue](#) (3 April, Joyce Frieden, 1.5M uvm; New York, NY)

Reaction to President Trump's nomination of White House physician Ronny Jackson, MD, as Secretary of Veterans Affairs (VA) has leaned toward the negative, with most people questioning whether Jackson has the experience needed to run the vast department. "I am deeply concerned about the nominee," (b) (6) executive director of AMVETS, a veterans service organization, said in a press release.

[Hyperlink to Above](#)

46 - KWTX (CBS-10): [Waco: Chris Kyle's family hopes new secretary will change VA culture](#) (3 April, John Carroll, 315k uvm; Waco, TX)

The brother and father of slain American Sniper Chris Kyle say they hope that Texas born and reared Navy Rear Adm. Ronny L. Jackson, whom the president has nominated as the next secretary of veterans affairs will change the culture in the VA to get veterans help more quickly. "Our veterans are not being taken care of here in America, no way, absolutely not," Kyle's father, Wayne said.

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47 - Creators Syndicate: [Marching Orders for Trump's New VA Secretary](#) (4 April, Betsy McCaughey, 318k uvm; Hermosa Beach, CA)

Since President Trump ousted Veterans Affairs Secretary David Shulkin, the question reverberating in Washington is whether Trump's new pick, Rear Adm. Ronny Jackson, is capable of heading a department with 360,000 employees and 9 million vets under its care. Senate Democrats carp he lacks experience running "a complex organization."

[Hyperlink to Above](#)

48 - Hawaii Tribune-Herald: [Senate should be wary of Veterans Affairs nominee](#) (4 April, 135k uvm; Hilo, HI)

Caring for our nation's military veterans was one of Donald Trump's most consistent promises on the presidential campaign trail, and certainly one of his least controversial. Getting veterans the care they need is a nonpartisan priority. But the increased quality of care Trump promised hasn't come.

[Hyperlink to Above](#)

49 - WUSF (NPR-89.7, Audio): [For Veterans Groups, Questions Surround Trump's VA Nominee](#) (6 April, Carson Frame, 197k uvm; Tampa, FL)

Some veterans groups say they're uncertain about the future of care at the Department of Veterans Affairs, after President Trump ousted Secretary David Shulkin and nominated White House physician Ronny Jackson to head the agency.

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50 - Lubbock Avalanche-Journal: [Levelland native talks about nomination as head of VA](#) (7 April, Karen Michael, 194k uvm; Lubbock, TX)

Levelland native Dr. Ronny Jackson -- the rear admiral who is President Donald Trump's nominee as secretary of the Department of Veterans Affairs -- knows he will someday be a veteran and his sons will be veterans.

[Hyperlink to Above](#)

51 - Tampa Bay Times: [Editorial: For the sake of Tampa Bay veterans, Senate should scrutinize Trump's VA pick](#) (7 April, 4.8M uvm; Saint Petersburg, FL)

President Donald Trump's decision to fire Veterans Affairs Secretary David Shulkin and to replace him with presidential physician Dr. Ronny Jackson has outsized ramifications for the Tampa Bay area, given the large number of veterans here and the expansive and unique role that two major VA health centers play on both sides of the bay. Whether Jackson is the right

person for the job, or whether this amounts to yet another glaring example of gross cronyism in the Trump White House, remains to be seen.

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52 - Washington Post: [Ronny Jackson, Trump's pick for Veterans Affairs, may pass up \\$1 million to join the Cabinet](#) (8 April, Andrew deGrandpre, 43.9M uvm; Washington, DC)
President Trump's controversial nomination of Ronny L. Jackson to head the Department of Veterans Affairs has grown further complicated by the Navy physician's pending military promotion, which he could be forced to pass up — along with an estimated \$1 million in future retirement income — if confirmed for the Cabinet post.

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53 - USA Today (Video): [VA pick Ronny Jackson: 'I've got what it takes' to lead the troubled agency](#) (8 April, Donovan Slack, 36.8M uvm; McLean, VA)
President Trump's pick to lead the Department of Veterans Affairs is dismissing concerns that he lacks the experience necessary to take over the massive agency, which has more than 300,000 employees and 1,200 medical facilities. Ronny Jackson, a Navy rear admiral, has been a White House physician since 2006 but has little executive management experience.

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54 - CNN (Video): [Trump's VA pick says he's 'got what it takes' to be secretary](#) (8 April, Devan Cole, 29.8M uvm; Atlanta, GA)
Ronny Jackson, President Donald Trump's physician and pick for secretary of the Department of Veterans Affairs, said in his first interview since being nominated that he's "got what it takes" to lead the department. In a Sunday profile of Jackson in the Lubbock Avalanche-Journal, a newspaper located near Jackson's hometown of Levelland, Texas, the White House doctor said: "I've been in leadership school for 23 years now."

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55 - The Hill: [Trump VA nominee: 'I think I've got what it takes'](#) (8 April Mallory Shelbourne, 11.9M uvm; Washington, DC)
President Trump's nominee to take over the Department of Veterans Affairs (VA) said in a new interview that he has "what it takes" to lead the agency. "You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions," Rear Adm. Ronny Jackson, who currently serves as the White House physician, told the Lubbock Avalanche-Journal.

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56 - The Hill: [Senate braces for showdown over Trump's nominees](#) (8 April, Jordain Carney, 11.9M uvm; Washington, DC)
The Senate is barreling toward a showdown over President Trump's latest Cabinet shuffle, with three critical departments looking for new leaders and more that could follow. Republicans are preparing for a weeks-long battle as they try to confirm CIA Director Mike Pompeo to be secretary of State and CIA deputy director Gina Haspel to succeed him.

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57 - Washington Examiner: [VA pick Ronny Jackson: 'I've got what it takes'](#) (8 April, Kelly Cohen, 4.8M uvm; Washington, DC)

The man picked by President Trump to take over as head of the Department of Veterans Affairs says he's "got what it takes" to lead the troubled agency. "I think I've got what it takes, and you know, I don't buy into that argument [that I lack experience] at all," Ronny Jackson said in a profile of him published in the Lubbock Avalanche-Journal on Sunday.

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58 - The Hill: [Senate uncertain how to proceed on dual Trump nominations for White House physician: report](#) (8 April, Brett Samuels, 11.9M uvm; Washington, DC)

Some lawmakers are unsure how to proceed with President Trump's pick for Veterans Affairs secretary because he also has a pending military promotion, The Washington Post reported Sunday. Trump nominated Rear Adm. Ronny Jackson to be promoted from a one-star admiral to a two-star admiral just days before the president ousted Veterans Affairs Secretary David Shulkin. Trump named Jackson as Shulkin's replacement, pending Senate confirmation.

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59 - Military Times: [VA secretary nominee brushes off criticism over inexperience](#) (9 April, Leo Shane III, 2.1M uvm; Springfield, VA)

President Donald Trump's pick to take over the Department of Veterans Affairs downplayed his management inexperience in his first public interview since his nomination, saying his time in the military has honed his leadership skills. Dr. Ronny Jackson, who has served as White House physician since 2006, told the Lubbock Avalanche-Journal of Texas, his hometown newspaper...

[Hyperlink to Above](#)

60 - ConnectingVets: [IAVA hopes VA Secretary nominee is the right choice](#) (9 April, Eric Dehm, 24k uvm; New York, NY)

The maelstrom continues to swirl atop the Department of Veterans Affairs. Shulkin is out, Wilkie is the acting secretary and Rear Admiral Ronny Jackson came out of left field as President Trump's nominee to permanently fill the position. It's been a wild few weeks in regards to veteran issues on Capitol Hill...

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61 - ConnectingVets: [VA pick Ronny Jackson says he's up for the job](#) (9 April, Matt Saintsing, 24k uvm; New York, NY)

President Donald Trump's pick to lead VA wants veterans to know he's up to the task and is dismissing fears he's not qualified to lead the second largest government agency, one with more than 300,000 employees. Randy Jackson certainly has the medical chops as a Navy doctor, but veterans groups were largely caught off guard when Trump tweeted his intent to nominate him as Secretary of Veterans Affairs.

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62 - Becker's Hospital Review: [How a military promotion could complicate Dr. Ronny Jackson's VA nomination](#) (9 April, Leo Vartorella, 441k uvm; Glencoe, IL)

President Donald Trump's nomination of White House physician Ronny Jackson, MD, to lead the Department of Veterans Affairs has been complicated by his simultaneous promotion to two-star admiral, according to The Washington Post. President Trump nominated Dr. Jackson for the promotion in late March, but he cannot stay on active duty and also direct the VA.

[Hyperlink to Above](#)

63 - Task & Purpose: [Trump's VA Pick Faces A Dilemma Most Troops Would Love To Have](#) (9 April, Adam Weinstein, 102k uvm; New York, NY)

I'm about to suggest something that would've been unthinkable to me as an E-3: Put yourself in the admiral's shoes. You're 23 years into a terrific career as a naval physician. For 12 of that, you've been the president's doctor, administering checkups to three very different POTUSes — high-stakes business, sure, but you've been doing it longer than most service members do anything.

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64 - Washington Post: [Senate Republicans express concerns about Trump's choice to lead Veterans Affairs](#) (11 April, Seung Min Kim, 43.9M uvm; Washington, DC)

Ronny L. Jackson, President Trump's choice to lead the Department of Veterans Affairs, is facing mounting skepticism from Senate Republicans over whether he has the management experience to lead the nation's second-largest bureaucracy. The comments from several GOP senators, particularly those with influence on veterans' issues, signal Jackson will have to work overtime to convince not just Democrats but Trump's own party that he is qualified...

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65 - The Hill: [VA privatization fight could erupt in confirmation hearing](#) (11 April, Nathaniel Weixel, 11.9M uvm; Washington, DC)

Long-simmering tensions about privatizing the Department of Veterans Affairs (VA) could erupt into a confirmation battle over President Trump's pick to lead the department. Trump's decision to oust former VA Secretary David Shulkin late last month and replace him with White House physician Ronny Jackson stoked speculation that the White House wants to allow veterans more access to private-sector health-care providers.

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66 - American Thinker: [VA privatization debate could derail new secretary's confirmation](#) (11 April, Rick Moran, 4.8M uvm; El Cerrito, CA)

When Donald Trump fired his secretary of Veterans Affairs, David Shulkin, and named his personal physician, Rear Admiral Ronny Jackson, to replace him, red flags went up on Capitol Hill and among some veterans groups who oppose privatizing the V.A. Indeed, in a parting shot to his detractors within the administration, Shulkin wrote an op-ed in the New York Times warning against forces inside the White House that want to privatize the entire agency.

[Hyperlink to Above](#)

67 - Herald-Tribune (Creators Syndicate): [McCaughey: Marching orders for Trump's new VA secretary](#) (11 April, Betsy McCaughey, 871k uvm; Sarasota, FL)

Since President Donald Trump ousted Veterans Affairs Secretary David Shulkin, the question reverberating in Washington is whether Trump's new pick, Rear Adm. Ronny Jackson, is

capable of heading a department with 360,000 employees and 9 million vets under its care. Senate Democrats carp he lacks experience running “a complex organization.”

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68 - Fayetteville Observer: [Our View: Does VA nominee have the right stuff?](#) (11 April, Editorial Board, 439k uvm; Fayetteville, NC)

We hope Robert Wilkie enjoys the challenge of running the Department of Veterans Affairs, because he may have the job for a bit longer than his “acting secretary” title might indicate. Storm clouds are already gathering for President Trump’s nominee for the permanent position, Navy Rear Adm. Ronny Jackson.

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Full Stories

1 - Washington Post (AP): [Trump’s VA pick draws concern over thin management record](#) (29 March, Hope Yen and Calvin Woodward, 43.9M uvm; Washington, DC)

President Donald Trump’s selection of his White House doctor to run the massive Department of Veterans Affairs triggered concern Thursday among lawmakers and veterans groups about whether he has the experience to manage an agency paralyzed over Trump’s push to expand private care.

Ronny Jackson, a Navy rear admiral entrusted with the health of the past three presidents, is a lifelong physician whose positions on privatizing operations in the second largest federal department and addressing ballooning health care costs are unknown. First named to the top White House post by President Barack Obama, he would be new to running a big bureaucracy if given leadership over a department of 360,000 employees serving 9 million veterans.

In a statement, Trump praised Jackson as “highly trained and qualified.” But representatives of veterans aren’t sold on the choice, or on Trump’s decision a day earlier to fire VA Secretary David Shulkin.

“There is little that we know about Dr. Ronny Jackson’s vision and qualifications,” said Paul Rieckhoff, founder and CEO of Iraq and Afghanistan Veterans of America. “Our concern is whether President Trump was more interested in picking a secretary who would be politically loyal rather than someone who can work across the aisle to fix long standing problems of bureaucratic delay.”

Similar doubts were expressed by Veterans of Foreign Wars, which praised Jackson’s military background in a statement but pointed to a nominee biography devoid of “any experience working with the VA or with veterans, or managing any organization of size, much less one as multifaceted as the Department of Veterans Affairs.” AMVETS echoed such sentiments.

“We look forward to a rigorous confirmation hearing,” Rieckhoff said.

Montana Sen. Jon Tester, top Democrat on the panel that will consider the nomination, said he had yet to determine if Jackson “is up to the job.”

It’s not clear from Jackson’s military service record how much, if any, management experience he has. His military assignments did not appear to include supervision over a large department or unit. His Navy biography says he deployed to Iraq with a Marine unit and served as the emergency physician in charge of resuscitative medicine for a trauma platoon.

Jackson joined the White House medical team in 2006 and is perhaps best known for his appearance before the press corps in January, announcing the results of Trump’s first physical in a performance that showed he was quick-witted and unfailingly complimentary of Trump.

Marveling at the 71-year-old president’s good health, Jackson opined, “It’s just the way God made him.”

A White House official said Shulkin himself had recommended Jackson for an undersecretary position at the VA in the fall, and Trump ultimately decided he was more comfortable with Jackson than with other top candidates. The official was not authorized to discuss personnel matters and spoke on condition of anonymity.

If confirmed by the Senate, Jackson would face immediate crises, like a multi-billion dollar revamp of electronic medical records now in limbo that members of Congress fear will prove too costly and wasteful, and a budget shortfall in the coming weeks in its private-sector Veterans Choice program.

Trump is seeking an aggressive expansion of the Choice program to make it easier for veterans to see private doctors outside the VA system at government expense, but proposals are stalled in Congress following a failed effort last week.

“We’re going to have real choice,” Trump said in Ohio. “That’s why I made some changes, because I wasn’t happy with it.”

Jackson’s nomination comes as Trump’s new Cabinet nominees begin to pile up in the Senate. That is certain to stir weeks of confirmation battles this spring when senators, especially those running for re-election, may prefer to shift focus away from the changes at the White House.

None of the nominees, including the president’s new picks for secretary of state and CIA director, is expected to sail to easy confirmation. The GOP-led Senate is narrowly divided 51-49 and Democrats — and some Republicans — are preparing to ask tough questions. Even though Congress has an otherwise slim legislative agenda before campaign season, prolonged confirmation fights could jam up the Senate and influence the election.

Pending Jackson’s confirmation, Robert Wilkie, a former Pentagon undersecretary for personnel and readiness, is serving as the acting head of the VA.

Lawmakers said they needed to learn more about Jackson’s record.

Republican Sen. Johnny Isakson of Georgia, chairman of the Senate Veterans Affairs Committee that will review the nomination, declined to indicate his support. He stressed that he looked forward to “meeting Admiral Jackson and learning more about him.” Isakson, a

moderate, has expressed skepticism in the past toward nominees who expressed strong views in favor of privatization.

Sen. Bernie Sanders, independent of Vermont and a former chairman of the panel, cautioned that Jackson would not be approved if he supported privatizing the VA. "Our job is to strengthen the VA in order to provide high-quality care to our veterans, not dismember it," he said.

Shulkin, a physician and the lone Obama administration holdover in Trump's Cabinet, was unceremoniously fired late Wednesday by Trump in a tweet. Shulkin had enjoyed support from Trump for much of his first year in the administration but support eroded last month after a bruising ethics scandal and political infighting at VA.

Dan Caldwell, executive director of the conservative Concerned Veterans for America, said the group is keeping an "open mind" about Jackson's nomination. Some of the names that had been in circulation for the post had previous ties to the group, which supports giving veterans greater access to private doctors outside the VA system.

"We'd like to hear more about his positions to reform and fix the VA," Caldwell said. "He has a very distinguished service record and it would be unfair to outright dismiss him — you have to be very professional to reach his rank."

A native of Levelland, Texas, Jackson, 50, graduated from Texas A&M with a degree in marine biology, then from medical school at the University of Texas Medical Branch.

He headed to the Navy, then in 2005 joined a 2nd Marines regiment. Jackson was deployed to Iraq as the physician in charge of resuscitative medicine for a trauma platoon, according to the White House.

Ned Price, a National Security Council spokesman under Obama, described the doctor as "the guy you always want to be around" because he's affable and funny. But Price said it was difficult to believe the nomination was unrelated to the "glowing assessment" of Trump's health that the doctor had provided.

Associated Press writers Jill Colvin, Lisa Mascaro, Lolita Baldor, Zeke Miller, Jonathan Lemire, Catherine Lucey and Darlene Superville contributed to this report.

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2 - Washington Post: [Trump's pick to head veterans department faces skepticism over his experience](#) (29 March, Lisa Rein, Seung Min Kim, Emily Wax-Thibodeaux, and Josh Dawsey, 43.9M uvm; Washington, DC)

The White House was thrown on the defensive Thursday over President Trump's choice to lead the Department of Veterans -Affairs, forcing officials to fend off mounting skepticism that Ronny L. Jackson has the experience to run the government's second-largest agency.

Trump announced by tweet late Wednesday that the White House physician would succeed ousted secretary David Shulkin, surprising veterans groups and lawmakers, who were not

notified beforehand and scrambled to learn the policy views of someone whose positions on the chronic challenges facing VA are unknown.

Jackson is a career naval officer who was an emergency trauma doctor in Iraq before spending the past 12 years as a White House physician. But his résumé lacks the type of management experience usually expected from the leader of an agency that employs 360,000 people, has a \$186 billion annual budget and is dedicated to serving the complex needs of the country's veterans.

"It's great that he served in Iraq and he's our generation. But it doesn't appear that he's had assignments that suggest he could take on the magnitude of this job, and this makes Jackson a -surprising pick," said Paul Rieckhoff, chief executive of Iraq and Afghanistan Veterans of America.

Jackson was taken aback by his nomination, said senior White House officials, who spoke on the condition of anonymity to discuss internal deliberations. After aides gauged his interest in recent days, he hesitated to take on such a big job. But the president continued to push and told his senior staff Monday that the doctor was his top choice. A senior White House official described an informal interview process, without the extensive vetting that typically accompanies a Cabinet selection.

Navy Rear Adm. Ronny L. Jackson, the lead White House doctor, said on Jan. 16 that President Trump's "overall health is excellent." (Bastien Inzaurrealde/The Washington Post)

"The President has full confidence in Dr. Jackson's abilities to give our veterans the care they've earned," spokesman Raj Shah said.

The White House planned to announce Wednesday that Shulkin would leave the administration and be replaced on an interim basis by Robert Wilkie, undersecretary for defense personnel and readiness at the Defense Department, until a nominee was found.

But Trump preempted the plan when he tweeted that he intended to nominate Jackson, administration officials said.

The active-duty rear admiral had been a behind-the-scenes figure while serving the past three administrations as a White House physician, but he moved into the spotlight in January when he delivered a glowing assessment of Trump's physical and mental health to reporters, which aides said endeared him to the president.

The White House on Thursday defended Trump's choice of Jackson, saying his hands-on experience as a doctor would serve him well as Veterans Affairs secretary.

"He knows what soldiers need on the battlefield and what they need when they come home as veterans," deputy White House press secretary Lindsay Walters told reporters aboard Air Force One en route to Cleveland, where Trump delivered a speech on his infrastructure plan. "The president has full confidence in his pick and trusts he will be able to give veterans the care they deserve."

Key congressional Republicans publicly took a cautious approach to the nomination.

“We are doing our homework on Dr. Jackson,” said Amanda Maddox, spokeswoman for Sen. Johnny Isakson (R-Ga.), chairman of the Senate Veterans’ Affairs Committee, which will hold Jackson’s nomination hearing. Trump called Isakson after announcing that he had picked the doctor to replace Shulkin, she said.

“His name was never floated around,” Maddox said, “so we are doing our due diligence.”

Trump’s decision to upend VA’s leadership comes as Senate Republicans were already worried about other potentially difficult nominations in the months leading up to midterm elections, when they want to focus their message on the recently passed tax cuts rather than deal with more upheaval in the administration.

“Any time Republicans are not selling the tax bill over the next seven months is a missed opportunity,” said GOP strategist Brian Walsh, a former spokesman for the National Republican Senatorial Committee. “I will say Senate Republicans are a little more insulated by the nature of the seats that are up. But there’s no question that these are unhelpful distractions.”

The stack of Trump nominees includes Gina Haspel, who was picked this month to be the director of the Central Intelligence Agency and is facing opposition from members of both parties because of her ties to the agency’s past use of brutal interrogation measures on terrorism suspects, which critics say amounted to torture.

Senate Republicans have told White House officials in recent days that the process of confirming CIA Director Mike Pompeo to replace Rex Tillerson as secretary of state is going to be challenging even though he is expected to be approved, according to two people briefed on the discussions. Democratic senators said privately when Pompeo was tapped to replace Tillerson that they expect far fewer Democrats to back him than the 14 who voted for him to lead the CIA.

Senior Senate Republicans have privately expressed frustration over the personnel battles that have raged since the beginning of Trump’s presidency and recently told the White House that they did not want to have to consider a series of nominees this year, according to aides and officials who have heard the complaints.

The move to dismiss Shulkin — as well as the lack of communication about Jackson — only fueled concerns on Capitol Hill that the administration was not doing enough to help Congress defend or even respond to the president’s rush of personnel changes.

Jackson’s policy views are unknown, particularly on the most pressing issue facing VA: how much access veterans should have to private doctors outside the system at government expense. Shulkin’s moderate views on the subject, which were at odds with many administration officials, helped end his tenure.

VA secretary is one of Washington’s most unforgiving jobs even for someone with extensive management experience. Shulkin, also a physician, had run large hospital systems — including VA’s — before taking the job. His predecessor, Robert McDonald, was a chief executive of Procter & Gamble. The secretary before him was a decorated retired Army general, Eric K. Shinseki, who was forced out after managers in the far-flung health system were found to have fudged waitlists for veterans’ medical appointments.

As recently as February, Jackson was a candidate to run VA's health-care arm, the Veterans Health Administration, the country's largest health-care system, with 1,200 hospitals and medical clinics. On the day of his interview, he told a selection panel that the president was unwilling to let him leave his White House job, according to two people familiar with the discussion.

The panel interviewed him informally anyway, asking him how he would drive change in such a large organization but not about his views on policy. One person who sits on the panel, and who spoke on the condition of anonymity because its proceedings are confidential, said they didn't think Jackson had the requisite skills to transition from overseeing a team of about 20 doctors, nurses and physician assistants in the White House medical office to overseeing the health administration.

"I don't remember him coming in trying to convince us he had the experience to do the job. He did not inflate his qualifications," this person said. "The tone was, 'Maybe I don't have the same kind of experience as others who came before me in the job.'"

Jackson's former colleagues in the Obama White House, who have publicly praised him in the past, said his nomination caught them off guard as they swapped text messages to ask how an extremely likable but unlikely candidate could end up running VA in the Trump administration.

"I've seen him managing a staff of a couple dozen, which he did to perfection," said Ned Price, a National Security Council spokesman under Obama who recalled that he was treated by Jackson for a toe injury in the Philippines.

"But how that would translate to managing the second-largest department in federal government I have no idea," Price said. "He has competence and integrity. I don't think he's going to fly around the world first-class or be buying thousands of dollars in furniture. But can he run VA? Anyone's guess is as good as mine."

Colleagues described the schedule of the White House physician as grueling, with continual foreign and domestic travel, always at the president's side.

Some Democrats warned that if Jackson embraced the idea of privatizing more of VA's health coverage, his nomination would be met with stiff resistance.

"I will carefully review Dr. Jackson's qualifications to determine whether he has the best interests of our Veterans at heart or whether he, like many in the Trump administration, wants to push VA down the dangerous path of privatization," Sen. Tammy Duckworth (D-Ill.), a wounded Iraq veteran, said in a statement.

At the American Legion, the country's largest veterans organization, senior officials were putting together ideas to help Jackson acquaint himself with the agency and its challenges.

"He's going to have a huge learning curve," Executive Director Verna Jones said, "but we stand ready to assist and educate him."

Robert Costa and Julie Tate contributed to this report.

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3 - Wall Street Journal: [Lawmakers Respond Cautiously to Little-Known VA Pick Ronny Jackson - Key senators on panel say they don't know enough about White House doctor to form an opinion about his ability to lead a vast bureaucracy](#) (29 March, Louise Radnofsky and Peter Nicholas, 43.6M uvm; New York, NY)

Capitol Hill lawmakers reacted guardedly to President Donald Trump's nomination of the White House physician to head the Department of Veterans Affairs, with key members noting that they know little about him.

Dr. Ronny Jackson, a U.S. Navy rear admiral who has served as a White House physician during the past three administrations, is slated to succeed Secretary David Shulkin, who was ousted Wednesday. Mr. Trump indicated on Thursday that he removed Dr. Shulkin because change at the agency was coming too slowly. The secretary had also been the subject of a travel-expenses scandal.

The lead Republican and Democratic senators who will decide whether to confirm Dr. Jackson said they didn't yet know enough to form an opinion about his ability to lead a bureaucracy of 370,000 employees. The department, which is the second-biggest government agency, is also still recovering from a 2014 scandal in which employees were found to have falsified records to hide delays in patient care.

"I look forward to meeting Adm. Jackson and learning more about him," said Sen. Johnny Isakson (R., Ga.), chairman of the Committee on Veterans' Affairs, which will vote on confirmation.

Sen. Jon Tester of Montana, the top Democrat on the panel, offered a near-identical sentiment, adding that he is looking forward to "seeing if he is up to the job."

Veterans service organizations and some other lawmakers have expressed skepticism about Dr. Jackson, raising concern over the propriety of an active-duty military officer holding a political appointment, and saying his biography showed scant experience at running a bureaucracy on the scale he would inherit.

"He's more of a hands-on physician—not a lot of desk time in terms of administrative leadership," said Rep. Mike Coffman (R., Colo.), a member of the House Veterans' Affairs Committee who was among Dr. Shulkin's harshest critics.

It's unclear how Dr. Jackson would address the issue of his active military status, including whether he would seek to relinquish it before securing confirmation to the new job.

Dr. Jackson's confirmation will come as senators are debating legislation that would increase veterans' ability to seek non-government medical care. Congress is approaching an early June deadline to agree to new funds for the existing system allowing some veterans to go outside the VA for care, or to create a new policy allowing all veterans to participate.

"I made some changes, because I wasn't happy with the speed with which our veterans were taken care of," Mr. Trump said Thursday in a speech in Ohio. "We want them to have choice so that they can run to a private doctor and take care of it."

The White House informed Mr. Isakson's committee of the leadership change in a courtesy call Wednesday; a timeline for proceeding with the nomination, or preliminary introduction meetings,

wasn't discussed, a spokeswoman said. Mr. Isakson and Dr. Jackson spoke by phone Thursday afternoon, in an informal introduction, the spokeswoman said.

Past and present White House officials have praised Dr. Jackson as a steady force, deft in caring for different presidents and cabinet members. They said they found him friendly, bright and knowledgeable about medicine, including on issues specifically affecting veterans.

"If you're not calmly decisive, the job of White House physician ain't for you," said Paul Winfree, a former deputy director of Mr. Trump's Domestic Policy Council.

Dr. Jackson has been sought out for management positions before, though on a significantly smaller scale. Toward the end of the Obama administration, he was invited to interview by the Cleveland Clinic for an international posting managing a handful of people because of his affability, versatility and experience with VIPs, a person familiar with the interview said.

The federal agency Dr. Jackson would inherit is notoriously riven with competing power centers, and has now churned through three secretaries in four years.

Dr. Shulkin came directly from a health-care management background into the Obama administration when he took over the VA. He stayed on for Mr. Trump and initially received high reviews. He lost credibility recently when the VA inspector general found that, during a trip to Europe, he improperly accepted Wimbledon tennis tickets, misspent thousands of dollars of taxpayer money on his wife's airfare and improperly used a department employee as a "personal travel concierge."

Dr. Shulkin denied wrongdoing. He repaid the \$4,312 cost of his wife's airfare and then sent the U.S. Treasury a check equal to the amount of the tennis tickets.

Mr. Trump's advisers had openly explored possible successors for Dr. Shulkin in recent weeks, including having conversations with potential candidates, people familiar with the matter had said.

Still, the nomination of Dr. Jackson stunned some White House aides, who hadn't known the president was even considering his physician for the role.

It became clearer Thursday that Mr. Trump had been thinking about moving Dr. Jackson to the VA for months. Last fall, Dr. Shulkin recommended that Dr. Jackson take an undersecretary job at the department, a White House official said. At that time, Dr. Jackson and the president discussed plans for improving the VA—talks that set in motion the announcement on Thursday.

Lindsay Walters, a White House spokeswoman, on Thursday said the White House believed Dr. Jackson had "bipartisan respect."

"The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary," she added. "The president has full confidence in his pick and trusts he will be able to give veterans the care they deserve."

Some lawmakers expressed dismay over the treatment and departure of Dr. Shulkin, which could linger into the new confirmation process. "By once again choosing chaos over consistent leadership, Donald Trump is hurting veterans around the country," said Illinois Democratic Sen. Tammy Duckworth, who is a retired U.S. Army lieutenant colonel.

—Kristina Peterson and Ben Kesling contributed to this article.

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4 - USA Today (Video): [6 big things the new Veterans Affairs chief will have to address](#)

(29 March, Donovan Slack and Dennis Wagner, 36.8M uvm; McLean, VA)

On the front lines at the Department of Veterans Affairs — in the agency's 1,240 hospitals and clinics — it doesn't much matter these days who holds the secretary's job in Washington.

David Shulkin, who was fired Wednesday, was the third VA secretary in four years. If President Trump's nominee to lead the agency, physician and Navy Rear Adm. Ronny Jackson, is confirmed, he will be the fourth.

Each has sought to fix the department, laying out visions and priorities — Shulkin's top priority was "access," making sure veterans get appointments when they need them. His predecessor, former Procter and Gamble CEO Bob McDonald, focused on staffing, training and veteran-centered customer service.

But year after year, critical deficiencies remain and veterans are bearing the brunt of the failures. Here are some key, seemingly intractable shortfalls that continue to plague the system — and that Jackson will face if confirmed.

Veterans are still waiting

The furor over VA health care exploded in 2014 when whistle-blowers in Arizona divulged that thousands of patients were backlogged at the Phoenix veterans hospital, and some of them had died awaiting care. VA investigators soon determined that medical center administrators knew about the crisis, yet put out fraudulent wait-time data to collect bonus pay.

The problems weren't just in Phoenix. A USA TODAY investigation in 2016 found supervisors instructed employees to falsify patient wait times at VA medical facilities in at least seven states. And employees at 40 VA medical facilities in 19 states and Puerto Rico regularly "zeroed out" veteran wait times.

A few weeks after Shulkin was sworn in last year, the VA inspector general released a report finding widespread inaccuracies in scheduling records at a dozen hospitals in North Carolina and Virginia. The records vastly understated how long veterans were waiting for appointments and prevented as many as 13,000 from getting VA-funded care in the private sector — an option they were entitled to if they waited longer than 30 days. At the time, Shulkin said the findings were based on outdated rules and that he had instituted new regulations to prevent such problems in the future.

But just two weeks ago, another inspector general investigation found the problems continued.

Looking at 64 VA hospitals and clinics in a swath of states from Kentucky to Illinois, investigators found scheduling staff entered the wrong dates in the system in more than 5,000 cases. That masked how long veterans were actually waiting for specialty care and mental health appointments.

VA-18-0457-A-000909

They estimated 2,500 of those waited longer than a month, but the scheduling system falsely showed only 1,300 waited that long. Even in the cases accurately reflected in the system, they concluded, most weren't offered the chance to get care in the private sector.

"VA data continues to be a high-risk area," wrote Larry Reinkemeyer, VA assistant inspector general for audits and evaluations.

Quality of care

The VA's lowest performing hospitals remained at the bottom of the pack on the agency's own internal quality measures for two years in a row.

The VA regularly scores its medical centers based on dozens of quality factors, including death and infection rates, instances of avoidable complications and wait times. The agency uses a five-star scale with one being the worst and five being the best.

The rankings compare VA hospitals against each other but the number of one-star hospitals is not constant. Medical centers in that bracket can be elevated to two stars based on quality-of-care factors.

Among the facilities who received only one star in both 2015 and 2016 were the VA hospital in Phoenix and another in Memphis, Tenn. One Memphis employee dubbed the facility a "house of horrors" when USA TODAY obtained internal documents revealing reported threats to patient safety soared in recent years from 700 to more than 1,000.

One veteran had to have his leg amputated after a VA provider there left a piece of plastic tubing in a critical blood vessel during a procedure.

On a number of patient safety factors, the VA overall on average scores better than the private sector on many key patient-safety measures, including instances of avoidable death, respiratory failure, and infection. But there are vast disparities among VA hospitals, according to VA data collected from October 2015 to March 2017.

The death rate for surgical patients with treatable complications ranged from zero at the VA hospital in Sacramento, Calif., to more than 20% in Miami; Columbia, Mo.; and Washington, D.C. In Long Beach, Calif., it was 29%. That's more than double the private sector average of 14%, according to Medicare data.

Bureaucratic breakdowns

In Washington, the VA inspector general issued a rare emergency report last year saying that patients were in imminent danger at the hospital. The facility had dirty sterile storage areas and was regularly running out of critical supplies needed for surgeries and other procedures, including patches to seal blood vessels and tubes for kidney dialysis.

Shulkin quickly removed the hospital director there and sent teams from headquarters to try to fix the problems. But an inspector general report released this month found that VA officials at every level — local, regional and national — knew about the problems for years but didn't fix them.

Investigators found “a culture of complacency and a sense of futility pervaded offices at multiple levels.”

“In interviews, leaders frequently abrogated individual responsibility and deflected blame to others,” the investigation report says. “Despite the many warnings and ongoing indicators of serious problems, leaders failed to engage in meaningful interventions of effective remediation.”

Morale at the agency has taken a beating amid the constant drumbeat of crises. Employees ranked it as the second to worst agency to work for among large departments last year. The only department scoring lower was Homeland Security.

The inspector general singled out frontline workers at the Washington hospital, saying they went to great lengths to make do and they may be the only reason no patients were actually harmed.

“The OIG did not find evidence of adverse clinical outcomes, a condition that is largely attributable to front-line care providers who were committed to providing the best possible care by borrowing supplies, improvising, or personally ensuring patients received what they needed,” the investigation report said.

Vetting failures

The VA has had persistent difficulties recruiting and keeping enough medical care providers to meet veterans needs.

In 2015, one in six critical VA jobs — intake workers, doctors, nurses and assistants — were unfilled, a USA TODAY investigation found. Though the agency has made headway, there are still shortfalls.

In some cases, that has created an incentive to hire medical care providers with problem records that may have prevented them from getting jobs in the private sector.

A VA hospital in Oklahoma knowingly hired a psychiatrist sanctioned for sexual misconduct who went on to sleep with a VA patient, according to internal documents obtained by USA TODAY. A Louisiana VA clinic hired a psychologist with felony convictions. The VA ended up firing him after they determined he was a “direct threat to others” and the VA’s mission.

The Iowa City VA hospital knowingly hired John Henry Schneider last year, a neurosurgeon who had racked up more than a dozen malpractice claims in two states and had his license revoked in one.

After USA TODAY revealed the case in December, the VA forced him out and discovered that conflicting VA policies allowed its hospitals to illegally hire doctors with revoked licenses for 15 years. Shulkin ordered the policies rewritten but with the current process, that could take up to two years.

In a report released Monday, the inspector general found vetting failures go beyond medical providers. Investigators determined that the VA did not conduct required background checks on more than 6,000 employees and managers failed to properly document and oversee background checks.

“As a result, VA cannot reliably attest to the suitability of its largest workforce, exposing veterans and employees to individuals who have not been properly vetted,” the report said. “Unless internal controls and data are improved, VA and the public lack assurance that VHA has a workforce suitable for serving our nation’s veterans.”

Hiding shoddy care

The agency has failed for years to ensure medical care providers found to have provided poor care are reported to state licensing boards or to a national database created to prevent them from crossing state lines and endangering other patients.

In one case in Maine revealed in a USA TODAY investigation, the VA found a podiatrist had harmed 88 patients but didn’t report him to the national database and took years to report him to state boards. By the time the VA told his patients, one of them, U.S. Army veteran April Wood, had decided to have her leg amputated after two failed surgeries by the podiatrist.

The investigation found VA hospitals also signed secret settlement deals with dozens of doctors, nurses and health care workers in recent years that included promises to conceal serious mistakes — from inappropriate relationships and breakdowns in supervision to dangerous medical errors — even after forcing them out of the VA.

In response to the story last fall, Shulkin required increasing vetting of future such deals and he ordered policies on reporting to state boards and the national database rewritten. Again, five months later, the new policies still are not in place and could take months or years more.

Politics

Jackson, Trump's pick to be the new secretary, has no experience running a huge government agency, and dealing with veterans’ health care challenges will require deft politics and bureaucratic acumen.

His predecessor, Shulkin, was ousted despite being well regarded in Congress and assured of job security by Trump.

Now, a White House physician and former Navy admiral faces not just a plethora of VA maladies, but partisan politics and special interests that bitterly disagree on the cures.

The most perilous and important controversy involves decisions on privatizing veterans’ healthcare.

Powerful unions and veteran service organizations, such as the American Legion, oppose a radical change, and they are supported by most Democrats on Capitol Hill. But Republicans and key advocacy groups, such as Concerned Veterans for America, are demanding a system that would let veterans decide whether they go to the VA for care, or get private treatment subsidized by the government.

On Thursday, Trump suggested that Shulkin was dismissed because he was not aggressive enough in promoting the private-care option.

The existing Choice Program, which ate up billions of dollars and had to be re-funded, promises to be even more expensive if expanded. And those costs already have included tens of millions of dollars in improper payments to contractors.

Veteran enrollment for healthcare has skyrocketed, and Congress continues to expand benefits for those already in the system, with care for Agent Orange victims and high-cost medications for hepatitis patients. Bringing in enough funding to meet that demand also requires political aplomb.

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5 - Politico: [Trump's VA pick blindsides staff, deepens agency disarray - 'He's got a department that's in turmoil,' a former VA secretary said. 'It's in crisis.'](#) (29 March, Lorraine Woellert, Eliana Johnson and Connor O'Brien, 23.9M uvm; Arlington, VA)

The timing of President Donald Trump's announcement to name Rear Admiral Ronny Jackson to lead Veterans Affairs was a snap decision that surprised his own chief of staff and knocked the government's second-largest agency, already bedeviled by scandal, deeper into disarray.

White House chief of staff John Kelly had spoken with David Shulkin by phone Wednesday morning, reassuring the now-former VA secretary that he wouldn't be fired by tweet that afternoon. Hours later, Kelly had to phone Shulkin again telling him plans had changed.

Trump declared Jackson's nomination on Twitter at 5:31 p.m. The tweet was big news — not just to the public, but to some senior aides, according to one White House official.

The chaos — by now a typical part of the president's management style — has for months upended Kelly's attempts to ensure that an unorthodox White House adheres to traditional processes. But while White House aides are left unpacking the day's events, the drama at the VA is just beginning.

Deputy Secretary Thomas Bowman, a Trump appointee who is the agency's No. 2, is widely expected to leave soon, either by choice or by force. Kelly and other aides wanted Bowman gone before Shulkin left to avoid installing the deputy at the helm, even temporarily. Bowman had pushed back on broad privatization efforts, leading Trump to berate him in an Oval Office meeting for his lack of loyalty.

Trump got around the Bowman problem by naming Robert Wilkie, an undersecretary at the Department of Defense, to the temporary job. A Capitol Hill veteran and member of Trump's transition team, Wilkie is a former senior adviser to Sen. Thom Tillis (R-N.C.), who supports expanding service members' access to private doctors.

"He's got a department that's in turmoil. It's in crisis. There's warfare there," said Anthony Principi, who led the agency under former President George W. Bush. "And you have an acting secretary who doesn't know the VA."

But if and when Bowman departs, Wilkie will be left with a shallow bench at an agency already paralyzed by political mistrust, some veterans' advocates say. The VA's health and benefit agencies — which administer tens of billions of dollars in health programs, pensions, survivor

benefits and other forms of assistance to some 9 million service members — have been without Senate-confirmed officials since the Obama administration.

Veterans Affairs is the second-largest federal agency, behind only the Department of Defense, with 377,000 employees. And it has proven unwieldy even when led by highly decorated, experienced administrators such as Eric Shinseki, a retired four-star Army general who resigned during the Obama administration amid a scandal over lengthy wait times and faulty scheduling practices for medical appointments.

Shinseki was followed by Bob McDonald, an Army veteran and former Procter & Gamble CEO. Shulkin, McDonald's successor, was the first non-veteran to lead the VA.

As recently as two weeks ago, the Trump White House was still making overtures to potential candidates for the top job, according to a person with direct knowledge of the inquiries. Trump reportedly agonized over the decision, changing his mind several times, a senior administration official said.

“Instead of going through the paces to convince the best possible person to take this job, they’re going with the person who’s still on active duty in the Navy and can’t say no to the commander in chief,” said one Obama White House aide, who spoke highly of Jackson as a doctor and individual. “You could look at it as them giving up trying to find a competent commander or manager to fix the problems.”

Shulkin had come under fire after a VA inspector general's report accused him of improperly accepting tickets to the Wimbledon tennis tournament and using his agency staff to arrange a sightseeing tour of Denmark and England. He repaid the VA for the trip. The longtime hospital administrator, who was engaged in open warfare with conservatives in the department intent on privatizing the VA, contended he was set up.

Veterans' groups remained loyal to Shulkin, whom they saw as their best line of defense of against privatization. During his campaign, Trump made promises that veterans would be allowed to seek medical treatment outside the VA's system, statements taken by some to mean a step toward handing the system to commercial companies to manage.

Jackson, while well-liked by both Republicans and Democrats, is a cipher on privatization and other policy issues. With no agency experience to speak of, veterans suspect he could be installed as a figurehead, leaving lower-level appointees to steer the agency toward privatization.

“He’s a blank slate. Nobody knows really anything about his competency or capacity for this job,” said Paul Rieckhoff, CEO of Iraq and Afghanistan Veterans of America. “We especially know that being a veteran doesn’t qualify you to run the VA any more than being a soldier qualifies you to run the DoD.”

Principi urged Jackson to move quickly on his own agenda.

“The new secretary, really, if he wants to accomplish anything, has to hit the deck running and has to bring in some very, very good people,” he said. “I hope and pray he’s a success. Because if he’s not, American veterans are going to be the losers.”

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6 - Task & Purpose: [What's In Store For The Next VA Chief? Let's Break It Down](#) (29 March, James Clark, 102k uvm; New York, NY)

It's been an awkwardly long time coming, but as of yesterday afternoon embattled Veterans Affairs secretary David Shulkin is out of a job. The news comes after a month and a half of uncertainty that began when a scathing inspector general report detailed "serious derelictions" in expensing a Europe trip last summer. And then there were all the accusations and counter accusations of political infighting and rumors of possible replacements — at least all that is over:

Rear Adm. Ronny Jackson, the president's appointed White House physician, who drew national attention when he complimented President Trump on his "incredibly good genes," has been tapped to lead the Department of Veterans Affairs — pending approval by the Senate. Given that this leadership post has been described as "one of the most difficult jobs in government" — which has stymied generals, CEOs and health care executives — we thought it was time to give you a rundown of what's in store for the next officeholder, by the numbers:

More than 1,243 health care facilities. These Veterans Health Administration facilities include 170 VA Medical Centers, and 1,063 outpatient sites — making it the largest health care system in the United States.

9,000,000 veterans.. That's the number who receive medical care from VA, and many of these patients are older and suffer from multiple traumas and injuries that require specialized care: amputations, traumatic brain injuries, post-traumatic stress disorder, military sexual trauma, and as of 2013, half of all VA patients suffer from chronic pain, to name just a few. And as many as 2 million patients receive in-facility care, according to an American Legion statement.

20,000,000 veterans in the United States... we think. There could be far more veterans than we realize, since an individual's military history isn't tracked by the census bureau, which is a concern since the VA relies on headcount of its target population to get a feel for the size and scope of the services it needs to provide.

\$10,000,000,000 contract for Electronic Health Records. A long-term plan to modernize the VA's health records system could be jeopardy, with Shulkin's dismissal coming just as the VA was set to finalize the acquisition of a new electronic health record system.

2nd largest federal agency. The only one bigger is the Department of Defense.

\$186,000,000,000 budget for fiscal year 2018.

360,000 employees spread across three separate administrations within the department; the Veterans Health Administration, Veterans Benefit Administration, and the National Cemetery Administration.

23 years active duty. Jackson's Navy career began in 1995, and includes postings as an instructor, diving medical officer, diving safety officer, from Panama City, Florida Sigonella, Italy, to Norfolk, Virginia. By 2005 he deployed to Taqaddum, Iraq as part of a Surgical Shock Trauma platoon.

3 presidents. While still in Iraq in 2006, Jackson was selected as a White House physician and served as the supervising physician for the Camp David Presidential Retreat under the George W. Bush administration. Later he led the White House Medical Unit as its director and was the appointed White House physician for Presidents Barack Obama and Donald Trump.

Soon to be 7 VA secretaries in 4 years. The department has been beset by turmoil and scandal. Eric Shinseki resigned from his post as VA chief following the 2014 wait-list scandal the department. Since then, the VA has gone through three sitting secretaries, and is on its third acting secretary, with Robert Wilkie, previously the Pentagon's undersecretary of personnel and readiness, now tasked as the interim chief until Shulkin's replacement is approved by the Senate.

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7 - Washington Post: [Opinions - Surprise: Trump's newest Cabinet nominee has no relevant experience](#) (29 March, Eugene Robinson, 43.9M uvm; Washington, DC)

You can't make this stuff up: President Trump has announced he will nominate a medical doctor who has no discernible management experience to run the second-largest agency in the federal government.

Can presidents be sued for malpractice?

The man Trump has named to become secretary of veterans affairs, Ronny L. Jackson , happens to be the president's personal doctor. More to the point, given Trump's perpetual hunger for sycophancy, is the fact that Jackson showered the president with hyperbolic Dear-Leader-style praise during a widely viewed television appearance in January.

Trump has "incredibly good genes," the White House physician said in describing a examination he had given the president. Trump's overall health is "excellent." His "cardiac assessment" put him "in the excellent range." If his diet were a bit better, "he might live to be 200 years old." In any event, "I think he will remain fit for duty for the remainder of this term and even for the remainder of another term if he's elected."

That is an unusual way to describe a 71-year-old man whose height was reported as a generous 6 feet 3 inches , and weight at an eyebrow-raising 239 pounds, which classifies him as overweight — but conveniently one pound short of obese. Jackson's are odd words characterizing a man whose cheeseburger-laden diet my doctor would describe as suicidal and whose coronary calcium scan results, according to many other physicians, indicate some degree of heart disease and a clearly elevated risk of heart attack.

I assume Jackson has been more, shall we say, plain-spoken with the president about his health than he was with the public. But am I suggesting that flattery, rather than merit, is what makes him Trump's choice to replace ousted VA Secretary David Shulkin? Absolutely, because no other explanation makes sense.

Pliability may also be playing a role. In a New York Times op-ed, Shulkin wrote that he believed he was being sacked because he opposed a push by the Trump administration "to put VA health care in the hands of the private sector."

Shulkin is a physician, but before he took over VA, he also had experience running hospitals. With no comparable administrative background, Jackson — if confirmed by the Senate — would take over a sprawling agency with about 360,000 employees, a \$186 billion budget and responsibility for providing medical care to 9 million veterans who deserve better, faster service than they now receive.

Shulkin was one of several high-ranking Trump appointees under fire for lavish spending on the taxpayers' dime. He was also a holdover from the Obama administration, and even though the job is perhaps the least partisan in the Cabinet, that prior association clashed with Trump's bratty determination to oppose everything President Barack Obama supported and support everything he opposed.

But Shulkin, by most accounts, had stabilized VA's vast system of hospitals and health clinics. What he refused to do was support the notion of privatizing veterans' health care — an idea pushed by some of the political appointees the White House had installed under him.

"I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans," Shulkin wrote in his Times op-ed. "The private sector . . . is ill-prepared to handle the number and complexity of patients that would come from closing or downsizing VA hospitals and clinics, particularly when it comes to the mental health needs of people scarred by the horrors of war."

Shulkin wrote that "in recent months" the political environment in Washington had become "toxic, chaotic, disrespectful and subversive," making it impossible for him to do his job. "It should not be this hard to serve your country," he wrote.

But it should be hard to get a job running any organization as big, complex and vital as the Department of Veterans Affairs. Perhaps Jackson has an innate genius for management that awaits only the opportunity to flower. If not, Trump will be doing a grave disservice to men and women who are owed the nation's thanks and gratitude.

I can't say I'm surprised. Trump put neurosurgeon Ben Carson in charge of the Department of Housing and Urban Development, despite Carson having zero experience in housing policy. He put Betsy DeVos in charge of the Department of Education, despite her apparent unfamiliarity with actual schools. He put politician Rick Perry in charge of the Department of Energy, which Perry wanted to eliminate until he learned what the agency does.

Perry actually said that during his confirmation hearing. One doesn't know whether to laugh or cry.

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8 - Washington Post (The Fix): [Who is Trump's new Veterans Affairs pick, Ronny Jackson?](#) (29 March, Aaron Blake, 43.9M uvm; Washington, DC)

The seemingly never-ending parade of staff changes in the Trump administration continued apace Wednesday, with the president announcing that Veterans Affairs Secretary David Shulkin is out and that White House physician Ronny L. Jackson will replace him.

Jackson's name will be familiar to political watchers across the country for one main reason: He's the physician who delivered what some felt to be a suspiciously rosy picture of Trump's health in January. But he's an interesting pick for a whole host of other reasons.

For one, Jackson is something of a nonpartisan pick. Like Shulkin, he served in the Obama administration, where he was also President Barack Obama's White House physician. A native of Texas and a graduate of Texas A&M and University of Texas Medical Branch, he's a rear admiral in the U.S. Navy who has spent decades practicing medicine in the military. Jackson was nominated for a promotion to rear admiral (upper half) as recently as last week, which would give him his second star. According to his Navy biography, he was deployed to Iraq in the mid 2000s to head up an emergency medical unit tasked with resuscitating troops.

While there, he was chosen to join President George W. Bush's White House as a physician. In 2013, Obama promoted him to the top job in the West Wing. Trump elected to keep him on. In that role, Jackson oversees not just Trump's health, but also that of the first family and White House staff and guests. He mostly stayed behind the scenes but made headlines after treating a girl who got bit by one of the Obamas' dogs in January 2017.

Navy Rear Adm. Ronny L. Jackson, the lead White House doctor, said on Jan. 16 that President Trump's "overall health is excellent." (Bastien Inzaurrealde/The Washington Post)

Jackson reached his highest degree of notoriety in January, when he delivered a promised review of Trump's health. Trump, who at 70 was the oldest newly elected president ever, is known to eschew exercise and dine on fast food. There have also been persistent questions — especially among his critics — about his mental health. And Trump's medical reviews during the campaign were both ridiculously hyperbolic — claiming he would be the most healthy president ever — and omitted key pieces of information, including a hair-loss drug Trump takes.

Jackson's review played up a cognitive test Trump had passed that seeks out early signs of dementia and other kinds of mental deterioration. He said Trump had "incredible genes" and (seemingly) joked that if Trump's diet had been better he might live to be 200 years old. He denied Trump had heart disease even as the data suggested he might. He listed Trump's weight at 239 pounds, which left Trump exactly one pound shy of the definition of "obese" and spawned a whole host of dubious reactions. (Call it the "girther" movement.)

The whole thing earned Jackson a send-up during the cold open of "Saturday Night Live."

Despite the ridicule, members of the Obama administration vigorously defended Jackson as a patriot and an honest man.

If nothing else, Jackson's ascension seems to reinforce that the best way to get ahead in the Trump administration is to say nice things about him. Some defended Jackson's credentials, but that review will likely be a topic at his confirmation hearings.

Perhaps the main reason Jackson is a somewhat controversial pick, though, is his lack of management experience. VA has been a department beset by scandals in recent years — including before Shulkin — and has proved a logistical and bureaucratic nightmare. Jackson has headed up medical units in the White House and Iraq, but he has never dealt with anything close to the scale of what he's set to take on. It may be the toughest Cabinet job in the entire administration, in fact.

Trump, though, as he often does, has gone with a nontraditional pick who said things he liked on television.

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9 - FOX News: [Ronny Jackson picked by Trump to lead the VA: What to know about the president's physician](#) (29 March, Kaitlyn Schallhorn, 32.5M uvm; New York, NY)

President Trump gave Dr. Ronny Jackson a clean bill of health in March – to run the Department of Veterans Affairs.

A Navy rear admiral, Jackson is the president's personal physician who rose to prominence after he addressed the press from the White House briefing room in January to discuss Trump's health. While Jackson said the president needs to lose some weight, he said the physical exam he conducted showed overall that Trump was in good physical and mental health.

Trump fired Secretary David Shulkin on March 28, and Robert Wilkie is serving as interim secretary until Jackson is confirmed.

He has a marine biology degree

From Texas, Jackson, 50, graduated from Texas A&M University in 1991 with a degree in marine biology, according to his Navy biography. He graduated from the University of Texas Medical Branch with his medical degree in 1995.

That same year, Jackson joined the Portsmouth Naval Medical Center – located just outside Chesapeake, Virginia – which kicked off his active duty military career. It was there that he finished an internship in transitional medicine.

Later, he would return to the naval center to complete his residency in emergency medicine, graduating at the top of his class in 2004.

Jackson is a veteran

Jackson was deployed to Iraq after he joined the 2nd Marines in 2005, according to his Navy biography.

He served as the emergency medicine physician in charge of resuscitative medicine for a forward deployed Surgical Shock Trauma Platoon.

He's been a White House physician since Bush

While still in Iraq, Jackson was tapped as a White House physician in 2006. He has overseen the physicians for Camp David presidential retreats, led the White House Medical Unit and directed the executive health care for the Cabinet and senior staff members, according to his biography.

It was former President Barack Obama who selected Jackson to fill the position of physician to the president.

The Associated Press contributed to this report.

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10 - FOX News (Video): [John Brennan: Trump's nomination for VA secretary is 'terribly misguided'](#) (29 March, Nicole Darrah, 32.5M uvm; New York, NY)

Former CIA Director John Brennan once again took a shot at President Trump on Twitter Thursday, saying he believes the decision to nominate Adm. Ronny Jackson to run the Department of Veterans Affairs is "terribly misguided."

"I personally know and greatly respect Ronny Jackson....as a terrific doctor and Navy officer," Brennan tweeted. "However, he has neither the experience nor the credentials to run the very large and complex VA. This is a terribly misguided nomination that will hurt both a good man and our veterans."

Trump announced via Twitter Wednesday his intention to replace current VA Secretary David Shulkin with Jackson, a 50-year-old Navy rear admiral who has served as personal physician to the president since 2013, when he was appointed by former President Obama, after being tapped to serve as a White House doctor in 2006.

Jackson's also a veteran. He was deployed to Iraq after he joined the 2nd Marines in 2005, according to his Navy biography.

Jackson's nomination triggered some concern among lawmakers and veterans groups about his experience to manage a federal agency, but Trump praised the lifelong doctor as "highly trained and qualified."

Trump decided to oust Shulkin from his Cabinet after he served just over a year in office. An internal VA watchdog found last month that Shulkin improperly accepted Wimbledon tennis tickets and that his then-chief of staff had doctored emails to justify his wife traveling to Europe with him at taxpayer's expense.

The swipe from Brennan, now an analyst for NBC News and MSNBC, isn't the first he's made against Trump.

Just last week, he suggested that the Russians "may have something" against the president, and days prior to that in response to former FBI official Andrew McCabe's firing: "When the full extent of your venality, moral turpitude, and political corruption becomes known, you will take your rightful place as a disgraced demagogue in the dustbin of history."

Fox News' Kaitlyn Schallhorn and Elizabeth Llorente, along with The Associated Press, contributed to this report.

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11 - New York Times: [Op-ed - Ronny Jackson's Disturbing Lack of Independence](#) (29 March, Norman L. Eisen and Bandy X. Lee, 30M uvm; New York, NY)

In announcing Dr. Ronny Jackson, the White House physician, as his choice to be the new secretary for veterans affairs, President Trump has taken his latest misstep in what has been the worst presidential personnel process in modern history.

We take no pleasure in saying so, including because one of us (Mr. Eisen) worked with Dr. Jackson in the White House, was even treated by him, and can testify that he is a very capable physician. But that good opinion of Dr. Jackson, which was widely held in the Obama administration, by no means qualifies him to run one of the largest, most complex and troubled cabinet agencies in the federal government.

Indeed, the very affability of Dr. Jackson's approach when it comes to his current presidential patient is perhaps his greatest disqualification, followed closely by his lack of relevant management experience and the apparent absence of a normal pre-nomination personnel vetting.

Dr. Jackson's January examination of President Trump, and subsequent news conference, give us great pause because they evinced a disturbing lack of independence — one of the most important qualities in a cabinet member. Dr. Jackson startled observers by not only finding the president healthy, but declaring he would remain so in the future. The doctor even looked into his crystal ball to predict good health for a second term, a pronouncement extending seven years into the future and so more fit for a fortuneteller than a scientist.

Some expert observers also felt Dr. Jackson may have understated the president's heart disease, and even fudged the president's height (his driver's license says 6 feet 2 inches; Dr. Jackson reported 6 feet 3 inches) because the lower number would have forced the doctor to admit his patient was obese. When asked why he had such glowing things to say about the president's health when Mr. Trump gorges on McDonalds, guzzles diet Coke, and seldom exercises, Dr. Jackson said: "Some people have just great genes. I told the president that if he had a healthier diet over the last 20 years, he might live to be 200 years old."

That is hardly the objectivity that America needs from its cabinet members. But Dr. Jackson's worst failing was his purported examination of the president's psychological fitness, resulting in his pronouncement that "the president is mentally very, very sharp." The examination came at a time when there was widespread public discussion about the president's mental state, driven by reporting about some of the president's startling behind-the-scenes behavior. The scrutiny was so intense that the president himself asked Dr. Jackson for testing.

But the test that Dr. Jackson administered was not fit for his conclusion. It was a short examination known as the Montreal Cognitive Assessment, which is generally used as a screen for Alzheimer's and similar symptoms. One of us (Dr. Lee) is a mental health professional who has expertise in these examinations, and would never have utilized this narrow test under these circumstances. It is the equivalent of pronouncing a patient cancer-free because she has a good complexion.

A full history should have been taken and a standardized battery of tests given, such as the Minnesota Multiphasic Personality Inventory. Among the other, more appropriate tests that should also have been considered are the Wisconsin Card Sorting Test, the California Verbal Learning Test and the Stroop Test. The MoCA examination was simply not sufficient under the circumstances to support Dr. Jackson's declaration that he had "absolutely no concerns" about the president's cognitive ability or neurological functions.

All of this matters because, if Dr. Jackson cannot be trusted to act independently when it comes to the president's mental and physical health, we cannot be confident that he will do so when it comes to the fitness of the Department of Veterans Affairs. The department has the sacred charge of repaying our soldiers for their service by providing them with health care and other support. If Dr. Jackson tells the president — and the country — what Mr. Trump wants to hear about his own health, how can we trust him to honestly and rigorously diagnose the ailments of the V.A., and to treat them appropriately?

Having a candid V.A. secretary is all the more important because the department faces profound challenges. Since 2014, it has dealt with a pattern of negligent treatment at hospitals operated by one of its agencies, the Veterans Health Administration. Outgoing Secretary David Shulkin revealed yesterday that he had fought Trump administration proposals to privatize services provided by the V.A. — a move that could undermine the quality of health care provided to our veterans. Dr. Jackson's treatment of the president does not inspire confidence that he will take on the V.A.'s problems with the brutal honesty that the job demands.

Dr. Jackson's nomination is also undermined by the fact that although he is a medical professional, he lacks the management experience that the job demands. The V.A. secretary is responsible for a department that provides health care services to over nine million individuals. While Dr. Jackson has served his country with distinction, both in Iraq and as the White House physician, managing a relatively small medical team is not preparation for leading a vast and sprawling bureaucracy. The V.A. is one of the most complex health care management jobs in the world, and ideally would be run by someone with experience operating hospital systems or health businesses or enterprises, and large ones.

The nomination fits a pattern of cronyism, with the president appointing those of dubious qualifications to patronage jobs across the administration. The president's former golf caddy is now the White House social media director. A contractor married to one of the Trump's former household staff members now has a job at the Environmental Protection Agency. And a longtime friend of the Trump family who has been involved in planning golf tournaments and Eric Trump's wedding is the head of the New York and New Jersey office of the Department of Housing and Urban Development. And now he has appointed his White House doctor to oversee the health care of millions of veterans.

Finally, in addition to concerns about independence and qualifications, it appears that Dr. Jackson had not undergone the normal vetting process for White House presidential personnel. Reportedly, the tweet-from-the-hip nomination of Dr. Jackson by the president surprised even his own advisers. That suggests that Dr. Jackson has not in fact received the careful review that is normally completed before such an announcement.

One of us worked (just down the hall from Dr. Jackson, actually) on vetting hundreds of senior administration officials. Very presentable and capable individuals — sometimes even those with existing security clearances — are sometimes disqualified by the rigorous personnel investigations that are normally undertaken for cabinet positions. Such cabinet-level vets complement but are more thorough than a typical pre-existing security clearance, and can uncover conflicts, misdeeds or other disqualifying information.

We are not suggesting that vetting will uncover anything improper, but caution is warranted, since many of Mr. Trump's nominees have had unprecedented conflicts and other issues.

Norman L. Eisen (@NormEisen) is a senior fellow at the Brookings Institution and was President Obama's ethics czar from 2009 to 2011. Bandy X.Lee is a forensic psychiatrist at the Yale School of Medicine and a project leader for the World Health Organization.

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12 - ABC News (Video): [Veterans groups respond cautiously to VA secretary nomination](#)
(29 March, Sarah Kolinovsky, 24.2M uvm; New York, NY)

Despite his active duty status as a Navy rear admiral (lower half) and his medical experience, veterans service organizations are responding cautiously to the nomination of Dr. Ronny Jackson for secretary of Veterans Affairs, with some expressing concern about his lack of managerial experience or what his views are on reforming the VA.

Jackson has served as White House Physician in the past three administrations and in January gave President Donald Trump a glowing health review. Recently, Trump nominated Jackson to receive a second star, promoting him to the rank of full rear admiral. Jackson has deployed to Iraq as an emergency medicine physician in charge of resuscitative medicine for a forward-deployed Surgical Shock Trauma Platoon.

Iraq and Afghanistan Veterans of America, an organization serving the post-9/11 generation of veterans, say it looks "forward to learning more about Dr. Ronny Jackson's vision and qualifications." The statement underscores the fact that Jackson lacks significant managerial experience as he is poised to lead the government's second largest agency, which cares for more than nine million veterans and has an annual budget of nearly \$200 billion.

"Nobody really knows who is he. Is he an empty vessel? Does he have strong views on privatization, or reforming the VA?" asked IAVA CEO and Founder Paul Rieckhoff during an appearance on CNN Thursday morning. "So the confirmation hearings are going to be really really important. The Senate, House, time for you guys to step up and grill this guy and find out if he is qualified to not only run the agency but care for our veterans in a time of war."

IAVA welcomed the news that "finally puts an end to weeks of painful speculation that was negatively impacting VA and veterans nationwide," referring to media reports that President Trump had lost confidence in Secretary Shulkin. IAVA pointed out that in a recent survey, only 24% of the organization's members approved of the job Shulkin was doing.

Veterans of Foreign Wars (VFW) echoed IAVA's hesitation about Jackson's experience. "The VFW will be closely monitoring the Senate confirmation process, because what Dr. Jackson's bio does not reflect is any experience working with the VA or with veterans, or managing any organization of size, much less one as multifaceted as the Department of Veterans Affairs," VFW Director of Communications Joe Davis said in a statement.

The conservative group Concerned Veterans for America expressed more optimism about the change, saying in a statement "We are hopeful that this change will end the recent distractions at the VA and put the focus back on advancing policy that will ensure veterans get the health care and other benefits they have earned. The Trump administration has made great progress over the last year reforming and fixing the VA, however, there is still much work to be done."

The American Legion declined to comment directly on Jackson's qualifications. Instead, the group highlighted their intention to work "directly with the President through this transition and going forward, and providing him an increased level of advice and feedback on the issues important to America's veterans."

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13 - The Atlantic: [The Doctor Who Suddenly Got Nine Million Patients - For a position that demands high-level policy expertise, President Trump appointed his personal physician, Ronny Jackson.](#) (29 March, James Hamblin, 23.9M uvm; Washington, DC)

Nine million veterans will soon be under the care of the emergency-physician rear admiral Ronny Jackson, pending confirmation of his appointment Wednesday to lead the U.S. Department of Veterans Affairs.

This seemingly mundane appointment—a doctor and naval officer with years of experience as White House physician under both Trump and Obama—is of great consequence. It comes at a time when the VA is in need of a politically savvy expert on health-care administration, budgeting, and resource allocation, as the system is on the brink of major changes that bear on national security. The system has proven to require a leader who can thread multiple bureaucratic needles with his or her eyes closed. Jackson does not clearly fit this bill.

The VA is the second-largest federal department, overseeing 1,243 health-care facilities including 170 hospitals, which tend to be a ghostly network of dim, mid-century structures that bear the scars of serving as constant political battlefields. They tend to have bad food and no marble and bizarre gift shops that I've seen sell knives and cured meats. Yet VA hospitals seem to underscore the waste of the glitz of five-star-hospital-style academic medical centers. The system punches above its weight in the quality and safety of care it delivers compared to most of the private health-care industry.

While it is crucial to have experienced veterans and physicians in the upper echelons of a system like this, the work is mostly about politics and economics. Jackson is not an expert in policy, and he lacks work experience in health-care administration or management. His chief credential is that he is a physician. I'm also a physician, and—ask anyone—I'm wholly unqualified to lead a hospital system, much less to lead the one most crucial to our national security.

Even as a doctor, Jackson's judgment has been dubious at times. The press conference in January where he extolled President Trump's soundness of mind suggested allegiance to the president above the public or the profession: "I've found no reason whatsoever to think that the president has any issues whatsoever with his thought process," Jackson said, after having administered a 10-minute test for dementia in which the president was asked to do basic math, identify zoo animals, and draw a clock. (A useful and good test, the results of which were, I've argued, overstated in the context of widespread physician concern over the president's soundness of mind.)

Professional bearing intact, Jackson also said that the borderline-obese (BMI 29.9), 71-year-old president—who does not exercise and eats McDonald's to excess (Filet-o-Fish, no less) and is known for angry outbursts and drinks around 144 ounces of Diet Coke per day and barely sleeps—is in "very good health, excellent health." He speculated that the president would

remain fit for service until the end of a second term and said he told Trump that “if he had a healthier diet over the last 20 years, he might live to be 200 years old.”

As David Axelrod, former adviser to President Obama and now the director of the University of Chicago Institute of Politics, responded publicly to the appointment: “Dr. Jackson is a good and honorable person, [a] fine doctor and career military, but you do get the sense that this [appointment] has as much to do with his boffo press conference on the president’s physical [exam] as anything else.”

Trump has become known for proximity-based, loyalty-based promotions made with apparent haste. Jackson may simply have been the only doctor in Trump’s field of view. With doctors Oz and Phil being televisually obligated, and Harold Bornstein all the way up in New York ... who else is there?

Though if the move was deliberate to a policy end, it was a savvy move from the perspective of those who would like to see the VA privatized. There has been a creeping movement to privatize elements of the VA system, backed by the Koch brothers, among others. At a policy level, the concept is worthy of consideration and debate. Some experts argue that certain elements being privatized could improve quality and decrease costs.

But that doesn’t seem to be what’s happening. The outgoing VA secretary David Shulkin made this clear on Thursday in an op-ed in The New York Times. He argued that some public-private cooperation had been fruitful: “We have expanded access to health care by reducing wait times, increasing productivity, and working more closely with the private sector.” But he also warned that the push toward complete privatization was not being undertaken in good faith. Shulkin writes:

It seems that these successes within the department have intensified the ambitions of people who want to put VA health care in the hands of the private sector. I believe differences in philosophy deserve robust debate, and solutions should be determined based on the merits of the arguments. The advocates within the administration for privatizing VA health services, however, reject this approach. They saw me as an obstacle to privatization who had to be removed. That is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans.

With Shulkin out of the way, the next secretary of the VA would need to approach the job with strong moral bearing and willingness to resist political expedience for the sake of improving the system. Without this force, special interests could sway the system toward privatization at a cost to taxpayers and veterans.

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14 - The Hill: [White House: Trump has 'full confidence' in presidential physician to lead VA](#) (29 March, Max Greenwood, 11.9M uvm; Washington, DC)

President Trump has “full confidence” in White House physician Ronny Jackson’s ability to head the Veterans Affairs (VA) Department, a spokeswoman for the White House said Thursday, despite reported concerns from some aides.

"As I said earlier, the president has full confidence in Adm. Jackson," White House deputy press secretary Lindsay Walters told reporters.

"The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary and ultimately decided that his health care experience, his distinguished career in the medical profession, was something that would be beneficial at the VA," she continued.

"At the end of the day, as I said earlier, the status quo was not working. We need somebody who understands the health care system," she said.

Trump continued a spate of shake-ups in his Cabinet on Wednesday by dismissing VA Secretary David Shulkin and tapping Jackson, a rear admiral in the Navy and the current White House physician, for the role.

The New York Times reported Wednesday that some White House aides had privately expressed concern about the decision to nominate Jackson for the VA's top job, because of his lack of experience managing a large organization.

At the same time, some aides acknowledged that Trump's relationship with Jackson carried more weight in making the decision than the physician's prior experience, the Times reported. Jackson gave Trump his first physical in office earlier this year.

Walters told reporters Thursday that Jackson "has bipartisan respect" in Congress, and said his experience in the Navy gives him an insight into "what soldiers need on the battlefield and what they need when they come home as veterans."

She also said the decision to oust Shulkin and nominate Jackson was in no way part of an effort to privatize veterans' health care, as Shulkin had implied in an op-ed he wrote the day after his ouster.

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15 - The Hill: [GOP, vet groups react with caution to Trump VA pick](#) (29 March, Rebecca Kheel, 11.9M uvm; Washington, DC)

Senators and influential veterans groups are withholding judgment on President Trump's pick to lead the Department of Veterans Affairs (VA), a Navy doctor with no experience leading a federal bureaucracy.

Both the Republican chairman and the Democratic ranking member of the Senate Veterans Affairs Committee said only that they look forward to meeting Rear Adm. Ronny Jackson. Several veterans groups expressed some concern about Jackson's qualifications, but did not immediately oppose him, saying that questions need to be answered during the confirmation process.

"We look forward to understanding more about the qualifications of Admiral Ronny L. Jackson, MD to helm the VA during this critical time," Carl Blake, executive director of Paralyzed Veterans of America, said in a statement. "The VA has a broad mission and the secretary must be someone who is eminently qualified to lead the nation's second largest cabinet agency."

VA-18-0457-A-000926

On Wednesday night, Trump announced on Twitter that he'd tapped Jackson to replace David Shulkin, who fell out of the president's good graces after turmoil over the direction of private health care for veterans and a scathing inspector general report accusing him of misusing taxpayer dollars on a trip to Europe.

Shulkin's firing was expected, but Jackson was not among the names circulating as possible replacements.

Statements from lawmakers and veterans groups poured in Wednesday night, heavily praising Shulkin for his service at the department.

When it came to Jackson, though, the statements were generally shorter and more neutral.

"I look forward to meeting Admiral Jackson and learning more about him," Senate Veterans Affairs Chairman Johnny Isakson (R-Ga.) said in a statement.

In a separate statement, committee ranking member Sen. Jon Tester (D-Mont.) likewise said he looks "forward to meeting Admiral Jackson soon and seeing if he is up to the job."

Jackson was first thrust into the public spotlight when he gave Trump a clean bill of health in January during a lengthy and unusual press briefing at the White House.

Jackson told reporters that a cognitive test showed "no reason whatsoever to think the president has any issues whatsoever with his thought processes." He also proclaimed Trump's "overall health is excellent," crediting the president's "good genes" despite a well-known penchant for fast food and lack of exercise.

Jackson has served as a White House physician since 2006 and was promoted by former President Obama in 2013 to become the physician to the president.

Just last week, Trump nominated Jackson for a promotion in rank from rear admiral (lower half) to rear admiral. Jackson is expected to retire from active duty if confirmed.

A Texas native who received his doctorate of medicine from the University of Texas Medical Branch, Jackson started his naval career in 1995 at the Portsmouth Naval Medical Center in Virginia, according to his Navy biography.

In 2005, Jackson deployed as part of the Surgical Shock Trauma Platoon in Taqaddum, Iraq. There, he served as the emergency physician in charge of resuscitative medicine.

His bio lists several awards, including the Defense Superior Service Medal, the Legion of Merit, the Navy/Marine Corps Commendation Medal and the Navy/Marine Corps Achievement Medal.

But it makes no mention of any work on veterans issues.

Still, the White House says Trump has "full confidence" in Jackson, adding he believes the department needs someone who understands health care.

If confirmed, Jackson would take the helm at the government's second largest bureaucracy at a time when the VA is still regaining trust after a 2014 scandal over long and falsified wait times for veterans seeking health care.

In addition to overseeing 1,700 health-care sites serving almost 9 million veterans annually, the doctor would be in charge of benefits delivery, 360,000 employees and a nearly \$200-billion budget.

Jackson would also come in during a raging debate over legislation to expand a program known as Choice that provides private health care to some veterans -- a concern seen as central to Shulkin's undoing.

At issue is how much to expand the program. Veterans groups and Democrats fear the White House wants to essentially privatize veterans health care, which they warn would not be able to address the unique challenges veterans face.

Jackson's position on the issue is unknown, though the White House said Thursday in response to accusations made by Shulkin that "there are no discussions about privatizing" the VA.

Veterans service organizations, which are congressionally chartered and hold substantial sway over veterans issues in Congress, raised questions about Jackson's qualifications.

AMVETS listed several questions for Jackson, including how someone who's never held a command is qualified to lead a massive bureaucracy and what his qualifications are to address issues outside of health care including claims, appeals, benefits and cemetery affairs.

"I am deeply concerned about the nominee," AMVETS Executive Director Joe Chenelly said in a statement. "Veterans' lives depend on this decision, and the Trump administration needs to substantiate that this active-duty Navy officer is qualified to run a \$200 billion bureaucracy, the second largest agency in the government."

Disabled American Veterans (DAV) said they look forward to "learning more about the qualifications and views" of Jackson and expressed concern about a leadership vacuum.

"At a time of critical negotiations over the future of veterans healthcare reform, VA today has no secretary, no under secretary of health or benefits, and the named acting secretary has no background in health care and no apparent experience working in or with the department," DAV Commander Delphine Metcalf-Foster said in a statement, referring to acting Secretary Robert Wilkie, who comes from the Pentagon.

"We certainly expect the next secretary to continue the path set by VA, Congress and veterans organizations in recent years to strengthen the VA healthcare system while ensuring that all enrolled veterans have timely access to quality care, whenever and wherever they need it."

Still, Vietnam Veterans of America (VVA) said Jackson will understand veterans' needs.

"We are pleased that he is a combat veteran with firsthand knowledge of the trauma of war, and as such, will understand what our veterans need," VVA National President John Rowan said in a statement.

VA secretaries typically receive strong bipartisan support in their confirmation. Shulkin was confirmed unanimously, as was his predecessor Bob McDonald. The secretary before that, Eric Shinseki, was confirmed by voice vote.

Nominees only need a simple majority to be confirmed. But Republicans only have a two-seat advantage over Democrats in the Senate, and one Republican, Sen. John McCain (Ariz.), has not voted in months as he receives cancer treatment in his home state.

Republicans on the Senate Veterans Affairs Committee appeared inclined to support Jackson.

"I look forward to working with Dr. Ronny Jackson on modernizing and reforming the VA, fixing the VA Choice Program, and implementing the major reforms that Congress has passed over the last year," Sen. Thom Tillis (R-N.C.) said in a statement.

Sen. Jerry Moran (R-Kan.), who in January accused Shulkin of "double-talk" in negotiating on Choice, said the VA secretary needs to focus on changing the department's bureaucracy.

"Rear Admiral Jackson has a career in service and I look forward to discussing his plans for the VA to make certain veterans receive access to care they deserve," Moran said in a statement.

Committee Democrats, meanwhile, promised close scrutiny of Jackson's qualifications and his position on privatization.

"I will seriously scrutinize the president's nominee, Ronny Jackson, because our nation's veterans deserve the best," Sen. Richard Blumenthal (D-Conn.) said in a statement.

Sen. Bernie Sanders (I-Vt.), who caucuses with Democrats, was more blunt.

"The Senate Committee on Veterans Affairs should not approve any nominee for secretary who supports the privatization of the VA," he said in a statement.

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16 - Military.com: [Others Considered for VA Job Before Trump Picked His Personal Doctor](#) (29 March, Richard Sisk, 9M uvm; San Francisco, CA)

Rear Adm. Ronny L. Jackson, the personal physician to President Donald Trump, was not his first choice to replace fired VA Secretary Dr. David Shulkin, the White House said Thursday.

"The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary," White House deputy press secretary Lindsay Walters told reporters.

She said Trump "ultimately decided that his [Jackson's] health care experience, his distinguished career in the medical profession, was something that would be beneficial at the VA."

Walters added that Trump "has full confidence in Admiral Jackson" to fulfill the demanding job at the Department of Veterans Affairs despite his lack of experience in running large organizations.

Walters did not name the others who were considered to head the VA, but they reportedly included Toby Cosgrove, former head of the \$8 billion Cleveland Clinic health care system, and Pete Hegseth, an Army National Guard veteran of Iraq, former head of the advocacy group Concerned Veterans of America and co-host of the weekend "Fox & Friends" program.

Cosgrove, a Vietnam veteran, was among those invited in 2016 to Trump's Mar-a-Lago estate in Florida to be interviewed for the VA post before Trump settled on Shulkin, a holdover from the Obama administration.

Others who were under consideration as VA secretary included former Rep. Jeff Miller, R-Florida, who had been chairman of the House Veterans Affairs Committee; retired Army Lt. Gen. Keith Kellogg; Michael Kussman, a former VA undersecretary of health; and Leo Mackay Jr., a former VA deputy secretary who is now senior vice president at Lockheed Martin Corp., The Associated Press reported.

The surprise announcement of his nomination Wednesday afternoon, his status as a relative unknown on Capitol Hill, and the ongoing turmoil at the VA indicate Jackson will have little in the way of a honeymoon period if he is confirmed by the Senate.

Shulkin wasn't even out the door when Jackson faced a barrage of conflicting demands from the White House, Congress and the major Veterans Service Organizations (VSOs).

The immediate concern is the upcoming decision by the VA to award a contract that could run up to \$10 billion and is aimed at finally giving the agency electronic health records. There are also the perennial disagreements on what to do about benefits, wait times, suicides, PTSD, corruption, caregivers and the crumbling infrastructure at VA hospitals.

However, at the top of Jackson's to-do list is reaching a final resolution on the extension and expansion of the Veterans Choice Program, which allows vets to opt for private health care.

Proponents, including Trump, see Choice as guaranteeing that vets get the best health care available; opponents, including the VSOs, see overreliance on Choice as threatening the core mission of VA as the primary provider and payer for the care of nine million vets annually.

In leaving, Shulkin sidestepped the scandal over his travel expenses. He portrayed himself as the victim of palace intrigues hatched by White House political appointees advocating the full "privatization" of VA health care.

In an op-ed for The New York Times, Shulkin wrote that the political appointees, at the White House and within the VA, "saw me as an obstacle to privatization who had to be removed."

"That is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans," he said.

In testimony to the House Veterans Affairs Committee earlier this month, Shulkin warned that the Choice program could run out of money as early as June.

Sen. Johnny Isakson, R-Georgia, chairman of the Senate Veterans Affairs Committee, had co-sponsored a bill that would have extended Choice while keeping the decision on whether vets could go to private doctors within the VA, but the bill was not included in the \$1.3 billion omnibus spending package signed by Trump last week.

Isakson has pledged to renew his efforts on Choice when Congress returns after the Easter recess. In a statement Thursday, he also hinted at the conflicts with the White House by heaping praise on Shulkin and pointing to improvements at the VA in the past year.

Shulkin "has made a tremendous impact toward improving the lives of veterans," Isakson said. "He has been instrumental in all that we have accomplished in the last year, and I thank Dr. Shulkin for his dedicated service to our country and our veterans."

As for Jackson's nomination, Isakson said, "I look forward to meeting Admiral Jackson and learning more about him."

If confirmed by the Senate, Jackson, who has little administrative experience and none in running an organization such as the VA, could be expected to rely on the insider knowledge of the No. 2 at the agency, Deputy VA Secretary Thomas Bowman. The VA, the largest healthcare system in the United States, has 370,000 employees and a budget of nearly \$200 billion.

However, Bowman, a retired Marine colonel and military attorney, has already been targeted for removal by Jake Leinenkugel, a former brewery company executive and now a senior White House adviser on veterans issues.

In December, Leinenkugel wrote in an email to Camilo Sandoval, a political appointee at the VA, that they should lobby for the ousters of both Shulkin and Bowman. The email was first reported by The Washington Post and later obtained by Military.com.

Isakson and the VSOs came to the defense of Bowman, a long-time former staffer on the Senate Veterans Affairs Committee.

"Tom Bowman is a veteran and a patriot, a public servant and a good man," Isakson said in a statement. "If this is true, it will be a mistake, and I am deeply disappointed in the president. Veterans will suffer because of this decision if it's true."

The VSOs have partly blamed the moves against Shulkin and Bowman, and the efforts at privatization, on the work of the advocacy group Concerned Veterans for America, which is funded by the conservative Koch brothers organization.

In a statement, CVA's executive director, Dan Caldwell, said that Shulkin "made significant headway in reforming the department, but ultimately became a distraction from the important task of improving health care for our veterans."

Without mentioning Choice, Caldwell said, "Congress needs to continue work with the president to pass legislation that will give veterans more health care options and better access to care through the VA."

In a statement, Sen. John McCain, R-Arizona, chairman of the Senate Armed Services Committee, said of Choice that "much more work remains to improve the Veterans Choice Program and ensure our nation's heroes have access to the best possible services."

"Let me be very clear: none of us committed to reform wants to privatize care. We simply believe the VA must put the needs of veterans first, and ensure they receive timely, quality and uncompromised health care, whether that's in the VA or in the community," McCain said.

Sen. Jack Reed, D-Rhode Island, ranking member of the Senate Armed Services Committee, said, "I admire Dr. Jackson's service to the nation, but I don't know if he is the right person to lead the VA."

"One thing is clear -- the Trump administration seems to devolve further into turmoil by the day," Reed said. "I hope the level of dysfunction that has engulfed other parts of the administration does not impact the care that our veterans receive."

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17 - Government Executive: [Lawmakers, Veterans Groups and Former Officials Worry VA Nominee Is Not 'Up to the Job'](#) (29 March, Eric Katz, 870k uvm; Washington, DC)

With David Shulkin now ousted from the Veterans Affairs Department, all eyes are on President Trump's nominated replacement to see where he comes down on the most pressing issue at VA: How large a role should the private sector play in providing health care to veterans?

One problem for observers and stakeholders in the veteran community is Trump's pick, Dr. Ronny Jackson, has very little experience in public policy or veterans issues. Veterans service organizations and lawmakers were effusive in their praise of Shulkin, while expressing disappointment in his firing and noting the new relationships they would have to now forge.

"I don't know if he ever set foot in a VA [facility]," Louis Celli, the national VA director at American Legion, a group that represents more than 2 million veterans, said of Jackson. By the time the secretary designate is fully able to understand all the issues facing the department, Celli said, "this administration could be over."

As VA secretary, Jackson would be responsible for managing 370,000 employees spread across 3,000 facilities. Administering veterans disability benefits, education subsidies and cemeteries number among the department's dozens of lines of business. Still, its responsibility to provide health care to veterans is by far its biggest operation—the Veterans Health Administration runs the largest hospital network in the country—and is what led Jackson, a physician, to get the job.

Trump "ultimately decided that his health care experience, his distinguished career in the medical profession was something that would be beneficial at the VA," Lindsay Walters, a White House spokeswoman, told reporters Thursday. "At the end of the day . . . the status quo was not working. We need somebody who understands the health care system."

While Jackson has served as White House physician since 2006 and the president's personal doctor since 2013, his background is atypical for VA secretaries. While Shulkin was the first to helm the department without himself being a veteran, he had served at VA as an undersecretary as head of the Veterans Health Administration. He had previously led multiple private medical centers and health systems. His predecessor was Bob McDonald, who came from the private sector but whose nomination was met with plaudits because of his experience leading the Fortune 50 company Procter & Gamble. McDonald replaced Eric Shinseki, who had previously served as chief of staff of the Army.

In a New York Times op-ed published after his firing, Shulkin warned that his political enemies from within the Trump administration pushed him out not due to the scandals surrounding him but because of ideological differences about the future of VA.

"I have been falsely accused of things by people who wanted me out of the way," Shulkin said. "But despite these politically based attacks on me and my family's character, I am proud of my record and know that I acted with the utmost integrity. Unfortunately, none of that mattered."

Shulkin added that the environment surrounding him became "so toxic, chaotic, disrespectful and subversive" that he could no longer accomplish his job. He said his opponents within the department, whom he repeatedly vowed to oust, were fighting to privatize VA health care and saw him as a barrier in achieving that goal.

"They saw me as an obstacle to privatization who had to be removed," Shulkin said. "That is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans."

Opponents of privatization, including Shulkin, nearly all veterans service organizations and key lawmakers on both sides of the aisle on Capitol Hill, could breathe at least a momentary sigh of relief when Trump announced Jackson as his nominee to be the next VA secretary. Jackson is in many ways an unknown, but is not associated with any previous push to minimize the government's role in providing veterans health care as were some of the other candidates Trump was reportedly considering.

"I am deeply concerned about the nominee," said Joe Chenelly, executive director of AMVETS, another congressionally chartered veterans service organization. "Veterans' lives depend on this decision, and the Trump administration needs to substantiate that this active-duty Navy officer is qualified to run a \$200 billion bureaucracy, the second largest agency in the government."

AMVETS added it was pleased Jackson had a medical background, but noted VA is "more than healthcare."

"What qualifications does the president's nominee have to address claims, appeals, benefits and cemetery affairs?" the group asked.

Celli noted that even McDonald, a veteran who came to the department with vast managerial experience, took a while to fully "wrap his arms around the entire mission of what VA was" and was therefore only able to make a significant impact in two or three areas of VA's operation.

President Obama was wise to recognize he needed a veteran who had also run a large company with a big budget and many employees, much like VA itself, McDonald told Government Executive.

"That intersection is very small and I think [Obama] recognized that," McDonald said. "While Adm. Ronny must be a great doctor, the question the Senate will need to address is does he have sufficient management experience."

Even Shulkin seemed to suggest the job requires a large learning curve.

"No one is naturally prepared to take on a task like this," Shulkin told NPR on Thursday. Jackson would not be met with political leadership at the department to help guide him through

the ins and outs of its medical network, as Trump has yet to nominate an undersecretary to head VHA.

"Given the state of the VA today, the most important thing is the leadership experience of a very large organization," McDonald said. Having medical experience would only be the third top priority, McDonald said, after being a veteran.

Several groups expressed concern over the fate of reforms VA had already initiated under Shulkin. The now former secretary was in the process of realigning the department's regions, or Veterans Integrated Service Networks, and the larger structure of the department. He had worked with oversight committees in Congress on a proposal to consolidate existing programs giving veterans access to private sector care on the government's dime and easing veterans access to such programs, while maintaining a tight balance with those who tend to have a knee-jerk reaction against any reform that could be construed as VA privatization. The existing Veterans Choice Program is expected to run out of funding this summer. He had won approval for his plan to shutter underutilized facilities and had already help shepherd measures to expedite firing of problematic employees and reform the disability appeals process through Congress and into law.

"I have enjoyed getting to know Secretary Shulkin, and I'm glad to call David a friend," said Rep. Phil Roe, R-Tenn., who chairs the House Veterans Affairs Committee. "I think he's done a fantastic job and I hate to see him go."

Roe pledged to work with Jackson and build "a strong relationship with him also." Roe's counterparts in the Senate made clear they would not automatically grant their approval, as will be necessary for his confirmation.

"I look forward to meeting Admiral Jackson and learning more about him," Sen. Johnny Isakson, chairman of the Senate VA committee, said after praising Shulkin for the "tremendous impact" he made during his tenure.

Sen. Jon Tester, D-Mont., was even more non-committal.

"Moving forward, the VA needs a strong leader at the top who will listen to veterans, strengthen the VA and work with Congress to implement bipartisan reform," Tester said. "I look forward to meeting Rear Adm. Jackson soon and seeing if he is up to the job."

McDonald suggested Trump's selection could mark a departure from the path on which he and Shulkin put the department, which the former secretary said he formulated after hundreds of visits around the country to listen to VA beneficiaries.

"Veterans don't want the privatization of the VA," McDonald. "I hope President Trump is listening to veterans."

The American Legion's Celli speculated that Trump's choice of Jackson was a matter of happenstance rather than qualification. His selection was not as "draconian" as he and many had feared, Celli said, but it still appeared as if Jackson got the nod because he was "someone with military experience who [Trump] just happened to know." Celli was at least pleased that Jackson's demeanor and medical abilities were "above reproach," but said he would still have to prove himself beyond that to earn the support of the veteran community.

“Great, he’s a nice guy,” Celli said. “There’s a lot of nice guys out there.”

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18 - PBS: [Who is Ronny Jackson, Trump’s pick to lead the Department of Veterans Affairs?](#) (30 March, Gretchen Frazee, 22M uvm; Arlington, VA)

Rear Admiral Ronny Jackson has garnered almost universal praise for his skills as a military physician and his character. But his appointment to lead the Department of Veterans Affairs is proving divisive as critics point to his lack of experience managing a large organization.

On Wednesday, President Donald Trump named Jackson, the top White House physician, to replace David Shulkin, a holdover from the Obama administration, as secretary of Veterans Affairs.

The nomination immediately sparked criticism over Jackson’s limited management experience. The Department of Veterans Affairs has a \$182 billion budget and hundreds of medical facilities and offices across the country. The agency has 385,233 employees, a spokesperson for the agency said.

“I personally know and greatly respect Ronny Jackson ... as a terrific doctor and Navy officer,” former CIA Director John Brennan tweeted Thursday. “However, he has neither the experience nor the credentials to run the very large and complex VA. This is a terribly misguided nomination that will hurt both a good man and our veterans.”

Others defended Jackson, citing his decades-long career as a military physician and ability to perform in high stress situations and coordinate large operations.

“Ronny Jackson will be just damn fine in management skills,” said Dan Bongino, a former Secret Service special agent who worked with Jackson on the presidential protective division from 2006 to 2011. Bongino has since run for political office as a Republican and been a conservative commentator on numerous television programs.

Jackson has served under three presidents, which gives him bipartisan appeal. Both Democrats and Republicans say he is a superb doctor.

Trained in emergency medicine in the U.S. Navy, Jackson was appointed as a White House physician in 2006 under President George W. Bush. In 2013, President Barack Obama appointed him as physician to the president. He now serves in that same role under Trump.

Jackson is not well known outside of Washington, but he attracted national attention recently after conducting Trump’s medical exam, when he gave the president a glowing assessment at a press conference.

“The president’s overall health is excellent,” Jackson said at the time. “His cardiac performance during his physical exam was very good. He continues to enjoy the significant long-term cardiac and overall health benefits that come from a lifetime of abstinence from tobacco and alcohol.”

Jackson put the president at 6-foot-3 and 239 pounds, sparking widespread memes and photo comparisons to famous athletes online that poked fun at whether those numbers were accurate.

Yet those who have worked with Jackson say Americans should look past that episode and focus on his years of experience coordinating advance medical teams for presidential visits abroad.

As part of his job at the White House, Jackson helped create a contingency plan in case of a medical emergency so the president could receive the best treatment as quickly as possible.

The job has required coordinating with the Secret Service, foreign government leaders, and hundreds of medical staff to determine the closest medical facilities in locations where the president traveled, what their treatment specialties were, and whether they had access to things like a helicopter landing pad, for example.

“Quite literally the president’s life is in his hands,” Bongino said.

It is a high-stress environment, according to Jonathan Wackrow, another Secret Service agent who served under the Obama administration from 2009 to 2014. The president’s physician must handle the presidential family’s medical needs, the everyday stresses of the White House, political influences and constant travel.

“What Dr. Jackson has always done is put his head down and move forward,” Wackrow said. “He is going to take on this challenge like he has everything else in his career.”

Jackson graduated from Texas A&M University in 1991 with a bachelor’s degree in marine biology. He attended medical school at the University of Texas Medical Branch.

After graduating he became an instructor at the Naval Diving and Salvage Training Center in Panama City, Florida. He went on to serve as a diving medical officer for an explosive ordnance disposal unit in Sigonella, Italy, and a diving safety officer at the Naval Safety Center in Norfolk, Virginia.

He later served as an emergency medicine physician in Iraq before joining the White House.

If he is confirmed by the Senate, Jackson would be the first Veterans Affairs secretary to have served in either the Iraq or Afghanistan wars — an experience that will likely resonate with the more than 2.7 million soldiers who have been deployed to the countries since 2001.

“It means he will relate with the people who he is serving,” said Melissa Bryant, the chief policy officer for the advocacy group Iraq and Afghanistan Veterans of America. “But it doesn’t necessarily translate into managing the bureaucracy.”

Even those who support Shulkin’s resignation said Jackson will have a steep learning curve.

“The VA is a very complicated and complex medical system. There is a lot that anybody will need to learn about it,” said Dan Caldwell, the policy director for Concerned Veterans for America, an advocacy group funded by the conservative billionaire Koch brothers.

There are also questions about whether Jackson would be required to retire from the military or be granted a waiver from Congress because active members of the military are generally barred from holding civilian office.

And for all his military and experience, Johnson is still a largely unknown quantity in the larger veterans community.

At the fore of many veterans group's minds is whether Jackson might privatize more agency services. In a New York Times op-ed after he was fired by Trump, Shulkin warned that the department has "become entangled in a brutal power struggle," with political appointees seeking to "privatize veteran health care," a point he echoed in an interview Wednesday with the PBS NewsHour. Shulkin, who has been under fire for an inspector general report that suggested he misused government funds during a trip to Europe, added the chaos surrounding that debate played a role in his ouster.

When he was asked by the NewsHour's Judy Woodruff whether Jackson might push for more privatization, Shulkin said he had not discussed the issue with his successor.

"But I certainly hope he's going to continue the work that I've been doing to move the department to transform it in a better way," Shulkin said of Jackson. "I will certainly do everything I can to help Dr. Jackson succeed in that role," he added.

Shulkin is one of several top administration officials dismissed by Trump in recent weeks. The president has also recently ousted Rex Tillerson as secretary of state, and nominated CIA Director Mike Pompeo as his replacement. He also picked John Bolton, a former U.S. ambassador to the United Nations, to replace National Security Adviser H.R. McMaster. Bolton, unlike Shulkin and Pompeo, do not require Senate confirmation.

Veterans advocates said they would follow Jackson's confirmation process closely. If he does get the Senate's stamp of approval, Caldwell argued, Jackson would have one major advantage: he has the trust of President Trump, at least for now.

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19 - NPR (Morning Edition, Audio): [Trump Pick For VA Secretary May Get Additional Scrutiny](#) (30 March, 22M uvm; Washington, DC)

Noel King talks to Democratic Sen. Richard Blumenthal about President Trump's decision to fire VA Secretary David Shulkin, and the confirmation process of the president's pick to replace him.

Transcript:

NOEL KING, HOST:

President Trump has nominated White House physician Ronny Jackson to replace David Shulkin as the secretary of Veterans Affairs. But Doctor Jackson will still need to be confirmed by the Senate. One man who will help decide whether Jackson gets the job is Connecticut Democrat Richard Blumenthal. He's on the Senate committee for veterans affairs (ph), and he was also a reservist in the Marines in the 1970s. Good morning, Senator.

RICHARD BLUMENTHAL: Good morning to you. Thank you for having me.

KING: We're glad to have you. Before we move on to Ronny Jackson, I want to quickly get your take on the firing of Dr. Shulkin. What's your understanding of why he was let go?

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BLUMENTHAL: I take the president at his word - that he was dissatisfied with his performance. But he contributed a lot to the VA at very difficult times. And I think that Dr. Jackson is going to face a buzz saw of skepticism and scrutiny about his management expertise and ability to face exactly the challenges that Dr. Shulkin eventually found unsurmountable (ph).

KING: We'll talk about that buzz saw in a second. But we did talk to Dr. Shulkin on MORNING EDITION yesterday, and he suggested that one issue behind his being let go may have been his views on privatization at the VA. Let me have you listen to him for a sec.

(SOUNDBITE OF ARCHIVED BROADCAST)

DAVID SHULKIN: It's essential for national security and for the country that we honor our commitment by having a strong VA. I was not against reforming VA, but I was against privatization. Do you think his use played a role in his dismissal?

BLUMENTHAL: There is no question that a segment and maybe a dominant part of the Trump administration is looking to privatize the VA health care system. Dr. Shulkin resisted it and rightly so. I have no question that his opposition to privatization played a role in his dismissal. And it will play a role in the confirmation hearings that Dr. Jackson face because he's going to have to state unequivocally and clearly that he, too, opposes privatization for his nomination to be confirmed in my view.

KING: Will you ask him during the confirmation hearing if he does?

BLUMENTHAL: I will not only ask him to state his views, I will eventually demand, respectfully, but still very directly that he commit that he will sustain and, in fact, improve the current VA health care system rather than abandoning it, in effect, to a privatized system that relies on private providers rather than the VA facilities. There is a role for private providers when the wait are too long or the length of time and distance are too large. But the VA health care facility serves, very well, many veterans needs. And it should be improved to be a first-rate, world-class system rather than gradually reduced and abandoned.

KING: Dr. Jackson is a career military doctor. He also served as a personal doctor to President Obama. But the VA is a very big bureaucracy. Do you have specific concerns about his ability to lead such a large organization?

BLUMENTHAL: You know, the VA is kind of like the Mount Everest of public management challenges. It is the second largest agency in the government. It's a sprawling bureaucracy of 360,000 people with a budget of 186 billion. And it will present a challenge. And I have very strong questions about Dr. Jackson's expertise and experience to lead that kind of very, very challenging management bureaucracy.

KING: Questions that you will get to put to him. Senator Richard Blumenthal, Democrat of Connecticut, thank you so much.

BLUMENTHAL: Thank you.

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20 - MSNBC (Video): [Reines: 'There's never been a no vote against a VA nominee, this might be the time to change that record'](#) (30 March, 11.8M uvm; New York, NY)

In yet another White House personnel shakeup, President Trump ousts Secretary of Veterans Affairs David Shulkin and appoints his personal doctor Ronny Jackson. Philippe Reines, former adviser to then-Secretary of State Hillary Clinton, and Shermichael Singleton, former Deputy Chief of Staff for the Department of Housing and Urban Development, discuss with Kristen Welker whether the president's new appointee is qualified for the position. The panel also joins Ari Melber, host of MSNBC's The Beat, to weigh in on the breaking news of a federal judge denying Stormy Daniels' motion to depose Trump.

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21 - The Hill: [Trump VA pick hesitated to take job: report](#) (30 March, Max Greenwood, 11.8M uvm; Washington, DC)

White House physician Ronny Jackson initially hesitated at the suggestion that he be nominated to lead the Department of Veterans Affairs, The Washington Post reported Thursday.

Jackson was reportedly shocked when Trump tapped him for the top job at the nation's second largest government agency, the Post reported, citing senior White House officials.

The sources said that when aides initially gauged Jackson's interest, he hesitated. But Trump continued to push for the nomination, insisting that the White House physician was his top choice.

One senior White House official described the interview process to the Post as very informal and without the extensive vetting typical for a Cabinet appointment.

The choice of Jackson has prompted concern among some White House aides, who have privately expressed unease about Jackson's lack of experience managing a large organization.

The New York Times reported Wednesday that some aides acknowledged that Trump's personal relationship with Jackson carried more weight in the decision to nominate him to the VA job than the doctor's professional experience.

Jackson performed Trump's first physical exam since taking office in January, and assured reporters of the president's good health in an hourlong press briefing shortly after that.

The White House has insisted that Trump has full confidence in Jackson's ability to lead the VA, and has pointed to his experience in the Navy as a valuable asset.

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22 - New York Daily News: [A novice in the VA OR: Dr. Ronny Jackson is a very puzzling choice to lead a Veterans Affairs turnaround](#) (31 March, 26.1M uvm; New York, NY)

The 20 million-plus veterans of the U.S. Armed Forces served this country with the eminently deserved expectation that their country would serve them.

Now even as the heart of that trust, the VA health care system, recovers from deadly delays in getting patients care, and after summarily dispatching his first head of the U.S. Department of Veterans Affairs, David Shulkin, President Trump inflicts risky experimental treatment, nominating as the new chief a doctor who has never come close to the operating room of managing a large organization — never mind one with nearly 378,800 employees.

The distinguished career of Rear Admiral Ronny Jackson, a medical doctor, has put him everywhere from the Iraq battlefield to the deep sea, demonstrating impressive courage and resourcefulness, starting from humble roots in Texas.

In recent years he has served as the White House physician, in which capacity he pronounced Donald J. Trump to be in excellent health. His team of 58 or so medical pros treats a few thousand executive employees, including cabinet members and senior staff.

No doubt Trump is fond of Jackson, and Jackson in no position to decline the demand of his commander-in-chief. So it must fall to the Senate to make full use of its confirmation powers to press Jackson on the hows, whys and wherefores of delivering complex services across more than 1,200 facilities.

This, after the VA's inspector general laid at Shulkin's feet alarming failures that ranged from inventory mismanagement to costly accounting laxity to misapplication of anesthesia. And Shulkin was an experienced hospital administrator who once ran New York City's own Beth Israel.

If Jackson cannot prove himself poised to do any better, he should not get the job.

Congress must also stay alert to forces eager to meddle with VA's core mission and services by putting vets' health care in the hands of for-profit businesses, a possibility Shulkin warned of after his firing in an extraordinary New York Times Op-Ed.

"I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits," he wrote, "even if it undermines care for veterans."

To the extent private players can deliver better services for less money, go for it. Indeed, greater freedom to visit private physicians was a breakthrough in solving the VA's patient-care crisis.

But Shulkin's dark prognosis casts doubt that improving the VA's own services is part of the plan. A Department of Veterans Affairs that fails to put veterans first, middle and last will be unworthy of the name.

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23 - NPR (All Things Considered, Audio): [Veteran Congressman On Trump's New VA Secretary Nominee](#) (31 March, 22M uvm; Washington, DC)

President Trump has picked Rear Adm. Ronny Jackson to be secretary of Veterans Affairs. Veteran and Rep. Mike Coffman (R-Colo.) tells NPR's Michel Martin why he supports the new leadership.

MICHEL MARTIN, HOST:

We're going to start the program today with the recent shakeup at the Department of Veterans Affairs. President Trump nominated Rear Admiral Ronny Jackson, the top White House physician, to replace Dr. David Shulkin as secretary of the Department of Veterans Affairs. It's a huge and complex job overseeing medical facilities around the country, hundreds of thousands of employees, not to mention programs that distribute hundreds of millions of dollars in benefits to veterans and beneficiaries. Jackson will need to be confirmed by the Senate before he officially steps into the job.

Needless to say, no one veteran can speak for all veterans, but we thought we'd like to hear from one of the military veterans serving in Congress, so we called Republican Congressman Mike Coffman. He represents Colorado's 6th District. He serves on the House Armed Services Committee, and he's with us now from Aurora. Congressman, thanks so much for joining us.

MIKE COFFMAN: Thanks for having me.

MARTIN: You served in both the Army and the Marine Corps. So if I may, thank you for that. So I understand that you have expressed the frustration that the incumbent of that position, whoever it is, needs to clean house. The question is, does Dr. Jackson have the kind of experience leading a large, complex organization to not just clean house but then to fix the house? Do you think he has that experience?

COFFMAN: Well, no matter how good he is, no matter what experiences he has, if he's not going clean the house, the VA will not change. It did not change under Secretary Shulkin. It did not change under Secretary McDonald. It did not change under Secretary Shinseki before then because none of them took the actions to clean house at the top. And I think that he clearly needs a strong deputy secretary who has a lot of administrative skills in terms of managing an organization that is over half the size of the United States Army.

MARTIN: Some of the veterans organizations, and frankly, some members of Congress, suspect that the real agenda here is to move faster toward privatization. Do you think that that's true?

COFFMAN: No. I know Secretary Shulkin had raised that issue. But, no, I think it's going to be the preservation of the Choice Act, which essentially states if a veteran lives a certain distance away from a VA facility or if a veteran can't get an appointment wait time within a reasonable period of time that that veteran have access to community providers that augment the capacity of the VA health care system. That program is temporary. Now we want to reauthorize it and make it permanent, make it work. It's not working very well. But that's not privatization. I think that that's just a red herring.

MARTIN: I'm wondering if you have any sense of what the Senate's posture is toward this nomination. Do you have any sense of - what are you hearing?

COFFMAN: I think he needs - in order to be confirmed, I believe he's going to have to dispel this notion of privatization. He certainly can be supportive of augmenting the Department of Veterans Affairs with community providers under the Choice program. But if he does do what Secretary Shulkin says he will do, which I don't believe he will do, he will not be confirmed.

MARTIN: Before we let you go, Congressman, it's an election year. There's a Democrat running against you, Jason Crow, who is also a veteran. A number of veterans are, you know, running this year. I wonder if you feel that that kind of interest in running for office among veterans might be part of the thing that creates a change here?

COFFMAN: Well, I think that it's good that we have veterans running and serving in Congress, either it's on the veterans committee or on the Armed Services Committee. I think there are a deficit of veterans serving on those committees that are entrusted to make very key policy decisions. And I think that that's the individual to understand those issues is another veteran.

MARTIN: That's Congressman Mike Coffman, Republican of Colorado, who represents the 6th Congressional District in Colorado. He was kind enough to join us from Aurora. Congressman, thanks so much for speaking with us today.

COFFMAN: Oh, thanks so much for having me.

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24 - The Washington Post (Video): [Does Trump believe in the value of expertise, or does he disdain it?](#) (31 March, Dan Balz, 43.9M uvm; Washington, DC)

The shake-up at the Department of Veterans Affairs — out with Secretary David Shulkin and potentially in with White House physician Ronny L. Jackson — is being portrayed, correctly, as President Trump surrounding himself with Cabinet officials with whom he feels personally comfortable. A broader question arises, however, over the extent to which this president prizes or disparages expertise.

Defenders of the president can point to his national security team to rebut suggestions that he resists recruiting people with experience and expertise to advise him. Though he has run through more than his share of foreign policy advisers, one reality is that they have mostly brought either military, business or relevant congressional experience to their positions.

That was certainly true of his early team: Defense Secretary Jim Mattis, national security adviser H.R. McMaster, Secretary of State Rex Tillerson, CIA Director Mike Pompeo and Homeland Security Secretary John F. Kelly, who has since become White House chief of staff. McMaster and Tillerson are on their way out, however, with Pompeo nominated for State and John Bolton selected as the president's third national security adviser.

Bolton comes to the job with many critics, who see him as far too hawkish at such a dangerous time internationally. But he is no novice when it comes to the issues, nor is he a stranger to the inner workings of government and the bureaucracy. For Pompeo's replacement, Trump has picked CIA Deputy Director Gina Haspel, a career intelligence official. She could face a challenging confirmation process but nonetheless has strong support from former intelligence community officials for her capabilities and experience.

The domestic side of Trump's Cabinet is another story. Shulkin was a holdover from the Obama administration and early on was praised — even singled out — by Trump for his leadership of an agency long plagued by scandal and inefficiencies. Though he had the background to run the agency, he leaves under a cloud of his own making — the misuse of taxpayer money that drew

a rebuke from the department's inspector general. In his final weeks, he ran a divided agency bunkered in his office, as portrayed vividly by The Washington Post's Lisa Rein. Shulkin is among several Trump Cabinet officers who have faced ethical questions.

Trump concluded a change was needed and looked no farther than inside his own White House, tapping Jackson, even though the White House physician has had no experience running a big operation, let alone something as complicated and dysfunctional as VA. What counted in the decision seemed to be Jackson's compelling performance briefing reporters about the president's physical examination.

Look beyond VA.

Ben Carson was one of the world's foremost pediatric neurosurgeons before he entered politics, and he had a compelling personal story of rising from the inner city of Detroit to the highest ranks of medicine. But he had never served in government, nor did he have specific credentials to oversee the Housing and Urban Development Department. His main qualification seems to have been running against and later endorsing Trump.

Carson has made little substantive mark at HUD, though he has recently been caught up in the embarrassment of having a \$31,000 dining set ordered for his private office. Testifying before Congress, Carson declined to accept full responsibility for the purchase, saying he had left redecorating to his wife and others and "dismissed myself from the issues." Days later, he took responsibility.

At the Education Department, Secretary Betsy DeVos arrived on a mission — to build up charter schools and to push for school choice and school vouchers, while reducing the federal government's role in education — issues she championed as a Republican activist and philanthropist in Michigan. She has no experience in the classroom, nor has she overseen a local school district or served in a state government education position, the backgrounds of recent education secretaries.

That DeVos was a polarizing choice was not a surprise, given the policies she believes in and her political advocacy before coming to Washington. Her lack of preparation about the status of public education and schools was displayed most recently on national television earlier this year when she was interviewed on CBS's "60 Minutes" and repeatedly could not answer questions from correspondent Lesley Stahl.

Others in the administration — Environmental Protection Agency head Scott Pruitt the most prominent — reject the overwhelming scientific consensus about climate change.

Expertise isn't everything. Vietnam showed how even the so-called best and brightest could lead the country astray. It was then-House speaker Sam Rayburn (D-Tex.) — who after hearing then-vice president Lyndon B. Johnson rave about the brains and credentials of the Cabinet assembled by President John F. Kennedy — reportedly said, "Well, Lyndon, they may be every bit as intelligent as you say, but I'd feel a whole lot better if just one of them had run for sheriff, once."

Rayburn's instincts proved tragically correct, showing that brains alone weren't sufficient for those in positions of responsibility and that both an absence of hubris and a connection to everyday Americans were vital to the careful exercise of power. But he also understood, as one

of the strongest House speakers in history, that to be successful, he needed an intimate understanding of the institution and the people he was leading.

In today's political climate, skepticism of expertise is widespread.

During a television interview ahead of the Brexit vote, Michael Gove, a British Conservative Party official, was read a list of domestic and foreign leaders, including then-president Barack Obama, who were uniformly warning that leaving the European Union would have dire consequences for the United Kingdom.

"I think the people in this country have had enough of experts with organizations with acronyms saying that they know what is best and getting it consistently wrong," Gove famously replied.

He was proved right when the British public voted narrowly to leave the E.U., a vote that foreshadowed the even bigger earthquake months later in the 2016 U.S. presidential election, when Trump defeated Hillary Clinton, the embodiment of the country's political and cultural elite.

Trump played on those anti-expertise sentiments as a candidate, appealing to voters to reject the establishment's policies and leadership, and instead to trust themselves and especially him, a political novice. He carried that viewpoint to an extreme when, at the Republican National Convention, he declared, "I alone can fix it."

Trump's presidency continues as an extension of that pronouncement, with the nation's leader increasingly trusting in himself rather than those around him on critical decisions. Some — not all, but some — of his personnel choices underscore the related belief, that expertise or relevant experience is overrated, perhaps even a handicap. It is an experiment, to say the least, and a risky one at that.

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25 - Politico Magazine: [When Our President Put His Doctor in Charge of Everything](#) (31 March, Marius Stan and Vladimir Tismaneanu, 23.9M uvm; Arlington, VA)

No one knows more about leaders' bodies than their personal physicians. Notoriously, Joseph Stalin mistrusted the Kremlin doctors, whom he suspected of trying to poison him and the other Soviet magnates. In February 1953, a month before Stalin passed away, they were arrested and horribly tortured. The ones still left alive were too terrified to treat him as he lay dying in March.

An avowed Stalinist, the late Romanian dictator Nicolae Ceausescu held a different vision for his medical entourage. Not only did he trust his doctors, he also made one of them—professor Theodor Burghel—the country's minister of health. Even by the standards of Romanian dictatorships, this was new. So as U.S. President Donald Trump taps the White House physician to head the Department of Veterans Affairs, a vast and sprawling bureaucracy, he might want to brush up on some recent Romanian history.

It's not that Burghel, the former rector of the respected Bucharest Institute of Medicine and Pharmacy (the country's top medical school), was not a capable person. He was, but his administrative experience was limited to a small-size bureaucracy. He was said to be an excellent urologist, a decent person and a respected professor. As a surgeon, he was highly regarded. But the Ministry of Health was a different business. What Ceausescu wanted to

emphasize with such an appointment was that human life was a state affair and that he, as the supreme leader, could sweep aside any past criteria of administrative competence. According to our sources, Dr. Burghela was quite reluctant to accept the ministerial job, but no one in the Securitate-controlled regime could say NO to Ceausescu without facing unpleasant consequences. So, Burghela said yes and served between 1972 and 1975. During this period, he reluctantly complied with Ceausescu's increasingly erratic orders and eventually, he resigned.

Another telltale case was Dr. Iulian Mincu, Ceausescu's last personal doctor, whom he entrusted with designing the notorious Rational Nourishment Program, a set of draconian policies imposed in the 1980s to justify starvation in the name of medical progress. Ersatz food (adulterated oil made from unrefined soy, fake cheese fluffed up with flour, dregs of meat like chicken claws, fake coffee called "Nechezol," and so on) proclaimed superior to natural products. In the meantime, the regime could export food for hard currency. For instance, one ration card for one person in the city of Galați, eastern Romania, from the late 1980s contained: Bread—300gr/daily; poultry—1 kilo/month; pork or beef—500gr/month, or meat cans from Czechoslovakia or the Soviet Union as replacements; other meat products (salami, sausages, usually made of soy)—800gr/month; salted cheese—500gr/each trimester; butter—100gr/month; oil—750ml/month; sugar—1 kilo/month; corn flour—1 kilo/month; flour—1 kilo/each semester; eggs—8 to 12/month; and a supplement for hard workers, meaning 300 more grams monthly for diverse products.

In spite of his dismal record—including a deliberate concealment of HIV and AIDS data in the 1980s—Dr. Mincu was resurrected after the Romanian December 1989 revolution as Minister of Health under the reign of Ceausescu's authoritarian successor, Ion Iliescu. During a research interview in 2007 conducted by one of this article's authors (Marius Stan), Mincu stood by his bizarre food ideas and denied any wrongdoing.

One of the lessons from these two Romanian stories is that expertise matters decisively. Another is that proximity to the leader (even if he or she is democratically elected, as Trump was) does not qualify one for running huge bureaucracies in need of urgent overhaul. Managing complex organizations is a skill in its own right. Putting someone unqualified in charge of a massive system such as the Romanian Ministry of Health could lead to amateurism, improvisation and, eventually, mission failure. In our case, it did—twice.

This seems to be the case right now in Washington: A person with impressive credentials in terms of running small medical units, Dr. Ronny Jackson, has suddenly been catapulted to the top of a government agency dealing with veteran affairs—thanks in no small measure, it seems, to his robust defense of Trump's personal health. Yet taking the president's blood pressure or even performing surgery, the Romanian case suggests, has nothing to do with being in charge of major institutions that affect the lives of millions. Ceausescu was certain that personal loyalty to him was the most important quality of any top official. He shared this illusion with most of the last century's dictators. Is this now a litmus test for promotion in the Trump administration? At the end of the Ceausescu regime, the Romanian health system was a complete disaster. Intrahospital infections and scarcity of medical drugs were rampant. Doctors' salaries were miserable and, in order to increase their incomes, many expected to be paid with Kent cigarettes, whiskey, and other coveted goods. As a result of the restrictive reproductive health policies enforced under the 25-year Ceausescu dictatorship, Romania ended the 1980s with the highest recorded maternal mortality of any country in Europe—159 deaths per 100,000 live births in 1989.

One can only hope America's veterans will fare better. For Ceausescu, such promotions meant an assertion of his autocratic ruling style. Like Italy's Benito Mussolini, he saw himself as the successor to Roman emperors. And, as we know, Caligula could appoint anyone to any position, even the Roman Senate. On the other hand, no one is ever better placed than a personal doctor to subvert the tyrant's glorious self-image with a few well-placed details—see Li Zhisui's devastating critique of Mao Zedong as a manipulative egomaniac who boasted about his unorthodox sexual appetites. Dare we quote William Gladstone's suddenly apt admonition? "The disease of an evil conscience is beyond the practice of all the physicians of all the countries in the world."

Marius Stan is research director of the Hannah Arendt Center at the University of Bucharest. Vladimir Tismaneanu is professor of politics at the University of Maryland, College Park. They have a co-authored book coming out from Cambridge University Press in May 2018, Romania Confronts its Communist Past. Democracy, Memory, and Moral Justice.

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26 - CBS News (Face the Nation, Video): [Sen. Bernie Sanders on "Face the Nation," April 1, 2018](#) (1 April, 26M uvm; New York, NY)

President Trump announced the ouster of David Shulkin as secretary of Veterans Affairs this week, nominating longtime White House physician Adm. Ronny Jackson as his replacement. Shulkin had come under withering criticism from lawmakers on Capitol Hill over his travel expenses and a blistering inspector general's report on conditions at the VA.

Sen. Bernie Sanders, an independent from Vermont, is the ranking member of the Senate Budget Committee and former chairman of the Senate Committee on Veterans Affairs. He joined us to discuss the reforming the VA, Jackson's nomination and more.

The following is a transcript of the interview with Sanders that aired Sunday, April 1, 2018, on "Face the Nation."

MARGARET BRENNAN: We turn now to Vermont independent Senator Bernie Sanders who sits on the Senate Veterans Affairs Committee. He joins us from Burlington in his home state this morning. Senator the VA is the largest health care system in this country. Will you support Dr. Ronnie Jackson as the nominee?

SEN. BERNIE SANDERS: Well we know nothing about what Dr. Jackson stands for and what his vision is for the VA. But Margaret this is what I will tell you. What concerns me very much is that right now in Washington we have a family called the Koch brothers, third wealthiest family in America a family that is prepared with a few of their other billionaire friends to spend four hundred million dollars on the coming elections. They are now the most powerful political force in America, stronger than the Democratic National Committee or the Republican National Committee. Their view has been we have got to privatize, privatize and privatize. And what Dr. Shulkin, who Trump just fired this week has told us is that the reason for his firing is that he resisted privatization of the Veterans Administration. Now I work very closely with the major veterans organizations, the American Legion, VFW, DAV Vietnam vets all of the veterans organizations. And what they say is they want to strengthen the VA not dismember it, not privatize it. So we will see what Dr. Jackson has to say.

BRENNAN: Well the White House says at this time they have no intent to privatize the VA. Do you know what the Trump administration policy is?

SANDERS: Yeah of course I do. They have been putting more and more money into the private sector with VA money. I do not believe them on that issue. I think they are listening to the Koch brothers and I think that that is a very, very bad idea. If you listen to veterans all across this country as I do they will tell you sure there are problems with the VA but by and large once they get into the system they are proud of the quality that the - quality care that the VA provides in fact the American Legion has just come out with a publication which vigorously opposes privatization. So I do believe that the Trump administration no matter what they are now saying I think they are working on behalf of the Koch brothers, look these are the guys, Koch brothers who want to privatize everything. You have a Trump administration that in their budget, the Trump budget proposed 500 billion dollar cuts in Medicare. Trillion dollar cuts in Medicaid. You have a Secretary of Education who doesn't believe in public education a head of the EPA.

BRENNAN: Sir on the issue of the VA you did last year vote for a bill that allowed at least more leeway for veterans and their doctors -

SANDERS: Right.

BRENNAN: - to decide whether they wanted to opt in for private care. So it sounds like you are open to some private sector option here.

SANDERS: Well there has always been private sector option if you live in a rural community you don't want 75, 80 year old veterans to travel two hours to get a physical examination. If there is a VA facility in the country that is not treating veterans in a timely manner of course you want to allow veterans to go to the private sector. That is the case now that has always been the case. But what the Koch brothers want and what I feared the Trump administration wants is to rip that wide open and to take many. We got a 200 billion dollar veterans budget.

BRENNAN: Yeah.

SANDERS: There are special corporate interests that want a big chunk of that money. We must not allow that to happen.

BRENNAN: Senator we have to take a quick break and we'll talk to you on the other side of it. We'll be right back.

SANDERS: Thank you.

(COMMERCIAL BREAK)

BRENNAN: Welcome back to "Face the Nation." I'm Margaret Brennan. We're back now with Vermont independent Senator Bernie Sanders who is going to be asking some tough questions of that next nominee to be the VA secretary, Senator. The VA says the average wait time at some facilities can be as long as 100 days. President says he's not happy with the speed of reform there. What is the source of this problem?

SANDERS: Well look the VA is the largest integrated health care system in the country. And as I said previously if you asked the veterans organizations they by and large think the VA is providing good quality care. You know Margaret there is a lot of attention paid to the VA

because it's a government agency. But I've got news for you. People all over this country when they want to get to a doctor or they need hospital care they don't get in the very next day. So I am sure that there are some VA facilities where the waiting time is too long. That has got to be addressed. There are other VA facilities for example I know here in Vermont that if you are dealing with a psychiatric crisis, an emotional crisis you get in that day that's pretty good. So the VA does a lot of good things. It has problems. We have got to improve the VA. But I think we've got to listen to the veterans of this country and not privatize it.

BRENNAN: Senator you also sit on the Environment Committee and you've been a harsh critic of EPA Administrator Scott Pruitt. He's facing a number of questions about ethics and these new reports that he rented a residence here in Washington partly owned by the wife of a top energy lobbyist whose firm did business with the EPA. Do you think your committee should hold hearings on this?

SANDERS: I do. But I think the issue goes well beyond that problem. The issue goes to the fact that the vast majority of people in this country understand that climate change is real. It is already doing devastating problems throughout our nation and throughout the world and yet we have a president and a head of the EPA who do not even recognize the reality of climate change let alone the need to transform our energy system away from fossil fuel to energy efficiency and sustainable energy. So you got a guy who's head of the EPA now who is nothing more than a front man for the fossil fuel industry and that is a very serious problem and the Congress has got to stand up and oppose that line of policy.

BRENNAN: I imagine you oppose the lowering of emission standards that the administration is expected to announce this week.

SANDERS: Well, of course. I mean what we have got to do is understand that we have over the last number of years made success against air pollution and against water pollution. We have made some success in transforming our energy system and the idea to go back and listen to the short term needs of the coal industry or the oil industry makes no sense to me at all. Look, here is the truth. What the scientific community is telling us is that climate change is one of the great environmental crises facing this planet and if we don't get a handle on that we're going to be leaving this planet - a planet to our kids, that is not healthy or habitable. We've got to address that. The Trump administration is moving in exactly the wrong direction.

BRENNAN: Sir you have been critical of the Israeli government's decision to use lethal force against Palestinian demonstrators killing 15 wounding over 700. The Trump administration has stopped short of calling on Israel for restraint. Should they explicitly do so.

SANDERS: Yes they should look, Gaza as I think everybody knows is a humanitarian disaster. The unemployment rate there is beyond comprehension. And there is just enormous unrest. What the function of the United States government should be right now is to sit down with the Israelis sit down with the Palestinians and figure out how, we can rebuild Gaza and also to tell the Israelis that when you've got tens and tens of thousands of people protesting, they cannot overreact and the idea of 15 or so people being killed and hundreds being wounded is - is to me unacceptable.

BRENNAN: We should note the Palestinian Authority already did boycott a meeting at the White House recently to talk about rebuilding Gaza. Senator thank you so much for your time.

We'll be right back with our political panel.

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27 - CBS News (Video): [Sen. Bernie Sanders says privatizing the VA a "very, very bad idea"](#) (1 April, Emily Tillett, 26M uvm; New York, NY)

Sen. Bernie Sanders, I-Vermont, says that he thinks it's too early to tell what President Trump's pick to take over leadership at the embattled Department of Veterans Affairs "stands for," but cautioned that privatizing the VA to be a "very, very bad idea."

Former VA Secretary Shulkin became the latest member of Mr. Trump's cabinet to be terminated last week. The president announced that he was replacing Shulkin in a series of tweets, and said he would nominate Adm. Ronny Jackson, who had been serving as the president's doctor, to replace him.

"I work very closely with the major veterans organizations, the American Legion, VFW, DAV, Vietnam vets, all of the veterans organizations. And what they say is they want to strengthen the VA, not dismember it, not privatize it. So we will see what Dr. Jackson has to say," said Sanders.

Transcript: Sen. Bernie Sanders on "Face the Nation," April 1, 2018

Shulkin came under fire for a series of blunders including reported insurgencies inside his own department and improper use of travel expenses. The former secretary said he was ousted over internal and administration disputes over privatizing the VA.

"Privatization leading to the dismantling of the department's extensive health care system is a terrible idea. The department's understanding of service-related health problems, its groundbreaking research and its special ability to work with military veterans cannot be easily replicated in the private sector," Shulkin wrote in an op-ed for the New York Times last week.

Sanders agreed, saying that while the VA has problems that need to be addressed, "We've got to listen to the veterans of this country and not privatize it."

"If you listen to veterans all across this country as I do they will tell you sure there are problems with the VA but by and large once they get into the system they are proud of the quality care that the VA provides."

He added, "There is a lot of attention paid to the VA because it's a government agency. But I've got news for you. People all over this country, when they want to get to a doctor or they need hospital care, they don't get in the very next day. So I am sure that there are some VA facilities where the waiting time is too long. That has got to be addressed. There are other VA facilities -- for example, I know here in Vermont that if you are dealing with a psychiatric crisis, an emotional crisis you, get in that day. That's pretty good."

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28 - Politico: [Sanders: 'We know nothing' about Trump's VA pick](#) (1 April, Connor O'Brien, 23.9M uvm; Arlington, VA)

Sen. Bernie Sanders wouldn't commit to supporting President Donald Trump's pick to lead the Department of Veterans Affairs, Rear Adm. Ronny Jackson, on Sunday.

In an interview on CBS' "Face the Nation," the Vermont independent noted that Jackson, Trump's personal physician, is a virtual unknown on veterans issues. He also expressed concerns the Trump administration is pushing to privatize the nearly \$200 billion bureaucracy, citing the conservative agenda of the influential donors Charles and David Koch.

"We know nothing about what Dr. Jackson stands for and what his vision is for the VA," Sanders said.

Trump replaced VA Secretary David Shulkin last week after months of criticism over reports he misused government travel. Shulkin has since said he was forced out for pushing back against efforts to privatize veterans services.

Jackson's nomination came as a surprise. And the pick has raised questions about his qualifications to manage the myriad health services and benefits provided by VA and whether the administration is indeed pressing to privatize more veterans services.

"I do believe that the Trump administration, no matter what they are now saying, I think they are working on behalf of the Koch brothers," Sanders said, adding they "want to privatize everything."

"They have been putting more and more money into the private sector with VA money. I do not believe them on that issue," he added. "I think they are listening to the Koch brothers and I think that that is a very, very bad idea."

While he helped negotiate additional funding for veterans to access private medical care, Sanders, a former Senate Veterans' Affairs chairman, has said beefing up VA's budget and health services should be the priority.

"The VA does a lot of good things. It has problems. We have got to improve the VA," Sanders said. "But I think we've got to listen to the veterans of this country and not privatize it."

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29 - The Hill: [Sanders: I will work against any VA nominee backing privatization](#) (1 April, Mallory Shelbourne, 11.9M uvm; Washington, DC)

Sen. Bernie Sanders (I-Vt.) said Sunday he will work against any Veterans Affairs (VA) nominee who supports privatizing the agency.

"I will do everything I can as a member of the veterans committee not to approve any nominee who is not going to strengthen the VA and who will oppose privatization," Sanders told CNN's "State of the Union."

The comments from Sanders come after Trump announced Rear Adm. Ronny Jackson, who currently serves as the presidential physician, would replace David Shulkin as the Secretary of Veterans Affairs.

Shulkin penned an op-ed in The New York Times opposing the privatization of the agency after his exit and saying there are officials within the administration pushing for it.

Sanders, a member of the Senate Veterans' Affairs Committee, said veterans' organizations argue the agency should be strengthened rather than privatized. He also blamed billionaire brothers Charles and David Koch, arguing their influence over the Trump administration is what's pushing privatization.

"So what you're looking at under the leadership of the Koch brothers, is a massive effort to privatize agencies of the United States government and give them over to private corporations," said Sanders. "That is what the removal of Shulkin is all about."

The Koch brothers did not contribute to Trump's presidential campaign, breaking with years of donations to Republican candidates.

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30 - Miami Herald: [Trump's doc shouldn't be a slam dunk to lead Veterans Affairs](#) (1 April, Editorial Board, 8.9M uvm; Miami, FL)

The U.S. Department of Veterans Affairs has enough problems. It doesn't need one in the form of a leader who, very possibly, has no idea what he's doing.

In yet another nomination made under President Trump's "You'll do — for now" philosophy of hiring the "very best people," White House physician Ronny Jackson is up for the vital job of secretary of Veterans Affairs.

If confirmed by the Senate, Jackson will replace David Shulkin, a rare and respected Obama administration holdover who sullied his tenure by not only misusing taxpayers' funds to take a swell trip to London and Copenhagen. His wife's expenses were also paid for by the government. A bit of business, indeed, was done — meetings and such — but then there was the shopping, the castle tours and tickets to the Wimbledon tennis finals, free of charge, in violation of rules that ban gifts to government employees.

Shulkin defended the trip, blamed the media — in this case the Washington Post, which broke the story — and worst of all, lied about it. In addition, he enlisted colleagues to assist in the coverup. According to a VA inspector general's report, Vivieca Wright Simpson, Shulkin's chief of staff, rejiggered documents to make it seem as if Shulkin had received an award in Copenhagen. He didn't. In fact, no such award existed.

Simpson, ahem, has retired. Last week, Shulkin was out, rightly.

In Miami alone, the Veterans Administration's medical facilities do not always measure up, failing the people who have put their lives on the line for this country through military service, but putting those lives in danger again when they need that care back home. In February, an

investigation confirmed discrepancies in HIV test results when some veterans were also tested by an outside lab.

Last fall, an inspection found the public cafeteria in Miami's VA healthcare system egregiously unsanitary — pest droppings, unrefrigerated foods and the like. Though hospitalized vets were not served meals from this cafeteria, the point is that no one should be exposed to the dangers of unclean conditions. And that's just in one region. The VA is the second-largest department in the federal government, with almost 400,000 employees and more than 1,200 health-care facilities.

President Trump nominated Jackson to replace Shulkin. Jackson's credentials as a medical doctor are solid. His ability to run this consistently challenged system? Not so much in evidence. In fact, there is little in his professional background that shows he has what it takes to ensure the VA can truly serve its clients. This is one more nomination that should not be rubber-stamped.

The Senate, if it truly cares for the nation's veterans, will ask Jackson the tough, uncomfortable questions and say No if he's deemed deficient.

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31 - Washington Examiner: [Bernie Sanders: Ronny Jackson will bend to pressure to privatize the VA](#) (1 April, Kyle Feldscher, 4.8M uvm; Washington, DC)

Sen. Bernie Sanders, I-Vt., said he thinks Dr. Ronny Jackson will likely be tasked with privatizing the U.S. Department of Veterans Affairs due to his lack of experience manning a large organization.

Sanders said on CNN's "State of the Union" Jackson, the White House physician and a rear admiral in the U.S. Navy, doesn't know much about heading a large bureaucracy. If he's the one Trump picked to replace David Shulkin, ousted on Wednesday, Sanders said, then he must be in favor of privatization.

"He has no experience in this area but I would strongly suspect that if you get rid of Shulkin, who opposed privatization, and you put in Dr. Jackson, that is what his mission will be," Sanders said.

Sanders, an independent who caucuses with the Democrats, said one only needs to look at the past decisions of the Trump administration to know what the end result will be.

Sanders said the Koch brothers, powerful Republican donors, are going to push for privatization and the administration will likely accede.

"What the Koch brothers believe is not just that we have to privatize the Veterans administration, they want to privatize Medicare, and the Trump administration had a \$500 billion cut in Medicare," he said. "They want to privatize Medicaid. They had a trillion-dollar cut in Medicaid. They're beginning to go after Social Security."

"We have a secretary of education who does not believe in public education. A secretary of the environment, EPA, who does not believe in environmental protection. So, what you're looking at

under the leadership of the Koch brothers is a massive effort to privatize agency of the U.S. government and give them over to private corporations.”

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32 - Newsday: [Senate should be wary of Dept. of Veterans Affairs nominee](#) (1 April, Editorial Board, 3.2M uvm; Melville, NY)

Caring for our nation’s military veterans was one of Donald Trump’s most consistent promises on the presidential campaign trail, and certainly one of his least controversial. Getting veterans the care they need is a nonpartisan priority.

But the increased quality of care Trump promised hasn’t come.

Facilities on Long Island and in many other communities are falling apart. The Department of Veterans Affairs is increasingly being exposed as dangerous and dysfunctional. Last week, as was expected, Trump fired the secretary of veterans affairs, David Shulkin, who could never rise above his ethical violations and his shoddy leadership. His designated replacement is Navy Rear Adm. Ronny Jackson, the White House physician for the past three administrations who garnered praise from Trump for performing well during a news conference about the results of the president’s physical exam.

While Jackson is highly regarded as a physician, his resume does not include a shred of evidence that he can lead the government’s second-largest bureaucracy (it has a \$186 billion budget) and probably its most dysfunctional. This might be the toughest management job in Washington.

Before the Senate confirms Jackson, it must elicit his views on further privatization of medical care, which other Trump appointees are recklessly pushing as a way to dismantle the agency instead of providing improved service. And unless the Senate can ensure that Jackson can overcome his lack of management experience and create a solid plan for building a leadership team that can improve care, it should reject his nomination.

Here on Long Island, the problems are increasingly daunting, and care for our veterans is suffering. Last month, we learned that the Northport VA Medical Center was again forced to stop performing surgeries when a faulty air conditioner forced the hospital to close all five of its operating rooms. The shutdown went on for about a week, and 18 surgeries had to be rescheduled while the \$58,000 repair was performed.

That’s only the latest breakdown at the Northport facility, where surgeries were halted for four months in 2016 when another air-conditioning system failure sent metal fragments flying into the air, threatening to contaminate patients with open wounds. Another cooling system problem a year earlier led to pipe ruptures and a \$12 million repair. And in January, Northport had to close its 42-bed veterans homeless shelter after the heat failed.

A recent report estimated the cost of Northport’s repair and renovation to be \$273 million. Long Island’s 130,000 veterans rely heavily on the facility, which has traditionally maintained a top reputation. Its quality cannot be allowed to decline.

If Jackson is confirmed, Trump, who has a warm personal relationship with his nominee, must make sure their communications remain constant. Jackson will need the president's full support to get the VA running properly and all of its facilities up to par, including Northport.

We owe these veterans. There can be no reneging. — The editorial board

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33 - Las Vegas Sun: [Heller's dilemma: Side with Trump or veterans on VA pick](#) (1 April, Editorial Board, 1.5M uvm; Las Vegas, NV)

Assuming Donald Trump follows through in nominating Dr. Ronny Jackson to lead the Department of Veterans Affairs, Sen. Dean Heller will soon face an ugly consequence for becoming a team player for the president.

For Heller, Jackson's confirmation offers a lose-lose proposition. Either he votes against Jackson and runs the risk of getting dinged by Trump before the midterm elections, or he votes for Jackson and alienates veterans groups that have raised concerns about the White House doctor's qualifications for the position.

Granted, Jackson deserves a fair confirmation hearing, and maybe during his testimony he'll be able to convince Americans that he's the perfect person for the job.

But that's an enormous maybe, given Jackson's razor-thin resume for the job.

The biggest organization Jackson has overseen numbers in the several dozens. The VA employs 360,000 people, has a \$186 billion budget and is the second-largest entity in the federal government, ranking only behind the Pentagon.

This is an organization that was once led by the former CEO of Procter & Gamble, a former member of the U.S. House and a former high-ranking official with the Disabled Veterans of America, among others.

Jackson's qualifications appear to be that he served in the Navy and is apparently a fine doctor. Trump reportedly also likes how Jackson looks and thought he did a nice job in handling the January news conference in which he reported the results of Trump's physical examination.

But where Trump saw greatness, others saw a toady whose glowing remarks about Trump seemed like they could have been copied from Kim Jong Un's physician.

Jackson described a man who is noticeably overweight, disdains vigorous exercise and regularly gorges on fast food as being in "excellent" health, and went as far as to say that if Trump had eaten more healthily during the last several years he might "live to be 200." He predicted that Trump would be fine throughout this term and even through a second term. "It's just the way God made him," Jackson said.

This may sound like satire, but for veterans groups it's no joke. It's potentially a life-and-death matter, as advocates have raised concerns that the Trump administration is angling toward privatizing the VA's health services. Privatization, they believe, would erode the quality of care and lead to higher costs.

The outgoing VA secretary, David Shulkin, fueled advocates' concerns in saying the Trump administration saw him as "an obstacle to privatization who had to be removed." The White House responded by saying Shulkin's ouster was not an indication that the administration was moving toward privatization.

But considering that conservatives like the Koch brothers are pushing for the change, veterans advocates are justifiably uneasy.

For Heller, the nomination process comes at an inopportune time politically. Although Trump cleared a path for Heller to the general election by encouraging Danny Tarkanian to seek a House seat instead of opposing Heller, Heller will be heavily targeted by Democrats in the general election and can scarcely risk alienating Trump's base.

Heller has already faced Trump's wrath. After he initially voted not to repeal the Affordable Care Act, Trump "joked" that Heller would come around if he wanted to "remain a senator." Heller did so, and he has been subjugating himself to Trump ever since.

If the Jackson nomination plays out as expected and the doctor proves to be as bad as a nominee as he looks on paper, Nevada's veterans will be watching him closely to see who he cares more about — the nation's 21 million veterans or Trump.

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34 - **Times Union:** [Editorial: VA pick insults veterans](#) (1 April, Editorial Board, 1.5M uvm; Albany, NY)

THE ISSUE:

The president picks his White House doctor to run the second largest federal agency.

THE STAKES:

The health and welfare of millions of veterans rest on what feels more like a casting call.

Donald Trump has long promoted himself as a champion of military veterans, but when he finally had a chance last week as president to demonstrate that they were more than political props for him, he failed miserably.

In the same cavalier way in which he has appointed so many people who have turned out to be disasters in their jobs, Mr. Trump named his White House physician as secretary of veterans affairs. He thus thrust a man with no experience running a big bureaucracy to the helm of the second-largest federal agency. If the Senate goes along with this, Dr. Ronny L. Jackson, a Navy rear admiral, would go from monitoring the president's health to overseeing a department of more than 366,000 employees.

By all accounts, Dr. Jackson is a nice guy. But this is as absurd as taking a pleasant cashier off the register to be CEO of McDonalds, or plucking a friendly delivery boy off his route to run FedEx.

Dr. Jackson's main qualification to head a department bigger than any branch of the military or the Department of Homeland Security seems to be his talking up of the president's health in January, when he credited Mr. Trump with what he assumed must be "incredibly good genes." Mr. Trump could hardly have been more bombastic himself.

All this might be delightfully surprising in a reality TV show sort of way were the stakes not so high. The VA's mission is not one to take lightly. It's responsible for the health care of more than 9 million veterans served by its 145 hospitals, 300 vet centers, and more than 1,200 outpatient sites. It also handles disability and education benefits, home loans, life insurance, pensions and vocational rehabilitation for millions of vets. Choosing a leader for it should not be treated like a casting call.

Dr. Jackson would succeed David J. Shulkin, who was trying to reform a department in need of modernization and marred by scandal over long waiting lists. Dr. Shulkin, however, had a scandal of his own stemming from his overseas travel, giving Mr. Trump a ready excuse to fire him.

There are concerns that this is part of a conservative small-government quest to end the VA as veterans have known it and privatize its work. A lack of competence at the top would no doubt bolster the case for a radical overhaul. That, however, is not something that should be done in haste or on ideological whim any more than the pick for the secretary of veterans affairs should be the last person to check the president's vitals.

Mr. Trump, who never served in the military thanks to five deferments, may see this all as part of the chaos on which he seems to thrive, and which has left his administration with more high-level turnover in 14 months than some presidents have had in entire terms. But the veterans he claims to cherish don't need what passes for excitement in Mr. Trump's life. They've had quite enough, thank you. That's the message the Senate should send back to Mr. Trump if he doesn't rethink this ridiculous appointment.

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35 - Montana Standard: [For pity's sake, don't privatize Veterans Affairs](#) (1 April, Editorial Board, 202k uvm; Butte, MT)

Just when it was starting to look like Montana's veterans could expect a little more stability from the federal agency charged with providing their health care, another major shakeup at the Department of Veterans Affairs has placed the future of their care in doubt.

Of course, the VA has long stood on shaky ground. However, the current push toward privatization, if successful, could completely erode the foundations of this critical agency and leave millions of veterans — and tens of thousands of Montanans — without the support they earned in service to our country.

The VA's experiment with privatization through the Veterans Choice Program provides a good example of the potential risk. The program was created in 2014 in response to audits that found many veterans faced long waiting periods before they could see a physician. Some even died while they were waiting for an appointment, and some VA employees fudged the data to make it appear they had met the official 14-day target.

Congress passed the Veterans Choice bill to fix the problem by creating a new program that would allow veterans who live more than 40 miles away from the nearest VA clinic to see health care providers in their own community. Obviously, this held a lot of appeal for veterans in rural states like Montana. But U.S. Sen. Jon Tester, D-Montana, a ranking member of the Senate Veterans' Affairs Committee, favors scrapping the program and replacing it with a different system.

The bill provided roughly \$2 billion to hire more physicians and nurses, build more facilities and expand services for underserved populations, such as women and those seeking mental health care. Unfortunately, from its inception, Veterans Choice has relied on third-party administrators to manage the program, and their track record has shown a lot of room for improvement. One of the health insurance companies awarded a major contract, Health Net, was severely chastised just last month in a letter from Tester and Sen. Mike Crapo, R-Idaho.

"Our home state providers deserve better than the miserable customer service provided to them by Health Net, who appears to be devoting even less attention to the Choice Program as its expiration nears," wrote the two senators, who also noted providers' complaints that the company has not paid them on time, and when they attempt to collect their payments, Health Net either puts them on hold or ignores them altogether.

In March 2016, Health Net was acquired by an even larger company, the publicly traded Centene Corporation, for a reported \$6.8 billion. Any hopes that the acquisition would lead to improved services were soon dashed when, last year, a whistleblower alerted authorities to Health Net's complete failure to schedule appointments for some veterans in New Hampshire, some of whom had to wait for longer than six months to schedule an appointment despite the fact that they suffered from life-threatening conditions.

That scandal, among others, helped prompt President Donald Trump to sign an executive order providing better protections for whistleblowers within the agency and establishing a more streamlined system of accountability.

Montana is still working through its own whistleblower scandal. A dentist with the Montana Veterans Affairs Health Care System in Billings, Kelly Hale, reported that veterans faced long wait times due to problems with the clinic's management. The report was confirmed through an internal investigation that found problems dating back to mid-2016. After the investigation, the head of dental services, Robert Bourne, resigned but was rehired on a fee basis so he could continue providing dental services.

The Montana VA then put Hale through a misconduct review and tried to terminate his employment. That action is on hold while the Merit System Protection Board weighs whether it was taken in retaliation for Hale's whistleblowing. Meanwhile, Hale remains a paid staff member but is not allowed to see patients, meaning that for many months in 2017, patients were referred to the nearest VA dental clinic — in Sheridan, Wyoming. This past February, the VA finally hired another dentist, but Hale's case is still pending.

Also in February, the Montana VA issued a press release explaining how it is working to overcome an ongoing shortage of primary care providers. In Montana, the system is required to have about 37 full-time-equivalent positions, but only about 34.5 were filled at last count. Further, providers accounting for 5.5 of those positions have announced they are either leaving or reducing their hours.

The VA responded by explaining that it has already scheduled 8.5 to be filled by the end of May, which would bring it above the 37-position threshold. It is actively recruiting to fill vacant positions in Billings and Helena, and will rely on temporary relief from other providers to meet any other needs throughout its network of 15 facilities in Montana.

Last month, the Montana VA learned it will at last be able to move forward with expansion plans at several of these clinics, including the expansion and upgrade of facilities in Missoula and construction of new sites in Butte, Helena and Fort Harrison.

The exact construction costs are not yet known, but it's likely to cost many millions of dollars. The investment is worth every penny — so long as every one of those pennies goes to providing the best possible care to veterans. Money spent on anything else is money wasted.

In fact, recognition of this value — that private profit off the backs of our veterans is wrong — may have been why former Veterans Affairs Secretary David Shulkin was fired last week. President Trump has already announced that he would like to replace Shulkin with White House physician Ronny L. Jackson.

Shulkin said he suspects he was targeted by supporters of privatization. It likely also had something to do with allegations of ethics violations. An internal investigation found that Shulkin accepted tickets to Wimbledon, and that he not only brought his wife with him on a trip to Europe at taxpayer expense, he directed his chief of staff to go back and change emails in an attempt to justify it. Shulkin denies these accusations.

Nevertheless, his apparent abuse of public dollars for private benefit was soundly criticized, even by his most loyal supporters. It's a lesson that ought to resound throughout the agency.

The VA is still struggling to overcome major problems. Whoever eventually replaces Shulkin must have the depth of experience and expertise to tackle these problems, and the wisdom to avoid creating new ones — and that includes the misguided push to privatize the VA.

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36 - Washington Examiner: [Ron Johnson: Trump 'deserves' a VA secretary who agrees with him on policy](#) (1 April, Naomi Lim, 4.8M uvm; Washington, DC)

Sen. Ron Johnson, R-Wi., agreed Sunday President Trump was right to fire former Veterans Affairs Secretary David Shulkin.

"Well, I think the IG report's pretty troubling," Johnson told NBC, referring to VA inspector general Michael Missal's finding that Shulkin improperly used taxpayer dollars for a trip to Europe with his wife in July.

"Presidents do deserve and have advisers that actually agree with them on policies. And apparently, there were some policy disputes," Johnson continued in reference to alleged disagreements between Trump and Shulkin over the direction of the VA, particularly regarding whether aspects of the department be privatized.

But Johnson added he would not have dismissed Shulkin via social media.

"The president does need to understand the effect it has on attracting other people," he said.

Trump announced Shulkin's departure on Twitter Wednesday, adding that Navy Rear Adm. Ronny Jackson, who has served as White House physician for former Presidents George W. Bush, Barack Obama, as well as Trump, would be nominated to replace Shulkin.

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37 - U.S. News & World Report (AP): [Shulkin Says He Has 'Comfort' With Potential Successor at VA](#) (2 April, Hope Yen, 24M uvm; Washington, DC)

Former Veterans Affairs Secretary David Shulkin downplayed concerns about his potential successor's lack of managerial experience Monday, saying the key for improving the VA will be surrounding White House doctor Ronny Jackson with a good team "because no one person can do this alone."

Shulkin and the White House have engaged in a highly public campaign surrounding his departure from the VA last week. Shulkin said he was fired. The White House said he resigned.

On Monday, Shulkin told CNN there was no reason he would resign. He said he had been given a heads-up on his ouster by Chief of Staff John Kelly moments before President Donald Trump tweeted it.

Shulkin said he supports the person President Donald Trump selected to replace him.

"I have comfort because I know Dr. Jackson," Shulkin said. "Dr. Jackson is a very honorable man who wants to do the right thing."

Shulkin's comments represented a different tone from the fractious back-and-forth Sunday when the White House hit back at Shulkin for claiming that he was fired from his job and that he was only informed about it shortly before President Donald Trump tweeted about his replacement.

The Trump administration says he left his job willingly amid a bruising ethics scandal and mounting rebellion within the agency.

On Sunday, chagrined by Shulkin's public statements blaming his ouster on unfair "political forces" in the Trump administration, the White House circulated a "talking points" memo to some veterans groups in a bid to discredit him.

The three-page memo, obtained by The Associated Press, points out seven "lies" that it said Shulkin had spread. They include statements in which he minimizes a VA watchdog report in February that concluded he violated ethics rules by accepting free Wimbledon tennis tickets. The VA inspector general has previously found Shulkin made misleading statements about the trip to investigators and the news media.

In television interviews earlier Sunday, Shulkin said he had not submitted a resignation letter, or planned to, and was only told of Trump's decision to replace him shortly before the Twitter announcement. He said he had spoken to Trump by phone earlier that day about VA improvements, with no mention of his job status, and was scheduled to meet with the president the next morning.

"I came to run the Department of Veterans Affairs because I'm committed to veterans," Shulkin said. "And I would not resign because I'm committed to making sure this job was seen through to the very end."

Last week, Trump named Defense Department official Robert Wilkie to the acting position, bypassing Shulkin's deputy secretary, Tom Bowman. Bowman has come under criticism for being too moderate to push Trump's agenda.

Under federal law, a president has wide authority to temporarily fill a federal agency job if someone "dies, resigns, or is otherwise unable to perform the functions and duties of the office." There is no mention of a president having that authority if the person is fired. Still, it's unclear if courts would seek to draw a legal distinction between a firing and a forced resignation, if that is indeed what happened to Shulkin.

The day after announcing he was replacing Shulkin, Trump told a rally in Richfield, Ohio, that he had been dissatisfied with efforts to improve the VA. Shulkin had enjoyed Trump's support for much of his first year in the administration, but that eroded in February after mounting ethics questions and political infighting at the VA.

Wilkie, now listed on the VA website as acting secretary, took over Shulkin's duties last week.

The back and forth over the circumstances behind Shulkin's departure — and what it could mean for Wilkie's status — comes as the nomination of Jackson is drawing concern among lawmakers and veterans groups. They worry the Navy rear admiral and lifelong physician lacks the experience to manage an enormous agency paralyzed over Trump's push to expand private care.

Trump's new Cabinet nominees also are beginning to pile up in the Senate, likely leading to weeks of confirmation battles and other delays in the run-up to congressional midterm elections in November. That could mean an extended reign for an acting VA secretary.

Shulkin's dismissal comes amid a broader shakeup of top Trump administration officials and accusations of excessive spending by Cabinet officials. Also currently under fire are Environmental Protection Agency Administrator Scott Pruitt, Interior Secretary Ryan Zinke and Housing and Urban Development Secretary Ben Carson.

Shulkin had agreed to reimburse the government more than \$4,000 after the VA's internal watchdog concluded last month that he had improperly accepted Wimbledon tennis tickets and that his then-chief of staff had doctored emails to justify his wife traveling to Europe with him at taxpayer expense. Shulkin also blamed internal drama at the agency on a half-dozen or so rebellious political appointees, insisting he had White House backing to fire them.

Associated Press writer Darlene Superville contributed from Palm Beach, Florida.

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38 - Military Times: [White House doctor could face the most contentious VA confirmation process ever](#) (2 April, Leo Shane III, 2.1M uvm; Springfield, VA)

Ronny Jackson's nomination to become the next Veterans Affairs secretary could become the most contentious confirmation process since the department was founded 30 years ago.

But that's also a fairly low bar.

Since the department was elevated to a Cabinet-level post back in 1988, no senator has ever voted against a VA secretary pick. All of the confirmations have been unanimous or near-unanimous votes (with a handful of lawmakers absent), or procedural votes where no opposition was formally recorded.

That includes former VA Secretary David Shulkin, confirmed by a 100-0 vote in February 2017. His total support from the Senate was frequently touted by President Donald Trump in public appearances, including one just a few weeks before Shulkin was fired by the president over social media on March 28.

In fact, no nominee for a confirmable department post over the last 30 years — totaling more than 150 individuals — has ever received a vote of opposition from the Senate, underscoring the non-partisan nature of VA work.

Rear Adm. Ronny Jackson, the White House physician, is a relative unknown in the veterans community.

By: Leo Shane III

That means even a single vote against Jackson's confirmation could send a message of irreversible political division on the once seemingly untouchable approach to the department issues.

Jackson, who retired from the Navy last week as a rear admiral with 23 years of service, was a surprise nominee for the post. He's an Iraq War veteran who served under three presidents as the top White House medical officer, and is best known for giving Trump a clear bill of health in January.

But little is known about his familiarity with the department, which boasts a budget this fiscal year of more than \$186 billion and a staff of more than 370,000 employees. Senate Democrats have openly questioned the pick, and hinted he may not receive the same support as past nominees.

"I admire Dr. Jackson's service to the nation, but I don't know if he is the right person to lead the VA," Sen. Jack Reed, D-R.I., and ranking member on the Senate Armed Services Committee, said in a statement last week. "The VA is a large and intricate agency that requires steadfast leadership and an understanding of how to run a complex organization."

Sen. Tammy Duckworth, D-Ill., is a combat-wounded Iraq War veteran and a frequent critic of the Trump administration. Like Reed, she promised to "carefully review Dr. Jackson's qualifications to determine whether he has the best interests of our veterans at heart."

But she also accused Trump of wanting “to push VA down the dangerous path of privatization” and warned that “the next VA secretary must be able to protect the department from becoming consumed by partisan politics.”

Former Senate Veterans’ Affairs Committee Chairman Bernie Sanders, I-Vt., similarly said the Senate “should not approve any nominee for secretary who supports the privatization of the VA,” a charge which he has also leveled at Trump. The current top Democrat on the committee, Montana Sen. Jon Tester, said simply that he is “looking forward to meeting Admiral Jackson soon and seeing if he is up to the job.”

Few Republicans in the chamber have offered strong praise for Jackson thus far, though none have offered serious public concerns, either.

No timetable has been set for the confirmation hearings. Senate officials still have not received the formal nominating paperwork from the White House, which will start the background check and confirmation process.

That work typically takes between one and two months. Senate leaders have said they hope to move quickly on the work to ensure a vote on Jackson’s nomination before the summer.

Confirmation votes by the Senate on VA secretary nominees

David Shulkin, 100-0 (Feb. 13, 2017)
Bob McDonald, 97-0 (July 29, 2014)
Eric Shinseki, voice vote (Jan. 20, 2009)
James Peake, voice vote (Dec. 14, 2007)
John Nicholson, voice vote (April 11, 2003)
Anthony Principi, 100-0 (Jan. 23, 2001)
Togo West Jr., voice vote (April 28, 1998)
Jesse Brown, unanimous consent (Jan. 23, 1993)
Edward Derwinski, 94-0 (March 2, 1989)

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39 - The Vindicator: [Trump’s choice to lead VA raises questions on intent](#) (3 April, Editorial Board, 193k uvm; Youngstown, OH)

The physician who gave President Donald J. Trump a squeaky clean bill of health could soon lead the Department of Veterans Affairs, even though he lacks the experience to manage an enormous agency that has long been steeped in controversy.

Trump’s nomination of Rear Admiral Ronny Jackson, the White House physician since President George W. Bush’s administration, has raised eyebrows on Capitol Hill and triggered concerns among veterans service organizations.

There is nothing in Dr. Jackson’s background to suggest he could lead a government agency with a \$200 billion budget and a staff of 370,000 spread across 3,000 facilities.

While providing health care to veterans is the main focus of the VA – the Veterans Health Administration operates the largest hospital network in the U.S. – there are other important services veterans depend on.

Disability benefits, education subsidies and cemeteries are just a few of the numerous programs available to the men and women who served this country.

The VA is second only to the Department of Homeland Security in terms of its budget and its importance.

That is why Trump's nomination of Dr. Jackson is so troubling. It seems that he is being rewarded for saying the president is in "excellent health" and "fit for duty."

Jackson claimed Trump had "incredible genes" that kept him healthy despite his well-documented affinity for fast food and abhorrence of exercise.

"It's called genetics. I don't know," the doctor said at one point. "Some people have just great genes. I told the president that if he had a healthier diet over the last 20 years, he might live to be 200 years old. I just don't know."

He added, "It's just the way God made him."

It is no secret that the billionaire real- estate developer from New York City expects to be showered with high praise from those around him and does not like to be second-guessed.

Secretary fired

Indeed, his nomination of Jackson to be secretary of the Department of Veteran Affairs came in the wake of his firing of David Shulkin, who was cool to the idea of privatizing some of the health-care services.

Shulkin, who is not a veteran but had served at VA as head of the Veterans Health Administration, was popular with veterans service organizations and lawmakers.

In an opinion piece published in the New York Times after his firing, Shulkin sought to set the record straight by saying he had been fired and had not resigned, as the White House claimed.

"I have been falsely accused of things by people who wanted me out of the way," the former secretary of the VA wrote. "But despite these politically based attacks on me and my family's character, I am proud of my record and know that I acted with utmost integrity. Unfortunately, none of that mattered."

As for the campaign by some Trump insiders to privatize the delivery of health care, Shulkin wrote:

"They saw me as an obstacle to privatization who had to be removed. This is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans."

That goes to the heart of the matter and must be the focus of confirmation hearings in Congress.

The website Government Executive Management quoted Joe Chenelly, executive director of AMVETS, as saying, "I am deeply concerned about the nominee. Veterans' lives depend on this decision, and the Trump administration needs to substantiate that this active-duty Navy officer is qualified to run a \$200 billion bureaucracy, the second largest agency in government."

AMVETS also has this question that members of Congress should pursue when they meet with Jackson:

"What qualifications does the president's nominee have to address claims, appeals, benefits and cemetery affairs?"

Throughout the 2016 presidential campaign and since he took office in January 2017, Trump has claimed to be the greatest advocate for the military and veterans this country has ever had.

Yet, the Republican president did not hesitate to get rid of an individual who enjoyed wide support among veterans. Indeed, Shulkin's popularity stems from the fact that he has put in place programs and initiatives that address past problems with the delivery of services, especially health care.

Given the conflicting reports regarding the VA secretary's departure, we believe President Trump should tell the American people if he wants health-care services to be privatized.

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40 - Washington Post: [Perspective - I've seen what a mess Veterans Affairs is. Ronny L. Jackson can't fix it. Trump's new pick to lead the cabinet is a fine doctor. That doesn't mean he can handle a massive, dysfunctional bureaucracy.](#) (2 April, Mikki Kendal, 43.9M uvm; Washington, DC)

The mission of the Department of Veterans Affairs was laid down in the wake of the Civil War, in a promise by President Abraham Lincoln to care for the men who fought, as well as their widows and orphans. The scope of that promise has broadened as women have enlisted. It is the only department that focuses exclusively on caring for veterans and their families in times of crisis spawned by injury, illness and death, a mission most Americans would agree is vital, if not sacred.

Yet every administration going back decades has failed to appoint a leader capable of guiding the agency to fulfill its mission. Ronny L. Jackson, President Trump's pick to lead the department after Secretary David Shulkin was fired, will continue that legacy. And veterans will continue to pay for it.

Whether the problem was covering up shoddy health care or questionable hiring practices, there is no question that Shulkin was ill-equipped for the position. His predecessor, Bob McDonald, did not adequately address staffing problems and wait times that were present before and during his tenure, and still remain. During the quality-of-care scandal at Walter Reed Army Medical Center, President George W. Bush appointed three men to the role of Veterans Affairs secretary. Since the position was created in 1989, 16 leaders have been appointed or stepped in as acting secretary, and the department continues to fail veterans.

I'm a veteran and former employee of the department. Although I enjoyed some aspects of my work as a veterans services representative, I'm the first to admit that VA is deeply dysfunctional. The reasons are well documented and myriad: chronic understaffing, limited investment in infrastructure, an ever-changing array of guidelines for who is eligible for benefits, and what those benefits consist of from year to year. It's a complicated system prone to backlogs that can run more than two years deep — in part because of the administrative issues that arise when management and funding don't match need.

Jackson is an experienced physician and a rear admiral with an awareness of the medical concerns of military members and their families. He's certainly qualified to work for a VA facility, and quite possibly qualified to run a medical department, with the support of a good staff.

What he lacks experience in is responding to the concerns of veterans. Hospitals don't run on doctors alone. Doctors don't direct cleaning schedules, seek donors, or do dozens of other things that make their work possible.

Veterans Affairs isn't just hospitals treating injuries. It's compensation and pensions, it's mental health care, rehab, and programs to house homeless veterans. It is a massive department with a staff of almost 378,000 people, a small city of workers that serves about 22 million veterans and their families. In raw numbers, that means every staff member has 58 veterans relying on them to do their jobs. In actual numbers, it means that every veterans services representative can have a caseload in the hundreds. It's a hard job, made worse when the people making decisions about policy have no idea what the population being served needs, or how to provide it. And it's just one aspect of the multistep process required to help veterans build a new life.

Cases are often far more complicated than they appear. A veteran who is chronically unemployed can't simply be referred to a job program. A VSR needs to examine the reasons for unemployment. That might mean compensation for depression or for post-traumatic stress disorder, drawing on VA benefits. On the medical side, that means a referral to therapy, possibly a program for substance abuse if the veteran is self-medicating. If the unemployment has led to homelessness, housing assistance is needed through the HUD VASH, which brings in yet another side of the department. And this would be just one case handled by one representative.

Is it possible to learn? Absolutely. To be a good VSR, you need two months of classes, at eight hours a day. Then you need at least six months of supervised on-the-job training. It is a lot of paperwork and memorization and asking questions about conditions you may have never imagined were possible for one person to face. It's complex work on the best day with all the training and experience. Jackson has no training in so much as building a file. He lacks experience in managing a large staff, directing any federal department, or even directing troops at this scale. He doesn't understand the work or the people who do it, and that's not how effective leadership models are built in any industry.

Jackson's only apparent qualification, besides a medical degree, is being able to stand in front of a lectern and respond to reporters. He has that in common with Ben Carson, another doctor who was appointed to a Cabinet position and who has not generated anything but scandals and subpar policy decisions. In the parade of failed appointees under this administration, Jackson is almost the least objectionable, if you ignore the effect his inexperience will have on a system that is not adequately serve a vulnerable population.

I was a good soldier. I'm a successful writer. But I wasn't especially good at being a VSR, and ultimately I recognized that my talents could be put to better use elsewhere. One can only hope

that after Jackson gets past feeling flattered by the attention, he'll set aside his ego long enough to recognize that he isn't qualified to lead this department at this time. Veterans deserve better.

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41 - Fierce Healthcare: [5 things to know about Ronny Jackson, Trump's pick to replace Shulkin at the VA](#) (2 April, Paige Minemyer, 141k uvm; Washington, DC)

President Donald Trump fired David Shulkin as Department of Veterans Affairs secretary last week and tapped White House physician Ronny Jackson as Shulkin's replacement.

Trump praised Jackson as "highly respected" in his Twitter announcement, and White House Press Secretary Sarah Huckabee Sanders echoed the sentiment in a tweet of her own, saying that he and other cabinet nominees should be confirmed "without delay."

However, veterans' groups expressed concern about Jackson's lack of experience in managing government agencies, let alone one the size of the VA. A former VA official told Politico that his "first reaction" to the announcement was "OMG."

"[Jackson] has no experience," the official told the publication. "The VA is the hardest department to manage because it is so political."

Jackson's experience—or lack thereof—will certainly be a point of contention in his confirmation hearings. Here are a few more facts to know about Trump's pick to head the VA:

1. He has served in three presidential administrations.

Jackson first joined the White House medical staff in 2006 during the Bush administration, according to his Navy biography, and has directed the Executive Health Care for the President's Cabinet and Senior Staff. He was named Physician to the President by President Barack Obama in 2008, a role he continued under Trump.

Jackson has also served as physician supervisor for the Camp David presidential retreat.

2. Jackson is still an active duty soldier.

Jackson was serving in Iraq as an emergency physician and specializing in resuscitating troops when he was notified that he would be joining the White House Medical Unit. He began active duty naval service in 1995, according to his biography.

The White House announced on March 23 that it had nominated Jackson for a promotion to rear admiral (upper half), which would make him a two-star admiral, CNN reported.

3. He caught Trump's eye after announcing the results of the president's physical in January.

The president was impressed with Jackson's performance at a January press conference where he revealed the results of Trump's annual physical, CBS News reported. A source told CBS that Trump is also personally fond of Jackson.

At the press conference, Jackson answered reporters' questions about Trump's health for more than an hour, saying that if the president had maintained a healthier diet over the past 20 years, "he might live to be 200 years old."

4. His stance on key VA issues is an unknown.

Where Jackson stands on crucial issues at the agency he could soon command is not publicly known, according to Politico. This extends to privatizing the department's health system. Shulkin said that his opposition to VA privatization is the main reason he was pushed out.

Jackson does have Trump's ear, though. Richard Tubb, M.D., the longest-tenured White House physician and Jackson's mentor, told CBS that White House doctors have been "figuratively Velcro-ed" to Trump since he won the election.

"On Jan. 20, 2017, Dr. Jackson became that Velcro," Tubb said.

5. Shulkin has praised his potential replacement

Following his ouster, Shulkin didn't mince words about what it was like at the VA, writing in a New York Times op-ed last week that "the environment in Washington has turned so toxic, chaotic, disrespectful and subversive" that he struggled to accomplish his goals at the agency.

However, he told ABC News that Jackson, despite his lack of experience, should be able to build a team around him that will allow him to succeed at the VA if he's confirmed. Shulkin told CNN that Jackson is a friend, and that he "will do everything that I can" to help him in the transition.

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42 - Aiken Standard: [Column: Surprise: Trump's newest cabinet nominee has no relevant experience](#) (2 April, Eugene Robinson, 68k uvm; Aiken, SC)

You can't make this stuff up: President Trump has announced he will nominate a medical doctor who has no discernible management experience to run the second-largest agency in the federal government.

Can presidents be sued for malpractice?

The man Trump has named to become secretary of veterans affairs, Dr. Ronny Jackson, happens to be the president's personal physician. More to the point, given Trump's perpetual hunger for sycophancy, is the fact that Jackson showered the president with hyperbolic Dear-Leader-style praise during a widely viewed television appearance in January.

Trump has "incredibly good genes," Jackson said in describing the physical examination he had given the president. Trump's overall health is "excellent." His "cardiac assessment" put him "in the excellent range." If his diet had been a bit better, "he might live to be 200 years old." In any event, "I think he will remain fit for duty for the remainder of this term and even for the remainder of another term if he's elected."

That is an unusual way to describe a 71-year-old man whose height was reported as a generous 6 feet 3 inches and weight at an eyebrow-raising 239 pounds, which classifies him as overweight – but conveniently just one pound short of obese. Jackson's are odd words for a man whose cheeseburger-laden diet my doctor would describe as suicidal and whose coronary calcium scan results, according to many other physicians, indicate some degree of heart disease and a clearly elevated risk of heart attack.

I assume Jackson has been more, shall we say, plain-spoken with the president about his health than he was with the public. But am I suggesting that flattery, rather than merit, is what makes him Trump's choice to replace ousted VA Secretary David Shulkin? Absolutely, because no other explanation makes sense.

Pliability may also be playing a role. In a New York Times op-ed, Shulkin wrote that he believed he was being sacked because he opposed a push by the Trump administration "to put VA health care in the hands of the private sector."

Shulkin is also a physician, but before he took over at the VA he had experience running hospitals. With no comparable administrative background, Jackson – if confirmed by the Senate – would take over a sprawling agency with 360,000 employees, a \$186 billion budget and responsibility for providing medical care to 9 million veterans who deserve better, faster service than they now receive.

Shulkin was one of several high-ranking Trump appointees under fire for lavish spending on the taxpayers' dime. He was also a holdover from the Obama administration, and even though the job is perhaps the least partisan in the cabinet, that prior association clashed with Trump's bratty determination to oppose everything Obama supported and support everything he opposed.

But Shulkin, by most accounts, had stabilized the VA's vast system of hospitals and health clinics. What he refused to do was support the notion of privatizing veterans' health care – an idea pushed by some of the political appointees the White House had installed under him.

"I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans," Shulkin wrote in his op-ed. "The private sector ... is ill-prepared to handle the number and complexity of patients that would come from closing or downsizing VA hospitals and clinics, particularly when it comes to the mental health needs of people scarred by the horrors of war."

Shulkin wrote that "in recent months" the political environment in Washington has become "toxic, chaotic, disrespectful and subversive," making it impossible for him to do his job. "It should not be this hard to serve your country," he wrote.

But it should be hard to get a job running any organization as big, complex and vital as the Department of Veterans Affairs. Perhaps Jackson has an innate genius for management that awaits only the opportunity to flower. If not, Trump will be doing a grave disservice to men and women who are owed the nation's thanks and gratitude.

I can't say I'm surprised. Trump put neurosurgeon Ben Carson in charge of the Department of Housing and Urban Development, despite Carson having zero experience in housing policy. He put Betsy DeVos in charge of the Department of Education, despite her apparent unfamiliarity with actual schools. He put politician Rick Perry in charge of the Department of Energy, which Perry wanted to eliminate until he learned what the agency does.

Perry actually said that at his confirmation hearing. One doesn't know whether to laugh or cry.

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43 - Truthout: [Trump's New VA Pick Appears Poised to Rubber-Stamp Privatization of Veterans Affairs](#) (3 April, Michael Corcoran, 422k uvm; Chicago, IL)

For the last year, Veterans Affairs Secretary David Shulkin insisted the VA would not be privatized on his watch. Now, thanks to a Koch-supported coup at the top of the second-largest department in government, his watch has ended -- and the battle over privatization persists.

For years the Koch brothers have been hovering around the Department of Veterans Affairs and its \$186 billion budget like vultures surrounding a carcass. The billionaires have been pushing a radical legislative agenda, using the front group Concerned Veterans for America. Their goal is to dismantle the Veterans Health Administration (VHA) -- the only system of socialized medicine in the United States -- to the benefit of for-profit providers.

So, one can only imagine the glee felt in the Kochs' offices on Thursday when the president finally sent Shulkin packing. The VA Chief had retained the support of most Veterans Service Organizations (VSOs), which generally are opposed to privatization of the VHA, but it was not enough to save his job. This is a strong indicator of the Kochs' influence over the Trump administration on veterans' issues.

Experts and advocates now fear that Ronny Jackson, the White House doctor and Trump's pick to replace Shulkin, will rubber-stamp the Koch agenda. "I think [Jackson] will be a puppet that will put the VHA and the VA on a starvation diet," said Suzanne Gordon, a journalist and author who covers the VA, in an interview with Democracy Now.

Among the legislation the Kochs are pushing is the Veterans Community Care and Access Act (S.2184, which was introduced by Sens. John McCain and Jerry Moran), the Veteran Empowerment Act (HR.4457, introduced by Rep. Doug Lamborn), which seek to privatize much of the VHA, and the Vet Protection Act (HR.1461), which would weaken the rights of VA employees.

Passing this legislative agenda would radically remake the VA in the Kochs' image. Can anyone stop it from happening?

Privatization of VA Enters Mainstream Debate

Shulkin's firing brought one silver lining for those seeking to preserve the VHA. The drama surrounding the firing -- and the curveball appointment of Trump's physician to replace him -- has elevated the issue of the privatization of the VHA into the national debate.

Shulkin did not go quietly after his dismissal. He penned an op-ed in The New York Times and appeared on shows like "Meet the Press" to pointedly explain why he was removed.

"They saw me as an obstacle to privatization who had to be removed," Shulkin wrote in the Times. "That is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans.

"His ringing defense of the VA in the New York Times is very important for people to read. I'm sad that [he] didn't articulate that kind of defense earlier," Gordon said. "But the fact that he's [speaking out on privatization] now is really to be commended."

Shulkin's language was not very different from that of Sen. Bernie Sanders, who said at a news conference in Vermont, "The firing of Shulkin has everything to do with the administration's desire to privatize the VA, and I think that that is a disastrous idea."

This has led to a rare public discussion of VA privatization -- and the role of the Koch brothers in advancing the cause -- in the dominant media. Jackson's confirmation hearings could provide more chances to educate the public about the Koch's war on the VHA. Democratic opponents will have a chance to step up and confront Jackson on these privatization efforts in public.

The fact that Trump chose his own White House doctor to replace Shulkin only adds to the media's interest in the pick. It seems likely that the process of replacing Shulkin will take place with a much wider audience than it would have if Trump had made a less controversial decision.

"We know nothing about what Dr. Jackson stands for and what his vision is for the VA," Sanders said of Jackson on CBS's Face the Nation.

Koch-Approved Legislation: Exploitation of Choice

This mysterious physician, however, may well end up running the largest health care system in the United States.

So, what do the Kochs have planned for the new VA chief? They do not make you search hard for these answers. In Concerned Veterans for America's statement responding to Shulkin's firing, they celebrate that the "distractions" are over and quickly pivot to their legislative agenda.

"Concerned Veterans for America's grassroots leaders flew in from around the country earlier this month and held nearly 100 meetings with legislative leaders to discuss the group's policy agenda," the statement reads.

It then lists its legislative agenda. The top two bills it is pushing would, to varying degrees, fundamentally alter the VHA through privatization: the Veterans Community Care and Access Act (S.2184) and the Veterans Empowerment Act (HR.4457), which is sponsored by Rep. Doug Lamborn, a Republican from Colorado.

These two pieces of legislation must be considered in the context of the 2014 VA Scandal, when VA employees were accused of falsifying records about long wait times. After the wait-time scandal, a bipartisan agreement called Veteran Choice Act of 2014, allowed veterans who do not live near a VA clinic, or are subject to long wait times, to seek care at a private provider.

There was no real opposition to this plan, which created the Veteran Choice Program, and it was supposed to be an emergency measure. "This particular program was authorized as a temporary fix in the midst of a crisis," said Allison Jaslow, executive director of Iraq and Afghanistan Veterans of America, in an interview with The Atlantic. "We always viewed it as an experiment."

This experiment, however, has turned into the primary means by which the GOP is trying to privatize the VA. The program was set to expire this year, but Trump extended it in April and

December 2017. Now GOP legislation, supported by the Koch brothers, would, as Nikki Wentling of the Stars and Stripes reported, "overhaul the controversial Choice program and create a network of community medical providers that veterans could use at taxpayers' expense."

The more radical of the Kochs' two bills is Lamborn's legislation, which was introduced in November. The Veterans' Empowerment Act, as Wentling describes, "mirrors a proposal from the conservative group, Concerned Veterans for America, which is part of the Koch brothers' political network, to create a government-chartered organization to operate a new veterans health insurance system."

The bill drew immediate resistance from opponents of privatization, such as the Veterans of Foreign Wars (VFW). "We hope that it has absolutely no chance of becoming law," said Carlos Fuentes, legislative director for the VFW, in response to Lamborn's bill.

The Kochs, who, according to The Wall Street Journal, are spending millions to influence this debate, praised the bill. In an op-ed for The Hill, Dan Caldwell, executive director of Concerned Veterans for America, said the bill would "truly expand veterans' health care choice in an effective and sustainable way."

The Veterans Community Care and Access Act (S.2184, which is sometimes called McCain-Moran) is similar to the Lamborn bill but not quite as militant. Unlike with the Lamborn act, under McCain-Moran the VA is maintained "as a gatekeeper to private-sector treatment," Wentling reports, whereas the VA can be bypassed entirely under the Veterans Empowerment Act.

"The bill would require the VA to use objective data on healthcare demand to set standards for access and quality, and to identify and bridge gaps in veterans' care -- whether in VA or community facilities," according to a press release from Moran about the bill.

"It is as if they want the VA staff to serve as billers for the private sector," Gordon told Truthout.

The McCain-Moran legislation goes well beyond the accommodations made for rural veterans as envisioned by the Choice program. Some estimate that "McCain-style privatization" could triple the cost of veterans' care to almost \$450 billion a year.

Both the Lamborn and McCain-Moran bills also overlook the possibility that the private sector is not ready for the specific health needs of veterans, according to a Rand Report published in March, which studied New York State providers. The report found that private providers knew "little about the military or veterans" and are "not routinely screening for conditions common among veterans," among other critiques.

"These bills have lots of nice words, about empowerment, or choice, but what those bills do is hurt veterans," said William Attig, executive director of the Union Veterans Council, AFL-CIO, in an interview with Truthout. "There is a lot of money for some to make by farming out services to the private sector, but what the VHA needs is to be fully funded, not privatized."

The Kochs' attack on the VA is also an attack on federal employees and public-sector unions. Their legislative agenda includes the Vet Protection Act (HR.1461), which makes it easier to fire employees and tries to weaken public sector unions.

Concerned Veterans for America says the bill would involve monitoring "the amount of time VA employees can devote to union activities during work hours and ensure clinicians are doing the work the VA hired them to do -- care for patients."

The law is an attack on the collective bargaining rights of federal employees at the VA, according to the National Federation of Federal Employees.

"This legislation does not help veterans or taxpayers. Rather, it serves only to weaken federal employee unions," the union said in response to the proposal.

The Fight Ahead

These big legislative efforts are ongoing, as are other acts of "stealth privatization," such as hiring freezes, and plans laid out in the Trump VA budget, which undermine the VA without an act of Congress. These practices are likely to continue.

From a wider-angle lens, the goal of the Koch brothers is not just to pass these bills to dismantle the VHA, but to undermine the very idea of government-run health care.

However, while the Kochs have enormous resources invested in their effort to dismantle the VA, there is organized resistance from most Veterans Service Organizations, as well as from progressives like Bernie Sanders, who seek to defend government-run health care on principle.

With the Koch brothers' role in trying to privatize the VHA now a matter of national debate, the best way to maximize opposition to their agenda is to make sure the US public knows who is most hurt by it: veterans.

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44 - We Are The Mighty: [No one was ready for President Trump's next VA secretary](#) (3 April, Ben Brimelow, 3.6M uvm; New York, NY)

Questions have emerged about the managerial ability of White House physician Admiral Ronny L. Jackson, President Donald's Trump pick to run the Department of Veterans Affairs, the federal government's second-largest agency.

If confirmed, Jackson would replace David Shulkin as the secretary of veterans affairs. Trump announced his decision to fire Shulkin on March 28, 2018.

Though Jackson has an impressive resume as a career naval officer who served as an emergency trauma doctor in Iraq, as well as a White House physician for the 12 years, he seems to lack any management experience.

Considering the VA has 360,000 employees and a \$186 billion annual budget, that has some people worried.

"It's great that he served in Iraq and he's our generation. But it doesn't appear that he's had assignments that suggest he could take on the magnitude of this job, and this makes Jackson a -surprising pick," Paul Reckhorn, the chief executive of Iraq and Afghanistan Veterans of America, told the Washington Post.

Shulkin had managed several hospitals before, including some that were part of the VA, and almost all of his predecessors were either high ranking managers in the private sector, or military leaders.

Senior White House officials told the Washington Post that Jackson "was taken aback by his nomination," and was reportedly hesitant to take the position. One official described an "informal interview" process, without the traditional Cabinet-level vetting.

The White House had reportedly planned to announce that Shulkin would leave on March 28, 2018, with an interim director to run the department until a permanent head could be found. Trump apparently changed that plan when he tweeted that Jackson was his pick to lead the VA.

Virtually nothing at all is known about Jackson's views on the issues that currently face the VA, like Trump's views on privatization of elements of the VA.

"We are doing our homework on Dr. Jackson," Amanda Maddox, a spokeswoman for the chairman of the Senate Veterans' Affairs Committee, Sen. Johnny Isakson, told the Washington Post.

"His name was never floated around," Maddox said, "so we are doing our due diligence."

It is unclear if Democrats will support Jackson's nomination. Senator Tammy Duckworth of Illinois, an Iraq veteran who lost both of her legs when the helicopter she was co-piloting was shot down, released a statement saying that she would "carefully review" his qualifications.

"The next VA Secretary must be able to protect the department from becoming consumed by partisan politics," Duckworth said.

"I hope Dr. Jackson is someone who is willing and able to do that by continuing the important tradition of VA Secretaries working in a bipartisan manner."

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45 - MedPage Today: [Jackson's Nomination to Run VA Brings Questions, Lack of management experience cited as major issue](#) (3 April, Joyce Frieden, 1.5M uvm; New York, NY)

Reaction to President Trump's nomination of White House physician Ronny Jackson, MD, as Secretary of Veterans Affairs (VA) has leaned toward the negative, with most people questioning whether Jackson has the experience needed to run the vast department.

"I am deeply concerned about the nominee," Joe Chenelly, executive director of AMVETS, a veterans service organization, said in a press release. "Veterans' lives depend on this decision, and the Trump administration needs to substantiate that this active-duty Navy officer is qualified to run a \$200-billion bureaucracy, the second largest agency in the government."

Chenelly posed several questions that he said needed to be answered about Jackson, including:

"Is it appropriate for an active-duty military officer to run a federal agency?"

"With an official bio that does not seem to contain any indication that he's held a command, is the president's nominee fully prepared to lead such a massive bureaucracy?"

"While we are pleased this nominee has a medical background, the VA is much more than healthcare. What qualifications does the president's nominee have to address claims, appeals, benefits, and cemetery affairs?"

Michael Carome, MD, director of Public Citizen's Health Research Group, was even more blunt. "Dr. Jackson appears to lack the type of management experience that the VA secretary position demands," he wrote in an email to MedPage Today. "There are undoubtedly dozens of other individuals who would be more qualified, but many are likely unwilling to serve under President Trump."

But not everyone agreed. "The questions ... raised about his [lack of] experience in managing a large bureaucracy [are] relevant, but there is a lot of precedence about having the deputy secretary being the main management person," said Gail Wilensky, PhD, senior fellow at Project HOPE, in Bethesda, Md. "The bigger question is, do you know what you know and know what you don't know?"

If Jackson doesn't have management experience, "he needs to understand the importance of working as a team with regard to the skill sets he doesn't have, and if he understands that, most potential problems are relatively easily resolved."

Mike Haynie, PhD, director of the Institute for Veterans and Military Families at Syracuse University, said that while Jackson's background will become clearer during the nomination process, the change in leadership also raises other issues.

"The conversation should be much greater than just about Dr. Jackson," he said in an email. "What is missing is the larger issue of the other key vacancies across the agency – to include the Undersecretary for Health and Undersecretary for Benefits. These are key leadership roles, and the absence of leaders in these roles will further complicate Dr. Jackson's transition."

Jackson, a rear admiral in the Navy, has served as White House physician since 2006, according to his official bio. He has served as an instructor at a naval diving and salvage training center as well as an emergency physician in Iraq before being selected for the White House post. He has served as director of the White House medical unit but there is no other reference in his biography of having run a larger organization.

President Trump announced on Twitter on March 28th that he would be nominating Jackson to replace Shulkin, although there is some dispute over whether Shulkin was fired or he resigned. Shulkin maintains he was fired while the White House says he resigned. The Trump administration and Shulkin were at odds over whether the VA should become more privatized.

Privatization would hurt the agency, said Eugene Gu, MD, a surgery resident at the VA medical center in Nashville, Tenn., who has been speaking out on the issue. "Privatizing means veterans are shipped off to a small private hospital in whatever community they're in," he said in a phone interview. "They're not going to get the same level of integrated care ... What they should be focusing on is giving veterans the best care that they deserve, which means investing more money into [this] single-payer nationally integrated health system."

Right now, privatization is being used as a crutch to avoid fixing problems within VA facilities, he continued. For example, Gu said that at the hospital he works at, broken sterilization equipment is not being fixed because, under the current Choice program allowing veterans to go outside the VA for care, staff can just send surgery patients elsewhere.

"How can you have a hospital without completely working sterilizing system? That should be a scandal," said Gu. Although it's true that the hospital can send surgery patients elsewhere, "that delays their care. If we didn't have [the] Choice [program] they would have been working around the clock to fix the sterilizer and we would have clean tools to operate on patients ... Relying on [Choice] is a disservice to veterans."

Haynie urged going slow on expanding privatization. "A wholesale dismantling of the VA healthcare system is not in the best interest of veterans, or American medical education," he said. "The administration has made it clear they want to see more choice for veterans when it comes to their healthcare, but it is important to expand choice in a way that preserves the core integrity of the VA healthcare system."

Although Jackson would be new to the VA, no one should assume he will be a pushover for those who want to increase privatization, Wilensky said. "Most of the flag officer-level people I've met in the military are not so easy to manipulate.... He has spent his adult life in the military, where they rely on government-funded healthcare."

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46 - KWTX (CBS-10): [Waco: Chris Kyle's family hopes new secretary will change VA culture](#) (3 April, John Carroll, 315k uvm; Waco, TX)

The brother and father of slain American Sniper Chris Kyle say they hope that Texas born and reared Navy Rear Adm. Ronny L. Jackson, whom the president has nominated as the next secretary of veterans affairs will change the culture in the VA to get veterans help more quickly.

"Our veterans are not being taken care of here in America, no way, absolutely not," Kyle's father, Wayne said.

"We're hopeful that somebody has been placed there that understands our veterans and understands what they are going through," he said.

Kyle's sons Chris and Jeff both served overseas in foreign wars.

Chris, known as the American Sniper, was shot and killed at a gun range five years ago in Erath County while attempting to help a troubled vet.

President Donald Trump has been moving to privatize some healthcare for veterans, saying he wants them to get the help they need.

"We need to address it immediately. Get them the care that they need and get the problem resolved," the elder Kyle says.

"I hate to say this, but to me the VA has up until now been like a revolving drug dispensary. These young men and women have become addicted to prescription drugs and they become like zombies."

Jackson is a Texas native, a 1991 graduate of Texas A&M University and a 1995 graduate of the University of Texas Medical Branch.

On the subject of school safety, both Kyle and his son Jeff believe veterans could be one answer to making campuses safer for students.

Jeff Kyle says schools should hire two to three Veterans per campus to guard the students.

"Making sure that their mental health is checked out, there's plenty of guys, men and women, both out there that are well trained and ready to standby and you know do what is necessary to protect these kids."

His father Wayne agrees.

"I just feel like we could make better use of our veterans if there are unemployed then put them to work."

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47 - Creators Syndicate: [Marching Orders for Trump's New VA Secretary](#) (4 April, Betsy McCaughey, 318k uvm; Hermosa Beach, CA)

Since President Trump ousted Veterans Affairs Secretary David Shulkin, the question reverberating in Washington is whether Trump's new pick, Rear Adm. Ronny Jackson, is capable of heading a department with 360,000 employees and 9 million vets under its care. Senate Democrats carp he lacks experience running "a complex organization."

Experience is overrated. President Obama's VA Secretary, Robert McDonald, failed miserably, despite having run Procter & Gamble. Vets died on phony wait lists on McDonald's watch.

Jackson's last combat role was with a surgical shock trauma unit in Iraq. Sounds like good preparation for battling the killer VA bureaucracy.

Jackson also shares Trump's vision of putting vets in the driver's seat about their own medical care. Here's what Jackson can learn from his predecessors' failures.

Lesson 1: Make vets the priority, not protecting the VA bureaucracy. Shulkin refused to do that.

Trump has pledged to fix the Veterans Choice Program so vets can see private doctors when they decide it's necessary. VCP was created in 2014 after revelations that sick vets were dying on wait lists at VA hospitals. VCP is supposed to allow vets to get private care if they live far from a VA facility or have waited too long. But VCP's red tape makes seeing an outside doctor almost impossible. That's deliberate. Senator Bernie Sanders, who co-authored VCP legislation, relies on union campaign contributions and will do just about anything to protect union jobs at the VA. Keeping vets trapped at the VA with no alternatives is a job protection racket.

Shulkin was part of that racket, too. He misled Trump and Congress with double talk about reforming VCP "in a way that will work for veterans and work for VA." But protecting VA bureaucracy shouldn't be a consideration, when vets' lives are at stake.

Shulkin showed his true colors when Congress passed last month's big spending package. Trump and congressional Republicans had pushed hard to include VA reforms helping vets see outside doctors.

But the key person to sell this to Congress was Shulkin, and he equivocated, allowing Democrats to block its passage. It was a setback for Trump and vets. No wonder Shulkin was canned days later — not because of flimsy travel expense abuse allegations.

Lesson 2: Cut wait times in half at the VA.

Shulkin claimed success in reducing waits, but that's questionable. VA bureaucrats are still fudging the numbers, according to the inspector general.

Here's a remedy. A whopping 47 percent of VA health care users are 65 or older. They need angioplasty and bypass surgery like other seniors. They use the VA to avoid Medicare's out-of-pocket expenses, because their median annual income is only \$24,000. Picking up their co-pays would cost very little and encourage them to use Medicare instead of the VA Bingo, and it would cut VA wait times by nearly half, making room for younger vets to get combat-related care only the VA can provide.

Lesson 3: Don't count on VA bureaucrats to fess up when things go wrong. Jackson should use unannounced audits to uncover dangerous conditions at medical facilities, instead of trusting officials to report them up the chain of command.

An inspector general report last month exposed "a breakdown of core services" at medical centers under Shulkin's command. At the Washington, D.C., facility, under Shulkin's nose, patients were needlessly overexposed to anesthesia due to inventory mismanagement. After patients were put under, surgeons sometimes discovered they were out of equipment and had to race across the street to borrow it from another hospital or reschedule the procedure. Shulkin claims he could "not recall" ever being notified of such problems. He expected to be notified?

Pundits are predicting a confirmation battle. The smart money should be on Jackson. He's combat tested. Disregard the partisan drivel about his lack of experience running a big organization. It's coming from the same people who had no problem making a community organizer the president.

Betsy McCaughey is a senior fellow at the London Center for Policy Research and a former lieutenant governor of New York State.

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48 - Hawaii Tribune-Herald: [Senate should be wary of Veterans Affairs nominee](#) (4 April, 135k uvm; Hilo, HI)

Caring for our nation's military veterans was one of Donald Trump's most consistent promises on the presidential campaign trail, and certainly one of his least controversial. Getting veterans the care they need is a nonpartisan priority.

But the increased quality of care Trump promised hasn't come.

Facilities on Long Island and in many other communities are falling apart. The Department of Veterans Affairs is increasingly being exposed as dangerous and dysfunctional. Last week, as was expected, Trump fired the secretary of veterans affairs, David Shulkin, who could never rise above his ethical violations and his shoddy leadership. His designated replacement is Navy Rear Adm. Ronny Jackson, the White House physician for the past three administrations who garnered praise from Trump for performing well during a news conference about the results of the president's physical exam.

While Jackson is highly regarded as a physician, his resume does not include a shred of evidence that he can lead the government's second-largest bureaucracy (it has a \$186 billion budget) and probably its most dysfunctional. This might be the toughest management job in Washington.

Before the Senate confirms Jackson, it must elicit his views on further privatization of medical care, which other Trump appointees are recklessly pushing as a way to dismantle the agency instead of providing improved service. And unless the Senate can ensure that Jackson can overcome his lack of management experience and create a solid plan for building a leadership team that can improve care, it should reject his nomination.

On Long Island, the problems are increasingly daunting, and care for veterans is suffering. Last month, it was learned that the Northport VA Medical Center again was forced to stop performing surgeries when a faulty air conditioner forced the hospital to close all five of its operating rooms. The shutdown went on for about a week, and 18 surgeries had to be rescheduled while the \$58,000 repair was performed.

That's only the latest breakdown at the Northport facility, where surgeries were halted for four months in 2016 when another air-conditioning system failure sent metal fragments flying into the air, threatening to contaminate patients with open wounds. Another cooling system problem a year earlier led to pipe ruptures and a \$12 million repair. And in January, Northport had to close its 42-bed veterans homeless shelter after the heat failed.

A recent report estimated the cost of Northport's repair and renovation to be \$273 million. Long Island's 130,000 veterans rely heavily on the facility, which has traditionally maintained a top reputation. Its quality cannot be allowed to decline.

If Jackson is confirmed, Trump, who has a warm personal relationship with his nominee, must make sure their communications remain constant. Jackson will need the president's full support to get the VA running properly and all of its facilities up to par.

We owe these veterans. There can be no reneging.

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49 - WUSF (NPR-89.7, Audio): [For Veterans Groups, Questions Surround Trump's VA Nominee](#) (6 April, Carson Frame, 197k uvm; Tampa, FL)

VA-18-0457-A-000978

Some veterans groups say they're uncertain about the future of care at the Department of Veterans Affairs, after President Trump ousted Secretary David Shulkin and nominated White House physician Ronny Jackson to head the agency.

Navy Rear Admiral Ronny Jackson has served as a White House physician during the last three presidential administrations, starting with George W. Bush.

It's typically a low-profile position, but Jackson had a rare moment in the media spotlight in January, when he appeared in the White House briefing room to release the results of President Trump's annual physical.

"All clinical data indicates that the President is currently very healthy, and that he will remain so for the duration of his presidency," Jackson declared. "I told the President that if he'd had a healthier diet over the last 20 years that he might live to be 200 years old."

Some observers speculate that Jackson's glowing report on President Trump's health played a role in the President's decision to nominate him as Secretary the Department of Veterans Affairs. President Trump ousted Secretary David Shulkin after a turbulent 14 months in the position.

"I think that Donald Trump was enamored by having Ronny Jackson go out and say something like that before the press corps," said Will Fischer at the left-leaning political action committee VoteVets. "And it was that moment that I think Ronny Jackson probably became Donald Trump's new VA secretary."

A native Texan, Jackson joined the active duty Navy in 1995 after finishing medical school at the University of Texas Medical Branch in Galveston. He went on to graduate from the Navy's Undersea Medical Officer program, and specialized in resuscitating troops during the Iraq war in 2005 and 2006.

But Fischer suspects that his nomination may be part of a larger push to privatize the VA.

"There is a coordinated effort being led by Donald Trump and others to destroy and privatize our VA healthcare system," Fischer said.

Other veterans groups are taking more of a "wait and see" attitude and asking a lot of questions.

"We were surprised," said American Legion Executive Director Verna Jones. "He seemed to have just come out of nowhere."

The VA is one of the largest healthcare systems in the world, with a budget of almost 200 billion dollars and around 350 thousand employees. Jones says Jackson will have a lot on his plate, and that the American Legion will try to support him.

"There are 20 million veterans in the United States and nine million are enrolled in the VA," Jones said. "So the new secretary's going to have to come in and manage all of that."

He also would take over the agency at a tumultuous time. President Trump ousted Shulkin after about 13 months on the job. Shulkin called the Washington environment "toxic, chaotic, disrespectful and subversive."

Richard Delgado of the San Antonio Coalition for Veterans and Families said Jackson's military experience is appealing in such an environment and could help him get a handle on the VA.

"With him being an admiral, that also shows his leadership style and the type of person that he is," Delgado said. "You don't make admiral just willy nilly."

Outside San Antonio's Audie Murphy Memorial VA hospital, Army veteran Melissa Cervantes was caught off guard by news that the VA would be getting a different leader

"I felt like Shulkin had more experience," Cervantes said. "I don't know anything about this one coming in."

Cervantes said she worries the change will affect quality of care for her and her husband, who's also a veteran.

"Everyone has different plans, agendas," Cervantes said. "You never know what the new person coming in is going to do, whether they care about veterans or not."

A White House official told CNN that Jackson will resign his commission and retire from active duty if he's confirmed as VA Secretary. In the interim, Robert Wilkie, the Undersecretary of Defense for Personnel and Readiness, will be the acting VA secretary.

This story was produced by the American Homefront Project, a public media collaboration that reports on American military life and veterans. Funding comes from the Corporation for Public Broadcasting and the Bob Woodruff Foundation.

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50 - Lubbock Avalanche-Journal: [Levelland native talks about nomination as head of VA](#)
(7 April, Karen Michael, 194k uvm; Lubbock, TX)

Levelland native Dr. Ronny Jackson -- the rear admiral who is President Donald Trump's nominee as secretary of the Department of Veterans Affairs -- knows he will someday be a veteran and his sons will be veterans.

"I'm going to be a vet one day soon. If I do get confirmed, I won't stay on active duty, I'll be a vet right away," Jackson said Thursday in a phone interview with the Avalanche-Journal, the first interview he did after being nominated.

Jackson, currently the physician to the president, noted that it's in his best interest and his children's best interest to do what is right for veterans. He is also a United States Navy rear admiral.

"I've been overseas, and I've been deployed in combat zones with Marines and soldiers and airmen and sailors, and I've seen first-hand what they go through, the injuries and the things they come home with. I've seen how that happens, and how devastating it is to them and their families. I just want to make sure that we do our part as a country and we let them know that we appreciate that and we take care of them," Jackson said.

Veterans are like anyone else -- they don't see themselves as entitled or eligible for anything that normal people don't expect, the VA nominee said. Veterans just want good quality care and they want to know that they have access to care.

"We owe the vets the absolute best care that's available out there," Jackson said.

The naval officer was appointed as a White House physician under President George W. Bush, whom he calls "Bush 43" to distinguish him from his father, President George H.W. Bush, whom Jackson calls "Bush 41". He served as First Lady Laura Bush's personal physician, and also spent a lot of time at the Bush ranch in Texas with the family.

"I was the first lady's assigned physician. I traveled everywhere she went," Jackson said. "She and I got along really well, as did President Bush and I, because we were all from Texas. Obviously I grew up just due north from where they grew up."

He continued as a White House physician under President Barack Obama, when several of the physicians who had seniority at the time left for a variety of reasons.

"I kind of got catapulted toward the top of the docs who were currently there, as far as seniority goes," Jackson said, noting that he was the deputy director of the White House medical unit for about a year before becoming director. Then Obama appointed him as his personal physician.

As a personal physician to the president, Jackson does not wait in his office for the president to have a medical problem.

"I take care of basically the entire White House compound. I oversee all of the care here," Jackson said, adding that over 18 acres, that's about 7,000 people.

"We do urgent care here, anybody who is injured or they are sick, they come see us. We do a lot of travel medicine, because, of course, we have a lot of travelers here, so immunizations and travel preparation, we do all of that," Jackson said. "And we do, basically, a lot of primary care as well, and I take care of and end up being a primary-care provider for most of the senior folks in the White House who work in the East Wing and the West Wing, the president's senior staff and cabinet members."

When Obama left in 2017, Jackson said he was ready to retire because he had 20-plus years in the military and a new administration was coming into the White House.

"Typically, anyone who's in an appointed spot in one administration, they won't carry on to the next administration, especially when it changes from one party to the other," he said.

"I made a lot of good relationships in the Bush 43 administration, and some of the people that were working on the Trump transition had been a part of the Bush 43 administration, and they knew me," Jackson said. "They talked to President Trump about it, and I talked about it with him, and he just immediately appointed me as his physician as well."

Some national critics have acknowledged that Jackson is a great doctor while also questioning his experience in management, particularly of a large agency like the VA.

"I've been in leadership school for 23 years now. ... And I've been able to rise to the level of an admiral, a flag officer in the Navy. I didn't just stumble into that. So I've gotten a lot of leadership

background, I've got a lot of leadership experience as a Navy officer, and I've got a lot of day-to-day leadership experience," he said. "You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions.

"I think I've got what it takes, and you know, I don't buy into that argument at all."

Despite his assertion that he didn't stumble into the VA nomination, Jackson said much of his life has been serendipitous.

When he started college, he never dreamed of going to medical school or becoming a doctor.

After taking classes at South Plains College and going on to Texas A&M in Galveston to pursue a degree in marine biology, Jackson found himself with a problem common to college students: he needed money. He applied for a job at the University of Texas medical school in Galveston as an autopsy assistant and found it interesting.

"It sounds a little bit gross, but you know, it was pretty educational. They would teach me a lot of stuff about different disease processes as we were doing an autopsy. That's what got me interested in medical school," Jackson said.

His mother, Norma, also told the A-J in a Jan. 26 story that her son had never wanted to be a doctor.

"He was fixing to graduate, and he called me and his daddy, and told us he had decided he wanted to be a doctor. And we thought, 'What in the world?' But anyway, he made a doctor, and we're glad for that," Norma Jackson said.

He didn't have any plans of joining the military, either, but didn't have money for medical school. Once he was admitted, he called a Navy recruiter who had told him to call back once he was admitted to a medical school, and he learned about a program in which he could be a Navy diver and a doctor.

"I really liked diving, so I signed on," he said.

He never dreamed of becoming a White House physician, but he was nominated by his specialty leader, who is responsible for all emergency medicine doctors in the Navy.

"I didn't even know the job existed," Jackson said. "I just got an email out of nowhere saying that I'd been nominated for a job at the White House. Luckily, it was on an old email account that I wasn't checking very often, but I saw it before the deadline, but only shortly before the deadline, maybe just four or five days."

He scrambled to get an application package in.

"I kind of cut a lot of corners," Jackson said.

But a few months later, he got an email out of the blue, and this one said he was one of three physicians selected for an interview. Unfortunately, it was 2005 and he was stationed in Iraq.

“Once again, I thought that was it -- this is where the road stops because I wasn’t going to be able to be back in D.C. for an interview, because I was once again in the middle of the desert,” Jackson said. But his supervisor wanted him to succeed.

That supervisor was Lt. Gen. John E. Wissler, who had been a military aide to Bush 41. Wissler summoned him to his office and told him to pack his bags for a flight on a transport plane full of broken helicopters back to the United States.

After a crazy few days in Washington D.C. , had to get a new suit because he’d lost 40 pounds in Iraq, and interviewed for three days at the White House. He got the job that launched him on an unthinkable trajectory to possibly get a seat on the president’s cabinet.

“I really haven’t planned my life out real meticulously. I’ve just kind of tried to enjoy what I’m doing and do a good job, and one think has led to another,” Jackson said.

Looking back at growing up in Levelland, Jackson said: It was an experience that I appreciate now more as I’ve gotten older and I’ve lived all over the world. Levelland and that part of West Texas is just a special place with people that are like nowhere else in the world,” Jackson said. “It instilled a lot of small town values with me that I’ve carried with me throughout my career. So you know, I can’t say enough good things about West Texas. I’m proud to be a West Texan.”

Jackson said he misses the people of Levelland, but not the sand storms and weather extremes. He remembers Levelland as a place that had only two restaurants: The Spot and The Chat ‘n’ Chew. He preferred The Spot, he said.

“It’s grown a little bit,” he said.

Those West Texas values probably led him into the Navy.

“My parents, they didn’t really have the money to fork over and help me pay for med school,” Jackson said. “My mom and dad kind of instilled in me, and I think a lot of other people when I was growing up in Levelland were the same way, they didn’t like to spend money they didn’t have.”

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51 - Tampa Bay Times: [Editorial: For the sake of Tampa Bay veterans, Senate should scrutinize Trump’s VA pick](#) (7 April, 4.8M uvm; Saint Petersburg, FL)

President Donald Trump’s decision to fire Veterans Affairs Secretary David Shulkin and to replace him with presidential physician Dr. Ronny Jackson has outsized ramifications for the Tampa Bay area, given the large number of veterans here and the expansive and unique role that two major VA health centers play on both sides of the bay. Whether Jackson is the right person for the job, or whether this amounts to yet another glaring example of gross cronyism in the Trump White House, remains to be seen. But the Senate needs to use the confirmation process to explore not only Jackson’s management ability but his vision for a health system that despite all its faults delivers critical care for millions of Americans.

Shulkin was an Obama-era holdover and his firing was no surprise, coming after a critical report in February by the VA inspector general’s office that faulted him for improperly accepting

Wimbledon tickets during an official trip to Europe last summer. Shulkin needs to answer for his conduct, but his bigger offense may have been to slow-walk the administration's efforts to privatize VA health care services. While Shulkin agreed to explore limited privatization in some service areas and markets, he also recognized that the VA delivered a unique level of care to a specialized patient base. He was widely lauded in his tenure for improving accountability in the VA's entrenched bureaucracy and for moving to modernize the VA's delivery of care.

Jackson has won admirers for his service under two presidents prior to Trump as White House physician and for his distinguished career in emergency medicine. His service with a trauma unit in Iraq certainly makes him familiar with and sensitive to the VA's patient profile and the vital role the agency plays in caring for wounded warriors. But what appears to have propelled him to a Cabinet nominee was Jackson's televised appearance this year strongly hailing Trump's physical condition. Having the president's confidence is invaluable. But it should reflect core competence in a nominee, not merely fealty to any single president.

Jackson's lack of management experience is an obvious concern for anyone hoping to lead the nation's largest integrated health care system. With more than 1,700 hospitals and other health care facilities, and nearly 40,000 providers, the VA is the second-largest federal department, and there is nothing automatic about delivering quality, responsive services to 20 million veterans. The VA has rebounded from the recent scandals of secret waiting lists, but its bureaucratic culture still protects many incompetent leaders and outdated practices that harm its quality of care. And that in turn has colored the VA's public narrative. For all its faults, the VA has been recognized in recent years for outperforming non-VA facilities in outpatient services. And in the most recent survey of customer satisfaction, released in February, VA patients rated their experience higher than did those who were treated in private hospitals.

The next secretary needs to recognize the unique role the VA plays in treating complex cases that involve the intersection of blunt physical trauma and post-traumatic stress. The next leader needs to recognize the challenge of meeting the evolving patient profile, as older veterans require more care and as younger ones cope with regaining physical and emotional skills necessary to get back into civilian life.

The agency also needs to plan for the special needs that veteran-heavy states like Florida — which ranks third in the nation's veteran population, with 1.6 million — are facing. With 200,000 veterans in Pinellas and Hillsborough counties alone, the VA needs to continue investing in a modern health care delivery system. The Senate should press Jackson on how he would fulfill this mission and examine his commitment to put the interests of veterans ahead of any political agenda by this administration.

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52 - Washington Post: [Ronny Jackson, Trump's pick for Veterans Affairs, may pass up \\$1 million to join the Cabinet](#) (8 April, Andrew deGrandpre, 43.9M uvm; Washington, DC)

President Trump's controversial nomination of Ronny L. Jackson to head the Department of Veterans Affairs has grown further complicated by the Navy physician's pending military promotion, which he could be forced to pass up — along with an estimated \$1 million in future retirement income — if confirmed for the Cabinet post.

Jackson, a one-star admiral and the president's White House doctor, was nominated by Trump for promotion to be a two-star admiral in the days leading up to VA Secretary David Shulkin's

departure late last month. The White House has said Jackson intends to remain on active duty until the Senate confirms him to become VA secretary, at which point he would retire from the service. A Navy spokesman said there's been no change in the admiral's duty status.

The dual nominations and a lack of clarity from the White House have left lawmakers flummoxed about how to proceed, said a Senate aide who spoke on the condition of anonymity to offer a candid assessment of Jackson's unusual circumstances. The situation is symptomatic of broader frustration on Capitol Hill, particularly among Senate Republicans, with the administration's contentious personnel moves. They have complained that the time and effort required to consider multiple Cabinet nominations — the top jobs at VA, the State Department and CIA all are pending — is an unwanted distraction during a challenging midterm election cycle.

"This whole situation is very much out of the norm," the Senate aide said. "There's some question here whether [Jackson's] flag officer nomination will move forward given his VA nomination. It's all TBD, because he can't serve in both positions concurrently, so it wouldn't make sense for the Senate to move the nominations concurrently."

The timing most likely is coincidental, as the military evaluates those eligible for promotion months before their nominations are sent to Congress.

[VA's acting secretary takes over: 'I don't think he has any idea what he's gotten himself into']

The White House did not respond to questions seeking clarity on whether it intends to deconflict Jackson's two nominations, if the admiral has discussed his pending promotion with Trump or if it's the president's goal for Jackson to be promoted before he joins the Cabinet.

The dilemma adds another dimension to Trump's surprising announcement that he had chosen Jackson, whose flattering assessment of the president's health was met with skepticism earlier this year, to lead the government's second-largest agency — and arguably its most challenged. His nomination stunned lawmakers, advocacy groups and former White House colleagues dubious of his qualifications or suspicious of Trump's desire to expand a program that enables veterans to seek medical care outside the VA network.

In an interview published over the weekend by the *Avalanche-Journal* in Lubbock, Tex., Jackson, a Texas native, pushed back against his critics and suggested that his military experience has prepared him for the challenges he would face leading such a sprawling and complex bureaucracy.

"I've been in leadership school for 23 years now," he told the newspaper, "... and I've been able to rise to the level of an admiral, a flag officer in the Navy. I didn't just stumble into that. So I've gotten a lot of leadership background, I've got a lot of leadership experience as a Navy officer, and I've got a lot of day-to-day leadership experience. You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life-and-death decisions.

"I think I've got what it takes, and you know, I don't buy into that argument at all."

Jackson is well liked inside the White House, where he's worked for the past 12 years, and he is respected by those who know him and have been in his care. Trump is said to have marveled at Jackson's January appearance in the White House briefing room, where he praised the

president's physical wellness and cognitive acuity. Before settling in Washington, Jackson was deployed to Iraq, where he led an emergency trauma unit responsible for treating troops grievously wounded during one of the war's most violent stretches.

He was surprised, however, by the president's offer to run VA, White House officials have said, and initially questioned whether, as a career Navy officer with limited managerial experience, he's an optimal candidate to lead an agency of more than 360,000 employees.

By all accounts, "he's an extremely sharp officer and a terrific doc," said Barry McCaffrey, a retired Army general who served as President Bill Clinton's drug czar. "If he retired from the military with two stars and went back to civilian life, he would have career prospects for sure. But after 12 years in the White House . . . the only qualification he has [to run VA] is the confidence of the president.

"I think it's 50-50 he is confirmed. And if he's confirmed, I have great empathy. Why would he succeed? The answer is: Because the president put him there."

Jackson's political views and his positions on key policy questions have not surfaced publicly, though he told the *Avalanche-Journal* that military veterans "want to know that they have access" to medical care.

"We owe the vets the absolute best care that's available out there," he said. It's unclear whether Jackson was weighing in specifically on the administration's drive to outsource more medical services. There is deepening concern among those who oppose that effort that the admiral won't stand up to those closest to Trump who have proposed the most aggressive measures. As such, it is believed Jackson will face a difficult confirmation.

Separately, a move to VA could entail financial sacrifice. As a Cabinet secretary, Jackson would earn a salary of \$210,000, though a pay freeze has the rate locked at \$200,000 through the end of this year. That's up significantly from the \$150,000 he earns as a one-star admiral and the \$170,000 he would make as a two-star, according to current Defense Department pay tables. But as a senior officer living in Washington, he also rates thousands of dollars annually in housing allowance plus other special incentive pay the military makes available to medical professionals.

In the long term, a higher rank would qualify Jackson for a more generous pension, which is determined in part by a service member's final pay grade and years of service. Assuming Jackson lives to age 90, the difference before taxes is \$6.4 million versus \$5.3 million, according to estimates based on the Defense Department's retirement pay calculator.

Specialists with First Command Financial Services, which offers financial planning and advice for the military community, independently verified these results at The Washington Post's request but cautioned that other variables could influence Jackson's decision-making in forgoing the promotion in favor of joining Trump's Cabinet.

For instance, he would probably boost his future marketability and earning power in the private sector if he can demonstrate success while running VA. Chief executives of major medical networks can command sizable salaries, and Jackson, 50, though of age to retire from the military, is at the outset of his prime earning years.

There's also the satisfaction that comes from working in service to the nation -and for those who've sacrificed on its behalf, said Arnold Punaro, a retired Marine general who also spent many years on the staff of the Senate Armed Services Committee, overseeing, among other matters, the promotion confirmation process.

"It's been my experience," Punaro said, "that senior military officers — like Admiral Jackson — aren't motivated by money. They're motivated by service. They're motivated by mission."

Senate leaders have not set a date for Jackson's confirmation hearing or a vote on his nomination for promotion.

This article was updated to include Jackson's comments to the Lubbock Avalanche-Journal.

Eric Yoder contributed to this report.

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53 - USA Today (Video): [VA pick Ronny Jackson: 'I've got what it takes' to lead the troubled agency](#) (8 April, Donovan Slack, 36.8M uvm; McLean, VA)

President Trump's pick to lead the Department of Veterans Affairs is dismissing concerns that he lacks the experience necessary to take over the massive agency, which has more than 300,000 employees and 1,200 medical facilities.

Ronny Jackson, a Navy rear admiral, has been a White House physician since 2006 but has little executive management experience.

"You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions," he told the Lubbock Avalanche-Journal in his first interview since Trump announced his intent to nominate Jackson March 28. "I think I've got what it takes, and you know, I don't buy into that argument at all."

"Dr. Ronny," as colleagues call him, rose to national prominence in January when he conducted a White House press conference after giving the president a check up and mental acuity exam and proclaimed Trump's "overall health is excellent." But little has been publicly reported beyond his official bio on the Pentagon website.

For that reason, some lawmakers and veterans' groups have said they are withholding judgment on his nomination to be VA secretary.

"Dr. Jackson's bio does not reflect any experience working with the VA or with veterans, or managing any organization of size, much less one as multifaceted as the Department of Veterans Affairs, so the VFW will be closely monitoring his Senate confirmation process," the Veterans of Foreign Wars said in a statement.

Trump announced his intent to nominate Jackson in a tweet March 28. At the same time he fired David Shulkin from the secretary's post, saying he wasn't happy with the pace of improvements to the VA and wanted veterans to have more options for private care.

Shulkin wrote in an op-ed at the time that he believed he was removed because he refused to privatize the agency. He told USA TODAY that he believes Jackson can do the job if he builds the right team around himself.

Jackson, in his interview with the Lubbock Avalanche-Journal, did not outline his views on giving veterans more options to get VA-sponsored health care in the private sector. But he said, "We owe the vets the absolute best care that's available out there."

"I've been overseas, and I've been deployed in combat zones with Marines and soldiers and airmen and sailors, and I've seen first-hand what they go through, the injuries and the things they come home with," Jackson said.

"I've seen how that happens, and how devastating it is to them and their families. I just want to make sure that we do our part as a country and we let them know that we appreciate that and we take care of them."

The VA has been buffeted by scandal since 2014, when news reports revealed veterans had died waiting for appointments in Phoenix while schedulers kept secret wait lists masking how long they were waiting.

Since then, USA TODAY has reported on poor quality of care, misdiagnoses, supply shortages and failures in hiring and firing medical providers, among other problems that still plague the VA.

If confirmed, Jackson will be the fourth VA secretary in four years.

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54 - CNN (Video): [Trump's VA pick says he's 'got what it takes' to be secretary](#) (8 April, Devan Cole, 29.8M uvm; Atlanta, GA)

Ronny Jackson, President Donald Trump's physician and pick for secretary of the Department of Veterans Affairs, said in his first interview since being nominated that he's "got what it takes" to lead the department.

In a Sunday profile of Jackson in the Lubbock Avalanche-Journal, a newspaper located near Jackson's hometown of Levelland, Texas, the White House doctor said: "I've been in leadership school for 23 years now. ... And I've been able to rise to the level of an admiral, a flag officer in the Navy. I didn't just stumble into that. So I've gotten a lot of leadership background."

"You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions," Jackson told the paper.

Jackson, whom Trump picked to be the VA's next secretary last month, first worked in the White House under President George W. Bush, where he was assigned to care for first lady Laura Bush. After Bush left office, then-President Barack Obama appointed Jackson as his own physician, and he maintained the role under Trump.

Jackson, a rear admiral, told the paper that former Bush employees who were on the Trump transition team helped him keep his job under Trump.

"Some of the people that were working on the Trump transition had been a part of the Bush 43 administration, and they knew me," Jackson told the paper. "They talked to President Trump about it, and I talked about it with him, and he just immediately appointed me as his physician as well."

If confirmed, Jackson said he "won't stay on active duty, I'll be a vet right away." His predecessor, who was dismissed by Trump last month, was not a veteran, which was widely noted after he was nominated in 2017.

According to the paper, Jackson noted in his interview that it's in "his best interest and his children's best interest to do what is right for veterans."

"We owe the vets the absolute best care that's available out there," Jackson said.

CNN's Kevin Liptak contributed to this report.

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55 - The Hill: [Trump VA nominee: 'I think I've got what it takes'](#) (8 April Mallory Shelbourne, 11.9M uvm; Washington, DC)

President Trump's nominee to take over the Department of Veterans Affairs (VA) said in a new interview that he has "what it takes" to lead the agency.

"You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions," Rear Adm. Ronny Jackson, who currently serves as the White House physician, told the Lubbock Avalanche-Journal.

"I think I've got what it takes, and you know, I don't buy into that argument at all."

Trump announced Jackson as his choice to serve as the new VA secretary late last month in a tweet, in which he also announced the departure of embattled Secretary David Shulkin.

"I am pleased to announce that I intend to nominate highly respected Admiral Ronny L. Jackson, MD, as the new Secretary of Veterans Affairs," Trump wrote on Twitter on March 28.

"In the interim, Hon. Robert Wilkie of [the Department of Defense] will serve as Acting Secretary. I am thankful for Dr. David Shulkin's service to our country and to our GREAT VETERANS!"

Shulkin later claimed he did not resign from the position, though the White House maintains he stepped down from his post.

Senators have said they look forward to hearing from Jackson as he goes through the confirmation process.

Jackson told the Texas newspaper that veterans deserve "the absolute best care that's available out there."

"I just want to make sure that we do our part as a country and we let them know that we appreciate that and we take care of them," he told the Journal.

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56 - The Hill: [Senate braces for showdown over Trump's nominees](#) (8 April, Jordain Carney, 11.9M uvm; Washington, DC)

The Senate is barreling toward a showdown over President Trump's latest Cabinet shuffle, with three critical departments looking for new leaders and more that could follow.

Republicans are preparing for a weeks-long battle as they try to confirm CIA Director Mike Pompeo to be secretary of State and CIA deputy director Gina Haspel to succeed him.

Haspel's nomination in particular is controversial, and the GOP has little margin for error given Sen. Rand Paul's (R-Ky.) opposition to both of Trump's picks.

"I mean that's going to take a lot of floor time," Sen. John Thune (R-S.D.), the No. 3 Senate Republican, told The Hill. "Who knows how long and how much the Democrats are going to want to weigh in with some of those. But it will for sure be time consuming. That's not going away."

Senators also will need to consider Ronny Jackson, the top White House physician, to replace David Shulkin as Department of Veterans Affairs secretary.

GOP senators have largely remained mum over Jackson's nomination, which has come under scrutiny given the physician's lack of experience in running a large bureaucratic organization.

"I've never met him, don't know him. And what I do know does suggest that he needs to demonstrate that he has the qualifications, the capabilities despite the lack of experience," Sen. Jerry Moran (R-Kansas), a member of the Senate Veterans Affairs Committee, told NPR.

Nominations need just a simple majority to clear the Senate. But with a fragile 51-seat grip on the chamber, Republicans have no room for error.

Democrats haven't signaled if they will unanimously vote against the three nominees.

The White House, GOP leadership and outside groups are expected to pressure red and purple state Democrats up for reelection to vote for Trump's picks, and there's reason to think some Democrats could see reason to vote for one or more of the nominees.

Haspel is seen as facing a more challenging confirmation battle than Pompeo, as several key Republican senators remain on the fence.

Sen. John McCain (R-Ariz.), who has been absent from Washington for months as he battles brain cancer, wants Haspel to detail her views and involvement on Bush-era "enhanced interrogation techniques," which are now widely viewed as torture, saying the issue is critical to the Senate's consideration of her nomination.

Director of National Intelligence Dan Coats would not commit to fully declassifying all information on Haspel's involvement in the techniques but said "every effort will be made to fully explain exactly what her role was and what wasn't."

Outside groups and advocates are already gearing up for an intense fight.

Dozens of former Pompeo staffers released a letter on Friday urging support for his nomination. The letter said that Pompeo had "never shied away from speaking the truth" and that his "leadership at State will empower American diplomacy, strengthen America's influence and make the world a better place."

Progressive and human rights groups want the Senate to reject Haspel's nomination over her role in interrogations at a so-called black site prison and the destruction of videotapes documenting the waterboarding sessions of an al Qaeda suspect there.

Several Democratic senators—including Sen. Ron Wyden (D-Ore.), a member of the Senate Intelligence Committee—have already come out against her.

The Senate Intelligence Committee hasn't yet scheduled a hearing date for Haspel.

Pompeo is scheduled to testify before the Senate Foreign Relations Committee on Thursday. Aides to several Democratic senators on the panel noted their bosses are also expected to meet privately with him.

The fight comes as Republicans and Democrats bicker over the length of time it has taken to consider Trump nominees.

Under the rules, senators can force up to 30 hours of post-cloture debate time, eating up days of Senate floor time. It has taken Trump's nominees an average of 84 days to be confirmed, according to a tracker from The Washington Post and the Partnership for Public Service.

Changing the rules to speed up votes for Trump's nominees has been under discussion among Senate Republicans for roughly a year.

GOP Sen. James Lankford's (Okla.) proposal would cut down debate time from 30 hours to eight hours for most nominations once they've overcome an initial hurdle that shows they have the simple majority to pass. Most Cabinet-level nominations would not qualify for the shorter debate time under Lankford's proposal.

A GOP aide told The Hill that the proposal could see movement in the Rules Committee in May. Sen. Roy Blunt (R-Mo.), the next chairman of the committee, predicted the proposal will get a vote, adding that "Republicans have every right to be offended by the way the rules have been abused."

Republicans are putting the fight over Trump's nominees at the center of their messaging heading into the 2018 election.

"Even if we were to lose the House and be stymied legislatively, we could still approve appointments, which is a huge part of what we do," Majority Leader Mitch McConnell (R-Ky.) told the Kentucky Today editorial board.

It's unlikely that the current slate of confirmation fights will be the final Cabinet shakeup senators face amid speculation that several officials—including EPA Administrator Scott Pruitt, Attorney General Jeff Sessions and Housing and Urban Development Secretary Ben Carson—could be next on the chopping block.

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57 - Washington Examiner: [VA pick Ronny Jackson: 'I've got what it takes'](#) (8 April, Kelly Cohen, 4.8M uvm; Washington, DC)

The man picked by President Trump to take over as head of the Department of Veterans Affairs says he's "got what it takes" to lead the troubled agency.

"I think I've got what it takes, and you know, I don't buy into that argument [that I lack experience] at all," Ronny Jackson said in a profile of him published in the Lubbock Avalanche-Journal on Sunday.

The Texas native was appointed to be the doctor to the president by former President Barack Obama in 2013, and retained by President Trump. Last month, Trump announced he planned to replace David Shulkin with Jackson as the VA secretary.

"I've been in leadership school for 23 years now. ... And I've been able to rise to the level of an admiral, a flag officer in the Navy. I didn't just stumble into that. So I've gotten a lot of leadership background, I've got a lot of leadership experience as a Navy officer, and I've got a lot of day-to-day leadership experience," Jackson told the newspaper.

He added: "You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions."

Jackson, a Navy rear admiral, first worked in the White House under former President George W. Bush. He told the paper that former Bush employees who were on Trump's presidential transition team helped him remain in his role in the Trump administration.

"Some of the people that were working on the Trump transition had been a part of the Bush 43 administration, and they knew me," Jackson explained. "They talked to President Trump about it, and I talked about it with him, and he just immediately appointed me as his physician as well."

Jackson also said he "won't stay on active duty" and will "be a vet right away."

"I've been overseas, and I've been deployed in combat zones with Marines and soldiers and airmen and sailors, and I've seen first-hand what they go through, the injuries and the things they come home with. I've seen how that happens, and how devastating it is to them and their families. I just want to make sure that we do our part as a country and we let them know that we appreciate that and we take care of them," he said.

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58 - The Hill: [Senate uncertain how to proceed on dual Trump nominations for White House physician: report](#) (8 April, Brett Samuels, 11.9M uvm; Washington, DC)

VA-18-0457-A-000992

Some lawmakers are unsure how to proceed with President Trump's pick for Veterans Affairs secretary because he also has a pending military promotion, The Washington Post reported Sunday.

Trump nominated Rear Adm. Ronny Jackson to be promoted from a one-star admiral to a two-star admiral just days before the president ousted Veterans Affairs Secretary David Shulkin. Trump named Jackson as Shulkin's replacement, pending Senate confirmation.

However, the timing of the two nominations has created confusion on how to proceed, The Washington Post reported. To lead the VA, Jackson may be forced to give up his military promotion and roughly \$1 million in future pension earnings.

The White House has said Jackson will remain on active duty until he is confirmed to run the VA. However, the White House did not respond to inquiries from the Post about whether it will address Jackson's conflicting nominations.

Jackson, who has served as the presidential physician since 2013, has drawn criticism from outside groups and some lawmakers who worry he does not have the managerial experience to run an operation as large as the VA.

The White House brushed aside those concerns, saying Trump has "full confidence" in Jackson to replace Shulkin.

Shulkin was fired amid intense scrutiny after an inspector general report found he spent most of his time during a trip to Europe last summer sightseeing rather than conducting official business and improperly accepted tickets to a Wimbledon tennis match as a gift.

Following his ouster, Shulkin defended his tenure, speculated he was pushed out because he opposed privatization and railed against the "toxic" atmosphere in Washington.

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59 - Military Times: [VA secretary nominee brushes off criticism over inexperience](#) (9 April, Leo Shane III, 2.1M uvm; Springfield, VA)

President Donald Trump's pick to take over the Department of Veterans Affairs downplayed his management inexperience in his first public interview since his nomination, saying his time in the military has honed his leadership skills.

Dr. Ronny Jackson, who has served as White House physician since 2006, told the Lubbock Avalanche-Journal of Texas, his hometown newspaper, that he has heard the criticism concerning his ability to take over the nearly \$200 billion department with 385,000-plus employees.

But he remains undeterred.

"I've been in leadership school for 23 years now ... and I've been able to rise to the level of an admiral, a flag officer in the Navy," he said. "I didn't just stumble into that. So I've gotten a lot of

leadership background, I've got a lot of leadership experience as a Navy officer, and I've got a lot of day-to-day leadership experience

"You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions."

Jackson was a surprise pick as the next VA secretary, following the dismissal of David Shulkin from the role last month.

He is an Iraq war veteran who deployed as an emergency medicine physician with the Surgical Shock Trauma Platoon in Taqaddum, Iraq, in 2005. He served as the White House doctor for Trump and also former presidents George W. Bush and Barack Obama, directing health care for not only the commander in chief but their senior staff and Cabinet officials.

Jackson told the *Avalanche-Journal* he had planned to retire from the military after Obama's presidency ended, but Trump convinced him to stay on staff. Now, he's poised to make the move from leading a small medical staff at the White House to a Cabinet secretary post.

He acknowledged it's a promotion he never expected.

"I really haven't planned my life out real meticulously," he told the paper. "I've just kind of tried to enjoy what I'm doing and do a good job, and one thing has led to another."

Jackson still has not retired from the military, but White House officials said he intends to do so as his confirmation process progresses. Active duty military officers cannot serve in Cabinet roles.

Although not a veteran yet himself, Jackson said he is familiar with the needs of his fellow service members and is focused on delivering "the absolute best care" to them.

"I've been overseas, and I've been deployed in combat zones with Marines and soldiers and airmen and sailors, and I've seen first-hand what they go through, the injuries and the things they come home with," he said.

"I've seen how that happens, and how devastating it is to them and their families. I just want to make sure that we do our part as a country, and we let them know that we appreciate that and we take care of them."

No timetable has been set for Jackson's confirmation hearings.

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60 - ConnectingVets: [IAVA hopes VA Secretary nominee is the right choice](#) (9 April, Eric Dehm, 24k uvm; New York, NY)

The maelstrom continues to swirl atop the Department of Veterans Affairs. Shulkin is out, Wilkie is the acting secretary and Rear Admiral Ronny Jackson came out of left field as President Trump's nominee to permanently fill the position.

It's been a wild few weeks in regards to veteran issues on Capitol Hill, and Iraq and Afghanistan Veterans of America (IAVA) has been closely watching as it has all unfolded. Chief Policy

Officer Melissa Bryant says the organization has concerns over recent events, but maintains hope that it will all work out in the best interests of veterans.

During an appearance on the Morning Briefing, Bryant said the upcoming hearings on Admiral Jackson's nomination should shed quite a bit of light on the nominee's qualifications, and his vision for the future of the VA. At this point, Bryant believes it unfair to reach any conclusion on Jackson as there's simply not enough information available on him and until his thoughts on important matters like privatization are known, IAVA will maintain a "wait and see" approach to the presidential physician's nomination.

Bryant's full interview, focusing on the VA and other issues like the omnibus spending bill and IAVA's "Big 6" legislative items is available below.

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61 - **ConnectingVets:** [VA pick Ronny Jackson says he's up for the job](#) (9 April, Matt Saintsing, 24k uvm; New York, NY)

President Donald Trump's pick to lead VA wants veterans to know he's up to the task and is dismissing fears he's not qualified to lead the second largest government agency, one with more than 300,000 employees.

Randy Jackson certainly has the medical chops as a Navy doctor, but veterans groups were largely caught off guard when Trump tweeted his intent to nominate him as Secretary of Veterans Affairs. In his first media appearance since Trump nominated him, Jackson says he's more than just a Naval officer.

"You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life and death decisions," Jackson told the Lubbock Avalanche-Journal.

"I think I've got what it takes, and you know, I don't buy into that argument at all."

Trump announced his intent to nominate Jackson March 28 in a tweet, citing his displeasure with the slow pace of improvements under David Shulkin's tenure.

Shulkin penned an op-ed the day after he was fired taking to task what he calls the administration's attempt to privatize the agency. However, Shulkin told USA TODAY that he believes Jackson can do the job, but he has to build the right team around himself.

In his interview with the Avalanche-Journal, Jackson didn't outline any policy or his views on how best to give veterans care. He did say, however, that "we owe the vets the absolute best care that's available out there."

"I've been overseas, and I've been deployed in combat zones with Marines and soldiers and airmen and sailors, and I've seen first-hand what they go through, the injuries and the things they come home with," said Jackson.

The VA has been beleaguered by scandals since 2014, when it was revealed veterans had died while waiting for appointments at a VA clinic in Phoenix, Ariz.

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If confirmed, Jackson will be the fourth Secretary of Veterans Affairs in four years.

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62 - Becker's Hospital Review: [How a military promotion could complicate Dr. Ronny Jackson's VA nomination](#) (9 April, Leo Vartorella, 441k uvm; Glencoe, IL)

President Donald Trump's nomination of White House physician Ronny Jackson, MD, to lead the Department of Veterans Affairs has been complicated by his simultaneous promotion to two-star admiral, according to The Washington Post.

President Trump nominated Dr. Jackson for the promotion in late March, but he cannot stay on active duty and also direct the VA. A Senate aide told The Washington Post that lawmakers are confused on how to proceed with the dual nomination tasks. Dr. Jackson will retire from active duty upon assuming the role of VA secretary, but he stands to gain nearly \$1 million in pension benefits if the Senate confirms his promotion before retiring.

"This whole situation is very much out of the norm," the unnamed Senate aide told The Washington Post. "There's some question here whether [Dr. Jackson's] flag officer nomination will move forward given his VA nomination. It's all [to be determined], because he can't serve in both positions concurrently, so it wouldn't make sense for the Senate to move the nominations concurrently."

Dr. Jackson's nomination has faced criticism over his lack of formal management experience, but he believes his military career has adequately prepared him for the job's responsibilities.

"I've been in leadership school for 23 years now," Dr. Jackson told the Lubbock Avalanche-Journal, ". . . and I've been able to rise to the level of an admiral, a flag officer in the Navy. I didn't just stumble into that. So I've gotten a lot of leadership background, I've got a lot of leadership experience as a Navy officer, and I've got a lot of day-to-day leadership experience. You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life-and-death decisions."

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63 - Task & Purpose: [Trump's VA Pick Faces A Dilemma Most Troops Would Love To Have](#) (9 April, Adam Weinstein, 102k uvm; New York, NY)

I'm about to suggest something that would've been unthinkable to me as an E-3: Put yourself in the admiral's shoes.

You're 23 years into a terrific career as a naval physician. For 12 of that, you've been the president's doctor, administering checkups to three very different POTUSes — high-stakes business, sure, but you've been doing it longer than most service members do anything.

You've got a star on your shoulder, and you've just been selected to collect a second one... along with a nice bump to \$14,268.30 in base monthly pay — which would also add a welcome

boost to your already-rich retirement pension, whenever you feel like actually retiring. You're a spry 50, so no need to worry about that just now.

But then a president asks you to do a daunting job you have no hard experience for: joining his Cabinet to run the Department of Veterans Affairs, the nation's second-largest publicly funded institution. You'll face a tough Senate confirmation. If confirmed, you'll enter a snake's nest of competing interests and ponderous bureaucracies, where your standing with the POTUS who hired you is in doubt from day to day.

Also, you'll have to forgo that second star and retire from the only organization that's employed you since med school. Like, now.

Such is the dilemma that Rear Adm. (lower half) Ronny Jackson, U.S. Navy, faces this week, as he prepares for Senate hearings about his nomination to run VA.

Jackson, a highly respected physician, first garnered headlines when he declared after President Donald Trump's first physical that the portly POTUS "might live to be 200 years old... He has incredibly good genes, and it's just the way God made him." Whatever else may have transpired between Jackson and Trump since then, the boss evidently has the impression that Jackson's got the right stuff to run 1,250 hospitals and clinics serving 9 million veterans across the U.S.

We should have such problems, you say: Take the extra star and the \$171,000 admiral's salary, or get out with an annual retirement of more than \$50,000 to take a prestigious six-figure job working directly for the president of the United States?

Of course, there's a lot more to it than money. Here are three reasons Jackson isn't living the dream, so much as facing a nightmare:

His choice isn't really a choice.

You're an active duty military officer, and the president asked you point blank to do a thing that is neither illegal nor immoral. Could you really say no? Perhaps, but most officers wouldn't, even if they hated the proposal. And though he's all in, it's not at all clear where Jackson really stands on his job offer; White House sources tell the Washington Post that the admiral "initially questioned whether, as a career Navy officer with limited managerial experience, he's an optimal candidate to lead an agency of more than 360,000 employees."

He's being set up for failure.

Lately, Jackson's been expressing enthusiasm about the job Trump offered him. "I've been able to rise to the level of an admiral, a flag officer in the Navy. I didn't just stumble into that," he told a hometown paper when asked what qualified him to run VA. "I think I've got what it takes." That's undoubtedly true! But far more politically savvy hospital administrators and CEO types — like David Shulkin and Robert McDonald — have been smashed by the daily grind of nervous veterans' groups, rattled civil servants, and strident political lobbyists who cloy the VA secretary on a daily basis. The uniform provided Jackson a modicum of safety: Tell your truth and take your orders. (Not that it did Lt. Gen. H.R. McMaster any good.) Now you're a civilian, and you going to have to bring bad news the president's way — with a lot more at stake than another star.

He's probably not gonna make it that far.

Nominating a sitting flag officer to run VA is largely unprecedented — Gen. Omar Bradley did it after World War II, until pro-privatization vets' groups pushed him out in 1946 — and nominating a flag officer with a promotion pending before the Senate has caused a bunch of procedural problems that the Trump administration doesn't seem to care about, leaving “lawmakers flummoxed about how to proceed,” one Senate aide suggested to the Washington Post. “There's some question here whether [Jackson's] flag officer nomination will move forward given his VA nomination. It's all TBD, because he can't serve in both positions concurrently, so it wouldn't make sense for the Senate to move the nominations concurrently.” Senators are already expected to squeeze Jackson hard, on television, on his qualifications and preparations for a Cabinet post. The pending promotion just gives them another reason to question whether the VA post is the best use of Jackson's talents — and whether the White House that tapped him has its crap together.

In the end, this grunt's dream — which prestigious six-figure gig to take? — is a career officer's nightmare: Jackson could avoid an iffy nomination and a thankless job while collecting a \$25,000-a-year promotion... but that would require him to say “No, sir” to a president. So far, Jackson's doing what you'd expect a career officer to do: trying to polish this turd. For his sake and the sake of vets all over America, here's hoping that shit will keep a shine for a while.

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64 - Washington Post: [Senate Republicans express concerns about Trump's choice to lead Veterans Affairs](#) (11 April, Seung Min Kim, 43.9M uvm; Washington, DC)

Ronny L. Jackson, President Trump's choice to lead the Department of Veterans Affairs, is facing mounting skepticism from Senate Republicans over whether he has the management experience to lead the nation's second-largest bureaucracy.

The comments from several GOP senators, particularly those with influence on veterans' issues, signal Jackson will have to work overtime to convince not just Democrats but Trump's own party that he is qualified to oversee the beleaguered agency. That challenge comes at a time when Senate Republicans are already juggling other controversial nominations that will consume much of the political oxygen on Capitol Hill.

Jackson has served three administrations under both parties as the White House physician yet has little management experience on his résumé as he gears up to take over a sprawling agency of 360,000 workers and deal with the vexing challenges of providing health care and benefits to military veterans. Republicans say they know little to nothing about Jackson and are quickly studying up as they prepare for one-on-one meetings with the nominee.

“Certainly, I do have concerns about his experience, as far as managing people,” said Sen. John Boozman (R-Ark.), who sits on the Senate Committee on Veterans' Affairs, which will vet Jackson's nomination. “There is some concern about whether he's been in a position to lead an organization like that.”

Sen. Jerry Moran (R-Kan.), another committee member, also expressed worries about Jackson.

White House physician Ronny L. Jackson is facing questions about whether he has the right experience to lead the Department of Veterans Affairs. (Jabin Botsford/The Washington Post)

“The VA is a difficult place to manage, regardless of what your background experience is. I want to know more about how he believes that he’s capable of fulfilling those responsibilities, and I have a wide array of questions in regard to his experience and background,” Moran said. “I need to be convinced that he can make a difference at a department in which the culture and the upper echelons of its leadership need to have somebody who can take charge.”

At best, Jackson is getting a tepid reaction from Senate Republicans, many of whom had praised his ousted predecessor, David Shulkin, even if they occasionally clashed with him over policy. Democrats were also vocal supporters of Shulkin, the sole Cabinet holdover from the Obama administration and who was the rare Trump-appointed official who sailed through the Senate with no objections.

A White House spokesman did not return a request for comment Tuesday on the Senate Republicans’ concerns surrounding Jackson’s qualifications. But the White House has defended Jackson’s credentials in the past, and the physician himself laid out his leadership background in an interview with a local newspaper in Texas published over the weekend.

“I’ve been in leadership school for 23 years now. . . . And I’ve been able to rise to the level of an admiral, a flag officer in the Navy. I didn’t just stumble into that,” he told the Lubbock Avalanche-Journal.

He added: “I think I’ve got what it takes, and you know, I don’t buy into that argument at all.”

Democrats are also questioning whether Jackson can handle oversight of the massive bureaucracy, which is second only to the Pentagon in size. And they’re making it clear that Jackson’s nomination will be intertwined with the broader fight about whether veterans should have more access to private doctors at taxpayers’ expense.

Shulkin had worked with senators on a bipartisan compromise that would largely keep VA in control if veterans can obtain private health care, while removing some restrictions. But the White House has pushed for a more aggressive turn toward privatization, which has alarmed Democrats and some veterans’ groups who worry about outsourcing so much of veterans’ care.

Sen. Patty Murray (D-Wash.) said she wants to hear from Jackson that he is “unequivocally opposed to privatization.”

“This is also a concern across the board, from all sides and from the veterans organizations that want to see a VA that was promised to them,” Murray said. “We don’t want to send the millions of veterans out into a system where the doctors meeting them may not be qualified.”

Compounding the challenges for the Trump administration is that Jackson is just one of a handful of Cabinet vacancies that the Senate is suddenly facing after a recent wave of dismissals and resignations.

Republicans are scrambling to quickly install Mike Pompeo as secretary of state. His nomination to be CIA director was supported by 15 members of the Senate Democratic Caucus last year, but he will face a much more sharply partisan confirmation battle to become the nation’s chief diplomat. Gina Haspel’s nomination to succeed Pompeo at the CIA will be a greater challenge for the administration, with both Democrats and Republicans raising questions about her involvement in the agency’s “enhanced interrogation” program, which critics say is tantamount to torture.

Both nominees are already facing opposition from Sen. Rand Paul (R-Ky.). Pompeo's confirmation hearing is scheduled for Thursday. Haspel's paperwork has yet to be submitted to the Senate and a hearing is not on the books. Jackson's hearing has yet to be scheduled.

Senators are also carefully watching the controversies surrounding Scott Pruitt, the embattled administrator of the Environmental Protection Agency, which would be another challenging vacancy to fill in an election year.

Republican lawmakers are much more eager to focus on touting their legislative accomplishments, such as the recently passed tax law, rather than grueling confirmation battles that will only ignite partisan tensions in the Senate.

"The confirmations, they're important," Moran said. "But it is very difficult for us to deal with other issues, any things that are pending, that are important to the country when we're consumed with confirmations, and confirmations that are ones that we had confirmed within the last year or so. And so it reduces the time in which we have to pursue other important issues for the country."

"It would be good to have consistency [among the Cabinet secretaries] to develop the relationships on Capitol Hill," said Sen. Mike Rounds (R-S.D.). "I think today, that is lacking with this administration."

Senate Republicans and the White House have hammered Democrats, most recently this week, for stalling key administration nominees. But by adding more Cabinet-level picks to the Senate's to-do list, the administration is only further delaying consideration of those lower-level picks.

The White House keeps a list of nominees that ranks each of them by priority, according to one GOP official familiar with the tally. Once Cabinet-level nominations are moved to the top, it moves other picks down, potentially for months, the official said.

Sen. Jon Tester (Mont.), the top Democrat on the veterans' committee, said he urged Jackson to submit his paperwork to the Senate soon so a review of his qualifications can begin.

"I think both the management experience as well as his view on where he wants to take VA is really going to be important," Tester said. "I'm very concerned about VA right now."

When asked if he believes Jackson is qualified to run the agency, Sen. Johnny Isakson (R-Ga.), who chairs the veterans' committee, said, "I don't know enough to know anything."

"I'm a blank slate," said Isakson, who has spoken on the phone with Jackson. Senate Majority Leader Mitch McConnell (R-Ky.) has yet to comment on Jackson's nomination.

Sen. Thom Tillis (R-N.C.), a member of the veterans' committee, also said he has yet to make a judgment on whether Jackson is qualified. Sen. Dan Sullivan (R-Alaska), a fellow committee member, said he wants to question Jackson about "his experience, or lack thereof, on the management side."

"That's the most difficult, frustrating bureaucracy in Washington," Sullivan said. "I think most people would absolutely agree with that."

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65 - The Hill: [VA privatization fight could erupt in confirmation hearing](#) (11 April, Nathaniel Weixel, 11.9M uvm; Washington, DC)

Long-simmering tensions about privatizing the Department of Veterans Affairs (VA) could erupt into a confirmation battle over President Trump's pick to lead the department.

Trump's decision to oust former VA Secretary David Shulkin late last month and replace him with White House physician Ronny Jackson stoked speculation that the White House wants to allow veterans more access to private-sector health-care providers.

In an op-ed published in The New York Times just hours after he was removed, Shulkin blamed his ouster on forces within the administration that he said are pushing hard for privatization "The advocates within the administration for privatizing VA health services ... saw me as an obstacle to privatization who had to be removed," Shulkin wrote.

Dismantling the department's health-care system "is a terrible idea," Shulkin wrote, adding that the private sector "is ill-prepared to handle the number and complexity of patients that would come from closing or downsizing VA hospitals and clinics."

Groups like the Koch brothers-backed Concerned Veterans for America (CVA) are pushing to loosen current restrictions on veterans receiving private-sector care.

Democrats and veterans' advocates are concerned that the White House is taking those calls for privatizing the VA system seriously, but the VA denied last week that there is any push to privatize its health system.

"There is no effort underway to privatize VA, and to suggest otherwise is completely false and a red herring designed to distract and avoid honest debate on the real issues surrounding veterans' health care," the agency said in a statement.

Democrats and veterans' advocacy groups have been wary of Republican efforts to privatize the VA since before Trump took office.

In a 2016 campaign rally in Virginia Beach, Trump called the VA corrupt and inefficient.

"Veterans should be guaranteed the right to choose their doctor and clinics, whether at a VA facility or at a private medical center," Trump said. "We must extend this right to all veterans."

Senate Democrats and veterans groups have not yet drawn any hard lines against Jackson, partly because they said they don't know what his positions are.

Verna Jones, the executive director of the American Legion, said she would have to sit down and speak with Jackson before passing judgment on his nomination.

"It seems like people are putting the cart before the horse. Jackson hasn't had a confirmation and none of us know his views," Jones said. "To be clear, the Legion opposes privatization. How all this ties into Jackson — we owe it to him to wait and see."

Jackson is an active-duty Navy admiral who has worked as the White House physician for three presidents. Lawmakers have expressed skepticism over whether Jackson, who doesn't have experience working with the VA or managing a health-care organization, has the qualifications to run the agency.

Senate Democrats on the Veterans' Affairs Committee said they also don't know where Jackson stands on privatization. Still, they don't trust the administration's motives and are gearing up for a fight.

Sen. Jon Tester (D-Mont.), the ranking Democrat on the committee, told The Hill he has only had a brief phone call with Jackson since Trump nominated him for the position.

"There are two areas of concern ... one is privatization and the other is management. So that's what we're going to focus on," Tester said.

"Our job is to strengthen the VA in order to provide high-quality care to our veterans, not dismember it," Sen. Bernie Sanders (I-Vt.) said in a statement. "The Senate Committee on Veterans Affairs should not approve any nominee for secretary who supports the privatization of the VA."

Sen. Richard Blumenthal (D-Conn.) told The Hill privatization is a "serious concern" that he hopes to address with Jackson.

A spokeswoman for the VA committee said a hearing would be scheduled as soon as Jackson submits his paperwork and finishes a background check.

Jackson's nomination could also spotlight legislation that is intended to make it easier for veterans to get care outside the VA system without completely privatizing the system.

The legislation from Tester and Senate Veterans' Affairs Committee Chairman Johnny Isakson (R-Ga.) has backing from major veterans groups such as the American Legion and Veterans of Foreign Wars.

The bill would overhaul VA Choice, a temporary program that allows veterans to seek care outside the VA network — but only in cases where they have to wait more than 30 days for an appointment or drive more than 40 miles to a facility.

It would eliminate the waiting period and distance requirements and allow veterans to seek community care outside the VA if veterans and their providers agree it's the best method of treatment.

But the Koch-backed CVA has lobbied hard against it, because they think it doesn't loosen regulations enough.

Opposition has also come from the left. House Democrats blocked the bill from being included in the omnibus funding bill that passed last month because they think it moves the VA too far toward privatization.

A Senate VA committee aide said Isakson has spoken to Majority Leader Mitch McConnell (R-Ky.), and hopes to bring the bill to the floor for a stand-alone vote in the next few weeks.

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66 - American Thinker: [VA privatization debate could derail new secretary's confirmation](#)
(11 April, Rick Moran, 4.8M uvm; El Cerrito, CA)

When Donald Trump fired his secretary of Veterans Affairs, David Shulkin, and named his personal physician, Rear Admiral Ronny Jackson, to replace him, red flags went up on Capitol Hill and among some veterans groups who oppose privatizing the V.A.

Indeed, in a parting shot to his detractors within the administration, Shulkin wrote an op-ed in the New York Times warning against forces inside the White House that want to privatize the entire agency.

The Hill:

In an op-ed published in the New York Times just hours after he was removed, Shulkin blamed his ouster on forces within the administration that he said are pushing hard for privatization[.]

"The advocates within the administration for privatizing V.A. health services ... saw me as an obstacle to privatization who had to be removed," Shulkin wrote.

Dismantling the department's health care system "is a terrible idea," Shulkin wrote, adding that the private sector "is ill-prepared to handle the number and complexity of patients that would come from closing or downsizing V.A. hospitals and clinics."

Groups like the Koch brothers-backed Concerned Veterans for America (CVA) are pushing to loosen current restrictions on veterans receiving private sector care.

Very few veterans groups want to eliminate the V.A. or downsize it. But it's a convenient red herring for liberal groups and Democrats in Congress to bash Trump:

"There is no effort underway to privatize VA, and to suggest otherwise is completely false and a red herring designed to distract and avoid honest debate on the real issues surrounding veterans' health care," the agency said in a statement.

Democrats and veterans' advocacy groups have been wary of Republican efforts to privatize the VA since before Trump took office.

In a 2016 campaign rally in Virginia Beach, Trump called the VA corrupt and inefficient.

"Veterans should be guaranteed the right to choose their doctor and clinics, whether at a VA facility or at a private medical center," Trump said. "We must extend this right to all veterans."

Senate Democrats and veterans groups have not yet drawn any hard lines in the sand [sic – a line in the sand...? –DJB] against Jackson, partly because they said they don't know what his positions are.

Verna Jones, the executive director of the American Legion, said she would have to sit down and speak with Jackson before passing judgment on his nomination.

"It seems like people are putting the cart before the horse. Jackson hasn't had a confirmation and none of us know his views," Jones said. "To be clear, the Legion opposes privatization. How all this ties into Jackson – we owe it to him to wait and see."

That's a rare sentiment in these partisan times. But Democrats will also look to diminish Jackson by claiming he is unqualified to lead such a large agency:

Jackson is an active-duty Navy admiral who has worked as the White House physician for three presidents. Lawmakers have expressed skepticism over whether Jackson, who doesn't have experience working with the VA or managing a health care organization, has the qualifications to run the agency.

Senate Democrats on the Veterans' Affairs Committee said they also don't know where Jackson stands on privatization. Still, they don't trust the administration's motives and are gearing up for a fight.

AT contributor Ed Timperlake, a former V.A. assistant secretary, weighed in on Jackson's qualifications:

The selection of Admiral Jackson is being attacked on the issue of his lack of significant command qualifications. In fact, Jackson's immediate experience will ultimately prove to be a boon for the VA. Navy doctors are trained professionals for big-deal thinking. I would never typecast a Navy doctor with the rank of Admiral as someone who doesn't understand how to take command of an organization the size of the VA.

As for privatization of the V.A., it's not going to happen. Every major veterans group is opposed to privatizing the agency, and most Republicans oppose it, too. But the scandals in recent years involving unacceptable wait times for veterans who need care have begun the process of much needed reforms that include some care being supplied in certain circumstances by the private health care industry. As Mr. Timperlake points out, there may be issues with timely payments by the government to private providers, which he recommends an agency-wide audit to discover. But with so many returning veterans from Iraq, Afghanistan, and other combat zones who have serious health issues, it seems that an expansion of choices for veterans is logical and necessary.

How this impacts Jackson's confirmation isn't clear, except that Democrats will seek any opportunity to damage the president, and the Jackson nomination is setting up to give them exactly what they want.

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67 - Herald-Tribune (Creators Syndicate): [McCaughey: Marching orders for Trump's new VA secretary](#) (11 April, Betsy McCaughey, 871k uvm; Sarasota, FL)

Since President Donald Trump ousted Veterans Affairs Secretary David Shulkin, the question reverberating in Washington is whether Trump's new pick, Rear Adm. Ronny Jackson, is capable of heading a department with 360,000 employees and 9 million vets under its care.

Senate Democrats carp he lacks experience running “a complex organization.”

Experience is overrated. President Barack Obama’s VA Secretary, Robert McDonald, failed miserably, despite having run Procter & Gamble. Vets died on phony wait lists on McDonald’s watch.

Jackson’s last combat role was with a surgical shock trauma unit in Iraq. Sounds like good preparation for battling the killer VA bureaucracy.

Jackson also shares Trump’s vision of putting vets in the driver’s seat about their own medical care. Here’s what Jackson can learn from his predecessors’ failures.

Lesson 1: Make vets the priority, not protecting the VA bureaucracy. Shulkin refused to do that. Trump has pledged to fix the Veterans Choice Program so vets can see private doctors when they decide it’s necessary. VCP was created in 2014 after revelations that sick vets were dying on wait lists at VA hospitals. VCP is supposed to allow vets to get private care if they live far from a VA facility or have waited too long. But VCP’s red tape makes seeing an outside doctor almost impossible. That’s deliberate. Sen. Bernie Sanders, who co-authored VCP legislation, relies on union campaign contributions and will do just about anything to protect union jobs at the VA. Keeping vets trapped at the VA with no alternatives is a job-protection racket.

Shulkin was part of that racket, too. He misled Trump and Congress with double talk about reforming VCP “in a way that will work for veterans and work for VA.” But protecting VA bureaucracy shouldn’t be a consideration, when vets’ lives are at stake.

Shulkin showed his true colors when Congress passed last month’s big spending package. Trump and congressional Republicans had pushed hard to include VA reforms helping vets see outside doctors.

But the key person to sell this to Congress was Shulkin, and he equivocated, allowing Democrats to block its passage. It was a setback for Trump and vets. No wonder Shulkin was canned days later -- not because of flimsy travel expense abuse allegations.

Lesson 2: Cut wait times in half at the VA.

Shulkin claimed success in reducing waits, but that’s questionable. VA bureaucrats are still fudging the numbers, according to the inspector general.

Here’s a remedy. A whopping 47 percent of VA health care users are 65 or older. They need angioplasty and bypass surgery like other seniors. They use the VA to avoid Medicare’s out-of-pocket expenses, because their median annual income is only \$24,000. Picking up their co-pays would cost very little and encourage them to use Medicare instead of the VA Bingo, and it would cut VA wait times by nearly half, making room for younger vets to get combat-related care only the VA can provide.

Lesson 3: Don’t count on VA bureaucrats to fess up when things go wrong. Jackson should use unannounced audits to uncover dangerous conditions at medical facilities, instead of trusting officials to report them up the chain of command.

An inspector general report last month exposed “a breakdown of core services” at medical centers under Shulkin’s command. At the Washington, D.C., facility, under Shulkin’s nose,

patients were needlessly overexposed to anesthesia due to inventory mismanagement. After patients were put under, surgeons sometimes discovered they were out of equipment and had to race across the street to borrow it from another hospital or reschedule the procedure. Shulkin claims he could “not recall” ever being notified of such problems. He expected to be notified?

Pundits are predicting a confirmation battle. The smart money should be on Jackson. He’s combat-tested. Disregard the partisan drivel about his lack of experience running a big organization. It’s coming from the same people who had no problem making a community organizer the president.

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68 - Fayetteville Observer: [Our View: Does VA nominee have the right stuff?](#) (11 April, Editorial Board, 439k uvm; Fayetteville, NC)

We hope Robert Wilkie enjoys the challenge of running the Department of Veterans Affairs, because he may have the job for a bit longer than his “acting secretary” title might indicate. Storm clouds are already gathering for President Trump’s nominee for the permanent position, Navy Rear Adm. Ronny Jackson.

Storm clouds, and rough seas, may be appropriate for the man whose unconventional route to the nomination was primarily hitting it off with the commander in chief while serving as his personal physician.

His path to becoming a flag officer certainly involved command responsibilities at times, and he’s by all descriptions an excellent physician, dedicated to medicine, and he clearly sees the need for providing great care for the nation’s veterans.

But we don’t see anything that prepares him to run the federal government’s second-largest bureaucracy, supervising more than 360,000 workers spread across the country in an unwieldy bureaucracy, providing health care and benefits to veterans.

Members of the Senate Committee on Veterans Affairs, which will hold hearings on his nomination, are keptical. That includes the committee’s Republican members. One of them, Sen. Jerry Moran of Kansas, told The Washington Post that, “The VA is a difficult place to manage, regardless of what your background experience is. I want to know more about how he believes that he’s capable of fulfilling those responsibilities and I have a wide array of questions in regard to his experience and background.” Moran added that, “I need to be convinced that he can make a difference at a department in which the culture and the upper echelons of its leadership need to have somebody who can take charge.”

That was the undoing of former VA Secretary David Shulkin, a physician with a resume that included running big hospital systems. Shulkin was the sole cabinet holdover from the Obama administration and as recently as last summer, the president said he was the last member of his cabinet who’d hear the Trump trademark, “You’re fired.” Six months later, that’s exactly what Shulkin heard after he was caught in the nasty crossfire of VA bureaucrats trying to thwart him, and of others determined to privatize many VA services. Shulkin stood with most national veterans groups in opposing privatization. But other high-ranking VA leaders succeeded in undermining him and it was clear that he was losing control of the organization.

Asked about his lack of large-scale management experience in a GateH Gouse Media interview, Jackson said, "I've been in leadership school for 23 years now. ... And I've been able to rise to the level of admiral, a flag officer in the Navy." Jackson added that, "You know, I'm not just an officer in the Navy; I'm an emergency medicine physician in the military. I've been confronted on a day-to-day basis with life-and-death decisions. I think I've got what it takes, and you know, I don't buy into that argument at all."

Maybe Jackson should talk with Ben Carson, the brilliant pediatric neurosurgeon who has had a rough first year trying to manage the Department of Housing and Urban Development. He's told several interviewers lately that brain surgery was a lot easier than what he's trying to do now.

Meanwhile, acting VA chief Wilkie, a Fayetteville native and veteran of military service and several management tours at the Defense Department, is settling in at VA headquarters. The Post reported that he sent out a video to all VA staffers, urging them to communicate openly. He emphasized the VA's mission of caring for our veterans. "Being with you today is the culmination of a lifetime of watching those who have borne the battle." We hope he's able to stay out of the management warfare that did in David Shulkin, but the battle over privatization is likely to continue. And the country needs a permanent VA secretary who can take control, lead the agency and solve its problems.

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From: (b) (6) </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)>
To: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)>
Cc:
Bcc:
Subject: Re: VSO Breakfast Invite List
Date: Wed Apr 04 2018 12:47:59 CDT
Attachments:

(b) (6)
Executive Director,
Concerned Veterans for America
(b) (6) cv4a.org

From: (b) (6) <(b) (6) va.gov>
Date: Wednesday, April 4, 2018 at 12:32 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Subject: RE: VSO Breakfast Invite List

Sure thing, hope appointment goes well:)

(b) (6) M.B.A.
Acting Special Assistant to the Secretary for VSOs
Office of the Secretary
Department of Veterans Affairs
810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:27:19 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

Ok, it was being tossed around. I'm getting a chipped tooth looked at by my dentist here in a minute, I'll follow up when I get back!

Thanks man!

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:25:45 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

(b) (6) I tried calling but didn't reac (b) (5)

Thanks

(b) (6)

(b) (6) M.B.A.
Acting Special Assistant to the Secretary for VSOs
Office of the Secretary
Department of Veterans Affairs
810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:21:52 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

Shoot, I wanted to (b) (5) No worries, we will adapt.

Who is the Legion sending?

Thanks,

(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:17:28 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

(b) (6) I already sent invites to DAV, Legion, VFW, PVA, AMVETS, VVA WWP, IAVA and MOAA. All have confirmed except for VFW, their principal will be on travel, and the Legion is sending their Director as their principal will be on travel.

Thanks

(b) (6)

(b) (6) M.B.A.
Acting Special Assistant to the Secretary for VSOs
Office of the Secretary
Department of Veterans Affairs
810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:12:10 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

Hold on sending invites if you can, if already out that's ok.

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:08:23 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

Thanks (b) (6) - will update the list as well as provide a list of VSO RSVPS by CoB today. Do you have the contact info and/or want to invite (b) (6) (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C)

(b) (6) M.B.A.
Acting Special Assistant to the Secretary for VSOs
Office of the Secretary
Department of Veterans Affairs
810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 8:54:36 AM
To: (b) (6)
Subject: Re: VSO Breakfast Invite List

Peter is going to work on the list of VA employees in attendance so make more room for VSO's, but for the external list, lets start by adding:

(b) (6) CVA
(b) (6) Independence Fund
(b) (6), (b) (7)(C) White House Office of Public Liaison
(b) (6), (b) (7)(C) White House Domestic Policy Council

I'll let you know when we are final.

Thanks!

(b) (6)

From: "(b) (6) <(b) (6)@va.gov>
Date: Wednesday, April 4, 2018 at 10:06 AM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>
Subject: VSO Breakfast Invite List

(b) (6) per our discussion, here's the VSO breakfast invite list – please let me know if you and the team have any suggested edits/corrections.

Event/Meeting: VSO Breakfast with Acting Secretary Robert Wilkie

Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

VA Invitees:

- The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs
- The Honorable Thomas Bowman, Deputy Secretary of Veterans Affairs, Department of Veterans Affairs
- Peter O'Rourke, Chief of Staff, Office of the Secretary
- Jacquelyn Hayes-Byrd, Deputy Chief of Staff, Office of the Secretary, Office of the Secretary
- Brooks Tucker, Assistant Secretary, Office of Congressional and Legislative Affairs, VA
- John Ulliot, Assistant Secretary, Office of Public and Intergovernmental Affairs, VA
- Dr. Lynda Davis, Chief Veterans Experience Officer, VA
- Dr. Carolyn Clancy, Executive in Charge, Veterans Health Administration, VA
- Randy Reeves, Under Secretary for Memorial Affairs, VA
- (b) (6) Special Assistant to the Secretary for VSOs, VA

VSO Invitees:

- Ms. (b) (6) Executive Director, The American Legion (TAL)
- Mr. (b) (6) Executive Director, Disabled American Veterans (DAV)
- Mr. (b) (6) Executive Director, Veterans of Foreign Wars (VFW)
- Mr. (b) (6) Executive Director, Paralyzed Veterans of America (PVA)
- Mr. (b) (6) Executive Director, American Veterans (AMVETS)
- Mr. (b) (6) Executive Director of Policy and Government Affairs, Vietnam Veterans of America (VVA)
- Ms. (b) (6) Chief Policy Officer, Iraq and Afghanistan Veterans of America (IAVA)
- Mr. (b) (6) Lieutenant General, U.S. Air Force (Ret), President and CEO Military Officers Association of America (MOAA)
- Ms. (b) (6) Government and Community Relations Director, Wounded Warrior Project (WWP)
- Mr. (b) (6) Director of Government Relations, Student Veterans of America (SVA)

(b) (6) M.B.A.
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Department of Veterans Affairs
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Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

From: (b) (6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (5), (b) (6)
To: Hutton, James </o=va/ou=exchange
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(fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6) (b) (6)
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Cc: (b) (6) </o=va/ou=exchange
administrative group
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</o=va/ou=va martinsburg/cn=recipients/cn=(b) (5), (b) (6)
Bcc:
Subject: Adm. Jackson clips compilation - March 30
Date: Fri Mar 30 2018 09:42:48 CDT
Attachments: 180330_Jackson News Clips.docx

Attached are the requested clips related to Adm. Jackson.

Thanks,
Gina

(b) (6)
Office of Public Affairs
U.S. Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420
(202) 461-(b) (6)
www.va.gov

Owner: (b) (6) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (5), (b) (6)
Filename: 180330_Jackson News Clips.docx
Last Modified: Fri Mar 30 09:42:48 CDT 2018



Rear Adm. Ronny Jackson News Clips

30 March 2018

1. Washington Post (AP): [Trump's VA pick draws concern over thin management record](#)

(29 March, Hope Yen and Calvin Woodward, 43.9M uvm; Washington, DC)

President Donald Trump's selection of his White House doctor to run the massive Department of Veterans Affairs triggered concern Thursday among lawmakers and veterans groups about whether he has the experience to manage an agency paralyzed over Trump's push to expand private care. Ronny Jackson, a Navy rear admiral entrusted with the health of the past three presidents, is a lifelong physician whose positions on privatizing operations in the second largest federal department...

[Hyperlink to Above](#)

2. Washington Post: [Trump's pick to head veterans department faces skepticism over his experience](#)

(29 March, Lisa Rein, Seung Min Kim, Emily Wax-Thibodeaux, and Josh Dawsey, 43.9M uvm; Washington, DC)

The White House was thrown on the defensive Thursday over President Trump's choice to lead the Department of Veterans Affairs, forcing officials to fend off mounting skepticism that Ronny L. Jackson has the experience to run the government's second-largest agency. Trump announced by tweet late Wednesday that the White House physician would succeed ousted secretary David Shulkin, surprising veterans groups and lawmakers...

[Hyperlink to Above](#)

3. Wall Street Journal: [Lawmakers Respond Cautiously to Little-Known VA Pick Ronny Jackson - Key senators on panel say they don't know enough about White House doctor to form an opinion about his ability to lead a vast bureaucracy](#)

(29 March, Louise Radnofsky and Peter Nicholas, 43.6M uvm; New York, NY)

Capitol Hill lawmakers reacted guardedly to President Donald Trump's nomination of the White House physician to head the Department of Veterans Affairs, with key members noting that they know little about him. Dr. Ronny Jackson, a U.S. Navy rear admiral who has served as a White House physician during the past three administrations, is slated to succeed Secretary David Shulkin, who was ousted Wednesday.

[Hyperlink to Above](#)

4. USA Today (Video): [6 big things the new Veterans Affairs chief will have to address](#)

(29 March, Donovan Slack and Dennis Wagner, 36.8M uvm; McLean, VA)

On the front lines at the Department of Veterans Affairs — in the agency's 1,240 hospitals and clinics — it doesn't much matter these days who holds the secretary's job in Washington. David Shulkin, who was fired Wednesday, was the third VA secretary in four years. If President Trump's nominee to lead the agency, physician and Navy Rear Adm. Ronny Jackson, is confirmed, he will be the fourth.

[Hyperlink to Above](#)

5. New York Times: [Veterans Affairs Shake-Up Stirs New Fears of Privatized Care](#)

(29 March, Nicholas Fandos, 30M uvm; New York, NY)

President Trump's dismissal of David J. Shulkin, the secretary of veterans affairs — and the nomination of a man with no known policy views to take his place — has brought renewed focus to an increasingly contentious debate over whether to give veterans the option of using the

VA-18-0457-A-001015

benefits they earned through military service to see private doctors rather than going to government hospitals and clinics.

[Hyperlink to Above](#)

6. Politico: [Trump's VA pick blindsides staff, deepens agency disarray - 'He's got a department that's in turmoil,' a former VA secretary said. 'It's in crisis.'](#) (29 March, Lorraine Woellert, Eliana Johnson and Connor O'Brien, 23.9M uvm; Arlington, VA)

The timing of President Donald Trump's announcement to name Rear Admiral Ronny Jackson to lead Veterans Affairs was a snap decision that surprised his own chief of staff and knocked the government's second-largest agency, already bedeviled by scandal, deeper into disarray. White House chief of staff John Kelly had spoken with David Shulkin by phone Wednesday morning, reassuring the now-former VA secretary that he wouldn't be fired by tweet that afternoon.

[Hyperlink to Above](#)

7. NPR (All Things Considered, Audio): [Departure Of VA Secretary Shulkin Doesn't End Debate Of Privatization](#) (29 March, 22M uvm; Washington, DC)

The departure of Veterans Affairs Secretary David Shulkin does not end the debate over how far the agency should privatize. Neither the president nor his nominee have given their views on the subject.

[Hyperlink to Above](#)

8. Daily KOS: [Trump replaces experienced hospital administrator with personal doc in fight to privatize the VA](#) (29 March, Mark Sumner, 19.1M uvm; Oakland, CA)

The replacement of Secretary of Veterans Affairs David Shulkin has two narratives in the media—that Shulkin “embarrassed” Donald Trump with a trip to Europe that included days of sightseeing, and that Shulkin “clashed” with other officials at the VA.

[Hyperlink to Above](#)

9. Task & Purpose: [What's In Store For The Next VA Chief? Let's Break It Down](#) (29 March, James Clark, 102k uvm; New York, NY)

It's been an awkwardly long time coming, but as of yesterday afternoon embattled Veterans Affairs secretary David Shulkin is out of a job. The news comes after a month and a half of uncertainty that began when a scathing inspector general report detailed “serious derelictions” in expensing a Europe trip last summer. And then there were all the accusations and counter accusations of political infighting and rumors of possible replacements — at least all that is over:

[Hyperlink to Above](#)

10. Washington Post: [Opinions - Surprise: Trump's newest Cabinet nominee has no relevant experience](#) (29 March, Eugene Robinson, 43.9M uvm; Washington, DC)

You can't make this stuff up: President Trump has announced he will nominate a medical doctor who has no discernible management experience to run the second-largest agency in the federal government. Can presidents be sued for malpractice? The man Trump has named to become secretary of veterans affairs, Ronny L. Jackson, happens to be the president's personal doctor.

[Hyperlink to Above](#)

11. Washington Post (The Fix): [Who is Trump's new Veterans Affairs pick, Ronny Jackson?](#) (29 March, Aaron Blake, 43.9M uvm; Washington, DC)

The seemingly never-ending parade of staff changes in the Trump administration continued apace Wednesday, with the president announcing that Veterans Affairs Secretary David Shulkin is out and that White House physician Ronny L. Jackson will replace him. Jackson's name will be familiar to political watchers across the country for one main reason: He's the physician who delivered what some felt to be a suspiciously rosy picture of Trump's health in January.

[Hyperlink to Above](#)

12. FOX News: [Ronny Jackson picked by Trump to lead the VA: What to know about the president's physician](#) (29 March, Kaitlyn Schallhorn, 32.5M uvm; New York, NY)

President Trump gave Dr. Ronny Jackson a clean bill of health in March – to run the Department of Veterans Affairs. A Navy rear admiral, Jackson is the president's personal physician who rose to prominence after he addressed the press from the White House briefing room in January to discuss Trump's health.

[Hyperlink to Above](#)

13. FOX News (Video): [John Brennan: Trump's nomination for VA secretary is 'terribly misguided'](#) (29 March, Nicole Darrah, 32.5M uvm; New York, NY)

Former CIA Director John Brennan once again took a shot at President Trump on Twitter Thursday, saying he believes the decision to nominate Adm. Ronny Jackson to run the Department of Veterans Affairs is "terribly misguided." "I personally know and greatly respect Ronny Jackson....as a terrific doctor and Navy officer," Brennan tweeted. "However, he has neither the experience nor the credentials to run the very large and complex VA.

[Hyperlink to Above](#)

14. New York Times: [Op-ed - Ronny Jackson's Disturbing Lack of Independence](#) (29 March, Norman L. Eisen and Bandy X. Lee, 30M uvm; New York, NY)

In announcing Dr. Ronny Jackson, the White House physician, as his choice to be the new secretary for veterans affairs, President Trump has taken his latest misstep in what has been the worst presidential personnel process in modern history. We take no pleasure in saying so, including because one of us (Mr. Eisen) worked with Dr. Jackson in the White House, was even treated by him...

[Hyperlink to Above](#)

15. ABC News (Video): [Veterans groups respond cautiously to VA secretary nomination](#) (29 March, Sarah Kolinovsky, 24.2M uvm; New York, NY)

Despite his active duty status as a Navy rear admiral (lower half) and his medical experience, veterans service organizations are responding cautiously to the nomination of Dr. Ronny Jackson for secretary of Veterans Affairs, with some expressing concern about his lack of managerial experience or what his views are on reforming the VA.

[Hyperlink to Above](#)

16. The Atlantic: [The Doctor Who Suddenly Got Nine Million Patients - For a position that demands high-level policy expertise, President Trump appointed his personal physician, Ronny Jackson.](#) (29 March, James Hamblin, 23.9M uvm; Washington, DC)

Nine million veterans will soon be under the care of the emergency-physician rear admiral Ronny Jackson, pending confirmation of his appointment Wednesday to lead the U.S. Department of Veterans Affairs. This seemingly mundane appointment—a doctor and naval officer with years of experience as White House physician under both Trump and Obama...

[Hyperlink to Above](#)

17. NPR (All Things Considered, Audio): [Republican Sen. Jerry Moran Weighs In On Firing Of VA Secretary Shulkin](#) (29 March, 22M uvm; Washington, DC)

There's more turnover in President Trump's cabinet — this time at the Department of Veterans Affairs. NPR's Ailsa Chang talks to Sen. Jerry Moran, R-Kan., and member of the Senate Veterans Affairs Committee, about oversight of the department and the confirmation process of the person picked to lead it.

[Hyperlink to Above](#)

18. NPR (All Things Considered, Audio): [How Veteran Groups Are Reacting To The Departure Of VA Secretary Shulkin](#) (29 March, 22M uvm; Washington, DC)

Garry Augustine, executive director of Disabled American Veterans, speaks with NPR's Audie Cornish about how veteran groups are responding to the the news of VA Secretary David Shulkin's firing.

[Hyperlink to Above](#)

19. The Hill: [White House: Trump has 'full confidence' in presidential physician to lead VA](#) (29 March, Max Greenwood, 11.9M uvm; Washington, DC)

President Trump has "full confidence" in White House physician Ronny Jackson's ability to head the Veterans Affairs (VA) Department, a spokeswoman for the White House said Thursday, despite reported concerns from some aides. "As I said earlier, the president has full confidence in Adm. Jackson," White House deputy press secretary Lindsay Walters told reporters.

[Hyperlink to Above](#)

20. The Hill: [GOP, vet groups react with caution to Trump VA pick](#) (29 March, Rebecca Kheel, 11.9M uvm; Washington, DC)

Senators and influential veterans groups are withholding judgment on President Trump's pick to lead the Department of Veterans Affairs (VA), a Navy doctor with no experience leading a federal bureaucracy. Both the Republican chairman and the Democratic ranking member of the Senate Veterans Affairs Committee said only that they look forward to meeting Rear Adm.

Ronny Jackson. Several veterans groups expressed some concern about Jackson's qualifications...

[Hyperlink to Above](#)

21. Military.com: [Others Considered for VA Job Before Trump Picked His Personal Doctor](#) (29 March, Richard Sisk, 9M uvm; San Francisco, CA)

Rear Adm. Ronny L. Jackson, the personal physician to President Donald Trump, was not his first choice to replace fired VA Secretary Dr. David Shulkin, the White House said Thursday. "The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary," White House deputy press secretary Lindsay Walters told reporters.

[Hyperlink to Above](#)

22. Government Executive: [Lawmakers, Veterans Groups and Former Officials Worry VA Nominee Is Not 'Up to the Job'](#) (29 March, Eric Katz, 870k uvm; Washington, DC)

With David Shulkin now ousted from the Veterans Affairs Department, all eyes are on President Trump's nominated replacement to see where he comes down on the most pressing issue at VA: How large a role should the private sector play in providing health care to veterans? One problem for observers and stakeholders in the veteran community is Trump's pick, Dr. Ronny Jackson, has very little experience in public policy or veterans issues...

[Hyperlink to Above](#)

Full Text:

1. Washington Post (AP): [Trump's VA pick draws concern over thin management record](#) (29 March, Hope Yen and Calvin Woodward, 43.9M uvm; Washington, DC)

President Donald Trump's selection of his White House doctor to run the massive Department of Veterans Affairs triggered concern Thursday among lawmakers and veterans groups about whether he has the experience to manage an agency paralyzed over Trump's push to expand private care.

Ronny Jackson, a Navy rear admiral entrusted with the health of the past three presidents, is a lifelong physician whose positions on privatizing operations in the second largest federal department and addressing ballooning health care costs are unknown. First named to the top White House post by President Barack Obama, he would be new to running a big bureaucracy if given leadership over a department of 360,000 employees serving 9 million veterans.

In a statement, Trump praised Jackson as "highly trained and qualified." But representatives of veterans aren't sold on the choice, or on Trump's decision a day earlier to fire VA Secretary David Shulkin.

"There is little that we know about Dr. Ronny Jackson's vision and qualifications," said Paul Rieckhoff, founder and CEO of Iraq and Afghanistan Veterans of America. "Our concern is whether President Trump was more interested in picking a secretary who would be politically

loyal rather than someone who can work across the aisle to fix long standing problems of bureaucratic delay.”

Similar doubts were expressed by Veterans of Foreign Wars, which praised Jackson’s military background in a statement but pointed to a nominee biography devoid of “any experience working with the VA or with veterans, or managing any organization of size, much less one as multifaceted as the Department of Veterans Affairs.” AMVETS echoed such sentiments.

“We look forward to a rigorous confirmation hearing,” Rieckhoff said.

Montana Sen. Jon Tester, top Democrat on the panel that will consider the nomination, said he had yet to determine if Jackson “is up to the job.”

It’s not clear from Jackson’s military service record how much, if any, management experience he has. His military assignments did not appear to include supervision over a large department or unit. His Navy biography says he deployed to Iraq with a Marine unit and served as the emergency physician in charge of resuscitative medicine for a trauma platoon.

Jackson joined the White House medical team in 2006 and is perhaps best known for his appearance before the press corps in January, announcing the results of Trump’s first physical in a performance that showed he was quick-witted and unfailingly complimentary of Trump.

Marveling at the 71-year-old president’s good health, Jackson opined, “It’s just the way God made him.”

A White House official said Shulkin himself had recommended Jackson for an undersecretary position at the VA in the fall, and Trump ultimately decided he was more comfortable with Jackson than with other top candidates. The official was not authorized to discuss personnel matters and spoke on condition of anonymity.

If confirmed by the Senate, Jackson would face immediate crises, like a multi-billion dollar revamp of electronic medical records now in limbo that members of Congress fear will prove too costly and wasteful, and a budget shortfall in the coming weeks in its private-sector Veterans Choice program.

Trump is seeking an aggressive expansion of the Choice program to make it easier for veterans to see private doctors outside the VA system at government expense, but proposals are stalled in Congress following a failed effort last week.

“We’re going to have real choice,” Trump said in Ohio. “That’s why I made some changes, because I wasn’t happy with it.”

Jackson’s nomination comes as Trump’s new Cabinet nominees begin to pile up in the Senate. That is certain to stir weeks of confirmation battles this spring when senators, especially those running for re-election, may prefer to shift focus away from the changes at the White House.

None of the nominees, including the president’s new picks for secretary of state and CIA director, is expected to sail to easy confirmation. The GOP-led Senate is narrowly divided 51-49 and Democrats — and some Republicans — are preparing to ask tough questions. Even though Congress has an otherwise slim legislative agenda before campaign season, prolonged confirmation fights could jam up the Senate and influence the election.

Pending Jackson's confirmation, Robert Wilkie, a former Pentagon undersecretary for personnel and readiness, is serving as the acting head of the VA.

Lawmakers said they needed to learn more about Jackson's record.

Republican Sen. Johnny Isakson of Georgia, chairman of the Senate Veterans Affairs Committee that will review the nomination, declined to indicate his support. He stressed that he looked forward to "meeting Admiral Jackson and learning more about him." Isakson, a moderate, has expressed skepticism in the past toward nominees who expressed strong views in favor of privatization.

Sen. Bernie Sanders, independent of Vermont and a former chairman of the panel, cautioned that Jackson would not be approved if he supported privatizing the VA. "Our job is to strengthen the VA in order to provide high-quality care to our veterans, not dismember it," he said.

Shulkin, a physician and the lone Obama administration holdover in Trump's Cabinet, was unceremoniously fired late Wednesday by Trump in a tweet. Shulkin had enjoyed support from Trump for much of his first year in the administration but support eroded last month after a bruising ethics scandal and political infighting at VA.

Dan Caldwell, executive director of the conservative Concerned Veterans for America, said the group is keeping an "open mind" about Jackson's nomination. Some of the names that had been in circulation for the post had previous ties to the group, which supports giving veterans greater access to private doctors outside the VA system.

"We'd like to hear more about his positions to reform and fix the VA," Caldwell said. "He has a very distinguished service record and it would be unfair to outright dismiss him — you have to be very professional to reach his rank."

A native of Levelland, Texas, Jackson, 50, graduated from Texas A&M with a degree in marine biology, then from medical school at the University of Texas Medical Branch.

He headed to the Navy, then in 2005 joined a 2nd Marines regiment. Jackson was deployed to Iraq as the physician in charge of resuscitative medicine for a trauma platoon, according to the White House.

Ned Price, a National Security Council spokesman under Obama, described the doctor as "the guy you always want to be around" because he's affable and funny. But Price said it was difficult to believe the nomination was unrelated to the "glowing assessment" of Trump's health that the doctor had provided.

Associated Press writers Jill Colvin, Lisa Mascaro, Lolita Baldor, Zeke Miller, Jonathan Lemire, Catherine Lucey and Darlene Superville contributed to this report.

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2. Washington Post: [Trump's pick to head veterans department faces skepticism over his experience](#) (29 March, Lisa Rein, Seung Min Kim, Emily Wax-Thibodeaux, and Josh Dawsey, 43.9M uvm; Washington, DC)

The White House was thrown on the defensive Thursday over President Trump's choice to lead the Department of Veterans -Affairs, forcing officials to fend off mounting skepticism that Ronny L. Jackson has the experience to run the government's second-largest agency.

Trump announced by tweet late Wednesday that the White House physician would succeed ousted secretary David Shulkin, surprising veterans groups and lawmakers, who were not notified beforehand and scrambled to learn the policy views of someone whose positions on the chronic challenges facing VA are unknown.

Jackson is a career naval officer who was an emergency trauma doctor in Iraq before spending the past 12 years as a White House physician. But his résumé lacks the type of management experience usually expected from the leader of an agency that employs 360,000 people, has a \$186 billion annual budget and is dedicated to serving the complex needs of the country's veterans.

"It's great that he served in Iraq and he's our generation. But it doesn't appear that he's had assignments that suggest he could take on the magnitude of this job, and this makes Jackson a -surprising pick," said Paul Rieckhoff, chief executive of Iraq and Afghanistan Veterans of America.

Jackson was taken aback by his nomination, said senior White House officials, who spoke on the condition of anonymity to discuss internal deliberations. After aides gauged his interest in recent days, he hesitated to take on such a big job. But the president continued to push and told his senior staff Monday that the doctor was his top choice. A senior White House official described an informal interview process, without the extensive vetting that typically accompanies a Cabinet selection.

Navy Rear Adm. Ronny L. Jackson, the lead White House doctor, said on Jan. 16 that President Trump's "overall health is excellent." (Bastien Inzaurrealde/The Washington Post)

"The President has full confidence in Dr. Jackson's abilities to give our veterans the care they've earned," spokesman Raj Shah said.

The White House planned to announce Wednesday that Shulkin would leave the administration and be replaced on an interim basis by Robert Wilkie, undersecretary for defense personnel and readiness at the Defense Department, until a nominee was found.

But Trump preempted the plan when he tweeted that he intended to nominate Jackson, administration officials said.

The active-duty rear admiral had been a behind-the-scenes figure while serving the past three administrations as a White House physician, but he moved into the spotlight in January when he delivered a glowing assessment of Trump's physical and mental health to reporters, which aides said endeared him to the president.

The White House on Thursday defended Trump's choice of Jackson, saying his hands-on experience as a doctor would serve him well as Veterans Affairs secretary.

“He knows what soldiers need on the battlefield and what they need when they come home as veterans,” deputy White House press secretary Lindsay Walters told reporters aboard Air Force One en route to Cleveland, where Trump delivered a speech on his infrastructure plan. “The president has full confidence in his pick and trusts he will be able to give veterans the care they deserve.”

Key congressional Republicans publicly took a cautious approach to the nomination.

“We are doing our homework on Dr. Jackson,” said Amanda Maddox, spokeswoman for Sen. Johnny Isakson (R-Ga.), chairman of the Senate Veterans’ Affairs Committee, which will hold Jackson’s nomination hearing. Trump called Isakson after announcing that he had picked the doctor to replace Shulkin, she said.

“His name was never floated around,” Maddox said, “so we are doing our due diligence.”

Trump’s decision to upend VA’s leadership comes as Senate Republicans were already worried about other potentially difficult nominations in the months leading up to midterm elections, when they want to focus their message on the recently passed tax cuts rather than deal with more upheaval in the administration.

“Any time Republicans are not selling the tax bill over the next seven months is a missed opportunity,” said GOP strategist Brian Walsh, a former spokesman for the National Republican Senatorial Committee. “I will say Senate Republicans are a little more insulated by the nature of the seats that are up. But there’s no question that these are unhelpful distractions.”

The stack of Trump nominees includes Gina Haspel, who was picked this month to be the director of the Central Intelligence Agency and is facing opposition from members of both parties because of her ties to the agency’s past use of brutal interrogation measures on terrorism suspects, which critics say amounted to torture.

Senate Republicans have told White House officials in recent days that the process of confirming CIA Director Mike Pompeo to replace Rex Tillerson as secretary of state is going to be challenging even though he is expected to be approved, according to two people briefed on the discussions. Democratic senators said privately when Pompeo was tapped to replace Tillerson that they expect far fewer Democrats to back him than the 14 who voted for him to lead the CIA.

Senior Senate Republicans have privately expressed frustration over the personnel battles that have raged since the beginning of Trump’s presidency and recently told the White House that they did not want to have to consider a series of nominees this year, according to aides and officials who have heard the complaints.

The move to dismiss Shulkin — as well as the lack of communication about Jackson — only fueled concerns on Capitol Hill that the administration was not doing enough to help Congress defend or even respond to the president’s rush of personnel changes.

Jackson’s policy views are unknown, particularly on the most pressing issue facing VA: how much access veterans should have to private doctors outside the system at government expense. Shulkin’s moderate views on the subject, which were at odds with many administration officials, helped end his tenure.

VA secretary is one of Washington's most unforgiving jobs even for someone with extensive management experience. Shulkin, also a physician, had run large hospital systems — including VA's — before taking the job. His predecessor, Robert McDonald, was a chief executive of Procter & Gamble. The secretary before him was a decorated retired Army general, Eric K. Shinseki, who was forced out after managers in the far-flung health system were found to have fudged waitlists for veterans' medical appointments.

As recently as February, Jackson was a candidate to run VA's health-care arm, the Veterans Health Administration, the country's largest health-care system, with 1,200 hospitals and medical clinics. On the day of his interview, he told a selection panel that the president was unwilling to let him leave his White House job, according to two people familiar with the discussion.

The panel interviewed him informally anyway, asking him how he would drive change in such a large organization but not about his views on policy. One person who sits on the panel, and who spoke on the condition of anonymity because its proceedings are confidential, said they didn't think Jackson had the requisite skills to transition from overseeing a team of about 20 doctors, nurses and physician assistants in the White House medical office to overseeing the health administration.

"I don't remember him coming in trying to convince us he had the experience to do the job. He did not inflate his qualifications," this person said. "The tone was, 'Maybe I don't have the same kind of experience as others who came before me in the job.'"

Jackson's former colleagues in the Obama White House, who have publicly praised him in the past, said his nomination caught them off guard as they swapped text messages to ask how an extremely likable but unlikely candidate could end up running VA in the Trump administration.

"I've seen him managing a staff of a couple dozen, which he did to perfection," said Ned Price, a National Security Council spokesman under Obama who recalled that he was treated by Jackson for a toe injury in the Philippines.

"But how that would translate to managing the second-largest department in federal government I have no idea," Price said. "He has competence and integrity. I don't think he's going to fly around the world first-class or be buying thousands of dollars in furniture. But can he run VA? Anyone's guess is as good as mine."

Colleagues described the schedule of the White House physician as grueling, with continual foreign and domestic travel, always at the president's side.

Some Democrats warned that if Jackson embraced the idea of privatizing more of VA's health coverage, his nomination would be met with stiff resistance.

"I will carefully review Dr. Jackson's qualifications to determine whether he has the best interests of our Veterans at heart or whether he, like many in the Trump administration, wants to push VA down the dangerous path of privatization," Sen. Tammy Duckworth (D-Ill.), a wounded Iraq veteran, said in a statement.

At the American Legion, the country's largest veterans organization, senior officials were putting together ideas to help Jackson acquaint himself with the agency and its challenges.

“He’s going to have a huge learning curve,” Executive Director Verna Jones said, “but we stand ready to assist and educate him.”

Robert Costa and Julie Tate contributed to this report.

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3. Wall Street Journal: [Lawmakers Respond Cautiously to Little-Known VA Pick Ronny Jackson - Key senators on panel say they don’t know enough about White House doctor to form an opinion about his ability to lead a vast bureaucracy](#) (29 March, Louise Radnofsky and Peter Nicholas, 43.6M uvm; New York, NY)

Capitol Hill lawmakers reacted guardedly to President Donald Trump’s nomination of the White House physician to head the Department of Veterans Affairs, with key members noting that they know little about him.

Dr. Ronny Jackson, a U.S. Navy rear admiral who has served as a White House physician during the past three administrations, is slated to succeed Secretary David Shulkin, who was ousted Wednesday. Mr. Trump indicated on Thursday that he removed Dr. Shulkin because change at the agency was coming too slowly. The secretary had also been the subject of a travel-expenses scandal.

The lead Republican and Democratic senators who will decide whether to confirm Dr. Jackson said they didn’t yet know enough to form an opinion about his ability to lead a bureaucracy of 370,000 employees. The department, which is the second-biggest government agency, is also still recovering from a 2014 scandal in which employees were found to have falsified records to hide delays in patient care.

“I look forward to meeting Adm. Jackson and learning more about him,” said Sen. Johnny Isakson (R., Ga.), chairman of the Committee on Veterans’ Affairs, which will vote on confirmation.

Sen. Jon Tester of Montana, the top Democrat on the panel, offered a near-identical sentiment, adding that he is looking forward to “seeing if he is up to the job.”

Veterans service organizations and some other lawmakers have expressed skepticism about Dr. Jackson, raising concern over the propriety of an active-duty military officer holding a political appointment, and saying his biography showed scant experience at running a bureaucracy on the scale he would inherit.

“He’s more of a hands-on physician—not a lot of desk time in terms of administrative leadership,” said Rep. Mike Coffman (R., Colo.), a member of the House Veterans’ Affairs Committee who was among Dr. Shulkin’s harshest critics.

It’s unclear how Dr. Jackson would address the issue of his active military status, including whether he would seek to relinquish it before securing confirmation to the new job.

Dr. Jackson’s confirmation will come as senators are debating legislation that would increase veterans’ ability to seek non-government medical care. Congress is approaching an early June

deadline to agree to new funds for the existing system allowing some veterans to go outside the VA for care, or to create a new policy allowing all veterans to participate.

“I made some changes, because I wasn’t happy with the speed with which our veterans were taken care of,” Mr. Trump said Thursday in a speech in Ohio. “We want them to have choice so that they can run to a private doctor and take care of it.”

The White House informed Mr. Isakson’s committee of the leadership change in a courtesy call Wednesday; a timeline for proceeding with the nomination, or preliminary introduction meetings, wasn’t discussed, a spokeswoman said. Mr. Isakson and Dr. Jackson spoke by phone Thursday afternoon, in an informal introduction, the spokeswoman said.

Past and present White House officials have praised Dr. Jackson as a steady force, deft in caring for different presidents and cabinet members. They said they found him friendly, bright and knowledgeable about medicine, including on issues specifically affecting veterans.

“If you’re not calmly decisive, the job of White House physician ain’t for you,” said Paul Winfree, a former deputy director of Mr. Trump’s Domestic Policy Council.

Dr. Jackson has been sought out for management positions before, though on a significantly smaller scale. Toward the end of the Obama administration, he was invited to interview by the Cleveland Clinic for an international posting managing a handful of people because of his affability, versatility and experience with VIPs, a person familiar with the interview said.

The federal agency Dr. Jackson would inherit is notoriously riven with competing power centers, and has now churned through three secretaries in four years.

Dr. Shulkin came directly from a health-care management background into the Obama administration when he took over the VA. He stayed on for Mr. Trump and initially received high reviews. He lost credibility recently when the VA inspector general found that, during a trip to Europe, he improperly accepted Wimbledon tennis tickets, misspent thousands of dollars of taxpayer money on his wife’s airfare and improperly used a department employee as a “personal travel concierge.”

Dr. Shulkin denied wrongdoing. He repaid the \$4,312 cost of his wife’s airfare and then sent the U.S. Treasury a check equal to the amount of the tennis tickets.

Mr. Trump’s advisers had openly explored possible successors for Dr. Shulkin in recent weeks, including having conversations with potential candidates, people familiar with the matter had said.

Still, the nomination of Dr. Jackson stunned some White House aides, who hadn’t known the president was even considering his physician for the role.

It became clearer Thursday that Mr. Trump had been thinking about moving Dr. Jackson to the VA for months. Last fall, Dr. Shulkin recommended that Dr. Jackson take an undersecretary job at the department, a White House official said. At that time, Dr. Jackson and the president discussed plans for improving the VA—talks that set in motion the announcement on Thursday.

Lindsay Walters, a White House spokeswoman, on Thursday said the White House believed Dr. Jackson had “bipartisan respect.”

“The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary,” she added. “The president has full confidence in his pick and trusts he will be able to give veterans the care they deserve.”

Some lawmakers expressed dismay over the treatment and departure of Dr. Shulkin, which could linger into the new confirmation process. “By once again choosing chaos over consistent leadership, Donald Trump is hurting veterans around the country,” said Illinois Democratic Sen. Tammy Duckworth, who is a retired U.S. Army lieutenant colonel.

—*Kristina Peterson and Ben Kesling contributed to this article.*

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4. USA Today (Video): [6 big things the new Veterans Affairs chief will have to address](#) (29 March, Donovan Slack and Dennis Wagner, 36.8M uvm; McLean, VA)

On the front lines at the Department of Veterans Affairs — in the agency’s 1,240 hospitals and clinics — it doesn’t much matter these days who holds the secretary’s job in Washington.

David Shulkin, who was fired Wednesday, was the third VA secretary in four years. If President Trump’s nominee to lead the agency, physician and Navy Rear Adm. Ronny Jackson, is confirmed, he will be the fourth.

Each has sought to fix the department, laying out visions and priorities — Shulkin’s top priority was “access,” making sure veterans get appointments when they need them. His predecessor, former Procter and Gamble CEO Bob McDonald, focused on staffing, training and veteran-centered customer service.

But year after year, critical deficiencies remain and veterans are bearing the brunt of the failures. Here are some key, seemingly intractable shortfalls that continue to plague the system — and that Jackson will face if confirmed.

Veterans are still waiting

The furor over VA health care exploded in 2014 when whistle-blowers in Arizona divulged that thousands of patients were backlogged at the Phoenix veterans hospital, and some of them had died awaiting care. VA investigators soon determined that medical center administrators knew about the crisis, yet put out fraudulent wait-time data to collect bonus pay.

The problems weren’t just in Phoenix. A USA TODAY investigation in 2016 found supervisors instructed employees to falsify patient wait times at VA medical facilities in at least seven states. And employees at 40 VA medical facilities in 19 states and Puerto Rico regularly “zeroed out” veteran wait times.

A few weeks after Shulkin was sworn in last year, the VA inspector general released a report finding widespread inaccuracies in scheduling records at a dozen hospitals in North Carolina and Virginia. The records vastly understated how long veterans were waiting for appointments and prevented as many as 13,000 from getting VA-funded care in the private sector — an option they were entitled to if they waited longer than 30 days. At the time, Shulkin said the findings

were based on outdated rules and that he had instituted new regulations to prevent such problems in the future.

But just two weeks ago, another inspector general investigation found the problems continued.

Looking at 64 VA hospitals and clinics in a swath of states from Kentucky to Illinois, investigators found scheduling staff entered the wrong dates in the system in more than 5,000 cases. That masked how long veterans were actually waiting for specialty care and mental health appointments.

They estimated 2,500 of those waited longer than a month, but the scheduling system falsely showed only 1,300 waited that long. Even in the cases accurately reflected in the system, they concluded, most weren't offered the chance to get care in the private sector.

"VA data continues to be a high-risk area," wrote Larry Reinkemeyer, VA assistant inspector general for audits and evaluations.

Quality of care

The VA's lowest performing hospitals remained at the bottom of the pack on the agency's own internal quality measures for two years in a row.

The VA regularly scores its medical centers based on dozens of quality factors, including death and infection rates, instances of avoidable complications and wait times. The agency uses a five-star scale with one being the worst and five being the best.

The rankings compare VA hospitals against each other but the number of one-star hospitals is not constant. Medical centers in that bracket can be elevated to two stars based on quality-of-care factors.

Among the facilities who received only one star in both 2015 and 2016 were the VA hospital in Phoenix and another in Memphis, Tenn. One Memphis employee dubbed the facility a "house of horrors" when USA TODAY obtained internal documents revealing reported threats to patient safety soared in recent years from 700 to more than 1,000.

One veteran had to have his leg amputated after a VA provider there left a piece of plastic tubing in a critical blood vessel during a procedure.

On a number of patient safety factors, the VA overall on average scores better than the private sector on many key patient-safety measures, including instances of avoidable death, respiratory failure, and infection. But there are vast disparities among VA hospitals, according to VA data collected from October 2015 to March 2017.

The death rate for surgical patients with treatable complications ranged from zero at the VA hospital in Sacramento, Calif., to more than 20% in Miami; Columbia, Mo.; and Washington, D.C. In Long Beach, Calif., it was 29%. That's more than double the private sector average of 14%, according to Medicare data.

Bureaucratic breakdowns

In Washington, the VA inspector general issued a rare emergency report last year saying that patients were in imminent danger at the hospital. The facility had dirty sterile storage areas and was regularly running out of critical supplies needed for surgeries and other procedures, including patches to seal blood vessels and tubes for kidney dialysis.

Shulkin quickly removed the hospital director there and sent teams from headquarters to try to fix the problems. But an inspector general report released this month found that VA officials at every level — local, regional and national — knew about the problems for years but didn't fix them.

Investigators found “a culture of complacency and a sense of futility pervaded offices at multiple levels.”

“In interviews, leaders frequently abrogated individual responsibility and deflected blame to others,” the investigation report says. “Despite the many warnings and ongoing indicators of serious problems, leaders failed to engage in meaningful interventions of effective remediation.”

Morale at the agency has taken a beating amid the constant drumbeat of crises. Employees ranked it as the second to worst agency to work for among large departments last year. The only department scoring lower was Homeland Security.

The inspector general singled out frontline workers at the Washington hospital, saying they went to great lengths to make do and they may be the only reason no patients were actually harmed.

“The OIG did not find evidence of adverse clinical outcomes, a condition that is largely attributable to front-line care providers who were committed to providing the best possible care by borrowing supplies, improvising, or personally ensuring patients received what they needed,” the investigation report said.

Vetting failures

The VA has had persistent difficulties recruiting and keeping enough medical care providers to meet veterans needs.

In 2015, one in six critical VA jobs — intake workers, doctors, nurses and assistants — were unfilled, a USA TODAY investigation found. Though the agency has made headway, there are still shortfalls.

In some cases, that has created an incentive to hire medical care providers with problem records that may have prevented them from getting jobs in the private sector.

A VA hospital in Oklahoma knowingly hired a psychiatrist sanctioned for sexual misconduct who went on to sleep with a VA patient, according to internal documents obtained by USA TODAY. A Louisiana VA clinic hired a psychologist with felony convictions. The VA ended up firing him after they determined he was a “direct threat to others” and the VA’s mission.

The Iowa City VA hospital knowingly hired John Henry Schneider last year, a neurosurgeon who had racked up more than a dozen malpractice claims in two states and had his license revoked in one.

After USA TODAY revealed the case in December, the VA forced him out and discovered that conflicting VA policies allowed its hospitals to illegally hire doctors with revoked licenses for 15 years. Shulkin ordered the policies rewritten but with the current process, that could take up to two years.

In a report released Monday, the inspector general found vetting failures go beyond medical providers. Investigators determined that the VA did not conduct required background checks on more than 6,000 employees and managers failed to properly document and oversee background checks.

“As a result, VA cannot reliably attest to the suitability of its largest workforce, exposing veterans and employees to individuals who have not been properly vetted,” the report said. “Unless internal controls and data are improved, VA and the public lack assurance that VHA has a workforce suitable for serving our nation’s veterans.”

Hiding shoddy care

The agency has failed for years to ensure medical care providers found to have provided poor care are reported to state licensing boards or to a national database created to prevent them from crossing state lines and endangering other patients.

In one case in Maine revealed in a USA TODAY investigation, the VA found a podiatrist had harmed 88 patients but didn’t report him to the national database and took years to report him to state boards. By the time the VA told his patients, one of them, U.S. Army veteran April Wood, had decided to have her leg amputated after two failed surgeries by the podiatrist.

The investigation found VA hospitals also signed secret settlement deals with dozens of doctors, nurses and health care workers in recent years that included promises to conceal serious mistakes — from inappropriate relationships and breakdowns in supervision to dangerous medical errors — even after forcing them out of the VA.

In response to the story last fall, Shulkin required increasing vetting of future such deals and he ordered policies on reporting to state boards and the national database rewritten. Again, five months later, the new policies still are not in place and could take months or years more.

Politics

Jackson, Trump's pick to be the new secretary, has no experience running a huge government agency, and dealing with veterans’ health care challenges will require deft politics and bureaucratic acumen.

His predecessor, Shulkin, was ousted despite being well regarded in Congress and assured of job security by Trump.

Now, a White House physician and former Navy admiral faces not just a plethora of VA maladies, but partisan politics and special interests that bitterly disagree on the cures.

The most perilous and important controversy involves decisions on privatizing veterans’ healthcare.

Powerful unions and veteran service organizations, such as the American Legion, oppose a radical change, and they are supported by most Democrats on Capitol Hill. But Republicans and key advocacy groups, such as Concerned Veterans for America, are demanding a system that would let veterans decide whether they go to the VA for care, or get private treatment subsidized by the government.

On Thursday, Trump suggested that Shulkin was dismissed because he was not aggressive enough in promoting the private-care option.

The existing Choice Program, which ate up billions of dollars and had to be re-funded, promises to be even more expensive if expanded. And those costs already have included tens of millions of dollars in improper payments to contractors.

Veteran enrollment for healthcare has skyrocketed, and Congress continues to expand benefits for those already in the system, with care for Agent Orange victims and high-cost medications for hepatitis patients. Bringing in enough funding to meet that demand also requires political aplomb.

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5. New York Times: [Veterans Affairs Shake-Up Stirs New Fears of Privatized Care](#) (29 March, Nicholas Fandos, 30M uvm; New York, NY)

President Trump's dismissal of David J. Shulkin, the secretary of veterans affairs — and the nomination of a man with no known policy views to take his place — has brought renewed focus to an increasingly contentious debate over whether to give veterans the option of using the benefits they earned through military service to see private doctors rather than going to government hospitals and clinics.

The issue, which has pitted almost every major veterans group against Concerned Veterans for America, an advocacy group funded by the billionaire conservative brothers Charles G. and David H. Koch, and its allies, has been at the center of months of intrigue at the sprawling Department of Veterans Affairs, which is charged with caring for the United States' 20 million veterans.

But Mr. Shulkin's departure and the abrupt elevation of Dr. Ronny L. Jackson, the White House physician, to the department's top job on Wednesday have raised new fears among Democrats and groups like the Veterans of Foreign Wars and the American Legion. They worry that the Trump administration will push for a major change in veterans' health care that they have bitterly opposed.

The groups say the end result would be disastrous, effectively bleeding to death a network of 1,700 hospitals and clinics that has taken decades to build.

Dr. Shulkin, who was dismissed Wednesday evening by presidential tweet, argued in an op-ed article in The New York Times and in a subsequent interview on Thursday that such radical restructuring of veterans' health care would not work.

He said that a middle path that he had tried to pursue — investing in the department's own health care system while offering veterans more, though not unfettered, access to private

doctors — had been rejected by Trump administration officials interested in rewarding private individuals and companies with a windfall in government money.

“They saw me as an obstacle to privatization who had to be removed,” he wrote in one of the most forceful statements offered yet by a fired Trump administration official.

Senior White House officials offered a different rationale for his firing that was based more on a damaging report about Dr. Shulkin’s use of government funds on a trip to Europe released last month than on a dispute over policy.

Lindsey Walters, a deputy White House press secretary, told reporters aboard Air Force One on Thursday that the nomination of Dr. Jackson should not be interpreted as a signal that Mr. Trump wants to privatize veterans’ health care.

But Mr. Trump seemed to renew those concerns just a short time later, promising in a speech in Ohio that he was going to ensure that veterans “have choice,” harkening back to a campaign promise to enact something like the Koch-backed plan.

The speculation on Thursday about a possible policy shift was mostly fed by the lack of information about Dr. Jackson, whose only prominent public statements have been about Mr. Trump’s health.

Veterans advocates are especially concerned that Dr. Jackson, a rear admiral in the Navy who has no real management or political experience in a large bureaucracy, will be pushed around or, worse, simply co-opted by officials in the administration set on drastically expanding private care.

“We don’t know what his agenda is. We don’t know what his views are,” said Verna L. Jones, the executive director of the American Legion. “No one has had an opportunity to talk to him.”

“Of course we are nervous,” she added.

Leaders of the older, congressionally chartered veterans groups like the Legion are not categorically opposed to easing restrictions on private care, particularly in cases where veterans are facing long wait times and subpar facilities. About 30 percent of veterans’ appointments are currently made with private health providers for those reasons.

But the groups prefer tweaking programs already in place while at the same time addressing the problems that made private care necessary.

John Hoellwarth, the communications director for Amvets, said he thought the first response of most veterans groups to Dr. Jackson was to search for him online.

Dr. Shulkin said that he had been friendly with Dr. Jackson for several years — both men also served in the Obama administration — and encouraged him to go through the interview process to lead the department’s health system this year. Still, he said that he thought concerns about Dr. Jackson’s résumé were justified.

“There is no question about it, but I can’t imagine any job that prepares you for this type of job,” Dr. Shulkin said.

By most accounts, Dr. Shulkin's rapid fall began as he increasingly butted heads with other Trump administration official over how to approach the expansion of private care. The officials — who included the department's press secretary and assistant secretary for communications — came to consider Dr. Shulkin as an obstacle and repeatedly tried to have him removed.

Many of those officials, several of whom have ties to the Concerned Veterans group, are still in the administration and are likely to have increased sway in the department. But the ultimate decision about the structure of the department's health care most likely resides on Capitol Hill, where lawmakers have been struggling for almost a year with the issue.

"I think that there was a miscalculation that if you could get rid of the secretary who is a moderate that things will fall in place, and I just don't think that is going to happen," Dr. Shulkin said.

Dan Caldwell, the executive director of Concerned Veterans for America, strenuously disputed Dr. Shulkin's analysis and said the secretary was using privatization as a "straw man" to distract from his own ethical lapses.

"The president has said he supports full V.A. choice," Mr. Caldwell said. "The president would not have selected Admiral Jackson if he did not believe he supports his full agenda."

Mr. Caldwell was referring to a damning report released in February by the department's inspector general that found "serious derelictions" related to a trip Dr. Shulkin took last year to Britain and Denmark. It concluded that he had spent much of the trip, which cost more than \$122,000, sightseeing and that he had improperly accepted Wimbledon tickets as a gift.

Dr. Shulkin has continued to deny any wrongdoing, and on Thursday blamed his political opponents in the department for the investigation itself.

"This is 100 percent about the politics and this is the way that people fight their battles in Washington rather than having intellectually honest discussions," he said.

The White House did not view it that way. Senior officials came to believe that Dr. Shulkin had misled them in the run-up to the report's release. His public declarations of innocence only further aggravated top officials, who felt he had too openly aired internal politics with news outlets and had repeatedly opened the White House to criticism.

The exact circumstances surrounding Dr. Shulkin's firing, and exactly how much the White House chief of staff, John F. Kelly, was aware of it, remained unclear.

One person with direct knowledge of the events said Dr. Shulkin had called Mr. Kelly around 10:30 a.m. Wednesday, asking if he were about to be fired. Mr. Kelly told that him he did not know, and that he would get back to him.

A White House official would not discuss the details of what took place, beyond saying that Mr. Kelly had called Dr. Shulkin to accept his resignation, and that the secretary gave it.

Dr. Shulkin declined to discuss the episode in detail, but said he did speak on the phone with Mr. Trump on Wednesday about the progress of various policy initiatives at the department and implied that his job status did not come up.

A few hours later, he was at home on the phone with his wife when she broke the news: the president had fired him in a tweet.

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6. Politico: [Trump's VA pick blindsides staff, deepens agency disarray - 'He's got a department that's in turmoil,' a former VA secretary said. 'It's in crisis.'](#) (29 March, Lorraine Woellert, Eliana Johnson and Connor O'Brien, 23.9M uvm; Arlington, VA)

The timing of President Donald Trump's announcement to name Rear Admiral Ronny Jackson to lead Veterans Affairs was a snap decision that surprised his own chief of staff and knocked the government's second-largest agency, already bedeviled by scandal, deeper into disarray.

White House chief of staff John Kelly had spoken with David Shulkin by phone Wednesday morning, reassuring the now-former VA secretary that he wouldn't be fired by tweet that afternoon. Hours later, Kelly had to phone Shulkin again telling him plans had changed.

Trump declared Jackson's nomination on Twitter at 5:31 p.m. The tweet was big news — not just to the public, but to some senior aides, according to one White House official.

The chaos — by now a typical part of the president's management style — has for months upended Kelly's attempts to ensure that an unorthodox White House adheres to traditional processes. But while White House aides are left unpacking the day's events, the drama at the VA is just beginning.

Deputy Secretary Thomas Bowman, a Trump appointee who is the agency's No. 2, is widely expected to leave soon, either by choice or by force. Kelly and other aides wanted Bowman gone before Shulkin left to avoid installing the deputy at the helm, even temporarily. Bowman had pushed back on broad privatization efforts, leading Trump to berate him in an Oval Office meeting for his lack of loyalty.

Trump got around the Bowman problem by naming Robert Wilkie, an undersecretary at the Department of Defense, to the temporary job. A Capitol Hill veteran and member of Trump's transition team, Wilkie is a former senior adviser to Sen. Thom Tillis (R-N.C.), who supports expanding service members' access to private doctors.

"He's got a department that's in turmoil. It's in crisis. There's warfare there," said Anthony Principi, who led the agency under former President George W. Bush. "And you have an acting secretary who doesn't know the VA."

But if and when Bowman departs, Wilkie will be left with a shallow bench at an agency already paralyzed by political mistrust, some veterans' advocates say. The VA's health and benefit agencies — which administer tens of billions of dollars in health programs, pensions, survivor benefits and other forms of assistance to some 9 million service members — have been without Senate-confirmed officials since the Obama administration.

Veterans Affairs is the second-largest federal agency, behind only the Department of Defense, with 377,000 employees. And it has proven unwieldy even when led by highly decorated, experienced administrators such as Eric Shinseki, a retired four-star Army general who resigned during the Obama administration amid a scandal over lengthy wait times and faulty scheduling practices for medical appointments.

Shinseki was followed by Bob McDonald, an Army veteran and former Procter & Gamble CEO. Shulkin, McDonald's successor, was the first non-veteran to lead the VA.

As recently as two weeks ago, the Trump White House was still making overtures to potential candidates for the top job, according to a person with direct knowledge of the inquiries. Trump reportedly agonized over the decision, changing his mind several times, a senior administration official said.

"Instead of going through the paces to convince the best possible person to take this job, they're going with the person who's still on active duty in the Navy and can't say no to the commander in chief," said one Obama White House aide, who spoke highly of Jackson as a doctor and individual. "You could look at it as them giving up trying to find a competent commander or manager to fix the problems."

Shulkin had come under fire after a VA inspector general's report accused him of improperly accepting tickets to the Wimbledon tennis tournament and using his agency staff to arrange a sightseeing tour of Denmark and England. He repaid the VA for the trip. The longtime hospital administrator, who was engaged in open warfare with conservatives in the department intent on privatizing the VA, contended he was set up.

Veterans' groups remained loyal to Shulkin, whom they saw as their best line of defense of against privatization. During his campaign, Trump made promises that veterans would be allowed to seek medical treatment outside the VA's system, statements taken by some to mean a step toward handing the system to commercial companies to manage.

Jackson, while well-liked by both Republicans and Democrats, is a cipher on privatization and other policy issues. With no agency experience to speak of, veterans suspect he could be installed as a figurehead, leaving lower-level appointees to steer the agency toward privatization.

"He's a blank slate. Nobody knows really anything about his competency or capacity for this job," said Paul Rieckhoff, CEO of Iraq and Afghanistan Veterans of America. "We especially know that being a veteran doesn't qualify you to run the VA any more than being a soldier qualifies you to run the DoD."

Principi urged Jackson to move quickly on his own agenda.

"The new secretary, really, if he wants to accomplish anything, has to hit the deck running and has to bring in some very, very good people," he said. "I hope and pray he's a success. Because if he's not, American veterans are going to be the losers."

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7. NPR (All Things Considered, Audio): [Departure Of VA Secretary Shulkin Doesn't End Debate Of Privatization](#) (29 March, 22M uvm; Washington, DC)

The departure of Veterans Affairs Secretary David Shulkin does not end the debate over how far the agency should privatize. Neither the president nor his nominee have given their views on the subject.

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8. Daily KOS: [Trump replaces experienced hospital administrator with personal doc in fight to privatize the VA](#) (29 March, Mark Sumner, 19.1M uvm; Oakland, CA)

The replacement of Secretary of Veterans Affairs David Shulkin has two narratives in the media—that Shulkin “embarrassed” Donald Trump with a trip to Europe that included days of sightseeing, and that Shulkin “clashed” with other officials at the VA.

Despite the amount of play the first item has received in the press, and despite some completely justified criticisms of Shulkin’s efforts both slip his wife’s travel costs onto the VA’s dime and indulgence in gifts he should never have accepted, the idea that the he was pushed out over travel costs is clearly ludicrous. Scott Pruitt has engaged in far more lavish—and ridiculous—travel policies, hauling along a vast entourage on trips to Italy and Morocco, and the only thing his actions have earned from Trump is a suggestion that Pruitt may get a promotion to some other department ripe for wrecking. Besides, Trump isn’t capable of embarrassment.

And when the press reports that Shulkin butted heads with officials, what they really mean is that Shulkin was blocking appointees from Trump who were pushing to privatize the VA. Fast. The conflict was simple: Shulkin, the only hold-over in Trump’s cabinet from the Obama administration, was trying to maintain the VA as a viable system of health care for veterans. The Trump appointees that filled all the other VA slots, were actively working to to do to the VA what Pruitt has done to the EPA—destroy it. This morning, hours after his firing, Shulkin makes the case for preserving in the VA in the New York Times.

During my tenure at the department, we have accomplished a tremendous amount. We passed critical legislation that improved the appeals process for veterans seeking disability benefits, enacted a new G.I. Bill and helped ensure that we hire the right people to work at the department. ... We are now processing more disability claims and appeals than ever before and, for the first time, allowing veterans to see the status of their appeals by simply logging on to their accounts. ...

It seems that these successes within the department have intensified the ambitions of people who want to put V.A. health care in the hands of the private sector.

To replace Shulkin, an experienced hospital administer who previously oversaw Beth Israel Medical Center and was a pioneer in patient centered care, Trump has selected ... his personal physician. The one who says Trump is 6’3” and not obese.

The experience that the new head of the Department of Veterans Affairs has in running healthcare organizations appears to be limited to the running of himself. He finished medical school in 2004, and served a year in Iraq as an an emergency physician. From there he was appointed a White House physician in 2006, and has been there ever since.

A biography released by the White House shows Jackson is credentialed and experienced in medicine but has no background in management. He nonetheless will be charged with

delivering on one of Trump's signature campaign promises: to fix the federal government's second-largest bureaucracy.

His biggest achievement in the White House seems to be his pioneering work in patient-centered flattery.

"Some people have just great genes," Jackson said. "I told the president that if he had a healthier diet over the last 20 years, he might live to be 200 years old . . . He has incredibly good genes, and it's just the way God made him."

So when Trump begins a series of tweets against the Twenty-Second Amendment and planning his 2040 campaign, Jackson will be the person to blame.

But the biggest concern isn't that Jackson has no management experience. It's that he doesn't plan to manage at all. Instead, he's being put in place as a figurehead whose real purpose is to just stay out of the way of the forces that ultimately ran over Shulkin.

Until the past few months, veteran issues were dealt with in a largely bipartisan way. (My 100-0 Senate confirmation was perhaps the best evidence that the V.A. has been the exception to Washington's political polarization). Unfortunately, the department has become entangled in a brutal power struggle, with some political appointees choosing to promote their agendas instead of what's best for veterans. These individuals, who seek to privatize veteran health care as an alternative to government-run V.A. care, unfortunately fail to engage in realistic plans regarding who will care for the more than 9 million veterans who rely on the department for life-sustaining care.

But at least there will be someone there with the experience to flatter them wildly.

"He's very sharp, and he's very articulate when he speaks to me, and I've never known him to repeat himself around me," Jackson said. "I've found no reason whatsoever to think the president has any issues whatsoever with his thought process."

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9. Task & Purpose: [What's In Store For The Next VA Chief? Let's Break It Down](#) (29 March, James Clark, 102k uvm; New York, NY)

It's been an awkwardly long time coming, but as of yesterday afternoon embattled Veterans Affairs secretary David Shulkin is out of a job. The news comes after a month and a half of uncertainty that began when a scathing inspector general report detailed "serious derelictions" in expensing a Europe trip last summer. And then there were all the accusations and counter accusations of political infighting and rumors of possible replacements — at least all that is over:

Rear Adm. Ronny Jackson, the president's appointed White House physician, who drew national attention when he complimented President Trump on his "incredibly good genes," has been tapped to lead the Department of Veterans Affairs — pending approval by the Senate. Given that this leadership post has been described as "one of the most difficult jobs in government" — which has stymied generals, CEOs and health care executives — we thought it was time to give you a rundown of what's in store for the next officeholder, by the numbers:

More than 1,243 health care facilities. These Veterans Health Administration facilities include 170 VA Medical Centers, and 1,063 outpatient sites — making it the largest health care system in the United States.

9,000,000 veterans.. That's the number who receive medical care from VA, and many of these patients are older and suffer from multiple traumas and injuries that require specialized care: amputations, traumatic brain injuries, post-traumatic stress disorder, military sexual trauma, and as of 2013, half of all VA patients suffer from chronic pain, to name just a few. And as many as 2 million patients receive in-facility care, according to an American Legion statement.

20,000,000 veterans in the United States... we think. There could be far more veterans than we realize, since an individual's military history isn't tracked by the census bureau, which is a concern since the VA relies on headcount of its target population to get a feel for the size and scope of the services it needs to provide.

\$10,000,000,000 contract for Electronic Health Records. A long-term plan to modernize the VA's health records system could be jeopardy, with Shulkin's dismissal coming just as the VA was set to finalize the acquisition of a new electronic health record system.

2nd largest federal agency. The only one bigger is the Department of Defense.

\$186,000,000,000 budget for fiscal year 2018.

360,000 employees spread across three separate administrations within the department; the Veterans Health Administration, Veterans Benefit Administration, and the National Cemetery Administration.

23 years active duty. Jackson's Navy career began in 1995, and includes postings as an instructor, diving medical officer, diving safety officer, from Panama City, Florida Sigonella, Italy, to Norfolk, Virginia. By 2005 he deployed to Taqaddum, Iraq as part of a Surgical Shock Trauma platoon.

3 presidents. While still in Iraq in 2006, Jackson was selected as a White House physician and served as the supervising physician for the Camp David Presidential Retreat under the George W. Bush administration. Later he led the White House Medical Unit as its director and was the appointed White House physician for Presidents Barack Obama and Donald Trump.

Soon to be 7 VA secretaries in 4 years. The department has been beset by turmoil and scandal. Eric Shinseki resigned from his post as VA chief following the 2014 wait-list scandal the department. Since then, the VA has gone through three sitting secretaries, and is on its third acting secretary, with Robert Wilkie, previously the Pentagon's undersecretary of personnel and readiness, now tasked as the interim chief until Shulkin's replacement is approved by the Senate.

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10. Washington Post: [Opinions - Surprise: Trump's newest Cabinet nominee has no relevant experience](#) (29 March, Eugene Robinson, 43.9M uvm; Washington, DC)

You can't make this stuff up: President Trump has announced he will nominate a medical doctor who has no discernible management experience to run the second-largest agency in the federal government.

Can presidents be sued for malpractice?

The man Trump has named to become secretary of veterans affairs, Ronny L. Jackson , happens to be the president's personal doctor. More to the point, given Trump's perpetual hunger for sycophancy, is the fact that Jackson showered the president with hyperbolic Dear-Leader-style praise during a widely viewed television appearance in January.

Trump has "incredibly good genes," the White House physician said in describing a examination he had given the president. Trump's overall health is "excellent." His "cardiac assessment" put him "in the excellent range." If his diet were a bit better, "he might live to be 200 years old." In any event, "I think he will remain fit for duty for the remainder of this term and even for the remainder of another term if he's elected."

That is an unusual way to describe a 71-year-old man whose height was reported as a generous 6 feet 3 inches , and weight at an eyebrow-raising 239 pounds, which classifies him as overweight — but conveniently one pound short of obese. Jackson's are odd words characterizing a man whose cheeseburger-laden diet my doctor would describe as suicidal and whose coronary calcium scan results, according to many other physicians, indicate some degree of heart disease and a clearly elevated risk of heart attack.

I assume Jackson has been more, shall we say, plain-spoken with the president about his health than he was with the public. But am I suggesting that flattery, rather than merit, is what makes him Trump's choice to replace ousted VA Secretary David Shulkin? Absolutely, because no other explanation makes sense.

Pliability may also be playing a role. In a New York Times op-ed, Shulkin wrote that he believed he was being sacked because he opposed a push by the Trump administration "to put VA health care in the hands of the private sector."

Shulkin is a physician, but before he took over VA, he also had experience running hospitals. With no comparable administrative background, Jackson — if confirmed by the Senate — would take over a sprawling agency with about 360,000 employees, a \$186 billion budget and responsibility for providing medical care to 9 million veterans who deserve better, faster service than they now receive.

Shulkin was one of several high-ranking Trump appointees under fire for lavish spending on the taxpayers' dime. He was also a holdover from the Obama administration, and even though the job is perhaps the least partisan in the Cabinet , that prior association clashed with Trump's bratty determination to oppose everything President Barack Obama supported and support everything he opposed.

But Shulkin, by most accounts, had stabilized VA's vast system of hospitals and health clinics. What he refused to do was support the notion of privatizing veterans' health care — an idea pushed by some of the political appointees the White House had installed under him.

"I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans," Shulkin wrote in his Times op-

ed. "The private sector . . . is ill-prepared to handle the number and complexity of patients that would come from closing or downsizing VA hospitals and clinics, particularly when it comes to the mental health needs of people scarred by the horrors of war."

Shulkin wrote that "in recent months" the political environment in Washington had become "toxic, chaotic, disrespectful and subversive," making it impossible for him to do his job. "It should not be this hard to serve your country," he wrote.

But it should be hard to get a job running any organization as big, complex and vital as the Department of Veterans Affairs. Perhaps Jackson has an innate genius for management that awaits only the opportunity to flower. If not, Trump will be doing a grave disservice to men and women who are owed the nation's thanks and gratitude.

I can't say I'm surprised. Trump put neurosurgeon Ben Carson in charge of the Department of Housing and Urban Development, despite Carson having zero experience in housing policy. He put Betsy DeVos in charge of the Department of Education, despite her apparent unfamiliarity with actual schools. He put politician Rick Perry in charge of the Department of Energy, which Perry wanted to eliminate until he learned what the agency does.

Perry actually said that during his confirmation hearing. One doesn't know whether to laugh or cry.

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11. Washington Post (The Fix): [Who is Trump's new Veterans Affairs pick, Ronny Jackson?](#) (29 March, Aaron Blake, 43.9M uvm; Washington, DC)

The seemingly never-ending parade of staff changes in the Trump administration continued apace Wednesday, with the president announcing that Veterans Affairs Secretary David Shulkin is out and that White House physician Ronny L. Jackson will replace him.

Jackson's name will be familiar to political watchers across the country for one main reason: He's the physician who delivered what some felt to be a suspiciously rosy picture of Trump's health in January. But he's an interesting pick for a whole host of other reasons.

For one, Jackson is something of a nonpartisan pick. Like Shulkin, he served in the Obama administration, where he was also President Barack Obama's White House physician. A native of Texas and a graduate of Texas A&M and University of Texas Medical Branch, he's a rear admiral in the U.S. Navy who has spent decades practicing medicine in the military. Jackson was nominated for a promotion to rear admiral (upper half) as recently as last week, which would give him his second star. According to his Navy biography, he was deployed to Iraq in the mid 2000s to head up an emergency medical unit tasked with resuscitating troops.

While there, he was chosen to join President George W. Bush's White House as a physician. In 2013, Obama promoted him to the top job in the West Wing. Trump elected to keep him on. In that role, Jackson oversees not just Trump's health, but also that of the first family and White House staff and guests. He mostly stayed behind the scenes but made headlines after treating a girl who got bit by one of the Obamas' dogs in January 2017.

Navy Rear Adm. Ronny L. Jackson, the lead White House doctor, said on Jan. 16 that President Trump's "overall health is excellent." (Bastien Inzaurrealde/The Washington Post)

Jackson reached his highest degree of notoriety in January, when he delivered a promised review of Trump's health. Trump, who at 70 was the oldest newly elected president ever, is known to eschew exercise and dine on fast food. There have also been persistent questions — especially among his critics — about his mental health. And Trump's medical reviews during the campaign were both ridiculously hyperbolic — claiming he would be the most healthy president ever — and omitted key pieces of information, including a hair-loss drug Trump takes.

Jackson's review played up a cognitive test Trump had passed that seeks out early signs of dementia and other kinds of mental deterioration. He said Trump had "incredible genes" and (seemingly) joked that if Trump's diet had been better he might live to be 200 years old. He denied Trump had heart disease even as the data suggested he might. He listed Trump's weight at 239 pounds, which left Trump exactly one pound shy of the definition of "obese" and spawned a whole host of dubious reactions. (Call it the "girther" movement.)

The whole thing earned Jackson a send-up during the cold open of "Saturday Night Live."

Despite the ridicule, members of the Obama administration vigorously defended Jackson as a patriot and an honest man.

If nothing else, Jackson's ascension seems to reinforce that the best way to get ahead in the Trump administration is to say nice things about him. Some defended Jackson's credentials, but that review will likely be a topic at his confirmation hearings.

Perhaps the main reason Jackson is a somewhat controversial pick, though, is his lack of management experience. VA has been a department beset by scandals in recent years — including before Shulkin — and has proved a logistical and bureaucratic nightmare. Jackson has headed up medical units in the White House and Iraq, but he has never dealt with anything close to the scale of what he's set to take on. It may be the toughest Cabinet job in the entire administration, in fact.

Trump, though, as he often does, has gone with a nontraditional pick who said things he liked on television.

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12. FOX News: [Ronny Jackson picked by Trump to lead the VA: What to know about the president's physician](#) (29 March, Kaitlyn Schallhorn, 32.5M uvm; New York, NY)

President Trump gave Dr. Ronny Jackson a clean bill of health in March — to run the Department of Veterans Affairs.

A Navy rear admiral, Jackson is the president's personal physician who rose to prominence after he addressed the press from the White House briefing room in January to discuss Trump's health. While Jackson said the president needs to lose some weight, he said the physical exam he conducted showed overall that Trump was in good physical and mental health.

Trump fired Secretary David Shulkin on March 28, and Robert Wilkie is serving as interim secretary until Jackson is confirmed.

He has a marine biology degree

From Texas, Jackson, 50, graduated from Texas A&M University in 1991 with a degree in marine biology, according to his Navy biography. He graduated from the University of Texas Medical Branch with his medical degree in 1995.

That same year, Jackson joined the Portsmouth Naval Medical Center – located just outside Chesapeake, Virginia – which kicked off his active duty military career. It was there that he finished an internship in transitional medicine.

Later, he would return to the naval center to complete his residency in emergency medicine, graduating at the top of his class in 2004.

Jackson is a veteran

Jackson was deployed to Iraq after he joined the 2nd Marines in 2005, according to his Navy biography.

He served as the emergency medicine physician in charge of resuscitative medicine for a forward deployed Surgical Shock Trauma Platoon.

He's been a White House physician since Bush

While still in Iraq, Jackson was tapped as a White House physician in 2006. He has overseen the physicians for Camp David presidential retreats, led the White House Medical Unit and directed the executive health care for the Cabinet and senior staff members, according to his biography.

It was former President Barack Obama who selected Jackson to fill the position of physician to the president.

The Associated Press contributed to this report.

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13. FOX News (Video): [John Brennan: Trump's nomination for VA secretary is 'terribly misguided'](#) (29 March, Nicole Darrah, 32.5M uvm; New York, NY)

Former CIA Director John Brennan once again took a shot at President Trump on Twitter Thursday, saying he believes the decision to nominate Adm. Ronny Jackson to run the Department of Veterans Affairs is "terribly misguided."

"I personally know and greatly respect Ronny Jackson....as a terrific doctor and Navy officer," Brennan tweeted. "However, he has neither the experience nor the credentials to run the very large and complex VA. This is a terribly misguided nomination that will hurt both a good man and our veterans."

Trump announced via Twitter Wednesday his intention to replace current VA Secretary David Shulkin with Jackson, a 50-year-old Navy rear admiral who has served as personal physician to the president since 2013, when he was appointed by former President Obama, after being tapped to serve as a White House doctor in 2006.

Jackson's also a veteran. He was deployed to Iraq after he joined the 2nd Marines in 2005, according to his Navy biography.

Jackson's nomination triggered some concern among lawmakers and veterans groups about his experience to manage a federal agency, but Trump praised the lifelong doctor as "highly trained and qualified."

Trump decided to oust Shulkin from his Cabinet after he served just over a year in office. An internal VA watchdog found last month that Shulkin improperly accepted Wimbledon tennis tickets and that his then-chief of staff had doctored emails to justify his wife traveling to Europe with him at taxpayer's expense.

The swipe from Brennan, now an analyst for NBC News and MSNBC, isn't the first he's made against Trump.

Just last week, he suggested that the Russians "may have something" against the president, and days prior to that in response to former FBI official Andrew McCabe's firing: "When the full extent of your venality, moral turpitude, and political corruption becomes known, you will take your rightful place as a disgraced demagogue in the dustbin of history."

Fox News' Kaitlyn Schallhorn and Elizabeth Llorente, along with The Associated Press, contributed to this report.

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14. New York Times: [Op-ed - Ronny Jackson's Disturbing Lack of Independence](#) (29 March, Norman L. Eisen and Bandy X. Lee, 30M uvm; New York, NY)

In announcing Dr. Ronny Jackson, the White House physician, as his choice to be the new secretary for veterans affairs, President Trump has taken his latest misstep in what has been the worst presidential personnel process in modern history.

We take no pleasure in saying so, including because one of us (Mr. Eisen) worked with Dr. Jackson in the White House, was even treated by him, and can testify that he is a very capable physician. But that good opinion of Dr. Jackson, which was widely held in the Obama administration, by no means qualifies him to run one of the largest, most complex and troubled cabinet agencies in the federal government.

Indeed, the very affability of Dr. Jackson's approach when it comes to his current presidential patient is perhaps his greatest disqualification, followed closely by his lack of relevant management experience and the apparent absence of a normal pre-nomination personnel vetting.

Dr. Jackson's January examination of President Trump, and subsequent news conference, give us great pause because they evinced a disturbing lack of independence — one of the most

important qualities in a cabinet member. Dr. Jackson startled observers by not only finding the president healthy, but declaring he would remain so in the future. The doctor even looked into his crystal ball to predict good health for a second term, a pronouncement extending seven years into the future and so more fit for a fortuneteller than a scientist.

Some expert observers also felt Dr. Jackson may have understated the president's heart disease, and even fudged the president's height (his driver's license says 6 feet 2 inches; Dr. Jackson reported 6 feet 3 inches) because the lower number would have forced the doctor to admit his patient was obese. When asked why he had such glowing things to say about the president's health when Mr. Trump gorges on McDonalds, guzzles diet Coke, and seldom exercises, Dr. Jackson said: "Some people have just great genes. I told the president that if he had a healthier diet over the last 20 years, he might live to be 200 years old."

That is hardly the objectivity that America needs from its cabinet members. But Dr. Jackson's worst failing was his purported examination of the president's psychological fitness, resulting in his pronouncement that "the president is mentally very, very sharp." The examination came at a time when there was widespread public discussion about the president's mental state, driven by reporting about some of the president's startling behind-the-scenes behavior. The scrutiny was so intense that the president himself asked Dr. Jackson for testing.

But the test that Dr. Jackson administered was not fit for his conclusion. It was a short examination known as the Montreal Cognitive Assessment, which is generally used as a screen for Alzheimer's and similar symptoms. One of us (Dr. Lee) is a mental health professional who has expertise in these examinations, and would never have utilized this narrow test under these circumstances. It is the equivalent of pronouncing a patient cancer-free because she has a good complexion.

A full history should have been taken and a standardized battery of tests given, such as the Minnesota Multiphasic Personality Inventory. Among the other, more appropriate tests that should also have been considered are the Wisconsin Card Sorting Test, the California Verbal Learning Test and the Stroop Test. The MoCA examination was simply not sufficient under the circumstances to support Dr. Jackson's declaration that he had "absolutely no concerns" about the president's cognitive ability or neurological functions.

All of this matters because, if Dr. Jackson cannot be trusted to act independently when it comes to the president's mental and physical health, we cannot be confident that he will do so when it comes to the fitness of the Department of Veterans Affairs. The department has the sacred charge of repaying our soldiers for their service by providing them with health care and other support. If Dr. Jackson tells the president — and the country — what Mr. Trump wants to hear about his own health, how can we trust him to honestly and rigorously diagnose the ailments of the V.A., and to treat them appropriately?

Having a candid V.A. secretary is all the more important because the department faces profound challenges. Since 2014, it has dealt with a pattern of negligent treatment at hospitals operated by one of its agencies, the Veterans Health Administration. Outgoing Secretary David Shulkin revealed yesterday that he had fought Trump administration proposals to privatize services provided by the V.A. — a move that could undermine the quality of health care provided to our veterans. Dr. Jackson's treatment of the president does not inspire confidence that he will take on the V.A.'s problems with the brutal honesty that the job demands.

Dr. Jackson's nomination is also undermined by the fact that although he is a medical professional, he lacks the management experience that the job demands. The V.A. secretary is responsible for a department that provides health care services to over nine million individuals. While Dr. Jackson has served his country with distinction, both in Iraq and as the White House physician, managing a relatively small medical team is not preparation for leading a vast and sprawling bureaucracy. The V.A. is one of the most complex health care management jobs in the world, and ideally would be run by someone with experience operating hospital systems or health businesses or enterprises, and large ones.

The nomination fits a pattern of cronyism, with the president appointing those of dubious qualifications to patronage jobs across the administration. The president's former golf caddy is now the White House social media director. A contractor married to one of the Trump's former household staff members now has a job at the Environmental Protection Agency. And a longtime friend of the Trump family who has been involved in planning golf tournaments and Eric Trump's wedding is the head of the New York and New Jersey office of the Department of Housing and Urban Development. And now he has appointed his White House doctor to oversee the health care of millions of veterans.

Finally, in addition to concerns about independence and qualifications, it appears that Dr. Jackson had not undergone the normal vetting process for White House presidential personnel. Reportedly, the tweet-from-the-hip nomination of Dr. Jackson by the president surprised even his own advisers. That suggests that Dr. Jackson has not in fact received the careful review that is normally completed before such an announcement.

One of us worked (just down the hall from Dr. Jackson, actually) on vetting hundreds of senior administration officials. Very presentable and capable individuals — sometimes even those with existing security clearances — are sometimes disqualified by the rigorous personnel investigations that are normally undertaken for cabinet positions. Such cabinet-level vets complement but are more thorough than a typical pre-existing security clearance, and can uncover conflicts, misdeeds or other disqualifying information.

We are not suggesting that vetting will uncover anything improper, but caution is warranted, since many of Mr. Trump's nominees have had unprecedented conflicts and other issues.

Norman L. Eisen (@NormEisen) is a senior fellow at the Brookings Institution and was President Obama's ethics czar from 2009 to 2011. Bandy X.Lee is a forensic psychiatrist at the Yale School of Medicine and a project leader for the World Health Organization.

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15. ABC News (Video): [Veterans groups respond cautiously to VA secretary nomination](#) (29 March, Sarah Kolinovsky, 24.2M uvm; New York, NY)

Despite his active duty status as a Navy rear admiral (lower half) and his medical experience, veterans service organizations are responding cautiously to the nomination of Dr. Ronny Jackson for secretary of Veterans Affairs, with some expressing concern about his lack of managerial experience or what his views are on reforming the VA.

Jackson has served as White House Physician in the past three administrations and in January gave President Donald Trump a glowing health review. Recently, Trump nominated Jackson to

receive a second star, promoting him to the rank of full rear admiral. Jackson has deployed to Iraq as an emergency medicine physician in charge of resuscitative medicine for a forward-deployed Surgical Shock Trauma Platoon.

Iraq and Afghanistan Veterans of America, an organization serving the post-9/11 generation of veterans, say it looks "forward to learning more about Dr. Ronny Jackson's vision and qualifications." The statement underscores the fact that Jackson lacks significant managerial experience as he is poised to lead the government's second largest agency, which cares for more than nine million veterans and has an annual budget of nearly \$200 billion.

"Nobody really knows who is he. Is he an empty vessel? Does he have strong views on privatization, or reforming the VA?" asked IAVA CEO and Founder Paul Rieckhoff during an appearance on CNN Thursday morning. "So the confirmation hearings are going to be really really important. The Senate, House, time for you guys to step up and grill this guy and find out if he is qualified to not only run the agency but care for our veterans in a time of war."

IAVA welcomed the news that "finally puts an end to weeks of painful speculation that was negatively impacting VA and veterans nationwide," referring to media reports that President Trump had lost confidence in Secretary Shulkin. IAVA pointed out that in a recent survey, only 24% of the organization's members approved of the job Shulkin was doing.

Veterans of Foreign Wars (VFW) echoed IAVA's hesitation about Jackson's experience. "The VFW will be closely monitoring the Senate confirmation process, because what Dr. Jackson's bio does not reflect is any experience working with the VA or with veterans, or managing any organization of size, much less one as multifaceted as the Department of Veterans Affairs," VFW Director of Communications Joe Davis said in a statement.

The conservative group Concerned Veterans for America expressed more optimism about the change, saying in a statement "We are hopeful that this change will end the recent distractions at the VA and put the focus back on advancing policy that will ensure veterans get the health care and other benefits they have earned. The Trump administration has made great progress over the last year reforming and fixing the VA, however, there is still much work to be done."

The American Legion declined to comment directly on Jackson's qualifications. Instead, the group highlighted their intention to work "directly with the President through this transition and going forward, and providing him an increased level of advice and feedback on the issues important to America's veterans."

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16. The Atlantic: [The Doctor Who Suddenly Got Nine Million Patients - For a position that demands high-level policy expertise, President Trump appointed his personal physician, Ronny Jackson.](#) (29 March, James Hamblin, 23.9M uvm; Washington, DC)

Nine million veterans will soon be under the care of the emergency-physician rear admiral Ronny Jackson, pending confirmation of his appointment Wednesday to lead the U.S. Department of Veterans Affairs.

This seemingly mundane appointment—a doctor and naval officer with years of experience as White House physician under both Trump and Obama—is of great consequence. It comes at a

time when the VA is in need of a politically savvy expert on health-care administration, budgeting, and resource allocation, as the system is on the brink of major changes that bear on national security. The system has proven to require a leader who can thread multiple bureaucratic needles with his or her eyes closed. Jackson does not clearly fit this bill.

The VA is the second-largest federal department, overseeing 1,243 health-care facilities including 170 hospitals, which tend to be a ghostly network of dim, mid-century structures that bear the scars of serving as constant political battlefields. They tend to have bad food and no marble and bizarre gift shops that I've seen sell knives and cured meats. Yet VA hospitals seem to underscore the waste of the glitz of five-star-hospital-style academic medical centers. The system punches above its weight in the quality and safety of care it delivers compared to most of the private health-care industry.

While it is crucial to have experienced veterans and physicians in the upper echelons of a system like this, the work is mostly about politics and economics. Jackson is not an expert in policy, and he lacks work experience in health-care administration or management. His chief credential is that he is a physician. I'm also a physician, and—ask anyone—I'm wholly unqualified to lead a hospital system, much less to lead the one most crucial to our national security.

Even as a doctor, Jackson's judgment has been dubious at times. The press conference in January where he extolled President Trump's soundness of mind suggested allegiance to the president above the public or the profession: "I've found no reason whatsoever to think that the president has any issues whatsoever with his thought process," Jackson said, after having administered a 10-minute test for dementia in which the president was asked to do basic math, identify zoo animals, and draw a clock. (A useful and good test, the results of which were, I've argued, overstated in the context of widespread physician concern over the president's soundness of mind.)

Professional bearing intact, Jackson also said that the borderline-obese (BMI 29.9), 71-year-old president—who does not exercise and eats McDonald's to excess (Filet-o-Fish, no less) and is known for angry outbursts and drinks around 144 ounces of Diet Coke per day and barely sleeps—is in "very good health, excellent health." He speculated that the president would remain fit for service until the end of a second term and said he told Trump that "if he had a healthier diet over the last 20 years, he might live to be 200 years old."

As David Axelrod, former adviser to President Obama and now the director of the University of Chicago Institute of Politics, responded publicly to the appointment: "Dr. Jackson is a good and honorable person, [a] fine doctor and career military, but you do get the sense that this [appointment] has as much to do with his boffo press conference on the president's physical [exam] as anything else."

Trump has become known for proximity-based, loyalty-based promotions made with apparent haste. Jackson may simply have been the only doctor in Trump's field of view. With doctors Oz and Phil being televisually obligated, and Harold Bornstein all the way up in New York ... who else is there?

Though if the move was deliberate to a policy end, it was a savvy move from the perspective of those who would like to see the VA privatized. There has been a creeping movement to privatize elements of the VA system, backed by the Koch brothers, among others. At a policy

level, the concept is worthy of consideration and debate. Some experts argue that certain elements being privatized could improve quality and decrease costs.

But that doesn't seem to be what's happening. The outgoing VA secretary David Shulkin made this clear on Thursday in an op-ed in The New York Times. He argued that some public-private cooperation had been fruitful: "We have expanded access to health care by reducing wait times, increasing productivity, and working more closely with the private sector." But he also warned that the push toward complete privatization was not being undertaken in good faith. Shulkin writes:

It seems that these successes within the department have intensified the ambitions of people who want to put VA health care in the hands of the private sector. I believe differences in philosophy deserve robust debate, and solutions should be determined based on the merits of the arguments. The advocates within the administration for privatizing VA health services, however, reject this approach. They saw me as an obstacle to privatization who had to be removed. That is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans.

With Shulkin out of the way, the next secretary of the VA would need to approach the job with strong moral bearing and willingness to resist political expedience for the sake of improving the system. Without this force, special interests could sway the system toward privatization at a cost to taxpayers and veterans.

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17. NPR (All Things Considered, Audio): [Republican Sen. Jerry Moran Weighs In On Firing Of VA Secretary Shulkin](#) (29 March, 22M uvm; Washington, DC)

There's more turnover in President Trump's cabinet — this time at the Department of Veterans Affairs. NPR's Ailsa Chang talks to Sen. Jerry Moran, R-Kan., and member of the Senate Veterans Affairs Committee, about oversight of the department and the confirmation process of the person picked to lead it.

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18. NPR (All Things Considered, Audio): [How Veteran Groups Are Reacting To The Departure Of VA Secretary Shulkin](#) (29 March, 22M uvm; Washington, DC)

Garry Augustine, executive director of Disabled American Veterans, speaks with NPR's Audie Cornish about how veteran groups are responding to the the news of VA Secretary David Shulkin's firing.

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19. The Hill: [White House: Trump has 'full confidence' in presidential physician to lead VA](#) (29 March, Max Greenwood, 11.9M uvm; Washington, DC)

President Trump has "full confidence" in White House physician Ronny Jackson's ability to head the Veterans Affairs (VA) Department, a spokeswoman for the White House said Thursday, despite reported concerns from some aides.

"As I said earlier, the president has full confidence in Adm. Jackson," White House deputy press secretary Lindsay Walters told reporters.

"The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary and ultimately decided that his health care experience, his distinguished career in the medical profession, was something that would be beneficial at the VA," she continued.

"At the end of the day, as I said earlier, the status quo was not working. We need somebody who understands the health care system," she said.

Trump continued a spate of shake-ups in his Cabinet on Wednesday by dismissing VA Secretary David Shulkin and tapping Jackson, a rear admiral in the Navy and the current White House physician, for the role.

The New York Times reported Wednesday that some White House aides had privately expressed concern about the decision to nominate Jackson for the VA's top job, because of his lack of experience managing a large organization.

At the same time, some aides acknowledged that Trump's relationship with Jackson carried more weight in making the decision than the physician's prior experience, the Times reported. Jackson gave Trump his first physical in office earlier this year.

Walters told reporters Thursday that Jackson "has bipartisan respect" in Congress, and said his experience in the Navy gives him an insight into "what soldiers need on the battlefield and what they need when they come home as veterans."

She also said the decision to oust Shulkin and nominate Jackson was in no way part of an effort to privatize veterans' health care, as Shulkin had implied in an op-ed he wrote the day after his ouster.

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20. The Hill: [GOP, vet groups react with caution to Trump VA pick](#) (29 March, Rebecca Kheel, 11.9M uvm; Washington, DC)

Senators and influential veterans groups are withholding judgment on President Trump's pick to lead the Department of Veterans Affairs (VA), a Navy doctor with no experience leading a federal bureaucracy.

Both the Republican chairman and the Democratic ranking member of the Senate Veterans Affairs Committee said only that they look forward to meeting Rear Adm. Ronny Jackson. Several veterans groups expressed some concern about Jackson's qualifications, but did not immediately oppose him, saying that questions need to be answered during the confirmation process.

"We look forward to understanding more about the qualifications of Admiral Ronny L. Jackson, MD to helm the VA during this critical time," Carl Blake, executive director of Paralyzed Veterans of America, said in a statement. "The VA has a broad mission and the secretary must be someone who is eminently qualified to lead the nation's second largest cabinet agency."

On Wednesday night, Trump announced on Twitter that he'd tapped Jackson to replace David Shulkin, who fell out of the president's good graces after turmoil over the direction of private health care for veterans and a scathing inspector general report accusing him of misusing taxpayer dollars on a trip to Europe.

Shulkin's firing was expected, but Jackson was not among the names circulating as possible replacements.

Statements from lawmakers and veterans groups poured in Wednesday night, heavily praising Shulkin for his service at the department.

When it came to Jackson, though, the statements were generally shorter and more neutral.

"I look forward to meeting Admiral Jackson and learning more about him," Senate Veterans Affairs Chairman Johnny Isakson (R-Ga.) said in a statement.

In a separate statement, committee ranking member Sen. Jon Tester (D-Mont.) likewise said he looks "forward to meeting Admiral Jackson soon and seeing if he is up to the job."

Jackson was first thrust into the public spotlight when he gave Trump a clean bill of health in January during a lengthy and unusual press briefing at the White House.

Jackson told reporters that a cognitive test showed "no reason whatsoever to think the president has any issues whatsoever with his thought processes." He also proclaimed Trump's "overall health is excellent," crediting the president's "good genes" despite a well-known penchant for fast food and lack of exercise.

Jackson has served as a White House physician since 2006 and was promoted by former President Obama in 2013 to become the physician to the president.

Just last week, Trump nominated Jackson for a promotion in rank from rear admiral (lower half) to rear admiral. Jackson is expected to retire from active duty if confirmed.

A Texas native who received his doctorate of medicine from the University of Texas Medical Branch, Jackson started his naval career in 1995 at the Portsmouth Naval Medical Center in Virginia, according to his Navy biography.

In 2005, Jackson deployed as part of the Surgical Shock Trauma Platoon in Taqaddum, Iraq. There, he served as the emergency physician in charge of resuscitative medicine.

His bio lists several awards, including the Defense Superior Service Medal, the Legion of Merit, the Navy/Marine Corps Commendation Medal and the Navy/Marine Corps Achievement Medal.

But it makes no mention of any work on veterans issues.

Still, the White House says Trump has “full confidence” in Jackson, adding he believes the department needs someone who understands health care.

If confirmed, Jackson would take the helm at the government’s second largest bureaucracy at a time when the VA is still regaining trust after a 2014 scandal over long and falsified wait times for veterans seeking health care.

In addition to overseeing 1,700 health-care sites serving almost 9 million veterans annually, the doctor would be in charge of benefits delivery, 360,000 employees and a nearly \$200-billion budget.

Jackson would also come in during a raging debate over legislation to expand a program known as Choice that provides private health care to some veterans -- a concern seen as central to Shulkin’s undoing.

At issue is how much to expand the program. Veterans groups and Democrats fear the White House wants to essentially privatize veterans health care, which they warn would not be able to address the unique challenges veterans face.

Jackson’s position on the issue is unknown, though the White House said Thursday in response to accusations made by Shulkin that “there are no discussions about privatizing” the VA.

Veterans service organizations, which are congressionally chartered and hold substantial sway over veterans issues in Congress, raised questions about Jackson’s qualifications.

AMVETS listed several questions for Jackson, including how someone who’s never held a command is qualified to lead a massive bureaucracy and what his qualifications are to address issues outside of health care including claims, appeals, benefits and cemetery affairs.

“I am deeply concerned about the nominee,” AMVETS Executive Director Joe Chenelly said in a statement. “Veterans’ lives depend on this decision, and the Trump administration needs to substantiate that this active-duty Navy officer is qualified to run a \$200 billion bureaucracy, the second largest agency in the government.”

Disabled American Veterans (DAV) said they look forward to “learning more about the qualifications and views” of Jackson and expressed concern about a leadership vacuum.

“At a time of critical negotiations over the future of veterans healthcare reform, VA today has no secretary, no under secretary of health or benefits, and the named acting secretary has no background in health care and no apparent experience working in or with the department,” DAV Commander Delphine Metcalf-Foster said in a statement, referring to acting Secretary Robert Wilkie, who comes from the Pentagon.

“We certainly expect the next secretary to continue the path set by VA, Congress and veterans organizations in recent years to strengthen the VA healthcare system while ensuring that all enrolled veterans have timely access to quality care, whenever and wherever they need it.”

Still, Vietnam Veterans of America (VVA) said Jackson will understand veterans’ needs.

"We are pleased that he is a combat veteran with firsthand knowledge of the trauma of war, and as such, will understand what our veterans need," VVA National President John Rowan said in a statement.

VA secretaries typically receive strong bipartisan support in their confirmation. Shulkin was confirmed unanimously, as was his predecessor Bob McDonald. The secretary before that, Eric Shinseki, was confirmed by voice vote.

Nominees only need a simple majority to be confirmed. But Republicans only have a two-seat advantage over Democrats in the Senate, and one Republican, Sen. John McCain (Ariz.), has not voted in months as he receives cancer treatment in his home state.

Republicans on the Senate Veterans Affairs Committee appeared inclined to support Jackson.

"I look forward to working with Dr. Ronny Jackson on modernizing and reforming the VA, fixing the VA Choice Program, and implementing the major reforms that Congress has passed over the last year," Sen. Thom Tillis (R-N.C.) said in a statement.

Sen. Jerry Moran (R-Kan.), who in January accused Shulkin of "double-talk" in negotiating on Choice, said the VA secretary needs to focus on changing the department's bureaucracy.

"Rear Admiral Jackson has a career in service and I look forward to discussing his plans for the VA to make certain veterans receive access to care they deserve," Moran said in a statement.

Committee Democrats, meanwhile, promised close scrutiny of Jackson's qualifications and his position on privatization.

"I will seriously scrutinize the president's nominee, Ronny Jackson, because our nation's veterans deserve the best," Sen. Richard Blumenthal (D-Conn.) said in a statement.

Sen. Bernie Sanders (I-Vt.), who caucuses with Democrats, was more blunt.

"The Senate Committee on Veterans Affairs should not approve any nominee for secretary who supports the privatization of the VA," he said in a statement.

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21. Military.com: [Others Considered for VA Job Before Trump Picked His Personal Doctor](#) (29 March, Richard Sisk, 9M uvm; San Francisco, CA)

Rear Adm. Ronny L. Jackson, the personal physician to President Donald Trump, was not his first choice to replace fired VA Secretary Dr. David Shulkin, the White House said Thursday.

"The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary," White House deputy press secretary Lindsay Walters told reporters.

She said Trump "ultimately decided that his [Jackson's] health care experience, his distinguished career in the medical profession, was something that would be beneficial at the VA."

Walters added that Trump "has full confidence in Admiral Jackson" to fulfill the demanding job at the Department of Veterans Affairs despite his lack of experience in running large organizations.

Walters did not name the others who were considered to head the VA, but they reportedly included Toby Cosgrove, former head of the \$8 billion Cleveland Clinic health care system, and Pete Hegseth, an Army National Guard veteran of Iraq, former head of the advocacy group Concerned Veterans of America and co-host of the weekend "Fox & Friends" program.

Cosgrove, a Vietnam veteran, was among those invited in 2016 to Trump's Mar-a-Lago estate in Florida to be interviewed for the VA post before Trump settled on Shulkin, a holdover from the Obama administration.

Others who were under consideration as VA secretary included former Rep. Jeff Miller, R-Florida, who had been chairman of the House Veterans Affairs Committee; retired Army Lt. Gen. Keith Kellogg; Michael Kussman, a former VA undersecretary of health; and Leo Mackay Jr., a former VA deputy secretary who is now senior vice president at Lockheed Martin Corp., The Associated Press reported.

The surprise announcement of his nomination Wednesday afternoon, his status as a relative unknown on Capitol Hill, and the ongoing turmoil at the VA indicate Jackson will have little in the way of a honeymoon period if he is confirmed by the Senate.

Shulkin wasn't even out the door when Jackson faced a barrage of conflicting demands from the White House, Congress and the major Veterans Service Organizations (VSOs).

The immediate concern is the upcoming decision by the VA to award a contract that could run up to \$10 billion and is aimed at finally giving the agency electronic health records. There are also the perennial disagreements on what to do about benefits, wait times, suicides, PTSD, corruption, caregivers and the crumbling infrastructure at VA hospitals.

However, at the top of Jackson's to-do list is reaching a final resolution on the extension and expansion of the Veterans Choice Program, which allows vets to opt for private health care.

Proponents, including Trump, see Choice as guaranteeing that vets get the best health care available; opponents, including the VSOs, see overreliance on Choice as threatening the core mission of VA as the primary provider and payer for the care of nine million vets annually.

In leaving, Shulkin sidestepped the scandal over his travel expenses. He portrayed himself as the victim of palace intrigues hatched by White House political appointees advocating the full "privatization" of VA health care.

In an op-ed for The New York Times, Shulkin wrote that the political appointees, at the White House and within the VA, "saw me as an obstacle to privatization who had to be removed."

"That is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans," he said.

In testimony to the House Veterans Affairs Committee earlier this month, Shulkin warned that the Choice program could run out of money as early as June.

Sen. Johnny Isakson, R-Georgia, chairman of the Senate Veterans Affairs Committee, had co-sponsored a bill that would have extended Choice while keeping the decision on whether vets could go to private doctors within the VA, but the bill was not included in the \$1.3 billion omnibus spending package signed by Trump last week.

Isakson has pledged to renew his efforts on Choice when Congress returns after the Easter recess. In a statement Thursday, he also hinted at the conflicts with the White House by heaping praise on Shulkin and pointing to improvements at the VA in the past year.

Shulkin "has made a tremendous impact toward improving the lives of veterans," Isakson said. "He has been instrumental in all that we have accomplished in the last year, and I thank Dr. Shulkin for his dedicated service to our country and our veterans."

As for Jackson's nomination, Isakson said, "I look forward to meeting Admiral Jackson and learning more about him."

If confirmed by the Senate, Jackson, who has little administrative experience and none in running an organization such as the VA, could be expected to rely on the insider knowledge of the No. 2 at the agency, Deputy VA Secretary Thomas Bowman. The VA, the largest healthcare system in the United States, has 370,000 employees and a budget of nearly \$200 billion.

However, Bowman, a retired Marine colonel and military attorney, has already been targeted for removal by Jake Leinenkugel, a former brewery company executive and now a senior White House adviser on veterans issues.

In December, Leinenkugel wrote in an email to Camilo Sandoval, a political appointee at the VA, that they should lobby for the ousters of both Shulkin and Bowman. The email was first reported by The Washington Post and later obtained by Military.com.

Isakson and the VSOs came to the defense of Bowman, a long-time former staffer on the Senate Veterans Affairs Committee.

"Tom Bowman is a veteran and a patriot, a public servant and a good man," Isakson said in a statement. "If this is true, it will be a mistake, and I am deeply disappointed in the president. Veterans will suffer because of this decision if it's true."

The VSOs have partly blamed the moves against Shulkin and Bowman, and the efforts at privatization, on the work of the advocacy group Concerned Veterans for America, which is funded by the conservative Koch brothers organization.

In a statement, CVA's executive director, Dan Caldwell, said that Shulkin "made significant headway in reforming the department, but ultimately became a distraction from the important task of improving health care for our veterans."

Without mentioning Choice, Caldwell said, "Congress needs to continue work with the president to pass legislation that will give veterans more health care options and better access to care through the VA."

In a statement, Sen. John McCain, R-Arizona, chairman of the Senate Armed Services Committee, said of Choice that "much more work remains to improve the Veterans Choice Program and ensure our nation's heroes have access to the best possible services."

"Let me be very clear: none of us committed to reform wants to privatize care. We simply believe the VA must put the needs of veterans first, and ensure they receive timely, quality and uncompromised health care, whether that's in the VA or in the community," McCain said.

Sen. Jack Reed, D-Rhode Island, ranking member of the Senate Armed Services Committee, said, "I admire Dr. Jackson's service to the nation, but I don't know if he is the right person to lead the VA.

"One thing is clear -- the Trump administration seems to devolve further into turmoil by the day," Reed said. "I hope the level of dysfunction that has engulfed other parts of the administration does not impact the care that our veterans receive."

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22. Government Executive: [Lawmakers, Veterans Groups and Former Officials Worry VA Nominee Is Not 'Up to the Job'](#) (29 March, Eric Katz, 870k uvm; Washington, DC)

With David Shulkin now ousted from the Veterans Affairs Department, all eyes are on President Trump's nominated replacement to see where he comes down on the most pressing issue at VA: How large a role should the private sector play in providing health care to veterans?

One problem for observers and stakeholders in the veteran community is Trump's pick, Dr. Ronny Jackson, has very little experience in public policy or veterans issues. Veterans service organizations and lawmakers were effusive in their praise of Shulkin, while expressing disappointment in his firing and noting the new relationships they would have to now forge.

"I don't know if he ever set foot in a VA [facility]," Louis Celli, the national VA director at American Legion, a group that represents more than 2 million veterans, said of Jackson. By the time the secretary designate is fully able to understand all the issues facing the department, Celli said, "this administration could be over."

As VA secretary, Jackson would be responsible for managing 370,000 employees spread across 3,000 facilities. Administering veterans disability benefits, education subsidies and cemeteries number among the department's dozens of lines of business. Still, its responsibility to provide health care to veterans is by far its biggest operation—the Veterans Health Administration runs the largest hospital network in the country—and is what led Jackson, a physician, to get the job.

Trump "ultimately decided that his health care experience, his distinguished career in the medical profession was something that would be beneficial at the VA," Lindsay Walters, a White House spokeswoman, told reporters Thursday. "At the end of the day . . . the status quo was not working. We need somebody who understands the health care system."

While Jackson has served as White House physician since 2006 and the president's personal doctor since 2013, his background is atypical for VA secretaries. While Shulkin was the first to helm the department without himself being a veteran, he had served at VA as an undersecretary as head of the Veterans Health Administration. He had previously led multiple private medical centers and health systems. His predecessor was Bob McDonald, who came from the private sector but whose nomination was met with plaudits because of his experience leading the

Fortune 50 company Proctor & Gamble. McDonald replaced Eric Shinseki, who had previously served as chief of staff of the Army.

In a New York Times op-ed published after his firing, Shulkin warned that his political enemies from within the Trump administration pushed him out not due to the scandals surrounding him but because of ideological differences about the future of VA.

"I have been falsely accused of things by people who wanted me out of the way," Shulkin said. "But despite these politically based attacks on me and my family's character, I am proud of my record and know that I acted with the utmost integrity. Unfortunately, none of that mattered."

Shulkin added that the environment surrounding him became "so toxic, chaotic, disrespectful and subversive" that he could no longer accomplish his job. He said his opponents within the department, whom he repeatedly vowed to oust, were fighting to privatize VA health care and saw him as a barrier in achieving that goal.

"They saw me as an obstacle to privatization who had to be removed," Shulkin said. "That is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans."

Opponents of privatization, including Shulkin, nearly all veterans service organizations and key lawmakers on both sides of the aisle on Capitol Hill, could breathe at least a momentary sigh of relief when Trump announced Jackson as his nominee to be the next VA secretary. Jackson is in many ways an unknown, but is not associated with any previous push to minimize the government's role in providing veterans health care as were some of the other candidates Trump was reportedly considering.

"I am deeply concerned about the nominee," said Joe Chenelly, executive director of AMVETS, another congressionally chartered veterans service organization. "Veterans' lives depend on this decision, and the Trump administration needs to substantiate that this active-duty Navy officer is qualified to run a \$200 billion bureaucracy, the second largest agency in the government."

AMVETS added it was pleased Jackson had a medical background, but noted VA is "more than healthcare."

"What qualifications does the president's nominee have to address claims, appeals, benefits and cemetery affairs?" the group asked.

Celli noted that even McDonald, a veteran who came to the department with vast managerial experience, took a while to fully "wrap his arms around the entire mission of what VA was" and was therefore only able to make a significant impact in two or three areas of VA's operation.

President Obama was wise to recognize he needed a veteran who had also run a large company with a big budget and many employees, much like VA itself, McDonald told Government Executive.

"That intersection is very small and I think [Obama] recognized that," McDonald said. "While Adm. Ronny must be a great doctor, the question the Senate will need to address is does he have sufficient management experience."

Even Shulkin seemed to suggest the job requires a large learning curve.

"No one is naturally prepared to take on a task like this," Shulkin told NPR on Thursday. Jackson would not be met with political leadership at the department to help guide him through the ins and outs of its medical network, as Trump has yet to nominate an undersecretary to head VHA.

"Given the state of the VA today, the most important thing is the leadership experience of a very large organization," McDonald said. Having medical experience would only be the third top priority, McDonald said, after being a veteran.

Several groups expressed concern over the fate of reforms VA had already initiated under Shulkin. The now former secretary was in the process of realigning the department's regions, or Veterans Integrated Service Networks, and the larger structure of the department. He had worked with oversight committees in Congress on a proposal to consolidate existing programs giving veterans access to private sector care on the government's dime and easing veterans access to such programs, while maintaining a tight balance with those who tend to have a knee-jerk reaction against any reform that could be construed as VA privatization. The existing Veterans Choice Program is expected to run out of funding this summer. He had won approval for his plan to shutter underutilized facilities and had already help shepherd measures to expedite firing of problematic employees and reform the disability appeals process through Congress and into law.

"I have enjoyed getting to know Secretary Shulkin, and I'm glad to call David a friend," said Rep. Phil Roe, R-Tenn., who chairs the House Veterans Affairs Committee. "I think he's done a fantastic job and I hate to see him go."

Roe pledged to work with Jackson and build "a strong relationship with him also." Roe's counterparts in the Senate made clear they would not automatically grant their approval, as will be necessary for his confirmation.

"I look forward to meeting Admiral Jackson and learning more about him," Sen. Johnny Isakson, chairman of the Senate VA committee, said after praising Shulkin for the "tremendous impact" he made during his tenure.

Sen. Jon Tester, D-Mont., was even more non-committal.

"Moving forward, the VA needs a strong leader at the top who will listen to veterans, strengthen the VA and work with Congress to implement bipartisan reform," Tester said. "I look forward to meeting Rear Adm. Jackson soon and seeing if he is up to the job."

McDonald suggested Trump's selection could mark a departure from the path on which he and Shulkin put the department, which the former secretary said he formulated after hundreds of visits around the country to listen to VA beneficiaries.

"Veterans don't want the privatization of the VA," McDonald. "I hope President Trump is listening to veterans."

The American Legion's Celli speculated that Trump's choice of Jackson was a matter of happenstance rather than qualification. His selection was not as "draconian" as he and many had feared, Celli said, but it still appeared as if Jackson got the nod because he was "someone with military experience who [Trump] just happened to know." Celli was at least pleased that

Jackson's demeanor and medical abilities were "above reproach," but said he would still have to prove himself beyond that to earn the support of the veteran community.

"Great, he's a nice guy," Celli said. "There's a lot of nice guys out there."

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To: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (5), (b) (6)>
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Bcc:
Subject: FW: Adm. Jackson clips compilation - March 30
Date: Fri Mar 30 2018 13:11:33 CDT
Attachments: 180330_Jackson News Clips.docx

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Sent: Friday, March 30, 2018 7:42:48 AM
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Cc: (b) (6); (b) (6)
Subject: Adm. Jackson clips compilation - March 30

Attached are the requested clips related to Adm. Jackson.

Thanks,

(b) (6)

(b) (6)
Office of Public Affairs
U.S. Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420
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Rear Adm. Ronny Jackson News Clips

30 March 2018

1. Washington Post (AP): [Trump's VA pick draws concern over thin management record](#)

(29 March, Hope Yen and Calvin Woodward, 43.9M uvm; Washington, DC)

President Donald Trump's selection of his White House doctor to run the massive Department of Veterans Affairs triggered concern Thursday among lawmakers and veterans groups about whether he has the experience to manage an agency paralyzed over Trump's push to expand private care. Ronny Jackson, a Navy rear admiral entrusted with the health of the past three presidents, is a lifelong physician whose positions on privatizing operations in the second largest federal department...

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2. Washington Post: [Trump's pick to head veterans department faces skepticism over his experience](#)

(29 March, Lisa Rein, Seung Min Kim, Emily Wax-Thibodeaux, and Josh Dawsey, 43.9M uvm; Washington, DC)

The White House was thrown on the defensive Thursday over President Trump's choice to lead the Department of Veterans Affairs, forcing officials to fend off mounting skepticism that Ronny L. Jackson has the experience to run the government's second-largest agency. Trump announced by tweet late Wednesday that the White House physician would succeed ousted secretary David Shulkin, surprising veterans groups and lawmakers...

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3. Wall Street Journal: [Lawmakers Respond Cautiously to Little-Known VA Pick Ronny Jackson - Key senators on panel say they don't know enough about White House doctor to form an opinion about his ability to lead a vast bureaucracy](#)

(29 March, Louise Radnofsky and Peter Nicholas, 43.6M uvm; New York, NY)

Capitol Hill lawmakers reacted guardedly to President Donald Trump's nomination of the White House physician to head the Department of Veterans Affairs, with key members noting that they know little about him. Dr. Ronny Jackson, a U.S. Navy rear admiral who has served as a White House physician during the past three administrations, is slated to succeed Secretary David Shulkin, who was ousted Wednesday.

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4. USA Today (Video): [6 big things the new Veterans Affairs chief will have to address](#)

(29 March, Donovan Slack and Dennis Wagner, 36.8M uvm; McLean, VA)

On the front lines at the Department of Veterans Affairs — in the agency's 1,240 hospitals and clinics — it doesn't much matter these days who holds the secretary's job in Washington. David Shulkin, who was fired Wednesday, was the third VA secretary in four years. If President Trump's nominee to lead the agency, physician and Navy Rear Adm. Ronny Jackson, is confirmed, he will be the fourth.

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5. New York Times: [Veterans Affairs Shake-Up Stirs New Fears of Privatized Care](#)

(29 March, Nicholas Fandos, 30M uvm; New York, NY)

President Trump's dismissal of David J. Shulkin, the secretary of veterans affairs — and the nomination of a man with no known policy views to take his place — has brought renewed focus to an increasingly contentious debate over whether to give veterans the option of using the

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benefits they earned through military service to see private doctors rather than going to government hospitals and clinics.

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6. Politico: [Trump's VA pick blindsides staff, deepens agency disarray - 'He's got a department that's in turmoil,' a former VA secretary said. 'It's in crisis.'](#) (29 March, Lorraine Woellert, Eliana Johnson and Connor O'Brien, 23.9M uvm; Arlington, VA)

The timing of President Donald Trump's announcement to name Rear Admiral Ronny Jackson to lead Veterans Affairs was a snap decision that surprised his own chief of staff and knocked the government's second-largest agency, already bedeviled by scandal, deeper into disarray. White House chief of staff John Kelly had spoken with David Shulkin by phone Wednesday morning, reassuring the now-former VA secretary that he wouldn't be fired by tweet that afternoon.

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7. NPR (All Things Considered, Audio): [Departure Of VA Secretary Shulkin Doesn't End Debate Of Privatization](#) (29 March, 22M uvm; Washington, DC)

The departure of Veterans Affairs Secretary David Shulkin does not end the debate over how far the agency should privatize. Neither the president nor his nominee have given their views on the subject.

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8. Daily KOS: [Trump replaces experienced hospital administrator with personal doc in fight to privatize the VA](#) (29 March, Mark Sumner, 19.1M uvm; Oakland, CA)

The replacement of Secretary of Veterans Affairs David Shulkin has two narratives in the media—that Shulkin “embarrassed” Donald Trump with a trip to Europe that included days of sightseeing, and that Shulkin “clashed” with other officials at the VA.

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9. Task & Purpose: [What's In Store For The Next VA Chief? Let's Break It Down](#) (29 March, James Clark, 102k uvm; New York, NY)

It's been an awkwardly long time coming, but as of yesterday afternoon embattled Veterans Affairs secretary David Shulkin is out of a job. The news comes after a month and a half of uncertainty that began when a scathing inspector general report detailed “serious derelictions” in expensing a Europe trip last summer. And then there were all the accusations and counter accusations of political infighting and rumors of possible replacements — at least all that is over:

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10. Washington Post: [Opinions - Surprise: Trump's newest Cabinet nominee has no relevant experience](#) (29 March, Eugene Robinson, 43.9M uvm; Washington, DC)

You can't make this stuff up: President Trump has announced he will nominate a medical doctor who has no discernible management experience to run the second-largest agency in the federal government. Can presidents be sued for malpractice? The man Trump has named to become secretary of veterans affairs, Ronny L. Jackson, happens to be the president's personal doctor.

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11. Washington Post (The Fix): [Who is Trump's new Veterans Affairs pick, Ronny Jackson?](#) (29 March, Aaron Blake, 43.9M uvm; Washington, DC)

The seemingly never-ending parade of staff changes in the Trump administration continued apace Wednesday, with the president announcing that Veterans Affairs Secretary David Shulkin is out and that White House physician Ronny L. Jackson will replace him. Jackson's name will be familiar to political watchers across the country for one main reason: He's the physician who delivered what some felt to be a suspiciously rosy picture of Trump's health in January.

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12. FOX News: [Ronny Jackson picked by Trump to lead the VA: What to know about the president's physician](#) (29 March, Kaitlyn Schallhorn, 32.5M uvm; New York, NY)

President Trump gave Dr. Ronny Jackson a clean bill of health in March – to run the Department of Veterans Affairs. A Navy rear admiral, Jackson is the president's personal physician who rose to prominence after he addressed the press from the White House briefing room in January to discuss Trump's health.

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13. FOX News (Video): [John Brennan: Trump's nomination for VA secretary is 'terribly misguided'](#) (29 March, Nicole Darrah, 32.5M uvm; New York, NY)

Former CIA Director John Brennan once again took a shot at President Trump on Twitter Thursday, saying he believes the decision to nominate Adm. Ronny Jackson to run the Department of Veterans Affairs is "terribly misguided." "I personally know and greatly respect Ronny Jackson....as a terrific doctor and Navy officer," Brennan tweeted. "However, he has neither the experience nor the credentials to run the very large and complex VA.

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14. New York Times: [Op-ed - Ronny Jackson's Disturbing Lack of Independence](#) (29 March, Norman L. Eisen and Bandy X. Lee, 30M uvm; New York, NY)

In announcing Dr. Ronny Jackson, the White House physician, as his choice to be the new secretary for veterans affairs, President Trump has taken his latest misstep in what has been the worst presidential personnel process in modern history. We take no pleasure in saying so, including because one of us (Mr. Eisen) worked with Dr. Jackson in the White House, was even treated by him...

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15. ABC News (Video): [Veterans groups respond cautiously to VA secretary nomination](#) (29 March, Sarah Kolinovsky, 24.2M uvm; New York, NY)

Despite his active duty status as a Navy rear admiral (lower half) and his medical experience, veterans service organizations are responding cautiously to the nomination of Dr. Ronny Jackson for secretary of Veterans Affairs, with some expressing concern about his lack of managerial experience or what his views are on reforming the VA.

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16. The Atlantic: [The Doctor Who Suddenly Got Nine Million Patients - For a position that demands high-level policy expertise, President Trump appointed his personal physician, Ronny Jackson.](#) (29 March, James Hamblin, 23.9M uvm; Washington, DC)

Nine million veterans will soon be under the care of the emergency-physician rear admiral Ronny Jackson, pending confirmation of his appointment Wednesday to lead the U.S. Department of Veterans Affairs. This seemingly mundane appointment—a doctor and naval officer with years of experience as White House physician under both Trump and Obama...

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17. NPR (All Things Considered, Audio): [Republican Sen. Jerry Moran Weighs In On Firing Of VA Secretary Shulkin](#) (29 March, 22M uvm; Washington, DC)

There's more turnover in President Trump's cabinet — this time at the Department of Veterans Affairs. NPR's Ailsa Chang talks to Sen. Jerry Moran, R-Kan., and member of the Senate Veterans Affairs Committee, about oversight of the department and the confirmation process of the person picked to lead it.

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18. NPR (All Things Considered, Audio): [How Veteran Groups Are Reacting To The Departure Of VA Secretary Shulkin](#) (29 March, 22M uvm; Washington, DC)

Garry Augustine, executive director of Disabled American Veterans, speaks with NPR's Audie Cornish about how veteran groups are responding to the the news of VA Secretary David Shulkin's firing.

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19. The Hill: [White House: Trump has 'full confidence' in presidential physician to lead VA](#) (29 March, Max Greenwood, 11.9M uvm; Washington, DC)

President Trump has "full confidence" in White House physician Ronny Jackson's ability to head the Veterans Affairs (VA) Department, a spokeswoman for the White House said Thursday, despite reported concerns from some aides. "As I said earlier, the president has full confidence in Adm. Jackson," White House deputy press secretary Lindsay Walters told reporters.

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20. The Hill: [GOP, vet groups react with caution to Trump VA pick](#) (29 March, Rebecca Kheel, 11.9M uvm; Washington, DC)

Senators and influential veterans groups are withholding judgment on President Trump's pick to lead the Department of Veterans Affairs (VA), a Navy doctor with no experience leading a federal bureaucracy. Both the Republican chairman and the Democratic ranking member of the Senate Veterans Affairs Committee said only that they look forward to meeting Rear Adm.

Ronny Jackson. Several veterans groups expressed some concern about Jackson's qualifications...

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21. Military.com: [Others Considered for VA Job Before Trump Picked His Personal Doctor](#) (29 March, Richard Sisk, 9M uvm; San Francisco, CA)

Rear Adm. Ronny L. Jackson, the personal physician to President Donald Trump, was not his first choice to replace fired VA Secretary Dr. David Shulkin, the White House said Thursday. "The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary," White House deputy press secretary Lindsay Walters told reporters.

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22. Government Executive: [Lawmakers, Veterans Groups and Former Officials Worry VA Nominee Is Not 'Up to the Job'](#) (29 March, Eric Katz, 870k uvm; Washington, DC)

With David Shulkin now ousted from the Veterans Affairs Department, all eyes are on President Trump's nominated replacement to see where he comes down on the most pressing issue at VA: How large a role should the private sector play in providing health care to veterans? One problem for observers and stakeholders in the veteran community is Trump's pick, Dr. Ronny Jackson, has very little experience in public policy or veterans issues...

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Full Text:

1. Washington Post (AP): [Trump's VA pick draws concern over thin management record](#) (29 March, Hope Yen and Calvin Woodward, 43.9M uvm; Washington, DC)

President Donald Trump's selection of his White House doctor to run the massive Department of Veterans Affairs triggered concern Thursday among lawmakers and veterans groups about whether he has the experience to manage an agency paralyzed over Trump's push to expand private care.

Ronny Jackson, a Navy rear admiral entrusted with the health of the past three presidents, is a lifelong physician whose positions on privatizing operations in the second largest federal department and addressing ballooning health care costs are unknown. First named to the top White House post by President Barack Obama, he would be new to running a big bureaucracy if given leadership over a department of 360,000 employees serving 9 million veterans.

In a statement, Trump praised Jackson as "highly trained and qualified." But representatives of veterans aren't sold on the choice, or on Trump's decision a day earlier to fire VA Secretary David Shulkin.

"There is little that we know about Dr. Ronny Jackson's vision and qualifications," said Paul Rieckhoff, founder and CEO of Iraq and Afghanistan Veterans of America. "Our concern is whether President Trump was more interested in picking a secretary who would be politically

loyal rather than someone who can work across the aisle to fix long standing problems of bureaucratic delay.”

Similar doubts were expressed by Veterans of Foreign Wars, which praised Jackson’s military background in a statement but pointed to a nominee biography devoid of “any experience working with the VA or with veterans, or managing any organization of size, much less one as multifaceted as the Department of Veterans Affairs.” AMVETS echoed such sentiments.

“We look forward to a rigorous confirmation hearing,” Rieckhoff said.

Montana Sen. Jon Tester, top Democrat on the panel that will consider the nomination, said he had yet to determine if Jackson “is up to the job.”

It’s not clear from Jackson’s military service record how much, if any, management experience he has. His military assignments did not appear to include supervision over a large department or unit. His Navy biography says he deployed to Iraq with a Marine unit and served as the emergency physician in charge of resuscitative medicine for a trauma platoon.

Jackson joined the White House medical team in 2006 and is perhaps best known for his appearance before the press corps in January, announcing the results of Trump’s first physical in a performance that showed he was quick-witted and unfailingly complimentary of Trump.

Marveling at the 71-year-old president’s good health, Jackson opined, “It’s just the way God made him.”

A White House official said Shulkin himself had recommended Jackson for an undersecretary position at the VA in the fall, and Trump ultimately decided he was more comfortable with Jackson than with other top candidates. The official was not authorized to discuss personnel matters and spoke on condition of anonymity.

If confirmed by the Senate, Jackson would face immediate crises, like a multi-billion dollar revamp of electronic medical records now in limbo that members of Congress fear will prove too costly and wasteful, and a budget shortfall in the coming weeks in its private-sector Veterans Choice program.

Trump is seeking an aggressive expansion of the Choice program to make it easier for veterans to see private doctors outside the VA system at government expense, but proposals are stalled in Congress following a failed effort last week.

“We’re going to have real choice,” Trump said in Ohio. “That’s why I made some changes, because I wasn’t happy with it.”

Jackson’s nomination comes as Trump’s new Cabinet nominees begin to pile up in the Senate. That is certain to stir weeks of confirmation battles this spring when senators, especially those running for re-election, may prefer to shift focus away from the changes at the White House.

None of the nominees, including the president’s new picks for secretary of state and CIA director, is expected to sail to easy confirmation. The GOP-led Senate is narrowly divided 51-49 and Democrats — and some Republicans — are preparing to ask tough questions. Even though Congress has an otherwise slim legislative agenda before campaign season, prolonged confirmation fights could jam up the Senate and influence the election.

Pending Jackson's confirmation, Robert Wilkie, a former Pentagon undersecretary for personnel and readiness, is serving as the acting head of the VA.

Lawmakers said they needed to learn more about Jackson's record.

Republican Sen. Johnny Isakson of Georgia, chairman of the Senate Veterans Affairs Committee that will review the nomination, declined to indicate his support. He stressed that he looked forward to "meeting Admiral Jackson and learning more about him." Isakson, a moderate, has expressed skepticism in the past toward nominees who expressed strong views in favor of privatization.

Sen. Bernie Sanders, independent of Vermont and a former chairman of the panel, cautioned that Jackson would not be approved if he supported privatizing the VA. "Our job is to strengthen the VA in order to provide high-quality care to our veterans, not dismember it," he said.

Shulkin, a physician and the lone Obama administration holdover in Trump's Cabinet, was unceremoniously fired late Wednesday by Trump in a tweet. Shulkin had enjoyed support from Trump for much of his first year in the administration but support eroded last month after a bruising ethics scandal and political infighting at VA.

Dan Caldwell, executive director of the conservative Concerned Veterans for America, said the group is keeping an "open mind" about Jackson's nomination. Some of the names that had been in circulation for the post had previous ties to the group, which supports giving veterans greater access to private doctors outside the VA system.

"We'd like to hear more about his positions to reform and fix the VA," Caldwell said. "He has a very distinguished service record and it would be unfair to outright dismiss him — you have to be very professional to reach his rank."

A native of Levelland, Texas, Jackson, 50, graduated from Texas A&M with a degree in marine biology, then from medical school at the University of Texas Medical Branch.

He headed to the Navy, then in 2005 joined a 2nd Marines regiment. Jackson was deployed to Iraq as the physician in charge of resuscitative medicine for a trauma platoon, according to the White House.

Ned Price, a National Security Council spokesman under Obama, described the doctor as "the guy you always want to be around" because he's affable and funny. But Price said it was difficult to believe the nomination was unrelated to the "glowing assessment" of Trump's health that the doctor had provided.

Associated Press writers Jill Colvin, Lisa Mascaro, Lolita Baldor, Zeke Miller, Jonathan Lemire, Catherine Lucey and Darlene Superville contributed to this report.

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2. Washington Post: [Trump's pick to head veterans department faces skepticism over his experience](#) (29 March, Lisa Rein, Seung Min Kim, Emily Wax-Thibodeaux, and Josh Dawsey, 43.9M uvm; Washington, DC)

The White House was thrown on the defensive Thursday over President Trump's choice to lead the Department of Veterans -Affairs, forcing officials to fend off mounting skepticism that Ronny L. Jackson has the experience to run the government's second-largest agency.

Trump announced by tweet late Wednesday that the White House physician would succeed ousted secretary David Shulkin, surprising veterans groups and lawmakers, who were not notified beforehand and scrambled to learn the policy views of someone whose positions on the chronic challenges facing VA are unknown.

Jackson is a career naval officer who was an emergency trauma doctor in Iraq before spending the past 12 years as a White House physician. But his résumé lacks the type of management experience usually expected from the leader of an agency that employs 360,000 people, has a \$186 billion annual budget and is dedicated to serving the complex needs of the country's veterans.

"It's great that he served in Iraq and he's our generation. But it doesn't appear that he's had assignments that suggest he could take on the magnitude of this job, and this makes Jackson a -surprising pick," said Paul Rieckhoff, chief executive of Iraq and Afghanistan Veterans of America.

Jackson was taken aback by his nomination, said senior White House officials, who spoke on the condition of anonymity to discuss internal deliberations. After aides gauged his interest in recent days, he hesitated to take on such a big job. But the president continued to push and told his senior staff Monday that the doctor was his top choice. A senior White House official described an informal interview process, without the extensive vetting that typically accompanies a Cabinet selection.

Navy Rear Adm. Ronny L. Jackson, the lead White House doctor, said on Jan. 16 that President Trump's "overall health is excellent." (Bastien Inzaurrealde/The Washington Post)

"The President has full confidence in Dr. Jackson's abilities to give our veterans the care they've earned," spokesman Raj Shah said.

The White House planned to announce Wednesday that Shulkin would leave the administration and be replaced on an interim basis by Robert Wilkie, undersecretary for defense personnel and readiness at the Defense Department, until a nominee was found.

But Trump preempted the plan when he tweeted that he intended to nominate Jackson, administration officials said.

The active-duty rear admiral had been a behind-the-scenes figure while serving the past three administrations as a White House physician, but he moved into the spotlight in January when he delivered a glowing assessment of Trump's physical and mental health to reporters, which aides said endeared him to the president.

The White House on Thursday defended Trump's choice of Jackson, saying his hands-on experience as a doctor would serve him well as Veterans Affairs secretary.

“He knows what soldiers need on the battlefield and what they need when they come home as veterans,” deputy White House press secretary Lindsay Walters told reporters aboard Air Force One en route to Cleveland, where Trump delivered a speech on his infrastructure plan. “The president has full confidence in his pick and trusts he will be able to give veterans the care they deserve.”

Key congressional Republicans publicly took a cautious approach to the nomination.

“We are doing our homework on Dr. Jackson,” said Amanda Maddox, spokeswoman for Sen. Johnny Isakson (R-Ga.), chairman of the Senate Veterans’ Affairs Committee, which will hold Jackson’s nomination hearing. Trump called Isakson after announcing that he had picked the doctor to replace Shulkin, she said.

“His name was never floated around,” Maddox said, “so we are doing our due diligence.”

Trump’s decision to upend VA’s leadership comes as Senate Republicans were already worried about other potentially difficult nominations in the months leading up to midterm elections, when they want to focus their message on the recently passed tax cuts rather than deal with more upheaval in the administration.

“Any time Republicans are not selling the tax bill over the next seven months is a missed opportunity,” said GOP strategist Brian Walsh, a former spokesman for the National Republican Senatorial Committee. “I will say Senate Republicans are a little more insulated by the nature of the seats that are up. But there’s no question that these are unhelpful distractions.”

The stack of Trump nominees includes Gina Haspel, who was picked this month to be the director of the Central Intelligence Agency and is facing opposition from members of both parties because of her ties to the agency’s past use of brutal interrogation measures on terrorism suspects, which critics say amounted to torture.

Senate Republicans have told White House officials in recent days that the process of confirming CIA Director Mike Pompeo to replace Rex Tillerson as secretary of state is going to be challenging even though he is expected to be approved, according to two people briefed on the discussions. Democratic senators said privately when Pompeo was tapped to replace Tillerson that they expect far fewer Democrats to back him than the 14 who voted for him to lead the CIA.

Senior Senate Republicans have privately expressed frustration over the personnel battles that have raged since the beginning of Trump’s presidency and recently told the White House that they did not want to have to consider a series of nominees this year, according to aides and officials who have heard the complaints.

The move to dismiss Shulkin — as well as the lack of communication about Jackson — only fueled concerns on Capitol Hill that the administration was not doing enough to help Congress defend or even respond to the president’s rush of personnel changes.

Jackson’s policy views are unknown, particularly on the most pressing issue facing VA: how much access veterans should have to private doctors outside the system at government expense. Shulkin’s moderate views on the subject, which were at odds with many administration officials, helped end his tenure.

VA secretary is one of Washington's most unforgiving jobs even for someone with extensive management experience. Shulkin, also a physician, had run large hospital systems — including VA's — before taking the job. His predecessor, Robert McDonald, was a chief executive of Procter & Gamble. The secretary before him was a decorated retired Army general, Eric K. Shinseki, who was forced out after managers in the far-flung health system were found to have fudged waitlists for veterans' medical appointments.

As recently as February, Jackson was a candidate to run VA's health-care arm, the Veterans Health Administration, the country's largest health-care system, with 1,200 hospitals and medical clinics. On the day of his interview, he told a selection panel that the president was unwilling to let him leave his White House job, according to two people familiar with the discussion.

The panel interviewed him informally anyway, asking him how he would drive change in such a large organization but not about his views on policy. One person who sits on the panel, and who spoke on the condition of anonymity because its proceedings are confidential, said they didn't think Jackson had the requisite skills to transition from overseeing a team of about 20 doctors, nurses and physician assistants in the White House medical office to overseeing the health administration.

"I don't remember him coming in trying to convince us he had the experience to do the job. He did not inflate his qualifications," this person said. "The tone was, 'Maybe I don't have the same kind of experience as others who came before me in the job.'"

Jackson's former colleagues in the Obama White House, who have publicly praised him in the past, said his nomination caught them off guard as they swapped text messages to ask how an extremely likable but unlikely candidate could end up running VA in the Trump administration.

"I've seen him managing a staff of a couple dozen, which he did to perfection," said Ned Price, a National Security Council spokesman under Obama who recalled that he was treated by Jackson for a toe injury in the Philippines.

"But how that would translate to managing the second-largest department in federal government I have no idea," Price said. "He has competence and integrity. I don't think he's going to fly around the world first-class or be buying thousands of dollars in furniture. But can he run VA? Anyone's guess is as good as mine."

Colleagues described the schedule of the White House physician as grueling, with continual foreign and domestic travel, always at the president's side.

Some Democrats warned that if Jackson embraced the idea of privatizing more of VA's health coverage, his nomination would be met with stiff resistance.

"I will carefully review Dr. Jackson's qualifications to determine whether he has the best interests of our Veterans at heart or whether he, like many in the Trump administration, wants to push VA down the dangerous path of privatization," Sen. Tammy Duckworth (D-Ill.), a wounded Iraq veteran, said in a statement.

At the American Legion, the country's largest veterans organization, senior officials were putting together ideas to help Jackson acquaint himself with the agency and its challenges.

“He’s going to have a huge learning curve,” Executive Director Verna Jones said, “but we stand ready to assist and educate him.”

Robert Costa and Julie Tate contributed to this report.

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3. Wall Street Journal: [Lawmakers Respond Cautiously to Little-Known VA Pick Ronny Jackson - Key senators on panel say they don’t know enough about White House doctor to form an opinion about his ability to lead a vast bureaucracy](#) (29 March, Louise Radnofsky and Peter Nicholas, 43.6M uvm; New York, NY)

Capitol Hill lawmakers reacted guardedly to President Donald Trump’s nomination of the White House physician to head the Department of Veterans Affairs, with key members noting that they know little about him.

Dr. Ronny Jackson, a U.S. Navy rear admiral who has served as a White House physician during the past three administrations, is slated to succeed Secretary David Shulkin, who was ousted Wednesday. Mr. Trump indicated on Thursday that he removed Dr. Shulkin because change at the agency was coming too slowly. The secretary had also been the subject of a travel-expenses scandal.

The lead Republican and Democratic senators who will decide whether to confirm Dr. Jackson said they didn’t yet know enough to form an opinion about his ability to lead a bureaucracy of 370,000 employees. The department, which is the second-biggest government agency, is also still recovering from a 2014 scandal in which employees were found to have falsified records to hide delays in patient care.

“I look forward to meeting Adm. Jackson and learning more about him,” said Sen. Johnny Isakson (R., Ga.), chairman of the Committee on Veterans’ Affairs, which will vote on confirmation.

Sen. Jon Tester of Montana, the top Democrat on the panel, offered a near-identical sentiment, adding that he is looking forward to “seeing if he is up to the job.”

Veterans service organizations and some other lawmakers have expressed skepticism about Dr. Jackson, raising concern over the propriety of an active-duty military officer holding a political appointment, and saying his biography showed scant experience at running a bureaucracy on the scale he would inherit.

“He’s more of a hands-on physician—not a lot of desk time in terms of administrative leadership,” said Rep. Mike Coffman (R., Colo.), a member of the House Veterans’ Affairs Committee who was among Dr. Shulkin’s harshest critics.

It’s unclear how Dr. Jackson would address the issue of his active military status, including whether he would seek to relinquish it before securing confirmation to the new job.

Dr. Jackson’s confirmation will come as senators are debating legislation that would increase veterans’ ability to seek non-government medical care. Congress is approaching an early June

deadline to agree to new funds for the existing system allowing some veterans to go outside the VA for care, or to create a new policy allowing all veterans to participate.

“I made some changes, because I wasn’t happy with the speed with which our veterans were taken care of,” Mr. Trump said Thursday in a speech in Ohio. “We want them to have choice so that they can run to a private doctor and take care of it.”

The White House informed Mr. Isakson’s committee of the leadership change in a courtesy call Wednesday; a timeline for proceeding with the nomination, or preliminary introduction meetings, wasn’t discussed, a spokeswoman said. Mr. Isakson and Dr. Jackson spoke by phone Thursday afternoon, in an informal introduction, the spokeswoman said.

Past and present White House officials have praised Dr. Jackson as a steady force, deft in caring for different presidents and cabinet members. They said they found him friendly, bright and knowledgeable about medicine, including on issues specifically affecting veterans.

“If you’re not calmly decisive, the job of White House physician ain’t for you,” said Paul Winfree, a former deputy director of Mr. Trump’s Domestic Policy Council.

Dr. Jackson has been sought out for management positions before, though on a significantly smaller scale. Toward the end of the Obama administration, he was invited to interview by the Cleveland Clinic for an international posting managing a handful of people because of his affability, versatility and experience with VIPs, a person familiar with the interview said.

The federal agency Dr. Jackson would inherit is notoriously riven with competing power centers, and has now churned through three secretaries in four years.

Dr. Shulkin came directly from a health-care management background into the Obama administration when he took over the VA. He stayed on for Mr. Trump and initially received high reviews. He lost credibility recently when the VA inspector general found that, during a trip to Europe, he improperly accepted Wimbledon tennis tickets, misspent thousands of dollars of taxpayer money on his wife’s airfare and improperly used a department employee as a “personal travel concierge.”

Dr. Shulkin denied wrongdoing. He repaid the \$4,312 cost of his wife’s airfare and then sent the U.S. Treasury a check equal to the amount of the tennis tickets.

Mr. Trump’s advisers had openly explored possible successors for Dr. Shulkin in recent weeks, including having conversations with potential candidates, people familiar with the matter had said.

Still, the nomination of Dr. Jackson stunned some White House aides, who hadn’t known the president was even considering his physician for the role.

It became clearer Thursday that Mr. Trump had been thinking about moving Dr. Jackson to the VA for months. Last fall, Dr. Shulkin recommended that Dr. Jackson take an undersecretary job at the department, a White House official said. At that time, Dr. Jackson and the president discussed plans for improving the VA—talks that set in motion the announcement on Thursday.

Lindsay Walters, a White House spokeswoman, on Thursday said the White House believed Dr. Jackson had “bipartisan respect.”

“The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary,” she added. “The president has full confidence in his pick and trusts he will be able to give veterans the care they deserve.”

Some lawmakers expressed dismay over the treatment and departure of Dr. Shulkin, which could linger into the new confirmation process. “By once again choosing chaos over consistent leadership, Donald Trump is hurting veterans around the country,” said Illinois Democratic Sen. Tammy Duckworth, who is a retired U.S. Army lieutenant colonel.

—*Kristina Peterson and Ben Kesling contributed to this article.*

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4. USA Today (Video): [6 big things the new Veterans Affairs chief will have to address](#) (29 March, Donovan Slack and Dennis Wagner, 36.8M uvm; McLean, VA)

On the front lines at the Department of Veterans Affairs — in the agency’s 1,240 hospitals and clinics — it doesn’t much matter these days who holds the secretary’s job in Washington.

David Shulkin, who was fired Wednesday, was the third VA secretary in four years. If President Trump’s nominee to lead the agency, physician and Navy Rear Adm. Ronny Jackson, is confirmed, he will be the fourth.

Each has sought to fix the department, laying out visions and priorities — Shulkin’s top priority was “access,” making sure veterans get appointments when they need them. His predecessor, former Procter and Gamble CEO Bob McDonald, focused on staffing, training and veteran-centered customer service.

But year after year, critical deficiencies remain and veterans are bearing the brunt of the failures. Here are some key, seemingly intractable shortfalls that continue to plague the system — and that Jackson will face if confirmed.

Veterans are still waiting

The furor over VA health care exploded in 2014 when whistle-blowers in Arizona divulged that thousands of patients were backlogged at the Phoenix veterans hospital, and some of them had died awaiting care. VA investigators soon determined that medical center administrators knew about the crisis, yet put out fraudulent wait-time data to collect bonus pay.

The problems weren’t just in Phoenix. A USA TODAY investigation in 2016 found supervisors instructed employees to falsify patient wait times at VA medical facilities in at least seven states. And employees at 40 VA medical facilities in 19 states and Puerto Rico regularly “zeroed out” veteran wait times.

A few weeks after Shulkin was sworn in last year, the VA inspector general released a report finding widespread inaccuracies in scheduling records at a dozen hospitals in North Carolina and Virginia. The records vastly understated how long veterans were waiting for appointments and prevented as many as 13,000 from getting VA-funded care in the private sector — an option they were entitled to if they waited longer than 30 days. At the time, Shulkin said the findings

were based on outdated rules and that he had instituted new regulations to prevent such problems in the future.

But just two weeks ago, another inspector general investigation found the problems continued.

Looking at 64 VA hospitals and clinics in a swath of states from Kentucky to Illinois, investigators found scheduling staff entered the wrong dates in the system in more than 5,000 cases. That masked how long veterans were actually waiting for specialty care and mental health appointments.

They estimated 2,500 of those waited longer than a month, but the scheduling system falsely showed only 1,300 waited that long. Even in the cases accurately reflected in the system, they concluded, most weren't offered the chance to get care in the private sector.

"VA data continues to be a high-risk area," wrote Larry Reinkemeyer, VA assistant inspector general for audits and evaluations.

Quality of care

The VA's lowest performing hospitals remained at the bottom of the pack on the agency's own internal quality measures for two years in a row.

The VA regularly scores its medical centers based on dozens of quality factors, including death and infection rates, instances of avoidable complications and wait times. The agency uses a five-star scale with one being the worst and five being the best.

The rankings compare VA hospitals against each other but the number of one-star hospitals is not constant. Medical centers in that bracket can be elevated to two stars based on quality-of-care factors.

Among the facilities who received only one star in both 2015 and 2016 were the VA hospital in Phoenix and another in Memphis, Tenn. One Memphis employee dubbed the facility a "house of horrors" when USA TODAY obtained internal documents revealing reported threats to patient safety soared in recent years from 700 to more than 1,000.

One veteran had to have his leg amputated after a VA provider there left a piece of plastic tubing in a critical blood vessel during a procedure.

On a number of patient safety factors, the VA overall on average scores better than the private sector on many key patient-safety measures, including instances of avoidable death, respiratory failure, and infection. But there are vast disparities among VA hospitals, according to VA data collected from October 2015 to March 2017.

The death rate for surgical patients with treatable complications ranged from zero at the VA hospital in Sacramento, Calif., to more than 20% in Miami; Columbia, Mo.; and Washington, D.C. In Long Beach, Calif., it was 29%. That's more than double the private sector average of 14%, according to Medicare data.

Bureaucratic breakdowns

In Washington, the VA inspector general issued a rare emergency report last year saying that patients were in imminent danger at the hospital. The facility had dirty sterile storage areas and was regularly running out of critical supplies needed for surgeries and other procedures, including patches to seal blood vessels and tubes for kidney dialysis.

Shulkin quickly removed the hospital director there and sent teams from headquarters to try to fix the problems. But an inspector general report released this month found that VA officials at every level — local, regional and national — knew about the problems for years but didn't fix them.

Investigators found “a culture of complacency and a sense of futility pervaded offices at multiple levels.”

“In interviews, leaders frequently abrogated individual responsibility and deflected blame to others,” the investigation report says. “Despite the many warnings and ongoing indicators of serious problems, leaders failed to engage in meaningful interventions of effective remediation.”

Morale at the agency has taken a beating amid the constant drumbeat of crises. Employees ranked it as the second to worst agency to work for among large departments last year. The only department scoring lower was Homeland Security.

The inspector general singled out frontline workers at the Washington hospital, saying they went to great lengths to make do and they may be the only reason no patients were actually harmed.

“The OIG did not find evidence of adverse clinical outcomes, a condition that is largely attributable to front-line care providers who were committed to providing the best possible care by borrowing supplies, improvising, or personally ensuring patients received what they needed,” the investigation report said.

Vetting failures

The VA has had persistent difficulties recruiting and keeping enough medical care providers to meet veterans needs.

In 2015, one in six critical VA jobs — intake workers, doctors, nurses and assistants — were unfilled, a USA TODAY investigation found. Though the agency has made headway, there are still shortfalls.

In some cases, that has created an incentive to hire medical care providers with problem records that may have prevented them from getting jobs in the private sector.

A VA hospital in Oklahoma knowingly hired a psychiatrist sanctioned for sexual misconduct who went on to sleep with a VA patient, according to internal documents obtained by USA TODAY. A Louisiana VA clinic hired a psychologist with felony convictions. The VA ended up firing him after they determined he was a “direct threat to others” and the VA’s mission.

The Iowa City VA hospital knowingly hired John Henry Schneider last year, a neurosurgeon who had racked up more than a dozen malpractice claims in two states and had his license revoked in one.

After USA TODAY revealed the case in December, the VA forced him out and discovered that conflicting VA policies allowed its hospitals to illegally hire doctors with revoked licenses for 15 years. Shulkin ordered the policies rewritten but with the current process, that could take up to two years.

In a report released Monday, the inspector general found vetting failures go beyond medical providers. Investigators determined that the VA did not conduct required background checks on more than 6,000 employees and managers failed to properly document and oversee background checks.

“As a result, VA cannot reliably attest to the suitability of its largest workforce, exposing veterans and employees to individuals who have not been properly vetted,” the report said. “Unless internal controls and data are improved, VA and the public lack assurance that VHA has a workforce suitable for serving our nation’s veterans.”

Hiding shoddy care

The agency has failed for years to ensure medical care providers found to have provided poor care are reported to state licensing boards or to a national database created to prevent them from crossing state lines and endangering other patients.

In one case in Maine revealed in a USA TODAY investigation, the VA found a podiatrist had harmed 88 patients but didn’t report him to the national database and took years to report him to state boards. By the time the VA told his patients, one of them, U.S. Army veteran April Wood, had decided to have her leg amputated after two failed surgeries by the podiatrist.

The investigation found VA hospitals also signed secret settlement deals with dozens of doctors, nurses and health care workers in recent years that included promises to conceal serious mistakes — from inappropriate relationships and breakdowns in supervision to dangerous medical errors — even after forcing them out of the VA.

In response to the story last fall, Shulkin required increasing vetting of future such deals and he ordered policies on reporting to state boards and the national database rewritten. Again, five months later, the new policies still are not in place and could take months or years more.

Politics

Jackson, Trump's pick to be the new secretary, has no experience running a huge government agency, and dealing with veterans’ health care challenges will require deft politics and bureaucratic acumen.

His predecessor, Shulkin, was ousted despite being well regarded in Congress and assured of job security by Trump.

Now, a White House physician and former Navy admiral faces not just a plethora of VA maladies, but partisan politics and special interests that bitterly disagree on the cures.

The most perilous and important controversy involves decisions on privatizing veterans’ healthcare.

Powerful unions and veteran service organizations, such as the American Legion, oppose a radical change, and they are supported by most Democrats on Capitol Hill. But Republicans and key advocacy groups, such as Concerned Veterans for America, are demanding a system that would let veterans decide whether they go to the VA for care, or get private treatment subsidized by the government.

On Thursday, Trump suggested that Shulkin was dismissed because he was not aggressive enough in promoting the private-care option.

The existing Choice Program, which ate up billions of dollars and had to be re-funded, promises to be even more expensive if expanded. And those costs already have included tens of millions of dollars in improper payments to contractors.

Veteran enrollment for healthcare has skyrocketed, and Congress continues to expand benefits for those already in the system, with care for Agent Orange victims and high-cost medications for hepatitis patients. Bringing in enough funding to meet that demand also requires political aplomb.

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5. New York Times: [Veterans Affairs Shake-Up Stirs New Fears of Privatized Care](#) (29 March, Nicholas Fandos, 30M uvm; New York, NY)

President Trump's dismissal of David J. Shulkin, the secretary of veterans affairs — and the nomination of a man with no known policy views to take his place — has brought renewed focus to an increasingly contentious debate over whether to give veterans the option of using the benefits they earned through military service to see private doctors rather than going to government hospitals and clinics.

The issue, which has pitted almost every major veterans group against Concerned Veterans for America, an advocacy group funded by the billionaire conservative brothers Charles G. and David H. Koch, and its allies, has been at the center of months of intrigue at the sprawling Department of Veterans Affairs, which is charged with caring for the United States' 20 million veterans.

But Mr. Shulkin's departure and the abrupt elevation of Dr. Ronny L. Jackson, the White House physician, to the department's top job on Wednesday have raised new fears among Democrats and groups like the Veterans of Foreign Wars and the American Legion. They worry that the Trump administration will push for a major change in veterans' health care that they have bitterly opposed.

The groups say the end result would be disastrous, effectively bleeding to death a network of 1,700 hospitals and clinics that has taken decades to build.

Dr. Shulkin, who was dismissed Wednesday evening by presidential tweet, argued in an op-ed article in The New York Times and in a subsequent interview on Thursday that such radical restructuring of veterans' health care would not work.

He said that a middle path that he had tried to pursue — investing in the department's own health care system while offering veterans more, though not unfettered, access to private

doctors — had been rejected by Trump administration officials interested in rewarding private individuals and companies with a windfall in government money.

“They saw me as an obstacle to privatization who had to be removed,” he wrote in one of the most forceful statements offered yet by a fired Trump administration official.

Senior White House officials offered a different rationale for his firing that was based more on a damaging report about Dr. Shulkin’s use of government funds on a trip to Europe released last month than on a dispute over policy.

Lindsey Walters, a deputy White House press secretary, told reporters aboard Air Force One on Thursday that the nomination of Dr. Jackson should not be interpreted as a signal that Mr. Trump wants to privatize veterans’ health care.

But Mr. Trump seemed to renew those concerns just a short time later, promising in a speech in Ohio that he was going to ensure that veterans “have choice,” harkening back to a campaign promise to enact something like the Koch-backed plan.

The speculation on Thursday about a possible policy shift was mostly fed by the lack of information about Dr. Jackson, whose only prominent public statements have been about Mr. Trump’s health.

Veterans advocates are especially concerned that Dr. Jackson, a rear admiral in the Navy who has no real management or political experience in a large bureaucracy, will be pushed around or, worse, simply co-opted by officials in the administration set on drastically expanding private care.

“We don’t know what his agenda is. We don’t know what his views are,” said Verna L. Jones, the executive director of the American Legion. “No one has had an opportunity to talk to him.”

“Of course we are nervous,” she added.

Leaders of the older, congressionally chartered veterans groups like the Legion are not categorically opposed to easing restrictions on private care, particularly in cases where veterans are facing long wait times and subpar facilities. About 30 percent of veterans’ appointments are currently made with private health providers for those reasons.

But the groups prefer tweaking programs already in place while at the same time addressing the problems that made private care necessary.

John Hoellwarth, the communications director for Amvets, said he thought the first response of most veterans groups to Dr. Jackson was to search for him online.

Dr. Shulkin said that he had been friendly with Dr. Jackson for several years — both men also served in the Obama administration — and encouraged him to go through the interview process to lead the department’s health system this year. Still, he said that he thought concerns about Dr. Jackson’s résumé were justified.

“There is no question about it, but I can’t imagine any job that prepares you for this type of job,” Dr. Shulkin said.

By most accounts, Dr. Shulkin's rapid fall began as he increasingly butted heads with other Trump administration official over how to approach the expansion of private care. The officials — who included the department's press secretary and assistant secretary for communications — came to consider Dr. Shulkin as an obstacle and repeatedly tried to have him removed.

Many of those officials, several of whom have ties to the Concerned Veterans group, are still in the administration and are likely to have increased sway in the department. But the ultimate decision about the structure of the department's health care most likely resides on Capitol Hill, where lawmakers have been struggling for almost a year with the issue.

"I think that there was a miscalculation that if you could get rid of the secretary who is a moderate that things will fall in place, and I just don't think that is going to happen," Dr. Shulkin said.

Dan Caldwell, the executive director of Concerned Veterans for America, strenuously disputed Dr. Shulkin's analysis and said the secretary was using privatization as a "straw man" to distract from his own ethical lapses.

"The president has said he supports full V.A. choice," Mr. Caldwell said. "The president would not have selected Admiral Jackson if he did not believe he supports his full agenda."

Mr. Caldwell was referring to a damning report released in February by the department's inspector general that found "serious derelictions" related to a trip Dr. Shulkin took last year to Britain and Denmark. It concluded that he had spent much of the trip, which cost more than \$122,000, sightseeing and that he had improperly accepted Wimbledon tickets as a gift.

Dr. Shulkin has continued to deny any wrongdoing, and on Thursday blamed his political opponents in the department for the investigation itself.

"This is 100 percent about the politics and this is the way that people fight their battles in Washington rather than having intellectually honest discussions," he said.

The White House did not view it that way. Senior officials came to believe that Dr. Shulkin had misled them in the run-up to the report's release. His public declarations of innocence only further aggravated top officials, who felt he had too openly aired internal politics with news outlets and had repeatedly opened the White House to criticism.

The exact circumstances surrounding Dr. Shulkin's firing, and exactly how much the White House chief of staff, John F. Kelly, was aware of it, remained unclear.

One person with direct knowledge of the events said Dr. Shulkin had called Mr. Kelly around 10:30 a.m. Wednesday, asking if he were about to be fired. Mr. Kelly told that him he did not know, and that he would get back to him.

A White House official would not discuss the details of what took place, beyond saying that Mr. Kelly had called Dr. Shulkin to accept his resignation, and that the secretary gave it.

Dr. Shulkin declined to discuss the episode in detail, but said he did speak on the phone with Mr. Trump on Wednesday about the progress of various policy initiatives at the department and implied that his job status did not come up.

A few hours later, he was at home on the phone with his wife when she broke the news: the president had fired him in a tweet.

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6. Politico: [Trump's VA pick blindsides staff, deepens agency disarray - 'He's got a department that's in turmoil,' a former VA secretary said. 'It's in crisis.'](#) (29 March, Lorraine Woellert, Eliana Johnson and Connor O'Brien, 23.9M uvm; Arlington, VA)

The timing of President Donald Trump's announcement to name Rear Admiral Ronny Jackson to lead Veterans Affairs was a snap decision that surprised his own chief of staff and knocked the government's second-largest agency, already bedeviled by scandal, deeper into disarray.

White House chief of staff John Kelly had spoken with David Shulkin by phone Wednesday morning, reassuring the now-former VA secretary that he wouldn't be fired by tweet that afternoon. Hours later, Kelly had to phone Shulkin again telling him plans had changed.

Trump declared Jackson's nomination on Twitter at 5:31 p.m. The tweet was big news — not just to the public, but to some senior aides, according to one White House official.

The chaos — by now a typical part of the president's management style — has for months upended Kelly's attempts to ensure that an unorthodox White House adheres to traditional processes. But while White House aides are left unpacking the day's events, the drama at the VA is just beginning.

Deputy Secretary Thomas Bowman, a Trump appointee who is the agency's No. 2, is widely expected to leave soon, either by choice or by force. Kelly and other aides wanted Bowman gone before Shulkin left to avoid installing the deputy at the helm, even temporarily. Bowman had pushed back on broad privatization efforts, leading Trump to berate him in an Oval Office meeting for his lack of loyalty.

Trump got around the Bowman problem by naming Robert Wilkie, an undersecretary at the Department of Defense, to the temporary job. A Capitol Hill veteran and member of Trump's transition team, Wilkie is a former senior adviser to Sen. Thom Tillis (R-N.C.), who supports expanding service members' access to private doctors.

"He's got a department that's in turmoil. It's in crisis. There's warfare there," said Anthony Principi, who led the agency under former President George W. Bush. "And you have an acting secretary who doesn't know the VA."

But if and when Bowman departs, Wilkie will be left with a shallow bench at an agency already paralyzed by political mistrust, some veterans' advocates say. The VA's health and benefit agencies — which administer tens of billions of dollars in health programs, pensions, survivor benefits and other forms of assistance to some 9 million service members — have been without Senate-confirmed officials since the Obama administration.

Veterans Affairs is the second-largest federal agency, behind only the Department of Defense, with 377,000 employees. And it has proven unwieldy even when led by highly decorated, experienced administrators such as Eric Shinseki, a retired four-star Army general who resigned during the Obama administration amid a scandal over lengthy wait times and faulty scheduling practices for medical appointments.

Shinseki was followed by Bob McDonald, an Army veteran and former Procter & Gamble CEO. Shulkin, McDonald's successor, was the first non-veteran to lead the VA.

As recently as two weeks ago, the Trump White House was still making overtures to potential candidates for the top job, according to a person with direct knowledge of the inquiries. Trump reportedly agonized over the decision, changing his mind several times, a senior administration official said.

"Instead of going through the paces to convince the best possible person to take this job, they're going with the person who's still on active duty in the Navy and can't say no to the commander in chief," said one Obama White House aide, who spoke highly of Jackson as a doctor and individual. "You could look at it as them giving up trying to find a competent commander or manager to fix the problems."

Shulkin had come under fire after a VA inspector general's report accused him of improperly accepting tickets to the Wimbledon tennis tournament and using his agency staff to arrange a sightseeing tour of Denmark and England. He repaid the VA for the trip. The longtime hospital administrator, who was engaged in open warfare with conservatives in the department intent on privatizing the VA, contended he was set up.

Veterans' groups remained loyal to Shulkin, whom they saw as their best line of defense of against privatization. During his campaign, Trump made promises that veterans would be allowed to seek medical treatment outside the VA's system, statements taken by some to mean a step toward handing the system to commercial companies to manage.

Jackson, while well-liked by both Republicans and Democrats, is a cipher on privatization and other policy issues. With no agency experience to speak of, veterans suspect he could be installed as a figurehead, leaving lower-level appointees to steer the agency toward privatization.

"He's a blank slate. Nobody knows really anything about his competency or capacity for this job," said Paul Rieckhoff, CEO of Iraq and Afghanistan Veterans of America. "We especially know that being a veteran doesn't qualify you to run the VA any more than being a soldier qualifies you to run the DoD."

Principi urged Jackson to move quickly on his own agenda.

"The new secretary, really, if he wants to accomplish anything, has to hit the deck running and has to bring in some very, very good people," he said. "I hope and pray he's a success. Because if he's not, American veterans are going to be the losers."

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7. NPR (All Things Considered, Audio): [Departure Of VA Secretary Shulkin Doesn't End Debate Of Privatization](#) (29 March, 22M uvm; Washington, DC)

The departure of Veterans Affairs Secretary David Shulkin does not end the debate over how far the agency should privatize. Neither the president nor his nominee have given their views on the subject.

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8. Daily KOS: [Trump replaces experienced hospital administrator with personal doc in fight to privatize the VA](#) (29 March, Mark Sumner, 19.1M uvm; Oakland, CA)

The replacement of Secretary of Veterans Affairs David Shulkin has two narratives in the media—that Shulkin “embarrassed” Donald Trump with a trip to Europe that included days of sightseeing, and that Shulkin “clashed” with other officials at the VA.

Despite the amount of play the first item has received in the press, and despite some completely justified criticisms of Shulkin’s efforts both slip his wife’s travel costs onto the VA’s dime and indulgence in gifts he should never have accepted, the idea that the he was pushed out over travel costs is clearly ludicrous. Scott Pruitt has engaged in far more lavish—and ridiculous—travel policies, hauling along a vast entourage on trips to Italy and Morocco, and the only thing his actions have earned from Trump is a suggestion that Pruitt may get a promotion to some other department ripe for wrecking. Besides, Trump isn’t capable of embarrassment.

And when the press reports that Shulkin butted heads with officials, what they really mean is that Shulkin was blocking appointees from Trump who were pushing to privatize the VA. Fast. The conflict was simple: Shulkin, the only hold-over in Trump’s cabinet from the Obama administration, was trying to maintain the VA as a viable system of health care for veterans. The Trump appointees that filled all the other VA slots, were actively working to to do to the VA what Pruitt has done to the EPA—destroy it. This morning, hours after his firing, Shulkin makes the case for preserving in the VA in the New York Times.

During my tenure at the department, we have accomplished a tremendous amount. We passed critical legislation that improved the appeals process for veterans seeking disability benefits, enacted a new G.I. Bill and helped ensure that we hire the right people to work at the department. ... We are now processing more disability claims and appeals than ever before and, for the first time, allowing veterans to see the status of their appeals by simply logging on to their accounts. ...

It seems that these successes within the department have intensified the ambitions of people who want to put V.A. health care in the hands of the private sector.

To replace Shulkin, an experienced hospital administer who previously oversaw Beth Israel Medical Center and was a pioneer in patient centered care, Trump has selected ... his personal physician. The one who says Trump is 6’3” and not obese.

The experience that the new head of the Department of Veterans Affairs has in running healthcare organizations appears to be limited to the running of himself. He finished medical school in 2004, and served a year in Iraq as an an emergency physician. From there he was appointed a White House physician in 2006, and has been there ever since.

A biography released by the White House shows Jackson is credentialed and experienced in medicine but has no background in management. He nonetheless will be charged with

delivering on one of Trump's signature campaign promises: to fix the federal government's second-largest bureaucracy.

His biggest achievement in the White House seems to be his pioneering work in patient-centered flattery.

"Some people have just great genes," Jackson said. "I told the president that if he had a healthier diet over the last 20 years, he might live to be 200 years old . . . He has incredibly good genes, and it's just the way God made him."

So when Trump begins a series of tweets against the Twenty-Second Amendment and planning his 2040 campaign, Jackson will be the person to blame.

But the biggest concern isn't that Jackson has no management experience. It's that he doesn't plan to manage at all. Instead, he's being put in place as a figurehead whose real purpose is to just stay out of the way of the forces that ultimately ran over Shulkin.

Until the past few months, veteran issues were dealt with in a largely bipartisan way. (My 100-0 Senate confirmation was perhaps the best evidence that the V.A. has been the exception to Washington's political polarization). Unfortunately, the department has become entangled in a brutal power struggle, with some political appointees choosing to promote their agendas instead of what's best for veterans. These individuals, who seek to privatize veteran health care as an alternative to government-run V.A. care, unfortunately fail to engage in realistic plans regarding who will care for the more than 9 million veterans who rely on the department for life-sustaining care.

But at least there will be someone there with the experience to flatter them wildly.

"He's very sharp, and he's very articulate when he speaks to me, and I've never known him to repeat himself around me," Jackson said. "I've found no reason whatsoever to think the president has any issues whatsoever with his thought process."

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9. Task & Purpose: [What's In Store For The Next VA Chief? Let's Break It Down](#) (29 March, James Clark, 102k uvm; New York, NY)

It's been an awkwardly long time coming, but as of yesterday afternoon embattled Veterans Affairs secretary David Shulkin is out of a job. The news comes after a month and a half of uncertainty that began when a scathing inspector general report detailed "serious derelictions" in expensing a Europe trip last summer. And then there were all the accusations and counter accusations of political infighting and rumors of possible replacements — at least all that is over:

Rear Adm. Ronny Jackson, the president's appointed White House physician, who drew national attention when he complimented President Trump on his "incredibly good genes," has been tapped to lead the Department of Veterans Affairs — pending approval by the Senate. Given that this leadership post has been described as "one of the most difficult jobs in government" — which has stymied generals, CEOs and health care executives — we thought it was time to give you a rundown of what's in store for the next officeholder, by the numbers:

More than 1,243 health care facilities. These Veterans Health Administration facilities include 170 VA Medical Centers, and 1,063 outpatient sites — making it the largest health care system in the United States.

9,000,000 veterans.. That's the number who receive medical care from VA, and many of these patients are older and suffer from multiple traumas and injuries that require specialized care: amputations, traumatic brain injuries, post-traumatic stress disorder, military sexual trauma, and as of 2013, half of all VA patients suffer from chronic pain, to name just a few. And as many as 2 million patients receive in-facility care, according to an American Legion statement.

20,000,000 veterans in the United States... we think. There could be far more veterans than we realize, since an individual's military history isn't tracked by the census bureau, which is a concern since the VA relies on headcount of its target population to get a feel for the size and scope of the services it needs to provide.

\$10,000,000,000 contract for Electronic Health Records. A long-term plan to modernize the VA's health records system could be jeopardy, with Shulkin's dismissal coming just as the VA was set to finalize the acquisition of a new electronic health record system.

2nd largest federal agency. The only one bigger is the Department of Defense.

\$186,000,000,000 budget for fiscal year 2018.

360,000 employees spread across three separate administrations within the department; the Veterans Health Administration, Veterans Benefit Administration, and the National Cemetery Administration.

23 years active duty. Jackson's Navy career began in 1995, and includes postings as an instructor, diving medical officer, diving safety officer, from Panama City, Florida Sigonella, Italy, to Norfolk, Virginia. By 2005 he deployed to Taqaddum, Iraq as part of a Surgical Shock Trauma platoon.

3 presidents. While still in Iraq in 2006, Jackson was selected as a White House physician and served as the supervising physician for the Camp David Presidential Retreat under the George W. Bush administration. Later he led the White House Medical Unit as its director and was the appointed White House physician for Presidents Barack Obama and Donald Trump.

Soon to be 7 VA secretaries in 4 years. The department has been beset by turmoil and scandal. Eric Shinseki resigned from his post as VA chief following the 2014 wait-list scandal the department. Since then, the VA has gone through three sitting secretaries, and is on its third acting secretary, with Robert Wilkie, previously the Pentagon's undersecretary of personnel and readiness, now tasked as the interim chief until Shulkin's replacement is approved by the Senate.

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10. Washington Post: [Opinions - Surprise: Trump's newest Cabinet nominee has no relevant experience](#) (29 March, Eugene Robinson, 43.9M uvm; Washington, DC)

You can't make this stuff up: President Trump has announced he will nominate a medical doctor who has no discernible management experience to run the second-largest agency in the federal government.

Can presidents be sued for malpractice?

The man Trump has named to become secretary of veterans affairs, Ronny L. Jackson , happens to be the president's personal doctor. More to the point, given Trump's perpetual hunger for sycophancy, is the fact that Jackson showered the president with hyperbolic Dear-Leader-style praise during a widely viewed television appearance in January.

Trump has "incredibly good genes," the White House physician said in describing a examination he had given the president. Trump's overall health is "excellent." His "cardiac assessment" put him "in the excellent range." If his diet were a bit better, "he might live to be 200 years old." In any event, "I think he will remain fit for duty for the remainder of this term and even for the remainder of another term if he's elected."

That is an unusual way to describe a 71-year-old man whose height was reported as a generous 6 feet 3 inches , and weight at an eyebrow-raising 239 pounds, which classifies him as overweight — but conveniently one pound short of obese. Jackson's are odd words characterizing a man whose cheeseburger-laden diet my doctor would describe as suicidal and whose coronary calcium scan results, according to many other physicians, indicate some degree of heart disease and a clearly elevated risk of heart attack.

I assume Jackson has been more, shall we say, plain-spoken with the president about his health than he was with the public. But am I suggesting that flattery, rather than merit, is what makes him Trump's choice to replace ousted VA Secretary David Shulkin? Absolutely, because no other explanation makes sense.

Pliability may also be playing a role. In a New York Times op-ed, Shulkin wrote that he believed he was being sacked because he opposed a push by the Trump administration "to put VA health care in the hands of the private sector."

Shulkin is a physician, but before he took over VA, he also had experience running hospitals. With no comparable administrative background, Jackson — if confirmed by the Senate — would take over a sprawling agency with about 360,000 employees, a \$186 billion budget and responsibility for providing medical care to 9 million veterans who deserve better, faster service than they now receive.

Shulkin was one of several high-ranking Trump appointees under fire for lavish spending on the taxpayers' dime. He was also a holdover from the Obama administration, and even though the job is perhaps the least partisan in the Cabinet , that prior association clashed with Trump's bratty determination to oppose everything President Barack Obama supported and support everything he opposed.

But Shulkin, by most accounts, had stabilized VA's vast system of hospitals and health clinics. What he refused to do was support the notion of privatizing veterans' health care — an idea pushed by some of the political appointees the White House had installed under him.

"I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans," Shulkin wrote in his Times op-

ed. “The private sector . . . is ill-prepared to handle the number and complexity of patients that would come from closing or downsizing VA hospitals and clinics, particularly when it comes to the mental health needs of people scarred by the horrors of war.”

Shulkin wrote that “in recent months” the political environment in Washington had become “toxic, chaotic, disrespectful and subversive,” making it impossible for him to do his job. “It should not be this hard to serve your country,” he wrote.

But it should be hard to get a job running any organization as big, complex and vital as the Department of Veterans Affairs. Perhaps Jackson has an innate genius for management that awaits only the opportunity to flower. If not, Trump will be doing a grave disservice to men and women who are owed the nation’s thanks and gratitude.

I can’t say I’m surprised. Trump put neurosurgeon Ben Carson in charge of the Department of Housing and Urban Development, despite Carson having zero experience in housing policy. He put Betsy DeVos in charge of the Department of Education, despite her apparent unfamiliarity with actual schools. He put politician Rick Perry in charge of the Department of Energy, which Perry wanted to eliminate until he learned what the agency does.

Perry actually said that during his confirmation hearing. One doesn’t know whether to laugh or cry.

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11. Washington Post (The Fix): [Who is Trump’s new Veterans Affairs pick, Ronny Jackson?](#) (29 March, Aaron Blake, 43.9M uvm; Washington, DC)

The seemingly never-ending parade of staff changes in the Trump administration continued apace Wednesday, with the president announcing that Veterans Affairs Secretary David Shulkin is out and that White House physician Ronny L. Jackson will replace him.

Jackson’s name will be familiar to political watchers across the country for one main reason: He’s the physician who delivered what some felt to be a suspiciously rosy picture of Trump’s health in January. But he’s an interesting pick for a whole host of other reasons.

For one, Jackson is something of a nonpartisan pick. Like Shulkin, he served in the Obama administration, where he was also President Barack Obama’s White House physician. A native of Texas and a graduate of Texas A&M and University of Texas Medical Branch, he’s a rear admiral in the U.S. Navy who has spent decades practicing medicine in the military. Jackson was nominated for a promotion to rear admiral (upper half) as recently as last week, which would give him his second star. According to his Navy biography, he was deployed to Iraq in the mid 2000s to head up an emergency medical unit tasked with resuscitating troops.

While there, he was chosen to join President George W. Bush’s White House as a physician. In 2013, Obama promoted him to the top job in the West Wing. Trump elected to keep him on. In that role, Jackson oversees not just Trump’s health, but also that of the first family and White House staff and guests. He mostly stayed behind the scenes but made headlines after treating a girl who got bit by one of the Obamas’ dogs in January 2017.

Navy Rear Adm. Ronny L. Jackson, the lead White House doctor, said on Jan. 16 that President Trump's "overall health is excellent." (Bastien Inzaurrealde/The Washington Post)

Jackson reached his highest degree of notoriety in January, when he delivered a promised review of Trump's health. Trump, who at 70 was the oldest newly elected president ever, is known to eschew exercise and dine on fast food. There have also been persistent questions — especially among his critics — about his mental health. And Trump's medical reviews during the campaign were both ridiculously hyperbolic — claiming he would be the most healthy president ever — and omitted key pieces of information, including a hair-loss drug Trump takes.

Jackson's review played up a cognitive test Trump had passed that seeks out early signs of dementia and other kinds of mental deterioration. He said Trump had "incredible genes" and (seemingly) joked that if Trump's diet had been better he might live to be 200 years old. He denied Trump had heart disease even as the data suggested he might. He listed Trump's weight at 239 pounds, which left Trump exactly one pound shy of the definition of "obese" and spawned a whole host of dubious reactions. (Call it the "girther" movement.)

The whole thing earned Jackson a send-up during the cold open of "Saturday Night Live."

Despite the ridicule, members of the Obama administration vigorously defended Jackson as a patriot and an honest man.

If nothing else, Jackson's ascension seems to reinforce that the best way to get ahead in the Trump administration is to say nice things about him. Some defended Jackson's credentials, but that review will likely be a topic at his confirmation hearings.

Perhaps the main reason Jackson is a somewhat controversial pick, though, is his lack of management experience. VA has been a department beset by scandals in recent years — including before Shulkin — and has proved a logistical and bureaucratic nightmare. Jackson has headed up medical units in the White House and Iraq, but he has never dealt with anything close to the scale of what he's set to take on. It may be the toughest Cabinet job in the entire administration, in fact.

Trump, though, as he often does, has gone with a nontraditional pick who said things he liked on television.

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12. FOX News: [Ronny Jackson picked by Trump to lead the VA: What to know about the president's physician](#) (29 March, Kaitlyn Schallhorn, 32.5M uvm; New York, NY)

President Trump gave Dr. Ronny Jackson a clean bill of health in March — to run the Department of Veterans Affairs.

A Navy rear admiral, Jackson is the president's personal physician who rose to prominence after he addressed the press from the White House briefing room in January to discuss Trump's health. While Jackson said the president needs to lose some weight, he said the physical exam he conducted showed overall that Trump was in good physical and mental health.

Trump fired Secretary David Shulkin on March 28, and Robert Wilkie is serving as interim secretary until Jackson is confirmed.

He has a marine biology degree

From Texas, Jackson, 50, graduated from Texas A&M University in 1991 with a degree in marine biology, according to his Navy biography. He graduated from the University of Texas Medical Branch with his medical degree in 1995.

That same year, Jackson joined the Portsmouth Naval Medical Center – located just outside Chesapeake, Virginia – which kicked off his active duty military career. It was there that he finished an internship in transitional medicine.

Later, he would return to the naval center to complete his residency in emergency medicine, graduating at the top of his class in 2004.

Jackson is a veteran

Jackson was deployed to Iraq after he joined the 2nd Marines in 2005, according to his Navy biography.

He served as the emergency medicine physician in charge of resuscitative medicine for a forward deployed Surgical Shock Trauma Platoon.

He's been a White House physician since Bush

While still in Iraq, Jackson was tapped as a White House physician in 2006. He has overseen the physicians for Camp David presidential retreats, led the White House Medical Unit and directed the executive health care for the Cabinet and senior staff members, according to his biography.

It was former President Barack Obama who selected Jackson to fill the position of physician to the president.

The Associated Press contributed to this report.

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13. FOX News (Video): [John Brennan: Trump's nomination for VA secretary is 'terribly misguided'](#) (29 March, Nicole Darrah, 32.5M uvm; New York, NY)

Former CIA Director John Brennan once again took a shot at President Trump on Twitter Thursday, saying he believes the decision to nominate Adm. Ronny Jackson to run the Department of Veterans Affairs is "terribly misguided."

"I personally know and greatly respect Ronny Jackson....as a terrific doctor and Navy officer," Brennan tweeted. "However, he has neither the experience nor the credentials to run the very large and complex VA. This is a terribly misguided nomination that will hurt both a good man and our veterans."

Trump announced via Twitter Wednesday his intention to replace current VA Secretary David Shulkin with Jackson, a 50-year-old Navy rear admiral who has served as personal physician to the president since 2013, when he was appointed by former President Obama, after being tapped to serve as a White House doctor in 2006.

Jackson's also a veteran. He was deployed to Iraq after he joined the 2nd Marines in 2005, according to his Navy biography.

Jackson's nomination triggered some concern among lawmakers and veterans groups about his experience to manage a federal agency, but Trump praised the lifelong doctor as "highly trained and qualified."

Trump decided to oust Shulkin from his Cabinet after he served just over a year in office. An internal VA watchdog found last month that Shulkin improperly accepted Wimbledon tennis tickets and that his then-chief of staff had doctored emails to justify his wife traveling to Europe with him at taxpayer's expense.

The swipe from Brennan, now an analyst for NBC News and MSNBC, isn't the first he's made against Trump.

Just last week, he suggested that the Russians "may have something" against the president, and days prior to that in response to former FBI official Andrew McCabe's firing: "When the full extent of your venality, moral turpitude, and political corruption becomes known, you will take your rightful place as a disgraced demagogue in the dustbin of history."

Fox News' Kaitlyn Schallhorn and Elizabeth Llorente, along with The Associated Press, contributed to this report.

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14. New York Times: [Op-ed - Ronny Jackson's Disturbing Lack of Independence](#) (29 March, Norman L. Eisen and Bandy X. Lee, 30M uvm; New York, NY)

In announcing Dr. Ronny Jackson, the White House physician, as his choice to be the new secretary for veterans affairs, President Trump has taken his latest misstep in what has been the worst presidential personnel process in modern history.

We take no pleasure in saying so, including because one of us (Mr. Eisen) worked with Dr. Jackson in the White House, was even treated by him, and can testify that he is a very capable physician. But that good opinion of Dr. Jackson, which was widely held in the Obama administration, by no means qualifies him to run one of the largest, most complex and troubled cabinet agencies in the federal government.

Indeed, the very affability of Dr. Jackson's approach when it comes to his current presidential patient is perhaps his greatest disqualification, followed closely by his lack of relevant management experience and the apparent absence of a normal pre-nomination personnel vetting.

Dr. Jackson's January examination of President Trump, and subsequent news conference, give us great pause because they evinced a disturbing lack of independence — one of the most

important qualities in a cabinet member. Dr. Jackson startled observers by not only finding the president healthy, but declaring he would remain so in the future. The doctor even looked into his crystal ball to predict good health for a second term, a pronouncement extending seven years into the future and so more fit for a fortuneteller than a scientist.

Some expert observers also felt Dr. Jackson may have understated the president's heart disease, and even fudged the president's height (his driver's license says 6 feet 2 inches; Dr. Jackson reported 6 feet 3 inches) because the lower number would have forced the doctor to admit his patient was obese. When asked why he had such glowing things to say about the president's health when Mr. Trump gorges on McDonalds, guzzles diet Coke, and seldom exercises, Dr. Jackson said: "Some people have just great genes. I told the president that if he had a healthier diet over the last 20 years, he might live to be 200 years old."

That is hardly the objectivity that America needs from its cabinet members. But Dr. Jackson's worst failing was his purported examination of the president's psychological fitness, resulting in his pronouncement that "the president is mentally very, very sharp." The examination came at a time when there was widespread public discussion about the president's mental state, driven by reporting about some of the president's startling behind-the-scenes behavior. The scrutiny was so intense that the president himself asked Dr. Jackson for testing.

But the test that Dr. Jackson administered was not fit for his conclusion. It was a short examination known as the Montreal Cognitive Assessment, which is generally used as a screen for Alzheimer's and similar symptoms. One of us (Dr. Lee) is a mental health professional who has expertise in these examinations, and would never have utilized this narrow test under these circumstances. It is the equivalent of pronouncing a patient cancer-free because she has a good complexion.

A full history should have been taken and a standardized battery of tests given, such as the Minnesota Multiphasic Personality Inventory. Among the other, more appropriate tests that should also have been considered are the Wisconsin Card Sorting Test, the California Verbal Learning Test and the Stroop Test. The MoCA examination was simply not sufficient under the circumstances to support Dr. Jackson's declaration that he had "absolutely no concerns" about the president's cognitive ability or neurological functions.

All of this matters because, if Dr. Jackson cannot be trusted to act independently when it comes to the president's mental and physical health, we cannot be confident that he will do so when it comes to the fitness of the Department of Veterans Affairs. The department has the sacred charge of repaying our soldiers for their service by providing them with health care and other support. If Dr. Jackson tells the president — and the country — what Mr. Trump wants to hear about his own health, how can we trust him to honestly and rigorously diagnose the ailments of the V.A., and to treat them appropriately?

Having a candid V.A. secretary is all the more important because the department faces profound challenges. Since 2014, it has dealt with a pattern of negligent treatment at hospitals operated by one of its agencies, the Veterans Health Administration. Outgoing Secretary David Shulkin revealed yesterday that he had fought Trump administration proposals to privatize services provided by the V.A. — a move that could undermine the quality of health care provided to our veterans. Dr. Jackson's treatment of the president does not inspire confidence that he will take on the V.A.'s problems with the brutal honesty that the job demands.

Dr. Jackson's nomination is also undermined by the fact that although he is a medical professional, he lacks the management experience that the job demands. The V.A. secretary is responsible for a department that provides health care services to over nine million individuals. While Dr. Jackson has served his country with distinction, both in Iraq and as the White House physician, managing a relatively small medical team is not preparation for leading a vast and sprawling bureaucracy. The V.A. is one of the most complex health care management jobs in the world, and ideally would be run by someone with experience operating hospital systems or health businesses or enterprises, and large ones.

The nomination fits a pattern of cronyism, with the president appointing those of dubious qualifications to patronage jobs across the administration. The president's former golf caddy is now the White House social media director. A contractor married to one of the Trump's former household staff members now has a job at the Environmental Protection Agency. And a longtime friend of the Trump family who has been involved in planning golf tournaments and Eric Trump's wedding is the head of the New York and New Jersey office of the Department of Housing and Urban Development. And now he has appointed his White House doctor to oversee the health care of millions of veterans.

Finally, in addition to concerns about independence and qualifications, it appears that Dr. Jackson had not undergone the normal vetting process for White House presidential personnel. Reportedly, the tweet-from-the-hip nomination of Dr. Jackson by the president surprised even his own advisers. That suggests that Dr. Jackson has not in fact received the careful review that is normally completed before such an announcement.

One of us worked (just down the hall from Dr. Jackson, actually) on vetting hundreds of senior administration officials. Very presentable and capable individuals — sometimes even those with existing security clearances — are sometimes disqualified by the rigorous personnel investigations that are normally undertaken for cabinet positions. Such cabinet-level vets complement but are more thorough than a typical pre-existing security clearance, and can uncover conflicts, misdeeds or other disqualifying information.

We are not suggesting that vetting will uncover anything improper, but caution is warranted, since many of Mr. Trump's nominees have had unprecedented conflicts and other issues.

Norman L. Eisen (@NormEisen) is a senior fellow at the Brookings Institution and was President Obama's ethics czar from 2009 to 2011. Bandy X.Lee is a forensic psychiatrist at the Yale School of Medicine and a project leader for the World Health Organization.

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15. ABC News (Video): [Veterans groups respond cautiously to VA secretary nomination](#) (29 March, Sarah Kolinovsky, 24.2M uvm; New York, NY)

Despite his active duty status as a Navy rear admiral (lower half) and his medical experience, veterans service organizations are responding cautiously to the nomination of Dr. Ronny Jackson for secretary of Veterans Affairs, with some expressing concern about his lack of managerial experience or what his views are on reforming the VA.

Jackson has served as White House Physician in the past three administrations and in January gave President Donald Trump a glowing health review. Recently, Trump nominated Jackson to

receive a second star, promoting him to the rank of full rear admiral. Jackson has deployed to Iraq as an emergency medicine physician in charge of resuscitative medicine for a forward-deployed Surgical Shock Trauma Platoon.

Iraq and Afghanistan Veterans of America, an organization serving the post-9/11 generation of veterans, say it looks "forward to learning more about Dr. Ronny Jackson's vision and qualifications." The statement underscores the fact that Jackson lacks significant managerial experience as he is poised to lead the government's second largest agency, which cares for more than nine million veterans and has an annual budget of nearly \$200 billion.

"Nobody really knows who is he. Is he an empty vessel? Does he have strong views on privatization, or reforming the VA?" asked IAVA CEO and Founder Paul Rieckhoff during an appearance on CNN Thursday morning. "So the confirmation hearings are going to be really really important. The Senate, House, time for you guys to step up and grill this guy and find out if he is qualified to not only run the agency but care for our veterans in a time of war."

IAVA welcomed the news that "finally puts an end to weeks of painful speculation that was negatively impacting VA and veterans nationwide," referring to media reports that President Trump had lost confidence in Secretary Shulkin. IAVA pointed out that in a recent survey, only 24% of the organization's members approved of the job Shulkin was doing.

Veterans of Foreign Wars (VFW) echoed IAVA's hesitation about Jackson's experience. "The VFW will be closely monitoring the Senate confirmation process, because what Dr. Jackson's bio does not reflect is any experience working with the VA or with veterans, or managing any organization of size, much less one as multifaceted as the Department of Veterans Affairs," VFW Director of Communications Joe Davis said in a statement.

The conservative group Concerned Veterans for America expressed more optimism about the change, saying in a statement "We are hopeful that this change will end the recent distractions at the VA and put the focus back on advancing policy that will ensure veterans get the health care and other benefits they have earned. The Trump administration has made great progress over the last year reforming and fixing the VA, however, there is still much work to be done."

The American Legion declined to comment directly on Jackson's qualifications. Instead, the group highlighted their intention to work "directly with the President through this transition and going forward, and providing him an increased level of advice and feedback on the issues important to America's veterans."

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16. The Atlantic: [The Doctor Who Suddenly Got Nine Million Patients - For a position that demands high-level policy expertise, President Trump appointed his personal physician, Ronny Jackson.](#) (29 March, James Hamblin, 23.9M uvm; Washington, DC)

Nine million veterans will soon be under the care of the emergency-physician rear admiral Ronny Jackson, pending confirmation of his appointment Wednesday to lead the U.S. Department of Veterans Affairs.

This seemingly mundane appointment—a doctor and naval officer with years of experience as White House physician under both Trump and Obama—is of great consequence. It comes at a

time when the VA is in need of a politically savvy expert on health-care administration, budgeting, and resource allocation, as the system is on the brink of major changes that bear on national security. The system has proven to require a leader who can thread multiple bureaucratic needles with his or her eyes closed. Jackson does not clearly fit this bill.

The VA is the second-largest federal department, overseeing 1,243 health-care facilities including 170 hospitals, which tend to be a ghostly network of dim, mid-century structures that bear the scars of serving as constant political battlefields. They tend to have bad food and no marble and bizarre gift shops that I've seen sell knives and cured meats. Yet VA hospitals seem to underscore the waste of the glitz of five-star-hospital-style academic medical centers. The system punches above its weight in the quality and safety of care it delivers compared to most of the private health-care industry.

While it is crucial to have experienced veterans and physicians in the upper echelons of a system like this, the work is mostly about politics and economics. Jackson is not an expert in policy, and he lacks work experience in health-care administration or management. His chief credential is that he is a physician. I'm also a physician, and—ask anyone—I'm wholly unqualified to lead a hospital system, much less to lead the one most crucial to our national security.

Even as a doctor, Jackson's judgment has been dubious at times. The press conference in January where he extolled President Trump's soundness of mind suggested allegiance to the president above the public or the profession: "I've found no reason whatsoever to think that the president has any issues whatsoever with his thought process," Jackson said, after having administered a 10-minute test for dementia in which the president was asked to do basic math, identify zoo animals, and draw a clock. (A useful and good test, the results of which were, I've argued, overstated in the context of widespread physician concern over the president's soundness of mind.)

Professional bearing intact, Jackson also said that the borderline-obese (BMI 29.9), 71-year-old president—who does not exercise and eats McDonald's to excess (Filet-o-Fish, no less) and is known for angry outbursts and drinks around 144 ounces of Diet Coke per day and barely sleeps—is in "very good health, excellent health." He speculated that the president would remain fit for service until the end of a second term and said he told Trump that "if he had a healthier diet over the last 20 years, he might live to be 200 years old."

As David Axelrod, former adviser to President Obama and now the director of the University of Chicago Institute of Politics, responded publicly to the appointment: "Dr. Jackson is a good and honorable person, [a] fine doctor and career military, but you do get the sense that this [appointment] has as much to do with his boffo press conference on the president's physical [exam] as anything else."

Trump has become known for proximity-based, loyalty-based promotions made with apparent haste. Jackson may simply have been the only doctor in Trump's field of view. With doctors Oz and Phil being televisually obligated, and Harold Bornstein all the way up in New York ... who else is there?

Though if the move was deliberate to a policy end, it was a savvy move from the perspective of those who would like to see the VA privatized. There has been a creeping movement to privatize elements of the VA system, backed by the Koch brothers, among others. At a policy

level, the concept is worthy of consideration and debate. Some experts argue that certain elements being privatized could improve quality and decrease costs.

But that doesn't seem to be what's happening. The outgoing VA secretary David Shulkin made this clear on Thursday in an op-ed in The New York Times. He argued that some public-private cooperation had been fruitful: "We have expanded access to health care by reducing wait times, increasing productivity, and working more closely with the private sector." But he also warned that the push toward complete privatization was not being undertaken in good faith. Shulkin writes:

It seems that these successes within the department have intensified the ambitions of people who want to put VA health care in the hands of the private sector. I believe differences in philosophy deserve robust debate, and solutions should be determined based on the merits of the arguments. The advocates within the administration for privatizing VA health services, however, reject this approach. They saw me as an obstacle to privatization who had to be removed. That is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans.

With Shulkin out of the way, the next secretary of the VA would need to approach the job with strong moral bearing and willingness to resist political expedience for the sake of improving the system. Without this force, special interests could sway the system toward privatization at a cost to taxpayers and veterans.

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17. NPR (All Things Considered, Audio): [Republican Sen. Jerry Moran Weighs In On Firing Of VA Secretary Shulkin](#) (29 March, 22M uvm; Washington, DC)

There's more turnover in President Trump's cabinet — this time at the Department of Veterans Affairs. NPR's Ailsa Chang talks to Sen. Jerry Moran, R-Kan., and member of the Senate Veterans Affairs Committee, about oversight of the department and the confirmation process of the person picked to lead it.

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18. NPR (All Things Considered, Audio): [How Veteran Groups Are Reacting To The Departure Of VA Secretary Shulkin](#) (29 March, 22M uvm; Washington, DC)

Garry Augustine, executive director of Disabled American Veterans, speaks with NPR's Audie Cornish about how veteran groups are responding to the the news of VA Secretary David Shulkin's firing.

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19. The Hill: [White House: Trump has 'full confidence' in presidential physician to lead VA](#) (29 March, Max Greenwood, 11.9M uvm; Washington, DC)

President Trump has "full confidence" in White House physician Ronny Jackson's ability to head the Veterans Affairs (VA) Department, a spokeswoman for the White House said Thursday, despite reported concerns from some aides.

"As I said earlier, the president has full confidence in Adm. Jackson," White House deputy press secretary Lindsay Walters told reporters.

"The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary and ultimately decided that his health care experience, his distinguished career in the medical profession, was something that would be beneficial at the VA," she continued.

"At the end of the day, as I said earlier, the status quo was not working. We need somebody who understands the health care system," she said.

Trump continued a spate of shake-ups in his Cabinet on Wednesday by dismissing VA Secretary David Shulkin and tapping Jackson, a rear admiral in the Navy and the current White House physician, for the role.

The New York Times reported Wednesday that some White House aides had privately expressed concern about the decision to nominate Jackson for the VA's top job, because of his lack of experience managing a large organization.

At the same time, some aides acknowledged that Trump's relationship with Jackson carried more weight in making the decision than the physician's prior experience, the Times reported. Jackson gave Trump his first physical in office earlier this year.

Walters told reporters Thursday that Jackson "has bipartisan respect" in Congress, and said his experience in the Navy gives him an insight into "what soldiers need on the battlefield and what they need when they come home as veterans."

She also said the decision to oust Shulkin and nominate Jackson was in no way part of an effort to privatize veterans' health care, as Shulkin had implied in an op-ed he wrote the day after his ouster.

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20. The Hill: [GOP, vet groups react with caution to Trump VA pick](#) (29 March, Rebecca Kheel, 11.9M uvm; Washington, DC)

Senators and influential veterans groups are withholding judgment on President Trump's pick to lead the Department of Veterans Affairs (VA), a Navy doctor with no experience leading a federal bureaucracy.

Both the Republican chairman and the Democratic ranking member of the Senate Veterans Affairs Committee said only that they look forward to meeting Rear Adm. Ronny Jackson. Several veterans groups expressed some concern about Jackson's qualifications, but did not immediately oppose him, saying that questions need to be answered during the confirmation process.

“We look forward to understanding more about the qualifications of Admiral Ronny L. Jackson, MD to helm the VA during this critical time,” Carl Blake, executive director of Paralyzed Veterans of America, said in a statement. “The VA has a broad mission and the secretary must be someone who is eminently qualified to lead the nation's second largest cabinet agency.”

On Wednesday night, Trump announced on Twitter that he'd tapped Jackson to replace David Shulkin, who fell out of the president's good graces after turmoil over the direction of private health care for veterans and a scathing inspector general report accusing him of misusing taxpayer dollars on a trip to Europe.

Shulkin's firing was expected, but Jackson was not among the names circulating as possible replacements.

Statements from lawmakers and veterans groups poured in Wednesday night, heavily praising Shulkin for his service at the department.

When it came to Jackson, though, the statements were generally shorter and more neutral.

“I look forward to meeting Admiral Jackson and learning more about him,” Senate Veterans Affairs Chairman Johnny Isakson (R-Ga.) said in a statement.

In a separate statement, committee ranking member Sen. Jon Tester (D-Mont.) likewise said he looks “forward to meeting Admiral Jackson soon and seeing if he is up to the job.”

Jackson was first thrust into the public spotlight when he gave Trump a clean bill of health in January during a lengthy and unusual press briefing at the White House.

Jackson told reporters that a cognitive test showed “no reason whatsoever to think the president has any issues whatsoever with his thought processes.” He also proclaimed Trump's “overall health is excellent,” crediting the president's “good genes” despite a well-known penchant for fast food and lack of exercise.

Jackson has served as a White House physician since 2006 and was promoted by former President Obama in 2013 to become the physician to the president.

Just last week, Trump nominated Jackson for a promotion in rank from rear admiral (lower half) to rear admiral. Jackson is expected to retire from active duty if confirmed.

A Texas native who received his doctorate of medicine from the University of Texas Medical Branch, Jackson started his naval career in 1995 at the Portsmouth Naval Medical Center in Virginia, according to his Navy biography.

In 2005, Jackson deployed as part of the Surgical Shock Trauma Platoon in Taqaddum, Iraq. There, he served as the emergency physician in charge of resuscitative medicine.

His bio lists several awards, including the Defense Superior Service Medal, the Legion of Merit, the Navy/Marine Corps Commendation Medal and the Navy/Marine Corps Achievement Medal.

But it makes no mention of any work on veterans issues.

Still, the White House says Trump has “full confidence” in Jackson, adding he believes the department needs someone who understands health care.

If confirmed, Jackson would take the helm at the government’s second largest bureaucracy at a time when the VA is still regaining trust after a 2014 scandal over long and falsified wait times for veterans seeking health care.

In addition to overseeing 1,700 health-care sites serving almost 9 million veterans annually, the doctor would be in charge of benefits delivery, 360,000 employees and a nearly \$200-billion budget.

Jackson would also come in during a raging debate over legislation to expand a program known as Choice that provides private health care to some veterans -- a concern seen as central to Shulkin’s undoing.

At issue is how much to expand the program. Veterans groups and Democrats fear the White House wants to essentially privatize veterans health care, which they warn would not be able to address the unique challenges veterans face.

Jackson’s position on the issue is unknown, though the White House said Thursday in response to accusations made by Shulkin that “there are no discussions about privatizing” the VA.

Veterans service organizations, which are congressionally chartered and hold substantial sway over veterans issues in Congress, raised questions about Jackson’s qualifications.

AMVETS listed several questions for Jackson, including how someone who’s never held a command is qualified to lead a massive bureaucracy and what his qualifications are to address issues outside of health care including claims, appeals, benefits and cemetery affairs.

“I am deeply concerned about the nominee,” AMVETS Executive Director Joe Chenelly said in a statement. “Veterans’ lives depend on this decision, and the Trump administration needs to substantiate that this active-duty Navy officer is qualified to run a \$200 billion bureaucracy, the second largest agency in the government.”

Disabled American Veterans (DAV) said they look forward to “learning more about the qualifications and views” of Jackson and expressed concern about a leadership vacuum.

“At a time of critical negotiations over the future of veterans healthcare reform, VA today has no secretary, no under secretary of health or benefits, and the named acting secretary has no background in health care and no apparent experience working in or with the department,” DAV Commander Delphine Metcalf-Foster said in a statement, referring to acting Secretary Robert Wilkie, who comes from the Pentagon.

“We certainly expect the next secretary to continue the path set by VA, Congress and veterans organizations in recent years to strengthen the VA healthcare system while ensuring that all enrolled veterans have timely access to quality care, whenever and wherever they need it.”

Still, Vietnam Veterans of America (VVA) said Jackson will understand veterans’ needs.

"We are pleased that he is a combat veteran with firsthand knowledge of the trauma of war, and as such, will understand what our veterans need," VVA National President John Rowan said in a statement.

VA secretaries typically receive strong bipartisan support in their confirmation. Shulkin was confirmed unanimously, as was his predecessor Bob McDonald. The secretary before that, Eric Shinseki, was confirmed by voice vote.

Nominees only need a simple majority to be confirmed. But Republicans only have a two-seat advantage over Democrats in the Senate, and one Republican, Sen. John McCain (Ariz.), has not voted in months as he receives cancer treatment in his home state.

Republicans on the Senate Veterans Affairs Committee appeared inclined to support Jackson.

"I look forward to working with Dr. Ronny Jackson on modernizing and reforming the VA, fixing the VA Choice Program, and implementing the major reforms that Congress has passed over the last year," Sen. Thom Tillis (R-N.C.) said in a statement.

Sen. Jerry Moran (R-Kan.), who in January accused Shulkin of "double-talk" in negotiating on Choice, said the VA secretary needs to focus on changing the department's bureaucracy.

"Rear Admiral Jackson has a career in service and I look forward to discussing his plans for the VA to make certain veterans receive access to care they deserve," Moran said in a statement.

Committee Democrats, meanwhile, promised close scrutiny of Jackson's qualifications and his position on privatization.

"I will seriously scrutinize the president's nominee, Ronny Jackson, because our nation's veterans deserve the best," Sen. Richard Blumenthal (D-Conn.) said in a statement.

Sen. Bernie Sanders (I-Vt.), who caucuses with Democrats, was more blunt.

"The Senate Committee on Veterans Affairs should not approve any nominee for secretary who supports the privatization of the VA," he said in a statement.

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21. Military.com: [Others Considered for VA Job Before Trump Picked His Personal Doctor](#) (29 March, Richard Sisk, 9M uvm; San Francisco, CA)

Rear Adm. Ronny L. Jackson, the personal physician to President Donald Trump, was not his first choice to replace fired VA Secretary Dr. David Shulkin, the White House said Thursday.

"The president did have some early individuals that he was looking at but continuously went back to Dr. Jackson to fulfill this role as VA secretary," White House deputy press secretary Lindsay Walters told reporters.

She said Trump "ultimately decided that his [Jackson's] health care experience, his distinguished career in the medical profession, was something that would be beneficial at the VA."

Walters added that Trump "has full confidence in Admiral Jackson" to fulfill the demanding job at the Department of Veterans Affairs despite his lack of experience in running large organizations.

Walters did not name the others who were considered to head the VA, but they reportedly included Toby Cosgrove, former head of the \$8 billion Cleveland Clinic health care system, and Pete Hegseth, an Army National Guard veteran of Iraq, former head of the advocacy group Concerned Veterans of America and co-host of the weekend "Fox & Friends" program.

Cosgrove, a Vietnam veteran, was among those invited in 2016 to Trump's Mar-a-Lago estate in Florida to be interviewed for the VA post before Trump settled on Shulkin, a holdover from the Obama administration.

Others who were under consideration as VA secretary included former Rep. Jeff Miller, R-Florida, who had been chairman of the House Veterans Affairs Committee; retired Army Lt. Gen. Keith Kellogg; Michael Kussman, a former VA undersecretary of health; and Leo Mackay Jr., a former VA deputy secretary who is now senior vice president at Lockheed Martin Corp., The Associated Press reported.

The surprise announcement of his nomination Wednesday afternoon, his status as a relative unknown on Capitol Hill, and the ongoing turmoil at the VA indicate Jackson will have little in the way of a honeymoon period if he is confirmed by the Senate.

Shulkin wasn't even out the door when Jackson faced a barrage of conflicting demands from the White House, Congress and the major Veterans Service Organizations (VSOs).

The immediate concern is the upcoming decision by the VA to award a contract that could run up to \$10 billion and is aimed at finally giving the agency electronic health records. There are also the perennial disagreements on what to do about benefits, wait times, suicides, PTSD, corruption, caregivers and the crumbling infrastructure at VA hospitals.

However, at the top of Jackson's to-do list is reaching a final resolution on the extension and expansion of the Veterans Choice Program, which allows vets to opt for private health care.

Proponents, including Trump, see Choice as guaranteeing that vets get the best health care available; opponents, including the VSOs, see overreliance on Choice as threatening the core mission of VA as the primary provider and payer for the care of nine million vets annually.

In leaving, Shulkin sidestepped the scandal over his travel expenses. He portrayed himself as the victim of palace intrigues hatched by White House political appointees advocating the full "privatization" of VA health care.

In an op-ed for The New York Times, Shulkin wrote that the political appointees, at the White House and within the VA, "saw me as an obstacle to privatization who had to be removed."

"That is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans," he said.

In testimony to the House Veterans Affairs Committee earlier this month, Shulkin warned that the Choice program could run out of money as early as June.

Sen. Johnny Isakson, R-Georgia, chairman of the Senate Veterans Affairs Committee, had co-sponsored a bill that would have extended Choice while keeping the decision on whether vets could go to private doctors within the VA, but the bill was not included in the \$1.3 billion omnibus spending package signed by Trump last week.

Isakson has pledged to renew his efforts on Choice when Congress returns after the Easter recess. In a statement Thursday, he also hinted at the conflicts with the White House by heaping praise on Shulkin and pointing to improvements at the VA in the past year.

Shulkin "has made a tremendous impact toward improving the lives of veterans," Isakson said. "He has been instrumental in all that we have accomplished in the last year, and I thank Dr. Shulkin for his dedicated service to our country and our veterans."

As for Jackson's nomination, Isakson said, "I look forward to meeting Admiral Jackson and learning more about him."

If confirmed by the Senate, Jackson, who has little administrative experience and none in running an organization such as the VA, could be expected to rely on the insider knowledge of the No. 2 at the agency, Deputy VA Secretary Thomas Bowman. The VA, the largest healthcare system in the United States, has 370,000 employees and a budget of nearly \$200 billion.

However, Bowman, a retired Marine colonel and military attorney, has already been targeted for removal by Jake Leinenkugel, a former brewery company executive and now a senior White House adviser on veterans issues.

In December, Leinenkugel wrote in an email to Camilo Sandoval, a political appointee at the VA, that they should lobby for the ousters of both Shulkin and Bowman. The email was first reported by The Washington Post and later obtained by Military.com.

Isakson and the VSOs came to the defense of Bowman, a long-time former staffer on the Senate Veterans Affairs Committee.

"Tom Bowman is a veteran and a patriot, a public servant and a good man," Isakson said in a statement. "If this is true, it will be a mistake, and I am deeply disappointed in the president. Veterans will suffer because of this decision if it's true."

The VSOs have partly blamed the moves against Shulkin and Bowman, and the efforts at privatization, on the work of the advocacy group Concerned Veterans for America, which is funded by the conservative Koch brothers organization.

In a statement, CVA's executive director, Dan Caldwell, said that Shulkin "made significant headway in reforming the department, but ultimately became a distraction from the important task of improving health care for our veterans."

Without mentioning Choice, Caldwell said, "Congress needs to continue work with the president to pass legislation that will give veterans more health care options and better access to care through the VA."

In a statement, Sen. John McCain, R-Arizona, chairman of the Senate Armed Services Committee, said of Choice that "much more work remains to improve the Veterans Choice Program and ensure our nation's heroes have access to the best possible services."

"Let me be very clear: none of us committed to reform wants to privatize care. We simply believe the VA must put the needs of veterans first, and ensure they receive timely, quality and uncompromised health care, whether that's in the VA or in the community," McCain said.

Sen. Jack Reed, D-Rhode Island, ranking member of the Senate Armed Services Committee, said, "I admire Dr. Jackson's service to the nation, but I don't know if he is the right person to lead the VA.

"One thing is clear -- the Trump administration seems to devolve further into turmoil by the day," Reed said. "I hope the level of dysfunction that has engulfed other parts of the administration does not impact the care that our veterans receive."

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22. Government Executive: [Lawmakers, Veterans Groups and Former Officials Worry VA Nominee Is Not 'Up to the Job'](#) (29 March, Eric Katz, 870k uvm; Washington, DC)

With David Shulkin now ousted from the Veterans Affairs Department, all eyes are on President Trump's nominated replacement to see where he comes down on the most pressing issue at VA: How large a role should the private sector play in providing health care to veterans?

One problem for observers and stakeholders in the veteran community is Trump's pick, Dr. Ronny Jackson, has very little experience in public policy or veterans issues. Veterans service organizations and lawmakers were effusive in their praise of Shulkin, while expressing disappointment in his firing and noting the new relationships they would have to now forge.

"I don't know if he ever set foot in a VA [facility]," Louis Celli, the national VA director at American Legion, a group that represents more than 2 million veterans, said of Jackson. By the time the secretary designate is fully able to understand all the issues facing the department, Celli said, "this administration could be over."

As VA secretary, Jackson would be responsible for managing 370,000 employees spread across 3,000 facilities. Administering veterans disability benefits, education subsidies and cemeteries number among the department's dozens of lines of business. Still, its responsibility to provide health care to veterans is by far its biggest operation—the Veterans Health Administration runs the largest hospital network in the country—and is what led Jackson, a physician, to get the job.

Trump "ultimately decided that his health care experience, his distinguished career in the medical profession was something that would be beneficial at the VA," Lindsay Walters, a White House spokeswoman, told reporters Thursday. "At the end of the day . . . the status quo was not working. We need somebody who understands the health care system."

While Jackson has served as White House physician since 2006 and the president's personal doctor since 2013, his background is atypical for VA secretaries. While Shulkin was the first to helm the department without himself being a veteran, he had served at VA as an undersecretary as head of the Veterans Health Administration. He had previously led multiple private medical centers and health systems. His predecessor was Bob McDonald, who came from the private sector but whose nomination was met with plaudits because of his experience leading the

Fortune 50 company Proctor & Gamble. McDonald replaced Eric Shinseki, who had previously served as chief of staff of the Army.

In a New York Times op-ed published after his firing, Shulkin warned that his political enemies from within the Trump administration pushed him out not due to the scandals surrounding him but because of ideological differences about the future of VA.

"I have been falsely accused of things by people who wanted me out of the way," Shulkin said. "But despite these politically based attacks on me and my family's character, I am proud of my record and know that I acted with the utmost integrity. Unfortunately, none of that mattered."

Shulkin added that the environment surrounding him became "so toxic, chaotic, disrespectful and subversive" that he could no longer accomplish his job. He said his opponents within the department, whom he repeatedly vowed to oust, were fighting to privatize VA health care and saw him as a barrier in achieving that goal.

"They saw me as an obstacle to privatization who had to be removed," Shulkin said. "That is because I am convinced that privatization is a political issue aimed at rewarding select people and companies with profits, even if it undermines care for veterans."

Opponents of privatization, including Shulkin, nearly all veterans service organizations and key lawmakers on both sides of the aisle on Capitol Hill, could breathe at least a momentary sigh of relief when Trump announced Jackson as his nominee to be the next VA secretary. Jackson is in many ways an unknown, but is not associated with any previous push to minimize the government's role in providing veterans health care as were some of the other candidates Trump was reportedly considering.

"I am deeply concerned about the nominee," said Joe Chenelly, executive director of AMVETS, another congressionally chartered veterans service organization. "Veterans' lives depend on this decision, and the Trump administration needs to substantiate that this active-duty Navy officer is qualified to run a \$200 billion bureaucracy, the second largest agency in the government."

AMVETS added it was pleased Jackson had a medical background, but noted VA is "more than healthcare."

"What qualifications does the president's nominee have to address claims, appeals, benefits and cemetery affairs?" the group asked.

Celli noted that even McDonald, a veteran who came to the department with vast managerial experience, took a while to fully "wrap his arms around the entire mission of what VA was" and was therefore only able to make a significant impact in two or three areas of VA's operation.

President Obama was wise to recognize he needed a veteran who had also run a large company with a big budget and many employees, much like VA itself, McDonald told Government Executive.

"That intersection is very small and I think [Obama] recognized that," McDonald said. "While Adm. Ronny must be a great doctor, the question the Senate will need to address is does he have sufficient management experience."

Even Shulkin seemed to suggest the job requires a large learning curve.

"No one is naturally prepared to take on a task like this," Shulkin told NPR on Thursday. Jackson would not be met with political leadership at the department to help guide him through the ins and outs of its medical network, as Trump has yet to nominate an undersecretary to head VHA.

"Given the state of the VA today, the most important thing is the leadership experience of a very large organization," McDonald said. Having medical experience would only be the third top priority, McDonald said, after being a veteran.

Several groups expressed concern over the fate of reforms VA had already initiated under Shulkin. The now former secretary was in the process of realigning the department's regions, or Veterans Integrated Service Networks, and the larger structure of the department. He had worked with oversight committees in Congress on a proposal to consolidate existing programs giving veterans access to private sector care on the government's dime and easing veterans access to such programs, while maintaining a tight balance with those who tend to have a knee-jerk reaction against any reform that could be construed as VA privatization. The existing Veterans Choice Program is expected to run out of funding this summer. He had won approval for his plan to shutter underutilized facilities and had already help shepherd measures to expedite firing of problematic employees and reform the disability appeals process through Congress and into law.

"I have enjoyed getting to know Secretary Shulkin, and I'm glad to call David a friend," said Rep. Phil Roe, R-Tenn., who chairs the House Veterans Affairs Committee. "I think he's done a fantastic job and I hate to see him go."

Roe pledged to work with Jackson and build "a strong relationship with him also." Roe's counterparts in the Senate made clear they would not automatically grant their approval, as will be necessary for his confirmation.

"I look forward to meeting Admiral Jackson and learning more about him," Sen. Johnny Isakson, chairman of the Senate VA committee, said after praising Shulkin for the "tremendous impact" he made during his tenure.

Sen. Jon Tester, D-Mont., was even more non-committal.

"Moving forward, the VA needs a strong leader at the top who will listen to veterans, strengthen the VA and work with Congress to implement bipartisan reform," Tester said. "I look forward to meeting Rear Adm. Jackson soon and seeing if he is up to the job."

McDonald suggested Trump's selection could mark a departure from the path on which he and Shulkin put the department, which the former secretary said he formulated after hundreds of visits around the country to listen to VA beneficiaries.

"Veterans don't want the privatization of the VA," McDonald. "I hope President Trump is listening to veterans."

The American Legion's Celli speculated that Trump's choice of Jackson was a matter of happenstance rather than qualification. His selection was not as "draconian" as he and many had feared, Celli said, but it still appeared as if Jackson got the nod because he was "someone with military experience who [Trump] just happened to know." Celli was at least pleased that

Jackson's demeanor and medical abilities were "above reproach," but said he would still have to prove himself beyond that to earn the support of the veteran community.

"Great, he's a nice guy," Celli said. "There's a lot of nice guys out there."

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From: (b) (6) <(b) (6)>
To: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (6)>
Cc:
Bcc:
Subject: Fwd: [EXTERNAL] Re: VA
Date: Thu Dec 07 2017 09:26:14 CST
Attachments: ATT00001.htm
(b) (6) Resume (1).pdf

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6)>
Date: March 22, 2017 at 4:31:25 PM EDT
To: (b) (6) A. <(b) (6) va.gov>
Subject: Re: [EXTERNAL] Re: VA

Hi (b) (6)

It was great talking to you and I am excited about this opportunity. My resume is attached. Let me know what else you need from me.

Thanks,

(b) (6)

On Wed, Mar 22, 2017 at 3:59 PM, (b) (6) A. <(b) (6) va.gov> wrote:

Yes, I do. Will call.

--

(b) (6)

White House Liaison

Department of Veterans Affairs

202-461-(b) (6) office

202-817-(b) (6) cell

From: (b) (6) (b) (6) [mailto:(b) (6)]
Sent: Wednesday, March 22, 2017 3:54 PM
To: (b) (6) A.
Subject: Re: [EXTERNAL] Re: VA

Hi (b) (6)

Just checking in to see if you still wanted to connect today.

Thanks,

(b) (6)

On Mar 21, 2017, at 5:46 PM, (b) (6) A. <(b) (6) va.gov> wrote:

Sorry, I'd tried calling just before I emailed and it just rang and rang. Can I try you tomorrow?

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(b) (6)

White House Liaison

Department of Veterans Affairs

202-461-(b) (6) office

202-817-(b) (6) cell

From: (b) (6) (b) (6) [mailto:(b) (6)]
Sent: Tuesday, March 21, 2017 4:48 PM
To: (b) (6) A.
Subject: [EXTERNAL] Re: VA

Good afternoon (b) (6)

I am available at your convenience to discuss.

Thank you,

(b) (6)

On Mar 21, 2017, at 4:21 PM, (b) (6) A. <(b) (6) va.gov> wrote:

Hi (b) (6)

I got your resume from the WH, was hoping to talk about positions at the VA. Do you have time to talk soon?

(b) (6)

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(b) (6)

White House Liaison

Department of Veterans Affairs

202-461-(b) (6) office

202-817-(b) (6) cell

Owner: (b) (6) (b) (6) (b) (6)
Filename: ATT00001.htm
Last Modified: Thu Dec 07 09:26:14 CST 2017

Owner: (b) (6) (b) (6) (b) (6)
Filename: (b) (6) Resume (1).pdf
Last Modified: Thu Dec 07 09:26:14 CST 2017

(b) (6)

(b) (6)

Work Experience

Digital Media and Content Manager

November 2015 – Present

Concerned Veterans for America – Arlington, VA

(b) (6)

Social Media Manager

January 2015 – December 2015

Department of Defense – Office of the Inspector General

- (b) (6)
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**References available upon request*

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Media Analyst

February 2014 – January 2015

Barbaricum – Washington, DC

(b) (6)

Research Associate

August 2013 – January 2014

Tiffin University – Tiffin, Ohio

(b) (6)

Communications Intern

June 2013 – August 2013

National Security Network – Washington, DC

(b) (6)

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Battalion Media Readiness NCO

August 2006 – August 2012

United States Army, Worldwide

-
-

Education

Tiffin University

(b) (6)

Activities and Credentials

(b) (6)

Phone: (202) 461-[REDACTED]

Cell: (202) 560-[REDACTED]

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Filename: Veterans Affairs Cabinet Report December 6 2017.docx
Last Modified: Wed Dec 06 08:35:57 CST 2017

December 6 2017 – January 5, 2018

INFORMATION

MEMORANDUM FOR THE WHITE HOUSE STAFF SECRETARY AND CABINET SECRETARY

FROM: Vivieca Wright Simpson, Chief of Staff

SUBJECT: Department of Veterans Affairs Weekly Update

(Blue Font = New Entries)

1. Department of Veterans Affairs 30-Day Policy Look Ahead

VA Secretary's Top Priorities

Greater Choice and Quality In Health Care for Veterans

VA is working to ensure Veterans have more options for care, including at VA Medical Centers (VAMC) or Health Care Systems (HCS), and care in the community when VAMCs do not meet their needs.

- December 7
- Dr. Peter Almenoff, Veterans Health Administration's (VHA) Director for Organizational Excellence, will brief **Congressman Salud Carbajal** on VA's **Strategic Analytics for Improvement and Learning Value Model** data.
- POC: Brooks Tucker, VA's Office of Legislative and Congressional Affairs

- December 8
- Margarita Devlin, VA's Benefits Assistance Service Director, will brief Senate Committee on Veterans Affairs (SVAC) staff on VA's efforts to **enroll service members transitioning** from active duty into **VA's health care system**.
- POC: Brooks Tucker, VA's Office of Legislative and Congressional Affairs

- December 11
- Mark Yow, Veterans Health Administration's (VHA) Chief financial Officer, will brief **House Committee on Veterans Affairs** (HVAC) minority staff on the **Veteran Integrated Service Network resource allocation process**.
- POC: Brooks Tucker, VA's Office of Legislative and Congressional Affairs

- December 12
- The Minneapolis VA HCS will hold a ribbon cutting and open house for VA's first **Center for Integrative Health and Healing**. Located in three large reconditioned rooms that were previously clinical spaces, the center will offer mindfulness, yoga,

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tai-chi and acupuncture. After remarks from Minneapolis VA HCS Director Patrick Kelly, the center will open for tours and demonstrations.

- POC: Ralph Heussner, Minneapolis VA HCS Public Affairs
- [December 13](#)
- [Secretary Shulkin will meet with House Majority Leader Kevin McCarthy and Congressman Steve Knight to discuss an **immediate care pilot in Southern California**.](#)
- [POC: Brooks Tucker, VA's Office of Legislative and Congressional Affairs](#)
- December 18
- VA leaders will provide **SVAC staff** an update on VA Office of Inspector General's recommendations on the **Veterans Crisis Line (VCL)**, and VCL performance indicators.
- POC: Brooks Tucker, VA's Office of Legislative and Congressional Affairs

Improve Timeliness of Service – Disability Claims and Appeals Decisions

The Veterans Benefits Administration (VBA) is working to improve the timeliness of adjudicating and paying disability claims.

- December 6
- VBA leaders will brief congressional staffers on the **Decision Ready Claims** process and **Rapid Appeals Modernization Program**. Specific members/committees are TBD.
- POC: Brooks Tucker, VA's Office of Legislative and Congressional Affairs
- **VBA Claims Clinics** are outreach events where VBA employees provide Veterans with in-person support and guidance related to claims processing. Claims clinics differ from traditional outreach events in that VA claims personnel are available to discuss with Veterans their unique individual issues. Upcoming claims clinics are:
 - December 6: Jackson, MS
 - December 5 [and 19](#): Brunswick, ME
 - December 5-7: St. Louis, MO
 - December 9: Irvington, NJ
 - [December 13: Anthem, AZ](#)
 - [December 13-15: Winston-Salem, NC](#)
 - [December 14: Somerset County, NJ and St. Petersburg, FL](#)
 - [December 18: Mather, CA](#)
 - [December 19: Louisville, KY](#)
 - [December 20: Trenton, NJ](#)
 - [December 26: Portland, ME](#)
- POC: Tom Murphy, Acting Under Secretary for Benefits

Modernize VA Systems and Infrastructure

VA is working to modernize information technology, other systems and physical infrastructure to improve our delivery of care and services to Veterans.

- December 7
- VA's Office of Information and Technology will deliver upgrades to **how VA's National Cemetery Administration (NCA) coordinates with memorial benefits** for recently deceased Veterans. The upgrades will improve the security of Personally Identifiable Information – Sensitive data when NCA corresponds with next-of-kin and funeral homes to arrange memorial benefits. This will ensure more safeguards of Veterans' personal information and add peace of mind for families as their Veteran family members are appropriately honored for service to the nation at their final places of rest.
- POC: Scott Blackburn, VA's Office of Information and Technology

Other Department Priorities

Reducing Veteran Homelessness

VA is working to reduce or eliminate Veteran homelessness through internal programs and leveraging partnerships with public and private entities.

- POC for all events: A ^{(b) (6)} Acting Director for Veteran Homeless Programs
- December 8
- Leaders from VA's Pacific Island Health Care System will participate in a ribbon cutting ceremony at the **Enhanced Use Lease facility at Barbers Point, HI**. U.S. Vets, the organization currently leasing the VA property to provide supportive transitional housing for Veterans, has added 50 additional units to house Veterans who are homeless or at risk of becoming homeless. The Barbers Point location currently houses over 300 Veterans per year. The supportive services include providing access to VA healthcare, job placement programs, and other transition services.
- **Veteran Homeless Standdowns** are outreach events where VAMCs address the unique care needs of homeless Veterans. Events include health screenings, VA benefits counseling, and referrals for housing or employment assistance. Upcoming Homeless Standdowns are:
 - December 8: Newport, OR
 - December 12: Brandon, FL
 - December 14: Horseheads, NY
 - December 14-15: Seattle, WA
 - December 16: Dallas, TX
 - December 23-25: Yuma, AZ

Leveraging Partnerships

VA is committed to working with public and private entities who wish to improve outcomes for Veterans.

- December 7
- The Ralph H. Johnson VAMC and the Fisher House Foundation will host a grand opening and ribbon cutting ceremony for the opening of the new **Fisher House in Charleston, SC**. The new Fisher House will provide lodging for up to 16 families of eligible Veterans and active duty military members at no cost, allowing them to be near loved ones receiving care at the nearby Ralph H. Johnson VAMC. Dr. Carolyn Clancy, VHA Executive in Charge, and Ke (b) (6) er House Chairman and CEO, will make opening remarks.
- December 13
- Secretary Shulkin will meet w (b) (6) and the **Association of American Medical Colleges** to discuss VA legislation and other issues of importance to academic medicine, like joint ventures.

Building and Sustaining a Quality VA Workforce

VA is reshaping its workforce to one that is Veteran-centric and committed to improving care and services for Veterans. Efforts include engaging with employees at facilities in the field to communicate priorities on cultural change and accountability, as well as recognizing employees as key and valued stakeholders.

- December 21
- VBA will conduct graduation ceremonies for 109 Wounded Warriors and transitioning Servicemembers completing VBA's **Warrior Training Advancement Course (WARTAC)**. The program educates participants on the skillsets needed to serve as a Veterans Service Representative or Rating Veteran Service Representative in VBA, and allows the participants to complete the program while still on active duty. The in-person courses began in October at six military installations in California, Texas, and Germany, and consisted of instructor led training, web based instruction, scheduled tests, and completing mock claims. WARTAC graduates will then have an **opportunity to be interviewed for employment** at one of VBA's 56 Regional Offices in the country.
- POC: Tom Murphy, Acting Under Secretary for Benefits

2. Key Events for the Upcoming 30-Days

VA Advisory Committees

Supporting VA Priority: Engaging with Key Stakeholders

Via the Federal Advisory Committee Act, advisory committees operate as another component of the "people's voice" in our democratic form of government, and are comprised of experts from the public and private sector. Upcoming meetings are:

- December 6: The **National Research Advisory Council** provides advice to the Secretary on research and development sponsored and/or conducted by the Veterans Health Administration, to include policies and programs of the Office of Research and Development.

- December 6-7: The **VA National Academic Affiliations Council** provides advice to the Secretary regarding partnerships between VA and its academic affiliates.
- December 12-14: The **Advisory Committee on Minority Veterans** Committee provides advice to the Secretary on the administration of VA benefits for Veterans who are minority group members in the areas of compensation, health care, rehabilitation, outreach, and other services. Secretary Shulkin will meet with the committee during its first day of discussions. (b) (6) VA's Center for Minority Veterans Director, will serve as the Designated Federal Officer for the Advisory Committee.
- December 13: The **Cooperative Studies Scientific Evaluation Committee** provides advice on VA cooperative studies, multi-site clinical research activities, and policies related to managing these efforts. The Committee also ensures that all projects maintain high quality, are based upon scientific merit, and are efficiently and economically conducted.
- POC: (b) (6) A Advisory Committee Office

Veteran Town Halls

Supporting VA Priority: Engaging with Veterans

Veteran Town Halls are outreach events where local VA leaders invite Veterans, family members, congressional offices and community stakeholders, to learn about VA health care, services and benefits. Town Halls are usually conducted at VA Medical Centers (VAMC) or VA Health Care Systems (HCS), and they often include claims assistance from Veteran Benefits Regional Offices. Upcoming Town Halls are:

- POC: (b) (6) Veterans Health Administration Public Affairs
- December 6:
 - Ashville VAMC in Ashville, NC
 - Gulf Coast Veterans HCS in Pensacola, FL
 - Rochester VA Outpatient Clinic in Rochester, NY
- December 7:
 - William S. Middleton Veterans Hospital in Madison, WI
 - Minneapolis VA HCS in Forest Lake, MN
- [December 11: Erie VAMC in Erie, PA](#)
- December 12:
 - Roseburg VAMC in Roseburg, OR
 - Long Beach HCS in Long Beach, CA
 - Oscar G. Johnson VAMC at community locations in Wabeno, WI, Stephenson, MI, and Rapid River, MI
 - [Wilkes-Barre VAMC in Wilkes-Barre, PA](#)
- December 13:
 - Fargo HCS in Grafton, ND

Armstrong Outpatient Clinic in Kittanning, PA
VA Pittsburgh HCS in Pittsburgh, PA
VA Portland HCS in Vancouver, WA
Oscar G. Johnson VAMC at community locations in St Ignace, MI and
DeTour Village, MI
[Northern Arizona HCS in Anthem, AZ](#)

- December 14:
 - Canandaigua VAMC in Canandaigua, NY
 - Oscar G. Johnson VAMC at community locations in Sault Ste. Marie, MI, Newberry, MI, and Manistique, MI
- December 20: Milwaukee VA Medical Center in Milwaukee, WI
- December 21: Overton Brooks VAMC in Shreveport, LA
- December 28: Louis A. Johnson VAMC in Clarksburg, WV

VA's Center for Women Veterans (CWV)

Supporting VA Priority: Advancing Women Veterans Issues

- POC for all events: K ^{(b) (6)} [REDACTED] irector for VA's Center for Women Veterans
- December 12-13
- CWV Director Kayla Williams will speak at the **Defense Advisory Committee on Women in the Services (DACOWITS) meeting**. Ms. Williams, who is an ex-officio member, will update the Committee on the Secretary's priorities, current Federal initiatives addressing women Veterans, and benefits and services. Established in 1951 by then Secretary of Defense, George C. Marshall, the Committee consists of civilian women and men who are appointed by the Secretary of Defense to provide advice and recommendations on matters related to the recruitment and retention, treatment, employment, integration, and well-being of professional women in the Armed Forces. Historically, DACOWITS' recommendations have been very instrumental in effecting changes to laws and policies pertaining to military women.
- [January 6](#)
- [CWV Director ^{\(b\) \(6\)} \[REDACTED\] will speak at the **Student Veterans of America 2018 National Conference** in San Antonio, Texas. The theme of the conference is "Defining Our Future." Ms. Williams will speak about "Resources to Boost Women Veterans' Career Readiness."](#)

VA's Center For Minority Veterans (CMV)

Supporting VA Priority: Advancing Minority Veterans Issues

- POC: ^{(b) (6)} [REDACTED] Director of VA's Center for Minority Veterans
- December 5

Dwayne Campbell, VA's CMV Hispanic Veterans Liaison, will conduct a Lunch and Learn to educate veterans and employees at the Small Business Administration.

- December 6
Dwayne Campbell, VA's CMV Hispanic Veterans Liaison will attend the Congressional Hispanic Caucus Institute (CHCI) Holiday Reception at the Library of Congress.
- December 8
Ronald Sagudan, VA's CMV Asian American/Pacific Islander Veterans Liaison, will attend an event welcoming of Philippine Ambassador to the United States, Jose Manuel Romualdez.
- December 15
- (b) (6) MV Asian American/Pacific Islander Veterans Liaison, and (b) (6) MV Hispanic Veterans Liaison, will staff an information table for an **outreach event at Defense Intelligence Agency at Bolling Air Force Base.**
- December 15
- (b) (6) VA's CMV Hispanic Veterans Liaison, will attend the "Reach Out to Military Ministry" Christmas Holiday Gala hosted by Ebenezer AME Church.

Media Engagements

Supporting VA Priority: Engaging with Key Stakeholders

- POC for all events: L (b) (6) fice of Public Affairs
- December 11
- Secretary Shulkin will meet with **Benjamin Patton, the youngest son of General George Patton.** Mr. Patton will talk about the Patton Veterans Project, an innovative filmmaking program he developed as a therapeutic intervention for Veterans struggling with post-traumatic stress disorder, transition, and suicidal ideation.
- December 12
- Secretary Shulkin will participate in a live **Politico event at the Newseum.** Secretary Shulkin and a Politico reporter will discuss solutions-driven ideas around improving the physical and mental health of active duty Servicemembers and Veterans.

Engagements with Congress, Veterans Service Organizations, and Other Stakeholders

Supporting VA Priority: Engaging with Key Stakeholders

- December 6
- Secretary Shulkin will attend a **Cabinet Meeting** at the White House with other Cabinet Secretaries.

- December 6-7
- Deputy Secretary Bowman will travel to St. Louis, MO to provide keynote remarks at the **2017 National Veterans Small Business Event**. While in St. Louis, Deputy Secretary Bowman will conduct site visits at local facilities.
- December 7
- Secretary Shulkin will meet with C (b) (6) **Paralyzed Veterans of America** for a meet and greet.
- December 7
- Secretary Shulkin will meet with D (b) (6) **Concerned Veterans of America** for a meet and greet.
- December 7
- Secretary Shulkin will speak to the **2017-2018 Class of White House Fellows** as part of their speaker seminar series at the White House Fellows Luncheon.
- December 9
- Deputy Secretary Bowman will travel to Breckenridge, CO to accept the **Disabled Sports USA 2017 Dr. Robert Harney Leadership Award** on Behalf of the Department.
- December 9
- Secretary Shulkin will be in Philadelphia to attend the **Army Navy Football Game**.
- December 11
- Secretary Shulkin will meet with **Congressman Michael Turner** on Capitol Hill. They will discuss issues at the **Dayton VA Medical Center**.
- December 11
- Deputy Secretary Bowman and Anthony Kurta, Performing the Duties of Under Secretary of Defense for Personnel and Readiness, will co-chair the **VA/DoD Joint Executive Committee Meeting**. Topics will include: Purchased Care Network; Professional Health Care Services Contracts; Joint Sharing of Facilities and Services; VA Adoption of Defense Medical Logistics Standard Support; Telehealth Quick Wins; Military-to-Civilian Transition and Pre-Registration in VA Health Care; Movement of DoD Medical Personnel to work at VA; Joint Suicide Prevention; and Sexual Trauma – Section 402.
- December 12
- Secretary Shulkin will meet with executives from **Genoa Healthcare** to discuss mental health. Genoa is the Nation's largest mental health care pharmacy and the company also does medication management therapy and tele-psychiatric services.

- December 12
- Secretary Shulkin will participate in the **Association of American Retired Persons' (AARP) Caregiving Conference**. AARP is bringing together employers, tech innovators, medical providers, public officials, non-profits, and other leaders to talk about how to build a caregiver-friendly society and create a plan to make it reality. Several business leaders are expected to announce new commitments that their organizations are making to support family caregivers.
- December 12-13
- Deputy Secretary Bowman will travel to Augusta, ME to provide the keynote address at the first annual **State of Maine and VA Maine Veterans Symposium**. The theme of the symposium is suicide prevention and awareness, and the agenda will include panel and group discussions with Deputy Secretary Bowman on options available to Veterans who are in crisis. The State of Maine Bureau of Veterans' Services will live-stream many of the sessions for interested stakeholders who cannot attend.
- December 14
- Secretary Shulkin will meet with **VFW's Commander-in-Chief, Keith Harman**, for a meet and greet while he is in town. Bob Wallace, VFW's Executive Director, will also attend.
- December 15
- Secretary Shulkin will speak with former **Senator Bob Kerrey**. Senator Kerrey will brief Secretary Shulkin on the efforts of Virta Health to help Veterans. Virta Health is an enterprise whose goal is to reduce the number of Americans who are suffering from Type Two diabetes.
- December 18
- Secretary Shulkin will host a **breakfast** for leaders from Veterans Service Organizations.

Note: Unless noted otherwise, all events are in the Washington D.C. / Maryland / Virginia metro area.

FREQUENTLY USED ACRONYMS:

CODEL – Congressional Delegation

DoD – Department of Defense

GAO – Government Accountability Office

HAC – House Appropriations Committee

IT – Information Technology

HCS – Health Care System

HVAC – House Veterans Affairs Committee

LGBT – Lesbian, Gay, Bisexual and Transgender

MILCON/VA – Subcommittee on Military Construction Veterans Affairs and Related Agencies

NCA – National Cemetery Administration

OEF – Operation ENDURING FREEDOM

SVAC – Senate Veterans Affairs Committee

USH – Under Secretary for Health

VA – Veterans Affairs

VAMC – VA Medical Center

VBA – Veterans Benefits Administration

VHA – Veterans Health Administration

VISN – Veterans Integrated Service Network

4-Corners –HVAC and SVAC Chairman and Ranking Members

From: Devine, Daniel C. </o=va/ou=va
martinsburg/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)>
To: Bowman, Thomas </o=va/ou=exchange
administrative group (fydibohf23spdl)/cn=recipients/cn=[REDACTED] (b) (5), (b) (6)>
Cc: Farrisee, Gina S. </o=va/ou=va
martinsburg/cn=recipients/cn=vacofarrig>
Bcc:
Subject: CVA and VHA
Date: Wed Mar 21 2018 09:29:13 CDT
Attachments:

A Koch-Supported Coup at the VA? The Veterans Health Administration Risks Being Dismantled

<http://www.truth-out.org/news/item/43893-a-koch-supported-coup-at-the-va-the-veterans-health-administration-risks-being-dismantled>

From: Dan Caldwell <(b) (6) @cv4a.org>
To: O'Rourke, Peter M. </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: [EXTERNAL] Congratulations
Date: Thu Mar 01 2018 20:58:37 CST
Attachments:

Peter,

I wanted to shoot you a note and congratulate you on your new role as Chief of Staff for the VA. Based on what you have done at the Office of Accountability and Whistleblower Protection, I am confident you will do a great job.

Obviously, this was not an ideal time to assume your new position. As I told Secretary Shulkin in a phone call last week, it is my hope that the VA can move past the recent drama and get back to focusing on the upcoming community care reform along with implementing new accountability/transparency measures. I think there is a great team in place and it has been unfortunate to so many of them personally attacked by those who think they are defending the VA or the Secretary.

In that regard, I feel compelled to provide some feedback regarding this recent USA Today article:

<https://www.usatoday.com/story/news/politics/2018/02/28/va-secretary-david-shulkins-top-pr-aide-lobbied-congress-get-him-fired-sources-say/380726002/>

I have known Curt Cashour for 5 years and I worked with him closely during the VA wait list scandal. He has always been a consummate professional and I could never see him doing what is described in the above article. As I am sure you know, he also served. Since taking the job at the VA, I have spoken to him at least twice a month and never once did Curt speak ill of the Secretary. He never asked me or anyone else at CVA to help push the Secretary out and in fact only asked us to help defend the agency when it faced attacks from those opposed to the President's agenda.

To be clear, I don't work at the VA on a day to day basis and don't know the full extent of Curt's performance – there could be things (or many things) I am not aware of. But as I said earlier, I think you have some great teammates with you at VACO and it would be a shame to see some of them pushed out over this recent drama that they did not clearly begin.

All that aside – we at CVA are committed to working to improve the VA for the veterans who rely on it. Please let me know how my team and I can be of service to you.

Thank you,

Dan Caldwell

Executive Director

Concerned Veterans for America

C: [602] 999-(b) (6)

Confidentiality:

The information contained in, and attached to, this communication may be confidential, and is intended only for the use of the recipient named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication, or any of its contents, is strictly prohibited. If you have received this communication in error, please re-send this communication to the sender and delete the original message and any copy of it from your computer system. Thank you.

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administrative group
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To: (b) (6) (OAWP) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6)
Cc:
Bcc:
Subject: print
Date: Fri Aug 25 2017 10:08:06 CDT
Attachments: smime.p7s
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Integrated_Report Mitre.pdf

(b) (6)

Please print the attached, double sided and put in a thin binder. Assuming it can be done across the street on our big printer.

Peter O'Rourke
Executive Director
Office of Accountability and Whistleblower Protection
Department of Veteran Affairs
C 202-823-(b) (6)

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Filename: Commission-on-Care_Final-Report_063016_FOR-WEB.pdf
Last Modified: Fri Aug 25 10:08:06 CDT 2017

Commission on Care

Final Report



COMMISSION ON CARE

June 30, 2016

VA-18-0457-A-001132

2155

COMMISSION ON CARE

Final Report of the Commission on Care

June 30, 2016

Commission on Care
1575 I Street, NW
Washington, DC 20005



commissiononcare.sites.usa.gov

COMMISSION ON CARE

1575 I Street, NW ▪ Washington, DC 20005

June 30, 2016

We are honored to submit to the President, through the Secretary of Veterans Affairs, in accordance with the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), the enclosed recommendations for transforming veterans' health care. We believe these recommendations are essential to ensure that our nation's veterans receive the health care they need and deserve, both now and in the future.

We worked with an absolute commitment to putting veterans at the heart of our deliberations, and believe our recommendations will create an integrated, community-based health care system for veterans that will be sustainable for the long term. During the term of the Commission on Care, we evaluated the 4,000-page *Independent Assessment Report*; held public meetings; listened to a broad range of stakeholders, including veterans and leaders of veterans service organizations; made site visits to Veterans Health Administration (VHA) facilities; and exchanged ideas with individual veterans, VA and VHA leaders, VHA employees and health care providers, members of Congress, economists, and health care experts.

Overall, the Commissioners agree with the findings of the *Independent Assessment Report*, which are consistent with the expansive body of other evidence the Commissioners have reviewed. This evidence shows that although care delivered by VA is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes. The Commissioners also agree that America's veterans deserve much better, that many profound deficiencies in VHA operations require urgent reform, and that America's veterans deserve a better organized, high-performing health care system.

VA-18-0457-A-001136

The most public and glaring deficiency was access problems. Congress attempted to solve this problem through a provision in VACAA that directed VHA to implement a temporary program allowing for greater choice. The Commission finds, however, that the design and execution of the *Choice Program* are flawed. In its place, we offer specific recommendations for standing up integrated veteran-centric, community-based delivery networks that will optimize the balance of access, quality, and cost-effectiveness.

The Commission also finds that the long-term viability of VHA care is threatened by problems with staffing, facilities, capital needs, information systems, health care disparities and procurement. Fixing these problems requires deliberate, concurrent, and sequential actions. It also requires fundamental changes in governance and leadership of VHA to guide the organization during the next two decades through the rapid changes coming in demographics, technology, and in the structure of the overall U.S. health care system.

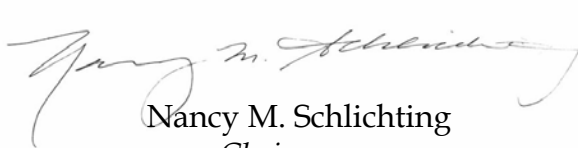
VHA has many excellent clinical programs, as well as research and educational programs, that provide a firm foundation on which to build. As the transformation process takes place, VHA must ensure that the current quality of care is not compromised, and that all care is on a trajectory of improvement. VHA has begun to make some of the most urgently needed changes outlined in the *Independent Assessment Report*, and we support this important work.

Implementing the recommendations in this report will greatly enhance VHA's ongoing reform efforts by providing both a systems-oriented framework and vitally needed changes in organizational structure. Foundational among these changes is forming a governing board to set long-term strategy and oversee the implementation of the transformation process, and building a strong, competency-based leadership system.

The remaining recommendations work in harmony to ensure veterans receive timely access to care, have options for where and how they receive care, are cared for in an environment that embraces diversity and inclusion, and are supported in making informed decisions about their own health and well-being. These recommendations are

not small-scale fixes to finite problems. Instead, they constitute a bold transformation of a complex system that will take years to fully realize, but that our country must undertake to provide our veterans with the high-quality health care they richly deserve.

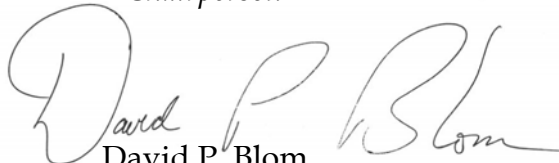
Respectfully Submitted,



Nancy M. Schlichting
Chairperson




Delos M. Cosgrove, MD
Vice Chairperson



David P. Blom
Commissioner



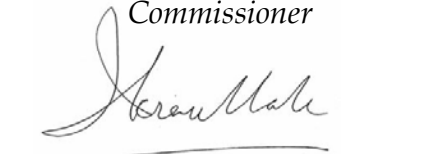
David W. Gorman
Commissioner



The Hon. Thomas E. Harvey, Esq.
Commissioner



Rear Adm. Joyce M. Johnson, DO, USPHS (ret.)
Commissioner




The Hon. Ikram U. Khan, MD
Commissioner



Phillip J. Longman
Commissioner



Col. Lucretia M. McClenney, USA (ret.)
Commissioner



Lt. Gen. Martin R. Steele, USMC (ret.)
Commissioner



Charlene M. Taylor
Commissioner



Marshall W. Webster, MD
Commissioner

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EXECUTIVE SUMMARY

Two years ago, a scandal over VHA employees' manipulation of data systems to cover up long appointment scheduling delays made headlines and left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. The White House appointed new leadership, including the secretary of veterans affairs (SECVA) and the undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program*, to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The independent assessment included an examination of the hospital care, medical services, and other health care provided in VA medical facilities.¹ The legislation identified 12 specific areas for in-depth evaluation:

- Demographics
- Health Care Capabilities
- Care Authorities
- Access Standards
- Workflow–Scheduling
- Workflow–Clinical
- Staffing/Productivity
- Health Information Technology
- Business Processes
- Supplies
- Facilities
- Leadership

The *Independent Assessment Report* provided a detailed analysis of the assessment and associated findings. The Commission work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

In an effort to focus the Commission's recommendations and set the tone for subsequent change, the Commissioners developed a vision, a mission, and a set of values to drive reform as shown below. The vision provides the conceptual framework for the model of veterans' health care put forth in this report, and the mission and values shape the content of the recommendations.

Vision

Transforming veterans' health care to enhance quality, access, choice, and well-being.

- *Quality: Provide community-based, innovative care that drives improved outcomes.*
- *Access: Ensure timely access to the best providers for meeting veterans' health care needs.*

¹ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113–146, § 201(a)(1).

COMMISSION ON CARE FINAL REPORT

- *Choice: Integrate health care within communities to foster convenience and efficiency.*
- *Well-Being: Support veterans in achieving optimal physical and mental health.*

Mission

Provide eligible veterans prompt access to quality health care.

Values

- Provide veteran-centric care.
- Involve all stakeholders, and especially veterans and their families, in designing the evolving future health care for veterans.
- Assimilate veterans into the greater community.
- Create community-based integrated networks to improve health care access and choice for veterans.

The recommendations in this report acknowledge that although VHA provides health care that is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes.

Some of these challenges are not exclusive to VHA, and reflect large-scale problems in the U.S. health system in general, such as acute shortages of primary care doctors and lack of health care capacity in poor and rural areas. Other challenges reflect deficiencies within VHA itself, in areas such as staffing, facilities, capital needs, information systems, healthcare disparities and procurement.

It is important to understand VA's long history as a health care provider, which has included previous cycles of crisis and renewal that offer lessons for the present. It is also important to consider how VHA can implement major reform in a manner that is sustainable. This report addresses both of these issues.

The Commission's focus on access to care clearly highlighted the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The report begins with an *Introduction* that addresses the controversy over veterans' health care and gives a brief description of the Commission's vision for improving it. There are three main recommendation sections: *Redesigning the Veterans' Health Care Delivery System*; *Governance, Leadership, and Workforce*; and *Eligibility*. Each section includes detailed discussions of the high-level areas in which change must occur in the respective areas to facilitate bold reform. The format for each discussion includes identification of the problem, the Commission's recommendations for addressing the problem, background information, analysis, and implementation steps for Congress, VA, and other agencies. This executive summary provides a brief overview of each of the recommendations.

For the ease of our readers, the appendices contain all additional content. Of particular interest are appendices on *Financing the Vision and Model*, *Leadership Implementation*, *History as a Context for Systemic Transformation*, *Veteran Feedback*, and *Additional Resources*. These and other appendices provide policymakers and those charged with implementing the plan with a clear picture of the rationale for the recommendations and the context that frames them.

Recommendations

The Commission does not intend for these recommendations to be piecemeal fixes to everyday problems. Instead, they are presented as the foundation for far-reaching organizational transformation that adheres to a systems approach. The Commission's recommendations comprise the essential elements for such transformation.

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Due to changing veteran demographics, increasing demand for VHA care in some markets and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Congress tasked VHA with creating the temporary *Choice Program*. It was designed to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

The Commission Recommends That . . .

- VHA Care System governing board (see recommendation on p. 94) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.

COMMISSION ON CARE FINAL REPORT

- Integrated community-based health care networks be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.
- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

The recommendations above work together to support the VHA Care System, as outlined in Table 1 below.

Table 1. VHA Care System Operations

Key Component	Expectations
Choice	<ul style="list-style-type: none"> ▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	<ul style="list-style-type: none"> ▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.²

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.³ For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified “not working to top of provider licensure” as a barrier in health care provision.⁴

² RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

³ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁴ Ibid., 95.

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VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

The Commission Recommends That. . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally supported programs.

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.⁵ Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).⁶

As part of the MyVA initiative, the Secretary of Veterans Affairs has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.⁷ The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.⁸

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a revised clinical-appeals process.

⁵ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

⁶ VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷ "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, <http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx>.

⁸ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.⁹

VHA has a program of system engineering — Veterans Engineering Resource Center (VERC) — that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to identify proactively problem areas within the system and offer assistance.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*, Assessment F (Workflow—Clinical), 14 and A-2, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

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A systematic review of VHA in 2007 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.¹⁰ VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues—the Health Equity Action Plan (HEAP)—but it has not been fully implemented.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.¹¹

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

Veterans who turn to VHA to meet health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of those barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks holds the promise of markedly improving veterans' access to care. That promise cannot be realized without transformative changes to VHA's capital structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of building out the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as

¹⁰ Somnath Saha et al., *Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review*, U.S. Department of Veterans Affairs, Health Services Research & Development Service, June 2007, accessed June 22, 2016, <http://www.hsrd.research.va.gov/publications/esp/RacialDisparities-2007.pdf>.

¹¹ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

much control as possible to drive the process to ensure that all facility plans are fully integrated with the strategic vision for the VHA Care System.

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meets its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission (BRAC) process to be implemented as soon as practicable. The Commission recommends the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems; enables scheduling, billing, claims, and payment, and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.¹² VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, VHA lacks an experienced senior health care IT leader focusing on the strategic health care IT needs of veterans.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing

¹² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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and implementing a comprehensive health IT strategy and developing and managing the health IT budget.

- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.¹³

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.

¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

Governance, Leadership, and Workforce

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center, and similar problems at multiple other VA medical centers, had both direct and indirect causes. Weak governance was found to be among those indirect causes.¹⁴ As the authors of a root-cause analysis of the Phoenix scandal highlighted, “a governance gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed to the wait-time problems.¹⁵ The report authors observed, “Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors.”¹⁶ The governance limitations made evident in the Phoenix scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration’s expectations for short-term results,¹⁷ and VHA’s operating in a “dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with competing demands”¹⁸ offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act (FACA) and be structured based on the key elements included in Table 5.

¹⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁵ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

Leadership

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

High-performing organizations have healthy cultures in which diverse staff feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government. For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

The Commission Recommends That . . .

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report on it to the CVCS and the new VHA Care System board of directors (see governance discussion in the previous section).

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and

promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an OMB management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and the functions overlap or are duplicated. The role of the VISN is not clear, and the delegated responsibilities of the medical center director are not defined.

The Commission Recommends That . . .

- VHA redesign VHACO to create high-performing support functions that serve VISNs and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the CVCS with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report.

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Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

To achieve the Commission’s vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set—identical to private-sector standards—will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes to veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders’ performance not just on *what* they achieve but *how* they achieve it.

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Personnel Performance Management System

- VHA create a new performance management system appropriate for health care executives, tied to health care executive competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of

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these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veterans' care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does all of the following:
 - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
 - Promotes veteran preferences and hiring.

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- Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, due process) through simplified, sensible processes that work for managers and employees.
 - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
 - Provides due process and appeals standards to adverse personnel actions.
 - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
 - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
 - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
 - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
 - Grandfathers current employees with respect to pay and benefits.
- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

Recommendation #16: Require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Effective planning for and management of human capital are core enabling requirements for any business: If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

The Commission Recommends That . . .

- VHA hire a chief talent leader who holds responsibility for the operation's entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the chief of VHA Care System.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.

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- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

In some cases, individuals have been dismissed from military services with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury [TBI], posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

The Commission Recommends That . . .

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an OTH discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Although VHA continues to offer the promise of health care to all eligible veterans, its capacity to meet that promise is constrained by appropriated funding.¹⁹

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use

¹⁹ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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underutilized VHA providers and facilities, providing payment through private insurance.

- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

Conclusion

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, though, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient-provider engagement and in where and how care is delivered. VHA must keep pace with, and even be a leader in, these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand access to reflect not only timeliness, but care quality, and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone: Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report* emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The Commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term transformation, the Commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the nation's obligation to those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission fully acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the Commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For

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example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net. Even considering these strengths, some may question how a system beleaguered with the problems VHA faces can achieve lofty transformation goals. This is not the first time VHA has faced challenges; however, and history has demonstrated that with appropriate structure and strategies in place, transformation can be achieved and sustained.

Transformation is a difficult process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. The Commission's recommendations in some areas acknowledge VHA's efforts to begin the transformation process and suggest that where these efforts align with the Commission's recommendations, they should be sustained. Reaping the fruits of transformation will take more than a single Congress or a single 4-year administration. For this reason, the Commission strongly recommends a new governance model and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission's recommendations, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

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INTRODUCTION

Two years ago, a scandal over VHA employees manipulating data systems to cover up long delays in scheduling care left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. In response, the White House appointed new leadership, including the secretary of veterans affairs (SECVA) and undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program*, to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The Commission on Care's work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

The charge given this Commission, with its emphasis on access to care, reflects the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the Commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, however, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient-provider engagement, and in where and how care is delivered. VHA must keep pace with, and even be a leader, in these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand *access* to reflect not only timeliness, but care quality and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone; Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report*

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emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term *transformation*, the commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the obligation owed those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net.

Others may question how a system with the range of problems VHA faces can meaningfully improve, let alone realize a transformation. Mindful of its 20-year charge, the Commission notes that VA health care faced similar challenges 20 years ago and underwent a historic transformation. The long history of the VA health care system has seen highs and lows. Among the lessons in that history is that the mission—to care for those who have borne the battle—is not only powerful, but enduring. History has demonstrated that transformation can be achieved, but also that structures and strategies for sustainability must be built into the framework.

As the commission report emphasizes, transformation is difficult. It is a process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. VHA has begun some of this work; our recommendations in some areas acknowledge VHA's efforts and suggest that where they are aligned with the Commission's recommendations, they should be sustained. The fruits of the transformation, though, will not be realized over the course of a single Congress or a single 4-year administration. For this reason, the Commission, strongly recommends a new form of governance and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission recommends, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

COMMISSION RECOMMENDATIONS

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Problem

Due to changing veteran demographics, increasing demand for VHA care in some markets, and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With the passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Congress tasked VHA with creating the temporary *Choice Program*. It was intended to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

The Commission Recommends That . . .

- VHA Care System governing board (see Recommendation #9) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.
- Integrated, community-based health care networks be developed with *local* VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.

Recommendations continue on next page. =>

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Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

Background

VHA has long had authority to purchase hospital care and medical services based on geographic inaccessibility or VHA's lack of a required service.²⁰ In 2013, VA moved beyond the use of individual purchased-care authorizations to regional contracting under the Patient-Centered Community Care (PC3) Program.²¹ In all cases, purchased care was a secondary means of providing care, to be used "when VA health care facilities are not feasibly available."²² Even before the creation of the *Choice Program* in 2014, some 10 percent of VHA medical spending went for purchased-care services.

When Congress enabled what became known as the *Choice Program*, it tasked VHA with implementing a fundamentally new mechanism for purchasing care. Unlike traditional purchased-care authority (which still exists), the *Choice Program* promises veterans who meet specific geographic or wait-time-related criteria that they can elect to receive treatment from within a network of a community providers.²³

Under the current *Choice Program*, however, most VHA patients are promised little or no actual choice of providers outside VHA. To be eligible for the program, VHA patients must meet the following criteria:²⁴

The Commission Recommends That . . .

<= Recommendations continued from previous page.

- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- The VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

²⁰ Contracts for Hospital Care and Medical Services in Non-Department Facilities, 38 U.S.C. § 1703(a).

²¹ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, 37, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

²² Non-VA Medical Care Program, VHA Directive 1601, (2013).

²³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014).

²⁴ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014), as amended by Construction Authorization and Choice Improvement Act, Pub. L. No. 114-19, 129 Stat. 215, (2015). The Independent Assessment proposed that VA should "Develop and implement more sensitive standards of geographic access to care. VA should compare the 'one-size-fits-all' approach of driving distance to alternative standards that are more sensitive to differences between Veteran subgroups, clinical populations, geographic regions, and individual facilities. This

- Live more than 40 miles from the closest VHA facility with a full-time primary care provider
- Cannot be seen within 30 days of the date veterans' providers indicate they need to be seen.
- Cannot be seen within 30 days of veterans' preferred appointment date if providers have not provided a specific appointment date.

This standard is difficult to reconcile with other statutory priorities for VA care.²⁵ For example, under the *Choice Program*, a veteran with severe service-incurred health conditions may have no access to providers outside VHA, yet a veteran with no service-related disabilities does have such a choice.²⁶ Implementing the *Choice Program* has posed challenges, including difficulties arising from overlapping, but fundamentally different, care-purchasing authorities. Veterans, VHA staff, and community providers²⁷ have been confused because of conflicting requirements and processes in eligibility rules, referrals and authorizations, provider credentialing and network development, care coordination, and claims management.²⁸

Adding to the confusion is the fact that VHA, facing a 90-day deadline for implementing the program, outsourced the creation and management of its provider networks to two private contractors, thus blurring lines of responsibility and leaving both patients and providers confused about who exactly holds responsibility for what. In execution, the program has aggravated wait times and frustrated veterans, private-sector health care providers participating in networks, and VHA alike.²⁹

In October 2015, VA submitted a report to Congress that proposed legislation to harmonize the different purchased-care authorities into a single approach.³⁰ VA's report also set out a plan for establishing high-performing networks. The report acknowledged that "[n]o organization can excel at every capability," and that "[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers."³¹ As further articulated by Dr. David Shulkin, USH:

assessment highlighted the importance of time spent driving, mode of transportation, traffic, and availability of needed services as key considerations in assessing geographic access to care."

²⁵ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705.

²⁶ Ibid.

²⁷ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, 43, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf. Pete Henry, retired VA medical center director, response to questions about the challenges facing field officials, email to Commission on Care staff, January 18, 2016.

²⁸ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

²⁹ "Despite \$10B 'Fix,' Veterans are Waiting Even Longer to See Doctors," Quil Lawrence, Eric Whitney, and Michael Tomsic, accessed May 16, 2016, <http://www.npr.org/sections/health-shots/2016/05/16/477814218/attempted-fix-for-va-health-delays-creates-new-bureaucracy>.

³⁰ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

³¹ Ibid., 18.

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It's become apparent that the VA alone cannot meet all the health care needs of U.S. veterans. The VA's mission and scope are not comparable to those of other U.S. health systems. Few other systems enroll patients in areas where they have no facilities for delivering care. Fewer still provide comprehensive medical, behavioral, and social services to a defined population of patients, establishing lifelong relationships with them. These realities, combined with the wait-time crisis, have led the VA to reexamine its approach to care delivery . . . [A]ddressing veterans' needs requires a new model of care: rather than remaining primarily a direct care provider, the VA should become an integrated payer and provider. This new vision would compel the VA to strengthen its current components that are uniquely positioned to meet veterans' needs, while working with the private sector to address critical access issues.³²

Analysis

VHA needs systemic transformation, and merely clarifying and simplifying the rules for purchased care, as proposed in the *Independent Assessment Report*, is not sufficient to achieve that goal. VHA must replace the arbitrary eligibility requirements and unworkable clinical and administrative restrictions of current purchased programs with the new VHA Care System, available to all enrolled veterans.

The VHA Care System is defined as VHA employed providers and facilities; Department of Defense (DoD) and other federally-funded providers and facilities; and community-based, VHA-credentialed community providers and facilities, forming integrated networks to deliver high-quality and high-access care to enrolled veterans across the United States. VHA may establish the networks with the use of national contractors or with internal resources, but networks should be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.

This new delivery model must preserve critical VHA programs and competencies that are unique to VHA or that are of higher quality or greater scope than is available in the private sector, either locally or nationally³³ They include specialized behavioral health care programs, integrated behavioral health and primary care (in patient-aligned care teams), specialized rehabilitation services, spinal cord injury centers, and services for homeless veterans.³⁴ These and similar programs and services are core competencies and special capabilities that serve the needs of combat veterans, veterans with conditions incurred or aggravated in service, and veterans reliant on safety-net services and supports.³⁵ Because of its unique capabilities and competencies, VHA should play an important role in expanding and enhancing the care of veterans across the United States by collaborating with local network providers to improve the

³² David J. Shulkin, "Beyond the VA Crisis — Becoming a High-Performance Network," *New England Journal of Medicine*, 374, (2016): 1003-1005, accessed June 15, 2016, <http://doi.org/10.1056/NEJMp1600307>.

³³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

³⁴ Special capabilities like spinal cord injury care, which draw from specialty care available in the full-service hospitals in which they are currently provided, merit continued support and investment. Thus, in instances where VHA might no longer operate a full-service hospital that had once housed a spinal cord injury center, it would need to establish community partnerships to assure veterans would continue to receive the same high quality care.

³⁵ David J. Shulkin, "Why VA Health Care Is Different," *Federal Practitioner*, 33, no. 5 (2016): 9-11, <http://www.fedprac.com/home/article/why-va-health-care-is-different/c8da5ba1261bdbc726bdddcbceea81f27.html>.

availability and quality of care in areas especially needed by veterans, such as mental health and rehabilitation.

Management and Oversight

VHA Care System networks will be built out in a well-planned, phased approach overseen by the new governing board, which will determine the criteria and sequencing for the phases, to ensure effective execution of the strategy. The timing and phasing criteria may include veteran service needs, access issues, quality issues, facility issues, and IT capabilities.

The networks within the VHA Care System will require ongoing management and evaluation of their performance. This process will be the responsibility of VHA management and board, with board oversight of network performance.

The governing board will oversee the budget for the VHA Care System. Local leadership will provide input on funding, and the local networks will determine their funding needs and submit their respective requests to the chief of VHA Care System (CVCS), formerly the undersecretary of health for VHA. The governing board will recommend to Congress the budget required to implement the VHA Care System, with multiyear appropriations. The local network leaders will have the flexibility to manage their respective network budgets based upon local needs. A key element of the new system will be combining a national strategy and local flexibility for managing the budget to allow for effective decision making to ensure veterans' needs are met.

Provider Payment

Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS). MACRA is intended to move the health care industry away from a fee-for-service model to value-based payments.³⁶ Such a system is expected to drive improved quality and lower costs.³⁷

Care Administration

From a strategic perspective, service-connected disabled veterans should receive the highest priority access to the VHA Care System. This principle should guide access to all types and points of care. Veterans with limited financial means should also have high priority. If needed, cost sharing (applicable only to those who are non-service-connected disabled and not financially needy) can provide a means for offering broader choice. The current time and distance criteria for community care access (30 days and 40 miles) should be eliminated. VISN geography should also be eliminated as a factor in determining where veterans can access care. Eligible veterans should be permitted to receive care at any facility and by any provider in the VHA Care System, whether in a veteran's home VISN or not.

Choice and Care Coordination

The topic of choice was the most contentious issue considered by the Commission. Some Commissioners advocated complete choice of providers for veterans, with no requirement for

³⁶ "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, <http://www.nationalpartnership.org/issues/health/macra.html>.

³⁷ Ibid.

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care coordination by primary care physicians. Others advocated for a tightly managed model with VHA controlling access to community providers, as is done today. After considering the costs of various design options, the importance of care coordination, and the need for greater veteran access to both primary care and specialty care services, the Commission agreed to the following design principles:

- VHA will establish and credential community networks with a focus on quality of providers, access to comprehensive services, and utilization of VHA resources.
- Veterans will have complete choice of primary care providers within the VHA Care System.
- All primary care providers in the VHA Care System (including VHA providers, DoD and other federally funded providers, and community providers) will coordinate veterans' care.
- Specialty care will require a referral from a primary care provider.
- VHA will assume overall responsibility for care coordination and navigation for all enrolled veterans.

Quality of care must be a core element of network design and consistently monitored with metrics that are routinely used by the private sector. Accordingly, VHA must adopt standards that both ensure networks are composed of high-quality providers and set appropriate expectations of those providers. Critically, all providers in the networks must have fully interoperable IT platforms to allow for complete data exchange. Providers must work together to maximize patients' well-being using evidence-based protocols of care.

Lack of coordination among providers is a major quality and patient-safety issue throughout the U.S. health care system. It is important for VHA to coordinate the care it provides because it serves an especially vulnerable population that has more chronic medical conditions, behavioral health conditions, and individuals of lower socioeconomic status than the general medical population.³⁸ Veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers.³⁹

³⁸ Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, <http://doi.org/10.1001/jama.2012.196>.

³⁹ "The Impact of the Affordable Care Act on VA's Dual Eligible Population," Patricia Vandenberg et al., Department of Veterans Affairs, accessed June 2, 2016, <http://www.hsrd.research.va.gov/publications/forum/apr13/apr13-1.cfm>. Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, <http://doi.org/10.1001/jama.2012.196>. Brigham R. Frandsen et al., "Care Fragmentation, Quality, and Costs Among Chronically Ill Patients," *American Journal of Managed Care*, 21, no. 5, (2015): 355-362, accessed June 20, 2016, <http://www.ajmc.com/journals/issue/2015/2015-vol21-n5/care-fragmentation-quality-costs-among-chronically-ill-patients>. Chuan-Fen Liu et al., "Use of Outpatient Care in Veterans Health Administration and Medicare among Veterans Receiving Primary Care in Community-Based and Hospital Outpatient Clinics," *Health Services Research*, 45, no. 5 part 1, (2010): 1268-1286, accessed June 20, 2016, <http://doi.org/10.1111/j.1475-6773.2010.01123.x>.

VHA Care System will operate as outlined in Table 2 below.

Table 2. VHA Care System Operations

Key Component	Expectations
Choice	<ul style="list-style-type: none"> ▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	<ul style="list-style-type: none"> ▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Scope of Provider Networks

In setting up networks within the VHA Care System, VHA must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans' choice, yet would also consume far more financial resources (i.e., taxpayer dollars) due to increased utilization or cost shifting. Currently, money VHA spends on expanding choice is not available to spend on other programs and services vital to its mission.⁴⁰

Health plans commonly limit the size and scope of networks as a cost-management tool, offering insurance products with narrow networks (managed care plans) or more open networks (preferred provider plans). Well-managed, narrow networks can maximize clinical quality by requiring participating clinicians to adhere to evidence-based protocols of care.⁴¹ Achieving high quality and cost effectiveness may constrain consumer choice. A patient's preferred doctor, clinic, or hospital may not be part of that smaller network or the narrow network may not offer sufficient geographic access for some patients.⁴²

VHA must balance these competing considerations. In doing so, it faces a variety of options. In addition to the scope of networks, for example, is the question of whether and how VHA will play a role in steering patients to different providers within the networks. This is another area involving tradeoffs among competing values and considerations. Private-sector health plans

⁴⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 23 accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴¹ "What Tier Networks Will Mean to You," Ken Terry, accessed June 2, 2016, <http://medicaleconomics.modernmedicine.com/medical-economics/content/what-tiered-networks-will-mean-you>.

⁴² Ibid. U.S. Congress, House of Representatives, Committee on Ways and Means, Subcommittee on Health, *Hearing on "Health Care Consolidation"*, 112th Congress, 1st Session, (2011), (Statement of Paul B. Ginsburg, President, Center for Studying Health System Change, Research Director, National Institute for Health Care Reform), accessed June 2, 2016, http://waysandmeans.house.gov/UploadedFiles/Ginsburg_Testimony_9-9-11_Final.pdf.

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often require all specialty care to be preapproved through a referral from a primary care physician. Managed care plans may also use prospective and concurrent utilization review and care management for hospitalization. For prospective reviews, patients must receive approval from their health plan before being admitted to the hospital to ensure the admission is clinically appropriate. Plans may also use concurrent utilization or case management for inpatient care to ensure the care and tests ordered and the length of stay in the hospital are appropriate.⁴³

The Commission carefully weighed these issues in recommending an approach. The Commission considered the effect of cost using various configurations of VHA services and community delivered services (CDS). Options considered by the commission include the following:

- **Recommended Option:** This option provides an integrated network of VHA, DoD and other federally funded providers, and community providers, credentialed by VHA. It requires veterans to attain a referral from their primary care provider to access specialty care.
- **CDS Alternative 1:** The main difference between this option and the *Recommended Option* is primary care, inpatient medical and surgical care, and some standard specialty care would not be eligible for CDS networks and would be accessed within VHA unless the *Choice Program* distance exception applies.
- **CDS Alternative 2:** The division of care between VHA providers and CDS network providers would be the same as for *CDS Alternative 1*; however, veterans would only need to consult their primary care provider before seeking specialty care, rather than obtaining a referral.
- **CDS Alternative 3:** This option would combine the broad network in the *Recommended Option*, but would have no referral or consultation requirement; thus, it would be an extremely generous benefits package.
- **Premium Support:** Under this scenario, enrollees who are younger than 65 would choose a subsidized insurance premium with cost sharing. Access to VA services, including special services, would be eliminated.
- **Eligibility Expansion:** Under this scenario the VA health care system would expand to allow all veterans, regardless of priority group.
- **Other-Than-Honorable Discharges:** A policy change for which individuals with other-than-honorable (OTH) discharge is outlined in Recommendation #17. This option would allow temporary eligibility for VA health care to those with an OTH discharge until the adjudication process to determine long-term eligibility took place.

⁴³ Paul B. Ginsburg, "Achieving Health Care Cost Containment Through Provider Payment Reform that Engages Patients and Providers," *Health Affairs*, 32, no. 5, (2013): 929-934, accessed June 20, 2016, <http://doi.org/10.1377/hlthaff.2012.1007>. While these approaches can help keep costs down, patients, doctors and hospitals can experience the process as bureaucratic interference in clinical care. To implement utilization management, health plans usually include a strong clinical appeals process that both doctors and patients can access to question the decisions made by administrators.

Below is a more detailed summary of the Commission's *Recommended Option*. Additional information, including cost projections for all of the options above, can be found in Appendix A.

Cost Model for Commission Recommended Option

This option would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VHA. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in a substantially different way than by VHA).⁴⁴ In 2014, 68 percent of care would have been eligible for CDS networks at current VHA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network (i.e., from any provider in the VHA Care System). In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

Both CDS networks and traditional Care in the Community (CITC) are priced at Medicare allowable rates by matching Medicare fee schedule data to VA Health Service Categories.⁴⁵ A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities. For care shifting into the CDS networks, we assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance; those costs are not modeled.

We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a provider in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and

⁴⁴ Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health, and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

⁴⁵ Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

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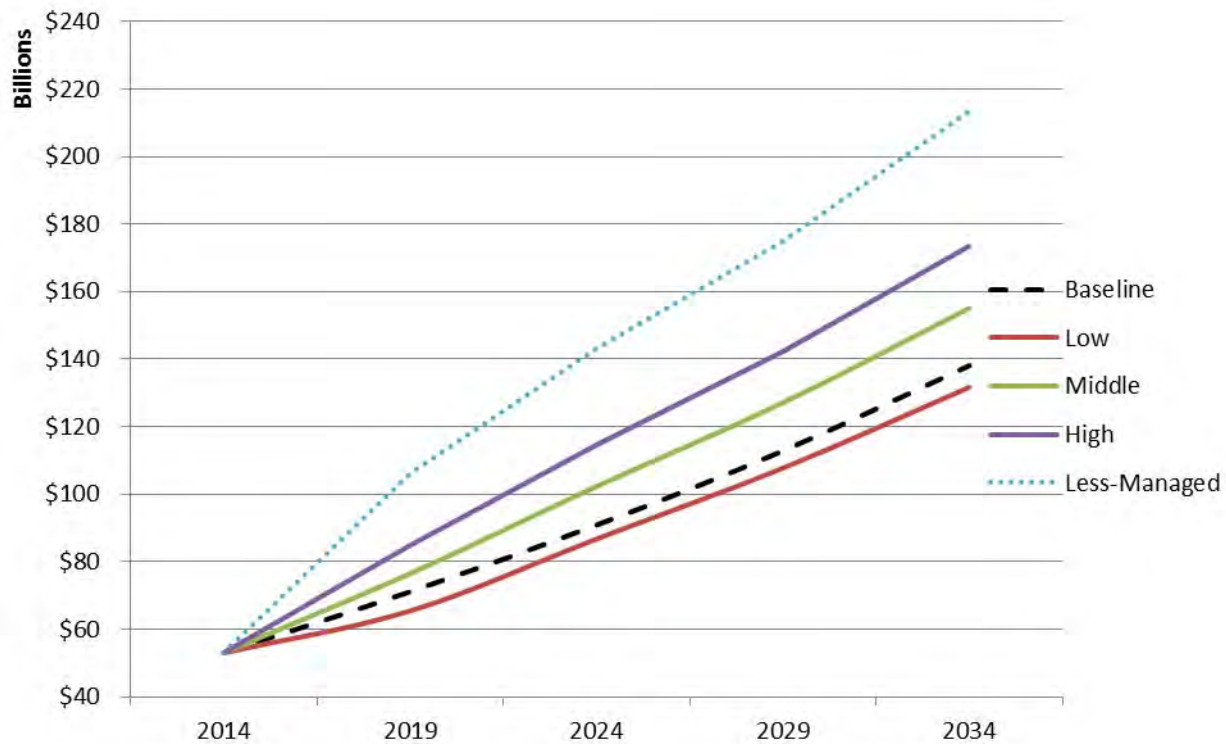
20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was formerly subject to sizable cost sharing with private insurance or Medicare and now would be subject to little, if any, cost sharing associated with VA-financed care.

There are a number of caveats associated with our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects on quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. Finally, estimates do not include administrative costs associated with CDS networks; these costs could be substantial.

Figure 1 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from \$65 billion to \$85 billion in 2019, with a middle estimate of \$76 billion. The middle estimate is moderately above the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is \$106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

This model is described more fully in Appendix A, along with models for a range of other options, some of which are previously described in this section. Consult Appendix A for more details on the technical assumptions necessary to understand the results presented here. The assumptions and caveats detailed in Appendix A play a critical role in our estimates, and any deviation from these assumptions could substantially affect the estimates.

Figure 1. Projected Costs of Recommended Option



Mitigating Risks

Choice involves tradeoffs. Reducing drive times to see a doctor may lead to longer wait times, for example, if it induces substantially more veterans to seek more care.⁴⁶ VHA reliance on contracting could also have unintended consequences for already underserved communities. Providers in such communities who join the local VHA network may decide to limit the number of Medicare and Medicaid patients they accept into their practices. In other, highly concentrated health care markets, which are increasingly common throughout the United States, VHA may not be able to contract for care in the community except at higher prices.⁴⁷ Such circumstances underscore the importance of VHA retaining the option of building its own capacity.

Policymakers must also carefully weigh concerns that leaders of seven major veterans organizations expressed in a recent joint letter in which they warned “choice should never be the ultimate goal of a health care system designed to meet the unique needs of veterans.”⁴⁸ These organizations do not support providing unfettered choice, and the VSO leaders stated that “any health care reform proposal that elevates the principle of ‘choice’ above all other clinical considerations would have severe consequences for veterans who rely on VA, resulting

⁴⁶ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 284, accessed May 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁴⁷ David M. Cutler and Fiona Scott Morton, “Hospitals, Market Share, and Consolidation,” *Journal of the American Medical Association*, 310, no. 18, (2013): 1964-1970, accessed June 20, 2016, <http://doi.org/10.1001/jama.2013.281675>.

⁴⁸ Garry J. Augustine, Disabled American Veterans et al., letter sent to Commission on Care, April 29, 2016.

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in less ‘choice’ rather than the intended desire for more health care options for many disabled veterans.”⁴⁹

The Commission has addressed this concern in several ways, including the following:

- recommendations to substantially improve VHA operations, thereby enhancing the attractiveness of using VHA providers and facilities by enrolled veterans
- VHA control of network design
- VHA Care System governing board oversight of network execution and phasing
- high standards for community provider participation, including credentialing, military competence, and quality and utilization performance
- VHA oversight of care coordination and navigation
- requirement of primary care referral for specialty care

The Commission recognizes that greater choice of provider can result in higher utilization of health care services, which increases costs. This risk can be mitigated by recommendations in this report that will produce cost savings. To incentivize cost mitigation, all cost savings associated with improved efficiency and operations should be reinvested into the VHA Care System. Examples of cost mitigation strategies include the following:

- recovering third-party payments owed to VHA more effectively
- maintaining VHA as a secondary payer when veterans have other health insurance and treatment is for non-service-connected care
- increasing cost-sharing or changes in eligibility and/or benefit design could also substantially contain the projected costs of increasing provider-choice
- reducing fixed costs of underutilized facilities and services
- managing the supply chain to produce cost savings
- improving facilities to increase provider productivity (e.g., increase in outpatient exam rooms)
- adopting information technology that improves the quality and efficiency of care

Effectively implementing and managing integrated networks will require extensive changes in the governance and leadership of VHA, as well as flexible and smart procurement policies and

⁴⁹ Ibid.

contracting authorities, as discussed elsewhere in this report. The highest priority for standing up networks should be locations where VHA quality of care is deficient or capacity is strained.⁵⁰

Where capacity constraints exist within networks, first priority for care should go to those veterans with greatest medical need, followed by service-connected disabled veterans and indigent veterans.⁵¹ VHA should develop processes and procedures for insuring that veterans have the knowledge and assistance they need to make informed health care decision and to navigate effectively through the expanding health care networks. By employing strategies proven by other managed care plans, VHA will find administrative means to guard against inappropriate treatment, wasteful spending, and fraud.

As many surgical and medical procedures that previously required inpatient hospital stays have routinely become outpatient procedures, there continues to be a substantial shift from inpatient to outpatient care.⁵² Consequently, to ensure improved access to care for veterans, the VHA Care System and long-term plans for facilities should focus on creating a robust ambulatory network and reshaping inpatient resources to match expected demand. Additionally, to inform veterans' and providers' decisions and create increased accountability for performance, all VHA and community network providers and facilities must provide transparent information on inpatient and outpatient quality, service, and access using the same performance metrics, including those used by Medicare.

Implementation

Legislative Changes

- Enact legislation amending 38 U.S. Code, Chapter 17 to consolidate existing purchased-care authorities and authorize the SECVA to furnish enrolled veterans needed hospital care and medical services through agreements with providers the SECVA deems meet quality standards the SECVA will establish. Veterans would be eligible for community care on the same basis as for VHA-furnished care, and current wait time and geographic distance criteria should no longer be applicable.

VA Administrative Changes

- Develop national policy to govern local establishment of networks, and in doing so, focus its design and long-term planning on creating a robust ambulatory capability and reshaping inpatient resources to match expected demand.
- Establish standards that community providers must meet to qualify for participation in community networks, to include becoming fully credentialed, meeting patient-access criteria, demonstrating high-quality clinical outcomes and appropriate use decisions, demonstrating military cultural competency, and having capability for interoperable data exchange.

⁵⁰ Information on what medical centers are deficient in their care is available, for example, from the VHA's own Strategic Analytics for Improvement and Learning (SAIL) data.

⁵¹ It would seem prudent to begin such phased development by piloting that effort, and limiting the scope of unfettered choice to service-connected veterans.

⁵² Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/21183845>.

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- Establish systems to ensure that all primary care providers in the VHA Care System can effectively coordinate veterans' care.
- Provide veterans navigation services for complex care needs, including information needed by patients and their families for informed decision making about treatments and providers. Navigation services should assist veterans and their families with eligibility, cost-sharing, and other administrative issues.
- Establish policies and procedures to ensure that VHA provider as well as community providers within each network, provide transparent information (using the same metrics) on care-quality, service, and access.
- Eliminate the practice of cross-country referrals if quality care is available locally.
- Employ the most current payment approaches that incentivize quality and appropriate use of health care services.

Other Department and Agency Administrative Changes

- None required.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

Problem

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.⁵³

The Commission Recommends That . . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.⁵⁴ For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified “not working to top of provider licensure” as a barrier in health care provision.⁵⁵

VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

Background

A large part of the VHA’s problem with inadequate clinical support staff derives from its difficulties in hiring, retaining, and training medical support assistants (MSAs). These individuals answer phones, schedule care, and verify health care eligibility, among other duties.

⁵³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁵⁴ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵⁵ *Ibid.*, 95.

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Congress has recently given VHA the flexibility to offer MSAs market-based pay rates.⁵⁶ VHA is changing cumbersome rules that have made hiring new MSAs exceptionally time-consuming.⁵⁷

VHA is working to resolve its problems with resource allocation in clinics. For example, the agency has committed to increasing use of clinical managers to help medical centers better match resources to patient demand. Widely used by other health care systems, clinic managers enhance operations by ensuring that telephone protocols, scheduling, and clinic workflow are operating at peak efficiency. They also ensure that staff members are assigned appropriate caseloads and are meeting productivity standards and wait time targets and that administrative staff has appropriate training in scheduling, coding, and/or documentation.

Many states have already taken the steps to ensure APRNs have full practice authority. VHA is working to do the same, which will allow a vast increase in the number of VHA clinicians available to treat patients independently.⁵⁸

To effectively manage clinician supply for the inpatient setting, administrators require accurate bed count data. Currently in VHA, data integrity of bed counts is compromised as a consequence of disclosure requirements of Congress. VHA is required by statute to complete a complicated reporting, approval, and notification process when it closes hospital beds.⁵⁹ To avoid the reporting requirements some VA medical centers count beds as unavailable indefinitely. This action can skew occupancy rates and thwart planning activities. VHA developed its guidance in part to satisfy the Millennium Act⁶⁰ and other requirements that essentially froze beds at FY 1998 levels.⁶¹

Analysis

VHA has taken a number of measures to address data integrity issues. VHA has started hiring clinical managers to assist in managing resources for effective performance. VHA has made efforts to address problems affecting supply and training of MSAs. Additionally, VHA has recently proposed a rule that would authorize full practice for APRNs working within the agency.⁶²

These measures by themselves, however, will not be sufficient to solve the current problems. VHA must ensure all facilities have enough support positions—both clerical and clinical—to

⁵⁶ Sloan D. Gibson, Deputy Secretary, Department of Veterans Affairs, presentation to Commission on Care, April 18, 2016.

⁵⁷ 38 U.S.C. § 7401(3)(A)(iii).

⁵⁸ Establishing Medication Prescribing Authority for Advanced Practice Nurses, VHA Directive 2008-049, (2008).

⁵⁹ Inpatient Bed Change Program and Procedures, VHA Handbook 1000.01, (2010).

⁶⁰ The Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545, Sec. 301. Title III of the Millennium Act prohibits the secretary from closing in any fiscal year more than 50 percent of the beds within a department medical center unless the secretary first submits to the veterans' committees a justification for such closure and waits to take action on a closure until 21 days after the submission of the report. It also requires the secretary to report annually to the veterans committees on bed closures during the preceding fiscal year.

⁶¹ Extended Care Services, 38 U.S.C. § 1710B(b) requires staffing for extended care to remain at FY 1998 levels.

⁶² "VA Proposes to Grant Full Practice Authority to Advanced Practice Registered Nurses," Department of Veterans Affairs, accessed June 3, 2016, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2793>.

enable all clinicians to work at the top of their licenses and to avoid problems with turnover, unexpected staff absences, and surges in patient demand.⁶³

VHA must have authority to pay competitive rates for the personnel it needs. This goal would be accomplished in part by adopting Recommendation #15 of this report for creating a new personnel system under Title 38 for all VHA employees. Currently, for example, clinical managers and practitioners earn far more in the private sector.⁶⁴

As VHA develops improved clinic management tools such as the Health Operations Dashboard, these tools draw from clinical data, patient data, and other sources to allow managers to make decisions using real-time data.⁶⁵ To be effective tools, the data fed into them must be accurate. Relieving VHA from some of the reporting requirements of the Millennium Act will help accomplish effective use of the dashboard for inpatient management.

Implementation

Legislative Changes

- Create a new alternative personnel system under Title 38 authority as mentioned in Recommendation #15.
- Eliminate bed reporting requirements under the Millennium Bill, and require VHA to report new beds as closed, authorized, operating, staffed, or temporarily inactive within 90 days of enactment.

VA Administrative Changes

- Develop policy to allow full practice authority for APRNs.
- Develop leadership tracks, including clinical and group practice managers, for ambulatory settings.
- Develop training programs for medical support assistants (MSAs).
- Modify policy in VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, as appropriate.

Other Department and Agency Administrative Changes

- None required.

⁶³ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 17-18, accessed June 3 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

⁶⁴ For example, Salaries.com listed a median salary for Clinic Manager III (a manager of a clinic with more than 50 physicians) in Dallas, TX, as \$94,000.⁶⁴ The pay grade assigned for this position is GS-13, which pays about \$73,800 in the first step and increases up to \$96,000. Office of Personnel Management, *Schedule 1 General Schedule*, accessed March 31, 2016, <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/pay-executive-order-2016-adjustments-of-certain-rates-of-pay.pdf>.

⁶⁵ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, presentation to Commission on Care, April 18, 2016.

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Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-supported programs.

Problem

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.⁶⁶ Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).⁶⁷

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a national revised clinical-appeals process.

As part of the MyVA initiative, the SECVA has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.⁶⁸ The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.⁶⁹

Background

VHA policy has long required medical centers to operate a patient advocate program to address patient complaints.⁷⁰ In 1996, Congress enacted an eligibility reform statute that, for the first time, gave enrolled veterans access to a uniform benefits package.⁷¹ In implementing that law, VHA conducted a systemwide review of how clinical disputes were handled and consequently instituted an external appeal system in FY 2000. The policy, as outlined in a subsequent directive, allowed VISNs to request external professional boards to conduct impartial reviews of clinical determinations.⁷² That directive also addressed a process for internal clinical appeals. It stated as policy that patients or their representatives who have disputes regarding clinical determinations or services pertaining to provision or denial of care that are not resolved at the facility level must have access to a fair and impartial review of those disputes that could result in a different and/or improved clinical outcome. That policy requires VISN directors to have written policy and procedures in place for how internal appeals are to be handled. Under this policy, VISNs still have authority to request an external review at any time during the clinical

⁶⁶ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

⁶⁷ VHA Clinical Appeals, VHA Directive 2006-057, (2006).

⁶⁸ "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, <http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx>.

⁶⁹ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷⁰ VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁷² VHA Clinical Appeals, VHA Directive 2006-057 (2006).

appeals process.⁷³ Although the directive itself expired in 2011, it continues to serve as guidance because it has not been renewed or replaced.

VHA policy directs that all facilities have a patient advocate office to manage and attempt to resolve complaints. That office, which can serve as the liaison between patients and clinicians, is generally the first stop for veterans who are dissatisfied with a clinical decision.⁷⁴ If a clinical issue is not resolved at the point of the service, it generally goes to the facility director, who is to provide veterans written notification of the facility's decision and inform veterans about the VISN's appeals process. Under the same policy directive, veterans may appeal the facility decision to the VISN director. That official, or a clinical review panel that he or she establishes, is to render a decision within 30 days (or 45 days if the director requests an external clinical review).⁷⁵ Should the VISN director agree with the facility, he or she must notify the veteran that the decision is final or may refer the matter to a VACO office to arrange for an external review.⁷⁶

The VHA process does not appear fully comparable to procedures required under other federal and federally-supported health care programs. For example, under the Affordable Care Act, health care plans are required to provide external reviews to beneficiaries whose internal appeals have been denied.⁷⁷ Unlike those and other appeals processes, veterans have no right to external review; such review is at the discretion of the VISN director. Medicare has an extensive review process for clinical disputes between its managed care organizations and beneficiaries. Beneficiaries have the right to an internal appeal with an option for an expedited review, an internal reconsideration of the initial review, an independent review, a hearing with an administrative law judge, a review by the Medicare Appeals Council and, finally, a federal district court review.⁷⁸ Medicaid has requirements for localities to review appeals from its beneficiaries and for states to offer timely access to fair hearings to determine whether managed care organizations have denied or terminated medically necessary care.⁷⁹ Although VHA's timeframe for decision making seems reasonable, the national policy makes no provision for an expedited review, unlike Medicare managed care organizations and plans providing health benefits to federal employees. VHA's policy is also silent on meeting with veterans to hear their cases much less hold hearings during any point of the appeal. Unlike Medicaid, VHA also lacks any provision for service-continuity while the matter is being appealed. The Commission recommends that VHA develop a revised clinical-appeals process that provides veterans protections at least comparable to those afforded patients under other federal and federally-supported programs, including, at a minimum, a right to an external review at the veteran's discretion.

⁷³ Ibid.

⁷⁴ VHA Patient Advocacy Program, VHA Handbook 1003.4, (2005).

⁷⁵ VHA Clinical Appeals, VHA Directive 2006-057, (2006).

⁷⁶ Ibid.

⁷⁷ "Appealing Health Plan Decisions," Department of Health & Human Services, accessed June 1, 2016, <http://www.hhs.gov/healthcare/about-the-law/cancellations-and-appeals/appealing-health-plan-decisions/index.html>.

⁷⁸ Centers for Medicare & Medicaid Services, *Managed Care Appeals Flowchart CY2016*, accessed May 26, 2016, <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Managed-Care-Appeals-Flow-Chart.pdf>.

⁷⁹ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

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Implementation***Legislative Changes***

- None required.

VA Administrative Changes

- Convene an interdisciplinary panel to assist in developing a revised clinical-appeals process and policy that includes all care provided within the VHA Care System, to include representation from Patient Care Services, MyVA's Patient Advocates and Veterans Experience Program, the Office of Equity, the National Center for Ethics in Health Care, and the Office of Access and Clinical Administration. VHA should have that panel examine and offer recommendations regarding the following:
 - Each level of review in the clinical-appeals process – from the facility's initial reconsideration to a final decision by the VISN director to assess the fairness and impartiality in those processes compared to Medicare Managed Care and Medicaid appeals processes and private-sector managed care providers' best practices.
 - Whether VHA should establish a uniform national clinical appeals process.
 - The advisability of requiring review panels consisting of individuals such as attorneys, clinicians, case managers, patient advocates, and administrators to review clinical appeals.
 - Whether hearings or judicial reviews are appropriate at any level of the appeals process.
 - Whether resolutions of clinical appeals are equitable for all types of veterans (service-connected or non-service-connected, by racial or ethnic group, by age, or gender).
 - Options for increasing veterans' awareness of the clinical-appeals process.
- Publish the new clinical appeals policy and process for comment and input by veterans, VHA business partners, and other stakeholders.
- Once the new policy is finalized, VHA must train staff on the new process.

Other Department and Agency Administrative Changes

- None required.

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

Problem

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.⁸⁰

VHA has a program of systems engineering — the Veterans Engineering Resource Center (VERC) — that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to proactively identify problem areas within the system and offer assistance.

Background

To become a truly veteran-centric care provider, VHA is working to become a learning organization.⁸¹ Learning organizations focus on worker competency rather than on rules compliance. Instead of using results to identify high- and low-performers, VHA will use this information to identify opportunities to intervene with training or other resources to improve employees' performance universally. Employees and patients should benefit from this approach because it values listening and encourages risk taking and innovation.

VA and VHA have adopted the tenets of LEAN Six Sigma as a systemic change approach to move the system forward. This methodology employs a rigorous define, measure, analyze, improve, and control approach to systemic change. LEAN, initially used by manufacturers, has been used successfully by many health care organizations.⁸² The goal of implementing LEAN practices is to eliminate waste, ensuring that any work done adds value. The MyVA plan calls for MyVA districts and the Office of Policy and Planning to ensure the transmission of best practices and the adopting of LEAN throughout the enterprise to provide a more comprehensive view of quality that balances a results-oriented approach with more process-

⁸⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow—Clinical)*, 14 and A-2 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁸¹ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.

⁸² MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 12, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

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oriented practice.⁸³ So far these efforts have been guided by trial and error, rather than directives and adopting a LEAN, process-driven model.⁸⁴ VHA must sustain its commitment to LEAN Six Sigma as a continuous improvement methodology.

VHA will have to use VERC staff and other trained staff members to ensure that principles of LEAN Six Sigma are applied at every level of the system. VERC has the mission to propose, develop, and facilitate innovative solutions to challenges within VHA health care delivery through the integration of systems engineering principles.

With VERC's reach already extending into access to care, health policy, population health, LEAN management, business systems, clinical systems, safety systems, and innovation, all other programs and initiatives become redundant or ancillary. VHA must assess its new system for best practice diffusion to ensure that selected practices are being appropriately scaled. This goal can best be achieved by collapsing all related efforts into VERC.

There are a number of emerging best practices within the health care sector that apply to all aspects of VHA – health care capabilities, staffing, access, supplies, and facilities – and involve the testing, dissemination, and application of procedures or systems that have been shown to improve approaches, processes, or systems.⁸⁵ VHA needs to have the opportunity to fully leverage and build on institutional strengths by implementing best practices.

VHA has recently developed the Diffusion of Excellence Initiative, which is designed to serve as the mechanism for improving practice through a combination of targeted national guidance and nationally-supported local best practice sharing and innovation.⁸⁶ Its organizational structure includes a governance board chaired by the USH, a Diffusion Council, and action teams responsible for implementing promising practices.

VHA also has many business lines charged with disseminating best practices information, including VERC, Systems Redesign SharePoint – Center for Improvement Education, VA Center for Innovation, MyVA – Best Practices in LEAN, MyVA Blog, MyVA Performance Improvement Hub, Knowledge Management System–Improvement in Action (I-ACT), VA Idea House, VA Pulse: Promising Practices Consortium, Evidence-based Synthesis Program (ESP), Quality Enhancement Research Initiative (QUERI), the Annual Conference on the Science of Dissemination and Implementation, and the Diffusion of Excellence Initiative.

Analysis

LEAN Six Sigma offers VHA a methodology to effect change and VERC offers VHA the agents to lead its implementation. VHA must consolidate its transformational tools, including its best

⁸³ MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 21, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

⁸⁴ The MITRE Corporation, Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow—Clinical), viii accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁸⁵ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 41, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁸⁶ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.

practice repositories within VERC. The VERC uses a systemic change process to streamline workflow and procedures by eliminating waste and redundancy to ensure that every step in the process adds value. The VERC offers services to VHA health care facilities upon request, but VHA would substantially benefit if the service was authorized to perform outreach to ensure awareness across the VHA Care System.⁸⁷

Until developing the Diffusion of Excellence Initiative, VHA lacked a uniform way to scale and optimize best practices throughout the enterprise. Although the Diffusion Initiative is initially targeting best practices from within VHA, to be successful, a long-term plan should also allow for the adoption of best practices from the private sector and other government sectors (e.g., the Medicare program related to pricing, contracting, privatization, value-based purchasing, management, and oversight). Plans should also allow for adaptation at the local and regional levels to reflect respective differences in provider supply, veteran needs, and marketplace characteristics.⁸⁸

VHA has multiple offices and sites invested in system reengineering, continuous process improvement, and best practices implementation. Repositories of best practices do not get information to the intended person or group that could benefit from the information and are dependent upon VHA employees knowing they exist.⁸⁹

VHA's National Leadership Council has proposed consolidating these best practice repositories under the VERC, which now serves within the Office of Organizational Excellence. Until recently, VERC has been underutilized because it is not known throughout the enterprise.⁹⁰

QUERI is a system that identifies evidence-based care practices that may be scaled for systemwide implementation. QUERI was integrally involved in the transformation of VHA from a largely hospital-based system to one centered on primary care⁹¹ and is now integral to the collaborative endeavor to transform VHA into a learning organization. QUERI recently released a policy brief that indicated veterans' reliance on VHA was strongly correlated to economic factors such as unemployment rates and availability of other health care coverage.⁹²

VA should use a systematic, continuous performance improvement process to improve access to care. Although many VA facilities achieve very high-performance ratings on key access and quality measures, a systematic effort is needed to improve performance. These efforts need to

⁸⁷ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

⁸⁸ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, 28, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf

⁸⁹ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

⁹⁰ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 27, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁹¹ "HSR&D Perspectives Blog, QUERI Corner: Surviving and Thriving," Amy Kilbourne, QUERI Program Director, January 20, 2015, accessed from VA Intranet, April 4, 2016, <http://vaww.blog.va.gov/hsrd/category/queri-corner/>.

⁹² Christine Yee, Austin Frakt, and Steven Pizer, U.S. Department of Veterans Affairs, "Economic and Policy Effects on Demand for VA Care," Partnered Evidence-based Policy Resource Center, Policy Brief, March 2016, accessed June 21, 2016, http://www.queri.research.va.gov/partnered_evaluation/YeeFraktPizer.pdf.

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be embedded into routine use across the VA system. The best solutions should be adjusted to reflect local needs and designed to respond to veterans' preferences, needs, and values.⁹³

A systems approach to health care is “one that applies scientific insights to understand the elements that influence health outcomes, models the relationships between those elements, and alters design, processes, or policies based on the resultant knowledge in order to produce better health at lower cost”⁹⁴ and would benefit VA greatly, especially with resources like VERC to serve as a guide.

Emerging best practices have improved health care access and scheduling in various locations and serve as promising bases for research, validation, and implementation.⁹⁵ A variety of quality improvement organizations are involved in establishing and maintaining standards in health care as well as developing measures for the monitoring and assessment of these standards, including The Centers for Medicare & Medicaid Services, the Joint Commission, the National Committee for Quality Assurance, and the National Quality Forum.⁹⁶

The tools of operations management, industrial engineering, and systems approaches are successful in increasing process gains and efficiencies. In particular, a wide range of industries have employed systems-based engineering approaches to address scheduling issues, among other logistical challenges.⁹⁷

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Consolidate all best practices and continuous improvement portals under VERC to provide a more accessible and comprehensive approach to best practice sharing and adoption.

Other Department and Agency Administrative Changes

- None required.

⁹³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 110 and 297 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁹⁴ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 27 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁹⁵ Ibid., 15.

⁹⁶ Ibid., 60.

⁹⁷ Ibid., 27-28.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

Problem

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.⁹⁸

A systematic review of VHA in 2015 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.⁹⁹ VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues—the Health Equity Action Plan (HEAP)—but it has not been fully implemented.

Background

It is time to refocus, reinforce, and repeat the message that health disparities exist and that health equity benefits everyone.¹⁰⁰

Across the nation, health care systems are raising awareness about health care equity, inequality, and disparities.¹⁰¹ The growing incidence of health care disparities and inequities is said to be ascribed to individual and collective cultural indifference on the part of health care

⁹⁸ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

⁹⁹ Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, accessed May 19, 2016, <http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf>.

¹⁰⁰ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

¹⁰¹ Centers for Disease Control and Prevention, *CDC Health Disparities and Inequalities Report – United States, 2013*, accessed April 5, 2016, <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>.

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providers and the health care system as a whole.¹⁰² A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on racial or ethnic group, gender, age, sexual orientation, military era, geographic location, religion, socioeconomic status, mental health, cognitive/sensory/physical disability, and other characteristics historically linked to discrimination or exclusion.¹⁰³

The United States is becoming increasingly diverse, with racial and ethnic minorities making up more than 36 percent of the population.¹⁰⁴ Indicators of overall health, such as life expectancy and infant mortality, have improved for most Americans; however, some minorities still face comparatively greater likelihood of preventable disease, death, and disability.¹⁰⁵

Although the country's veteran population is projected to decline from 22 million to 14.5 million by 2040, the percentage of minority veterans will increase from 20 percent to 34 percent during the same period.¹⁰⁶ Currently, African Americans make up 11 percent of the veteran population, and Hispanics, 6 percent.¹⁰⁷

Survey data show that minority veterans use VA health care more than White veterans, as shown below:¹⁰⁸

- African American: 38 percent
- Hispanic: 34 percent
- American Indian/ Alaska Native: 38 percent
- White: 32 percent

¹⁰² G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," *JHSA* (2011), 146.

¹⁰³ "Office of Health Equity," U.S. Department of Veterans Affairs, accessed June 12, 2016, <http://www.va.gov/HEALTHY/index.asp>.

¹⁰⁴ "Minority Health and Health Equity – CDC," Centers for Disease Control and Prevention (CDC), accessed March 28, 2016, <http://www.cdc.gov/minorityhealth/index.html>.

¹⁰⁵ *Ibid.*

¹⁰⁶ National Center of Veterans Analysis and Statistics, *Minority Veterans 2011 Report*, May 2013, accessed April 6, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf.

¹⁰⁷ U.S. Census Bureau, *American Community Survey, Public Use Microdata Sample (PUMS)*, 2011. Department of Defense, *Population Representation in the Military Services Fiscal Year 2011 Report*, accessed April 5, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf

¹⁰⁸ Reliance projections here are based on ambulatory care utilization. Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 82, accessed May 19, 2016,

http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

Survey data on racial and ethnic minority veterans' use of VHA health care offer revealing insights on current equity issues:¹⁰⁹

- Fifty-seven percent of African Americans indicated they are more likely to use VA as their primary source of health care as compared to 45 percent of Whites.¹¹⁰
- The percentage of African Americans who reported they use VA for all or most of their care needs is 18 percent higher than the percentage of Whites who do so.¹¹¹
- A higher percentage of Whites assessed their health to be good or excellent than did African Americans.¹¹²

Analysis

VHA Office of Health Equity

VA created the OHE in 2012 to identify health care inequities, understand the cause of them, and bring to clinical practice interventions intended to reduce disparity drivers within VA. OHE partners with other VA offices, federal government offices, and nongovernment institutions with missions aimed at promoting health equity.¹¹³ OHE has substantial stakeholder involvement from minority veterans groups, including the Advisory Committee on Minority Veterans (ACMV), rural veterans groups, women veterans, and the Office of Diversity and Inclusion (ODI).¹¹⁴ A staunch internal partner and stakeholder of OHE, ODI's mission is to foster a diverse workforce and an inclusive work environment. The OHE and ODI missions intersect with ODI's special emphasis programs, intended to engage affinity groups and agencies to raise the awareness of the importance of diversity and demonstrate VA's commitment to a diversity model.¹¹⁵

OHE's foundational work included updated systematic reviews and data analyses that not only revalidated VA's previous findings on health care inequities, but also identified more areas of health care disparity among veterans. For instance, hepatitis C virus (HCV) was noted to have disparate effect on racial/ethnic minority veterans and Vietnam-era veterans. Additionally, OHE convened stakeholders and worked with the Health Equity Coalition to develop the VHA Health Equity Action Plan (HEAP), which aligns with the VHA Strategic Plan Objective 1e: Quality & Equity, which states, "Veterans will receive timely, high quality, personalized, safe effective and equitable health care irrespective of geography, gender, race, age, culture or sexual

¹⁰⁹ Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.

¹¹⁰ Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, 85, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.

¹¹¹ Ibid.

¹¹² Ibid.

¹¹³ Department of Veterans Affairs, Office of Health Equity, *US Department of Veterans Affairs Office of Health Equity Mission and Accomplishments*, accessed March 30, 2016, http://www.va.gov/HEALTHEQUITY/docs/OHE_Mission_and_Accomplishments_November_2015.pdf.

¹¹⁴ "Office of Diversity and Inclusion (ODI)," Department of Veterans Affairs, accessed May 13, 2016, <http://www.diversity.va.gov/>.

¹¹⁵ "Office of Diversity and Inclusion (ODI), Special Emphasis Programs," Department of Veterans Affairs, accessed May 17, 2016, <http://www.diversity.va.gov/programs/default.aspx>.

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orientation.”¹¹⁶ HEAP aims to address five strategic areas: awareness, leadership, health system and life experience, cultural and linguistic competency, and data that are vital for effectively implementing its mission. HEAP implementation strategies are conceptually modeled after the goals and strategies of the National Partnership for Action to End Health Disparities’ National Stakeholder Strategy for Achieving Health Equity sponsored by the U.S. Department of Health and Human Services.¹¹⁷

Despite OHE’s best efforts, HEAP was not fully implemented because VHA leadership failed to establish it as a strategic priority with adequate staffing, resources, and support, and the departure of the then USH, a champion for health equity. These factors led to the reduction of OHE staffing from 8 to 2 FTEs in FY 2013 and a realignment of OHE to several layers down in the organization. As a result of an FY 2015 budget reduction, OHE continues to operate with a two-person staff.¹¹⁸ The reduced staffing level is inadequate to meet the requirements and mission of the office.

OHE has a broad and challenging mission, particularly given the number of minority veterans who rely on VA health care, the health risks in those populations, and the health care disparities those populations experience.¹¹⁹ OHE faces serious challenges in its efforts to carry out its action plan and to realize its broad and critical mission, challenges intensified by its limited staffing and the downgrade of this office within VHA’s organization structure. These include the following:¹²⁰

- lack of quality data on vulnerable populations and disparate health outcomes
- health equity projects that have been delayed or halted due to staff and resource limitations
- lack of data on the overall impact of existing health equity initiatives at facilities
- lack of common definitions on vulnerable populations and health equity concepts

Notwithstanding its limited staffing, OHE has compiled a substantial record of accomplishments. Among its initiatives, OHE embarked in 2015 on a strategy of working collaboratively with the Quality Enhancement Research Initiative (QUERI) to advance health equity. The two collaborative efforts focus on using a population health approach to examine the distribution of diagnosed health conditions, mortality, and health care quality across the VA health care system. A fully staffed OHE would have the capability of creating additional

¹¹⁶ Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018*, accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.

¹¹⁷ “National Partnership For Action (NPA), National Stakeholder Strategy for Achieving Health Equity,” U.S. Department of Health & Human Services, accessed May 16, 2016, <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286>

¹¹⁸ Uche S. Uchendu, Executive Director, OHE, briefing to Commission on Care, December 14, 2015.

¹¹⁹ “Management Brief no. 99,” Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=eBrief-no99. Somnath Saha et al., “Racial and Ethnic Disparities in the VA Health Care System: A Systematic Review,” *Journal of General Internal Medicine*, 23, no. 5, (2008): 654-671.

¹²⁰ Uche S. Uchendu, Executive Director, Office of Health Equity, briefing to Commission on Care, December 14, 2015.

analytical tools to manage the daily health care equity program and provide needed services to advance health equity.¹²¹

Health Care Disparities Among Minority Veterans

Minority groups are at increased risk of major, life-threatening health conditions, as documented in a substantial body of research¹²² and illustrated in the table below:¹²³

Table 3. Major Health Conditions in Racial/Ethnic Minority Groups

Major Health Conditions Identified and Examined in Racial/Ethnic Minority Groups		
African Americans	Hispanics	American Indian or Alaska Natives
<ul style="list-style-type: none"> ▪ Colon Cancer ▪ HIV ▪ Chronic Kidney Disease ▪ Diabetes ▪ Stroke ▪ Venous Thromboembolism (VTE) ▪ Cancer ▪ Heart Disease 	<ul style="list-style-type: none"> ▪ Hepatitis C ▪ Cancer ▪ Heart disease 	<ul style="list-style-type: none"> ▪ Major Non-cardiac Surgery ▪ Pregnant Women with PTSD

HCV is more prominent among some racial and ethnic minority veterans and they are less likely to receive treatment for HCV. In VHA, some racial and ethnic minorities diagnosed with HCV are disproportionately more at risk for having associated liver disease (ALD). Disparities among veterans in the incidence of HCV, illustrated in the graphs below, show the important policy and resource implications for VA.¹²⁴

¹²¹ Ibid.

¹²² Andy I. Choi et al., “White/Black Racial Differences in Risk of End-Stage Renal Disease and Death,” *The American Journal of Medicine*, 122, no. 7, (2009): 672-678. Andy I. Choi et al., “Racial Differences in End-Stage Renal Disease Rates in HIV Infection with Diabetes,” *Journal of the American Society of Nephrology*, 18, no. 11 (2007): 2968-2974. Hashem B. El-Serag et al., “Racial Differences in the Progression to Cirrhosis and Hepatocellular Carcinoma in HCV-Infected Veterans,” *The American Journal of Gastroenterology*, 109, no. 9, (2014): 1427-1435. Cleo A. Samuel et al., “Racial Disparities in Cancer Care in the Veterans Affairs Health Care System and the Role of Site of Care,” *American Journal of Public Health*, 104, Supplement 4, (2014): S562-571.

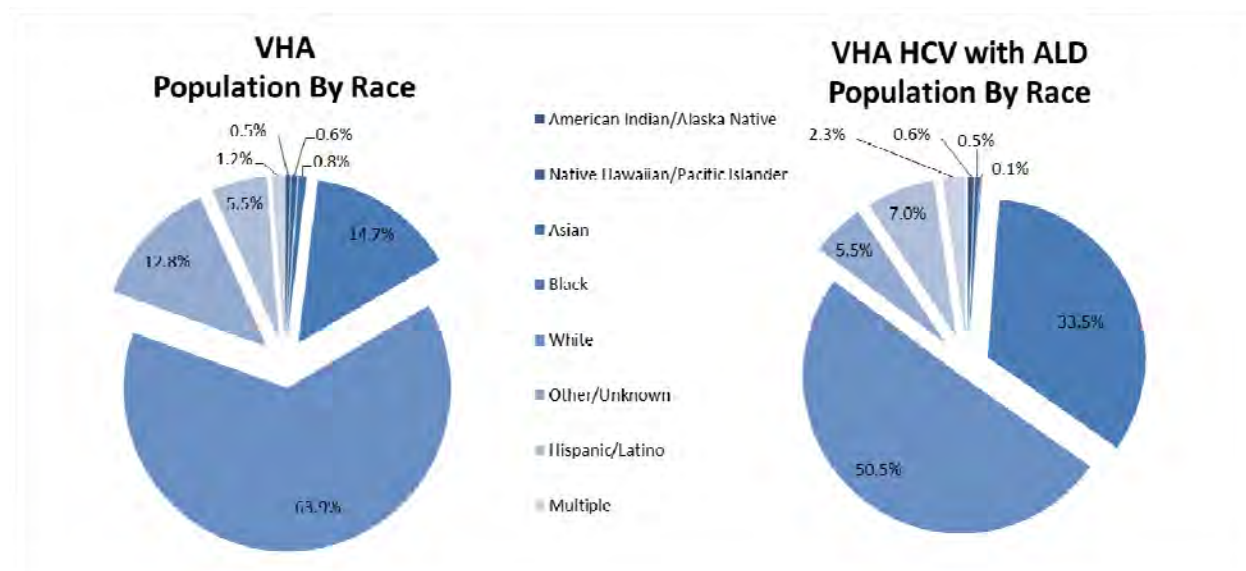
¹²³ Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, accessed May 19, 2016,

<http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf>.

¹²⁴ Department of Veterans Affairs, Office of Health Equity, *Hepatitis C Factsheet, Hepatitis C, Advanced Liver Disease & Health Care Disparities*, accessed May 25, 2016, <https://github.com/departments-of-veterans-affairs/VHA-Asset/raw/master/Hep%20C%20FACT%20SHEET%20FINAL%2010162015.pdf>.

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Figure 2. Disparities Among Veterans in the Incidence of Hepatitis C Virus



A recent review of evidence related to racial and ethnic differences in outcomes for VA patients showed moderate- and low-strength evidence suggestive of gaps in morbidity and mortality outcomes among vulnerable veteran populations with major health conditions. These data, presented in the table below, highlight targets for further research.¹²⁵

Table 4. Comparison of Health Outcomes by Race

Comparison		Worse Health Outcomes For Racial Minority Group Relative to Reference Population (usually White)
Moderate-Strength Evidence		
(based on VA data from the early 2000s)		
African American v. White	Increased end-stage renal disease among chronic kidney disease patients	
	Increased end-stage renal disease among HIV patients (with or without diabetes)	
	Decreased colon cancer survival 3 years after diagnosis	
Hispanic v. White	Increased cirrhosis and hepatocellular carcinoma among hepatitis C patients	
Low-Strength Evidence		
(each finding supported by only a single retrospective study with important methodological limitations)		
African American v. White	Increased mortality among diabetes patients	
	Increased risk of preterm birth among PTSD patients	
	Increased mortality at 2 years post-hospitalization among stroke patients	
	Decreased survival 3 years after diagnosis of rectal cancer	
American Indian or Alaskan Native v. White	Increased risk of 30-day post-op mortality after major noncardiac surgery	
	Increased risk of preterm birth among PTSD patients	
Combined other racial/ethnic minority groups v. African American	Increased injury-related death among alcohol use disorder patients	

¹²⁵ "Management Brief no. 99," Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=ebrief-no99.

OHE's focus, health equity, is intended to combat health care disparities, namely, the differences in the preventive, diagnostic, or treatment services offered to veterans with similar health conditions. Health care disparities stem from a combination of complex factors occurring at the level of the health system, provider, and patient.¹²⁶ Health care disparities can result from biological differences among various racial/ethnic groups as well as from social disparities,¹²⁷ also termed social determinants, which stem from such factors as socioeconomic status, discrimination, education levels, housing, transportation, and crime and violence, and are causally linked to subsequent adult disease.¹²⁸ For example, poor-quality housing poses a risk of exposure to many conditions that can contribute to poor health, such as indoor allergens that can lead to and exacerbate asthma, injuries, and exposure to lead and other toxic substances.¹²⁹ Social determinants that drive health disparities among African Americans, Hispanics, American Indians, and Alaska Natives include race/ethnicity; gender; age; geographic location; religion; socio-economic status; sexual orientation; military era; disabilities, including cognitive, sensory, or physical; and other characteristics historically linked to discrimination or exclusion. Positioned in a department that also provides benefits that fall within the social determinants of health, OHE is in a unique position to improve veterans' health.

The Henry Ford Health System (HFHS) is an example of a health system that is committed to health equity and one VHA can emulate as it works to improve health equity. HFHS is a nonprofit, vertically integrated health care organization that serves the primary and specialty health care needs of residents in southeastern Michigan, including Detroit and its surrounding metropolitan area.¹³⁰ HFHS's comprehensive health equity staff has a health care equity campaign with a goal of increasing knowledge, awareness, and opportunities to ensure health care equity is understood and practiced by HFHS providers and other staff, the research community, and the community-at-large.¹³¹ The campaign is also intended to make health care equity a key, measurable aspect of clinical quality.¹³² A similar effort by VHA would create a system for tracking improvement of health equity over time and holding the organization accountable for ongoing efforts in this regard.

The VHA strategic plan for FY 2013–2018 states that veterans will receive timely, high quality, personalized, safe, effective, and *equitable* health care, irrespective of geography, gender, race, age, culture, or sexual orientation.¹³³ Although that statement signals a sensitivity to health equity, the level of funding support for the VHA office with the lead role in promoting health equity and reducing disparity calls into serious question the leadership priority and commitment to that strategic goal. VHA leadership must make health care equity a strategic

¹²⁶ Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, <http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf>.

¹²⁷ James H. Price, Molly A. McKinney, and Robert E. Braun, *Social Determinants of Racial/Ethnic Health Disparities in Children and Adolescents*, accessed April 1, 2016, <http://www.sophe.org/Sophe/PDF/Webinars/20120416151902.pdf>.

¹²⁸ Ibid.

¹²⁹ "What Drives Health," Robert Wood Johnson Foundation, Commission to Build a Healthier America, accessed April 1, 2016, <http://www.commissiononhealth.org/WhatDrivesHealth.aspx>.

¹³⁰ Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, <http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf>.

¹³¹ Ibid.

¹³² Ibid.

¹³³ Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018*, accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.

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priority by directing and funding the implementation of VHA HEAP nationwide and designating a leader and clinical champions within each VISN and VAMC, as a designated full-time equivalent (FTE), providing OHE budgetary support in FY 2017 and beyond to fully staff the office so that it can successfully achieve its mission and goals, to include providing additional needed funding to support implementation of the VHA HEAP; and ensuring OHE reports to the chief of VHA Care System (CVCS).

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Make health equity a strategic priority by directing the implementation of the VHA HEAP nationwide and designating a leader and health equity clinical champion within each VISN and VAMC for whom part of their respective FTE position descriptions includes focusing on health equity issues.
- Reestablish OHE staffing based on the 2011 VHA Health Care Equality Workgroup recommendations to enable OHE to fulfill VHA's vision to provide appropriate individualized health care to each veteran in a method that eliminates disparate health outcomes and assures health equity. Action required includes, but is not limited to, funding FTE staffing levels commensurate with the scope and size of other federal offices of health equity.
- Reinstate OHE within the office of the CVCS to underscore health equity as a priority and to position the office to champion successfully the advancement of health equity for all veterans.¹³⁴
- Monitor and evaluate the department's success in implementing HEAP.

Other Department and Agency Administrative Changes

- None required.

¹³⁴ Department of Veteran Affairs, Health Equity Coalition Request for VHA Commitment, February 2016. Principal Deputy Under Secretary of Health Memorandum, Health Equity Coalition, March 21, 2013.

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

Problem

Veterans who turn to VHA to meet their health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern ambulatory health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of these barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks, as proposed in

Recommendation #1 holds the promise of markedly improving veterans' access to care.

That promise cannot be realized without transformative changes to VHA's capital

structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of the build out of the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as much control as possible to drive the process so that all facility plans are fully integrated with the strategic vision for the VHA Care System.

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meet its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission process to be implemented as soon as practicable. The Commission recommends that the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

Background

Most VHA health care centers were designed when care was focused on inpatient hospital treatment. VA acquired some of these facilities nearly a century ago from the Public Health Service; many others were transferred from the War Department shortly after World War II.¹³⁵ The average VHA building is 50 years old – five times older than the average building age of not-for-profit hospital systems in the United States.¹³⁶ Most of its facilities were designed to meet markedly different needs than today's health care facilities. Some were tuberculosis

¹³⁵ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

¹³⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, vi, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

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sanatoriums, others for years primarily housed patients with mental health conditions.¹³⁷ Although many have been extensively renovated, the renovations themselves are now outdated, and the condition of buildings shows this strain. Independent assessments of infrastructure and facilities showed that VHA facilities average a *C minus* score,¹³⁸ meaning much of the total facilities portfolio is nearing the end of its useful life, and 70 percent of facility correction repairs are being made on Grade D facilities.¹³⁹

During the past 8 years, veteran inpatient bed days of care have declined nearly 10 percent as outpatient clinic workload has increased more than 40 percent.¹⁴⁰ Current facilities, whether they have been maintained adequately or not, often do not support contemporary ambulatory care needs, with outpatient care often housed in converted inpatient spaces.

Through its capital planning methodology, VA has identified more than \$51 billion in total capital needs during the next 10 years.¹⁴¹ Capital funding during the past 4 years has averaged just \$2 billion annually.¹⁴² If funding levels remain consistent during the next 10 years, anticipated funding would be \$25 billion to \$35 billion less than the \$51 billion capital requirement.¹⁴³ VA planning must also take account of demographic changes and population migration that have led to underutilized medical centers in some areas of the country, and a need for new capacity in others.¹⁴⁴

Analysis

New Planning Paradigm

As the department acknowledged, “VA’s health care delivery model must . . . change.”¹⁴⁵ Importantly, it recognizes that “No organization can excel at every capability,” and stated “[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers.”¹⁴⁶ The acknowledgement that VHA can best serve veterans by focusing on its core competencies and unique capabilities, while relying more heavily on purchased care holds important implications for VHA’s capital needs and capital asset management. Rather than assessing VHA’s capital needs by reference to an expectation that each VA medical center, or constellation of medical centers, must provide virtually all needed hospital and medical services, capital needs must be redefined within the framework of the VHA Care System’s high-performing integrated community health care networks. VHA must determine what services it will continue to provide directly in a given community before it can determine its respective infrastructure needs. In identifying its core competencies, unique

¹³⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

¹³⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 27, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹³⁹ *Ibid.*

¹⁴⁰ *Ibid.*, 46.

¹⁴¹ *Ibid.*, 17.

¹⁴² *Ibid.*, 18.

¹⁴³ *Ibid.*, 18.

¹⁴⁴ *Ibid.*, 59-61.

¹⁴⁵ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 18, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

¹⁴⁶ *Ibid.*

capabilities, and needed ancillary services, VHA would be setting at least a general framework through which network and local planners could assess where and how needed services would be delivered, including which would be provided directly by VHA and which through purchased care. Such a mapping exercise would be a first step in developing the integrated community health care networks.

The shape of an integrated delivery network will take different forms in each service-area, and planning and developing those local networks will necessarily require assessing VHA's physical plant and capacity in a new light. That reassessment process would inform capital planning, and must take account of at least three distinct needs: capital needs associated with buildings VA would retain; meeting new or replacement space needs; and the disposal of unused, unneeded property.

Property Divestiture

VHA's principal mission is to provide health care to veterans, yet over time it has acquired an ancillary mission: caretaker of an extensive portfolio of vacant buildings. As recently as October 2015, VA reported that its inventory includes 336 buildings that are vacant or less than 50 percent occupied, requiring it to expend patient-care funds to maintain more than 10,500,000 square feet of unneeded space.¹⁴⁷ The SECVA recently testified that it costs VA an estimated \$26 million annually to maintain and operate vacant and underutilized buildings.¹⁴⁸

VA's authority to carry out property-management is circumscribed in law,¹⁴⁹ and the department at times faces insurmountable challenges in either attempting to repurpose or divest itself of underutilized or vacant property.¹⁵⁰ In contrast to more rigid property-divestiture provisions, VA has had success in using a flexible authority to enter into long-term leases of VA property for *enhanced use*.¹⁵¹ This authority allows VA to lease underutilized capital

¹⁴⁷ Ibid., 92.

¹⁴⁸ "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, <https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2>.

¹⁴⁹ Authority for Transfer of Real Property; Department of Veterans Affairs Capital Asset Fund, 38 U.S.C. § 8118 Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122. For example, under section 8118, VA must receive at least full market value in transferring property, unless the property is transferred to an entity that provides services to homeless veterans, and any proposed transfer is subject to the requirement in section 8122 that VA first hold hearings, notify Congress in advance, and not proceed for a specified period. VA property can be determined to be "excess," though under 38 U.S.C. § 8122(d)(1), VA may not make such a declaration unless the property is not suitable for use for provision of services to homeless veterans and reviewed for possible disposal under the Property Act Disposal, administered by the General Services Administration (GSA) (40 U.S.C., subchapter III). GSA employs a rigorous, multistep process to assure that the asset is not needed by any other Federal agency. Under the Act, the agency disposing of the asset is responsible for funding disposal costs, including environmental remediation. GAO has testified that properties remain in an agency's possession for years and continue to accumulate maintenance and operations costs because of the legal requirements agencies must meet and the length of the process. (U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain*, GAO-11-520T (Washington, DC, 2011), 5, <http://www.gao.gov/products/GAO-11-520T>).

¹⁵⁰ With many properties under the protection of the National Historic Preservation Act (16 U.S.C. § 470h-3), VA faces obstacles and delays in efforts to divest itself of these properties; VACO staff report that stakeholder concerns have been obstacles.

¹⁵¹ Enhanced-Use Leases of Real Property, 38 U.S.C. §§ 8161-8169, as amended by Veterans Millennium Health Care and Benefits Act, Section 208, Pub. L. No. 106-117, 113 Stat. 1545 (1999), as in effect when GAO testified on this successful program (U.S. Government Accountability Office, *VA Real Property: VA Emphasizes Enhanced-Use Leases to* VA-18-0457-A-001202

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assets to private-sector entities for up to 75 years to develop housing for homeless and at-risk veterans and their families. Most recently, however, Congress imposed severe limits on that leasing authority.¹⁵²

Ongoing Capital Needs

Establishing a transformative new health care delivery model that relies more on purchased care will not eliminate the need for new clinics, facility renovations, and remedying VHA space deficiencies. The scope of those needs must still be determined in light of a proposed new delivery system, but they cannot be ignored. The *Independent Assessment Report* catalogued the challenges of managing and operating VA's capital program and the need to deploy best practices to improve total performance, and clearly address the importance of more modern facilities for delivering high quality care.¹⁵³

Of particular concern is an apparent breakdown in the process of bringing new clinics online and renewing the leases of existing clinics. With current law requiring congressional approval of any lease with an average annual rental of more than \$1 million,¹⁵⁴ a Congressional Budget Office (CBO) ruling¹⁵⁵ has upended the approval process and halted the leasing program.¹⁵⁶ Indicative of the scope of the problem, VHA's then USH testified in 2013 that VA, since 2008, had opened 180 leased medical facilities, 50 of which required authorization as major leases.¹⁵⁷ Currently, 24 major VA leases are in limbo.¹⁵⁸

Manage its Real Property Portfolio, GAO-09-776T (Washington, DC, 2009), <http://www.gao.gov/assets/130/122697.pdf>. For example, VA has authority to outlease its facilities for up to 3 years, but may not retain the proceeds of any such leasing (Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122(a)(1)). U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain*, GAO-11-520T (Washington, DC, 2011), 5, <http://www.gao.gov/products/GAO-11-520T>.

¹⁵² Before the sunset of that authority in 2011, VA could enter into such a long-term lease if (1) at least part of the property's use would contribute to VA's mission, (2) the lease would not be inconsistent with that mission; and (3) the lease would enhance the use of the property (Enhanced-Use Leases, 38 U.S.C. § 8162(a)(2)). Congress reauthorized enhanced-use leasing, but limited it to a single use: the development of supportive-housing for veterans who are homeless or at risk of homelessness (Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Sec. 211, Pub. L. No. 112-154, 126 Stat. 1165 (2012).)

¹⁵³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁵⁴ Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104.

¹⁵⁵ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., 42 (June 27, 2013) (Statement of Robert A. Sunshine, Deputy Director, Congressional Budget Office), accessed June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

¹⁵⁶ *Ibid.* CBO maintains that the structure of VHA's lease transactions—the lease of a facility, designed by and built for VHA, and for which payments retire most or all of the debt over the life of the lease—is in the nature of a governmental purchase, and, as such, the full cost of acquiring the facility should be budgeted up front, rather than spread over the duration of the lease. As budget rules generally require that Congress offset that aggregate cost, CBO's position has had the effect of blocking what had previously been a manageable funding process.

¹⁵⁷ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., 44 (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

¹⁵⁸ "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, <https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2>.

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One of the primary benefits of leasing is that it can provide flexibility and speed.¹⁵⁹ But the time VHA has required to execute a lease, from planning through to activation, has taken almost 9 years in the case of a major lease,¹⁶⁰ in contrast with private-sector expectations of build-to-suit leases that often take fewer than 3 years.¹⁶¹

In acknowledging the magnitude of the challenges associated with VA's capital program and the budget constraints within which VA is operating, the *Independent Assessment Report* includes a suggestion that transformative options be considered, to include alternative vehicles for capital delivery such as public-private partnerships.¹⁶²

Capital Asset Management

Capital asset management itself requires reengineering. Facilities-related functions are dispersed through VA, resulting in a lack of accountability for outcomes, a mismatch between planning efforts and funding decisions, and separation of project execution and facilities management,¹⁶³ suggesting a need for transformative changes in operations.¹⁶⁴

In its work to foster transformation, department officials have recognized many organizational and process challenges that require priority attention, including the need to realign its infrastructure, identify new (private) sources of financing, streamline investment decision making and contracting, and improve the management of capital projects.¹⁶⁵ Organizational change aimed at streamlining and better aligning core processes is vital to effective operation of VA's facilities programs.

Capital-Asset Imperatives

The planning and development of a new delivery model centered on establishing integrated networks of care has major implications for identifying, planning for, and realizing VHA's capital needs. Greater reliance on community care, inherent in that model, establishes a new set of imperatives, specifically, a need for

- facility realignment
- more effective means of repurposing or other divestiture of unneeded buildings and land
- new, more effective tools to meet VHA's need for new clinic capacity and major construction
- more effective management of VHA's capital needs

¹⁵⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 159, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁶⁰ Ibid., 159-160.

¹⁶¹ Ibid., 160.

¹⁶² Ibid., vii-ix, 34.

¹⁶³ Ibid., vi, 20.

¹⁶⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, K-5, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁶⁵ Interviews of VA staff by Commission on Care staff, April 2016.

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Facility Realignment

VA planning must closely examine the role of, and future for, individual facilities, in light of a transformative new delivery model. For more than a quarter century, VHA leaders have cited the need for medical center mission changes, realignments, disposal of unneeded buildings, and where indicated, hospital closures.¹⁶⁶ The critical importance of transforming VA health care delivery gives new urgency to providing tools to realign VHA's care-delivery infrastructure. The Commission recognizes that the SECVA does have authority to "consolidate, eliminate, abolish, or redistribute the functions of . . . [VA] facilities, and to carry out an administrative reorganization" of a field facility.¹⁶⁷ But that authority may generally not be unilaterally exercised.¹⁶⁸ In addition, despite VA's having established two previous commissions to address the need for facility realignment, leaders have had only limited success in achieving that objective. The exercise of SECVA's broad authority to reorganize is tempered by the prerogatives and fiscal authority held by Congress. Congress has rejected legislation that proposed a process to reassess the future of individual VA facilities,¹⁶⁹ reflecting concerns over veterans losing access to care and the potential of constituents losing employment. Such concerns can be addressed. To be successful, a capital asset realignment process must be conducted on a systemwide basis within a framework that provides for sound planning; the exercise of objective, independent expertise; and a reliable mechanism for implementation. Congress can look to and adapt a proven model¹⁷⁰ — the military base realignment and closure (BRAC) process — to meet those objectives and achieve marked improvements in access to care.

Congress should enact legislation, based on DoD's BRAC model, to establish a VHA capital asset realignment process to more effectively align VHA facilities and improve veteran's access to care. Creating a robust capital asset realignment process is vital because previous capital divestiture efforts have failed.¹⁷¹ This process should offer a level of rigor far beyond what currently exists for repurposing and selling capital assets. It should require VHA to employ criteria set by the VHA Care System governing board (see Recommendation #9) to conduct locally-based analyses of capital assets, based on national process criteria. Information generated would be used to assist an independent commission, established under the

¹⁶⁶ "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com*, accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578>.

¹⁶⁷ Authority to Reorganize Offices, 38 U.S.C. § 510.

¹⁶⁸ Authority to Reorganize Offices, 38 U.S.C. § 510(c). In instances where a reorganization would reduce employment by 15 percent or more at a facility, VA must provide Congress a detailed plan and justification, and must defer implementation for at least 45 days.

¹⁶⁹ Veterans Millennium Health Care and Benefits Act, H.R. 2116, 106th Cong. (1999). Section 107 of House-passed H.R. 2116 would have established a mechanism for VA to cease providing hospital care at medical centers which were no longer providing high quality, efficient hospital care because of factors such as aging physical plant, functional obsolescence, and low utilization, and to redirect funds instead toward establishment of enhanced-service programs. In taking up H.R. 2116, the Senate did not adopt that provision, and it was not included in the Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545 (1999), accessed January 12, 2016, <https://www.gpo.gov/fdsys/pkg/PLAW-106publ117/html/PLAW-106publ117.htm>

¹⁷⁰ Defense Base Closure and Realignment Commission, *Defense Base Closure and Realignment Act of 1990 (as amended through FY 05 Authorization Act)*, accessed June 23, 2016, <http://www.brac.gov/docs/BRAC05Legislation.pdf>.

¹⁷¹ "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com*, accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578>.

legislation, in making recommendations regarding realignment and capital asset needs.¹⁷² The independent commission would conduct a thorough, one-time process, to include making site visits and holding hearings to inform recommendations that would constitute a proposed national realignment plan. The VHA Care System governing board would review, and adopt or make recommendations to revise, the independent commission's recommended realignment plan. The commission would then empower the VHA Care System governing board to implement the recommendations unless, within a specified timeframe, Congress disapproves the entire plan on an up or down vote. The Commission on Care envisions that after the completion of a realignment carried out under such proposed legislation and in the course of ongoing VHA transformation, the VHA Care System governing board would make all additional facility alignment decisions, to meet veterans' needs and to fully integrate with the strategic vision for the VHA Care System.

Repurposing and Divestiture of Unneeded Buildings and Land

Maintaining health care facilities to provide state-of-the-art care requires ongoing financial support. Bearing the additional cost of maintaining outdated, vacant, and unused buildings diminishes operating funds needed for patient care, and yields no benefit. Even taking unused buildings offline and placing them in *mothball status*, requires tens of millions of dollars in basic building maintenance.¹⁷³ If VA could sell, repurpose, or otherwise divest itself of unused or underutilized buildings in a timely, cost-effective manner, it would free funds for the purposes for which they are appropriated.¹⁷⁴

Enhanced-use leasing authority has in the past provided VHA a viable tool that prevents the need for such unnecessary spending, while permitting development of vacant property for uses compatible with VHA's mission, and effective use of the proceeds, whether in cash or in kind.¹⁷⁵ This leasing mechanism has been put to particularly effective use in leveraging an asset that VHA can no longer use, but which has development potential, as consideration for an asset it may need, such as clinic space. But limiting enhanced-use leasing to a single use that may not be feasible in many locations precludes effective use of a valuable capital-alignment tool.

In many instances, however, the condition or remote location of VHA buildings does not lend itself to enhanced-use leasing. Given the need to dispose of a large inventory of vacant

¹⁷² The process should take into account the community health needs assessments (CHNA) that not-for-profit hospitals are required to carry out under current law, (Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat.119, sec. 9007(a) (2010)) and opportunities to engage community providers in collaborative partnerships. This provision requires tax-exempt hospitals to create a hospital community health needs assessment every three years. This hospital CHNA is developed alongside community stakeholders. The community health needs assessment requirements include: demographic assessment identifying the community the hospital serves; a community health needs assessment survey of perceived healthcare issues; quantitative analysis of actual health care issues; appraisal of current efforts to address the healthcare issues; and formulation of a 3-year plan under which the community comes together to address those remaining issues collectively.

¹⁷³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 49, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁷⁴ *Ibid.*, B-13.

¹⁷⁵ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), accessed June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

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buildings for which there is no realistic prospect of their being repurposed, a streamlined divestiture process is needed.

Meeting Clinic Capacity and Other Infrastructure Needs

Developing a new delivery model and establishing a thorough realignment process may shrink VHA's future capital needs but will not eliminate them. As congressional budget rules have frustrated VHA efforts to lease needed clinic space, it is critical that VHA and Congress find models or remedies to establish new ambulatory care space and renew leases of existing clinics. Congress and VHA should work together to find the means to meet VHA's need for new clinic capacity. Given an impasse in congressional authorization of VA clinic leasing based on build-to-lease contracts, VA should explore the feasibility of restructuring those arrangements. VA should explore an arrangement that remedies the concern that it is entering into capital leases. Such an approach, for which VA provides the builder with space needs rather than a complete design, would have the additional benefit of bringing projects on line much sooner. Absent an effective solution to meeting VA's ongoing need for clinic space, Congress must be willing, as it was in passing VACAA, to take extraordinary steps¹⁷⁶ to overcome a funding challenge, and, in this instance to waive, or suspend for at least 5 years, the operation of current congressional authorization and scorekeeping requirements governing major medical leases.

In addition to severe leasing challenges, current statutory spending limits make it difficult for VHA to modernize and renovate its aging facilities.¹⁷⁷ Notably, minor construction funds, available for "constructing, altering, extending, and improving"¹⁷⁸ any VA facility, are limited to \$10 million,¹⁷⁹ yet such projects may require substantially more given the age and condition of many VA buildings. Congress last lifted the threshold of what constitutes a major medical facility project – the amount above which a project requires specific authorization – more than a decade ago.¹⁸⁰ The Commission believes that with the tight controls a governing board would exercise, that threshold should be lifted substantially, providing needed flexibility to carry out minor construction projects.

As VHA works more closely with community providers and participates in discussions regarding community health needs, it should be open to opportunities to discuss and potentially work toward joint efforts at meeting infrastructure needs.¹⁸¹

¹⁷⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 stat. 1754, sec. 803 (2014).

¹⁷⁷ VA Office of Inspector General, *Veterans Health Administration: Review of Minor Construction Program*, 8, accessed June 3, 2016, <http://www.va.gov/oig/pubs/VAOIG-12-03346-69.pdf>.

¹⁷⁸ Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242 Div. J., Title II, Department of Veterans Affairs (2015).

¹⁷⁹ A major medical facility project is one involving a total expenditure of more than \$10 million. Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(a)(3)(A).

¹⁸⁰ Sec. 812 of the Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. No. 109-461, 120 Stat. 3403 (2006), raised the threshold as to what constitutes a major medical facility project from more than \$7 million to more than \$10 million.

¹⁸¹ One such public-private model, such as under discussion in Omaha, NE, where talks have centered on private donors' partially funding construction of a replacement medical center, necessarily poses challenges, but merits exploration and support. ("VA Exploring Public-Private Plan for New Facility," Lincoln Journal Star, accessed June 3, 2016, http://journalstar.com/news/state-and-regional/nebraska/va-exploring-public-private-plan-for-new-facility/article_6a90778e-6962-545f-a86a-3f27930bd84e.html.) Although Congress must ultimately provide apt facilities for VA care-delivery, the law has long authorized the SECVA to accept gifts or donations, for purposes of facility

Capital Asset Management

The Commission fully recognizes that VHA has much to do on its own to more effectively meet its capital asset needs. At the core, leaders must strengthen and streamline the capital asset programs' management and operation, to include better aligning the component elements; streamlining the leasing program, contracting, and investment decisions; managing and streamlining project delivery for construction and renovation; and adopting a facility (or building) life-cycle-model planning tool. These are all important elements of needed system transformation.

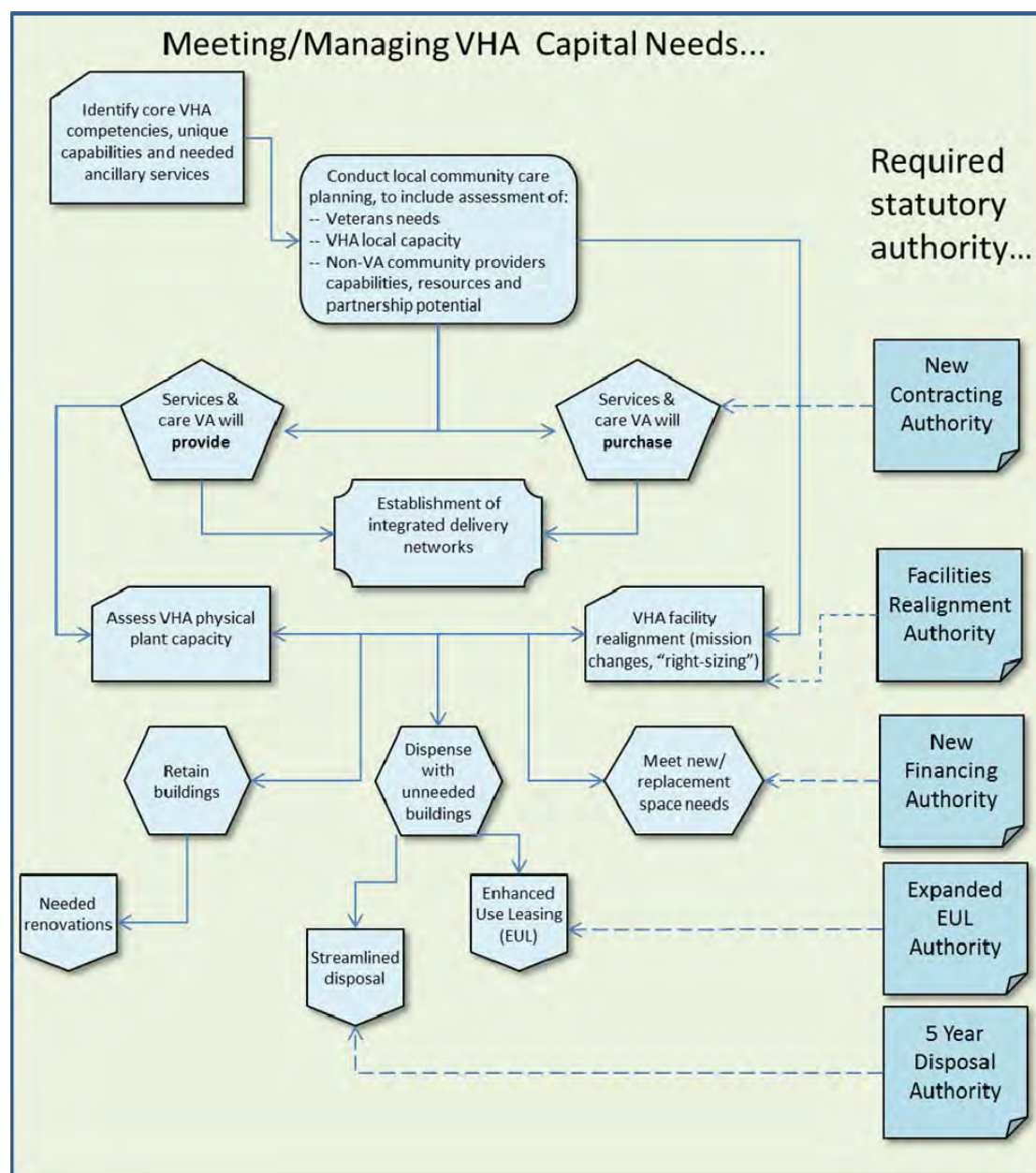
As depicted in Figure 3, meeting and managing VHA's capital-asset needs require an integrated approach that requires congressional support to tackle the multiple capital-asset challenges facing VHA. The Commission's recommendations for meeting and managing those interrelated capital-asset needs are set forth in the *Implementation* section following Figure 3.

construction. (Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(e)) Nevertheless, new legislative authority would almost assuredly be needed to permit development of public-private partnerships that provide new platforms for the construction of new or replacement medical facilities. For example, H.R. 5099 would establish a pilot program permitting VA to enter into public-private partnership agreements to plan, design, and construct new VA facilities using private donations. To Establish a Pilot Program on Partnership Agreements to Construct New Facilities for the Department of Veterans Affairs, H.R. 5099, 114th Cong. (2016), <https://www.congress.gov/bill/114th-congress/house-bill/5099>.

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Figure 3. The Complicated Process of Meeting and Managing VHA's Capital-Needs

**Implementation****Legislative Changes**

- Provide VA new, more flexible authorities to realign facilities, meet capital-asset needs, and divest itself of unneeded buildings.
- Establishing a VHA capital asset realignment process that provides (notwithstanding any other law) for more effectively aligning VHA facilities with the objective of improving the access, quality, and cost-effectiveness of VA care, and provides for:

COMMISSION RECOMMENDATIONS

- Establishing an independent commission (empowered to hold public hearings, make site visits, and have full access to VHA analyses and data) charged with developing a national capital asset realignment plan that would include recommendations to the VHA Care System governing board (see Recommendation #9) for systemwide facility realignment (to include changes in facility mission, facility downsizing, integration of facilities, and closures), with the rationale for each recommended change.
- The proposed plan would identify (a) the criteria used in developing realignment recommendations, (b) proposals for reinvestment and savings/cost avoidance resulting from the realignment, (c) the projected care improvements that would result, and (d) mechanisms to minimize the adverse effects on displaced employees, to include assuring that, to the extent feasible, VA retrain and reemploys displaced employees.
- The VHA Care System governing board would be empowered to adopt or alter the proposed realignment plan, and to implement the final plan unless, within a specified timeframe, Congress disapproves the plan as a whole on an up-or-down vote.
- Waive or suspend for at least 5 years current authorization and scorekeeping requirements governing major medical facility leases under 38 U.S.C. § 8104.
- Amend 38 U.S.C. § 8104 to lift the threshold of what constitutes a major medical facility project from \$10 million to \$50 million.
- Amend pertinent provisions of 38 U.S.C. § 8161, and what follows, to reinstate and extend for 10 years the authority in prior law (as in effect on December 30, 2011) for VHA to enter into enhanced-use leases for any use that is not incompatible with VA's mission.
- Provide the VHA Care System governing board authority to promulgate regulations that for a period of not more than 5 years, and notwithstanding any other law, would ease the divestiture of unneeded vacant VHA buildings, to include (a) shifting to a third party the cost of meeting environmental requirements, (b) allowing VHA to retain the proceeds of any property sale, and (c) creating a streamlined process to address historic preservation considerations.

VA Administrative Changes

- None required.

Other Department and Agency Administrative Changes

- None required.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

Problem

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems and other health care providers; enables scheduling, billing, claims, and payment; and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.¹⁸²

VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, currently within VHA, there is no experienced senior health care IT leader focusing on the strategic health care IT needs of veterans and VHA staff.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing and implementing a comprehensive health IT strategy and developing and managing the health IT budget.
- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Background

A fully functional electronic health record (EHR) can improve the quality of patient care, help avert medical errors, and improve communication among providers and with patients.¹⁸³ Starting in the 1970s, VHA became a leader in the development of EHR technology with VistA and a computerized patient record system (CPRS).¹⁸⁴ Full implementation of the EHR, together with other reforms, helped improve the quality of care at VHA.¹⁸⁵ During the last decade, VHA has not been able to maintain an IT advantage.¹⁸⁶ Although in the past most VHA clinicians

¹⁸² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁸³ "Does health information technology improve quality of care?" Robert Wood Johnson Foundation, accessed May 20, 2016, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71333.

¹⁸⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 29-30, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

¹⁸⁵ Phillip Longman, *Best Care Anywhere: Why VA Care Is Better Than Yours* (3rd ed., Berrett-Koehler Publishers, Inc., 2012). Jonathan B. Perlin, Robert M. Kolodner, and Robert H. Roswell, "The Veterans Health Administration: Quality, Value, Accountability, and Information as Transforming Strategies for Patient-Centered Care," *The American Journal of Managed Care* (November 2004), 828-836, accessed June 3, 2016, <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.476.450&rep=rep1&type=pdf>.

¹⁸⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, vi, accessed April 5, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

have had a high opinion of the clinical applications and databases enabled by VistA and CPRS, a lack of upgrades has put VHA's EHR at risk of becoming obsolete.¹⁸⁷ Many large U.S. health care systems that were early adopters of homegrown EHR systems found themselves in similar circumstances and have since purchased and migrated to commercial off-the-shelf (COTS) products.¹⁸⁸ DoD recently made the same choice.¹⁸⁹

To achieve the Commission's vision of a health care system that delivers quality, access, choice, and veteran well-being, VHA requires effective, robust, and modern information technology systems. A robust EHR system would allow veterans and clinical providers to send, receive, find, and use electronic health information in a manner that is appropriate, secure, timely, and reliable. It would be seamlessly interoperable with other systems including DoD, private-sector providers, and with other VA enterprise systems such as those in the Veterans Benefits Administration (VBA). It would support VHA clinical workflow, evidence-based practice, and patient safety. It would provide clinicians, patients, and administrators the data, analytic power, and user interfaces required to monitor the effectiveness of care and improve it over time. A robust IT system for VHA should include more than just the EHR, however, extending to all the systems and tools required to facilitate and automate business processes that support access and veterans' care. These capabilities include an effective scheduling system, telephone systems, mobile applications, telehealth, financial management systems, human resources systems, and other systems that enable community care.

To realize such a transformation of IT in a system as complex as VHA requires exceptional leadership and staff, sufficient budget, a robust change management plan, effective systems for accountability and quality control, and efficient and agile contracting.¹⁹⁰ Presently, VHA appears to lack a majority of these factors required for success.¹⁹¹

Analysis

Leadership and Staff

Prior to 2006, VHA had a chief health informatics officer responsible for the VHA electronic record system and for coordinating with VA on IT systems. The programmers in VHA worked closely with the clinicians who used the tool to create a system that met their needs.¹⁹² VHA was able to prioritize clinical needs and patient safety requirements within its overall budget and plan for IT spending; however, there was no specific budget line item for the electronic health

¹⁸⁷ Ibid., 29-30.

¹⁸⁸ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

¹⁸⁹ "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

¹⁹⁰ LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

¹⁹¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 41, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁹² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

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record system or related technology, and there was limited central oversight or accountability for information technology infrastructure.

VA's IT budget was centralized in 2006, and the Office of Information and Technology (OIT) was assigned to deliver, operate, and manage IT and its budget, across the department. With this change, VHA's needs became only one of the priorities that OIT has had to accommodate and VHA's priorities have not always prevailed.¹⁹³

To ensure that clinical needs and patient safety are a priority, many large health care systems, such as DoD, Cleveland Clinic, Geisinger, and Kaiser Permanente, have a medical CIO (i.e., CMIO) who manages and advocates for the clinical IT needs of the organization. A CMIO ensures that clinicians are involved in the selection of any IT systems they use to perform their job functions and provide patient care, including EHRs. Clinicians involved in the selection and deployment of an IT system are more likely to feel ownership of it and fully adopt its use. The CMIO usually reports to the health system's CEO or CMO, and working in concert with these individuals and the organization's CIO, makes sure that health information needs are prioritized and funded.¹⁹⁴

VA does not have staff with the necessary expertise to execute large-scale IT projects. Previous system implementations have failed because VA did not have individuals with adequate experience to effectively plan and manage system development and deployment. If VA had an adequate system and skilled staff to monitor and identify program and contracting problems affecting the progress of prior IT implementations, effective and timely decisions could have been made to either redirect or terminate VA IT projects that ultimately failed. To avoid repeating these previous IT implementation failures, VA needs to develop effective oversight systems and develop in-house staff with the expertise to oversee, fully support, manage, and execute complex integrated IT programs.¹⁹⁵

Given all of these critical needs, the Commission believes that it is essential for VHA to have a CIO with health care expertise and substantial experience, reporting to the chief of VHA Care System. The VHA CIO will be responsible for managing the complex implementation of a state-of-the-art comprehensive information system platform to support the new integrated VHA Care System, with the functionality, interoperability, and data management capabilities to support the delivery and coordination of high-quality health care for veterans. The CIO will need to work closely with clinical and operational leaders on the effective execution of the new system, and will also need to collaborate with the VA CIO to ensure the integration and coordination of the health care information system and the Veterans Benefit Administration system.

¹⁹³ Ibid., 10.

¹⁹⁴ "CMIOs Help Hospitals Make Tech Transitions," Naseem S. Miller, accessed May 13, 2016, <https://www.acep.org/content.aspx?id=79744>.

¹⁹⁵ Department of Veterans Affairs Office of the Inspector General, *Review of the Awards and Administration of Task Orders Issues by the Department of Veterans Affairs for the Replacement Scheduling Application Development Program*, accessed May 25, 2016, <http://www.va.gov/oig/52/reports/2009/VAOIG-09-01926-207.pdf>.

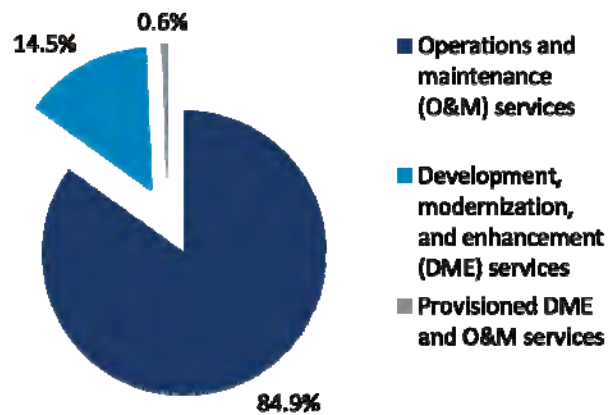
Budget

The 1-year budget appropriations cycle makes it difficult to secure multiyear funding for long-term development and important IT projects.¹⁹⁶ The budget process is disconnected from total lifecycle IT costs.¹⁹⁷ That disconnect has grown wider with a change in law¹⁹⁸ under which Congress provides VHA advanced medical care appropriations—in effect a 2-year budget—while health IT funding remains 1-year money.¹⁹⁹ As the Congressional Research Service (CRS) testified,

*providing an advance appropriation for some VHA accounts and funding IT accounts under a regular appropriation act could create a situation whereby, for example, VHA could not purchase computer software although it has procured medical equipment that needs software. Another example would be the difficulty of procuring IT infrastructure to support opening of a new community-based outpatient clinic (CBOC).*²⁰⁰

Spending on new systems and upgrades to existing systems now represents only 15 percent of VA's total IT budget (see Figure 4),²⁰¹ meaning that essential upgrades like a new scheduling package and EHR modernization have not had the funding or focus required to succeed. Clinical users have become increasingly frustrated by the lack of any clear advances with VistA during the past decade. Numerous VHA clinicians have experience with commercial EHR systems and want the same level of features, modern clinical capabilities, integration, and mobility they see emerging in the commercial marketplace.²⁰²

Figure 4. VA IT Spending



In July 2015, DoD awarded a \$4.3 billion, 10-year contract to overhaul the Pentagon's electronic health records for millions of active-duty military members and retirees. Officials estimate that

¹⁹⁶ "Coming in 2016: Cloud Legislation," Aisha Chowdhry and Adam Mazmanian, accessed January 12, 2016, <https://fcw.com/articles/2015/12/22/cloud-bill-2016.aspx>.

¹⁹⁷ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.

¹⁹⁸ Veterans Health Care Budget Reform and Transparency Act of 2009, Pub. L. No. 111-81, 123 Stat. 2137 (2009).

¹⁹⁹ With the Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235 (December 16, 2014), Congress expanded advanced appropriations to additional VA program accounts.

²⁰⁰ U.S. Congress, House of Representatives, Committee on Veterans Affairs, *Funding the U.S. Department of Veterans Affairs of the Future: Hearing before the Committee on Veterans Affairs U.S. House of Representatives*, 111th Congress, 1st Sess., April 29, 2009, 60, accessed June 3, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-111hhrg49914/pdf/CHRG-111hhrg49914.pdf>.

²⁰¹ Department of Veterans Affairs, *Information Technology Agency Summary*, accessed May 25, 2016, <https://itdashboard.gov/drupal/summary/029>.

²⁰² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

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during its potential 18-year life, the contract could be worth just less than \$9 billion.²⁰³ The recent Senate appropriations bill for VA OIT allots \$63 million toward development and modernization of VA's existing EHR (i.e., VistA Evolution).²⁰⁴ Assuming that VA's implementation of a new COTS EHR would be similar in size and scope to DoD's EHR implementation, VA would be short \$3.67 billion in funding for a new COTS EHR, given the current funding amount of \$63 million per year. VA will require a substantial increase in IT funding to support the successful implementation of a new comprehensive COTS EHR.

Robust Change Plan

Because VistA has been customized at each medical center, there are few standard data elements. The varied algorithms lead to a complex, heterogeneous mix of hardware and software that impedes system changes and new capabilities and raises operations and maintenance costs.²⁰⁵ Due to excessive project management overhead, a complex legacy IT infrastructure that is difficult to modernize, and more than 130 variations of the primary software system deployed across VHA medical facilities, the implementation of improved IT capabilities in the last 10 years has been extremely limited.²⁰⁶ VA is currently weighing whether to continue to modernize VistA or purchase a COTS health information technology platform. The Commission recommends moving to a COTS program.

Whether VHA moves forward with the purchase of a COTS product, as recommended by the Commission, or continues attempting to modernize VistA, VHA must effectively manage the change process. At present, a lack of standard clinical documentation has made it harder to develop effective clinical decision-support systems and hinders EHR information exchange among VA Medical Centers (VAMC), between VA and non-VA facilities (including those of DoD), and between VA and individual veterans. Shared data must be well labeled in a way that the receiving system can identify and properly ingest such data. An electronic medical record can contain as many as 100,000 different data fields. The lack of data standards presents challenges to using comparable data for analysis and disparities among the 130 tailored local instances of VistA, complicating information sharing, data aggregation, and analytics.²⁰⁷ VHA has not established comprehensive semantic definitions for data elements through the use of standard nomenclatures, terminologies, and code sets. Doing so is required to ensure consistency and integration across multiple systems, leverage follow-on IT products, and facilitate analytics for clinical decision making.²⁰⁸

The Office of the National Coordinator (ONC) for Health IT, under HHS, is responsible for advancing national connectivity and interoperability of health information technology. The

²⁰³ "Cerner wins \$4.3 billion DoD contract to overhaul electronic health records," Amy Brittain, *The Washington Post*, accessed May 25, 2016, https://www.washingtonpost.com/national/health-science/cerner-wins-dod-contract-to-overhaul-electronic-health-records/2015/07/29/7fbfccfa-35f5-11e5-b673-1df005a0fb28_story.html.

²⁰⁴ S. Rept. 114-237 – Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, 2017, accessed May 25, 2016, <https://www.congress.gov/congressional-report/114th-congress/senate-report/237/1>.

²⁰⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²⁰⁶ *Ibid.*, 41.

²⁰⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, vi, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁰⁸ *Ibid.*, viii.

ONC developed the National Interoperability Roadmap with the goal of being able to use electronic health information exchange, so information can follow a patient where and when it is needed, across organizational, health IT developer, and geographic boundaries. The roadmap lays out a clear path to catalyze the collaboration of stakeholders who are going to build and use the health IT infrastructure.²⁰⁹ VA's intent to expand veteran care to more community providers through the creation of locally-integrated health care networks will mean that it is important for VHA to follow the ONC roadmap and standards. Following this roadmap includes using the continuity of care document to exchange data, which was established by ONC and is followed by community health care providers. VA OIT is currently collaborating with the ONC on VA's plans for interoperability and has committed VA to following the roadmap.²¹⁰

VHA does not yet have a robust, detailed strategy and roadmap for IT initiatives across VHA that integrates veteran access to scheduling via phone, telehealth, and mobile apps.²¹¹ National deployment of the VistA Scheduling Enhancement and the veteran mobile scheduling Veteran Appointment Request app, are initial steps to prepare for the implementation of new COTS electronic medical system with a scheduling package.

To resolve the underlying systemic issues with VistA scheduling, VA awarded a contract for the implementation of VA's new COTS medical appointment scheduling system in August 2015.²¹² This system is a COTS scheduling solution that, when implemented, is expected to move VHA from primarily a face-to-face appointment model to a coherent, resource-based system with broad opportunities for improved services for VA stakeholders.²¹³ Deployment is awaiting the final decision on whether VHA will continue with VistA or purchase a full COTS product.

COTS Solution

The current VistA/computerized patient records systems are based on a tightly integrated, monolithic architecture and design with numerous and diverse functional components and associated interdependencies. These characteristics impose barriers to modernizing the respective systems. In addition, the high cost of infrastructure operation and maintenance (85 percent of the total IT budget) reduces funding available for new development efforts.²¹⁴ Maintenance and data sharing are further complicated because most VAMCs have customized their local versions of VistA, leading to approximately 130 different versions of VistA across the country.²¹⁵

²⁰⁹ "A Shared Nationwide Interoperability Roadmap Version 1.0," HealthIT.gov, accessed March 29, 2016, <https://www.healthit.gov/policy-researchers-implementers/interoperability>.

²¹⁰ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²¹¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 44, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²¹² "\$623M Medical Appointment Scheduling System (MASS) Contract," G2Xchange, accessed May 3, 2016, <https://www.g2xchange.com/statics/623m-medical-appointment-scheduling-system-mass-contract>.

²¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 40, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²¹⁴ *Ibid.*, vi.

²¹⁵ *Ibid.*, vi.

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VHA relies on a VistA scheduling package to provide veterans with access to health care. The system is antiquated, highly inefficient, does not optimally support processes or allow for efficient scheduling of appointments. A report on scheduling published by the Northern Virginia Technology Council (NVTC) in October 2014, showed that VA's exam-scheduling processes are not enabled by state-of-the-art technologies or consistently applied standard operating procedures.²¹⁶ To improve this situation, VHA has developed, and is in the process of a national roll out of, VistA scheduling enhancements, which provides an improved user interface (i.e., graphic user interface or GUI). Although the new GUI will help veterans gain access to care by implementing better scheduling procedures, it does not address the need that managers, planners, and administrators have for accurate and timely data on clinic use.²¹⁷ For instance, VHA's new health care operations dashboard shows that more than 55 percent of clinic slots in VHA go unused each day.²¹⁸ However when questioned about this data, VHA notes that it is not correct.²¹⁹ The underlying VistA scheduling software does not allow accurate representation of clinician time toward each clinic stop. As a result, whether data is presented in a dashboard or a new GUI tool, as long as the underlying data cannot be captured accurately, then VHA will not have the information it needs to effectively manage the supply of clinic slots.²²⁰

VA's financial management information technology system is woefully outdated and VA has previously wasted approximately \$500 million in two failed attempts to replace it. Given VA's lack of an integrated finance and logistics IT system, VA has no method to perform commitment accounting.²²¹ VA's current financial management system does not support streamlining and automation of VA's revenue cycle.²²²

Community care processes currently include eligibility determinations, referrals and authorizations, care coordination, network management, claims, and customer service.²²³ VA's information technology systems limitations often demand manual processes to support community care that can reduce the timeliness and accuracy of data and obscure the true state of VHA's activities. Relying on manual processes slows collections and payment activities and introduces errors and waste into the process.²²⁴ Barriers to automation are multifactorial,

²¹⁶ Ibid., 39-40.

²¹⁷ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

²¹⁸ Crystal Wilson, Office of Analytics and Business Intelligence, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.

²¹⁹ Joe Francis, Director of Clinical Analytics and Reporting, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.

²²⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

²²¹ Jan R. Frye, *Letter to Secretary McDonald, March 19, 2015*, accessed May 17, 2016, http://extras.mnginteractive.com/live/media/site36/2015/0522/20150522_025126_WhistleblowerMemo.pdf.

²²² Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, 24, accessed May 24, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf.

²²³ Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.

²²⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 42, accessed March 28, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

including confusing eligibility rules governing which veterans may receive care outside VHA and for what conditions, in what circumstances, and which services may be billed to third-party insurers.²²⁵ In addition, there are multiple authorities for purchasing community care—all with different business rules²²⁶ and reimbursement rates, as well as antiquated financial management information systems that are not standardized to private-sector processes. All of these impediments are exacerbated by workers throughout the revenue cycle who are poorly compensated and marginally trained, experience high turnover, and work in environments with a continuous 20 percent vacancy rate;²²⁷ thus, they cannot effectively manage certain business practices such as insurance verification and ensuring clinicians complete necessary coding documentation.²²⁸

Many large U.S. health care systems that originally developed in-house EHRs have since purchased and migrated to COTS EHRs.²²⁹ DoD recently made the same choice, deciding to replace its homegrown EHR with a COTS product to take advantage of private-sector innovation and have an EHR that communicates with private-sector systems. For a system in which 60 to 70 percent of military health care takes place outside the DoD,²³⁰ this was an important business consideration that is also consistent with VHA's long term direction. Very large IT programs with purpose-built systems and labor-driven business models are shifting rapidly toward more open source, COTS systems. Large proprietary IT solutions are increasingly being replaced by less risky, agile, and open-source solutions or IT as-a-service models, and getting away from client-server models.²³¹

Interoperability

VHA's EHR issues stymie interoperability among VHA facilities as well as between VHA and DoD and other non-VHA providers. Multiple assessments noted the lack of interoperability resulted in incomplete patient records with potentially substantial implications for veterans and VHA. Incomplete records introduce unnecessary clinical risk, complicate the transition from

²²⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I (Business Processes)*, 19-20, accessed April 26, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²²⁶ Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.

²²⁷ Healthcare Talent Management, Veterans Health Administration, email to Commission on Care, April 11, 2016. Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America's Veterans*, accessed April 25, 2016, <http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf>.

²²⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I, Business Processes*, I3-I4, accessed November 24, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²²⁹ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

²³⁰ "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

²³¹ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

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DoD to VHA care, and inhibit VHA's ability to bill and collect revenue in an accurate and timely manner.²³²

As GAO reported in August 2015, VA and DoD have taken initial steps to increase interoperability between their existing electronic health record systems.²³³ They have deployed the Joint Legacy Viewer (JLV), which provides a patient-centric, integrated view of a patient's health data from VA, DoD, and community health partners on one screen. It has been available at all VA medical centers since October 2014 and currently has more than 70,000 users.²³⁴ The JLV is a positive step in supporting coordination of care among VA, DoD, and community partners, but it only allows for providers to view veterans'/service members' medical records and does not yet allow for the other agencies' medical records to be updated by providers.²³⁵

VA's next evolution in interoperability with DoD and community partners is the deployment of their Enterprise Health Management Platform (eHMP). eHMP is intended to provide VA streamlined access to complete patient history from VA, DoD, and community health partners in a single, reliable, customizable, and secure interface that is easy to use. It is reported to deliver a modern, web-based user interface and supporting infrastructure and is intended to replace the Computerized Patient Record System (CPRS) as VA's primary point-of-care application. The national rollout of eHMP is expected to be completed by December 2017.²³⁶

VHA does not have everything that is needed in an IT system to manage the business and clinical aspects of care in the community and support the overall veteran experience in an expanded community network. To address these gaps and provide health care well into the future, VA intends to develop in house a comprehensive and interoperable digital health platform (DHP). The DHP is intended to seamlessly integrate all of VHA's core processes, including scheduling, supply chain management, billing, and claims. Through consolidation of more than 40 contact center systems and more than 130 versions of the VistA EHR and clinical procurement/inventory systems, the DHP is designed to enable VHA's operation as a holistic, platform business and greatly reduce the cost of system maintenance across the IT enterprise.²³⁷

Because there is no unique patient identifier, problems exist with "1) accessing and integrating information from different providers and provider computer systems, 2) aggregating and providing a lifelong view of a patient's information, and 3) supporting population-based research and development."²³⁸ To accurately match veteran patient data that is exchanged between VA and non-VA providers, both organizations need to use the same unique patient

²³² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 44, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²³³ "Electronic Health Records: VA and DOD Need to Establish Goals and Metrics for Their Interoperability Efforts," U.S. Government Accountability Office, accessed April 1, 2016, <http://www.gao.gov/products/GAO-16-184T>.

²³⁴ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²³⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, A-35, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²³⁶ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²³⁷ LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²³⁸ "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPAVU-508.pdf>.

identifier. This practice is currently not used.²³⁹ Each health care system uses a unique patient identifier number, but it is specific to that system.²⁴⁰ VA uses patients' social security numbers as unique identifiers; whereas, due to stricter security standards required by HIPPA privacy laws that community providers must adhere to, many non-VA providers use other personally identifiable information (e.g., first name, last name, date of birth, and phone number) to match patient identities between record systems. Studies have shown that patient identification error rates range from 7-20 percent.²⁴¹ For VA to accurately identify patients and their records, a unique national patient identifier is essential.

The security of electronic records is an ongoing concern. One in three Americans had health care records breached in 2015.²⁴² Recent hacks of U.S. hospital health care systems through the use of ransomware, viruses that hold systems hostage until victims pay for a key to regain access, further highlight the need for enhanced VA cybersecurity.²⁴³ VA's OIG has repeatedly identified the same weaknesses and deficiencies in VA's information security program in its annual FISMA audit reports.²⁴⁴ Although VA has recently made some progress in developing policies and procedures to address current security gaps, OIG's FY 2015 audit concluded that information security is still a *material weakness* for VA and that VA must take comprehensive measures to mitigate security vulnerabilities affecting VA's mission-critical systems.²⁴⁵ For sharing of veteran data to be secure, only the designated correct parties can have access to patients' data.²⁴⁶ Interoperability increases the risk to veterans' health records.²⁴⁷ Cybersecurity guidelines and best practices are being developed by HHS in response to the requirements in the recently enacted Cybersecurity Information Sharing Act;²⁴⁸ however, security protocols also cannot impede health information exchange with VA community providers and health systems. VA OIT needs to be involved in the health information exchange planning discussions, which

²³⁹ "Interoperability 2015: Current State and Next Steps", Kent Gale, KLAS Research, accessed March 9, 2016, <http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0>.

²⁴⁰ "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPAVU-508.pdf>.

²⁴¹ "The Right Fit: How We Solve the Puzzle of Interoperability," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, <http://www.futureofhealthcarenews.com/telemedicine/the-right-fit-how-we-solve-the-puzzle-of-interoperability>.

²⁴² "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, <http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records>.

²⁴³ "Virus Infects Medstar Health System's Computers, Forcing an Online Shutdown," John Woodrow Cox, Karen Turner and Matt Zapotosky, accessed March 28, 2016, https://www.washingtonpost.com/local/virus-infects-medstar-health-systems-computers-hospital-officials-say/2016/03/28/480f7d66-f515-11e5-a3ce-f06b5ba21f33_story.html?hpid=hp_local-news_medstar-health-virus-345pm%2Fstory.

²⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, A-24, accessed May 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁴⁵ Department of Veterans Affairs, Office of the Inspector General, *Federal Information Security Modernization Act Audit for Fiscal Year 2015*, accessed May 25, 2016, <http://www.va.gov/oig/pubs/VAOIG-15-01957-100.pdf>.

²⁴⁶ "Interoperability 2015: Current State and Next Steps; Market Immaturity Highlights Opportunity," Kent Gale, KLAS Research, accessed March 9, 2016, <http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0>.

²⁴⁷ Jon White, M.D., The Office of the National Coordinator for Health Information Technology, briefing to Commission on Care, December 15, 2015.

²⁴⁸ "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 17, 2016, <http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records>.

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are currently handled solely within VHA, so that VA OIT can assist in removing impediments to health information exchange.²⁴⁹

Veterans currently have to opt in (i.e., provide consent) to allow VA to share their health information with non-VHA/community care providers. Although the technology is in place for VA to exchange patient health information with more than 100 health information exchange partners, only a fraction of data can be exchanged in these networks because, due to lack of awareness, only 3 percent of veterans have opted in to allow VA to share their health information.²⁵⁰ The standard industry policy is to have patients opt out of having their health data shared with their other health care providers. VA is prohibited from taking this approach because statutory language in 38 U.S.C. § 7332 prohibits VA from disclosing information relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia, except when required in emergencies, without written authorized consent from the patient.²⁵¹

In response to this limitation, VA approved and submitted Legislative Proposal VHA-10 (10P-07), Authority for the Department of Veterans Affairs (VA) to Release Patient Information under 38 U.S.C. § 7332 to Health Care Providers for Treatment of Shared Patients in 2013. The proposal allows veterans to opt out of sharing their data with VA community providers instead of having to opt in. The proposal was approved by OMB and was included in the president's 2015 Budget. VHA provided a briefing to a Senate Veterans Affairs Committee staff in April 2015 on this legislative proposal. A House Bill was introduced, but it limited the opt-out option to the *Choice Program*. VA's Office of Congressional and Legislative Affairs responded back to Congress that the bill should be expanded to include all external purchased care options (i.e., community providers) thus directly supporting more veterans.²⁵²

Collaboration between VA OIT and VHA is paramount to transforming VHA's health IT infrastructure. Such collaboration would be most effectively achieved by establishing an IT leader for VHA who is focused on ensuring that the strategic and operational IT needs of VHA clinicians, staff, and veterans are met. Current OIT leadership is in the process of modernizing VA's IT management processes, to include putting in place IT account managers (ITAMs) for each of the agency's departments, including VHA.²⁵³ An account manager is neither senior enough, nor has the level of expertise and experience, to manage the complexity of the VHA IT system. VHA's extensive IT needs require a VHA CIO with authority over the health IT budget and the execution of the health IT strategy. VA needs a robust process for IT investment decisions, especially those relating to VHA's health strategy. The VHA CIO would work with the CVCS and the VA CIO to define the health IT strategy and key IT acquisitions/projects and ensure that health IT funding is aligned and committed to the execution of VHA's health IT

²⁴⁹ Jamie Bennett, VLER Health Program Manager, phone call with Commission on Care Staff, March 2, 2016.

²⁵⁰ Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015

²⁵¹ 38 U.S.C. § 7332 Subchapter III - Protection of Patient Rights Sec. 7332 - Confidentiality of certain medical records.

²⁵² Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015.

²⁵³ "OI&T Enterprise Strategy: Putting Veterans First," LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.

strategy. Rolling out a new system takes multiple years, and VA must commit to funding system deployments to completion.

The modernization of VHA's IT infrastructure requires a substantial increase in and reallocation of VA's IT budget to implement it. The budget process for VA health care IT funding should be the same as the process for VHA medical care funding. That shift can be accomplished by establishing a separate line item for *health* IT within VA's IT appropriation, and providing for advanced appropriations for that account. In addition, there is also a potential supplementary role for government-wide IT legislation. For example, H.R. 4897, the Information Technology Modernization Act of April 2016, would create a \$3.1 billion revolving fund for upgrading outdated federal IT systems.²⁵⁴

The Commission strongly recommends that VA purchase a comprehensive COTS health IT platform, and implement all information systems with minimal customization. VHA leadership is in the process of assessing whether VistA is the best solution to support veterans' future health care needs or whether a new EHR, such as a COTS product or open-source EHR, should be used.²⁵⁵ The decision to choose a COTS product would be consistent the approach adopted by DoD and by other large health systems that have moved away from homegrown solutions to commercial and open-source products. It would allow VHA to focus energy on excellent patient care as a core competency and shift the IT development and maintenance risk of software products to external vendors with more expertise in this area.²⁵⁶ It is also likely to accelerate interoperability as vendors continue to offer IT solutions that meet meaningful use standards and the roadmap published by ONC.

A COTS product must be able to execute key functionalities required by VHA. These requirements include one standard version of an EHR across all VHA sites of care; interoperability within VA, such as with Veterans Benefit Administration (VBA), and between VHA and DoD, and community providers; robust security; and the ability to accommodate a national unique patient identifier. This system must also be a robust clinical management tool that supports VHA clinical workflow and has a customizable interface for clinical users, allows for evidence-based clinical order sets and patient safety features like automated medication reconciliation, has robust analytic capability for both clinical and administrative functions, and enables automated abstraction and reporting of performance measures.

The system must also seamlessly support administrative functions like scheduling, patient intake, eligibility determination, referrals, and patient out-of-pocket expense determination. The system must enable effective business operations in billing coding, automated claims processing, and all aspects of supply chain management. This COTS purchase should include a scheduling package. Improvements in scheduling should dramatically increase access and satisfaction, as well as data quality, productivity, and operational reporting capabilities.

²⁵⁴ "Two IT Modernization Bills Could See Movement in Congress," Aisha Chowdhry, accessed April 28, 2016, <https://washingtontechnology.com/articles/2016/04/22/it-bills-congress.aspx>.

⁷³ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²⁵⁶ "DoD awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

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Broadening and improving scheduling capabilities will provide more opportunities for veterans to become active partners in their own care.²⁵⁷

For VHA to transition to a COTS product, the new VHA CIO must develop and implement a strategy that will allow the current nonstandard data to effectively roll into a new system, engage clinical-end users and internal experts in the procurement and transition process, ensure effective cybersecurity, and limit spending on the current systems to fund only critical changes required for continued operations. Finally, this plan should be coordinated with ONC and DoD.

Implementation

Legislative Changes

- Provide a specific appropriation to fully fund the complete development and deployment of the comprehensive COTS electronic health platform, recognizing this will require significant resources above the current annual appropriation and funding to support VHA's IT transformation; including funds that ensure appropriate training of all staff, recognize loss of staff productivity during implementation, and provide proper maintenance and upgrades of VA IT infrastructure in preparation for new and successor technologies.
- Establish within the Department's IT appropriation a line item for health IT, and provide for advanced appropriations for that account, consistent with the overall VHA IT strategy.
- Amend section 38 U.S.C. §7332, to authorize VA to share protected health information under the same rules as all other HIPAA protected information.

VA Administrative Changes

- Hire a CIO for the VHA IT transformation. The CIO should report to the CVCS, with secondary reporting responsibility to VA CIO.
- Establish a transformation strategy that addresses all of the following needs (as directed by the VHA CIO):
 - standardizes data elements in the current IT systems through the use of standard nomenclatures, terminologies and code sets in order to promote the transition to a COTS EHR and to support interoperability²⁵⁸
 - develops a robust cybersecurity plan for VHA IT infrastructure, in coordination with VA CIO and Chief Information Security Office, which addresses both current systems and defines
 - the requirements for new systems

²⁵⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 46, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁵⁸ *Ibid.*, 55.

- collaborates with the Office of the National Coordinator for Health IT on national interoperability standards and implementation
- limits any continued VistA development and associated spending to only those upgrades required to keep VistA functioning until a new system is in place
- Plan and implement procurement of a comprehensive COTS electronic health platform that executes all of the following requirements:
 - establishes one logical version of an electronic health record platform in VHA²⁵⁹
 - standardizes evidenced-based, best practice clinical order sets across VHA
 - incorporates effective analytic capabilities to drive health and business outcomes and offers the ability to interface with other tools for data management and presentation²⁶⁰
 - modernizes appointment scheduling so that it accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veterans²⁶¹
 - accomplishes a coordinated IT infrastructure for appointment scheduling, coding, billing, claims payment, third party collections, and other core VHA business processes, including the following specific capabilities: integration across patient intake, medical records, coding, and billing systems; single sign-on capability; automated first-party claims matching; real-time estimate of out-of-pocket patient expenses; and automation to support algorithmic edits and claims correction²⁶²
 - supports the business processes required to implement integrated community care networks, including eligibility determinations, referrals and authorizations, care coordination, network management, claims and customer service
 - promotes full interoperability with IT systems across VA (including VBA and National Cemetery Administration) and between VA and DoD
 - supports the development of full interoperability with integrated community care network facilities and providers

²⁵⁹ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²⁶⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, viii, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁶¹ The Independent Budget, *The Independent Budget—Veterans Agenda for the 114th Congress: Policy Recommendations for Congress and the Administration*, accessed May 17, 2016, http://www.independentbudget.org/2016/IB_FY16.pdf.

²⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 49, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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- enables automated abstraction and reporting of quality performance measures including process and outcome measures of clinical quality, access measures, and cost effectiveness that are the same as the private sector
- includes functionality to use a national unique patient identifier
- integrates supply chain and financial systems with the electronic health records to provide accurate operational data²⁶³
- Streamline its current IT procurement processes so that IT procurement is expeditious, including lengthier contract vehicles with more options, the use of indefinite delivery indefinite quantity vehicles, blanket purchase agreements, time and material contracts, and flexible contract structures to allow for the onboarding of emerging technologies in a competitive fashion.
- Increase health IT expertise within VHA.

Other Department and Agency Administrative Changes

- CMS and federal health care providers should collaborate to develop a national unique patient identifier standard. CMS should require health care providers to use these identifiers as a condition of participation in Medicare and HHS should require federally qualified health centers to use them as a condition of participation. The President should require all federal health care providers to adopt the standard.

²⁶³ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Problem

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.²⁶⁴

Background

Health systems nationwide, under pressure from reforms driven by the Affordable Care Act, are looking at every aspect of their business to maximize cost savings, while maintaining quality services.²⁶⁵ This effort includes examining the supply chain for ways to save money.²⁶⁶

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.
- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

²⁶⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁶⁵ Bob Kehoe, "Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness," *Health Facility Management Magazine*, 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.

²⁶⁶ "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, <http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends>. "5 Ways Supply Chain Can Reduce Rising Health Care Costs," Jasmine Pennie, accessed April 28, 2016, <http://hitconsultant.net/2013/05/13/5-ways-supply-chain-can-reduce-rising-health-care-costs/>.

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Price competition achieved through technology and aggressive management of supply chain efficiencies by retailers such as Walmart and Amazon are held up as just the kind of disruption that health care requires.²⁶⁷ Health care organizations as diverse as Kaiser Permanente, Cleveland Clinic, Stanford Medicine, and Johns Hopkins Health System have taken on the challenge of transforming their supply chains, realizing savings of as much as hundreds of millions of dollars.²⁶⁸ VHA, which in FY 2014 spent approximately \$3.4 billion on clinical supplies, medical devices, and prosthetic appliances, has an opportunity to realize similar savings.²⁶⁹

Opportunities for efficiency in the supply chain include reducing pricing for purchases and lowering operating costs of procurement processes. To achieve price savings, organizations must have detailed information on what products they use, understand and reduce variability in the products purchased, and aggressively negotiate pricing, usually by consolidating purchases to a small number of preferred vendors who are willing to offer volume discounts and improve service delivery. On the operations side, cost savings are achieved by managing inventory lifecycle and restocking processes; order management; and the logistics of shipping, receiving, and transportation to drive down costs and lower waste and breakage. In health care, it also pays to ensure that clinical staff, both nurses and doctors, are treating patients rather than conducting inventory checks or ordering and collecting supplies.²⁷⁰ To be successful in managing the supply chain in health care, a partnership with clinical staff is key. Variability in device and supply purchases can be driven by clinician preferences and thus, to reduce variability, clinicians must be engaged in analyzing product options and examining data on product effectiveness to determine what products to use with patients.²⁷¹

VHA has a successful internal model of aggressive supply chain management that can serve as a model for improving the management of medical, surgical and other supplies: the VHA Pharmacy Benefits Management Service (PBM). PBM has taken a systems approach to

²⁶⁷ John Agwunobi and Paul London, "Removing Costs from the Health Care Supply Chain: Lessons from Mass Retail," *Health Affairs*, 28, no 5, (2009): 1336-1342, accessed April 26, 2016, <http://content.healthaffairs.org/content/28/5/1336>.

²⁶⁸ "In Age of Mergers, Hospitals Get Strategic with Medical Supply Purchasing," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/age-mergers-hospitals-get-strategic-medical-supply-purchasing>. "Supply Chain Management," Cleveland Clinic, accessed April 27, 2016, <http://my.clevelandclinic.org/services/supply-chain-management>. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering>.

²⁶⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 47, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁰ "EY Provider Post: Choosing Your Innovation Pathway," EY, accessed April 26, 2016, <http://www.ey.com/US/en/Industries/United-States-sectors/Health-Care/Provider-Post--Choosing-your-innovation-pathway>.

²⁷¹ "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, <http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends>. "Strategic Supply Chain Management," Lee Ann Jarrow, accessed April 28, 2016, <http://www.hhnmag.com/articles/4522-strategic-supply-chain-management>. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering>.

managing pharmaceutical supplies, logistics, and prescribing.²⁷² PBM has largely solved the internal contracting deficiencies in VA by consolidating its activities under just two contracting organizations that oversee all national-level contracts for pharmaceuticals. PBM also applies effective mechanisms to drive standardization of supplies through a national formulary, clinical guidelines for prescribers and utilization review, and feedback to help clinicians identify outlier prescribing practices.²⁷³ Vital to the success of this program is the involvement of clinicians and pharmacists in a vertically integrated model of engagement and decision making through facility-level, Veterans Integrated Service Network (VISN)-level, and national-level PBM committees that contribute to formulary and clinical guideline decisions and manage utilization review with local clinicians.²⁷⁴ PBM also has a sophisticated web of communications, education, and engagement efforts to ensure clinical leaders across the system are helping drive PBM policy and practices.²⁷⁵ As a result, 90 percent of purchases are acquired through pharmaceutical prime vendor contracts.²⁷⁶

PBM, taking advantage of standardized industry nomenclature and bar codes for pharmaceuticals, has implemented automated dispensing, distribution, and ordering processes, including VA's Consolidated Mail Outpatient Pharmacy (CMOP).²⁷⁷ The use of CMOP, a system of seven highly automated pharmacies that process more than 460,000 prescriptions every work day, results in exceptional accuracy and lower processing costs than would result if filling prescriptions at each VAMC.²⁷⁸ Eighty percent of prescriptions in VHA are filled through CMOP,²⁷⁹ which has been recognized for the last 6 years as the best or one of the best mail order pharmacies in the country meeting or exceeding customer satisfaction scores of health care systems like Kaiser Permanente and on-line pharmacies like Express Scripts and Walgreens Online Pharmacy.²⁸⁰ Customer service, veteran satisfaction, and patient safety delivered through team-based care are a hallmark of the mission of PBM,²⁸¹ and are a useful reminder of the principles that must drive any successful transformation of supply chain management in VHA.

²⁷² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 19, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷³ *Ibid.*, 20.

²⁷⁴ VHA Formulary Management Process, VHA Handbook 1108.08 (2009).

²⁷⁵ Clinical Pharmacy Services, VHA Handbook 1108.11, 28-30 (2015). The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 32-34, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁷ *Ibid.*

²⁷⁸ "VA Mail Order Pharmacy," U.S. Department of Veterans Affairs, accessed April 29, 2016, http://www.pbm.va.gov/PBM/CMOP/VA_Mail_Order_Pharmacy.asp.

²⁷⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁸⁰ "U.S. Pharmacy Study – Mail Order (2015)," J.D. Power, accessed April 29, 2016, <http://www.jdpower.com/ratings/study/U.S.-Pharmacy-Study-Mail-Order/631ENG2>.

²⁸¹ "Pharmacy Benefits Management Services," U.S. Department of Veterans Affairs, accessed April 29, 2016, <http://www.pbm.va.gov/PBM/index.asp>.

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Analysis

VHA's supply chain for clinical supplies, medical devices, and related services is inadequate compared to the agency's pharmacy organization or to best practices in leading hospital systems.

*Its contracting processes are bureaucratic and slow, which can delay veterans access to care. Purchasing processes are cumbersome which has driven VHA staff to work arounds and exacerbates the variation in prices VA pays for products. Utilization is difficult to measure or manage given a lack of data which likely leads to significant avoidable expense for VA.*²⁸²

Leadership and Organizational Structure and Function

Best-in-class supply chain organizations typically have a single group responsible for the strategy, sourcing, procurement, and logistics of clinical supplies and medical devices. The organization is typically led by an executive-level leader, such as a chief supply chain officer (CSCO), and personnel are aligned along product categories to develop and use deep expertise in the products and suppliers they manage.²⁸³ In contrast, the organizational structure for contracting, logistics, and supply management in VA and VHA is complex and duplicative.²⁸⁴ Four contracting entities are located within VA central office but report to two different management offices within VA's office of acquisition, logistics, and construction (OALC).²⁸⁵ Procurement personnel within VHA's regional contracting and VISN offices report to VHA's national office of procurement. In contrast, facility-based and VISN logistics personnel report to their local VAMC or VISN director and not to the national VHA logistics office.²⁸⁶ To further complicate the management picture, clinical supplies are managed by the logistics organization, yet medical devices are managed by the Prosthetics and Sensory Aid Service (PSAS)²⁸⁷ (see Figure 5). In most health care organizations, the supply chain chief operating officer and their integrated supply chain group manages the procurement and distribution of all clinical supplies and medical devices.²⁸⁸ This is not the case in VA. Senior leaders in VA's and VHA's supply chain organizations and field-based supply chain personnel indicate current organizational structure is too complex and should be simplified.

*National supply chain leaders expressed lack of clarity regarding the scope of responsibilities of the entities for which they are responsible, which has led to some tension and what one leader described as a 'turf war.' Others described a vacuum of ownership and accountability, and lack of clarity on roles and responsibilities.*²⁸⁹

²⁸² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, v, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁸³ Ibid., 57-58.

²⁸⁴ Ibid., ix.

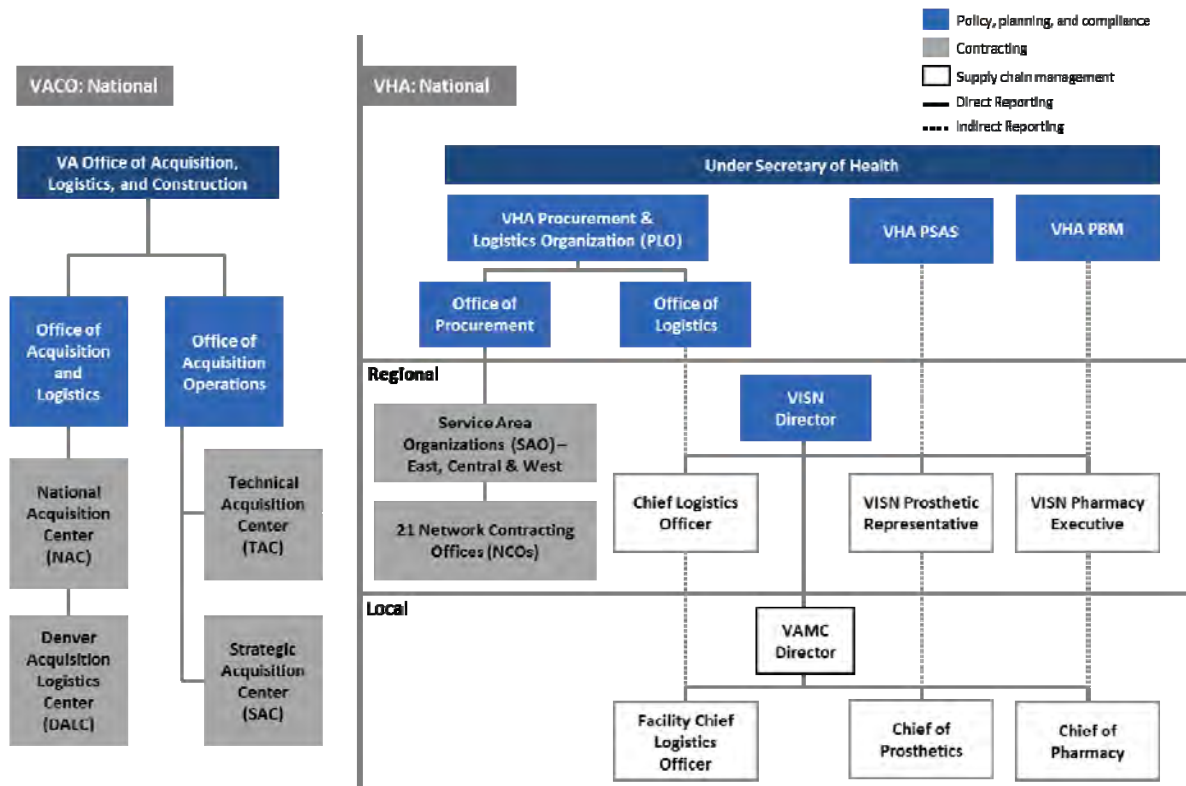
²⁸⁵ Ibid., 96-97.

²⁸⁶ Ibid., 47-50.

²⁸⁷ Ibid., 58.

²⁸⁸ Ibid.

²⁸⁹ Ibid., 55.

Figure 5. Organizations Comprising VA's Supply Chain²⁹⁰

Notes: Some VISNs may have different reporting relationships with facility prosthetics staff.

The separation of clinical supplies and prosthetics/medical devices causes issues in coordinating products needed for procedures. Frontline staff members indicate the time it takes to procure simple items through contracting (1 to 3 months) is problematic. For example, heart valve surgery may be delayed because some heart valves cost more than the micro-purchase threshold (\$3,000), thus the purchase must be made through the contracting process.²⁹¹ Medical center staff consistently expressed concern that VHA procurement offices are not responsive to the needs of a health care organization and do not communicate effectively with them,²⁹² findings borne out by low customer satisfaction scores given to these organizations.²⁹³

There is great overlap and redundancy in procurement and logistics functions in VA and VHA and the reporting structures are not aligned to ensure that the needs of veteran patients and their clinical providers are met. In an environment with limited sharing of best practices and a lack of transparent, open communications, the current complicated reporting structures impede customer-service quality and effectiveness. The original intent behind the current structure was to consolidate and strengthen purchasing power through the establishment of national contracts; however implementation of the vision has been poor and the result has been a

²⁹⁰ Ibid., 49.

²⁹¹ Ibid., 67.

²⁹² Ibid., 68.

²⁹³ Ibid., 69.

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complicated, bureaucratic system filled with redundancies.²⁹⁴ These broken processes serve as a precursor for catastrophic systems failures.²⁹⁵

There is an immediate need to consolidate and streamline procurement and logistics for medical and surgical supplies under one leader in VHA, the VHA chief supply chain officer (CSCO), who would be accountable for transforming VHA supply chain management. As identified under MyVA, medical and surgical supply chain management is the first priority but the rest of the supply chain needs to be addressed by the CSCO in a staged approach. The VERC or other experts in business process engineering must be engaged to create a vertically aligned organizational structure with clear delegated responsibilities at each level of the organization to create an efficient and responsive procurements and logistics process which the VHA CSCO would lead.

Clinical Engagement and Value Analysis

In contrast to pharmaceuticals, usage of clinical supplies and medical devices is not strictly monitored or managed in VA. In general, physicians and nurses can choose whichever products they believe are best for patients and the supply chain organization's role is to make those items available.²⁹⁶

VHA does not have a means to determine what supplies should be standardized or a feedback loop administrators and staff use to assess whether standards were being used when they did exist.²⁹⁷ As a result, limited product standardization has been achieved across VHA, despite VHA establishment of national standardization user groups in 2001 responsible for identifying items for standardization based on national procurement data.²⁹⁸ To date, national product standardization has been achieved in only a limited number of categories.²⁹⁹ Since 2011,

VHA required that medical centers establish Clinical Product Review Committees (CPRCs) to: (i) review and approve the use of new clinical items and reusable medical equipment (RME) at each medical center; (ii) maintain a list of approved expendable clinical supplies and RME by establishing and maintaining a Medical/Surgical Supply Formulary; and (iii) ensure compliance with nationally standardized contracts and blanket purchase agreements. In all sites visited, CPRCs exist and meet regularly but reviews were generally formalities.³⁰⁰

²⁹⁴ Ibid., 47-50.

²⁹⁵ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

²⁹⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 54, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁹⁷ Ibid., xii.

²⁹⁸ VHA Handbook 1761.1, Standardization of Supplies and Equipment Procedures, July 2003.

²⁹⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 81, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁰ Ibid., 82.

Under this 2011 policy, the establishment of VISN oversight committees was also required to provide accountability and feedback to the local committees, but these committees were apparently never established.³⁰¹

VHA, with the engagement of the Veterans Engineering Resource Center (VERC), is making progress on clinician alignment to accomplish value-based purchasing decisions for medical and surgical supplies. VERC has recently rolled out a national clinical product review committee (CPRC-E) e-portal to better organize this function. This portal provides a central system and standard processes for all new product requests and approvals to inform the procurement processes.³⁰²

In the area of medical and surgical supplies, clinician preference can drive variability in procurement and utilization. As has been done in VHA for pharmaceutical prescribing, a similar system to engage and align clinicians must be undertaken for medical devices and surgical supplies. VERC has started this process, but requires further funding and leadership support to fully implement a clinician-driven sourcing process. Current and future leaders of VA and VHA must ensure that VERC continues to receive the funding support and leadership engagement it needs to fully accomplish this transformation with support and direction from a VHA CSCO.

Information Technology, Data Standards, and Analytics

Information technology systems, data systems, and analytical capability for finance, inventory management, and purchasing impede VHA's ability to effectively manage its supply chain.³⁰³ VHA needs greater "end-to-end visibility into the operational and financial performance of their supply chain" and more effective means to accomplish supply chain budgeting, forecasting, inventory management and automation of at least some key supply chain functions.³⁰⁴

*VA lacks visibility into supplies and devices spending at the level of granularity usually seen in the private sector. For example, in the private sector, it is typically possible to measure clinical supply spend and utilization at the service, patient, or physician level. However, this is not possible in VHA because it does not capture such data. Therefore, supplies spend per case can only be calculated in aggregate, which is relatively meaningless and does not allow for fair comparison across hospitals, services, or physicians. This inhibits VA's ability to manage utilization and to understand fully the impact of product standardization efforts.*³⁰⁵

VERC is working to reduce the more than 130 versions of VistA in place across the country so that the same data sets can be tracked and reported.³⁰⁶ Funding was approved by OIT for the Future Transformation Tool (FTT) graphical user interface that will standardize product names

³⁰¹ Ibid., 54.

³⁰² Heather Woodward-Hagg, PhD, email to Commission on Care, March 17, 2016.

³⁰³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁴ Ibid.

³⁰⁵ Ibid., 60.

³⁰⁶ Ibid.

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and provide data integration across all of VHA. Point of Use Solution, a commercial off the shelf supply management software product, has been purchased to achieve better inventory and demand management control and has been deployed to 32 percent of facilities, as of April 2016.³⁰⁷

True sustainment of a clinician driven process cannot be achieved with fragmented information systems that do not communicate. Leaders at all levels of the organization are not able to effectively identify and manage procurement requirements or provide effective feedback to clinicians on utilization. Similarly, automated inventory control, ordering, billing, and payment cannot occur without a seamless information technology infrastructure. With a current IT system in which fiscal, supply chain, and clinical informatics systems do not interface, the hopes of moving to automated processes for supply ordering, equipment life cycle management, and vendor communications cannot be realized. A plan for the transformation of supply chain management, developed by a VHA CSCO with support from VERC, must be fully integrated with planning and procurement within OI&T and fully financed to accomplish these important goals.

Policy and Procedures

Ninety-eight percent of all clinical supplies are acquired using purchase cards³⁰⁸ and 75 percent of what VHA spends on clinical supplies is made through this purchase mechanism.³⁰⁹ This is not a surprise given that the standard contracting process can take anywhere from 150 to 180 days to complete,³¹⁰ yet use of purchase cards is inefficient as this mechanism does not take advantage of economies of scale and potential cost savings an organization the size of VHA can achieve through price negotiations and strategic sourcing.³¹¹ It can also be contrary to law, as use of purchase cards often necessitates orders be split to remain under the \$3,000 purchase card limit.³¹² An analysis of purchase records showed that 38 percent of supply orders were made through standing vendor contracts which is in stark contrast to the private sector benchmark of aiming to complete 80-90 percent of supply purchases from master contracts with negotiated price discounts.³¹³ Indeed, the private sector trend in health care has been for hospitals and health care systems to form alliances in “group purchasing organizations” to achieve the scale that VHA naturally enjoys.³¹⁴ Weaknesses in logistic management have been recognized in VHA for some time and still remain.³¹⁵ For instance, a review of logistics business

³⁰⁷ Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.

³⁰⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁹ Ibid., xii.

³¹⁰ Ibid., x.

³¹¹ U.S. Government Accountability Office, *Strategic Sourcing: Improved and Expanded Use Could Save Billions in Annual Procurement Costs*, accessed April 28, 2016, <http://www.gao.gov/assets/650/648644.pdf>.

³¹² U.S. Department of Veterans Affairs, Office of Inspector General, *Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System*, accessed April 28, 2016, <http://www.va.gov/oig/pubs/VAOIG-11-00826-261.pdf>.

³¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xii, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³¹⁴ Bob Kehoe, “Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness,” *Health Facility Management Magazine*, 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.

³¹⁵ U.S. Government Accountability Office, *Veteran’s Health Care: VHA Has Taken Steps to Address Deficiencies in Its Logistics Program, but Significant Concerns Remain*, accessed April 28, 2016, <http://www.gao.gov/assets/660/653886.pdf>.

practices at 17 VHA medical facilities in 2014 showed that none of the facilities achieved 100 percent compliance on the factors assessed, and the rate of noncompliance ranged from 53 to 88 percent, depending on the business metrics examined.³¹⁶

VA is inhibited by a failure to update its acquisition regulations to take advantage of modernization made in 2014 to the governmentwide regulations to promote simplified purchasing procedures.³¹⁷

VERC initiatives to improve VHA supply chain are intended to standardize business processes and address the great price variations for the purchasing of medical and surgical supplies. A national medical surgical prime vendor (MSPV) contract has been established. This development has several advantages to include (a) increased ability to leverage pricing negotiations; (b) standardized pricing; (c) elimination of redundant contract development, bidding, and selection; and (d) future ability to integrate with CPRC E-Portal.³¹⁸ VA has established a goal for 85 percent of all orders in FY 2016 be made under the prime vendor contract and has made 1,100 contracting officers available to meet demand against the contract.³¹⁹ As of April 2016, an estimated \$24.4 million in supply chain costs had already been avoided since January.³²⁰

The establishment of a new MSVP contract in April 2016, the assignment of 1,100 staff to support its use, and the expectation communicated to the field that 85 percent of all purchases be made from the contract are important steps in the right direction. For efficient ordering processes to take hold and be sustained across VHA, all of the policies and procedures from the bedside (or surgical suite) to the head contracting office must be reworked to align with the desired business outcomes. Reworking policies and procedures must occur together with appropriate training and communication at all levels of the organization. Each staff member involved in the procurement process must be held accountable for meeting the new requirements and expectations assigned to them. Updating the VA Acquisition Regulation (VAAR) is just one small piece of such a transformational change. The VERC or others with appropriate experience in aligning business processes within government should be assigned responsibility to finish developing and implementing plans for such a transformation under the direction of a VHA CSCO.

Contracting

Analysis of the *Independent Assessment Report* confirmed issues with the responsiveness of contracting. For example, at one facility, if a request was submitted to contracting that was incomplete or inaccurate, it took on average 21 to 39 days from the date of initial submission to

³¹⁶ U.S. Department of Veterans Affairs, *VA Supply Chain News*, Issue 13, Jan/Feb 2015.

³¹⁷ Jonathan Miller, Director of Logistics Operations, VHA Procurement & Logistics Office, phone call with Commission on Care, December 9, 2015.

³¹⁸ Heather Woodward-Hagg, PhD, Acting Director, Veterans Engineering Resource Center, phone call with Commission on Care, March 18, 2016.

³¹⁹ Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.

³²⁰ Ibid.

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receive the first response from contracting requesting, for example, additional information or paperwork.³²¹ This problem appears to be a widespread.

In another instance, interviews conducted as part of the independent assessment showed that VA vendor contracting processes to order equipment valued at less than \$3,000, for example, scalars for dentistry, can be confusing and lengthy, leading to shortages in equipment and delays in clinic as equipment is located. Delays in sterile processing were also indicated by providers as an issue pertaining to equipment availability.³²²

Communication with contracting is another substantial challenge within VHA. In surveys that assessed the effectiveness of VA's contracting organization, VHA employees' customers rated the communications received from contracting officials the lowest of all contracting dimensions that were evaluated.³²³ Several interviewees recommended that VA provide more clarity on the status of contracting requests to help them plan and schedule care.³²⁴

Individuals in contracting believed that VAMC staff members were responsible for some of the delays in the contracting process. They reported that requests submitted to them from VAMCs were often incomplete or unclear and that facilities were poor at forecasting demand for items, leading to unpredictable peaks in demand for contracting services that exceeded their capacity. The VHA Procurement and Logistics Organization (PLO) and facilities are seeking to address these challenges by placing contract liaisons in facilities to better support contracting officer representatives throughout the process.³²⁵

Contracting compliance analysis showed substantial opportunity for improvement. Analysis of purchase order data showed that 38 percent of purchases were made on a government contract, 27 percent were made at open-market prices, and 34 percent did not have a source type specified.³²⁶ Private-sector organizations typically aim to buy 80 to 90 percent of their clinical supplies and medical devices on some type of negotiated contract.³²⁷

Interviews and observations undertaken as part of the independent assessment revealed that there are two primary reasons for VHA's relatively high share of open-market purchasing. First, in contrast to pharmaceutical purchasing, VHA's supply purchasing systems are not integrated

³²¹ The consulting team based this on an IFCAP/eCMS transmission log received during a VAMC site visit (2015). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²² Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 91, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

³²³ The consulting team derived this from a VHA procurement metrics book. McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 69, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²⁴ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²⁵ Ibid.

³²⁶ Ibid., xii.

³²⁷ Ibid.

with contract or pricing catalogs. Therefore, the purchasing process relies on buyers (often clinical staff) to research whether an item is on contract and through which contract a purchase should be made. Because of that complexity, several buyers reported that they bypass this step and buy products through the channel that is most familiar and convenient, for example, by replicating previous orders to their usual supplier, despite changes that may have occurred (new contracts and pricing arrangements, for example). Second, VHA has limited ability to monitor and drive compliance with the contract hierarchy because the required data are not captured electronically. In fact, more than 60 percent of all clinical supply items do not have a contract number listed.³²⁸

VHA's fragmented inventory management systems and processes also create challenges. VHA's current inventory management does not have a feedback loop to link inventory to product use, contracting, ordering, and vice versa. This lacking information prevents optimal use of the MSPV contract program and creates missed opportunities to establish more effective volume-based national or regional contracts. It also leads to peaks and troughs in demand for contracting services, which can overwhelm contracting's capacity.³²⁹

There are pockets of good performance and innovation in VHA that could be replicated across its supply chain. The *Independent Assessment Report* notes that the Denver Acquisition and Logistics Center (DALC) is a bright spot within VHA's supply chain organization in its acquisition and distribution of select devices such as hearing aids to veterans. It has developed an integrated operating model that brings together clinicians, contracting, finance, logistics, and program management. That integrated team makes decisions around product and supplier selection based on a holistic view of what is best for veterans and for VHA.³³⁰

Talent Management

VHA is unable to hire good talent to manage its supply chain. In 2014, 20 to 30 percent of logistics positions were unfilled, and 20 percent of medical supply aide jobs were vacant.³³¹ The causes were identified as lengthy time-to-hire, nonexistent internal career progression ladders for these individuals, and inability to provide competitive pay due to position downgrades made by OPM under Title 5.³³² Examples of recent downgrades include supply technician, mail manager, administrative officer, and materials handler.³³³

*It is well known in the health care industry that there is a shortage of supply chain talent currently. The private sector organizations interviewed during this assessment stated that they are recruiting more highly trained individuals than they did in the past and, because of competition for talent, are paying them more than they used to. This may be contributing to VHA's recruitment and retention challenges.*³³⁴

In Recommendation #15, the application of the more than 60-year old standards and processes used in the Title 5 personnel system does not serve the needs of a modern health care delivery

³²⁸ Ibid.

³²⁹ Ibid.

³³⁰ Ibid., xiii.

³³¹ Ibid.

³³² Ibid.

³³³ Ibid., 87.

³³⁴ Ibid., 88.

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organization. Health care supply chain management is a recognized field of study and a valued component of leadership teams at the highest performing health care organizations. For VHA to compete for top leadership talent in this field and frontline staff, logistics and procurement personnel must be included in a new excepted personnel system for VHA under Title 38 (see Recommendation #15).

To address talent management issues, VERC has established a new VA Acquisition Academy (VAAA) Supply Chain Management School.

*The mission of the Supply Chain Management School is to provide best-in-class education, training, professional development, and certification of the VA supply chain workforce. VAAA's competency-based curriculum addresses general and technical skills, VA-specific functional areas, and core activities for VA logistics professionals. Emphasis is on translating theory, fundamentals, and concepts to practical application with realistic VA-based scenarios utilizing hands-on application of problem-solving skills.*³³⁵

The supply chain management school is organized under VAAA which has been recognized by external organizations to offer high quality training.³³⁶

Implementation

Legislative Changes

- Establish a new excepted personnel system under Title 38 to permit VHA to compete effectively with the private sector for personnel required to run a complex health care system, including staff to manage and operate a modern supply chain system.

VA Administrative Changes

- Establish an executive position for supply chain management, a VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- Transform policy and procedures for supply chain management in parallel with identification and procurement of new management software: new software should support the new processes and not the existing, poorly organized business processes and requirements.
- Establish a staged process for the transformation of all supply chain operations in VHA under the direction of a VHA CSCO, with support from VERC.
- Reconcile the VAAR with the Federal Acquisition Regulation (FAR) to ensure the VAAR aligns with recent updates to the FAR to permit streamlined acquisition processes.
- Provide consistent and standardized training to ensure those developing and administering contracts have updated information regarding FAR and VAAR

³³⁵ "Message from the Vice Chancellor," Veterans Affairs Acquisition Academy, accessed April 28, 2016, <http://www.acquisitionacademy.va.gov/schools/scm/message.asp>.

³³⁶ "VA Acquisition Academy Recognized as a 2016 Learning Elite Organization," U.S. Department of Veterans Affairs, accessed May 13, 2016, <http://www.acquisitionacademy.va.gov/rss/index.xml#20160413b>.

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regulations as well as a thorough understanding of their responsibilities under the new approach to supply chain management and how to carry out these duties.

Other Department and Agency Administrative Changes

- None required.

Governance, Leadership, and Workforce

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

Problem

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center (VAMC), and similar problems at multiple other VAMCs, had both direct and indirect causes. Weak governance was found to be among those indirect causes.³³⁷ As the authors of a root-cause analysis of the Phoenix scandal highlighted, “a governance gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed to the wait-time problems.³³⁸ The report authors observed, “Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors.”³³⁹ The governance limitations made evident in the Phoenix scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration’s expectations for short-term results,³⁴⁰ and VHA’s operating in a “dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act and be structured based on the key elements included in Table 5.
- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term to allow for continuity and to protect the CVCS from political transition. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

³³⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³³⁸ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.

³³⁹ Ibid.

³⁴⁰ Ibid.

competing demands”³⁴¹ offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

Background

VHA, as an agency within a cabinet department, is accountable to the secretary of Veterans Affairs (SECVA) and to the President. This framework, when it works well, can provide VHA access to, and support from, the President and White House staff. Like other executive branch agencies, VA and VHA undergo Office of Management and Budget (OMB) oversight; must win OMB approval of proposed rulemaking, budgets, IT development, and performance plans; and are also subject to governmentwide regulation of such areas as procurement, personnel, and property management. VHA health care and operations are subject to close congressional scrutiny.³⁴² VHA undergoes oversight from several independent bodies, including the internal Office of the Inspector General audits and external Government Accountability Office audits.

Within VA, VHA participates in the VA Executive Board (VAEB) and Senior Review Group, which are designated as the principal governance bodies of the department.³⁴³ VAEB serves as the department’s risk-governance board and determines VA’s strategic direction. VAEB oversees the department’s planning, programming, budgeting, and execution. Notwithstanding certain strengths inherent in this framework, VHA governance can be paralyzed by bureaucratic decision-making processes and competing stakeholder concerns.³⁴⁴

Among its principal recommendations, the *Independent Assessment Report* calls for “establishing a governance board to develop fundamental policy, define the strategic direction, insulate VHA leadership from direct political intervention, and ensure accountability for the achievement of established performance measures.”³⁴⁵

Analysis

In recent years, VHA leadership priorities and strategic direction have been unclear. Leaders have been consumed by crisis and by responding to congressional demands, creating a reactive, rather than proactive environment.³⁴⁶ Additionally, the leadership vision has lacked continuity.³⁴⁷ The SECVA and deputy secretary of Veterans Affairs may exercise oversight of

³⁴¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³⁴² “Legislation,” U.S. House of Representatives, House Committee on Veterans’ Affairs, accessed June 15, 2016, http://veterans.house.gov/legislation?type=hearing&tid=All&tid_1=All&page=3. Over the course of calendar year 2015, the House Veterans Affairs Committee and its subcommittees alone held 18 oversight hearings relating to the Veterans Health Administration, with VHA and/or VA officials testifying as often as three times in a month.

³⁴³ Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014).

³⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 26, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³⁴⁵ *Ibid.*, 23.

³⁴⁶ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 52-54.

³⁴⁷ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, vi-viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Linda Belton, former VHA VISN Director and Director of National Center for Organizational Development, written submission to the Commission on Care Staff, January 19, 2016.

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VHA and try to impose accountability, but incumbents do not necessarily have experience in federal health care administration or delivery.³⁴⁸ The SECVA has often lacked independent information and metrics on VHA performance, and the oversight, risk management, and compliance functions of VHA report to the undersecretary for health (USH) or to lower officials in VHA.³⁴⁹

Previous studies, dating back 20 years,³⁵⁰ have proposed fundamental change in VHA's governance and government structure, to include a proposal that it be restructured as a government corporation.³⁵¹ The earliest rationale for making VHA a government corporation was based on the view that the system needed a new service-delivery strategy,³⁵² and envisioned specific legislation to permit the corporation to operate more expansively under a wide range of reforms.³⁵³ Although the authors of the 1996 report presented a VHA government

³⁴⁸ Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Under Secretary of Health, 38 U.S.C. § 305. While statute requires the USH of VHA to be appointed “solely on the basis of demonstrated ability in the medical profession, in health-care administration and policy formulation, or in health-care fiscal management; and on the basis of substantial experience in connection with the programs of the Veterans Health Administration or programs of similar content and scope” there is no such selection criteria for the VA Secretary or VA Deputy Secretary. Of the eight men to hold the position of Secretary of Veterans Affairs, only one, James Peake would qualify to be USH (“United States Secretary of Veterans Affairs,” Wikipedia, accessed June 15, 2016, https://en.wikipedia.org/wiki/United_States_Secretary_of_Veterans_Affairs#List_of_Secretaries_of_Veterans_Affairs) and of the six men to hold the position of DEPSECVA, none would qualify to be USH.

³⁴⁹ Department of Veterans Affairs, *2014 Functional Organizational Manual v2.0: Description of Organization Structure, Missions, Functions, Tasks, and Authorities*, 57-58, accessed June 15, 2016, http://www.va.gov/ofcadmin/docs/va_functional_organization_manual_version_2.0a.pdf.

³⁵⁰ Veterans Benefits Improvement Act of 1994, Pub. L. No. 103-446, 108 Stat. 4645 (1994). In 1994, Congress in sec. 1104 of Public Law 103-446 called for an independent examination of the justifiability of establishing an alternative government structure to provide health care services for veterans, culminating in the 1996 report.

³⁵¹ Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. A government corporation has been described as “a government agency that is established by Congress to provide a market-oriented public service and to produce revenues that meet or approximate its expenditures.” Kevin R. Kosar, Congressional Research Service, *Federal Government Corporations: An Overview*, 2, accessed June 15, 2016, <https://fas.org/sgp/crs/misc/RL30365.pdf>. Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report* September 22, 2015. Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce*, accessed June 15, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>. Commission on the Future for America's Veterans, *Preparing for the Next Generation*, 3, accessed June 15, 2016, http://s3.amazonaws.com/siteninja/site-ninja1-com/1438121489/original/2014-05_Commission-Report-on-America-Veterans.pdf. That task force study, for example, called for an independent governance model and stated that “the operational structure of VHA does not lend itself to progress. Due to its size, governmental structure and geographic extension it does not readily foster innovation and faces challenges in addressing the politics of changing demographics and ancient facilities.” The study report states, “VHA provides excellence in care in spite of its operations/governance structure, not because of it.”

³⁵² Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. The strategy was premised in part on the view that VHA would be operating in a resource-constrained environment and lacked the resources it would need to invest in making significant changes.

³⁵³ Ibid. The 1996 report proposed such measures as providing VHA authority to seek additional revenue streams, to include billing and keeping funds from Medicare, Medicaid, and other government sources; authorizing it to invest nonappropriated funds; developing a trust fund for deposit of Medicare taxes by active-duty personnel; incorporating VHA as a Federal Employee Health Benefits Plan selection; allowing it to become part of health maintenance organization (HMO) networks and open HMO enrollment to veterans; changing appropriation law to create

corporation as a means of achieving specific objectives, those objectives were largely met (though ultimately not fully sustained) by reforms within existing government structures and processes set in place by former USH Kenneth W. Kizer.³⁵⁴

Nearly 20 years later, the report analyzing the root causes of delayed care at the Phoenix and other VA centers proposed creation of “governance mechanisms to bridge ‘Secretary suite’ leadership transitions and provide more stable strategy, oversight, and stewardship.”³⁵⁵ Explaining that “the study team feels that the complexity of this organization requires a more stable and professionalized governance model that more closely resembles the governance of large health care systems in the private sector,”³⁵⁶ the study authors proposed the creation of a board-of-directors-type oversight board to set the strategy for the organization, define priorities, provide operational oversight, and review budget requests. “The board would . . . create a body that would be the steward of the organizational vision, providing institutional memory and continuity as senior political appointees transition.”³⁵⁷

Frequent turnover of the USH is a critical problem. Recently, each USH has served for only a relatively short period, leaving office with a change in administration or sooner. This pattern has deprived VHA of vitally needed sustained leadership and has likely contributed to short-term decision making. VHA history shows a connection between longer tenure and transformative accomplishment.³⁵⁸ As testimony to the Commission from three former USHs would indicate, brevity of tenure tends to limit leaders’ strategic horizon and create a pattern of leadership discontinuity. Because transformative change can only be realized through many years of focused leadership, VHA and those who depend on it cannot afford the senior leadership turnover routinely associated with a change in administration.

The complex, sustainable transformation VHA needs will take years to implement. To succeed, VHA needs strong, consistent leadership and a governance framework that can assure effective development and execution of transformation plans over time. The current governance structure emphasizes operational, rather than strategic priorities; experience has shown it to be incapable of sustaining transformational change. Establishing a well-designed, overarching-governance model would provide an opportunity to achieve objectives shared by both the executive and legislative branches.

To be effective, a VHA Care System governance model should be empowered with a governing board that exercises fiduciary-like responsibilities (not subject to the Federal Advisory Committee Act) to carry out the following key functions:

multiyear/no-year appropriations; reforming human resources management practices for increased flexibility in hiring and firing, compensation, leave, and other functions; and reforming; and reforming procurement and contracting.

³⁵⁴ Ibid., 46, 48. The Klemm report saw a VHA corporation as having greater capacity to focus on strategic as well as short term goals; greater results orientation; greater flexibility; greater capacity to replicate and develop best practices; upgraded staff competence and expertise at senior levels; and greater political independence.

³⁵⁵ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 59.

³⁵⁶ Ibid.

³⁵⁷ Ibid.

³⁵⁸ See Dr. William S. Middleton, Chief Medical Director (1955-1963) and Dr. Kenneth W. Kizer, Under Secretary for Health (1994-1999).

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- select the chief of VHA Care System (CVCS) and recommend the appointment of the CVCS to the President
- provide long-term, strategic direction for VHA Care System and establish priorities, milestones, and timelines
- oversee, direct, and make critical decisions regarding the transformation process
- review and approve major operational, business, and organizational plans
- set VHA Care System performance objectives and provide annual reports to Congress and the President on VHA Care System performance
- review and make decisions regarding VHA's budget request, and independently assess and report to Congress on the adequacy of VHA budgets

New governance and changes to assure continuity of leadership are critical to meeting the needs of VHA and veterans who depend on it. At the core of this foundational recommendation, the Commission calls for establishing a VHA board of directors,³⁵⁹ referred to as the VHA Care System governing board, which is independent of department leadership to provide governance, strategic direction, decision making, and oversight of VHA Care System's operations and transformation. Table 5 provides details regarding the governing board.

Table 5. Overview of VHA Care System Governing Board

Detailed Outline for VHA Care System Governing Board	
Voting Members	The President, the majority leader of the Senate, speaker of the House, the minority leaders of the Senate and House would each appoint two members. In addition, the SECVA would serve on the Board as a voting member.
Qualifications	Members would be selected to achieve collectively broad experience, expertise, and leadership, such as experience in senior management of large, private, integrated health care systems; clinical expertise; extensive experience with federal government health care systems; extensive experience with (though not current employment in) VHA; expertise in federal medical facility construction and leasing, and commercial property transactions; expertise in government contracting; expertise in federal health care budgeting and finance; expertise in health equity and disparities; and veterans' representation. Because of the importance of veterans' representation, at least one of each congressional leader's two appointees would be a veteran; at least one of the appointees of the President would be a veteran who receives VHA care.

³⁵⁹ Michael A. Froomkin, "Reinventing the Government Corporation," *University of Illinois Law Review*, (1995): 543, accessed June 15, 2016, <http://osaka.law.miami.edu/~froomkin/articles/reinvent.htm>. Congress need not create a government corporation to meet VHA's governance needs. The Commission notes that Congress has created entities it has called government corporations that are not predominantly commercial enterprises, rely on appropriations, and do not have the potential to become self-sustaining. A principal intention behind assigning this status and title has been to provide insulation from central management oversight agencies and the application of general management laws. When the corporation relies in whole or in part on appropriations, Congress retains the power of the purse, and the means of exercising it on matters large and small, and through formal and informal means.

Detailed Outline for VHA Care System Governing Board	
Terms	Governing board members would serve staggered terms of up to 7 years, with the governing board members electing a chair and vice chair from among the membership (other than the SECVA, who would not be eligible to serve as the chair) for 3-year terms.
Personnel Matters	Compensation would be at a rate equal to the daily equivalent of annual pay prescribed for level IV of the executive level. ³⁶⁰
Funding	Congress would provide a specific budget for the operation of the governing board as a separate account within VA's appropriations.
Relationship to the CVCS	Relationship to the CVCS: The governing board would provide the President its recommendation for a chief of VHA Care System (CVCS); the President would appoint that executive to a 5-year term; the governing board would annually review the CVCS's performance and be empowered to reappoint that official to a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. The CVCS can be removed by mutual agreement of the President and the governing board.
Staff	The chairperson would determine the size and compensation of the permanent staff of the board, including an executive director responsible for governing board operations and a chief of staff. The director of the proposed transformation office within VHA would report to the chairperson through the CVCS.
Powers	<p>The board would have the power to do the following:</p> <ul style="list-style-type: none"> ▪ Select the CVCS and recommend the candidate to the President. ▪ Review the performance of the CVCS on an annual basis. ▪ Reappoint the CVCS to a second 5-year term. ▪ Remove the CVCS with the mutual agreement of the President. ▪ Direct and exercise decision-making authority regarding the transformation process and operations related to the transformation process. ▪ Establish priorities, milestones, and timelines for the transition process. ▪ Review and approve major new initiatives; major operational and organizational plans (including plans regarding capital asset and facility management); strategic and business plans; and goals and metrics for operational performance and established priorities. ▪ Oversee and manage facility and capital asset strategies and operations. ▪ Review, approve, and/or amend VHA's budget requests, and independently assess and comment on pertinent elements of the President's budget, as deemed appropriate.
Reporting	The board would report annually to the President and Congress on VHA's progress toward transformation.

Navigating transformation of one of the largest agencies in the federal government requires not only extraordinary leadership, but steady, sustained, long-range-focused governance. A governing board structured to provide continuity of membership—as the Commission proposes through staggered terms among members—is vital. A second critical step toward assuring such continuity would be to address the tenure of the CVCS and the process for selecting candidates for that position.³⁶¹ VHA, Congress, and the President would be better served by a VHA leader who holds a 5-year term of office, with the governing board empowered to reappoint that leader to a second 5-year term.

³⁶⁰ The rate of compensation provided for members of the Commission on Care.

³⁶¹ Under Secretary of Health, 38 U.S.C. § 305. Current law provides that the Under Secretary is appointed by the President with the advice and consent of the Senate. When a vacancy in that position occurs or is anticipated, the Secretary is to convene a commission (the composition of which is set forth in the statute) which is to recommend at least three individuals to the Secretary, who is to forward those names, with any comments the Secretary considers appropriate, to the President.

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It is important that that the CVCS report to the board and function as a chief executive officer of VHA. Although the Commission envisions that the President would appoint this official, it is critical that the governing board be empowered to recommend to the President an individual for appointment when the office becomes vacant. This would replace the framework in current law that requires the establishment of a new commission convened solely to carry out the task of recommending candidates to the President.³⁶²

A governing board must be tailored to the unique needs of VHA.³⁶³ It should include members of appropriate expertise and experience to provide strategic guidance and continuity of leadership and it should possess authority to exercise the powers needed to realize and sustain a VHA transformation.³⁶⁴

Although some might consider Congress to be VA or VHA's board of directors and might question the appropriateness of establishing a VHA board of directors, this governance model does not diminish Congress's role. Instead, a board that would report periodically to congressional committees would provide a level of close oversight and health care expertise that would complement, and in many ways enhance, Congress's work.

A change in governance alone will not bring about successful transformation. This recommendation must be instituted in concert with many other Commission recommendations. For example, a board will require data, and data systems, to carry out its responsibilities, and establishing these and other appropriate systems, as addressed throughout this report, is key to empowering a board to drive and sustain transformation.

Implementation

Legislative Changes

- Amend 38 U.S.C., Chapter 3 to establish a VHA Care System governing board.
 - Amend 38 U.S.C. § 305 – which currently provides in subsection (a) for the President to appoint the USH by and with the advice and consent of the Senate, and subsection (c) for the establishment of a commission to provide recommendations for appointees for USH when a vacancy is expected or has occurred – as follows:
 - Amend subsection (a) to provide for the President to appoint the CVCS to a 5-year term of office.
 - Repeal subsection (c) of that section.
 - Provide instead for the governing board to recommend a CVSC candidate.
 - Authorize the governing board to reappoint the CVSC to a second 5-year term.

VA Administrative Changes

- None required.

³⁶² Under Secretary of Health, 38 U.S.C. § 305.

³⁶³ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 60.

³⁶⁴ The Board is not an advisory body, and as such would not be subject to the Federal Advisory Committee Act.

Other Departments and Agency Administrative Changes

- None required.

Leadership

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

Problem

High-performing organizations have healthy cultures in which diverse staff members feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government.³⁶⁵ For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

The Commission Recommends That . . .

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report to the chief of the VHA Care System and the new VHA Care System governing board (also included in Recommendation #12).

Background

Healthy organizations successfully align, execute, and renew themselves through learning and innovation.³⁶⁶ They are characterized by a high level of trust, accountability, and ownership among staff; high functioning, empowered teams; and an environment that provides psychological safety and open communication, focuses on the needs of customers, and instills pride in performance.³⁶⁷ An inclusive workplace where diversity is valued, staff feel empowered and supported, are treated with fairness, and cooperation and open communication helps engage employees and drive organizational performance.³⁶⁸ Engaged

³⁶⁵ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 56, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

³⁶⁶ "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, <http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage>.

³⁶⁷ [http://organizationalhealth.vssc.med.va.gov/Resource percent20Library/Forms/AllItems.aspx](http://organizationalhealth.vssc.med.va.gov/Resource%20Library/Forms/AllItems.aspx)

³⁶⁸ "Diversity & Inclusion; Federal Workforce At-A-Glance," U.S. Office of Personnel Management, accessed May 13, 2016, <https://www.opm.gov/policy-data-oversight/diversity-and-inclusion/federal-workforce-at-a-glance/>.

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employees who are dedicated to their work and attached to the organization and its mission support a healthy organization.³⁶⁹

Companies that have a healthy organizational culture or engaged staff outperform those that do not. Companies that score in the top 25 percent of organizational health metrics outperform comparable companies in the bottom 25 percent by more than two-fold.³⁷⁰ Similarly, high employee engagement is correlated with better staff and customer experiences that include higher patient satisfaction, higher staff retention, better safety and quality, higher productivity and lower absenteeism.³⁷¹ Companies with engaged employees outperform those without by more than 200 percent.³⁷² Leaders and supervisors play a key role in establishing and sustaining employee engagement and in establishing a positive environment and culture that supports a healthy organization.³⁷³

Analysis

VHA staff and leaders are highly dedicated to the mission of VA and to serving veterans.³⁷⁴ This dedication is arguably VHA's greatest strength, and it can be leveraged to create and sustain positive change.³⁷⁵ There are substantial impediments to moving VHA forward, however, as noted in the *Independent Assessment Report*. There is a pervasive lack of trust throughout the organization.³⁷⁶ Staff perceives VHA to be bureaucratic and political and to lack a systems orientation.³⁷⁷ Employees want to work for an organization that is accountable and efficient, but instead they operate in a bureaucratic, siloed, and political organization.³⁷⁸ The culture creates risk aversion in staff, and when cultural factors are measured in VHA, none of the metrics align with the definition of a healthy organization.³⁷⁹ Staff find the work environment at VA challenging, with no connection to leadership, and feel they receive little positive

³⁶⁹ U.S. Office of Personnel Management, *Strategic Plan FY2014-2018: Recruit, Retain, and Honor*, 22, accessed January 25, 2016, <https://www.opm.gov/about-us/budget-performance/strategic-plans/2014-2018-strategic-plan.pdf>. Office of Management and Budget, *Memorandum for Heads of Executive Departments and Agencies: Strengthening Employee Engagement and Organizational Performance*, M-15-04, December 23, 2014, accessed May 16, 2016, <https://www.whitehouse.gov/sites/default/files/omb/memoranda/2015/m-15-04.pdf>.

³⁷⁰ "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, <http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage>.

³⁷¹ U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015, 4. Melissa Bottrell, *Ethics Quality Helps Build Healthy Organizations*, VHA Organizational Health, Volume 19, Summer 2013, 4-5, accessed January 25, 2016, http://www.ethics.va.gov/docs/integratedethics/art_bottrell_orghealth_v19_2013.pdf.

³⁷² U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015, 4. Dee Ramsel, Improving VHA's Culture: A Presentation Before the National Leadership Council, Veterans Health Administration, December 2015, 7-9. U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change*, 6, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.

³⁷³ Dee Ramsel, "Improving VHA's Culture. A Presentation Before the National Leadership Council, Veterans Health Administration," December 2015, 7-9.

³⁷⁴ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 43, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

³⁷⁵ *Ibid.*, 44.

³⁷⁶ *Ibid.*, 47.

³⁷⁷ *Ibid.*, 46.

³⁷⁸ *Ibid.*, 46.

³⁷⁹ *Ibid.*, 49-51.

reinforcement or clear feedback on performance.³⁸⁰ As demonstrated in the Federal Employee Viewpoint Survey for 2015, VHA staff does not believe top leaders lead (only 47 percent positive³⁸¹) and only 65 percent have a positive view of their immediate supervisor compared to 70 percent in other large federal agencies.³⁸²

Through the review of available documents and briefings from key staff, the Commission found VA and VHA have a number of activities intended to support a positive environment and culture in VHA (see Table 6), but the efforts are not systematic, integrated, or broadly deployed.³⁸³ The efforts are under-resourced to achieve success. Specifically, the effort lacks mandatory positions at the facilities to lead these efforts and has no requirements on the VHA Central Office (VHACO) program offices to participate in the efforts.³⁸⁴ At the same time, the efforts are duplicative in that multiple offices communicate similar, but distinct messages to field staff and leaders. VHA appears to lack systematic mechanisms to ensure leaders at all levels of the organization have the knowledge, skills, and ability to create an effective culture; metrics are not comprehensive or aligned with a single-change model; and leaders in VHACO and the field are not consistently held accountable for their actions in support of a positive organizational culture.³⁸⁵

*Table 6. Cultural Transformation Efforts in VA and VHA*³⁸⁶

Program/Initiative	Responsible Office
Servant Leadership	VHA National Center for Organizational Development
Leaders Developing Leaders	MyVA
Just Culture	VHA National Center for Patient Safety
Civility, Respect, and Engagement in the Workplace (CREW)	VHA National Center for Organizational Development
Organizational Transformation Pilot	MyVA
Employee Engagement Playbooks	MyVA
VHA Voices	VHA Office of Patient Centered Care and Cultural Transformation

³⁸⁰ Ibid., 53 and 60.

³⁸¹ U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change*, 47, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.

³⁸² Ibid.

³⁸³ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 29-31. Dee Ramsel, Virginia Ashby Sharpe, Veterans Health Administration, conference call with staff of the Commission on Care, November 9, 2015.

³⁸⁴ See “Ethical Leadership, Fostering an Ethical Environment and Culture,” National Center for Ethics in Health Care, U.S. Department of Veterans Affairs, accessed June 22, 2016, <http://www.ethics.va.gov/integratedethics/elc.asp>. “Stop the Line for Patient Safety Initiative,” U.S. Department of Veterans Affairs, accessed June 22, 2016, <http://www.qualityandsafety.va.gov/StoptheLine/StoptheLine.asp>. “VHA Center for Organizational Development,” U.S. Department of Veterans Affairs, accessed from VA Intranet, May 16, 2016, http://vaww.va.gov/NCOD/Organizational_Health.asp. U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015.

³⁸⁵ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 13-14. Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan, Network Director and Medical Center Director*, November 20, 2015.

³⁸⁶ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 29-31.

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VHA must rebuild a high-performing, healthy culture by cultivating greater employee collaboration, ownership, and accountability to accomplish its mission.³⁸⁷ This cultural transformation needs to occur at all levels of the organization (VA, VHACO, veterans integrated service network [VISN], VA medical center, and community-based outpatient clinic). To achieve transformation in VHA, create a healthy environment and culture, and sustain staff engagement, the solution must start with leaders. Leaders must understand and believe in the powerful effect they have on the climate and culture in their organization. Change occurs one employee at a time. Leaders at all levels must commit to this change process. They must be inspired by top executives and embrace the values and mission of VHA and then, in turn, inspire their teams, engaging with individual employees to make change. Leaders must be given the roadmap and tools to make such change and then be supported with training, coaching, and feedback to achieve success. They must also be held accountable for their personal behavior and for the actions they take to positively influence the environment and culture of their unit or facility. Leaders should not be on their own in this transformation. Fellow leaders, outside experts, national program offices, and VA and VHA top executives must provide them with incentives, support, feedback, coaching, and, when needed, admonishment to support this cultural transformation.

To align leaders at all levels with expectations for the cultural transformation, all leaders must understand the role they play in the process. VHA must create standards for the behavior and actions leaders adopt to accomplish the transformation and widely publicize the standards among leaders and staff to establish uniform expectations across the organization and a single vision of cultural transformation. The CVCS and other senior leaders must model and reinforce these behaviors to further embed expectations. These behaviors and actions should be integrated into leadership assessment tools such as a 360 evaluation, performance management frameworks, and coaching guides to ensure expected behaviors and actions are reinforced across the leadership development and advancement system. The strategy must include the development of tools, training, guidelines, and operating procedures that create a living curriculum to support leaders in developing and deploying these new skills and behaviors. Finally, to ensure leaders at all levels implement the behaviors and actions, the strategy must establish both explicit rewards and sanctions. The rewards and recognition (nonmonetary) should liberally acknowledge and publicize leaders and staff who embody the very best standards of behaviors and actions that support a positive organizational culture. At the same time, leaders and staff at all levels must clearly understand what behavior and actions are not acceptable and be held accountable through disciplinary action if they cross these boundaries. Expectations and repercussions should be clearly articulated.

VA and VHA have a number of competing models of organizational health and staff engagement. The models are not integrated with one another or with an overall leadership competency model. Some models are robust, coupling abundant resources and training, while others are not. To create a clear focus for engagement and organizational health and guide

³⁸⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 55 accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

transformation effectively, one model must be selected for use in VHA. To do so, VHA must establish a cross functional executive team to make this decision. The team should include all of the stakeholder offices involved in current efforts, but none of them should lead the effort, to avoid parochial interests driving decisions. Once a single model is selected, the executive team must then outline a clear strategy, involving and engaging the offices in VHA with relevant expertise and resources to support the execution, and put forward a single strategic plan. Consequently, each of those offices must also be required to stand down its own efforts that are not part of this new model going forward and align its work and budget behind a single focused model and strategy. Tools, training, and communication to support broad deployment must be part of the strategy, and the CVCS and the executive team must present a compelling, transparent rationale for what the model is, why it was selected, and how it is to be deployed. All leaders and staff members in the organization must understand their roles in cultural transformation and what is expected of them.

The strategy must establish and articulate a clear set of behaviors and actions expected of staff to ensure their alignment around the transformation. The standards should be incorporated into the hiring process to ensure that VHA is hiring into the new culture and avoids a poor fit from the start. These behavioral expectations must be articulated clearly in the on-boarding process and reinforced on an ongoing basis in performance evaluations, reviews, and individual development plans. Leaders at all levels of the organization must also reinforce these behavioral expectations with staff and be provided with tools, messages, and communication support to accomplish this. Leaders must also recognize and reward the positive examples of the desired behaviors and sanction the worst examples, up to and including discipline and removal.

The change strategy should also recognize that cultural transformation and staff engagement go beyond individual leader and staff behaviors. Systems and processes at both the local and national level can impede the realization of the positive organizational culture desired. As such, the transformation strategy must also anticipate changing systems and processes as an explicit component of transformation. Leaders at all levels must establish mechanisms to elicit staff concerns and have quality improvement tools in place to address them, such as LEAN Six Sigma. Line staff must be engaged as part of the solution to these system issues. Leaders should be transparent about these issues and publicly track and report on progress.

To ensure the effective execution of this strategy, specific responsibilities must be assigned to program offices. The program offices must also support the VISN and facilities in their transformation effort by developing the standards and guidance for them to use and making program office expertise available to support coordination, coaching, and sharing of best practices across the institution. The program offices must be held accountable for supporting the application of these same standards and process within VHACO.

Standards for facility implementation must include a funded, full-time equivalent employee to support each major facility director³⁸⁸ and be the point person to coordinate efforts with VHACO and other facilities. Facilities may take the opportunity to consolidate related functions that currently exist in the facility. Each facility must have a local mechanism, such as an organizational health council, to integrate and drive transformation locally. But this does not

³⁸⁸ This equates to one person at each of the approximately 141 VHA health care systems led by a facility director.

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mean the facility should create yet another committee or oversight group to accomplish the transformation. Instead, facilities must look to existing leadership structures and activities, consolidating similar efforts to create an efficient process.

Finally, the executive team must oversee the development of a consolidated and meaningful set of metrics, using community standards where available, to track cultural transformation, organizational health and staff engagement. The metrics should not only measure the desired outcomes but also provide insights to leaders on how to fix problems by providing sufficient detail and specificity to offer this insight. Once deployed, the metrics should be used by the executive team and responsible program offices to identify under-performing facilities and to provide additional expertise, resources, and support to help those facilities improve. If, after much support, the continuing behavior and actions of the leaders at the under-performing facility are identified as the cause of the long-term culture problem, these individuals must be removed from leadership positions in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Develop and implement a strategy for cultural transformation.
- Establish a cross-functional senior executive team reporting directly to the CVCS with long-term responsibility for creating, executing, and tracking the cultural transformation.
- Align frontline staff in support of the cultural transformation strategy.
- Require standards and a strategy for execution of the cultural transformation from every program office and facility and these efforts must be fully funded.
- Develop consolidated, meaningful metrics for organizational health and staff engagements with input from experts and field users.

Other Department and Agency Administrative Changes

- None required.

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

Problem

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an Office of Management and Budget management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Background

*Our Corps does two things for America: We make Marines and we win our nation's battles. Our ability to successfully accomplish the latter depends upon how well we do the former.*³⁸⁹

Effective leaders are required for organizational success. Thus, attracting, growing, and advancing leaders is a key business imperative across all sectors.³⁹⁰ The most urgent human capital management need worldwide, according to one survey, is the development of leadership talent.³⁹¹ This need is driven by a changing workforce that is motivated more by passion than by monetary incentives, a rapid advance in knowledge that quickly creates obsolescence, and technology drivers that change business practices over months instead of years.³⁹² Investing in new supervisors and emerging leaders is critically important because

³⁸⁹ U.S. Marine Corps, *Sustaining the Transformation*, Foreword, accessed June 9, 2016, [http://www.marines.mil/Portals/59/Publications/MCRP percent206-11D percent20Sustaining percent20the percent20Transformation.pdf](http://www.marines.mil/Portals/59/Publications/MCRP%20206-11D%20Sustaining%20the%20Transformation.pdf).

³⁹⁰ Jim Collins, *Good to Great: Why Some Companies Make the Leap . . . And Others Don't* (New York, NY: HarperCollins Publishers, Inc., 2001), 17-40. Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015).

³⁹¹ Deloitte Consulting LLP and Bersin by Deloitte, *Global Human Capital Trends 2014: Engaging the 21st Century Workforce*, 25, accessed June 10, 2016, http://dupress.com/wp-content/uploads/2014/04/GlobalHumanCapitalTrends_2014.pdf.

³⁹² *Ibid.*, 3.

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employees report that when they quit a job they leave their supervisors and not their organization.³⁹³ In an organization like VHA, with more than 300,000 employees but only a bit more than 200 executives, VHA's 28,000 supervisors are responsible for leading the staff.³⁹⁴

Going back to at least 1998, the federal civilian sector has had difficulty identifying and promoting individuals with leadership skills.³⁹⁵ Staff members who can produce results and meet organizational objectives are promoted into supervisory and leadership positions.³⁹⁶ Yet, the skills needed to be a successful leader are different than those needed to be a successful technical expert. Today, soft skills such as empathy, effective listening, and team coaching are valued in leaders.³⁹⁷ The most effective leaders are those who consistently display integrity, high moral character, and the ability to inspire others.³⁹⁸ An effective leadership system develops leaders at all levels, from frontline supervisor to executives, and does so in all dimensions of leadership: "knowing, doing, and being."³⁹⁹

Analysis

In a review of VHA's approach to leadership development, the *Independent Assessment Report* noted the current system was not sufficient to meet VHA's need for high-quality, prepared leaders.⁴⁰⁰ VHA lacks a comprehensive approach to leadership development that would include formal structured programs such as networking, reflection, goal setting, learning, mentoring, experiential learning, and a clear career ladder. As a result, leaders are unable to fully prepare

³⁹³ "People Leave Managers, Not Companies," Victor Lipman, accessed June 10, 2016, <http://www.forbes.com/sites/#/sites/victorlipman/2015/08/04/people-leave-managers-not-companies/#78b15df216f3>.

³⁹⁴ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 21-23, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

³⁹⁵ U.S. Merit Systems Protection Board, Office of Policy and Evaluation Perspectives, *Federal Supervisors and Strategic Human Resources Management*, accessed June 10, 2016, <http://www.mspb.gov/netsearch/viewdocs.aspx?docnumber=280538&version=280868&application=ACROBAT>.

³⁹⁶ Ibid. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

³⁹⁷ Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. "Creating and Retaining Great Leaders," Dominique Jones, accessed June 10, 2016, <http://www.hrreview.co.uk/analysis/analysis-hr-news/dominique-jones-creating-and-retaining-great-leaders/60419>. "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, <http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success>.

³⁹⁸ Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015). "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, <http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success>. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

³⁹⁹ Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. U.S. Marine Corps, *Sustaining the Transformation*, accessed June 9, 2016, [http://www.marines.mil/Portals/59/Publications/MCRP percent206-11D percent20Sustaining percent20the percent20Transformation.pdf](http://www.marines.mil/Portals/59/Publications/MCRP%20percent206-11D%20Sustaining%20the%20Transformation.pdf).

⁴⁰⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

for future roles.⁴⁰¹ Although VHA does have some components of a development program, the activities are not connected to a career path and not well coordinated. Comprehensive development efforts are impeded by the use of multiple competing competency models in VA that make it impossible to align assessment and development with a cohesive standard. Emerging leaders are left to navigate career progression largely on their own and may be stymied because development opportunities are cancelled due to budget restrictions. Even when promising young leaders complete the current activities, gaps remain in their experience and training because the training programs are not coordinated.⁴⁰² As a result, VHA does not have a robust pipeline of young leaders ready to take on higher-level responsibilities.⁴⁰³

Included in the *Independent Assessment Report* is a recommendation that VA stabilize, grow, and empower leaders. This recommendation includes suggestions to fill current vacancies with high-quality leaders, improve the attractiveness of the roles, ensure leaders are prepared to assume their roles, and create a comprehensive strategy that connects top performers to leadership opportunities and development plans.

There is little concrete information in the assessment to suggest how VA and VHA should accomplish these objectives. The commission examined VA's and VHA's current work to assess whether they have created plans to operationalize the leadership development recommendations articulated in the *Independent Assessment Report*.

Neither VA nor VHA has rationalized the multiple competency models within the department. A competency model is the core driver informing recruitment, development, assessment, and advancement in any comprehensive approach to leadership development and management.⁴⁰⁴ Having a cogent competency model is a prerequisite to a coherent strategy.⁴⁰⁵ Leading a health care organization requires specialized knowledge and skills not required of leaders in other fields.⁴⁰⁶ Thus, any competency model applied in VHA must include health care specific components. Health care executive competencies embrace such topics as an understanding of ethics in health care, management of self-governing professionals (e.g., physicians, nurses), the technical knowledge of health care regulation and operational management, and leading change, in addition to other leadership skills and knowledge.⁴⁰⁷

The current models used in VHA do not reference external benchmarks, and they are not health care specific. VHA plans to continue to use the High Performance Development Model (HPDM) as its competency model.⁴⁰⁸ HPDM was developed by VHA and is not benchmarked to private-sector competency models for health care executives. VHA plans to use the model to drive

⁴⁰¹ Ibid.

⁴⁰² Ibid., 38.

⁴⁰³ Ibid., 37.

⁴⁰⁴ The American College of Healthcare Executives, *ACHE Healthcare Executive: 2016 Competencies Assessment Tool*, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf.

⁴⁰⁵ Ibid.

⁴⁰⁶ Ibid.

⁴⁰⁷ Ibid. "Joint Medical Executive Skills," Joint Medical Executive Skills Program, U.S. Department of Defense, accessed May 16, 2016, http://www.au.af.mil/au/awc/awcgate/leadership/med_exec_skills.htm. "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁰⁸ "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

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position requirements, performance management, and training content.⁴⁰⁹ The plan mentions coordination with VA Learning University but provides no detail.⁴¹⁰ The plan also does not provide specific information about how the use of HPDM will link to formal recruitment, performance assessment, and advancement of leaders.⁴¹¹

VHA is working to understand the current career progression of candidates who move into field-based executive positions. VHA field leaders are cultivated from within VHA with about 98 percent advancing from lower-level field positions such as associate director, service chief, or chief of staff.⁴¹² As a result, field senior executives often lack outside experience and first-hand knowledge of alternative management methods.⁴¹³ Most companies look for a mix of internal and external hires, and the circumstances of the organization often drive the mix.⁴¹⁴ For instance, Henry Ford Health System, a successful growing company with a robust internal leadership development program has set a target of 70 percent internal promotions and 30 percent external hires.⁴¹⁵

The VHA pool of internal candidates is also deficient in racial and ethnic diversity with striking under-representation of women of color in all of the positions that constitute the pipeline for medical center director positions (see Figures 6 and 7).⁴¹⁶ VHA leadership development programs have failed to effectively recruit and advance under-represented minorities with a striking over-representation of White men in the leadership class that feeds the senior executive service (see Table 7).⁴¹⁷ Minority women shoulder the biggest burden of formal mentoring within the organization.⁴¹⁸ VHA also has the lowest representation of veterans among its staff (31 percent) compared to Veterans Benefit Administration (52 percent) and National Cemetery Administration (74 percent). The number of veterans among doctors and dentists in VHA is only about 14 percent of the employees.⁴¹⁹ Among leaders, 22 percent of senior executives are veterans and a similar number (23.8 percent) populate the leadership pipeline.⁴²⁰

⁴⁰⁹ Ibid.

⁴¹⁰ Ibid.

⁴¹¹ Ibid.

⁴¹² Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A*, November 23, 2015.

⁴¹³ Ibid.

⁴¹⁴ Eric Krell, "Staffing Management: Look Outside or Seek Within?" *HR Magazine*, January/February 2015.

⁴¹⁵ "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

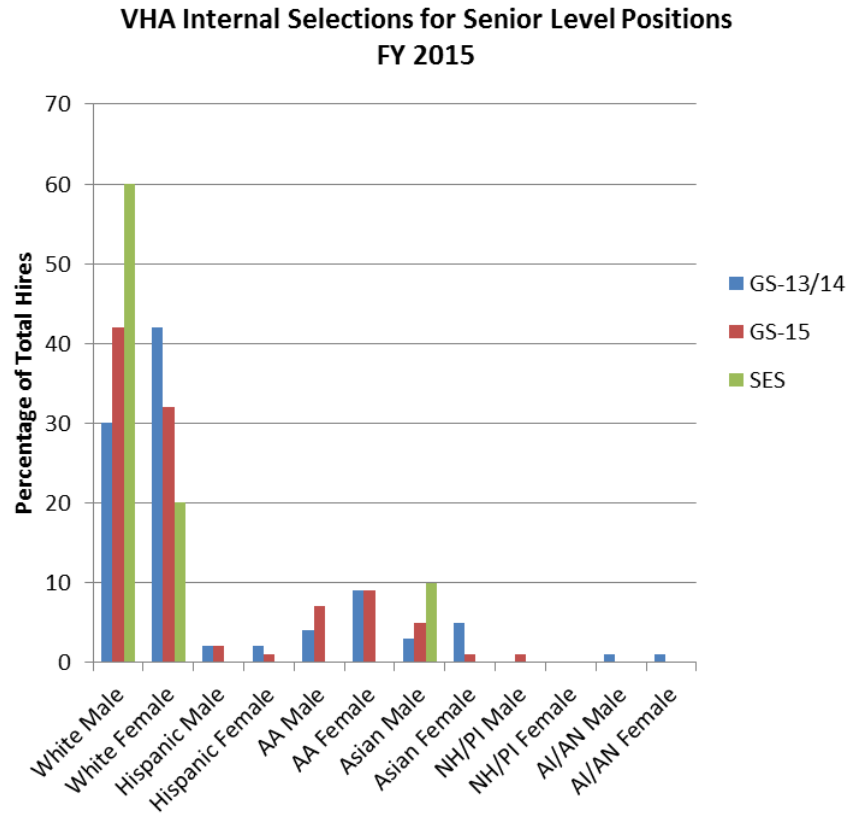
⁴¹⁶ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.sucession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

⁴¹⁷ Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A*, November 23, 2015.

⁴¹⁸ Ibid.

⁴¹⁹ Health Care Talent Management Office from PAID and NOA, September 17, 2015: Path to Medical Center Director, Healthcare Leadership Talent Institute.

⁴²⁰ VHA Health Care Talent Management Office, provided to Commission on Care for employees in VHA as of September 30, 2015 by request, March 8, 2016.

Figure 6. Diversity of Senior-Level Hires in VHA

AA = African American

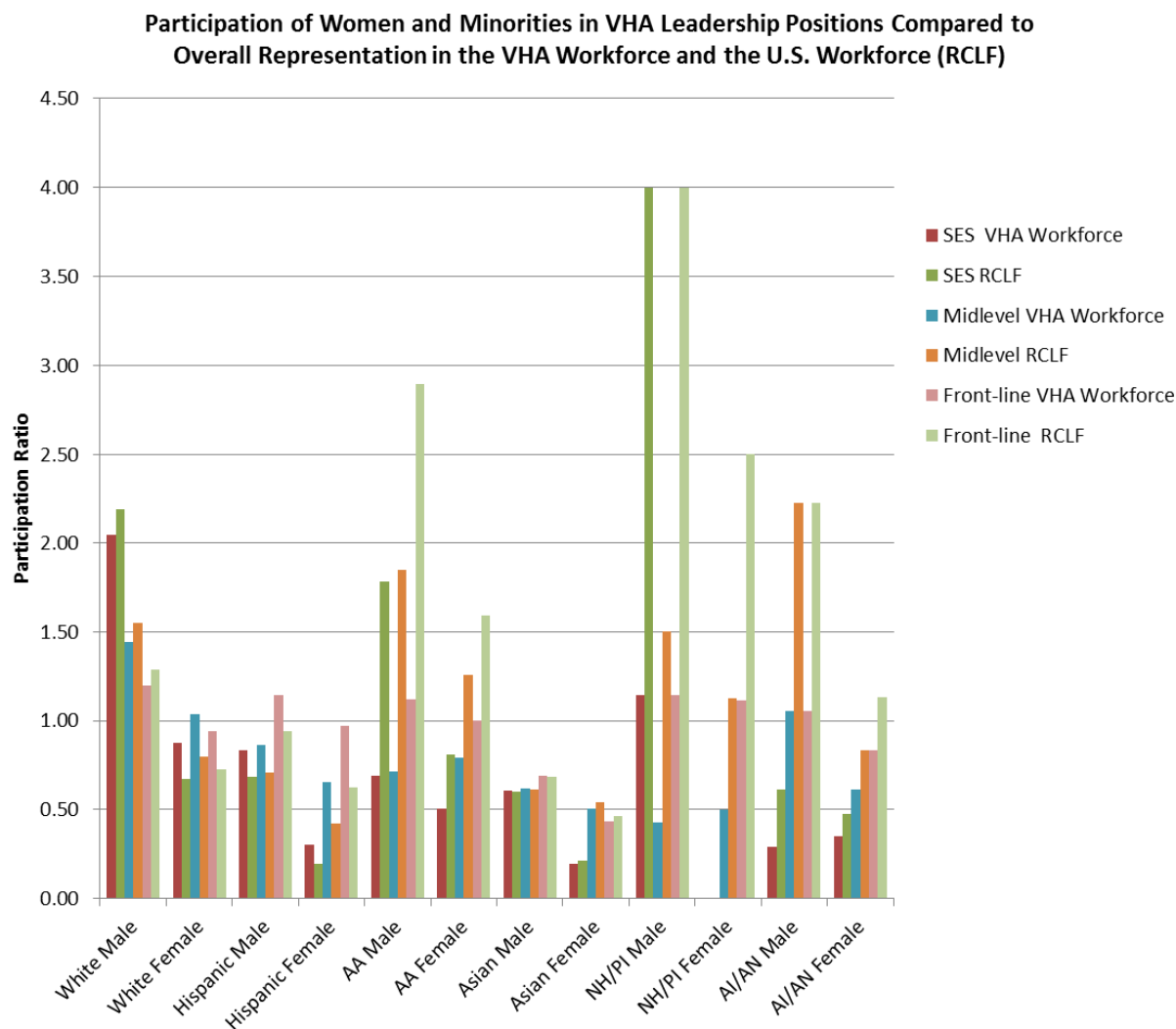
NH/PI = Native Hawaiian/Pacific Islander

AI/AN = American Indian/Alaska Native

Note: In FY 2015, VHA failed to select many candidates from diverse racial and ethnic backgrounds for senior executive positions. These data were drawn from the VHA annual equal employment opportunity (EEO) report.

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Figure 7. Minority Women are Under Represented in Higher-Level Positions in VHA



AA = African American

NH/PI = Native Hawaiian/Pacific Islander

AI/AN = American Indian/Alaska Native

Note: Women and particularly minority women are under-represented in comparison to their participation in the U.S. workforce (relevant civilian labor force [RCLF]) and their participation in the VHA workforce at higher levels in the organization. Some minority men are also under-represented in high-level positions. These data were derived from the VHA annual EEO report.

Table 7. White Males are Over Represented in VHA SES Development Program, HCLDP

	TCF 2015 (N)	GHATP 2014 (N)	Facility LEAD 2015 (N)	VISN/CO LEAD 2015 (N)	HCLDP 2015 (N)	VHA Workforce
White Male	35% (78)	30% (14)	19% (160)	22% (69)	41% (151)	23%
White Female	16% (35)	28% (13)	41% (342)	41% (127)	39% (144)	36%
African American Male	15% (33)	9% (4)	8% (66)	8% (24)	4% (14)	9%
African American Female	19% (42)	15% (7)	22% (180)	16% (50)	6% (23)	15%
Hispanic/Latino Male	4% (10)	4% (2)	3% (23)	4% (11)	1% (5)	3%
Hispanic/Latina Female	3% (7)	2% (1)	3% (29)	3% (10)	1% (4)	4%
Asian Male	4% (9)	2% (1)	1% (9)	>1% (2)	2% (7)	3%
Asian Female	2% (5)	9% (4)	2% (16)	4% (13)	3% (12)	5%
Native Hawaiian/Pacific Islander Male	0% (0)	0% (0)	>1% (3)	0% (0)	0% (0)	>1%
Native Hawaiian/Pacific Islander Female	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	>1%
American Indian/Alaska Native Male	2% (4)	0% (0)	>1% (1)	>1% (2)	1% (3)	1%
American Indian/Alaska Native Female	0% (0)	0% (0)	1% (7)	1% (4)	1% (3)	1%

Note: VHA offers career development opportunities from entry-level programs (TCF and GHATP) to an SES preparatory curriculum (HCLDP). Overall, White men make up about 23% of VHA employees but are over-represented in the HCLDP program at 41%. African American and Hispanic men and women are under-represented in the same program.

TCF= Technical Career Field; GHATP=Graduate Healthcare Administration Training Program; LEAD=Leadership, Effectiveness, Accountability, and Development; HCLDP=Health Care Leadership Development Program.

No evidence was presented to indicate that career progression mapping is occurring for positions within VHA central office, where high-quality leaders are also required.⁴²¹

⁴²¹ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

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VHA has much work to do to produce an effective leadership management system. Recruitment, retention, development and advancement are key processes that require immediate and sustained attention from VHA leaders. Without substantial changes, high-potential staff will continue to struggle to understand their career trajectory. Without a driving competency model and coordinated training to guide advancement, hiring decisions will continue to be made without uniform standards against which to measure applicants and new executive hires will continue to struggle to understand VHA and their role in leading it. Without the committed engagement and support of the chief of VHA Care System (CVCS) and the other top VHA executives for the leadership management system and their direct communications about and modeling of the leadership competencies, VHA will continue to flounder. As a result, veterans will be denied the high-performing health system they deserve.

Executive Commitment

The long-term success of any enterprise rests on having excellent leaders in key positions and sustaining them over time. To accomplish this goal, leadership management, development, and recruitment must be a core responsibility and a priority for VHA senior executives. To start, VA must include the goal of achieving an effective leadership management system in VHA as a component of the department's management agenda in the annual budget. The goal is a robust, high-quality, diverse leadership team in VHA. VA needs to establish a credible operational plan and accountability mechanisms for meeting this goal. Executive leaders are then held accountable for attaining the leadership management goals, including personally investing time in meeting diversity targets, recruitment plans, and succession planning objectives. These targets are to be reviewed in the individual performance of top leaders as well as in the Office of Management and Budget's ongoing review of the department's management objectives. Executive leaders need to also set and communicate clear expectations for the behavior of leaders and staff and to invest their own time in mentoring, coaching, and developing subordinate leaders and promising staff, including under-represented populations. They must be visible and role-model leadership competencies in meetings, training, and new-hire orientations. They must take an interest in developing leaders and help create opportunities for them to gain leadership experience and competencies. The CVCS and senior executives must keep in mind that their sole role is not to manage crises or to oversee a process or to manage up. Rather, their primary role is to lead their people. Their time and attention must reflect that priority.

Leadership Model

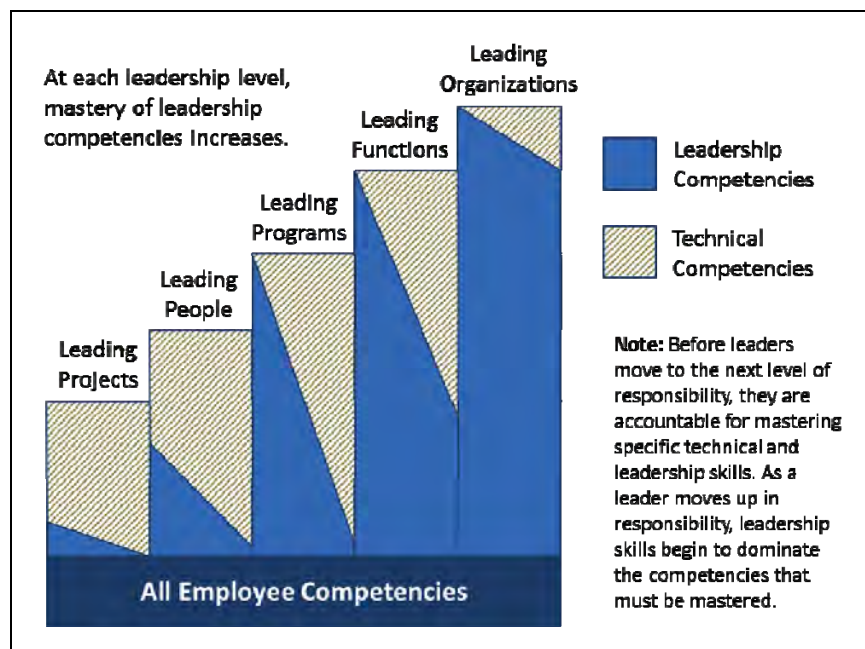
To establish clear leadership standards to guide hiring, development, and the advancement of leaders, VHA needs to adopt one benchmarked health care competency model. Currently, VHA is subject to the Office of Personnel Management executive core qualifications, HPDM, and standards for servant leadership. Although all of the models have value, none provide a clear trajectory for high-potential staff to follow, and they do not provide opportunities for VHA to intersect with leaders in the private sector. VHA must stop using these varied competency models and instead adopt a single model that is benchmarked to private-sector standards. The Commission is not making a recommendation about which model VHA should choose. Rather VHA should apply the criteria below to select a model around which to base its leadership development program:

- The standard must embrace leading through ethics and values, demonstrating character and concern for others, and creating a strong organizational culture.
- The standard must be health care based and describe the knowledge, skills, ability, and leadership bearing and behaviors that health care leaders must master to be effective.
- The standard must be a robust competency model including aligned training and tools to permit quick implementation.
- The model must describe different career tracks and the mastery requirements for key points in each career track. Key career tracks such as VISN director, facility director, and VHA Central Office (VHACO) program executive should fit into the competency model.
- A career path must specify the competencies that require mastery before moving to a higher position.
- VHA may need to enhance the model with competencies in care and services to Veterans and knowledge of military occupational health.

Training and Assessment

VHA needs to develop assessment tools based on the competency model, including 360, 180, self-assessment, and supervisory review processes. Leaders and developing leaders should be required to use at least one of the assessments each year and to apply the results to identifying their training and development needs. Findings from the assessments should be rolled into an individual development plan (IDP) for each leader or developing leader and enrollment in a leadership course should require a documented need from one of these assessments.

Figure 8. At Each Leadership Level, Mastery of Leadership Competencies Increases



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Training must be mapped against the competency model career track. All current leadership training should be mapped against the model. Gaps should be identified and filled with commercially available, or where needed, internally developed training. This training should include leadership competencies for the care of veterans, including an understanding of military occupational health, combat injuries and exposure, combat readjustments, and military sexual trauma. (See Appendix H for descriptions of such training material.) VHA should look for opportunities to partner with Department of Defense and the private sector to provide joint training and development opportunities to fill some of the identified gaps. VHA must develop one or more face-to-face training series that allow high-potential candidates to complete all the competencies required to move to the next career stage. As VHA strengthens its partnership with community providers and health systems, executive and high-potential training resources from VHA should be made available to community health care leaders and VHA should join training offered by these private-sector partners.

Based on the benchmarked competency model, VHA should collaborate with Academic Affiliates to establish two new programs. The first is to create opportunities for VHA physicians to gain masters-level training in health care management to prepare them to lead a medical facility. Second, VHA should work to create rotations in VHA for external physicians who are completing graduate health care management programs. Like academic affiliate residency training programs, VHA should collaborate with academic medicine to establish, fund, and run these programs with the goal that all participants rotate in management positions in VHA or VHA-partnered private-sector systems for six or more months during their training. Graduates of such programs would be candidates for recruitment into the VHA leadership pipeline and would encumber a pay-back commitment to VHA for any direct funding provided.

All training should include formal assessment to assure that learners have mastered the material and this mastery should be noted in their IDPs and training record.

As part of the leadership development model, experiential learning opportunities and formal coaching are critical to executive learning. Individual and group coaching standards and programs must be established for all developing and new leaders. A program for senior leaders to pair them with private-sector health care leaders must also be supported. VHA must establish rotation opportunities for developing leaders to rotate for substantial periods (e.g., 3 to 18 months) in not-for-profit hospital systems. This program could be structured as a certificate program that the employee and VHA jointly fund and include a payback commitment on the part of the trainee. Similar rotations from the private sector into VHA should be developed with health care system partners to help develop private-sector competencies in care for veterans and inject private-sector approaches into VHA.

Apply the Leadership Model

VHA is required to apply the competency model in all hiring decisions for executive career field positions. Thus all functional statements must be based on the model, all interview protocols must incorporate the competencies, and all candidates who are not internally certified to the standard of the job must undergo an assessment by a board to ensure they meet the position requirements. Conversely, internal candidates must be required to demonstrate mastery of the competencies before qualifying to apply for a position. VHA must adopt the strategies of executive recruiters to identify and recruit needed experts outside of government with the

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competencies VHA seeks. Recruiters can look to the pipelines the Commission has recommended building to bring military treatment facility commanders and other senior leaders and private sector experts into VHA as a network for identifying additional recruits. Executive recruiters can particularly help ensure diverse candidates are identified for open positions.

VHA will require competency assessments and IDPs for all existing executives, potential executives, and new hires. Current leaders and new hires who have an identified gap in any competency must have it included in their IDP and be required to fill these deficiencies by a specific deadline or face demotion or dismissal. Completion of IDP development opportunities is required for advancement in grade or promotion to higher position within the leadership pipeline.

VHA will aggressively manage its leadership candidate pool by identifying and tracking all high-potential individuals. Diversity statistics should be tracked and diversity in this pool actively managed. This pool of candidates derives from annual ratings as well as leadership development program graduates. Supervisors and executive leaders must provide ongoing coaching for higher positions to this pool of developing leaders. VHA must identify anticipated succession needs and offer development opportunities that would help prepare candidates for these anticipated openings. Once the positions are open, individuals in the high-potential pool must receive notices of new job postings and detail opportunities that provide experience into higher positions. Candidates who agree to be in this pool should be required to enter into formal mentoring relationships with leaders outside their chain of command to further advance their career development. For highest-level positions (VISN director, facility director, VHACO chief officer) a formal pool of approved or precertified candidates should be established.

To expand the perspectives and management experience in its leadership pipeline, VHA must develop explicit strategies to on-ramp diverse candidates at critical midcareer transition points. This process includes creating pathways for retiring commanders and other senior officers of military treatment facilities to compete effectively for leadership positions in VHA. To increase VHA understanding of private-sector health care, VHA must develop midcareer entry points for private-sector candidates. This could be accomplished through the use of temporary hiring authority and the ability to convert these positions to permanent staff positions if leadership competencies standards have been met by the candidates. Such opportunities can be modeled on efforts recently announced by DoD and, wherever practicable, should be developed collaboratively with DoD to establish the legal and policy requirements for implementing these programs. Finally, the current graduate health administration training program (GHATP) program should be expanded to include more schools and programs with diverse trainees. This expansion must allow high-performing residents to continue to convert to full time positions.

On-boarding

A formal on-boarding process should be instituted for all new executive hires. In addition to the transactional knowledge the individual will need, on boarding should establish the expectations for what it means for that executive to be successful in VHA. The values of the organization and the expectations for ethical practice must be conveyed by the CVCS and the top leadership team. A formal assessment of knowledge and skills should be made during on-boarding and an IDP established to cover the probationary period of new hires if any deficiencies are identified.

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Completion of the IDP is required for continued employment. All new leadership hires should be assigned a coach based on their individual needs. Within their first 6 months of employment, the undersecretary for health and Secretary should meet with these new executives to build a relationship with them and hear their fresh perspectives on the performance of VHA.

Stabilize Leadership

VHA should immediately stabilize its leadership ranks by authorizing VA medical center and veterans integrated services network (VISN) director details to last up to a year with no restrictions on an acting leader competing for the permanent position. VHA should also create flexible capacity by creating more assistant-level positions (e.g., assistant director, assistant VISN chief medical officer, assistant nurse executive, deputy chief officer). These individuals would comprise the pool of potential leaders and also allow for cross filling positions that are empty due to development assignments, training, or other leadership development opportunities.

Implementation

Legislative Changes

- Establish direct-hire authority from the graduate health care administration training program, military treatment facility, and private-sector fellow pools, clarifying application of merit-system principles, including approaches to managing veterans' preference in these programs.
- Establish Intergovernmental Personnel Act authority for VHA to include the for-profit private sector; this could be done as a pilot program with a report to Congress before considering whether to make the authority permanent.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.
- Aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: All hires and promotions are required to demonstrate these competencies.
- Require a formal on-boarding process for HPDM 3 and 4 leaders at all levels that reinforces the leadership competency model.
- Take immediate steps to stabilize the continuity of leadership by extending the length of authorized details to extend the continuity of leadership at medical centers and allow leaders detailed to a position to compete for a permanent appointment to the position by removing the non-compete requirements.

COMMISSION RECOMMENDATIONS

- Establish the competency model in regulation and include requirements for its use in hiring, promotion and dismissal and clarify the application of veterans' preference in executive development.

Other Department and Agency Administrative Changes

- None required.

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Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Problem

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and their functions overlap or are duplicative. The role of the Veterans Integrated Service Network (VISN) is not clear, and the delegated responsibilities of the medical center director are not defined.

Background

A prerequisite of a successful, high-performing system is having strong leaders and a strong leadership system.⁴²² An organization's leadership system is "the way leadership is exercised, formally and informally, throughout the organization; the basis for key decisions and the way they are made, communicated, and carried out."⁴²³ It includes "structures and mechanisms for making decisions; ensuring two-way communication; selecting and developing leaders and managers; and reinforcing values, ethical behavior, directions, and performance expectations."⁴²⁴ In an organization the size of VHA, with a budget of \$69 billion,⁴²⁵ more than 300,000 employees, and more than 1,000 sites of care,⁴²⁶ strong leadership systems are essential.

The Commission Recommends That . . .

- VHA redesign VHA Central Office (VHACO) to create high-performing support functions that serve Veterans Integrated Service Networks (VISNs) and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the chief of VHA Care System with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report (also included in Recommendation #10).

⁴²² Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 50.

James Collins, *Good to Great: Why Some Companies Make the Leap and Others Don't*, (New York, NY: HarperCollins, 2001), 17-64.

⁴²³ Ibid.

⁴²⁴ Ibid.

⁴²⁵ Department of Veterans Affairs, *VA 2017 Budget Request: Fast Facts*, accessed March 10, 2016, <http://www.va.gov/budget/docs/summary/FY2017-FastFactsVAsBudgetHighlights.pdf>.

⁴²⁶ "About VHA," Department of Veterans Affairs, accessed February 5, 2016, <http://www.va.gov/health/aboutVHA.asp>.

In the last successful reorganization of VHA in 1995,⁴²⁷ the organizational design and functional roles of the leadership system were organized into clear structures with clear functions. The VISNs were responsible for operations⁴²⁸ and VHACO program offices were responsible for policy, guidelines, and outcomes.⁴²⁹ The National Leadership Board (made up of VISN directors and all program office leaders) was responsible for collective, fact-based decision making and the Friday Hotline call was used to communicate leadership priorities and decisions directly to VA medical center (VAMC) leadership. A negotiated performance measurement system based on consistent, benchmarked, outcome-focused metrics⁴³⁰ was also established that was supported by centralized functions that benefit from economies of scale.⁴³¹ As part of the reorganization, VHA experienced a reduction in staff and consolidation of VHACO offices to create a flat, agile leadership system.⁴³² Because this functional matrix was not sustained, VHA now faces the challenge of reinstituting an effective leadership system.

Analysis

Twenty years after the Kizer reorganization, VHA has a very different leadership system, under which it “is intensely, unnecessarily complex due to a lack of clear operating model, limited role clarity, fragmentation of authority, and overlapping responsibilities.”⁴³³ The *Independent Assessment Report* included the following findings about the VHA operating model:⁴³⁴

- VHACO has grown rapidly since 2009 from 753 in FY 2009 to 1,990 in FY 2014.
- The VISNs’ ability to manage and support their regions is heavily hampered by resourcing restrictions and direct VHACO control over VAMC operations.
- The VAMCs’ operating model suffers from powerful silos, which prevent an effective end-to-end mission focus.
- VA’s increasingly top-down management style, coupled with poor prioritization and the external political environment, result in a lack of clarity around strategic direction, reactivity to external headwinds, and flawed efforts to standardize.

VHACO has grown rapidly in the past few years.⁴³⁵ The growth in central office was driven in part by new ideas, new priorities, and new crises being addressed through the creation of new

⁴²⁷ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco, CA: Berrett-Koehler Publishers, Inc., 2012), 54.

⁴²⁸ Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 35. Kizer, Kenneth W and Ashish Jha, “Restoring Trust in VA Health Care,” *New England Journal of Medicine*, 371, (2014): 295-297.

⁴²⁹ Ibid.

⁴³⁰ Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 61-72.

⁴³¹ Ibid., 33.

⁴³² Ibid., 60. Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation of the Veterans Healthcare System*, Objective 3 and 17, 1996.

⁴³³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 95, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁴³⁴ Ibid.

⁴³⁵ Ibid., 98.

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offices and new staff infrastructure to support it.⁴³⁶ A portion of the growth came from the centralization of functions that were previously managed in the field such as business office functions. The final component has come from the duplication in VHA of offices in which decision-making authority rests with VA, such as communications and regulatory management. VHA has also duplicated functions and responsibilities between two or more offices in VHA, such as primary care, surgery, mental health, and geriatrics and extended care. This increased growth in staff and offices has resulted in more complex and lengthy decision processes, often with little clarity as to whom ultimate responsibility for decisions or follow up falls.⁴³⁷

One symptom of the top-down management is VHACO control of budgeting and resource management. “Support funding is outside local control” and the “increasing share of Specific Purpose funding hinders” local leaders in their ability to use resources effectively.⁴³⁸ In FY 2015, specific-purpose funds were spread across more than 450 line items,⁴³⁹ taking money away from general purpose funding and restricting how this money can be used. Both VHACO and Congress have been complicit in taking control away from medical center directors through these budget controls.⁴⁴⁰ For instance, the congressional appropriation to fund VHA for 1998 included only five appropriation line items; medical care, medical administration, construction major, construction minor, and medical and prosthetic research.⁴⁴¹ In contrast, the budget request to Congress for FY 2016 included 12 budget categories relevant to VHA with some of those accounts having four or five subcategories.⁴⁴² In his testimony before the Commission and Congress, Secretary McDonald made the point that such fragmentation of the VHA budget and the prohibition to reallocate across budget categories without first receiving Congressional approval was an impediment to effective and agile management of the department.⁴⁴³ Greater Congressional control of VHA spending is understandable in light of VA’s lack of adequate management systems and data analytic capabilities to track expenditures in real time⁴⁴⁴ and report them to Congress and central office. The only means available to hold the medical centers

⁴³⁶ Ibid., 96-99.

⁴³⁷ Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health*, (Washington, DC, Veterans Health Administration, February 2015), 7-9.

⁴³⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership)*, 102, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴³⁹ Ibid., 107.

⁴⁴⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership)*, 102-108, accessed June 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴⁴¹ PL 105-65, October 27, 1997.

⁴⁴² Department of Veterans Affairs Fiscal Year 2016 Budget Submission, Volume II Medical Programs and Information Technology, Accessed June 10, 2016, <http://www.va.gov/budget/products.asp>.

⁴⁴³ On January 21, 2016, Secretary of Veterans Affairs, Robert A. McDonald, provided the following testimony before the U.S. Senate Committee on Veteran’s Affairs “Flexible Budget Authority: We need flexible budget authority to avoid artificial restrictions that impede our delivery of care and benefits to Veterans. Currently, there are over 70 line items in VA’s budget that dedicate funds to a specific purpose without adequate flexibility to provide the best service to Veterans. These include limitations within the same general areas, such as health care funds that cannot be spent on health care needs and funding that can be used for only one type of Care in the Community program, but not others. These restrictions limit the ability of VA to deliver Veterans with care and benefits based on demand, rather than specific funding lines.” accessed June 10, 2016,

<http://www.veterans.senate.gov/imo/media/doc/VA%20Sec%20Testimony%2001.21.2016.pdf>

⁴⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 105, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

accountable was to fund the priority initiatives as separate budget lines or indicate allocations to be made under the specific-purpose process.

To fix the overly complex and bureaucratic structure of VHA, the *Independent Assessment Report* suggests that VHA “redesign (its) operating model to create clarity for decision-making authority, prioritization, and long-term support.”⁴⁴⁵ VHA must take a systems approach to reorient its leadership operations, restructuring and re-orienting VHACO program offices to ensure all of the following:⁴⁴⁶

- fact based, innovative decision making that is responsive to the field, other offices, and external stakeholder requirements
- feedback mechanisms to incorporate system learning into policy development and operational guidance
- communication mechanisms to effectively share information across offices and reach VISN and facilities to explain expectations and tie decisions to organizational values and goals
- effective execution of policy decisions through expert coaching, deployment of resources, and guidance based on external benchmarks and sharing of internal best practices
- analytic capability and infrastructure to effectively monitor progress and outcomes of all organizational priorities

Such a reorientation will involve a different skill set and expertise than currently required in VHACO. Transformation will call for recruiting new expertise, making advancement decisions based on these new competencies, reinforcing them through recognition and performance assessment, and developing new skills in current staff through training and coaching. This skill set includes a high level of technical expertise relevant to the program office; the ability to build relationships with external stakeholders; demonstrated skills in coaching, staff development, and training; certification in quality improvement methodologies; analytic capabilities to develop and track metrics; and the ability to lead transformational change. VHA must fully fund the retraining and the hiring of skilled staff in VHACO to accomplish this transformation.

For the VHACO program offices to work effectively with one another and with the field, the specific authority of each office must also be defined. Where overlap and confusion exists between offices, programs must be combined and streamlined or eliminated with a corresponding reduction in force. In changing the structure and orientation of VHACO program offices, VHA leadership can take the opportunity to align functions to achieve its stated priority of patient-centered care. In a fully aligned operating structure, business processes from the VAMC front line to central office must be organized to deliver important

⁴⁴⁵ Ibid., ix.

⁴⁴⁶ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 7, 34, and 50.

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patient outcomes rather than aligned in professional silos. For instance, instead of having an office of nursing, one for social work, and a lead for physician assistants, business offices should be aligned around the work they do together, like patient aligned care teams, to deliver positive outcomes for veterans.

The administrative operations of VHACO should also be flattened. Senior staff should be speaking directly to other senior staff to discuss and make decisions rather than relying on bureaucratic, paper-based processes as a means of negotiation: It is neither a healthy culture nor an efficient process. At the same time, VHACO needs to take full advantage of being a large-scale enterprise by centralizing functions such as acquisition package development, recruitment package development, and account reconciliation so that staff is not required in each program office to take on these occasional but complex activities. The net savings resulting from this reorganization and delayering of the bureaucracy must be reinvested in the transformation process.

VISNs must also examine the skills needed to take on an expanded role as facilitators, coaches, and guides in improving services and sharing best practices across facilities. VISNs are critical players in the feedback loop between service delivery and VHACO to identify ineffective processes, problems, and emerging issues that need to be raised to VHACO for help in clearing away barriers to effective operations. Similar to VHACO, VISNs must define the new skill set required by their staffs and establish these requirements in hiring, promotion, and performance evaluation as well as training and coaching staff to develop these competencies. Finally, the chief of VHA Care System (CVCS) should establish a required staffing ratio for the VISN office and reduce the staffing in VISNs that exceed this standard.

A new operating model also means that medical center directors must control the budget, staff, supplies, and infrastructure required to deliver needed health care. This model includes consolidation of budget lines and new authority and expanded authority to reallocate funds across the remaining budget categories. To manage the new VHA Care System and ensure that facility and network directors have the local control needed to make decisions about how to deliver services, fewer restrictions should be placed on the VHA budget. To start, specific-purpose funds must no longer be used to direct obligations at facilities. Congress should also work with the administration to reduce the number of budget lines and specific spending authorities back to a simpler system like that used in 1998. To support these changes and create transparency, medical centers should be accountable for their expenditure of funds by ensuring accurate, complete, and timely cost accounting. This last requirement, however, can only be met if it is supported by effective financial management data systems and fully trained staff and leadership who understand how to use such systems.

To support the leaders, program offices, and the field in this transformation, the CVCS must establish a transformation office that has appropriate expertise in business process reengineering and is fully funded to conduct this work. Existing offices with the requisite expertise, including the Office of Strategic Integration and the Veterans Engineering Resource Center (VERC), should be rolled into the transformation office. This office would oversee transformation and incubate new initiatives with the goal of incorporating them into regular work of other program offices once the new initiative is established. This mechanism, if used consistently, would prevent VHA from growing new offices as new priorities arise.

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Finally, as part of cultural change within the leadership system, the CVCS, VISN directors, and program office leaders must promote open and productive dialogue among themselves about problems and solutions. To accomplish this goal, leaders must address both the culture within the leadership ranks, as well as establish systems and processes that support identification and discussion of problems. The CVCS must model this behavior by inviting input on problems and rewarding leaders when they bring issues forward, including rewarding them with access to expertise, staff, and money; removing barriers; and aligning other leaders in support of solutions.

In its work to oversee change in VHA, the transformation office will create an implementation plan for transformation, identifying key strategies and milestones. This plan will drive data collection, development of strategic goals and supporting objectives to encourage effective planning, accountability, and the ability to unearth critical gaps that need to be addressed. The transformation office will require each new initiative to establish a project plan and provide periodic reports that include all of the following components: tactic/action, initiative owner, cost (i.e., operational, equipment, contracts), number of FTEs, start and completion dates, outcome measures, strategic drivers, and milestone.⁴⁴⁷ The President's Management Agenda Scorecard will serve as the evaluation model. The Office of Management and Budget created this tool to evaluate new initiatives and track progress on outcomes over time with regular spotlight reports (red, yellow, green) to leadership.⁴⁴⁸

Implementation

Legislative Changes

- Simplify the VHA budget to include fewer accounts while at the same time requiring more transparent and detailed accounting of VHA expenditures.

VA Administrative Changes

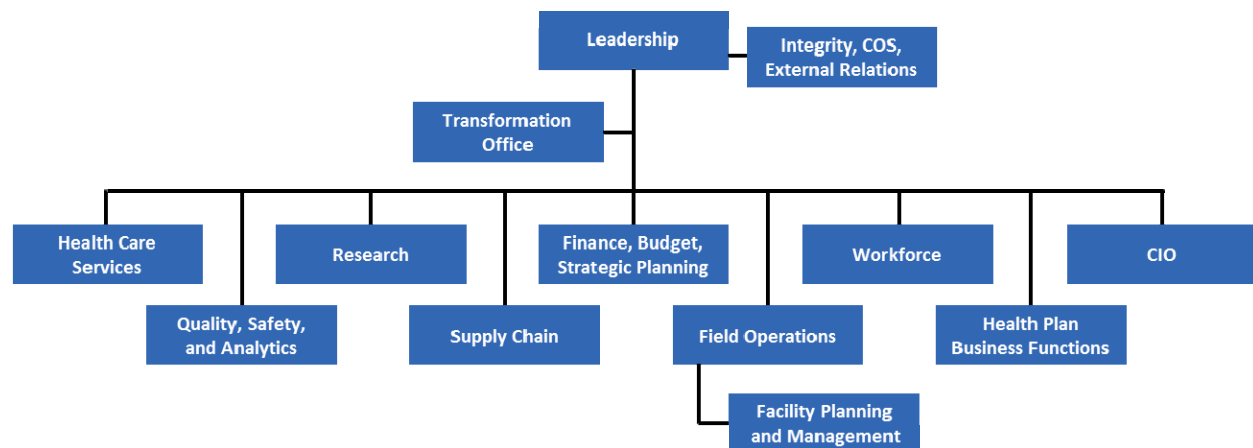
The following administrative changes are a priority during the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B. Responsibility for establishing a transformation plan with milestones, timelines, and evaluation of outcomes is assigned to the transformation office that the Commission recommends be established in VHA.

- Eliminate duplication within VHA and consolidate program offices to create a flat structure. Figure 9 is one model of an organizational chart for accomplishing this goal. This organizational chart shows how VHA can be streamlined to mirror the structure of large private-sector hospital systems. Figure 10 is the current VHA organizational chart, provided as a point of comparison and to emphasize the cumbersome nature of the current structure.

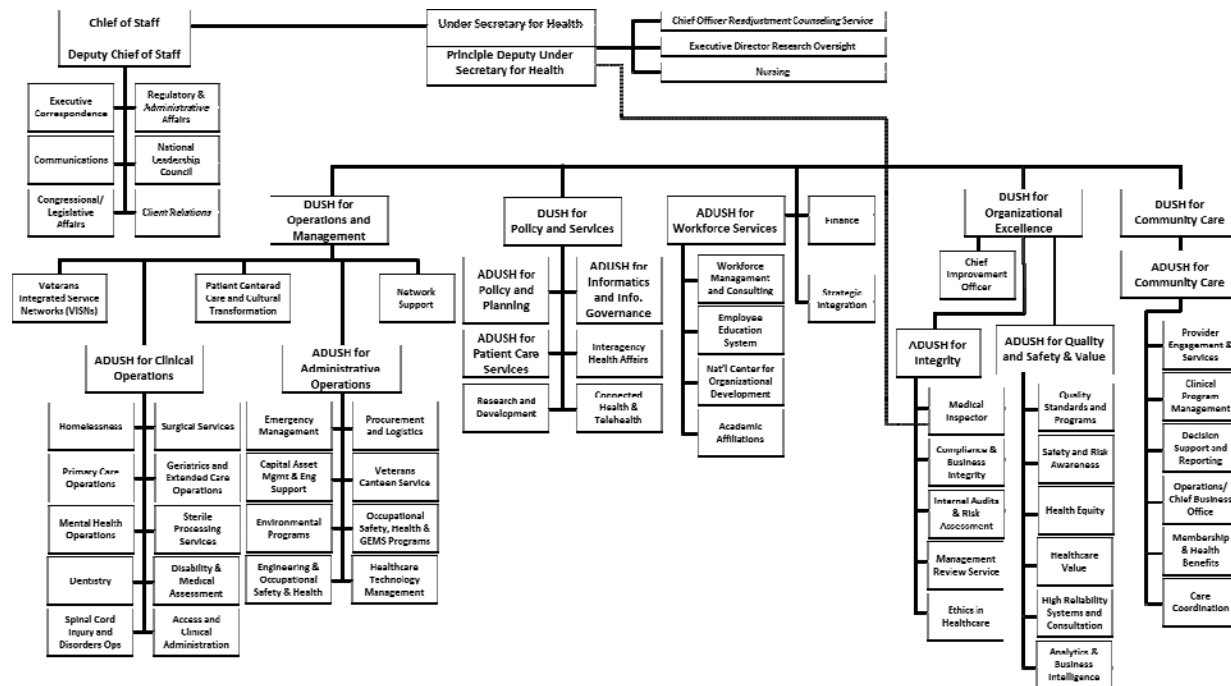
⁴⁴⁷ For example, see "VA Faith-based and Community Initiative President Management Agenda Scorecard," September 30, 2008,

⁴⁴⁸ "Office of Federal Financial Management President's Management Agenda," Office of Management and Budget, accessed June 15, 2016, https://www.whitehouse.gov/omb/financial_fia_pma/.

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Figure 9. Proposed VHA Organizational Chart⁴⁴⁹

Note: This organizational chart is an example of how to align VHA functions to create a flatter organization, remove duplication, and streamline decision making as discussed throughout this section of the report. Of note, the placement of the Transformation Office, CIO, and supply chain in this diagram is consistent with recommendations made by the Commission elsewhere in this report. In this chart, COS is chief of staff.

Figure 10. Current VHA Organizational Chart⁴⁵⁰

⁴⁴⁹ Modified from Appendix C, Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health*, (Washington, DC, Veterans Health Administration, February 2015), 41.

⁴⁵⁰ Ibid.

COMMISSION RECOMMENDATIONS

- Eliminate the duplication of functions between VHA and VA by closing VHA offices as needed.
- Create innovative organizational structures that are aligned to patient's needs rather than professional silos, to support clinical care.
- Undertake a reduction-in-force in VHACO that facilitates delayering and efficiency in communication and decision making.
- Establish a transformation office implementation plan to ensure effective and comprehensive implementation of the transformation across VHA. The transformation plan is to capture all of the transformation activities recommended in the Commission report, establish specific timelines and milestones for accomplishing each objective, and report on both progress and outcomes at least quarterly to VHA leadership and the governing board. Periodic evaluation of the effect of these change initiatives on internal and external stakeholders would also be appropriate.
- Clarify the roles and responsibilities of VISNs and facilities and implement a change strategy to orient staff and leaders to these new expectations. Establish effective leadership communication mechanisms to promote transparency, dialogue, and collaboration among VHACO offices and with the field.

Other Department and Agency Administrative Changes

- None required.

Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

Problem

To achieve the Commission's vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set, identical to private-sector standards, will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes for veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders' performance not just on *what* they achieve but *how* they achieve it.

Background

One of the criteria for performance excellence in health care is the measurement, analysis, and improvement of organizational performance.⁴⁵¹ Performance measurement is used to track daily operations, overall organizational performance, and progress in achieving organizational objectives and action plans. Performance measurement is also used to benchmark organizational performance against internal and external standards.

Organizational performance measurement is not the same as workforce performance management.⁴⁵² Workforce performance management is intended to reinforce intelligent risk taking, help focus the workforce on the needs of patients and other customers, and support

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Workforce and Leadership Performance Management System

- VHA create a new performance management system appropriate for health care leaders, tied to health care leadership competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

⁴⁵¹ Baldrige Performance Excellence Program, 2015-2016 *Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.

⁴⁵² *Ibid.*, 20.

health care delivery and the achievement of action plans.⁴⁵³ Although there is a relationship between organizational performance measurement and workforce performance management, they are not synonymous processes.

Workforce performance management is made up of much more than just clinical outcome measures. As noted by the American College of Healthcare Executives (ACHE), performance evaluations of hospital CEOs must also evaluate leadership traits such as judgment, communication, and diplomacy.⁴⁵⁴ Furthermore, ACHE emphasizes the inclusion of individual professional objectives in performance plans, such as promoting ethical behavior, supporting diversity and inclusion within the organization, or fostering effective medical staff relationships.⁴⁵⁵ ACHE and other leading practitioners⁴⁵⁶ emphasize that performance management is not a plan or an event, but rather a continuous, ongoing process and conversation among the leaders and their reviewers. A workforce performance management system must also make meaningful distinctions among individuals⁴⁵⁷ and promote high performance through rewards, recognition, and incentive practices.⁴⁵⁸ Ideally, when coupled with a leadership competency model and development program, workforce performance management should also help to identify high-performing potential leaders and provide guidance to the workforce on how to move up in the leadership ranks.⁴⁵⁹ As deployed in FY 2015 and evaluated by the *Independent Assessment Report*, VHA's performance management system failed to effectively achieve any of these objectives.⁴⁶⁰

Analysis

One of the findings in the *Independent Assessment Report* was that “hundreds of operational performance measures overwhelm leaders and this, combined with limited transparency and inconsistent data availability, makes it difficult to focus on what is most important.” More than 300 measures spanned everything from critical clinical metrics to political priorities introduced to address the most recent crisis. VHA reports that it was tracking approximately 500 measures,

⁴⁵³ Ibid.

⁴⁵⁴ “Policy Statement: Evaluating the Performance of Hospital or Health System CEO,” November 2013 (revised), American College of Healthcare Executives, accessed February 18, 2016, <https://www.ache.org/policy/ceo-perf.cfm>.

⁴⁵⁵ Ibid.

⁴⁵⁶ Ibid. NeuroLeadership Institute’s “Reengineering Performance Management: How Companies are Evolving Beyond Ratings” webinar, scheduled on January 14, 12-1.

⁴⁵⁷ “Implementing FCAT-M Performance Management Competencies: Differentiating Performance,” Office of Personnel Management, Performance Management: Performance Management Cycle, accessed June 10, 2016, <https://www.opm.gov/policy-data-oversight/performance-management/performance-management-cycle/developing/differentiating-performance/>.

⁴⁵⁸ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization’s Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.

⁴⁵⁹ Office of Personnel Management. Proficiency Levels for Leadership Competencies. <https://www.opm.gov/policy-data-oversight/proficiencylevelsforleadershipcompetencies/>. “Joint Medical Executive Skills Institute,” Health.mil: The official website of the Military Health System and the Defense Health Agency, accessed June 13, 2016, <https://www.jmesa.army.mil/documents.asp>, National Center for Healthcare Leadership. NCHL Healthcare Leadership Competency Model. <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁶⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 78-79, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

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including 156 related to access, 29 measuring employee engagement, 18 on high-performing networks, 250 best practice measures, and seven related to trust.⁴⁶¹

Distinct from performance measurement, the performance management process⁴⁶² is a cycle that begins with clear input from top leadership on the priorities of the organization, followed by clear targets, performance tracking, reviews, and rewards. The *Independent Assessment Report* noted that, “Individual performance management processes are hindered by targets inconsistent with the VHA mission, delayed implementation, lack of meaningful performance dialogue, and limited rewards.”⁴⁶³ Many of the same system flaws that impede effective organizational performance also impede individual success. Performance plans are released late in the performance cycle,⁴⁶⁴ metrics are hard to track in real time and lack the detail required for individual performance assessment,⁴⁶⁵ and few plans are written to support shared accountability and team-based solutions. In addition, participants observed that the current senior executive performance agreements and rating process (a) do not result in meaningful distinctions in performance between individuals, (b) do not drive meaningful conversations about individual performance, (c) and do not consistently focus on key health care metrics of quality, safety, patient experience, operational efficiency, finance, and human resources.⁴⁶⁶ The *Independent Assessment Report* notes that the rewards currently offered to employees do not motivate them to work toward exceptional performance.⁴⁶⁷

Information provided to the Commission indicates that VHA has taken action to address some of these findings. First, the USH has reestablished a performance accountability workgroup (absent for a number of years) comprising leaders from the field and VHACO to provide oversight and direction to the performance measurement process.⁴⁶⁸ The workgroup has been charged with aligning metrics to each level of VHA, dramatically simplifying metrics, and increasing the capacity of the organization to focus on measures that truly matter.⁴⁶⁹ The group has created an aspirational vision of a performance measurement system that describes cascading accountability from the top of the organization with health system outcomes (reported annually) through strategic measures (reported quarterly), to tactical measures (reported monthly) to transactional measures (reported in real time).⁴⁷⁰ It is critical that these aspirations become policy.

⁴⁶¹ Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.

⁴⁶² McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 78, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁴⁶³ Ibid., 82.

⁴⁶⁴ Ibid., 82.

⁴⁶⁵ Ibid., 84.

⁴⁶⁶ Ibid., 84.

⁴⁶⁷ Ibid., 87.

⁴⁶⁸ David Shulkin, *Charter of the Performance Accountability Workgroup*, (Washington, DC, Veterans Health Administration, September 22, 2015).

⁴⁶⁹ Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.

⁴⁷⁰ Ibid.

Starting in the 1990s, VHA has used performance measurement, benchmarking, and reporting internally to motivate higher clinical quality performance by individuals and teams.⁴⁷¹ As a large, national health care system, internal benchmarking can be a valid method to drive change, yet both internal and external audiences may ask how well VHA performance compares to that of private-sector providers. VHA currently posts some patient quality, safety, and outcome measures on both its website and on the Department of Health and Human Services (HHS) Hospital Compare website.⁴⁷² These measures allow patients to evaluate the quality of care they receive from VA and make informed health care decisions. They include measures of timely and effective health care; measures of readmissions; complications of death, surgical complication measures and health-care related infection measures; survey data of patient experiences; and other measures required of hospitals participating in Medicare.⁴⁷³ Former USH Kizer believes this reporting is insufficient, noting

*the VA health care system has become increasingly insular and inward-looking. It now has little engagement with private-sector health care, and too often it has declined to make its performance data public. For example, it contributes only a small proportion of its data to Hospital Compare and has declined to participate in other public performance reporting forums such as the Leapfrog Group's efforts to assess patient safety.*⁴⁷⁴

The Commission has reviewed VHA's principal measurement approach, Strategic Analytics for Improvement and Learning Value Model (SAIL) and has determined that although it is modelled on private-sector approaches to measurement and rating, measures are not exactly the same as those reported in the private sector and consequently impede direct benchmark comparisons of VHA to the private sector. Updating these measures so they are consistent with the private sector will be especially important as integrated delivery networks are established and more care is received in the community, as they will allow for making objective comparisons.

Measurement, analysis, and improvement of organizational performance work together as a key system.⁴⁷⁵ The USH has signed a new organizational chart for VHA that acknowledges the interconnection of these elements by establishing an office for organizational excellence that encompasses all of these functions.⁴⁷⁶ To be effective, not only must all of the various units within this office work together but also they must work with personnel in the field to coach and develop their ability to effectively apply performance measurement and improve organizational performance.

⁴⁷¹ "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation?" Ashish K. Jha, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, September 2006, accessed April 21, 2016, <https://psnet.ahrq.gov/perspectives/perspective/31/what-can-the-rest-of-the-health-care-system-learn-from-the-vas-quality-and-safety-transformation>.

⁴⁷² "Quality of Care: How Does Your Medical Center Perform?" Medical Center Performance Search (MCPS), U.S. Department of Veterans Affairs, accessed May 16, 2016, <http://www.va.gov/qualityofcare/apps/mcps-app.asp>.

⁴⁷³ Title XVIII of the Social Security Act 42 U.S.C. § 1395 et seq.

⁴⁷⁴ Kenneth Kizer and Ashish Jha, *Restoring Trust in VA Health Care*, N Engl J Med 2014; 371:295-297, July 24, 2014

⁴⁷⁵ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.

⁴⁷⁶ See the proposed organizational chart at end of Recommendation #12.

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These improvements in performance measurement do not appear to be mirrored on the performance management side of the equation. The draft FY 2016 performance plan template for network directors and medical center directors,⁴⁷⁷ although more streamlined than in previous years, continues to reflect confusion of performance measurement and performance management. It also continues to distribute all of the organization's key (and not so key) priorities under OPM executive core qualifications of leading change, leading people, business acumen, building coalitions, and results driven. The new, streamlined performance measures described above could be considered results-driven; however, the rest of the plan continues to be a confusing presentation of instructions to field leaders, restatements of policy, and performance objectives for action plans. Only the last category is appropriate for workforce performance management.⁴⁷⁸ The Corporate Senior Executive Management Office has implemented a new online performance management data tool that allows for tracking and assessment of the performance management process for senior executive service and equivalent leaders in VA.⁴⁷⁹

To improve performance measurement and organizational performance, the *Independent Assessment Report* recommends that VHA focus and simplify organizational performance measurement to clarify accountability, actively support the mission, and promote continuous improvement. Specifically, VHA must create a simplified, focused, balanced scorecard that reduces the total number of metrics to about 20; establish metrics that support cross-functional collaboration; cascade metrics down the organizational hierarchy; and make data tracking transparent, timely, broadly available, credible, reliable, and meaningful down to the lowest level of the organization. Furthermore, leaders should support continuous improvement, problem-solving, and the exchange of best practices across the organization rather than focusing on only correcting poor performance.⁴⁸⁰ The Commission broadly agrees with this approach to performance measurement. In addition, the Commission emphasizes that VHA customers and stakeholders require public reporting of clinical quality measures that are the same as, and therefore directly comparable to, measures used by the private sector. Although VHA may require an enhanced set of measures that reflects services not broadly deployed in the private sector, or for which measures do not yet exist, a minimum set that are the same as private-sector measures must be used by VHA. As VHA expands integration of care with the community, the use of the same measures as the private sector will be important so that direct comparisons can be made of care delivered inside VHA and that delivered under contract or partnership agreement by the VHA community care network.

VHA also requires a cohesive, integrated personnel performance management system that is specific to the knowledge, skills, and abilities required of health care leaders; includes

⁴⁷⁷ Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan Template*, Network Directors and Medical Center Director, November 20, 2015.

⁴⁷⁸ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.

⁴⁷⁹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁴⁸⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 81, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

accountability to key organizational outcomes; but also assesses organizational and professional objectives. A new personnel performance management system must be free of OPM requirements for executive core qualification and certification process and instead be benchmarked to the private sector⁴⁸¹ and consistent with the new leadership competency model. Congress required DoD to establish independent competency standards for the Commanders of Military Treatment Facilities (MTFs) and should consider doing the same for VHA.⁴⁸² This new performance management model must be based on both evaluation of leadership competencies and demonstrated success in delivering on strategic priorities. To break with current perceptions of the rating scales, it would be helpful to establish a new rating scale for the performance management system. Once the new system is developed, VHA must conduct training to describe the system, rating process, and expectations for both participants and raters.

A performance management system must also address the responsibilities of the rater. This includes clearly establishing written performance requirements for subordinates that are both timely (i.e., prior to the start of the rating period) and meaningful. Raters must be required to provide continuous feedback and assessment throughout the year to recognize and reward progress and outstanding achievements as well as to coach and trouble shoot when needed. The CVCS must establish this expectation by clearly communicating what is required of raters, and most importantly, by modeling the behavior. Finally, raters must provide meaningful ratings that distinguish achievement based on objective performance and demonstrated leadership skills. For instance, the Cleveland Clinic has moved to a system of forced rankings for which the top 10 percent of performers are celebrated and the bottom 10 percent are given intensive coaching or, if justified, sanctioned.⁴⁸³ To accomplish the last point, raters themselves must be given feedback and oversight to understand how their approach to rating compares to other leaders in the organization. If raters' assessments are not consistent with rating standards, their supervisor must bring this issue to their attention and include it in the performance assessment they receive.

The newly established performance management data tool can be used to support the performance management process. The submission of written performance plans (or failure to do so) can be tracked and reported; and the quality of those plans can be audited to provide feedback to raters. Final ratings and a comparison of raters can be conducted and provided to all of the executive raters in the organization. Finally, such a tool can also be used to identify and track high performers who deserve further investment and development as leaders from VHA.

⁴⁸¹ The American College of Healthcare Executives, *2016 Competencies Assessment Tool*, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf. "NCHL Health Leadership Competency Model™," National Center for Healthcare Leadership, accessed May 16, 2016 <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁸² Department of Defense Appropriations Act of 1999, Pub. L. No 105-262, Section 8052 (1998): "None of the funds appropriated in this Act may be used to fill the commander's position at any military medical facility with a health care professional unless the prospective candidate can demonstrate professional administrative skills."

⁴⁸³ Delos M. (Toby) Cosgrove, MD, CEO, Cleveland Clinic, statement during Commission on Care public meeting, March 22, 2016.

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Implementation***Legislative Change***

- Obtain legislative relief from the requirement to use the OPM executive core qualifications system of competencies and ratings and tied to new Title 38 pay authority for health care leaders (see Recommendation #15).

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Establish a workgroup and engage outside experts to create a new performance management system for VHA leaders that is appropriate for health care executives.
- Establish standards and processes to hold raters accountable for creating meaningful distinctions in performance between subordinate leaders.
- The new Office for Organizational Excellence should work with experts to reorganize their internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Other Department and Agency Administrative Changes

- None required.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

Problem

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans, and must become a strategic priority throughout the organization, because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veteran's care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Background

Cultural competence is the ability of health care organizations and their providers to understand and respond effectively to the cultural, language, and in VA's case, military service experience brought by the patient to the health care encounter. It has been endorsed as a viable skill set to reduce, if not eliminate, the rate at which health care disparities occur. VHA has recognized the problem of health disparities among its patient population and has taken steps to address it by tasking certain internal offices with building cultural and military competence throughout the organization. For example, VHA established the Office of Health Equity (OHE) and charged it with championing the efforts to identify, understand, and address health care disparities among veterans.

Analysis

There are seven essential strategies for promoting and sustaining organizational and systemic cultural competence. These strategies include the following:⁴⁸⁴

- Provide executive-level support and accountability.
- Foster patient, community, and stakeholder participation and partnerships.
- Conduct organizational cultural competence assessments.
- Develop incremental and realistic cultural competence action plans.

⁴⁸⁴ Miriam E. Delphin-Rittmon et al., "Seven Essential Strategies for Promoting and Sustaining Systemic Cultural Competence," *Psychiatric Quarterly*, 84, (2013), 53-64.

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- Ensure linguistic competence.
- Diversify, develop, and retain a culturally competent workforce.
- Develop an agency strategy for managing staff and patient grievances.

VA has taken some steps to address cultural and military competence strategies, but these programs are not sufficient to address the breadth and depth of the problem. These strategies will not take hold and become fully ingrained in VHA's culture unless VHA leadership makes them a key priority and commits the resources and on-going, comprehensive training required to build cultural competencies across the entire VHA workforce.

Military Competency

In addition to addressing the needs of minority veterans and vulnerable veterans populations, VA must address military-specific needs and ensure that all providers in the VHA Care System have sufficient military competency (i.e., knowledge of specific issues and health care needs of those who served in the military). VHA's Office of Academic Affiliations developed a *Clinician Pocket Card* for providers that includes questions for clinicians to ask veterans about their military health history.⁴⁸⁵ The *Pocket Card* and similar resources should be given to all VHA and community providers to leverage during veteran patient medical assessments and appointments. In addition, VA's Office of Public Health (OPH) provides information on VA health care programs for veterans who were exposed to environmental and occupational hazards during military service, such as Agent Orange, chemicals leading to Gulf War veterans' illnesses, and Camp Lejeune water contamination.⁴⁸⁶ This military exposure information should be leveraged in VA's cultural competency strategy.

Health care disparities often result from patients' lack of trust in their health care provider; therefore, enhancing the patient-provider relationship is paramount in overcoming these disparities. Stereotypical thinking on the part of providers about certain patient groups, including veterans, may unwittingly influence their prognosis.⁴⁸⁷ Specific reasons for the increase of health care disparities in the military population include the following:

- the cultural norms of the military are such that to admit or display any signs of perceived weakness, especially related to mental health issues, discourages military personnel and veterans from seeking medical care and treatment
- changes in the demographical makeup of the civilian population result in similar changes to the military population
- a small but gradual increase in the number of foreign born personnel who have joined the ranks of the military

⁴⁸⁵ Department of Veterans Affairs, Office of Academic Affiliations, *Military Health History: Pocket Card for Health Professions Trainees and Clinicians*, accessed June 12, 2016, <http://www.va.gov/oaa/archive/Military-Health-History-Card-for-print.pdf>.

⁴⁸⁶ "Public Health: Military Exposures," U.S. Department of Veterans Affairs Intranet, accessed June 12, 2016, <http://vaww.publichealth.va.gov/exposures/index.asp>

⁴⁸⁷ G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," JHHSA (2011), 148.

- a disengaged provider culture that may have become more immersed in the medical culture than the military culture

VA must make cultural and military competence a strategic priority, provide the resources needed to execute the strategy, and hold leadership and providers, both within VHA and community partners, accountable for strategy implementation and integration into VA's culture.

Women

Women are the fastest growing group within the veteran population.⁴⁸⁸ As of 2011, approximately 1.8 million (8 percent) of the 22.2 million veterans were women. Data indicate that by 2020 women veterans will comprise nearly 11 percent of the total veteran population. As the number of women veterans increases, VHA continues to prepare for an increasing demand for women veterans' health care needs.⁴⁸⁹ To address the health disparities affecting women veterans, VHA must provide high-quality, equitable care on par with that of men, deliver that care in a safe and healing environment, provide seamless coordination of services, and actively recognize women as veterans.⁴⁹⁰

In the past, VHA found gaps in its ability to provide comprehensive primary care for women veterans because many primary care providers had little or no exposure to women patients and women were often referred outside of primary care for gender-specific care. To close these gaps, VHA has implemented women's health comprehensive primary care clinic models with the goal of providing complete primary care from one designated women's health provider (DWHP) at one site. An analysis of FY 2012 data revealed that women assigned to DWHPs had more positive overall experiences with care and were more satisfied on six composite scores including access, communication, shared decision making, self-management support, comprehensiveness, and office staff.⁴⁹¹ VA has substantially reduced gender gaps in care,⁴⁹² but women veterans still encounter challenges when accessing care. VHA leadership must support the future planning of women's services and programming so that women veterans receive the highest quality health.⁴⁹³

LGBT Equity

In its systemwide implementation of cultural competency, VHA should leverage best practices from an area in which the agency is already an equity leader: treatment of LGBT patients. Every year since 2007, the Human Rights Campaign has published a Health Equality Index (HEI) report that aims to measure the quality of health care for LGBT patients based on core criteria

⁴⁸⁸ "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, <http://www.womenshealth.va.gov/>.

⁴⁸⁹ U.S. Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care*, April 2015, accessed June 12, 2016, http://www.womenshealth.va.gov/WOMENSHEALTH/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf.

⁴⁹⁰ Patricia M. Hayes, Chief Consultant Women's Health Services, VHA Office of Patient Services, briefing to the Commission on Care, October 19, 2015.

⁴⁹¹ Ibid.

⁴⁹² Ibid.

⁴⁹³ "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, <http://www.womenshealth.va.gov/>.

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that require health care systems to couple strong policies with appropriate training.⁴⁹⁴ In 2016, VAMCs made up 20 percent of all HEI participants. Among participating VAMCs, 84 percent were designated with *Leader* status.⁴⁹⁵ VHA hospitals publicize that discrimination against LGBT patients and employees is prohibited. Senior managers are registered for HEI training. And equal visitation rights are granted to families and friends of LGBT patients. VHA hospitals play a critical role in promoting patient care equality in states where VHA is the only Equality Leader.⁴⁹⁶ VHA should create strong policies and mandatory training, like that used to promote health equity for LGBT patients, to address equity issues for racial and ethnic minorities and women.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- VHA Care System providers should be required to ask patients about their military health history and incorporate veterans' responses into patients' treatment plans.
- VHA leadership should support the future planning of women's services and programming so that women veterans receive the highest quality health care.
- VHA should leverage the best practices developed in support of LGBT equity and implement them across VHA.
- VHA Care System providers should be required to attend comprehensive, on-going cultural and military competency training.

Other Department and Agency Administrative Changes

- None required.

⁴⁹⁴ "How the VA is leading the way on LGBT patient care," Andrew Park, The Week, February 25, 2014, accessed June 12, 2016, <http://theweek.com/articles/450361/how-v-a-leading-way-lgbt-patient-care>.

⁴⁹⁵ "Office of Health Equity: Healthcare Equality Index," U.S. Department of Veterans Affairs, accessed June 15, 2016, http://www.va.gov/HEALTHYEQUITY/Healthcare_Equality_Index.asp

⁴⁹⁶ "How the VA is leading the way on LGBT patient care," Andrew Park, The Week, February 25, 2014, accessed June 12, 2016, <http://theweek.com/articles/450361/how-v-a-leading-way-lgbt-patient-care>.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

Problem

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

Background

During the 1990s, Congress passed the Government Performance and Results Act⁴⁹⁷ to correct shortcomings in the way government was managed and assessed in an effort to bring modern business management practices into the federal government. The law was updated in 2011,⁴⁹⁸ yet one essential

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does all of the following:
 - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
 - Promotes veteran preferences and hiring.
 - Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, due process) through simplified, sensible processes that work for managers and employees.
 - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
 - Provides due process and appeals standards to adverse personnel actions.
 - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
 - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
 - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
 - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
 - Grandfathers current employees with respect to pay and benefits.
- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

⁴⁹⁷ Government Performance and Results Act of 1993, Pub. L. No. 103-62, 107 Stat. 285 (1993).

⁴⁹⁸ GPRA Modernization Act of 2010, Pub. L. No. 111-352, 124 Stat. 3866 (2011).

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component of modernizing the management of federal programs is still missing: reform of human capital management.⁴⁹⁹

The Civil Service Act was initially passed in 1883 and revised in 1978.⁵⁰⁰ The *general schedule*, which governs the pay and job classification process, was codified by regulation in 1949. The U.S. workforce, including the federal workforce, has changed dramatically since these laws and regulations were implemented. As noted in a recent report from the Partnership for Public Service, “the personnel system, designed more than 60 years ago, now governs more than 2 million workers and is a relic of a bygone era, reflecting a time when most federal jobs were clerical and required few specialized skills.”⁵⁰¹ As of 2013, nearly two-thirds of federal employees work in professional or administrative positions focused on knowledge-based work, with the Department of Veterans Affairs accounting for the largest percentage of such workers.⁵⁰²

The Partnership for Public Service calls for broad reform of the civil service system, noting that the

*the federal workforce has become an island disconnected from the larger talent market for knowledge-based professional and administrative occupations that are mission critical. . . . Federal employee pay . . . is not tied to the broader labor market, making it harder to compete with the private sector for talent. That disconnect is exacerbated by a job classification system that describes a workplace from the last century.*⁵⁰³

This system lacks mechanisms for rewarding top performers, demoting or firing poor performers, and holding managers accountable.⁵⁰⁴ The unnecessarily complex hiring system is difficult for applicants to navigate and makes it challenging for hiring managers to identify the most qualified candidates, hindering the ability to bring in experienced candidates from the private sector.⁵⁰⁵

*The civil service system has become a maze of rules and procedures that are not perceived as rational by the people who serve in government or by the general public. . . . Rigid policies . . . are now a burden on a government that needs to encourage flexibility and innovation to meet rapidly changing and difficult challenges.*⁵⁰⁶

⁴⁹⁹ U.S. General Accountability Office, Office of the Comptroller General, *Human Capital – A Self-Assessment Checklist for Agency Leaders*, accessed April 11, 2016, <http://www.gao.gov/assets/80/76520.pdf>. U.S. General Accountability Office, *Transforming the Civil Service: Building the Workforce of the Future – Results of a GAO Sponsored Symposium*, accessed April 11, 2016, <http://www.gao.gov/assets/200/197256.pdf>.

⁵⁰⁰ The Pendleton Civil Service Reform Act of 1883, Pub. L. No. 16, 22 Stat. 403 (1883).

⁵⁰¹ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵⁰² Ibid. The Department of Defense in total has more knowledge workers but the numbers for each service are reported independently and are below the total for the VA workforce.

⁵⁰³ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵⁰⁴ Ibid.

⁵⁰⁵ Ibid.

⁵⁰⁶ Ibid.

The General Accounting Office (GAO) also continues to point to human capital management as a high-risk area across government.⁵⁰⁷ DoD has proposed walking away from the Title 5 civil service system to support modernization of human capital management,⁵⁰⁸ President Barack Obama has repeatedly called for a commission to overhaul and modernize the civil service,⁵⁰⁹ and Congress is considering whether the time is right for civil service reform.⁵¹⁰

VHA currently uses three different personnel systems: Title 5 (the civil service/general schedule system) for senior executive service (SES) and other, mostly nonclinical, employees; Title 38 for physicians, dentists, and other specified health care professionals;⁵⁰⁹ and Title 38 Hybrid for allied health professionals such as pharmacists and licensed physical therapists.⁵¹⁰ Each system has its own set of requirements, procedures, and rules for the employees under its respective authority.⁵¹³ Currently, about two-thirds of VHA employees serve in the Title 38 Hybrid occupations.⁵¹⁴

VHA is not alone in having an excepted service system. More than a dozen agencies have special legislative authority to create a personnel system to fit their particular needs, including the Federal Bureau of Investigation, National Institutes of Health, National Security Agency, U.S. Public Health Service, Defense Intelligence Agency, U.S. Nuclear Regulatory Commission, and National Aeronautics and Space Administration.⁵¹¹ In an acknowledgement of the failure of the general schedule process to meet the needs of certain professions, OPM has also instituted governmentwide direct hiring authority for difficult-to-recruit positions, including medical officer, nurse, pharmacist, radiologic technician, and information technologist – all positions critically important to VHA’s mission success.

Modernizing human capital management is a global imperative for the private sector as well, with 92 percent of participants in one assessment of 7,000 businesses noting that a new approach to human resources is a critical organizational priority in 2016.⁵¹² According to a report from Deloitte, which examined broad human resource (HR) trends, “HR is redesigning almost everything it does – from recruiting to performance management to onboarding to reward systems” to learning and development.⁵¹³ Younger workers are driving many of these

⁵⁰⁷ U.S. GAO, *Federal Workforce—Human Capital Management Challenges and the Path to Reform, Testimony Before the Subcommittee on Federal Workforce U.S. Postal Service and the Census, Committee on Oversight and Government Reform, House of Representatives, Statement of Robert Goldenkoff*, GAO-14-723T, July 15, 2014, Washington, DC, 2014, accessed June 12, 2016, <http://www.gao.gov/assets/670/664772.pdf>.

⁵⁰⁸ “Draft Proposal Calls for Major Revamp of DoD Civilian Personnel System,” Jared Serbu, Federal News Radio, accessed April 8, 2016, <http://federalnewsradio.com/defense/2015/09/draft-proposal-calls-major-revamp-dod-civilian-personnel-system/>.

⁵⁰⁹ “Obama’s Budget Touts Progress Within Federal Workforce, but Offers It Nothing New,” Eric Katz, Government Executive, accessed April 8, 2016, <http://www.govexec.com/management/2016/02/obamas-budget-touts-progress-within-federal-workforce-offers-it-nothing-new/125815/>. The Office of Management and Budget, *Fiscal Year 2016 Budget of the U.S. Government*, accessed May 13, 2016, <https://www.whitehouse.gov/sites/default/files/omb/budget/fy2016/assets/budget.pdf>.

⁵⁰⁹ “Brace Yourselves: Congress Preps Civil Service Reform,” Andy Medici, Federal Times, accessed April 8, 2016, <http://www.federaltimes.com/story/government/management/oversight/2015/01/19/congress-civil-service-reform/21458717/>.

⁵¹⁰ Ibid.

⁵¹¹ See, e.g., 38 U.S.C. § 7401(1).

⁵¹² See, e.g., 38 U.S.C. § 7401(3).

⁵¹³ Joleen Clark, Jack Hetrick, and Donna Schroeder, “Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers,” Alternative Personnel System (2014).

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changes with expectations for meaningful work, learning opportunities, and career progression.⁵¹⁴ These workers have been choosing the federal government in diminishing numbers, with only 6 percent of federal employees currently younger than 30 years of age (compared to 23 percent of the civilian workforce).⁵¹⁵ In VHA, millennials (those 34 and younger) make up only 15 percent of the workforce, but are disproportionately over-represented among staff that quit VHA, at 20 percent.⁵¹⁶

As of January 2016, VHA had a vacancy rate of 16 percent for all positions, despite filling more than 40,000 positions in FY 2015.⁵¹⁷ VHA faces the additional challenge that 40 percent of its overall workforce is eligible for retirement in the next few years.⁵¹⁸ This problem occurs in the face of acknowledged national shortages of physicians⁵¹⁹ and geographic misalignment of the current health care workforce that leaves many localities short of needed providers.⁵²⁰ Taken together, this information makes clear that excellence in human capital management continues to be a business imperative for VHA.

Analysis

The human resource function within VHA needs a fundamental overhaul to increase responsiveness, efficiency, and customer service, as well as to align its orientation to the business needs of VHA.⁵²¹ Medical center directors do not receive the support they need from HR to accomplish hiring, disciplining, and planning for succession of employees.⁵²² During exit interviews, staff members who leave VHA cite barriers to career growth, insufficient professional development, a lack of promotions, and poor on-boarding and training as reasons for departing.⁵²³ In a recent national survey of VA employees, improving end-to-end hiring, recognizing stellar job performance, and providing professional development and career

⁵¹⁴ U.S. GAO, *The Excepted Service: A Research Profile*, GAO/GGD-97-92, accessed April 12, 2016, <http://www.gao.gov/assets/80/79968.pdf>.

⁵¹⁵ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 12, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵¹⁶ Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.

⁵¹⁷ “VA Struggles to Fill Medical Center Positions in Arizona, Across Nation,” Danika Worthington, Arizona Daily Sun, accessed April 5, 2016, http://azdailysun.com/news/local/va-struggles-to-fill-medical-center-positions-in-arizona-across/article_a14e6937-ecc1-5415-9391-7a6d759e5025.html.

⁵¹⁸ Joleen Clark, Jack Hetrick, and Donna Schroeder, *Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers, Alternative Personnel System* (2014).

⁵¹⁹ IHS Inc., *The Complexities of Physician Supply and Demand: Projections from 2013-2025*, accessed April 12, 2016, <https://www.aamc.org/download/426242/data/ihsreportdownload.pdf>.

⁵²⁰ “Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations,” U.S. Department of Health and Human Services, Health Resources and Services Administration, accessed April 12, 2016, <http://www.hrsa.gov/shortage/>.

⁵²¹ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, x, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵²² Ibid., vii.

⁵²³ Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.

planning ranked, numbers one, six, and nine respectively as top priorities for improving the employee experience at VA.⁵²⁴

The Civil Service System Does Not Support a High-Performing Health System.

Recruitment in VHA operates in an incredibly complex environment. Federal rules and regulations make HR more challenging than it is in the private sector.⁵²⁵ For example, interviews in 2014 with more than 500 VHA hiring managers and HR staff members pointed to the top problems with Title 5 recruitments as OPM classification standards, grading of position descriptions, position characterization, and the ranking and rating process.⁵²⁶ The group specifically noted that there are many staff positions required in a health care delivery system that do not translate into a general schedule occupational series; therefore, when the positions are graded, the grade and salary is too low to compete with the private sector. Examples of such positions are custodial workers (hospital employees need to apply antiseptic cleaning techniques, but general custodians do not) and general facilities and equipment maintenance (hospital employees need to understand the maintenance of such items as specialized medical equipment, positive pressure rooms, and sterile plumbing systems that are not requirements for general plant maintenance at an office building).⁵²⁷ In another example, VHA managers noted that the OPM classification standard for supply chain positions rendered VHA unable to compete for local talent because the assigned grade was too low.⁵²⁸

The general schedule system also has been identified as a barrier to career advancement.⁵²⁹ Clerical staff members in particular often cannot advance in pay and responsibility without leaving their positions and moving into a different job series.⁵³⁰ Similarly, frontline customer service staff under the general schedule cannot receive advanced steps within the grade for better performance or completing job-related certifications or degrees, unlike nurses and allied health professionals who can receive advances in pay for these accomplishments.⁵³¹

The hiring process in VHA is acknowledged to take too long.⁵³² “HR is expected to fill a position within 60 calendar days . . . but process requirements, even if perfectly executed, take about 49

⁵²⁴ “MyVA, Putting Veterans First,” MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.

⁵²⁵ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵²⁶ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People. Powerpoint of findings, July 29, 2014.

⁵²⁷ Veterans Health Administration, “Leading Access Scheduling Initiative – People, Assessment of Hiring Barriers,” VHA Classification Workgroup, 2014.

⁵²⁸ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xiii, accessed December 28, 2015, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

⁵²⁹ Ibid.

⁵³⁰ “Classification and Qualification: Classifying General Schedule Positions,” U.S. Office of Personnel Management, accessed November 24, 2015, <https://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/>.

⁵³¹ Pay Administration, VA Directive 5007 (2002). Staffing, VA Directive 5005 (2002).

⁵³² McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 109, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

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to 62 days.” Hiring timelines can span 4-8 months compared to private-sector hiring that takes between 0.5 and 2 months.⁵³³

This finding was echoed in a Northern Virginia Technology Council report on information technology challenges in VA that indicated across the board hiring of needed staff proceeds too slowly. “The causes are complex, but much of the delay can be traced to redundant, inconsistent, and inefficient hiring processes.”⁵³⁴ One driver of extended VHA hiring times is the government background checks and the licensing and credential review for clinical staff that is managed through VetPro, an internet-enabled data bank for credentialing VHA personnel.⁵³⁵

Although addressing recruiting and hiring problems will not be easy, doing so is essential to maintaining VHA’s workforce.⁵³⁶ An internal VHA workgroup that examined HR concluded that a complete break with Title 5 and a reworking of current Title 38 hiring authority is required, stating:

*The existing Personnel system does not meet today’s market or demand. With VHA’s tremendous volume of occupations to hire and significant turn-over rate in critical positions, it is necessary to promote an efficient organizational system to be able to hire qualified candidates as quickly as possible. The current classification system led to disparity across the systems and only looks at the duties of the position versus the qualifications of the person. The VHA hiring system must be agile and attractive to recruit those that just graduated or are entering the workforce... An agency specific excepted employment system would allow VHA to meet the unique staffing demands that are required of a complex health care organization.*⁵³⁷

VHA is Not Competitive in Pay for Many Positions

Many VHA staff have substantially lower earning potential than their private-sector counterparts. Despite a generous benefits package and the possible opportunities for greater work-life balance, and for research and teaching in a system that serves the important role of caring for the nation’s veterans, lower salaries reduce VHA’s competitive edge in the marketplace when trying to attract top talent.⁵³⁸ For example, although VHA is often able to provide physicians an entry salary that is comparable or better than industry standards, physicians’ long-term earning potential is dramatically less in VHA than that of their private-sector peers. “At the top of the salary ranges, VHA providers made less than their counter parts

⁵³³ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow-Clinical)*, 45-49, accessed May 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁵³⁴ Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America’s Veterans*, 12, accessed April 25, 2016, <http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf>.

⁵³⁵ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 37, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵³⁶ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵³⁷ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report*, August 2014.

⁵³⁸ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 39, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

by up to \$310,000 and on average, \$74,631. The only specialties for which VHA physicians made equal to or more than industry averages were anesthesiology, nephrology, ophthalmology, and psychiatry.”⁵³⁹ In another example of barriers to competitive pay, current provisions in law limit VA to a 60 percent level of market pay compensation for allied health professionals, even when recruitment failures demonstrate the need to offer higher salaries.⁵⁴⁰ As noted above in the discussion on classification, failure to appropriately classify positions also leads to a salary that is not competitive with private-sector health care organizations for positions such as customer service personnel.

In the area of educational debt repayment relief, VHA lags behind other federal and state agencies that use such programs to fill critical physician shortages in medically under-served areas.⁵⁴¹ VHA can offer up to a maximum of \$60,000 for 2 years (\$30,000 per year). HRSA National Health Service Corps (NHSC) runs three programs: the NHSC loan repayment program that provides up to \$50,000 in loan payments, the Student-to-Student Loan Repayment Program for up to \$120,000, and the State Loan Repayment Program with each state establishing loan amounts that are administered by HRSA.⁵⁴² These amounts range broadly from \$80,000 in Arizona and Arkansas, \$90,000 in Colorado, \$100,000 in Georgia and Alabama, and \$190,000 in California.⁵⁴³

Clinic Staffing Is Impaired by Current Law, Regulation, and Policy

Successfully reallocating staff to meet veterans’ needs in a rapidly evolving health care environment is difficult in VHA. The *Independent Assessment* recommended that VHA use extended clinic hours and weekend clinics to better optimize space and increase access to care for veterans.⁵⁴⁴ VA policy currently prohibits full-time VA physicians from receiving fee-basis compensation from the same VA facility in which they are salaried, although they can, under certain circumstances, receive fee-basis appointments at other VA facilities.⁵⁴⁵

These restrictions can make it hard to meet policy requirements for night and weekend schedules⁵⁴⁶ without reducing staffing on inpatient units or under-resourced primary care clinics. Use of alternative work schedules and overtime pay for physicians to meet local patient demands should be under control of local medical center directors.

⁵³⁹ Ibid., 40.

⁵⁴⁰ Increases in Rates of Basic Pay, 38 U.S.C. § 7455.

⁵⁴¹ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report*, August 2014.

⁵⁴² “Loan Repayment Program,” U.S. Department of Health and Human Services, National Health Service Corps, accessed June 9, 2016, <http://nhsc.hrsa.gov/loanrepayment/>.

⁵⁴³ “Physician Loan Repayment Guide,” Jimmy Karnezis, accessed April 13, 2016, <https://www.credible.com/blog/physician-loan-repayment-guide/>.

⁵⁴⁴ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 136, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵⁴⁵ VA Handbook 5005, pt. II, ch. 3, § A, para. 3b.

⁵⁴⁶ Extended Hours Access for Veterans Requiring Primary Care Including Women’s Health and Mental Health Services at Department of Veterans Affairs Medical Centers and Selected Community Based Outpatient Clinics, VHA Directive 2013-001 (2013).

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VHA Staff Receive Inadequate Training Including at Initial Hire

Leading practices include providing mandatory onboarding training that introduces policies, procedures, and necessary skills. Onboarding programs include various activities that expose new hires to the culture of the organization and expectations based on roles and responsibilities. A report released by the Society for Human Resources Management suggests, “Formal orientation programs help new employees understand many important aspects of their jobs and organizations, including the company’s culture and values, its goals and history and its power structure.”⁵⁴⁷ To make up for inadequate on-boarding and to fill current staff’s understanding of VA, VHA is providing VA 101 training for current employees, with 60 facilities having completed the training in FY 2015.⁵⁴⁸ Employees in VA continue to desire a wide array of training, including customer service training, professional development, peer-to-peer training, hands-on training, and role-specific training.⁵⁴⁹

HR Professionals Must Focus on People and Business Priorities Not Compliance

VHA job candidates indicate they have unsatisfactory recruiting experiences, noting failures in timely follow-up and communication.⁵⁵⁰ VA human resources management and administration indicate that VA HR professionals do not exhibit a uniform level of competency, frequently do not understand the employee recruitment process end-to-end, and fail to provide high quality consultative support to managers with respect to all HR functions, but particularly in the area of progressive discipline and firing of employees.⁵⁵¹ Currently HR professionals in VA are largely focused on compliance with a complex set of rules,⁵⁵² rather than adding true value to the organization and being able to be full partners in accomplishing VHA business objectives. Resolving these staffing issues would render the overall HR function more effective.

VHA must become the employer of choice to attract and retain the very best health care workforce. To help it accomplish this goal, VHA requires competitive pay and flexible hiring and talent management processes. VHA cannot achieve that goal within its current personnel systems. A uniform alternative personnel system under Title 38 for all VHA human capital management would accomplish all of the following:

- Meet the unique staffing demands of a health care delivery organization.
- Allow market-based compensation and pay-setting latitude using broad pay bands to support staff growth and progression within their job. VHA must consider total compensation (with benefits), as compared to market rates because the government provides many more benefits than private-sector organizations. Consequently, VA may

⁵⁴⁷Talya Bauer, Society for Human Resource Management, *Onboarding New Employees: Maximizing Success*, 2010, 9-10, accessed May 13, 2016, <https://www.shrm.org/about/foundation/products/documents/onboarding-percent20epg-percent20final.pdf>.

⁵⁴⁸ Veterans Health Administration, *Blueprint for Excellence: Fiscal Year 2015 Results: Communicating Accomplishments*, presented to the National Leadership Committee, March 22, 2016.

⁵⁴⁹ “MyVA, Putting Veterans First,” MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.

⁵⁵⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁵¹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁵² Ibid.

pay less than private-sector employers for a position, but the total compensation (with benefits) may end up being equivalent to private-sector total compensation.

- Allow flexibility in the processes used to hire staff including direct hiring when needed.
- Support career planning and professional development through the application of competency models and training specific for health care as part of position management.
- Simplify the management tasks for supervisors and hiring managers who will only need to know one set of rules and processes instead of four.
- Simplify the job of HR professionals who will only need to know one set of rules and processes instead of four.
- Allow development and training of the HR workforce in VHA to focus on only one personnel system to create true end-to-end hiring expertise.
- Reduce competition within government where shortages of HR professionals create competition for Title 5 trained HR professionals.
- Create streamlined and uniform standards and approach to discipline and dismissal.
- Create fairness among staff in sick leave, vacation pay, salary, awards and bonuses, and compensatory time off.
- Support flow of staff between the field and VHA Central Office (VHACO) under a single personnel system.

Establishing a new human capital management system in VHA will neither be easy nor quick, nor will it be a panacea that alone will fix all that is wrong with recruitment, retention, development, and advancement. In designing and implementing a new system, VHA must take full advantage of private-sector resources and expertise in human resource management and ensure that the new system is built to be compatible with the private-sector. As VHA moves toward greater integration of care delivery, with networks of community providers, compatibility in personnel systems and a resulting greater flow of employees between VHA and community sites can help create closer linkages between the two parts of the care delivery system.

Implementation

Legislative Changes

- Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.
- Update student loan reimbursement limits to be competitive with other federally administered programs and market conditions.

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- Establish an appeals process that provides staff appropriate due process that is based on the regulatory standards for the new alternative personnel system.

VA Administrative Changes

- Eliminate barriers to creating hiring pools for positions with frequent turnover (e.g., extend the length of time over which candidates can continue to be hired from a completed certification until all of the qualified candidates are hired or have declined offers).
- Eliminate barriers to initiating a recruitment process when vacancies are anticipated; positions need not be empty before recruitment ensues. In some cases, hires should also be made before the departure of key personnel to allow for on-the-job training and mentoring of the replacement.
- Benchmark credentialing to private-sector processes and consider outsourcing the process as much as practicable through centralized mechanisms.
- Release market pay and total compensation information to the field for all job categories using commercially available data and information, at least every 2 years.

Other Department and Agency Administrative Changes

- OPM should continue to oversee and administer benefits for VHA but not impose any of the other existing conditions or requirements on the management of the new alternative personnel system. The new personnel system should be governed by the new legislative requirements and those established during the anticipated rulemaking process in VA. These requirements include market-based pay, performance awards, or performance and disciplinary processes other than those imposed under Title 38.

Recommendation #16: Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Problem

Effective planning for and management of human capital are core enabling requirements for any organization. If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

Background

As recognized by GAO, “to attain the highest level of performance and accountability, federal agencies depend on three enablers: people, process, and technology. The most important of these is people, because an agency’s people define its character and its capacity to perform.”⁵⁵³ Human capital management, although often viewed as a cost, must be viewed as an investment in business success.⁵⁵⁴ For too long, VA human capital management has been undervalued and under resourced. A 1993 report from GAO outlined many of the same deficiencies found in 2016: a focus on compliance instead of outcomes, a lack of proactive human capital planning and management, and a weak system of rewards and incentives to attract and retain qualified personnel.⁵⁵⁵

Today, VA Human Resources and Administration (HRA) shares responsibility for human capital management with VHA. Neither organization has been able to establish a high-performing, effective, human capital management system. For VHA to transform to a high-performing organization, human capital management must do the same.

Analysis

VA “needs a fundamental overhaul of the core support functions (including human resources) . . . to increase responsiveness and efficiency and improve customer service. These functions should be aligned with the needs of the VHA organizations delivering care to

The Commission Recommends That . . .

- VHA hire a chief talent leader who holds responsibility for the operation’s entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the CVCS.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.
- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

⁵⁵³ U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders*, GAO/OCG-00-14G, version 1, September 2000, 3, accessed June 10, 2016, <http://www.gao.gov/assets/80/76520.pdf>.

⁵⁵⁴ Ibid.

⁵⁵⁵ U.S. General Accountability Office, *Management of VA: Improved Human Resource Planning Needed to Achieve Strategic Goals*, GAO/HRD-93-10, March 1993, accessed June 10, 2016, <http://www.gao.gov/assets/220/217512.pdf>.

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Veterans.”⁵⁵⁶ Governance and responsibility for human capital management is fragmented and complicated.⁵⁵⁷ Medical center directors appear to be largely on their own in addressing human capital management needs, without competent and timely assistance to support hiring employees, planning for succession, and taking disciplinary actions.⁵⁵⁸ Recruiting takes too long and is cumbersome because information is not shared freely among the various organizational components.⁵⁵⁹ Candidates are not treated with respect, experience lengthy intervals between contacts from VA, fail to receive timely follow-up once candidates are selected, and experience a lengthy on-boarding process.⁵⁶⁰ Human capital management also fails to effectively support the disciplinary process, which is perceived as too long and too difficult.⁵⁶¹ Insufficient resources are devoted to training,⁵⁶² leaving VHA vulnerable to failure.

VA requires a comprehensive redesign of the human resources function to be more responsive, more efficient, and more focused on customer service.⁵⁶³ Transforming HR will require “redesigning key processes, shifting the mindset of [human resources] staff from compliance to effectiveness, training [human resources] and its customers on key roles and responsibilities, and rationalizing its technology systems.”⁵⁶⁴

Some progress has been made in updating human capital management functions. VA is in the process of implementing new talent management software to provide better process management and analytics.⁵⁶⁵ HRA has also started a new HR Academy.⁵⁶⁶ The academy is intended to demonstrate alignment between training resources and competency requirements⁵⁶⁷ and to describe the experience needed to advance to the next position level in human resources.⁵⁶⁸ VA instituted a new online senior executive service performance management system that permits real-time tracking of the performance management process and analysis of

⁵⁵⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁵⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁵⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, L3, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁵⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 109, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁶⁰ *Ibid.*, 110.

⁵⁶¹ *Ibid.*, 61.

⁵⁶² *Ibid.*, 67.

⁵⁶³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, L5, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁶⁴ *Ibid.*

⁵⁶⁵ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁶⁶ *Ibid.*

⁵⁶⁷ Department of Veterans Affairs, HR Academy, *TMS User eIDP Checklist*, accessed January 25, 2016, www.vahracademy.va.gov/docs/TMSUserIDPChecklist.pdf.

⁵⁶⁸ “VA HR Academy: Resources,” Department of Veterans Affairs, accessed January 25, 2016, www.vahracademy.va.gov/resources.asp. Department of Veterans Affairs, *VA HR Competency Model Reference Guide*, accessed January 25, 2016, www.vahracademy.va.gov/docs/VAHRCompetencyModelReferenceGuide.pdf.

performance outcomes;⁵⁶⁹ however, HR specialists must still use as many as 30 different IT systems that do not communicate with each other to do their work.⁵⁷⁰ Although some new systems have been purchased, life cycle funding for them is not guaranteed by the Office of Information and Technology and no concrete plan has been approved to replace and consolidate the many current systems that are not interoperable. In addition, funding support for HRA initiatives overall are not planned, allocated, and maintained at consistent levels year-to-year in the departmental budget, impeding long term transformation.⁵⁷¹

A VHA workgroup was formed with HR subject matter experts and leadership to identify hiring barriers and develop recommendations for improvements. The workgroup fielded a survey in July 2014 to gather broad input from VHA on the deficiencies in the management of human capital in VHA. These experts concluded that VHA should move to a new alternative personnel system under Title 38.⁵⁷² (See Recommendation #15.)

Substantial deficiencies in human capital management still remain in VA. The funding mechanism to support the departments' human capital management does not support long-range planning and effective program implementation. The lines of authority and management for human capital management professionals do not permit consistency in the quality and skill of the human capital management professionals hired and promoted, nor does the reporting structure allow HRA to hold human capital management staff accountable for effective service delivery. The investment in human capital management information technology systems has been inadequate for decades.⁵⁷³

Top leadership, including the SECVA, DEPSECVA, and CVCS, must make the transformation of human resources a top priority as demonstrated by investing their personal time in human capital management transformation; reviewing and endorsing a transformation plan including the funding required to accomplish it; receiving regular progress updates; and engaging in problem-solving sessions with human capital management leaders to refine and advance transformation efforts. Top leadership must demonstrate to other leaders that human capital management transformation is an organizational priority by disseminating clear goals for transformation in planning documents, communicating expectations for change that are clear to all key employees, and sharing successes with subordinate leaders and employees. The CVCS must ensure that the executive who leads the human capital management function has the demonstrated knowledge, skills, and experience in human capital management to competently lead the function and make this individual part of the executive leadership team on par with other key functions like finance and clinical operations. (See suggested organization chart in Recommendation #12.)

⁵⁶⁹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁷⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 24, 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁷¹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁷² Ibid.

⁵⁷³ Ibid.

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The SECVA, DEPSECVA, and CVCS must engage subordinate leaders in the transformation process by ensuring the needs of these leaders have informed the transformation solutions; that subordinate leaders are assigned specific responsibilities under the transformation plan; and they are held accountable by the CVCS for outcomes. They must also ensure that the HR transformation and ongoing HR function is adequately resourced to be successful.

The VA HRA and VHA Workforce Management Office must engage change management experts to undertake a review of human resource business processes, management structures, funding, and technology needs to create a transformation agenda and human capital management plan. As VHA is shifting to a new alternative personnel system under Title 38, the human capital management plan should consolidate in VHA the HR functions, responsibility, and authority required to hire, manage, develop, reward, and discipline staff and consider whether functions such as benefit management remain with HRA or move to VHA. Furthermore, the plan should address all of the following issues:

- need for a chief of talent management
- consistency with benchmark standards of private-sector health care systems
- key organizational structures and roles and responsibilities of VA and VHA in human capital management that are clearly defined and consistent with benchmark organizations
- the full life cycle of human capital management (i.e., planning, recruitment, hiring, retention, development, performance management, and discipline), which should be supported effectively by human capital management and fully meet the needs of managers and staff
- federal sharing authority and the ability to outsource human capital management functions to the private sector are addressed
- IT investments and analytical capability to provide meaningful, timely data to managing staffing, performance tracking, and accountability
- meaningful performance metrics and risk management indicators that are established for human capital management⁵⁷⁴
- funding and full-time equivalent employee staffing for human capital functions that meet private-sector benchmark standards for health care
- knowledge, skills, and ability required of human capital management professionals at each grade and within each series, which should be clearly defined, and a requirement to assess current staff, new hires, and promotions against this standard, which should include procedures for dismissal

⁵⁷⁴ U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders*, GAO/OCG-00-14G, version 1, September 2000, 34, accessed June 10, 2016, <http://www.gao.gov/assets/80/76520.pdf>.

Once completed, this analysis and draft plan must be shared widely within the department to gain feedback and input, and it must be shared with OPM, OMB, and Congress. After incorporating feedback and finalizing the plan, HRA should engage change management experts to fully implement the transformation agenda and new human capital management plan. Implementation will require funding contributions from VA and VHA that the SECVA must mandate.

HRA must develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 Hybrid, Title 38 7306, and SES). This process must include clear standards, guidelines, and training for supervisors and managers on how to implement the new progressive discipline process. All managers and supervisors and human capital management professionals must complete the training, and VA must establish a process for ensuring that new supervisors and managers complete the training on an ongoing basis. HRA must develop HR staff to be effective coaches so they can provide the coaching and support that managers need as they embark on disciplinary procedures to ensure timely and effective interventions.

VHA supervisors and managers must be held accountable for applying these procedures when poor performance or conduct occurs. To enable accountability, VHA must have a technology infrastructure to actively track and manage poor performance (annual ratings and disciplinary actions) that both human capital managers and supervisors can use to keep track of issues.

The Commission notes GAO is launching a comprehensive audit of human capital management functions in VA to be delivered to Congress in September 2016.⁵⁷⁵ The review and resulting recommendations will provide further insights to promote meaningful transformation of human capital management in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Employ HR and change management experts to undertake a review of its business processes, management structures, funding, technology, and the legal authority needed in HR to create a transformation agenda and human capital management plan.
- Require VHA to allocate budget to fully support the change plan and ongoing HR operations.

⁵⁷⁵ Ms. Frieda Stenzel, lead investigator, U.S. Government Accountability Office, during an initial meeting with VACO HR&A about a new study being undertaken by GAO, December 18, 2015. The study is intended to 1) assess VHAs capacity to perform its workforce planning and talent management, and 2) evaluate the effectiveness of VHAs human capital functions.

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- Develop and implement an effective progressive discipline process for all staffing authorities.

Other Department and Agency Administrative Changes

- None required.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

Problem

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

The Commission Recommends That . . .

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an other-than-honorable discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

In some cases, individuals have been dismissed from military service with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury, posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

Background

Veteran status is the basis for eligibility for all VA benefits,⁵⁷⁶ and under law a veteran is a person who has met three criteria: active-duty military service (subject to specified exceptions), 2 years of continuous service, and discharge or separation from the military under conditions other than dishonorable.⁵⁷⁷ The military characterizes discharges into one of five categories: honorable, general (under honorable conditions), OTH, bad conduct (adjudicated by a general court or special court-martial), and dishonorable.⁵⁷⁸

Congress has established specific bars to VA benefits. Those barred by statute include deserters, individuals sentenced by a general court-martial, and conscientious objectors who refused to perform military duty.⁵⁷⁹ VA regulations interpret the phrase "discharged or released . . . under conditions other than dishonorable" to mean that a discharge or release because of one of the following offenses is considered to have been issued under dishonorable conditions:

(1) acceptance of an OTH discharge to escape trial by general court-martial, (2) mutiny or

⁵⁷⁶ Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁷⁷ Veterans Benefits, 38 U.S.C. § 101(2).

⁵⁷⁸ Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁷⁹ Certain Bars to Benefits, 38 U.S.C. § 5303(a).

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spying, (3) an offense involving moral turpitude, (4) willful and persistent misconduct, and (5) certain homosexual acts involving aggravating circumstances.⁵⁸⁰

Limited exceptions to those statutory and regulatory bars permit VA to award of benefits. A claimant may be granted benefits if VA determines that the claimant was insane at the time of the offense leading up to discharge.⁵⁸¹ Benefits may be granted based on a prior period of other-than-dishonorable service for individuals with two or more periods of service.⁵⁸²

Former service members with an OTH discharge as a result of a regulatory (rather than a statutory) bar are eligible for VA care for service-incurred conditions.⁵⁸³ Former service members with OTH discharges are not recognized as veterans, so they will be routinely denied treatment unless they initiate, and prevail in, an adjudication conducted by the Veterans Benefits Administration as to the character of their discharge. No routine mechanism exists to trigger adjudication to determine if such a discharge is not dishonorable. In many instances, the character of an individual's discharge is predicated on behaviors that resulted from, or are linked to, behavioral health conditions that had their origin in service, yet VA regulation bars the individual from receiving benefits.⁵⁸⁴

Analysis

Veterans' benefits are understood to be earned. The principle has been described as follows: In harsh environments in which lives may be on the line, serious breaches of conduct that interfere with the military mission should rightfully brand the offender for life and should likewise prohibit them from being eligible for the special military benefits and entitlements reserved for honorable and meritorious service.⁵⁸⁵

Some argue the offender's mental state at the time of the misconduct must be taken into account when considering veteran status.⁵⁸⁶ For example, many service members have experienced combat and sustained psychological wounds of war that manifest behaviors that lead to military discipline.⁵⁸⁷ VA regulations not only fail to account for the role of those psychic wounds, but are themselves overbroad, weak discriminators as to what is truly dishonorable service. To illustrate, commentators have identified two regulatory bars as particularly problematic: those based on moral turpitude,⁵⁸⁸ and willful and persistent misconduct.⁵⁸⁹ Neither of those two regulatory terms, which originated in 1944,⁵⁹⁰ are defined; neither provides

⁵⁸⁰ Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸¹ Certain Bars to Benefits, 38 U.S.C. § 5303(b).

⁵⁸² Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁸³ Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).

⁵⁸⁴ Certain Bars to Benefits, 38 U.S.C. § 5303(a). Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸⁵ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 12-13, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁸⁶ *Ibid.*, 13.

⁵⁸⁷ *Ibid.*

⁵⁸⁸ Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸⁹ *Ibid.*

⁵⁹⁰ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the

criteria or examples of what is or is not covered. Both are ambiguous and susceptible to subjective judgment,⁵⁹¹ with great potential for different VA regional offices reaching different outcomes on the same facts.⁵⁹² VA officials have acknowledged that these terms are broad and imprecise,⁵⁹³ and advocates have documented the resultant disparities in VA adjudicative decisions.⁵⁹⁴

The only specific mental-health exception to the bar-to-benefits rules — that the person was insane at the time of the commission of offense⁵⁹⁵ — is very limited. VA regulations define the term *insane*, as follows:

*An insane person is one who, while not mentally defective or constitutionally psychopathic, except when a psychosis has been engrafted upon such basis condition, exhibits, due to disease, a more or less prolonged deviation from his normal method of behavior; or who interferes with the peace of society; or who has so departed (become antisocial) from the accepted standards of the community to which by birth and education he belongs as to lack the adaptability to make further adjustments to the social customs of the community in which he resides.*⁵⁹⁶

VA's Office of General Counsel (OGC), in a now almost 20-year old precedential opinion, has construed that regulation narrowly. Responding to a request for an opinion regarding the parameters for behavior that would constitute insanity under the regulation, the General Counsel advised, as follows:

*The question of insanity arises in numerous legal proceedings, and its meaning may vary according to the jurisdiction and the object or purpose of the proceeding. However, in all contexts, the term indicates a condition involving conduct which deviates severely from the social norm. Black's Law Dictionary, at 794, states that '[t]he term is more or less synonymous with . . . psychosis, which itself has been defined as "a mental disorder characterized by gross impairment in reality testing' or, in a more general sense, as a mental disorder in which 'mental functioning is sufficiently impaired as to interfere grossly with the . . . capacity to meet the ordinary demands of life.'"*⁵⁹⁷

Armed Forces," *Military Law Review*, 214, Winter, (2012): 160-192, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁹¹ Ibid., 164, 186.

⁵⁹² Ibid., 10, 172. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable*, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁵⁹³ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 67, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁹⁴ Ibid., 68-70.

⁵⁹⁵ Characters of Discharge, 38 C.F.R. 3.12(b).

⁵⁹⁶ Determinations of Insanity, 38 C.F.R. 3.354(a).

⁵⁹⁷ "Office of General Counsel: Opinions Year 1997," U.S. Department of Veterans Affairs, accessed June 15, 2016, <http://www.va.gov/ogc/opinions/1997precedentopinions.asp>. Vet. Aff. Op. Gen Couns. Prec. 20-97, VAOPGCPREC 20-97, 1997, accessed June 15, 2016, <http://www.va.gov/ogc/docs/1997/Prc20-97.doc>.

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As understood by VA OGC at the time, *insanity*, with its emphasis on gross impairment, and as reflected in practice,⁵⁹⁸ is a highly restrictive standard. That narrow standard is also limiting with respect to the range of symptoms that could be considered under the *insanity* exception: gross cognitive impairment or gross impairment in capacity to function in daily life. That limited range effectively excludes behaviors associated with a widely prevalent service-related condition, PTSD. Those behaviors, which often lead to disciplinary actions, include aggressive behavior, substance-abuse,⁵⁹⁹ impulsivity, and risk-taking (including sensation seeking, aggressive driving, interpersonal violence, and self-injurious or suicide-related behavior).⁶⁰⁰ Research has shown that combat veterans with PTSD and other psychiatric diagnoses have a heightened risk of misconduct outcomes.⁶⁰¹ Other than its *insanity* rule, the regulations provide no specific opportunity to consider mental health as a likely cause of, or mitigating factor in, disciplinary issues leading to an individual's discharge.

The following are illustrative examples of how these regulations have worked in practice:

- John, a service member with multiple deployments to Iraq and Afghanistan and 7 years of service, received an OTH discharge after self-medicating with marijuana. He was denied VA treatment for PTSD.⁶⁰²
- Tim, a rifleman with two purple hearts and four campaign ribbons for service in Vietnam, was sent to combat while still 17 years old, and had a nervous breakdown and suicide attempt before his 18th birthday. He was sent back to Vietnam involuntarily for a second tour, and had a third nervous breakdown that led to an AWOL and OTH discharge. He was denied service connection for PTSD because the nature of his discharge.
- Tom, a combat infantryman in the first Gulf War, on his return, started experiencing symptoms of PTSD and attempted suicide. He was denied leave to be with his family,

⁵⁹⁸ Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable,"* accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁵⁹⁹ Deirdre MacManus et al., "Aggressive and Violent Behavior Among Military Personnel Deployed to Iraq and Afghanistan: Prevalence and Link with Deployment and Combat Exposure," *Epidemiologic Reviews*, 37, no. 1, (2015): 196-212, <http://doi.org/10.1093/epirev/mxu006>.

Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, <http://dx.doi.org/10.1186%2F1471-244X-10-88>.

⁶⁰⁰ Lisa M. James, Thad Q. Strom, and Jennie Leskela, "Risk-Taking Behaviors and Impulsivity Among Veterans With and Without PTSD and Mild TBI," *Military Medicine*, 179, no. 4, (2014): 357 – 363, <http://publications.amsus.org/doi/pdf/10.7205/MILMED-D-13-00241>.

⁶⁰¹ Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, <http://dx.doi.org/10.1186%2F1471-244X-10-88>.

⁶⁰² Swords to Plowshares, presentation to Commission on Care, January 21, 2016, accessed June 25, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former service members.

but left anyway. After a 60-day absence, he returned and was given an OTH discharge. He was denied services for 20 years.⁶⁰³

In short, the VA regulation used to determine whether the character of a veteran's OTH discharge is disqualifying does not take into account behavioral health problems associated with military service. As a result, former service members who were discharged for disciplinary problems that cannot be disassociated from PTSD or other behavioral health disorders are routinely barred from VA treatment for those disorders.

Individuals with PTSD and traumatic exposure are at heightened risk of substance abuse,⁶⁰⁴ depression,⁶⁰⁵ homelessness,⁶⁰⁶ premature mortality,⁶⁰⁷ and suicide.⁶⁰⁸ Access to VA health care is vital to successful reintegration of combat-traumatized veterans into society because it provides "the only reservoir of combat PTSD expertise."⁶⁰⁹

The importance of early access to needed treatment for behavioral health conditions like PTSD cannot be overstated,⁶¹⁰ yet many former service members are reluctant to seek treatment for behavioral health problems.⁶¹¹ Those with unfavorable discharge records who finally come forward to seek medical care must not only initiate a request for a character of discharge adjudication, but be prepared to confront a lengthy process if they elect to do so.⁶¹²

⁶⁰³ Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁶⁰⁴ Kipling M. Bohnert et al., "The Association Between Substance Use Disorders and Mortality among a Cohort of Veterans with Posttraumatic Stress Disorder: Variation by Age, Cohort, and Mortality Type," *Drug and Alcohol Dependence*, 128, no. 1-2, (2013): 98-103, <http://www.sciencedirect.com/science/article/pii/S0376871612003328>.

⁶⁰⁵ Leo Sher, Maria Dolores Braquehais, and Miquel Casas, "Posttraumatic Stress Disorder, Depression, and Suicide in Veterans" *Cleveland Clinic Journal of Medicine*, 79, no. 2 (2012): 92-97, <http://doi.org/10.3949/ccjm.79a.11069>.

⁶⁰⁶ Eve B. Carlson et al., "Traumatic Stressor Exposure and Post-Traumatic Symptoms in Homeless Veterans," *Military Medicine*, 178, no. 9, (2013): 970-973, <http://doi.org/10.7205/MILMED-D-13-00080>.

⁶⁰⁷ Joseph A. Boscarino, "Posttraumatic Stress Disorder and Mortality Among U.S. Army Veterans 30 Years After Military Service," *Annals of Epidemiology*, 16, no. 4 (2005): 248-256, <http://www.sciencedirect.com/science/article/pii/S1047279705001109>.

⁶⁰⁸ Holly J. Ramsawh et al., "Risk for Suicidal Behaviors Associated with PTSD, Depression, and their Comorbidity in the U.S. Army," *Journal of Affective Disorders*, 161, no. 1, (2014): 116-122, <http://www.sciencedirect.com/science/article/pii/S0165032714001189>.

⁶⁰⁹ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 14, accessed June 20, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁶¹⁰ Ronald C. Kessler, "Posttraumatic Stress Disorder: The Burden to the Individual and to Society," *Journal of Clinical Psychology*, 5, Suppl. 5, (2000): 4-12, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/10761674>.

⁶¹¹ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶¹² Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 74-78, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

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Several generations of former service members were exposed to combat trauma and continue to live with the psychological wounds of war. Lack of access to treatment for those who sustained psychological wounds that went untreated and were manifest in undesirable behavior in service is concerning. Although Congress could address this concern, VA has the means to remedy the problem without congressional action by amending its own regulations. VA could afford former service members needed treatment for their conditions when they are able to establish that their health problems were incurred in service.⁶¹³ In other circumstances, when it is likely an individual could establish eligibility for VA care, current regulation permits the individual to receive the care on the basis of a tentative eligibility determination.⁶¹⁴ This regulation permits VA to provide treatment without prior adjudication of the character of discharge.

VA should revise its regulations to lift the immediate bar to health care for former service members who have an OTH discharge. VA should award tentative eligibility for health care to at least some former service members who have an OTH discharge. The criteria for awarding tentative eligibility for care could include service in a combat theater, more than a single enlistment, duration of service, or some combination thereof. This approach would allow VA to provide meaningful access to treatment without delay for those likely to be granted eligibility. For health care purposes, VA should also revise its regulations by recognizing that the severe punishment of characterizing a person's service as OTH is not justified when extenuating circumstances (to include behavioral health issues at the time) explain or mitigate that misconduct that resulted in the OTH discharge.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Amend 38 C.F.R. 17.34 to provide for tentative eligibility determinations applicable to individuals with OTH discharges who have had substantial honorable service, including service in a combat theater.
- Amend of 38 C.F.R. 3.12(d) to provide for recognition of extenuating circumstances that show, for purposes of health care eligibility, that service was not OTH.

Other Departments and Agency Administrative Changes

- None required.

⁶¹³ Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).

⁶¹⁴ Tentative Eligibility Determinations, 38 C.F.R. 17.34.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Problem

Although VHA continues to offer the promise of health care to all veterans, its capacity to meet that promise is constrained by appropriated funding.⁶¹⁵ Congress and VA leadership must work to identify who VHA will serve, and what services it will provide, yet eligibility criteria have not been examined in 20 years.⁶¹⁶

Background

VHA's core mission is to care for veterans who has borne the battle. But its secondary mission of caring for veterans' non-service-connected health care needs is longstanding, dating back to Civil War origins. Congress has included veterans without service-connected needs among those eligible as highlighted below:

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use underutilized VHA providers and facilities, providing payment through private insurance.
- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

- In March 1865, Congress incorporated the National Home for Disabled Volunteer Soldiers and Sailors, originally intended for Union veterans who suffered economic distress from disabilities incurred during the Civil War. The National Home constructed the first hospitals for Civil War veterans in 1866, and after a series of acts of Congress, those hospitals were opened in 1887 to veterans suffering economic distress from disabilities not incurred in military service.⁶¹⁷
- The World War Veterans Act of 1924, which established the Veterans Bureau⁶¹⁸ (the predecessor to the Department of Veterans Affairs), authorized its director to provide hospitalization and related travel expenses to veterans whose services dated back as far as 1897, regardless of the type or cause of their disabilities, as long as those veterans who were unable to pay received preferential admission.⁶¹⁹
- Public Law 85-56 (1957), which codified prior VA laws and regulations, effectively expanded eligibility to veterans of future wars, providing needed hospital care for veterans with service-connected disability incurred or aggravated during war, or for any other disability if the veteran is unable to pay for hospital care.⁶²⁰

⁶¹⁵ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶¹⁶ *Ibid.*, 25.

⁶¹⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

⁶¹⁸ The Veterans Bureau consolidated the National Home and other veterans-related functions housed in different government bureaucracies.

⁶¹⁹ World War Veterans Act, 1924, Pub. L. No. 68-242, (1924).

⁶²⁰ Veterans Benefits Act of 1957, Pub. L. No. 85-56, 71 Stat. 83 (1957). That law provided separate authority in section 512 for outpatient medical treatment, which was limited to treatment for a service-connected disability.

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- In 1966, Congress expanded eligibility for hospital care to *peacetime* veterans (of service after January 1955).⁶²¹
- In 1970, Congress extended eligibility for hospital care to veterans 65 and older for a non-service-connected disability,⁶²² exempting that group of veterans from taking the then-required oath affirming their inability to defray the expense of care for non-service-connect ailments.⁶²³
- With the Veterans Health Care Expansion Act of 1973, Congress eliminated the distinction between wartime and peacetime veterans for purposes of eligibility for outpatient care, and further expanded eligibility to outpatient care. It granted veterans who are 80 percent or more service-connected disabled eligibility for treatment of any condition, and authorized others eligible for hospital care to receive outpatient care to prepare for or preclude a need for hospitalization or to complete treatment initiated during hospitalization.⁶²⁴
- Congress expanded eligibility again in 1976, authorizing hospital care for treating a non-service-connected condition of any veteran 65 or older (without regard to ability to pay), authorizing outpatient care for any disability to any veteran 50 percent or more service-connected disabled, and directing VA to ensure, by regulation, special treatment priority to service-connected veterans and others receiving benefits because of a need for aid and attendance, or being permanently housebound.⁶²⁵

Eligibility laws for veterans' health care have changed substantially during the past century, yet the commitment to serving service-connected veterans and veterans in financial need has remained constant.

Prior to enactment of the Veterans' Health Care Eligibility Reform Act of 1996,⁶²⁶ VHA was a hospital-based model with entirely different eligibility rules for hospital care than for outpatient care. The eligibility reform law was aimed at transforming access to VA care from a 1950s hospital-based model to one that erased distinctions between eligibility for hospital and outpatient care.⁶²⁷ It essentially provided that all veterans are eligible for VA hospital care and *medical services*.⁶²⁸

⁶²¹ Veterans Readjustment Benefits Act of 1966, Pub. L. No. 89-358, 80 Stat. 12 (1966).

⁶²² Pub. L. No. 91-500.

⁶²³ S. Rep. No. 91-481.

⁶²⁴ Veterans Health Care Expansion Act of 1973, Pub. L. No. 93-82, 87 Stat. (1973).

⁶²⁵ Veterans Omnibus Health Care Act of 1976, Pub. L. No. 94-581, 90 Stat. 2842 (1976). The patchwork of eligibility provisions resulting from a succession of incremental changes set the stage for development and enactment of the Veterans' Health Care Eligibility Reform Act of 1996, Pub. Law 104-262.

⁶²⁶ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁶²⁷ *Ibid.*

⁶²⁸ The term "medical services" was broadly defined to include in addition to medical examination and treatment, preventive health services; surgical services; wheelchairs, artificial limbs, and similar appliances; optometric and podiatric services; noninstitutional extended care services; and rehabilitative services (including services to restore physical, mental, and psychological functioning. Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C.

§ 1701(6),(8). VA regulations more fully set out the "medical benefits package" that VA is to provide patients, as needed; VA regulations detail that the benefits package includes services ranging from emergency care and prescription drugs to

Recognizing there could be circumstances in which VHA might lack capacity to provide timely care, Congress noted in the reform act that the requirement to provide care would be in effect only to the degree to which there were appropriated funds to pay for such care.⁶²⁹ This qualified availability of care clearly indicated veterans' health care is not an entitlement. Congress went further, though, and established a statutory patient enrollment mechanism for VA to manage access.⁶³⁰ The law specifically requires VA to establish and operate a patient enrollment system managed in accordance with statutory priorities and within any additional priority classifications established by VA. The eligibility reform act gave VA tools both to limit demand consistent with available funding and to discourage veterans from seeking VA care simply to fill an occasional need not met by a private health plan.⁶³¹ The act also requires the SECVA to manage the enrollment system such that care is timely and of acceptable quality.⁶³²

The enrollment system the department established is not being used today to calibrate supply and demand as envisioned.⁶³³ Although law and VA regulation require a system of annual patient enrollment,⁶³⁴ VHA last curtailed enrollment in 2003, and then only for veterans who were deemed eligible based on the category 8 criteria (see Table 8) that include those with higher-level incomes who lack any higher priority. In 2009, the Obama administration eased access for higher income veterans. Under that policy, veterans whose gross household income exceeds VA's current geographic income limit by 10 percent or less may enroll for VA care, subject to cost-sharing requirements.⁶³⁵ In 2014, Congress established the *Choice Program* to expand availability of care through contracts with community providers. Veterans' choice was limited by reference to distance and wait-time issues, but was otherwise broadly open to any enrolled veterans.⁶³⁶

comprehensive rehabilitative services, home health services, noninstitutional extended care services, hospice care, and pregnancy and delivery services and newborn care. Medical Benefits Package, 38 C.F.R. 17.38.

⁶²⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General 38 U.S.C. § 1710(a)(4).

⁶³⁰ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705. As explained in the report of the House Committee on Veterans Affairs which developed the legislation, "[T]he Act would...provide the VA with an important tool, the authority to design and manage access to care through a system of patient enrollment...Enrollment...would help the VA plan more effectively, so that facilities can better calculate and dedicate the resources needed to provide the care its enrollees require. The Act would direct the Secretary...to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment (or registration) system would operate. For example, the VA would be able to establish a system which simply registers patients throughout all or part of a fiscal year, or could employ a time-limited registration period. Significantly, the Act would permit the Secretary to set priorities within the specified priority classifications established in the Act. The Secretary could, for example, establish a policy which, within any priority classification, gives veterans who have previously been "enrolled" as VA patients priority over new applicants. However, the Committee expects any enrollment system to be designed and administered to assure that any veteran with a service-connected condition would receive priority treatment for that condition whether or not that veteran had enrolled for VA care." H. Rep. No.104-690, 6-7.

⁶³¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262; 110 Stat. 3177 (1996).

⁶³² Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705(b).

⁶³³ H. Rep. No. 104-690, 16.

⁶³⁴ Enrollment, 38 C.F.R. sec. 17.36(c). VA regulations state that "[i]t is anticipated that that each year the Secretary will consider whether to change the categories and subcategories of veterans eligible to be enrolled."

⁶³⁵ Enrollment, 38 C.F.R. 17.36(b)(8)(ii),(iv).

⁶³⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014). Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, Pub. L. No. 114-41 (2015).

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Table 8. Priority Groups

Priority Group	Definition
1	<ul style="list-style-type: none"> ▪ Veterans with VA-rated service-connected disabilities 50% or more disabling ▪ Veterans determined by VA to be unemployable due to service-connected conditions
2	<ul style="list-style-type: none"> ▪ Veterans with VA-rated service-connected disabilities 30% or 40% disabling
3	<ul style="list-style-type: none"> ▪ Veterans who are former prisoners of war ▪ Veterans awarded a Purple Heart medal ▪ Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty ▪ Veterans with VA-rated service-connected disabilities 10% or 20% disabling ▪ Veterans awarded special eligibility classification under Title 38, U.S.C. § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation" ▪ Veterans awarded the Medal of Honor
4	<ul style="list-style-type: none"> ▪ Veterans who are receiving aid and attendance or housebound benefits from VA ▪ Veterans who have been determined by VA to be catastrophically disabled
5	<ul style="list-style-type: none"> ▪ Non-service-connected veterans and noncompensable service-connected veterans rated 0% disabled by VA with annual income below VA's and geographically (based on resident zip code) adjusted income limits ▪ Veterans receiving VA pension benefits ▪ Veterans eligible for Medicaid programs
6	<ul style="list-style-type: none"> ▪ Compensable 0% service-connected veterans ▪ Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki ▪ Project 112/SHAD (shipboard hazard and defense) participants ▪ Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975 ▪ Veterans of the Persian Gulf War who served between August 2, 1990 and November 11, 1998 ▪ *Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987 ▪ Veterans who served in a theater of combat operations after November 11, 1998 as follows: <ul style="list-style-type: none"> – Currently enrolled veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge. – **Combat veterans who were discharged between January 2009 and January 2011, and did not enroll in the VA health care during their five-year period of eligibility have an additional one year to enroll and receive care. The additional one-year eligibility period began February 12, 2015 with the signing of the Clay Hunt Suicide Prevention for America Veterans Act. <p>Note: At the end of this enhanced enrollment priority group placement time period veterans will be assigned to the highest Priority Group (PG) their unique eligibility status at that time qualifies for.</p> <p>*Note: While eligible for PG 6; until system changes are implemented you would be assigned to PG 7 or 8 depending on your income.</p> <p>*Note: While eligible for PG 6; due to system limitations, veterans will be manually assigned to PG 8c, yet eligible for the enhanced benefits</p>
7	<ul style="list-style-type: none"> ▪ Veterans with gross household income below the geographically-adjusted income limits for their resident location and who agree to pay copays

Priority Group	Definition
8	<ul style="list-style-type: none"> ▪ Veterans with gross household income above VA and the geographically-adjusted income limits for their resident location and who agrees to pay copays <p>Veterans eligible for enrollment:</p> <p>Noncompensable 0% service-connected:</p> <ul style="list-style-type: none"> – Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA or geographic income limits by 10% or less <p>Non-service-connected and:</p> <ul style="list-style-type: none"> – Subpriority c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority d: Enrolled on or after June 15, 2009, whose income exceeds the current VA or geographic income limits by 10% or less <p>Veterans not eligible for enrollment:</p> <p>Veterans not meeting the criteria above:</p> <ul style="list-style-type: none"> – Subpriority e: Noncompensable 0% service-connected (eligible for care of their service-connected condition only) – Subpriority g: Non service-connected

Analysis

Two decades have passed since Congress last reexamined VHA eligibility and benefits, and many far-reaching changes that affect veterans' health care have occurred in that time. In more than a decade of war, 2.75 million troops have deployed to Iraq and Afghanistan⁶³⁷ where many have faced long and repeated deployments; constant risk of injury and death; and high levels of psychological disorders, substance abuse issues, and physical health problems.⁶³⁸ Post-9/11-era veterans are enrolling for VA care at historically high levels.⁶³⁹

Under current law and VA policy, enrollment is open to a relatively broad spectrum of veterans, though some veterans with higher incomes are not eligible to enroll.⁶⁴⁰ As discussed above, the law draws distinctions between those whose health problems have been adjudicated as service-connected and those whose problems are deemed non-service-connected. If Congress substantially reduced funding for VA medical care, the distinction would be important because those with service-connected issues have higher priority for enrollment. Under VA's current enrollment policy, which bars only veterans with higher incomes from receiving care, the

⁶³⁷ Defense Manpower Data Center, *Contingency Tracking System (CTS) Deployment File*, (Dec. 31, 2015).

⁶³⁸ Institute of Medicine of the National Academies, *Returning Home from Iraq and Afghanistan: Readjustment Needs of Veterans, Service Members, and Their Families*, (Washington, DC: The National Academies Press, 2013), accessed June 25, 2016, <http://www.nationalacademies.org/hmd/Reports/2013/Returning-Home-from-Iraq-and-Afghanistan.aspx>.

⁶³⁹ Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *Profile of Post-9/11 Veterans: 2014*, accessed May 27, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Post_911_Veterans_Profile_2014.pdf.

⁶⁴⁰ Veterans Health Administration, *Enrollment Determinations*, VHA Handbook 1601A.03, 9-10 (2015). Veterans with gross household income that do not exceed VA's means test threshold and a geographic means test by more than 10 percent may enroll for care, while those with higher income and no other special eligibility may not.

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statutory service-connected enrollment priority has little practical significance.⁶⁴¹ Future budget constraints could result in more restrictive enrollment criteria⁶⁴² or recurrence of lengthy wait times that hinder service-connected, disabled veterans' ability to receive timely care.

Current eligibility law does afford special status to veterans who deployed to a combat theater. It grants a 5-year window of eligibility for care to those veterans who are not otherwise eligible.⁶⁴³ All combat veterans are also eligible for readjustment counseling services at VHA Vet Centers without needing to enroll in VHA care and without time limitation.⁶⁴⁴ It is questionable, however, if the 5-year time limit takes sufficient account of continued reluctance of some veterans to seek care for behavioral health problems⁶⁴⁵ or of the difficulties of establishing service-connection years later for conditions that may be linked to wartime exposures to toxic substances.⁶⁴⁶ It is challenging for veterans to establish service-connection for health conditions that may have been caused by or associated with a long-distant exposure for which there may be no documentation. Given emerging evidence that combat exposure should be considered a risk factor for coronary heart disease,⁶⁴⁷ it has been suggested that combat exposure may not only take a toll on psychological health, but may exert a physiologic toll as well.⁶⁴⁸

Congress has attempted to remedy the challenge of documenting toxic exposures and establishing that particular illnesses are linked to wartime or other service exposure. It has, for example, enacted statutes that provide certain veterans eligibility for health care on the presumption that they were exposed to particular toxic substances.⁶⁴⁹ Congress went a step further in the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 which provided eligibility for care for several types of cancer and other specified conditions for family members of veterans who had been exposed to drinking water contaminated with industrial solvents and other toxic chemicals at the Marine Corp base.⁶⁵⁰

Congress has made only limited provision for VA to cover care for family members of certain veterans,⁶⁵¹ but with research suggesting that long combat deployments can take a

⁶⁴¹ Prior to 1996, provisions of law required VA to ensure special priority to service-connected veterans in furnishing outpatient care. 38 U.S.C. § 1712(i), repealed by § 101(c), Pub. L. No. 104-262.

⁶⁴² Enrollment, 38 C.F.R. 17.36(c)(1).

⁶⁴³ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(3), as amended by Sec. 7, Pub. L. No. 114-2 (2015), accessed June 20, 2016, <https://www.govtrack.us/congress/bills/114/hr203/text>.

⁶⁴⁴ Readjustment Counseling Service, 38 U.S.C. § 7309.

⁶⁴⁵ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶⁴⁶ Matthew S. King et al., "Constrictive Bronchiolitis in Soldiers Returning from Iraq and Afghanistan," *New England Journal of Medicine*, 365, no. 10 (2011): 222-230, accessed June 20, 2016, <http://doi.org/10.1056/NEJMoa1101388>.

⁶⁴⁷ Nancy F. Crum-Cianflone et. al., "Impact of Combat Deployment and Posttraumatic Stress Disorder on Newly Reported Coronary Heart Disease Among US Active Duty and Reserve Forces," *Circulation*, 129, (2014), accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.113.005407>.

⁶⁴⁸ Rachel Lampert, "Veterans of Combat: Still at Risk When the Battle is Over," *Circulation*, 129, (2014): 1797-1798, accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.114.009286>.

⁶⁴⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(10).

⁶⁵⁰ Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Pub. L. No. 112-154, 126 Stat. 1165 (2012).

⁶⁵¹ Health Care of Persons Other Than Veterans, 38 U.S.C. §§ 1781-1787.

psychological toll on family members,⁶⁵² there may be circumstances under which it might be argued that VA should afford such family members behavioral health services. Studies indicate that longer deployments, deployment extensions, and posttraumatic stress disorder in military personnel are associated with psychological problems for the spouse.⁶⁵³ Long-term effects are unknown, yet studies suggest children may have heightened risk for psychosocial issues during a parent's deployment.⁶⁵⁴

The experience of the nation's longest war and increased options available under the Affordable Care Act (ACA), particularly to previously uninsured non-service-connected veterans, may raise new questions for policymakers.⁶⁵⁵ VHA's most recent survey of enrollees showed that 20 percent of enrollees reported that they were uninsured, down from 22 percent in 2014.⁶⁵⁶ Enrollment in VHA-provided care meets the ACA requirement for health care coverage, creating pressure to continue to provide care to those enrolled.⁶⁵⁷ Given that VHA serves large numbers who are poor or near poor and have chronic medical conditions and behavioral health problems,⁶⁵⁸ it is important to note that receiving care under an ACA plan would not necessarily be a substitute for the rich benefits afforded through VHA. In addition, adults in this population are only eligible for coverage under ACA through state expansion of Medicaid that 19 states have elected not to accept, making this option unavailable to poor or near poor veterans in many parts of the country.⁶⁵⁹

Over time Congress has expanded VA health care eligibility to increasingly more cohorts of non-service-connected veterans. There is wide variability among different cohorts in the extent to which veterans rely on VA care. Those at the higher-income levels (priority categories 7 and 8) who were generally not eligible for ambulatory care prior to 1996, for example, rely on VA for

⁶⁵² Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, accessed June 20, 2016, <http://dx.doi.org/10.1186%2F1471-244X-10-88>. Swords to Plowshares, presentation to Commission on Care, January 21, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former servicemembers. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁶⁵³ H. Thomas De Burgh et al., "The Impact of Deployment to Iraq or Afghanistan on Partners and Wives of Military Personnel," *International Review of Psychiatry*, 23, no. 2 (2011): 192-200, <http://www.ncbi.nlm.nih.gov/pubmed/21521089>.

⁶⁵⁴ Gregory H. Gorman, Matilde Eide, and Elizabeth Hisle-Gorman, accessed June 20, 2016, "Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints," *Pediatrics*, 126, no. 6 (2010): 1058-1066, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-2856>. Anita Chandra et al., "Children on the Homefront: The Experience of Children from Military Families," *Pediatrics*, 125, no. 1 (2010): 16-25, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-1180>.

⁶⁵⁵ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁶ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁵⁷ "Affordable Care Act & Veterans," Department of Veterans Affairs, accessed May 27, 2016, <http://explore.va.gov/health-care-affordable-care-act?show=all>.

⁶⁵⁸ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁹ "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update," Rachel Garfield and Anthony Damico, Kaiser Family Foundation, accessed March 29, 2016, <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/>.

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less than 22 percent of their outpatient care-needs, based on VA's most recent survey of veteran enrollees' health and use of care.⁶⁶⁰

One consideration, as suggested by a few Commissioners, is the feasibility of allowing veterans' family members and currently ineligible veterans to purchase VHA care through their health plans in areas where VHA hospitals and other facilities might otherwise need to close. In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. A related challenge is maintaining safe volume of care when patient loads decline. As an extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁶¹ Similarly, VHA may be unable to continue offer specialty care in certain areas if it forced to close facilities. Patients in a polytrauma unit for example, require a full spectrum of routine and nonroutine health care.

Closing a low-volume hospital may be the answer in some instances. But closing VHA facilities reduces the choices available to veterans. Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. See Appendix C for a further discussion of the challenge of future VHA hospital closures and an outline of suggested pilot programs.

Substantial changes have occurred since Congress last comprehensively examined eligibility for VHA care. These changes merit a reexamination of VA health care eligibility.⁶⁶² The Commission did not, however, view its charge of examining veterans' access and how best to organize VHA, locate health care resources, and deliver care in the years ahead⁶⁶³ as calling for it to make recommendations on this fundamental policy issue, and recommends that the President or Congress consider tasking another body to develop recommendations for VA care eligibility and benefit design. The Commission's work, however, has illuminated the fact that nothing in law or regulation assures a service-connected, disabled veteran of priority for care. VA can and should amend its regulations to provide for such priority, subject to a necessarily higher priority for urgent and emergent care.

Implementation

Legislative Changes

- Task another body to examine the need for changing eligibility for VA care and benefits design, which would include simplifying eligibility criteria, and may include exploring

⁶⁶⁰ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 75, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁶¹ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

⁶⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 25, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶⁶³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

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pilots for expanding eligibility for nonveterans to use underutilized providers and facilities when paid for through private insurance.

VA Administrative Changes

- SECVA should amend 38 C.F.R., chapter 17 to establish that veterans with service-connected disabilities shall be afforded priority for access to care, subject to the priority dictated by clinical care needs.

Other Departments and Agency Administrative Changes

- None required.

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APPENDIX A: FINANCING THE VISION AND MODEL

Estimating the Cost of Alternative Policy Proposals

This chapter presents estimates of the costs of allowing veterans access to expanded community care through integrated networks, as well as a range of other options. In the *Recommended Option*, the one chosen by the Commission and described in Recommendation #1, veterans would be eligible to receive community care for primary and standard specialty care with a referral from any primary care doctor in the VHA Care System. Special emphasis care, care provided in a distinctive fashion by VHA, is not included in community networks.

In addition to the *Recommended Option*, we considered three alternatives that are based on a similar concept of integrated networks, but which have potential costs that could vary dramatically due to differences in the openness of access to community care and the breadth of services eligible. We also estimated the costs of three options that differ in focus from the integrated network options, including options that move selected services entirely to the community, set up a premium support model, and expand access to all Priority 8 veterans. Finally, we estimated costs for two additional policies: expanding nurse navigator/care coordinator staff to help guide and coordinate veterans' care in the integrated networks of expanded community care and granting temporary eligibility for VA health care to those with other-than-honorable discharges.

Baseline Projections

We used projections from the Enrollee Health Care Projection Model (EHCPM) produced by VHA and Milliman as the baseline upon which to build our estimates. However, with the exception of the options involving premium support and an expansion of Priority 8 enrollment, we use separate analyses and not the EHCPM to derive the estimates. Costs of VA care are modeled as the product of utilization and cost per unit of care (unit cost). Utilization is dependent on both enrollment in, and reliance on, the VA health care system, total demand for health care, and other factors. Enrollment measures how many people enroll to receive VA health care, and reliance is the percentage of their medical care that enrollees receive through VA or VA-financed community care. Unit costs measure the cost of each health care service. Unit costs can be calculated for care in VA facilities, for care outside of VA facilities, or for both, depending on the scenario being estimated.

Utilization

Utilization depends on enrollment, reliance, total demand for health care, and characteristics of the health care system, such as medical technology and practice patterns. We discuss enrollment and reliance in further detail below, but overall demand for health care is similarly important. Enrollment, reliance, and overall demand each have a multiplicative effect on

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utilization and total costs. For example, if enrollment increases by 10 percent, costs will increase by 10 percent (assuming new enrollees have the same characteristics as existing enrollees). Thus, it is important to consider carefully the effect of any policy change on enrollment, reliance, and overall demand for health care. Each of these factors is subject to effects by policies that make care more convenient, less expensive, or less restricted.

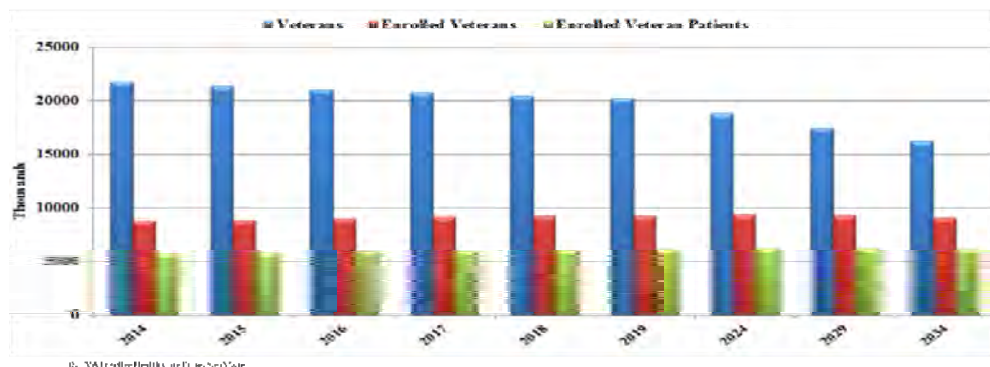
Enrollment

Currently there are 22 million veterans, 9 million of whom have enrolled and 7 million of whom are eligible to enroll but have not done so. Even though the number of veterans is decreasing, projected numbers of enrollees and patients should remain relatively stable during the next 20 years. Younger veterans enroll at particularly high rates, and once enrolled, they remain continuously enrolled until death.

This enrollment trend is subject to change based on various inputs. Enrollment rates are projected based on current policy, and if policy changes, the number of enrollees and patients will change. For example, an increase in cost sharing would likely decrease enrollment and the number of patients, yet easing access to care would likely increase enrollment and the number of patients. Changes to other health insurance policies outside of VA can also affect enrollment and the number of patients (for example, changes to the Affordable Care Act).

Figure A-1. Changes in Number of Veterans, Enrollees over a 20-year Period

Veterans, Enrollees, and Patients FY 2014-2034



Reliance

On average, enrolled veterans receive 34 percent of their health care through VHA, and approximately 80 percent of enrollees have other health insurance in addition to VA health care. Many factors affect reliance rates including, age, income, service-connected disabilities, distance from VA facilities, cost-sharing levels, and characteristics of other insurance options. Any policy that affects the cost of receiving VA care, the convenience of receiving VA care, the cost or convenience of other health insurance held by enrollees, or demographic or health characteristics of enrollees, is likely to change reliance. Any increase in reliance will increase

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costs to VHA, and the effect can be very large. In the absence of a policy change, VHA predicts that reliance will decline slightly from 34 percent to 32 percent during the next 20 years.

Unit Cost

Unit cost measures how much a particular service, procedure, or drug costs to provide. Unit costs can measure the cost of the unit of care in the VHA system or in the community, depending on where veterans receive care. We used unit cost projections from the EHCPM for 78 Health Care Service Categories (HSCs). The unit of measurement depends on the service. Examples include office visits, pathology procedures, vision exams, and inpatient surgical days. Unit cost projections reflect anticipated changes in price inflation and health care practice patterns, as well as historical trends. EHCPM projects separate unit costs, depending on whether veterans receive a service in a VA facility, in the community at historic Care in the Community (CITC) rates, or in the community at Medicare allowable rates. Any policy that affects the quantity of care provided in VA facilities, as opposed to the community, will have an effect on the total cost of care. If veterans receive care in the community, the rate of provider reimbursement will also affect costs.

Baseline Cost Projections

The baseline cost projections, produced by the EHCPM, show how cost will change in the future. They incorporate projected changes in enrollment, reliance, unit costs, and other factors. The projections reflect current policy with regard to enrollment eligibility and VA health care benefits, with the exception of the *Choice Program*, which is assumed to continue for veterans living more than 40 miles away from a VA medical care facility.⁶⁶⁴

We based the projections on assumptions about inflation and anticipated effects of changes in health care practice on the cost of VA health care in the next 20 years. New military conflicts, policies, legislation, regulations, and external factors, such as economic recession, can occur and change projected demand for VA health care during this period. The projections do not include requirements for several activities/programs not projected by the VA EHCPM, including nonrecurring maintenance; readjustment counseling; state-based, long-term services and support programs; and some components of the CHAMPVA program.

In the absence of any policy changes, costs increase from \$53 billion in 2014 to \$125 billion in 2032. This growth is largely due to inflation and how health care practices are expected to change over time, which reflects factors that affect the cost of both VA and non-VA health care. These trends increase the cost of VA health care regardless of changes in enrollment growth and demographics. Within enrollment, the increasing number of enrollees adjudicated for service-connected disabilities by the Veterans Benefit Administration (VBA) is the most significant driver of cost increases. Enrollees will likely increase their reliance to reflect the substantially higher reliance of enrollees in the service-connected Priorities 1-3.

These baseline estimates, along with our scenario estimates presented below, carry some key limitations. First, the EHCPM does not track capacity at VA facilities. We assume health care

⁶⁶⁴ Veterans qualifying based on wait times or excessive travel burdens are not included.

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utilization will increase or decrease at the average unit cost, when in fact it is the marginal cost that would be relevant for cost estimates. This marginal cost could be smaller or larger than the average cost, depending on existing capacity. Although we did make some assumptions about fixed and variable unit costs when care leaves VA facilities in our policy estimates below, precise estimates are not possible given data availability. Second, the EHCPM does not consider health care capacity in local communities. For these and other reasons, the EHCPM is best for the near future and for policy scenarios that do not stray dramatically from current policy. A 2008 RAND review of the EHCPM highlighted these limitations, which are particularly important for analyzing policy changes such as expanded community care.⁶⁶⁵ In light of the types of policy choices VHA is likely to consider in the future, it would be particularly beneficial for VHA to collect and incorporate the data necessary to mitigate these limitations. Due both to these limitations and to the general uncertainty regarding any long-term changes in the health care system, we suggest focusing attention on the 2019 estimates of the scenarios below, as 2019 is the first year to incorporate the fully phased-in effects of the scenarios.

Policy Estimates

In this section, we present results for the *Recommended Option* and three alternative options for expanding access to providers outside of VA through integrated networks. These options expand community care for different categories of care and vary by whether referrals are required to receive specialty care. We present estimates for several other scenarios we examined, each with a design or focus that differs from the integrated network options. Finally, we estimate costs for two other policies discussed in this report: (1) expanding the use of nurse navigators to help patients coordinate their care in VA and in the community, and (2) expanding eligibility to all veterans with an other-than-honorable (OTH) discharge until the adjudication process is complete to determine whether they will remain eligible.

Community-Delivered Services Networks

This section describes the *Recommended Option* and the first three alternative options. At least initially, all care currently provided by VA would continue to be provided by VA. In addition, expanded community care, also called Community-Delivered Services (CDS), will be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA. CDS will focus on tertiary and quaternary care, and may include primary care and all standard specialty care, depending on the scenario considered. CDS will not include special-emphasis care and some types of specialty care provided in a distinctive fashion by VHA. The network of CDS providers that VA will coordinate varies by community. To make the flow of service both appropriate and smooth in operation, there will be navigators who will help guide veterans to the best and most appropriate providers inside and outside VA.

The Commission's recommendation to create the VHA Care System (see Recommendation 1) considers the ways in which health plans can vary the size and scope of networks as a means of managing costs. It highlights that broad, open networks offer greater choice, but narrow, well-

⁶⁶⁵ Katherine M. Harris, James P. Galasso, and Christine Eibner, "Review and Evaluation of the Enrollee Health Care Projection Model," RAND Corporation, Santa Monica, CA, 2008.

managed networks potentially result in lower costs. It discusses ways in which, after networks are designed, VHA could exercise additional cost controls by steering patients to different providers within the networks. Finally, the recommendation regarding the VHA Care System emphasizes that access and local needs are important considerations in setting up the integrated networks, and that governance of the networks should be a process of ongoing management and evaluation.

In the estimates that follow, we assume that networks are designed and governed in a way that gives major consideration to cost, choice, and access. We assume that management of the integrated networks would be an iterative process that involves continual evaluation of resulting outcomes, including cost outcomes, and that networks would be adjusted in light of those outcomes. We also assume that local communities and services with poor access would require more community providers and/or expanded capacity within VHA than those that already have adequate access. Finally, we assume that the networks will be integrated, relatively narrow, and well-managed with the aim of controlling costs effectively. One exception is that for the *Recommended Option*, we added an estimate that assumes less-managed, broader networks to illustrate that costs are sensitive to network size and management.

Technical Assumptions for Community-Delivered Services Options

We based our estimates on utilization and unit cost data and projections for 78 HSCs that we obtained from the VHA Office of Policy and Planning. Starting from a base year of 2014, we projected utilization and unit costs through 2034. For HSCs that are eligible for CDS networks, we assume a certain fraction of care, depending on the option, shifts from VA facilities to the networks. We assume traditional CITC will be offered and used at baseline levels.⁶⁶⁶ We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks. All effects are phased in during the first 5 years.

Both CDS networks and CITC are priced at Medicare allowable rates by matching Medicare fee schedule data to VA HSCs.⁶⁶⁷ A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities.

For care shifting into the CDS networks, we use data on the components of HSC unit costs that we obtained from the VA Allocation Resource Center. We assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. These portions, which together averaged approximately 10 percent of care in 2014, form our proxy for the portion of unit costs that VA will not be able to shed in scenarios for which, on net, care leaves VA facilities for CDS networks. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance. These costs are not part of the EHCPM, and costs and/or savings associated with changes to facilities and nonrecurring maintenance are not included in our estimates.

⁶⁶⁶ CITC accounted for approximately 11 percent of modeled expenditures in the base year 2014.

⁶⁶⁷ Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

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Improving access, choice, and/or quality of services is likely to induce greater reliance and enrollment in the VA system. Although reliance and enrollment increases result in greater budgetary costs for VA, it is important to note that these increases do not represent societal costs or costs to the government. The VA budgetary cost increases may be associated with reductions in out-of-pocket expenses and improved health care benefits for patients, as well as savings to Medicare, Medicaid, and other government programs. Our cost estimates are confined solely to the VA budget.

Approximately 52 percent of eligible veterans have enrolled in VA health care, and enrolled veterans receive 34 percent of health care through VA. There is little data from which to anticipate how reliance and enrollment might change under the scenarios, and our estimates use wide ranges of assumptions for these parameters. In forming our assumptions, we consider a variety of factors, such as insurance coverage and other characteristics of eligible veterans (both enrolled and unenrolled), survey responses of veterans (both enrolled and unenrolled) on use and reasons for lack of use of VA health care, and research on take-up of health insurance coverage.⁶⁶⁸ We are confident that enrollment and reliance would increase more with greater patient choice and access. For all options, we present low, middle, and high estimates.

In addition to increases in reliance and enrollment, reduced cost sharing, increased convenience of receiving community care, and the removal of a requirement to get a referral for specialty care can increase the total amount of medical care that a patient receives. Depending on the option considered, some health care is subject to reduced cost sharing from levels typical of private insurance coverage and Medicare to the very small levels of cost sharing found in the VA system. We assume utilization increases for health care subject to lower cost sharing and/or removal of a requirement to get a referral, with our estimates based in part on the literature examining how cost sharing affects health care demand.⁶⁶⁹

Caveats

There are a number of caveats associated with all of our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. New enrollees are assumed to cost slightly less than existing enrollees for *CDS Alternative 3* and the

⁶⁶⁸ Examples of sources include: the 2014 American Community Survey; the 2010 National Survey of Veterans; the 2015 Survey of Veteran Enrollees' Health and Use of Health Care; Katherine Baicker, William J. Congdon and Sendhil Mullainathan, "Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics," *The Milbank Quarterly*, 90(1) (2012), 107-134.

⁶⁶⁹ Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," Washington, DC, 2008. Willard G. Manning, Joseph P. Newhouse, Naihua Duan, Emmett B. Keeler, Arleen Leibowitz, and M. Susan Marquis, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review* 77(3) (1987), 251-77.

same as existing enrollees in the *Recommended Option* and *CDS Alternatives 1 and 2*.⁶⁷⁰ Finally, we do not estimate any administrative costs associated with CDS networks other than the additional RN care managers hired to handle the increased clinical and administrative burden of expanded community care. These additional, nonmodeled administrative costs could be substantial.

Commission Recommended Option

The *Recommended Option* would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA or a third-party administrator. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in VA in a distinct fashion).⁶⁷¹ In 2014, 68 percent of care would have been eligible for CDS networks at current VA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network. In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a doctor in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and 20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was

⁶⁷⁰ Assumptions based on previous analysis by VHA and Milliman.

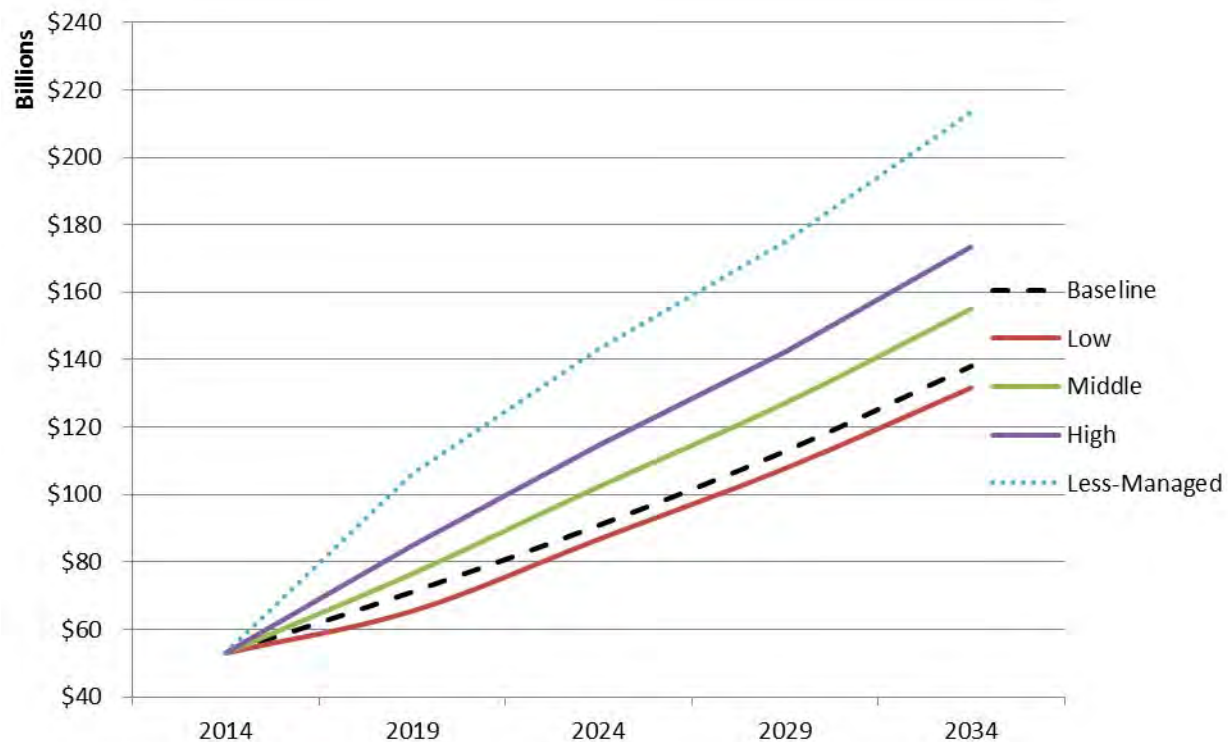
⁶⁷¹ Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

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formerly subject to sizable cost sharing with private insurance or Medicare, and now it would be subject to little if any cost sharing associated with VA-financed care.

Figure A-2 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from \$65 billion to \$85 billion in 2019, with a middle estimate of \$76 billion. The middle estimate is moderately above the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is \$106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

Figure A-2. Projected Costs of Recommended Option



APPENDIX A
FINANCING THE VISION AND MODEL

COST ESTIMATES Commission on Care Scenarios							
	Brief Description	Utilization Increase	Enrollment Increase (low, middle, high)	Reliance (low, middle, high)	Cost FY 2014 Actual (billions)	Cost FY 2019 Projected (billions)	Cost FY 2034 Projected (billions)
Baseline	2014 Actual		9,078,615	34%	\$53	\$ 71	\$ 138
Recommended (low)	Referral Based Care in VHCS (68% of current VHA care eligible as CDS)	+20% of new demand in CDS Care	5%	40%	\$	65	\$ 132
Recommended (middle)	same	same	15%	50%	\$	76	\$ 155
Recommended (high)	same	same	20%	60%	\$	85	\$ 173
Recommended (less-managed)	same	same	50%	60%	\$	106	\$ 213
Alternative 1 (low)	Similar to Recommended but primary care, inpatient med and surg and some standard specialty care not eligible for CDS remain in VHA (47% of care eligible for CDS)	+20% of new demand in CDS Care	0%	10%	\$	66	\$ 128
Alternative 1 (middle)	same	same	5%	35%	\$	73	\$ 140
Alternative 1 (high)	same	same	10%	50%	\$	78	\$ 151
Alternative 2 (low)	Similar to Alternative 1 but primary care coordinator must only be consulted; no referral required (47% of care eligible for CDS)	+20% CDS eligible Care	5%	60%	\$	97	\$ 191
Alternative 2 (middle)	same	same	10%	80%	\$	123	\$ 243
Alternative 2 (high)	same	same	20%	100%	\$	154	\$ 307
Alternative 3 (low)	Similar to Alternative 2 but primary care, inpatient med/surg and specialty care eligible for CDS and no consult required	+20% CDS eligible Care	75% (level)	80%	\$	167	\$ 320
Alternative 3 (middle)	same	same	85% (level)	90%	\$	206	\$ 395
Alternative 3 (high)	same	same	95% (level)	100%	\$	250	\$ 479
Keep Selected Services (low)	Move most standard ambulatory specialty care to community	+20% of new demand in CDS Care	0%	10%	\$	64	\$ 128
Keep Selected Services (middle)	same	same	4%	25%	\$	70	\$ 136
Keep Selected Services (high)	same	same	8%	40%	\$	75	\$ 145
Premium Support	Enrollees under age 65 can choose a subsidized insurance premium with cost sharing in lieu of VHA care	42% of enrollees <65 choose premium support	6%		\$	82	\$ 158
Eligibility Expansion	Allow all eligible veterans to enroll	increase to 30% market share among priority 8	5%		\$	72	\$ 140
Initiatives	Nurse navigators for CDS care				\$	71	\$ 138
	Make veterans with Other than Honorable Discharges Temporarily Eligible for VA Health Care While Claims are Adjudicated				\$	72	\$ 139

Additional Sample Cost Models

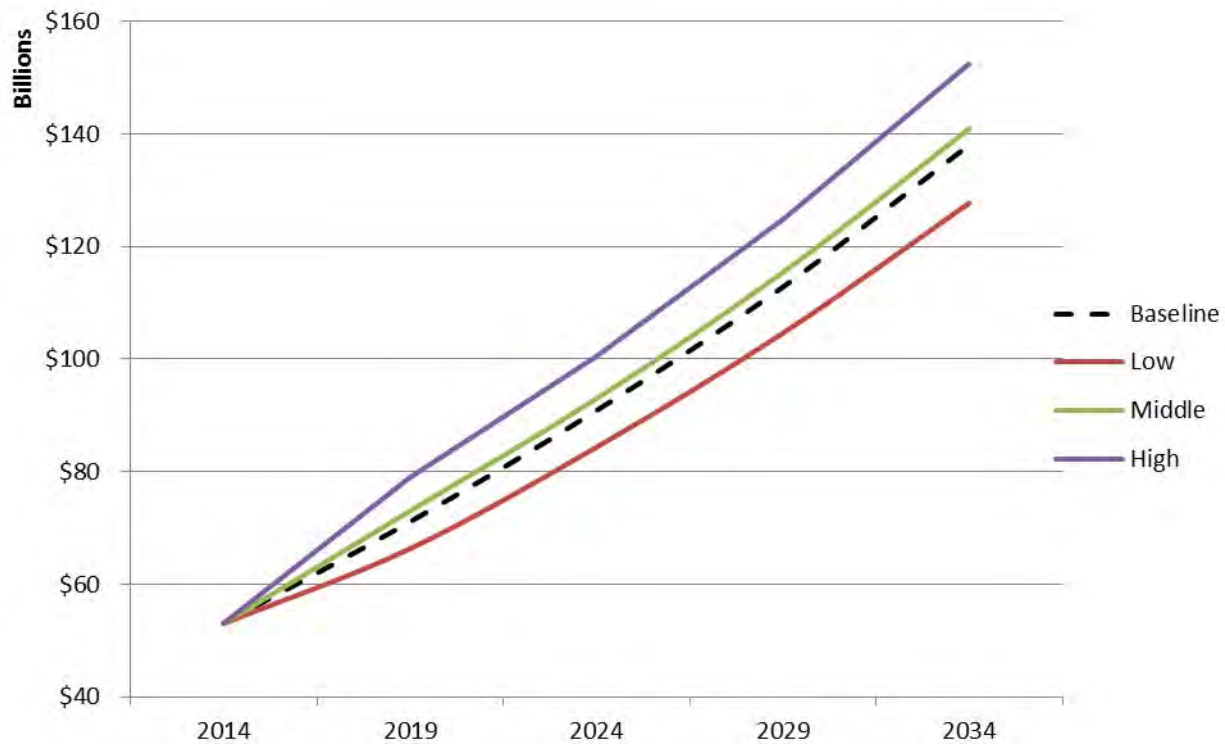
CDS Alternative 1

CDS Alternative 1 is similar to the Commission's *Recommended Option* above. The main difference is that a narrower subset of services is available in the CDS networks. Primary care, inpatient medical and surgical care, and some standard specialty care are not eligible for CDS networks and must be accessed within VA. The CDS network for *CDS Alternative 1* would focus on tertiary and quaternary care; it would not include primary care, some specialty care, inpatient medical and surgical care, and special-emphasis care (care that is provided in VA in a distinct fashion). In 2014, 47 percent of care would have been eligible for CDS networks.

Because less care is eligible for CDS networks than in the *Recommended Option*, less care will shift to CDS networks, reliance increases will be smaller, and enrollment increases will be smaller. We assumed that 50 percent of eligible care shifts from VA facilities to CDS networks. We modeled increases in reliance of 10, 35, and 50 percent, which correspond to reliance rates of approximately 37, 46, and 51 percent. These reliance increases pertain only to CDS care, not CDS-eligible care provided in VA facilities. We modeled enrollment increases of 0, 5, and 10 percent. As in the *Recommended Option*, we assume newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks.

Figure A-3 displays estimates for CDS Alternative 1. Estimates range from \$66 billion to \$78 billion in 2019, with a middle estimate of \$73 billion. As in the *Recommended Option*, the middle estimate is close to the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to Medicare allowable rates for CDS networks and CITC offsets these effects.

Figure A-3. Projected Costs of CDS Alternative 1



CDS Alternative 2

Like *CDS Alternative 1*, CDS care in *Alternative 2* would focus on tertiary and quaternary care. CDS networks would not include primary care, special-emphasis care, inpatient medical and surgical care, and some types of specialty care.

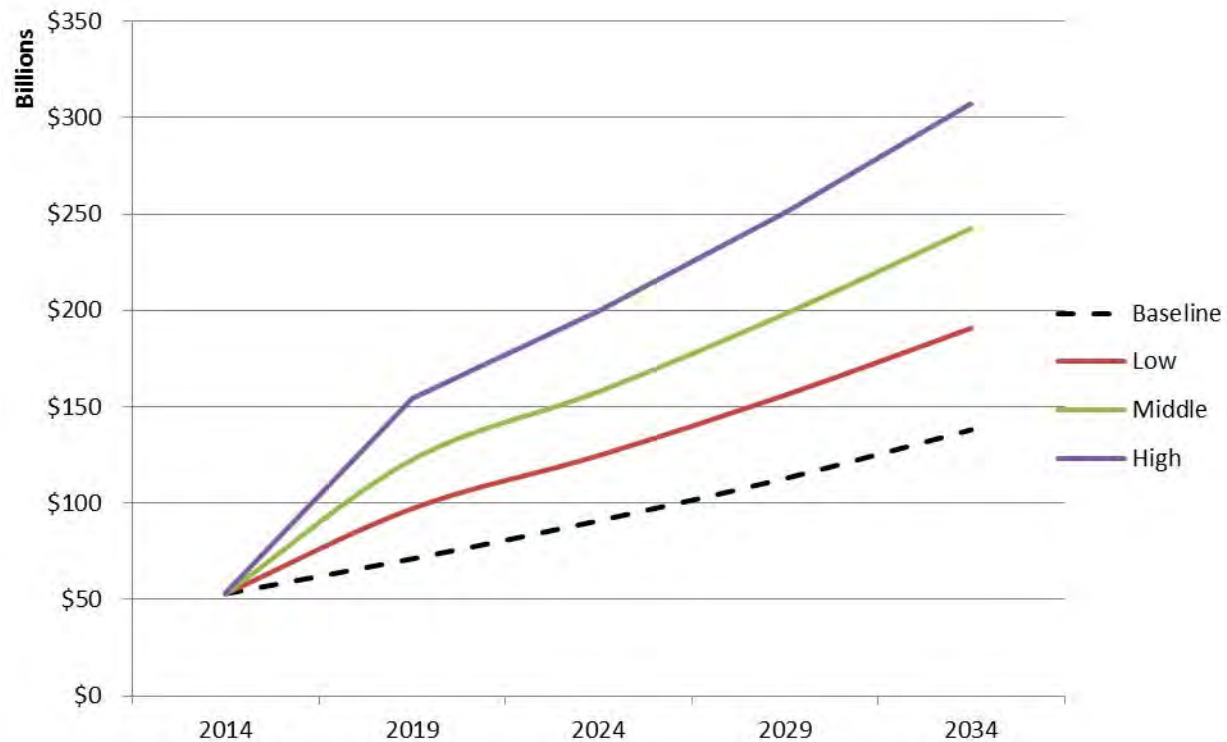
This option differs from the *Recommended Option* and *CDS Alternative 1* in that veterans must consult their VHA primary care provider in some way before seeking specialty care, but they *do not* need a referral to receive CDS eligible care whether they receive it in or out of VA. Some specialty care, all primary care, and all special-emphasis care are only provided in VA unless the veteran is eligible for traditional CITC. However, after the primary care consultation, the choice of whether to seek eligible care in CDS networks is entirely up to the veteran. As in *CDS Alternative 2*, the care eligible for CDS networks comprised 47 percent of total modeled expenditures in 2014.

We expect reliance increases to be relatively high, and we apply these reliance increases to CDS eligible care regardless of where veterans receive it because referrals are not required for any CDS eligible care. Further, we expect enrollment increases to be higher than the *Recommended Option* and *CDS Alternative 1* because the absence of a referral requirement makes this a more attractive policy for potential enrollees. We model reliance rates of 60, 80, and 100 percent for care eligible for CDS networks; enrollment increases of 5, 10, and 20 percent; 70 percent of VA facility care shifting into CDS networks; and a 20 percent utilization increase for CDS eligible care.

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Estimates are displayed in Figure A-4. In 2019, the baseline projection is \$71 billion. *CDS Alternative 2* estimates range from \$97 billion to \$154 billion, with a middle estimate of \$123 billion. The potential for considerable reliance and enrollment increases could push costs substantially higher than the baseline.

Figure A-4. Projected Costs of CDS Alternative 2



CDS Alternative 3

CDS Alternative 3 differs from *Alternative 2* in two main ways. First, a broader array of care is eligible for CDS networks. CDS would include primary and standard specialty care, including inpatient medical and surgical care. It would not include special-emphasis care (care that is provided in VA in a distinct fashion). This array of eligible care is the same as that for the *Recommended Option*, and comprised 68 percent of total modeled expenditures in 2014. Second, enrollees do not need to consult with a primary care doctor in order to access CDS eligible care.

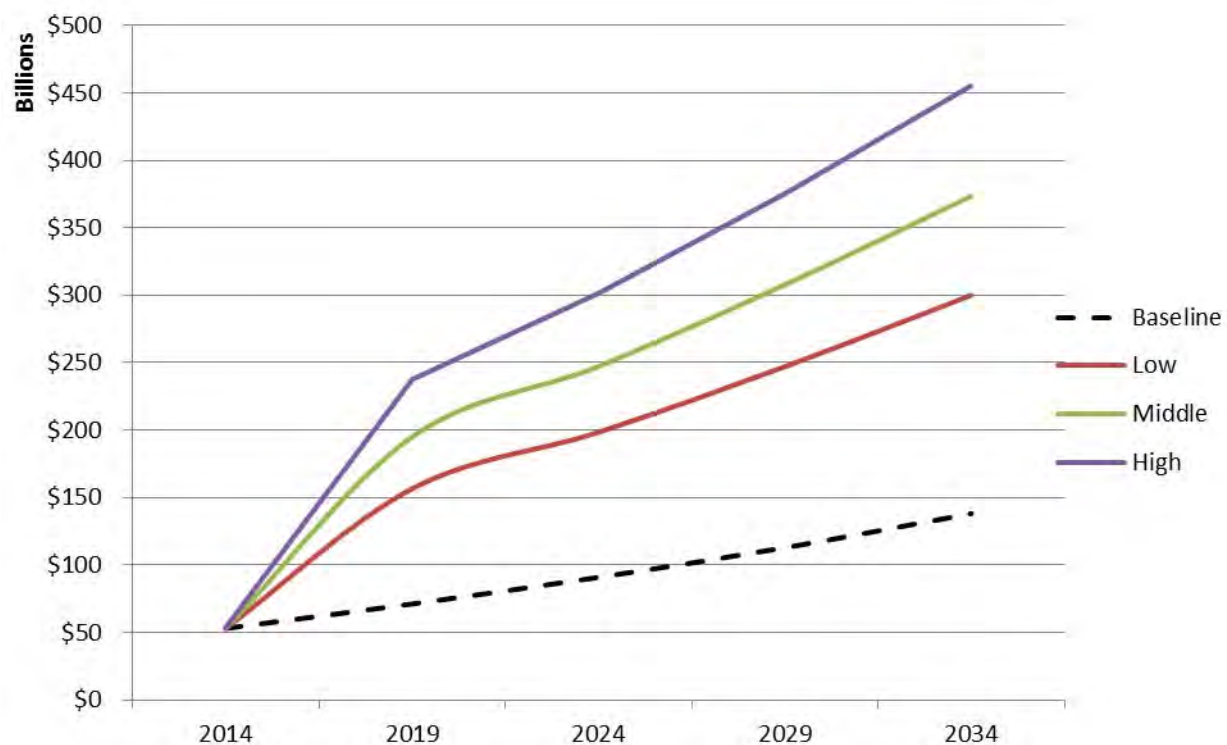
CDS Alternative 3 would offer an extremely generous benefits package for patients. With no referral or consultation, no premiums, and little if any copayments, patients would have access to a robust network of high-quality providers in their area. Although care within VA facilities would be available, no clinical contact would be necessary for those seeking care in CDS networks. Even within VA facilities, care is more attractive because patients would no longer need to consult their primary care doctors to receive specialty care. The benefits of this option contrast with the 10 to 30 percent cost sharing typical in Medicare and private coverage, the low

provider reimbursements, stigma and access barriers often associated with Medicaid,⁶⁷² and the requirements for referrals and/or prior authorizations that are widespread among health insurance plans. Few veterans would have reason to turn down such an attractive option.

Consequently, we model high ranges for reliance, enrollment, and care shifting into CDS networks. We model reliance rates of 80, 90, and 100 percent for all CDS eligible care; enrollment shares of 75, 85, and 95 percent; and a 70-percent rate of eligible care shifting from VA facilities to CDS networks. We apply the reliance increases to all care eligible for CDS networks, even if the care is provided in VA facilities or traditional CITC, because this option eliminates the need for consultations with primary care doctors for all CDS eligible care. Additionally, we assume that the total amount of CDS eligible care received by veterans from any provider and payer increases by 20 percent due to the lack of a referral requirement and/or reduced cost sharing.

Estimates are displayed in Figure A-5. In 2019, when effects are fully phased-in, estimated costs range from \$156 billion to \$237 billion, with a middle estimate of \$195 billion. This compares to a baseline projection of \$71 billion. Although estimates are highly uncertain, a key takeaway is that this option could result in very large cost increases relative to the baseline scenario, *Recommended Option*, and CDS Alternatives 1 and 2.

Figure A-5. Projected Costs of CDS Alternative 3



⁶⁷² Yu-Chu Shen and Stephen Zuckerman, "The Effect of Medicaid Payment Generosity on Access and Use among Beneficiaries," *Health Services Research* 40, no. 3 (2005), 723-44. Jennifer Stuber and Karl Kronebusch, "Stigma and Other Determinants of Participation in TANF and Medicaid," *Journal of Policy Analysis and Management* 23, no. 3 (2004), 509-530.

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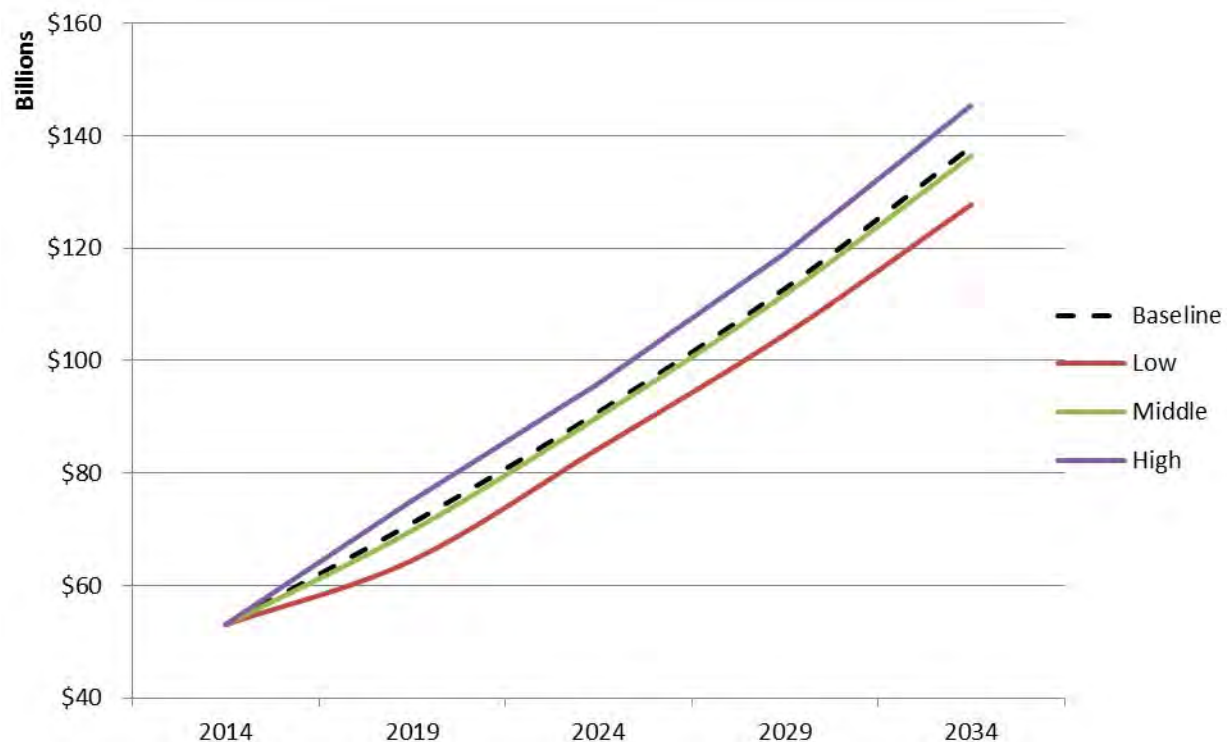
Keep Selected Services

The *Keep Selected Services (KSS)* scenario would move most standard ambulatory specialty care entirely into the community, yet keep the remainder of care entirely within VA facilities or traditional CITC. Although VA would no longer provide most standard ambulatory specialty care in VA facilities, it would continue to provide primary care, inpatient care, and special-emphasis care in VA facilities, including long term services and supports, prosthetics and orthotics services, inpatient and outpatient mental health and substance abuse, inpatient medical and surgical care, prescription drugs, medication management, recreational therapy, and immunizations. Under this scenario, approximately 35 percent of the cost of care currently provided in VA would be provided solely in the community. Providers in the community would receive Medicare rates.

We modeled increases in reliance of 10, 25, and 40 percent, which correspond to reliance rates of approximately 37, 43, and 48 percent. These reliance increases pertain only to care that moves into the community. We modeled enrollment increases of 0, 4, and 8 percent.

Estimates are displayed in Figure A-6. In 2019, when effects are fully phased-in, estimated costs range from \$64 billion to \$75 billion, with a middle estimate of \$70 billion. This estimate compares to a baseline projection of \$71 billion. Although estimates are highly uncertain, a key takeaway is that even with expanded community care, cost increases are constrained when veterans cannot choose whether they receive care in VA facilities or in the community.

Figure A-6. Projected Costs of Keep Selected Services Scenario



Premium Support⁶⁷³

Under the *Premium Support* (PS) scenario, all current and future enrollees younger than age 65 can choose a subsidized insurance premium with cost sharing (for some priorities) in lieu of their current VHA benefit. Enrollees electing the premium and cost sharing subsidy no longer have access to any VA services, including the special services VA offers. Under this scenario, there is an annual election period, and VA actively engages with enrollees to make a decision. Enrollees ages 65 and older receive no additional benefit options.

For those enrollees choosing the subsidized insurance program, the cost sharing varies by priority level: 10 percent for priorities 1 and 2; 20 percent for priorities 3 and 4; 30 percent for priorities 5 and 6; and 40 percent for priorities 7 and 8. Veterans would buy *Silver* policies on the state individual insurance exchanges, and VA would provide additional cost sharing assistance to meet the target subsidy. If enrollees purchased plans offered with lower cost sharing, such as *Gold* (20 percent cost sharing) or *Platinum* plans (10 percent cost sharing), the additional premium costs would likely exceed the cost of purchasing a Silver plan and subsidizing the cost sharing. The cost estimates did not consider the potential effect of adding a large number of veterans on exchange plans. Were VA to do this, considerations for veteran morbidity as well as the proposed cost sharing subsidies would need to be accounted for within the purchase of state exchange plans from commercial insurers.

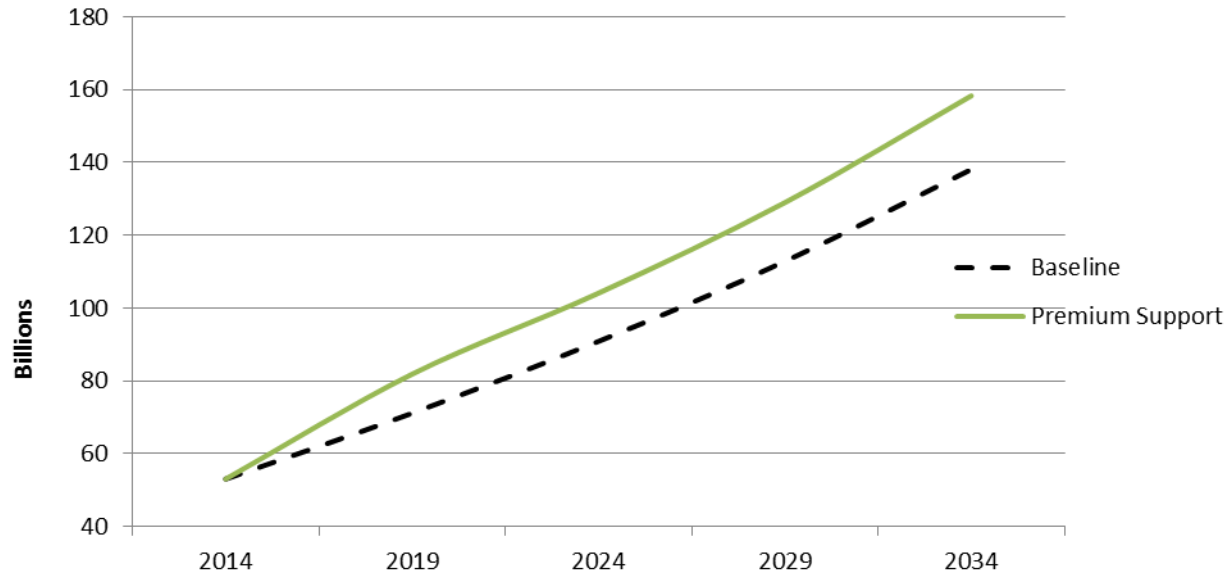
To determine participation rates in the subsidized premium program, we summarized enrollees' FY 2014 baseline data into cost brackets by attaching 2015 EHCPM unit costs to workload and then summarizing the total cost of workload provided to each enrollee. Overall, 42 percent of enrollees younger than age 65 were assumed to select the subsidized premium option, but the model assigned different rates of participation depending on enrollees' priority level and historical VA utilization. Enrollees with little to no costs were assumed to participate in the program at a higher rate as compared to those who had larger levels of VA costs. Participation rates for priority 5 veterans were assumed to be half the rates set for other priority levels. This assumption was made because many of these lower-income enrollees already have the option of participating in a highly subsidized state exchange plan with low cost sharing. It is also assumed that offering this option will motivate additional nonenrolled veterans to enroll to receive the subsidized premium plan. To estimate this effect, we analyzed the proportion of veterans by priority level with either no insurance or individual insurance plans, as reported in recent years of data captured by the American Community Survey (ACS). We estimated that this potential subsidy would lead to an additional 577,000 enrollees over the projection period.

Finally, it is assumed that the subsidized premium plan serves as a primary payer and does not supplement other coverage available to the enrollee, such as Medicare or employer sponsored insurance.

⁶⁷³ Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.

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Figure A-7. Projected Costs of Premium Support Scenario



Eligibility Expansion⁶⁷⁴

Under the *Eligibility Expansion* (EE) scenario, the VA health care system expands to allow all veterans to enroll in VA health care. In 2014, half of veterans eligible under priorities 1-7, 8b,⁶⁷⁵ and 8d were enrolled, representing a 50 percent *market share*,⁶⁷⁶ with the highest market share among those with service-connected priorities. The market share among Priorities 8a and 8c was an estimated 21 percent, reflecting enrollment from before suspension began in January 2003 and from enrollees who initially enrolled in another priority and later transitioned to Priorities 8a and 8c. If the suspension of new priority 8 enrollment had never occurred, we estimate that the market share would be 28 percent in 2014 and 30 percent in 2021 under natural growth and priority transition rates.

Under a scenario of lifting priority 8 enrollment suspension beginning in FY 2017, we estimate that the market share would climb steadily during a 5-year phase-in period to reach 30 percent in 2021, which equates to 464,000 new priority 8 enrollees. The market share is not expected to reach the level observed among other priorities because Priority 8 veterans have higher incomes, are not service-connected disabled, are more likely to have employer-sponsored coverage and individually purchased health plans, and are less likely to be uninsured relative to other priorities. Further, regression analysis of market shares among veterans in census data demonstrated that higher income veterans, nondisabled veterans and veterans with employer-sponsored health insurance are all less likely to enroll. To develop the cost estimates, newly

⁶⁷⁴ Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.

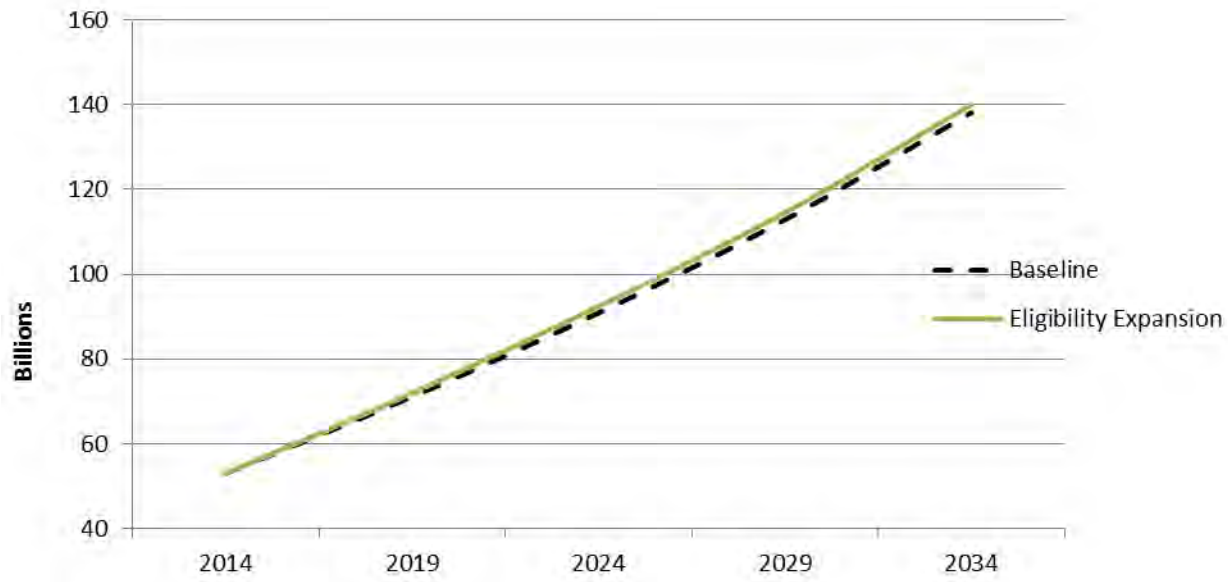
⁶⁷⁵ Priority 8b and 8d were enrolled on or after June 15, 2009 and have incomes that exceed the current VA or geographic income limits by 10 percent or less.

⁶⁷⁶ Market share is the percentage of veterans who are enrolled in VHA out of all veterans. This differs from the enrollment share, which is the percentage of eligible enrollees who are enrolled.

eligible priority 8 veterans are assumed to have the same morbidity and reliance as current priority 8 enrollees.

By 2032, based on the estimated market share, we project an additional 368,000 priority 8 enrollees with an additional \$1.8 billion in costs.

Figure A-8. Projected Costs of Eligibility Expansion Scenario



Additional Cost Factors

Nurse Navigators

VHA already has a robust care manager program that largely overlaps with the proposed nurse navigators in the CDS scenarios. VHA patient aligned care teams (PACTs) were created to coordinate care and maintain long-term relationships with patients. Most PACTs exist in a primary care setting, but there are also special-emphasis PACTs, such as those for spinal cord injury and disorders, geriatrics, and HIV care. All patients may choose to be assigned to a primary care PACT, and the vast majority do so: There are approximately 5.3 million unique patients in primary care PACTs out of a total of 5.8 million.

The primary care PACT typically consists of a provider, an RN care manager, a clinical associate, and a clerk. This team is assigned to a panel of approximately 1,200 patients. There are also expanded team members who are assigned to multiple panels, such as clinical pharmacy specialists, nutritionists, and behavioral health professionals. The RN care manager is the lynchpin of the primary care PACT.

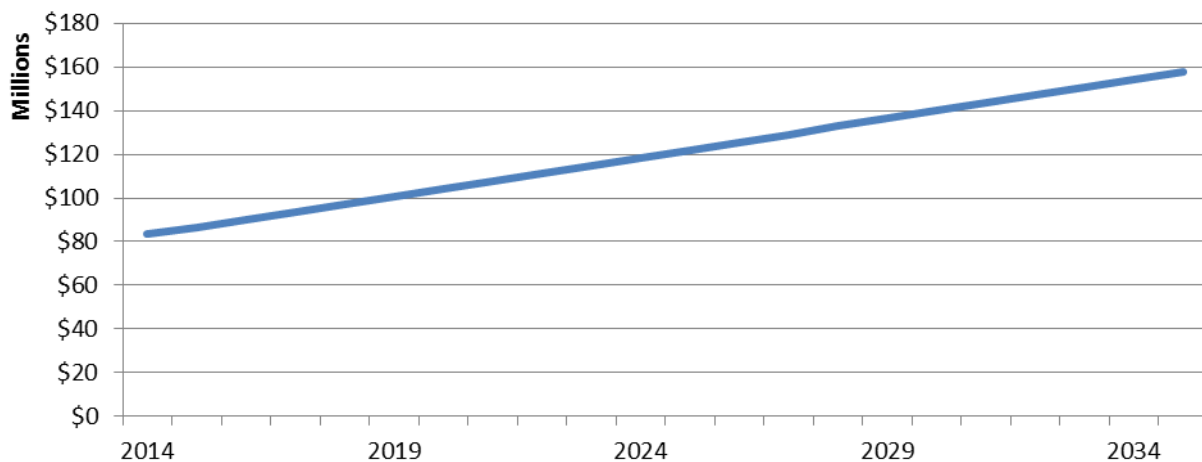
One of the tasks of the care manager is to coordinate care received in VHA facilities with care received in the community. Because this coordination role would increase with the CDS scenarios, we provide a notional estimate for expanding the number of care managers to account for the additional administrative and clinical burden of an increase in community care.

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Based on discussions with VHA primary care operations and policy staff, we assume that one additional RN care manager per five panels would be necessary to handle a substantial increase in community care such as that associated with the CDS scenarios.⁶⁷⁷ Based on 2014 data on the number of patients in PACTs and the recommended panel size, we estimate that 882 RN care managers would need to be hired if the CDS scenarios were fully phased in. Incorporating the average total compensation of RN care managers (\$94.4 thousand in FY 2014) and inflating costs using the projected patient population and personnel inflation trend from the EHCPM, we generate the following cost estimates. These estimates are assumed to be fully phased in. The cost of this policy is \$100 million in 2019 and rises to \$158 million in 2034.

Figure A-9. Cost of Hiring Additional RN Care Managers



Other-than-Honorable Discharges

We also consider a policy for which those with an OTH discharge are made temporarily eligible for VA health care while their claims are adjudicated. The adjudication process would determine whether these individuals would remain eligible for care or would lose eligibility. Adjudication would be based on the reason for the discharge. For example, if the discharge were due to behavior associated with a mental health condition caused by serving in the military, that person would likely be positively adjudicated. However, the specific criteria for adjudicating cases still needs to be determined.

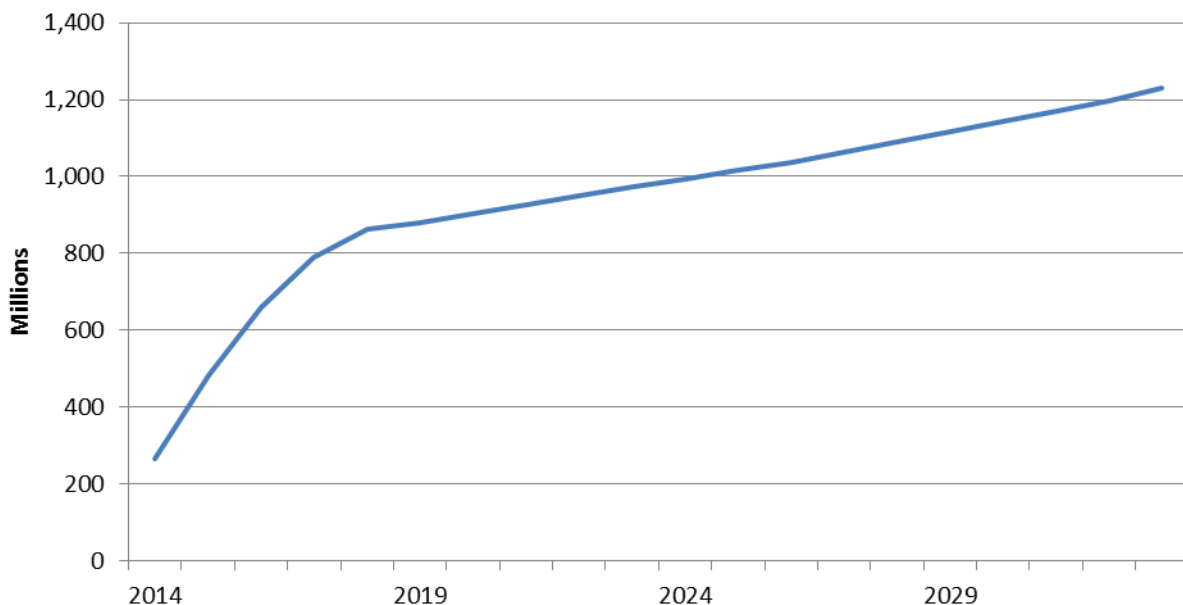
To model the cost of this proposal, we assume all people with an OTH discharge who would otherwise be eligible for VHA care are initially eligible. We assume that, consistent with the rest of the population, 73 percent of veterans with an OTH discharge are eligible for VA health care based on income and disability criteria. During a period of 5 years, their cases are examined, and 50 percent are positively adjudicated. Whether this number is actually higher or lower than 50 percent will depend on the exact details of the policy as well as the specific circumstances of veterans with an OTH discharge. In our model, the number of eligible veterans with an OTH discharge who enroll increases during the first 5 years as they become aware of the new rules. It

⁶⁷⁷ These estimates would differ depending on the CDS option pursued, but we provide a single notional estimate to give a sense of the magnitude of costs involved.

increases to 52 percent, which is the enrollment share of veterans who are currently eligible. In reality, this rate could be higher or lower for those with an OTH discharge if they are different from those who are already eligible. We assume costs per patient are similar to other veterans of the same age.

The cost of this policy increases from \$264 million in 2014 to \$1.23 billion in 2033. Fully phased-in, the cost is \$864 million in 2019. The shape of the cost curve reflects increasing enrollment during the first 5 years as veterans learn about the new rule and sign up. It also reflects adjudications as all enrolled veterans are initially eligible and then their eligibility is adjudicated during the 5 years. These calculations reflect estimates that the number of veterans with an OTH discharge for active duty military has fallen from a high of 8.8 percent in 2002 to 2.1 percent in 2015. We assume that the rate continues at 2.1 percent of discharges throughout the projection window.

Figure A-10. Projected Costs of Temporarily Covering Veterans with OTH Discharges



Conclusion

The estimated cost of allowing veterans to receive expanded community care through integrated networks varies dramatically depending on the specifics of the policy, including which categories of care are eligible for the community and whether referrals are required to access specialty care. We estimate that the *Recommended Option*, which provides increased community care that is reimbursed at Medicare allowable rates but maintains referrals for specialty care, increases costs modestly, assuming that networks are narrow and well-managed with cost as a major consideration. *CDS Alternative 1*, which offers a more restricted array of services eligible for CDS care, yet maintains a referral requirement, does not substantially increase costs. However, *CDS Alternative 3* and to a lesser degree *Alternative 2*, which eliminate the need for referrals for standard specialty care, potentially lead to very high costs. The estimated costs of the other scenarios range from small to substantial, though these costs would

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ultimately depend on the details of the proposals (e.g., the premium support schedule). Finally, we find that the costs of introducing expanded nurse navigators/care coordinators and making those with OTH discharge temporarily eligible are comparatively modest.

APPENDIX B: LEADERSHIP IMPLEMENTATION

Table B-1. Organizational Health and Cultural Transformation

Action	Responsible	Timeline
That VHA create a comprehensive, coordinated, sustainable cultural transformation effort by aligning programs and activities around a single, benchmarked concept.		
Establish the charter for the cross-functional SE team responsible for cultural transformation.	SECVA/DEPSECVA or CVCS depending on level	Now (0-6 mos)
Assess cultural transformation models and decide on a single model.	Chartered SE team	Now (0-6 mos)
Create an execution strategy for cultural transformation.	Chartered SE team	Now (0-6 mos)
Develop communication strategy and materials and release.	Chartered SE team	Near (18 mos)
That VHA aligns leaders at all levels in support of the cultural transformation strategy.		
Establish a subcommittee under the SE team to drive leadership transformation.	Chartered SE team	Near (6 mos)
Establish leadership standards for behaviors and actions.	Chartered SE team Subcommittee	Near (6-9 mos)
Publicize the standard.	Chartered SE team Subcommittee/CVCS/HTM	Near (12 mos)
Develop assessment tools.	SE Subcommittee/NCOD, NCEHC, HTM	Near (12-24 mos)
Establish expectations (in policy) for use of leadership standards in IDPs, performance review, hiring, promotions.	HTM/CVCS	Near (12-36 mos)
Provide coaching to the standard.	(Current HCM office responsible)	Near (24 mos)
Collect standards, training, support materials into a living curriculum for leaders.	EES/HTM	Near (24 mos)
Modify VA Directive 5021 (Employee/Management Relations) to include unacceptable behavior and unacceptable performance standards related to organizational transformation responsibilities of leaders and update table of penalties to correspond.	HRA/HTM	Future (36 mos)
That VHA align frontline staff in support of the cultural transformation strategy.		
Establish subcommittee to support staff transformation.	Chartered SE team	Near (9 mos)
Establish behavioral expectations/requirements for staff.	Subcommittee	Near (9-18 mos)
Develop hiring tools against the staff standard.	Subcommittee	Near (18-36 mos)
Establish requirements (in policy) for use of the standard for IDP, performance reviews, advancement in grade/promotions.	HTM/HRA/nursing and similar/unions	Near (18-36 mos)

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Action	Responsible	Timeline
Support leaders and supervisors at all levels of the organization to communicate and reinforce these standards with staff (see align leaders, above).	(Policy owner)	Near (18 mos)
Establish program office and VAMC standards and strategy for execution.		
Establish subcommittee to develop VAMC and PO execution standards.	Chartered SE team	Near (18 mos)
Establish execution strategy and policy requirements.	Chartered SE team Subcommittee/NCEHC/ NCOD	Near (18-36 mos)
Develop consolidated, meaningful metrics with input from experts and field users.		
Assign responsibility for metric development.	Chartered SE team/CVCS	Near (6 mos)
Develop and test metrics.	Organizational Excellence	Near (6-18 mos)
Deploy metrics.	Chartered SE team/CVCS/ (policy owner)	Near (18 mos)
Identify outliers and intervene.	SE team/CVCS/(policy owner)	Near (24 mos)

APPENDIX B
LEADERSHIP IMPLEMENTATION

Table B-2. Recruitment, Retention, Development, and Advancement

Action	Responsible	Timeline
VHA executives are required to make the leadership system a top priority for funding, strategic planning, and investment of their own time and attention.		
Establish a VHA leadership management goal for inclusion in the 2018 budget with specific targets, including diversity targets.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (3 mos)
Submit the leadership management goal to VA for inclusion in the budget submission for 2018.	VHA OPP and CVCS	Now (3 mos)
Adopt VHA leadership management goal and submit to OMB/White House.	VA OPP and SECVA	Now (3 mos)
Establish an operational plan and accountability mechanisms for meeting these goals.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (4 mos)
Include yearly targets in the performance plan of the CVCS and SES members.	VHA NLC subcommittee on performance planning	Now (4 mos)
Schedule regular communication (at least quarterly) to the field that speaks to mission, vision, values, and expectations for ethical behavior.	CVCS	Now – ongoing
Schedule regular meetings with VHACO and field senior staff that allows for a discussion of mission, vision, values and expectations for ethical behavior.	CVCS	Now – ongoing
Develop opportunities for developing leaders to participate in the leadership and management decisions and processes of VHA.	CVCS /ask NLC executive committee to develop and implement a plan	Now (6 mos)
Adopt and implement a comprehensive system for leadership development and management.		
Convene a group to review ACHE and the National Center for Health Care Executives and devise a benchmarked model that meets the needs of health care executives in VHA as well as the private sector.	NCEHC with NCOD, & Human Capital Management; report to the NLC subcommittee for leadership development	Now (6 mos)
Create career tracks for key positions based on this new competency model.	HTM	Near (within 12 mos)
Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.		
Develop assessment tools (360, 180, self-assessment, supervisory) to support the competency model.	HTM with support as required from other offices, e.g., NCOD, EES	Near (within 18 mos)
Assess existing training against the model and identify gaps.	EES	Near (18 mos)
Develop and implement a plan to fill these gaps.	EES/reporting to NLC to ensure funding	Near (plan 20 mos – fill gaps 36 mos depending on \$)

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Action	Responsible	Timeline
Assess opportunities to share additional leadership training with DoD and create a plan to implement it.	HEC/JEC	Near (9 mos)
Develop and fund a face-to-face training to fulfill competencies for critical career positions.	EES	Near (24 mos)
Develop a masters level training program for clinical leaders in partnership with academic medicine.	EES/Academic Affiliations	Near (36 mos)
Establish sharing agreements with non-profit institutions to permit the exchange of executives for extended rotations.	EES/Academic Affiliations	Near (18 mos)
Create an experiential learning program to parallel the competency model.	EES, HTM reporting to the leadership development subcommittee of the NLC	Near (24 mos)
Establish a coaching program.	HTM/EES	Near (18 mos)
Incorporate tracking of competency assessment, training, coaching, and IDP completion into an appropriate IT platform (e.g., TMS).	HRA/EES/Workforce Management and Consulting	Near (18 mos)
VHA is required to aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: all hires and promotions are required to demonstrate these competencies.		
Create functional statements for all key positions based on the competency model.	HTM	Near (18 mos)
Create interview questions incorporating competencies for all key positions.	HTM	Near (12 mos)
Establish a process for certifying internal candidates for advancement to the next position.	Human Capital Management	Near (18 mos)
Incorporate the tracking of competency achievement with performance ratings and create a tracking mechanisms and pool of high potential candidates.	Human Capital Management	Near (18 mos)
Create regulatory requirements for the use of the competency model in hiring, promotion, development opportunities, and discipline; and incorporate procedures for veterans preferences.	Human Capital Management in VHA	Near (36 mos)
Establish an IDIQ, PBA or similar contract for executive recruitment.	Human Capital Management	Now (6 mos)
Establish requirement in policy for all ECF, SES / SES equivalent to complete IDP.	Human Capital Management	Future (following regulatory change)
Create on-ramp for retiring MTF.	Human Capital Management / DoD Coordination	Now (6 mos)
Expand (GHATP) program.	EES	Now (6 mos)
Establish a plan for developing and managing the candidate pool.	NLC subcommittee for leadership	Now (6 mos)
Require a formal on boarding process for leaders at all levels that re-enforces the leadership competency model.		
Establish an onboarding curriculum and process.	Human Capital Management, EES, HTM	Now and Near (18 mos)

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APPENDIX B
LEADERSHIP IMPLEMENTATION

Action	Responsible	Timeline
VHA is required to take immediate steps to stabilize the continuity of leadership.		
Extend authority for length of details and ability to compete for the detail position.	Human Capital Management	Now (6 mos)
Establish and fund assistant level positions in all key career development tracks.	CVCS	Now (18 mos)

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Table B-3. Organizational Structure and Function

Action	Responsible	Timeline
Eliminate duplication within VHA and consolidate program offices to create a flat structure.		
Eliminate the duplication of functions between VHA and VA by closing VHA offices.		
Create innovative organizational structures to support clinical delivery that are aligned to patient's needs rather than professional silos.		
Undertake a reduction-in-force (RIF) in VHACO that promotes delayering and efficiency in communication and decision making.		
Publish a new organizational chart consistent with Figure 9.	CVCS	Now (1 mos)
Prepare an initial RIF for offices eliminated.	VHA Human Capital Management	Now (3 mos)
Engage VERC (or other resources with expertise in business process reengineering) to re-design the processes and structures with remaining offices to ensure end-to-end support for field function and to further reduce duplication; including clinical function re-organization.	Transformation Office/ VERC	Near (3-12 mos)
Each program office in collaboration with VERC or other transformation resources identifies areas of "stop work" with staffing and budget savings.	Transformation Office/ PO/ CVCS	Near (3-12 mos)
Publish clear roles, responsibilities and expectations that apply to all VHACO offices.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VHACO staff to the new expectations for the role of VHACO.	Transformation Office/ EES	Now (1 mos)
Develop training curriculum to support VHACO staff in developing the skills and competencies required.	Transformation Office/ EES	Near (18 mos)
Develop an engagement strategy to inspire VHACO staff to embrace their new role and tie to in-service training roll out.	Transformation Office/ CVCS	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VHACO employees.	Transformation Office/ EES	Now (6 mos)
Adopt customer service training in VHACO and roll it out; include as part of new employee on-boarding in VHACO.	Transformation Office/ EES	Near (12 mos)
Draft basic competencies for VHACO program staff (e.g., customer service, quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ Each PO	Near (18 mos)
Acquire, configure, and train PO staff on data analytics infrastructure to support program office and field tracking of key performance metrics.	Office of Organizational Excellence/OIT	Near (18 mos)

APPENDIX B
LEADERSHIP IMPLEMENTATION

Action	Responsible	Timeline
Clarify and specifically define the roles and responsibilities of the VISNs and facilities, pushing decision making down to the lowest level.		
Publish clear roles, responsibilities and expectations that apply to the VISNs.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VISN staff to the new expectations for the role of VISN.	Transformation Office/ EES	Now (1 mos)
Develop an engagement strategy to inspire VISN staff to embrace their new role and tie to in-service training roll out.	VISN directors	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VISN employees.	Transformation Office/ EES	Now (6 mos)
Draft basic competencies for VISN staff (e.g., quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ each PO	Near (18 mos)
Gain agreement from Congress to institute three appropriation lines only: medical, major construction, research.	CVCS/SECVA/OMB	Near (12 mos)
Eliminate segregation of specific-purpose funds to the VISNs and facilities.	CVCS/Office of Finance	Now (6 mos)
Modernize financial management system (FMS) to permit effective cost accounting and tracking of priority spending.	OIT/Office of Finance	Future (36 mos)
Develop training to support effective use of FMS to permit effective account tracking and reporting and roll it out.	Finance/EES	TBD post procurement
Establish quarterly spend reports covering all priority areas (e.g., NRM, IT, facility minor, purchased care, mental health, women's health, administration) by facility and release to Congress and the public.	Finance Office	TBD post procurement
Delegate decisions in recruitment, retention and advancement (e.g., hiring bonus, retention bonus, market pay) for staffing to the facility.	CVCS/HCM	Now (1 mos)
Delegate training and travel decisions.	CVCS/EES/OAA	Now (1 mos)
The USH establishes leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue and collaboration.		
Improve communication with field leadership and frontline employees through the liberal use of social media, town halls and other direct engagement channels with a dedicated champion to help the USH and senior staff in this endeavor.	CVCS	Now (3 mos)
Reestablish in-person leadership conferences, at least semi-annually, to foster communication and relationship building between VHACO, VISN and facility leadership.	CVCS/EES/NLC	Now (6 mos)
Add behavioral competencies to performance plans that promote effective communication amongst leaders.	CVCS	Near (12 mos)

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Action	Responsible	Timeline
Establish expectations and requirements for program office leaders to communicate the USH leadership messages, coordinate PO communications with the USH and with one another.	CVCS	Now (3 mos)
Establish a transformation office with broad authority and a supporting budget to accomplish the change.		
Establish the new transformation office in the organizational chart, populate with expertise in business process re-engineering, and fund initially using savings from closure and consolidation of offices in VHACO and a budget reduction to all other VHACO offices.	CVCS	Now (6 mos)
Create a Transformation Office strategic plan to educate and provide guidance to the new initiatives and support the goals of VA and VHA.	Transformation Office	Near (3-6 mos)
Create a new initiative implementation plan to include follow-on priorities, tasks and milestones. The Transformation Office will support the operation and the plan moving forward.	Transformation Office	Near (3-6mos)
The Transformation Office will be responsible for evaluating all new initiatives and programs using the President's Management Agenda Scorecard or a model that emulates its rating standards of Green represents success; yellow for mixed results; and red for unsatisfactory. These ratings are indicative of standards of success or failure.	Transformation Office	Near (3-6mos)

Table B-4. Performance Metrics and Management

Action	Responsible	Timeline
Create a new performance management system for VHA leaders appropriate for health care executives.		
Establish a workgroup and engage outside experts to create the new performance management system that is benchmarked to private-sector models, is consistent with the new leadership competency model, and recognizes both leadership competencies and success in delivering strategic priorities. The model should include a new rating scale.	Transformation Office/Human Capital Management	Now (6 mos)
Develop and conduct training on the new performance management system for all participants to describe the system, rating process, and expectations.	Human Capital Management	Near (6-12 mos)
Establish a mechanism to capture performance assessment outcomes and track and manage high-potential staff.	Human Capital Management/HRA	Now (3 mos)
Establish a project plan to deliver annual guidance on performance plans at least a month in advance of the new fiscal year (i.e., at the start of the new rating period).	Human Capital Management/CVCS/Sec/OMB	Now (3 mos)
Hold raters accountable for creating meaningful distinctions between leaders.		
Provide training to raters on the application of the new performance management system and expectations for ratings.	Human Capital Management	Future (12 mos)
Require raters to establish plans for subordinates that are timely and meaningful; track and provide feedback on meeting this goal.	Human Capital Management/HRA	Now (3 mos)
By modeling the behavior and communicating the requirement, establish expectations that raters, and secondary-level raters, engage in continuous dialogue and coaching with subordinates about performance throughout the year, not just at mid-year and at the end of the rating period.	CVCS	Now (3 mos)
Establish oversight and feedback process for raters and incorporate this into the raters performance evaluation.	Human Capital Management/CVCS	Now (12 mos)
Provide coaching to raters and focused reviews if their rating profile doesn't provide meaningful distinctions in performance.	Supervisors	Near (12 mos)

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Table B-5. Leadership Implementation: Human Capital Management

Action	Responsible	Timeline
VA re-align HR functions and processes to be consistent with best practice standards of high-performing health care systems.		
Charge HRA to undertake an HR transformation study and ensure budget and solicitation of customer requirements.	SECVA/DEPSECVA	Now (0-6 mos)
Engage HR and change management experts to develop a benchmark human capital management plan for VA.	HRA	Now (0-6 mos)
Circulate new human capital plan for feedback and finalize.	HRA with input from VHA, Congress, OPM, OMB, SECVA/DEPSECVA, CVCS	Now (6 mos)
That VA and VHA leaders make transformation of Human Capital management a priority, with adequate attention, funding and continuity of vision.		
Endorse human capital management plan and ensure alignment of budget, IT system funding, training resources, and accountability mechanisms to support it.	SECVA/DEPSECVA and CVCS, as applicable	Near (9 mos)
Employ HR and change management experts to fully implement the transformation agenda and the new human capital management plan.	HRA	Near (12-30 mos)
Create an HR IT technology plan.	HRA & OIT	Near (9 mos)
Establish meaningful measures and risk indicators for VA human capital management.	HRA	Future (24 mos)
Incorporate HR measures into systematic reporting to leadership; and as appropriate into performance plans for key subordinate leaders.	HRA, DEPSECVA, CVCS as appropriate	Near (18 mos)
VA develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 Hybrid, Title 38 7306, and SES).		
Develop clear standards, guidelines, and training on progressive discipline.	HRA (with support from OPM)	Now (6 mos)
Managers, supervisors and HR professionals complete training.	SECVA/ DEPSECVA and CVCS (HTM office)	Near (12 mos)
Train HR staff to be coaches in progressive discipline.	HRA	Now (6-12 mos)
Establish performance metrics for HR professionals and client feedback mechanisms to ensure effective coaching and support for progressive discipline process.	HRA	Near (12 mos)
Establish performance expectations for VA supervisors and managers to apply the progress discipline process.	SECVA/ DEPSECVA, CVCS	Near (12 mos)

APPENDIX C: PILOT PROJECTS FOR EVALUATING EXPANDED CARE

As discussed in Recommendation #18, some Commissioners support the idea of developing pilot programs to test the feasibility of avoiding VA hospital closures by allowing veterans' spouses and currently ineligible veterans to purchase VA care in selected areas.

Problem

In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. This trend is driven by four main factors: (a) the overall decline in the size of veterans population, (b) the migration of veterans away from some parts of the country, such as New England and the Upper-Midwest, (c) the general trend in health care toward less intensive use of acute-care hospital beds, and (d) increased use of purchased care, which now accounts for 27 percent of all appointments.

A related challenge is maintaining safe volume of care when patient loads decline. As extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁷⁸

Simply closing a low-volume hospital is sometimes the answer. But closing a local VA hospital may mean that area veterans will have reduced access not only to routine, but also to specialty care related to their military service, such as for spinal cord or traumatic brain injuries. In many areas, such care is not available or is in short supply outside VHA.

At the same time, it may not be clinically feasible for VHA to engage in highly specialized care if it lacks the ability to offer other forms of care in the same setting. Patients in a polytrauma unit for example, require a full-spectrum of routine and nonroutine health care.

Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. Toward that end, VHA could develop pilot programs to test the feasibility of enabling veterans' spouses and currently ineligible veterans in these areas to purchase VHA care through their health plans. These pilots could be tested in conjunction with the growth of the high-performance, integrated VHA networks recommended elsewhere in this report. These networks will allow VHA far more flexibility than in the past to expand or contract its local capacity in different markets as appropriate.

⁶⁷⁸ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

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Background***Current Nonveteran Access to VHA Care***

VHA already treats many nonveterans. VHA estimates it treated 694,120 unique nonveteran patients at a total cost of \$1.9 billion in 2015,⁶⁷⁹ or 3.6 percent of total VHA obligations.⁶⁸⁰

By far the largest subgroup within the nonveteran patient population are participants in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA beneficiaries are the dependents of permanently and totally disabled veterans, survivors of veterans who died from service-connected conditions or while on active duty, or spouses of veterans who at the time of death were rated permanently and totally disabled from a service-connected condition.

Congress authorized CHAMPVA in 1973. The authorization specifies that VHA is the secondary payer for those with Medicare Part A and B coverage. In cases for which VA medical facilities are equipped to provide the care, VA may use facilities not being used for the care of veterans to provide services to the dependent or survivor.

Congress has also directed VHA to offer specific health care services to many other classes of nonveterans. These include mental health and counseling services for family caregivers of seriously injured veterans of post-9/11 service. Several provisions of law also authorize VA care for certain family members of veterans who were exposed to toxic substances. In the case of veterans with 50 percent or more service-connected disability, VHA must provide by law “consultation, professional counseling, marriage and family counseling, training and mental health services as are necessary in connection with” the veteran’s treatment.⁶⁸¹

Analysis

Others who have developed strategic plans for the long-term future of VA health care have recommended expanding upon these precedents, specifically by allowing currently ineligible veterans and the spouses of veterans to purchase VHA care.⁶⁸² In effect, providing such care would allow VHA to operate as an accountable care organization, capable of receiving reimbursement from patients covered by Medicare, Medicaid, as well as by private insurance plans. Among the potential benefits envisioned are the following:

- optimizing patient safety, productivity, and cost-effectiveness by ensuring sufficient patient volumes in currently under-utilized facilities
- preserving mission critical veterans’ programs that would otherwise need to be terminated in many parts of the country
- optimizing the integration of VHA and non-VHA care within communities

⁶⁷⁹ Allocation Resource Center, information provided to Commission on Care, December 8, 2015.

⁶⁸⁰ Department of Veterans Affairs, “Volume II: Medical Programs and Information Technology Programs, Congressional Submission, FY 2016 Funding and FY 2017 Advance Appropriations,” accessed May 27, 2016, <http://www.va.gov/budget/products.asp>.

⁶⁸¹ Counseling, Training, and Mental Health Services for Immediate Family Members and Caregivers, 38 U.S.C. § 1782.

⁶⁸² Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce*, accessed May 27, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>.

APPENDIX C
PILOT PROJECTS FOR EVALUATING EXPANDED CARE

- providing a *public option* for health care to a wider range of veterans as well as nonveterans in communities where health care choices are currently limited
- bringing in new sources of revenue to contribute to the funding for veterans' healthcare

The pilot projects described below would specifically evaluate whether such a strategy will allow VHA to optimize the quality and cost-effectiveness of its health care system by avoiding low volumes of routine and specialty care in certain sections of the country. These pilot projects would also allow VHA to evaluate whether such a strategy could provide new revenues for sustaining the VA health system while providing other benefits to veterans and the public at large.

The chart below sketches six possible pilot projects designed to test different specific policy configurations. The configurations include projects in which VA care is marketed to health care plans on fee-for-service (FFS) basis, and plans in which VA facilities are markets to health care plans as Accountable Care Organizations that provide integrated health services to a fixed population of insured patients for a fixed cost.

*Demonstration Projects to Assess VHA's Capability to Treat
Nonveteran Spouses and Ineligible Priority 8 Veterans*

	Eligibility	Capitation/Fee For Service	Timing
Demonstration 1: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) With Private Insurance	FFS	Years 2-7
Demonstration 2: FFS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance	FFS	Years 2-7
Demonstration 3: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) with private insurance	FFS	Years 3-8
Demonstration 4: FSS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance and/or Medicare	FFS	Years 3-8
Demonstrations 5 and 6: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses	Enrollment: May choose higher cost plan with more coverage and less copayment; lower cost option with less coverage and higher copayments.	Years 4-9

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	Eligibility	Capitation/Fee For Service	Timing
Demonstrations 7 and 8: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses with private insurance and/or Medicare	Enrollment: May choose higher cost plan with more coverage and less copayment; or lower cost option with less coverage and higher copayments. Pilot sites would be deemed Accountable Health Care Organizations for Medicare Advantage plans.	Years 5-10

Certification of Access: Any participating VHA facility must certify that its waiting times for primary care, specialty care and behavioral health are less than 30 days.

Site selection: Sites should include facilities in different regions with various population densities (urban, suburban, rural) and levels of service complexity. VHA may also consider such factors as stability of medical center leadership, and whether local markets are underserved or subject to high degrees of market concentration among either providers or payers.

Assumptions

- Many provisions are subject to Congressional authorization.
- Participating VHA facilities will be able to retain any “profit” associated with treatment of new users without offset;
- Congress will (preferably) waive the current prohibition on Medicare funding federal health care programs,
- VHA will not be subject to proving “level of effort” in order to receive Medicare funds

Assessment

After the first year of operations, VHA will assess these projects according the following criteria:

- Was access to care or patient satisfaction among veterans already enrolled in the system affected by the demonstration?
- What was the level of patient satisfaction among new users purchasing VA care?
- Did VHA cover the costs of delivering care to its patients purchasing care? If so, what were its net revenues and how were they used?
- If VHA collected Medicare funds, did funding cover costs of delivering care?

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APPENDIX C
PILOT PROJECTS FOR EVALUATING EXPANDED CARE

- Were there administrative challenges in opening the VHA to new users? If so, what lessons were learned?
- How did VHA promote the demonstration project to those eligible?
- What are the recommended strategies for further implementation?
- Were there non-financial benefits to treatment of new users, such as diversifying case mix, providing sufficient volume to allow certain VHA services to remain available, or keeping scarce health professionals employed in an area that is medically underserved?
- How did the demonstrations affect the overall quality of care, market structure, pricing, and range of health care options available to both veterans and nonveterans in the surrounding community?

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APPENDIX D: HISTORY AS A CONTEXT FOR SYSTEMIC TRANSFORMATION

History provides opportunities to see the problems and challenges facing VHA today through the lens of recurring themes from the past. Veterans' health care has, over the course of its history, been marked by periods of both progress and problems. Understanding the challenges of the past and the solutions used to address them provides context for building a plan for reforming veterans' health care in a manner that is flexible and sustainable.

Challenges and Growth

The federal government's role as a care provider for veterans has evolved, paralleling, to some extent, medicine's evolution. Prior to World War I, the only benefits afforded then-eligible veterans were pensions and domiciliary care (which involved only incidental medical treatment), provided under the National Home for Disabled Volunteer Soldiers and Sailors established after the Civil War.⁶⁸³

World War I brought real change. At the time, no single agency was responsible for the anticipated deluge of sick and wounded soldiers. The more than 200,000 wounded who returned home from battle quickly exceeded capacity of the U.S. Public Health Service (PHS), the National Home, and other agencies. According to one account of the period, "[c]haos and confusion reigned for more than two years . . . [n]ew hospital construction languished," and "[b]y 1921, veterans' care had become a national embarrassment."⁶⁸⁴ At the recommendation of a presidential committee, Congress passed legislation in 1921 to consolidate the several veterans-related bureaucracies into a single Veterans Bureau, to which the President Warren Harding transferred 57 PHS hospitals. A new administrator, Frank T. Hines, proposed care and treatment of veterans' non-service-connected ailments when facilities and bed space were available. Congress adopted the proposal in the World War Veterans Act of 1924.⁶⁸⁵

Under Hines' tenure, VA grew from 64 to 91 hospitals, nearly doubling bed capacity. Civil Service Commission personnel rules and low pay led to generally poor quality VA physicians, yet Congress rebuffed VA proposals to set up a VA Medical Corps.⁶⁸⁶ With many physicians having left VA to serve in World War II or for more lucrative practice, the VA health care system was left critically understaffed.⁶⁸⁷

⁶⁸³ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 4.

⁶⁸⁴ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 13-14.

⁶⁸⁵ *Ibid.*, 19.

⁶⁸⁶ *Ibid.*, 21.

⁶⁸⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 149.

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World War II and the need to care for millions of service members, including 671,000 wounded, highlighted the problems facing VA. Scathing reports of shoddy veterans' care, including an exposé characterizing veterans' hospitals as backwaters of medicine, magnified the problems.⁶⁸⁸

Congressional hearings led to a shakeup in leadership and General Omar Bradley was appointed to head the agency, with its network of 97 hospitals, and a need for more.⁶⁸⁹ Dr. Paul Magnuson, who served as VA's chief medical director (CMD) from 1948 to 1951, later described the conditions at the time:

The majority of Veterans Administration hospitals were stuck in far off places, some of them on Indian reservations, others as much as fifty miles from the nearest through-line railway stop. The doctors were all full-time Civil Service employees, hemmed in by regulations and practically forbidden to do any research, attend any medical meetings or otherwise keep in touch with scientific progress. Operating rooms closed at noon so everybody could spend the afternoon happily doing required paperwork, while patients waited days and weeks for surgery.⁶⁹⁰

With President Harry Truman's statement that "the Veterans Administration will be modernized," new VA leadership worked with Congress to pass far-reaching legislation, Public Law 293, which created a VA Department of Medicine and Surgery (DM&S), and freed VA physicians, dentists, and nurses from the Civil Service Commission and its rules.⁶⁹¹ Within weeks, the chief medical director of the new DM&S issued a policy memorandum that outlined a cooperative affiliation agreement between VA and medical schools under which deans' committees would recommend consultants and attending physicians for appointment to VA, and residency-training programs would be established at VA hospitals. The law, and Policy Memorandum #2, broke a recruitment logjam and enabled the short-staffed department to hire medical professionals needed for the dozens of new VA hospitals being built. Soon after, medical students and residents began working in 32 VA hospitals. The reforms instituted under Bradley and his team were palpable,⁶⁹² with the physician staff at VA hospitals increasing from 2,300 (1,700 of whom were detailed by the military) in June 1945 to 4,000 full-time staff a year later.⁶⁹³ By 1948, VA had 125 hospitals in operation with 60 medical school affiliations and 2,000 residents.⁶⁹⁴

After this turn-around, Bradley left to become Army Chief of Staff, and under his successor, "who did not enjoy the same level of prestige and support that Bradley did . . . VA quickly

⁶⁸⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 22.

⁶⁸⁹ *Ibid.*, 23-25.

⁶⁹⁰ *Ibid.*, 22.

⁶⁹¹ "31: The President's News Conference," Harry S. Truman Library & Museum, accessed June 3, 2016, <http://trumanlibrary.org/publicpapers/viewpapers.php?pid=38>.

⁶⁹² James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 27.

⁶⁹³ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 214.

⁶⁹⁴ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 28.

reverted to its pre-Bradley ways and remained that way for the next forty years,”⁶⁹⁵ according to one account.

By the early 1950s, the veteran population had grown to more than 20 million.⁶⁹⁶ VA was operating 162 hospitals, with an average census of more than 104,000 patients.⁶⁹⁷ A VA historian observed that “waiting lists contained 22,613 applicants awaiting admission, none of whom were service-connected, although some of the latter were hospitalized in other than VA hospitals.”⁶⁹⁸ At the time, non-service-connected veterans seeking care had to state under oath that they could not afford to pay for hospitalization, and admission was granted only when beds were available in VA or other federal hospitals.⁶⁹⁹ Critics called for reducing free medical care of non-service-connected veterans, and questioned whether some were getting care that they could afford. This issue led VA to institute a policy of formal counseling under which hospitals would supply the veterans with an estimated cost of care to assist them in determining their ability to pay.⁷⁰⁰

In contrast to the generous Bradley-era funding, the 1950s funding cuts necessitated layoffs, bed-closures, and moth-balling of newly constructed hospital wards.⁷⁰¹ During this period, annual debates over the DM&S budget centered on the number of beds VA should operate. VA leaders contended that the number should be 125,000, yet the director of the Bureau of the Budget (the predecessor to the Office of Management and Budget [OMB]) asserted 87,000 was sufficient.⁷⁰²

The expiration of the incumbent CMD’s term led to the appointment in 1955 of medical educator Dr. William Middleton, dean of the Wisconsin Medical School, and a long-time member of a VA special medical advisory group. One of his first acts as CMD was to champion medical research in VA and broaden its scope to include geriatric research. Soon after, Congress began earmarking funds for VA research, and expanded DM&S’ statutory role to include medical research.⁷⁰³ During Middleton’s tenure, from 1955 to 1963, VA research funding grew from some \$6 million to more than \$30 million.⁷⁰⁴ Middleton’s work laid the foundation for a research program long recognized for pioneering important medical technologies, including medical use of radioisotopes, dialysis, cardiac pacemakers, liver transplantation, as well as seminal studies that documented the benefits of coronary artery bypass surgery and drug treatment of hypertension.⁷⁰⁵ The program also stood out for its capacity to design and rapidly implement large-scale cooperative trials, first mounted in the 1950s with successful evaluation

⁶⁹⁵ Ibid., 29.

⁶⁹⁶ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 254.

⁶⁹⁷ Ibid.

⁶⁹⁸ Ibid.

⁶⁹⁹ Ibid., 253.

⁷⁰⁰ Ibid., 253-254.

⁷⁰¹ Ibid., 256.

⁷⁰² Ibid., 258.

⁷⁰³ Ibid., 262-263.

⁷⁰⁴ Ibid., 263-264.

⁷⁰⁵ Stanley Zucker et al., “Veterans Administration Support for Medical Research: Opinions of the Endangered Species of Physician-Scientists,” *The FASEB Journal*, 18, no. 13, (2004): 1481-1486, <http://doi.org/10.1096/fj.04-1573lfe>.

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of chemotherapy for tuberculosis.⁷⁰⁶ Working on issues relevant to veterans, VA researchers developed functional electrical stimulation systems to allow patients to move paralyzed limbs, helped develop the first ankle-foot prosthesis, and launched the largest-ever trial of psychotherapy to treat posttraumatic stress disorder.⁷⁰⁷

Middleton expanded the VA educational program. In addition to growing the number of medical residents it helped train, VA provided training to a large share of clinical psychologists, graduate dentists, student nurses, occupational and physical therapists, social work students, and dietetic interns. Middleton instituted numerous advances in VA care such as introducing outpatient care for preadmission workups and post-hospital treatment that allowed earlier release from inpatient stays. He moved VA away from operating hospitals for specific diseases (as had been done for tuberculosis and mental illness).⁷⁰⁸

The enactment of Medicare in 1965 raised questions about the effect that program would have on the VA health care system. The House Veterans Affairs Committee sent a questionnaire to a group of 10,000 veterans explaining the new program and asking the veteran to if they preferred VA care or treatment in a community hospital under Medicare.⁷⁰⁹ Some 59 percent responded, and nearly two-thirds of respondents preferred VA.⁷¹⁰ At the time, the policy governing those eligible for VA care based on financial need was that Medicare benefits were to be considered in determining an individual's ability to pay for needed care.⁷¹¹

The enactment of Medicare and other changes in health care in 1977, led to a commission being established by the National Academy of Sciences (NAS) which issued a report pursuant to a congressional directive to evaluate the VA health care system. Among its findings, the commission reported that VA had a surplus of acute beds and recommended that new facilities be constructed only after examining bed availability in the community. It also recommended that underutilized VA hospitals be closed or converted to long-term care facilities, and resources redistributed to permit a shift from inpatient to outpatient care. The NAS commission also recommended that VA experiment with models for community-based integrated care.⁷¹² The commission's recommendation for integrating the VA system into the nation's civilian health care program⁷¹³ provoked objection, particularly in Congress.⁷¹⁴ Hearings produced sharp rejections of the NAS commission findings and its call to end VA's role in providing health care to veterans.

⁷⁰⁶ Ibid.

⁷⁰⁷ Veterans Health Administration, *History of VA Research Accomplishments*, accessed June 3, 2016, http://www.research.va.gov/researchweek/press_packet/Accomplishments.pdf.

⁷⁰⁸ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 265-267.

⁷⁰⁹ Ibid., 390.

⁷¹⁰ Ibid.

⁷¹¹ Ibid.

⁷¹² *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs*, 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.

⁷¹³ J. William Hollingsworth and Philip K. Bondy, "The Role of Veterans Affairs Hospitals in the Health Care System," *New England Journal of Medicine*, 322, no. 10, (1990): 1851-1857, <http://doi.org/10.1056/NEJM199006283222605>.

⁷¹⁴ *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs*, 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.

The VA of the 1970s and 1980s is remembered as bureaucratic, reliant on paper health care records, and driven by patient admissions (on which budgets were based).⁷¹⁵ The quality of VA care was also an issue. Complaints from Vietnam veterans and critical media accounts fueled outrage, and led to the view that the system was broken. The question, how to fix it, reopened an earlier dialogue around making VA a cabinet-level department, a view strongly supported by veterans service organizations (VSOs) and veterans' leaders in the House of Representatives. In 1988, after years of debate, and opposition from administration offices and advisors, President Reagan signed legislation creating a Department of Veterans Affairs.⁷¹⁶ The new department, with DM&S now renamed the Veterans Health Services and Research Administration (to emphasize its research legacy in such fields as infectious disease, pacemaker technology, and prosthetics), employed some 194,000 people with a \$12 billion budget.⁷¹⁷

Facing an aging veteran population⁷¹⁸ expected to overwhelm the system by 2010, the new secretary, Edward Derwinski, in 1989 requested Congress establish an independent commission to review the alignment and mission structure of VA's hospitals. Congress rebuffed the request after VSOs, suspecting a plan to close hospitals, lobbied against it.⁷¹⁹ Derwinski created his own "Commission on the Future Structure of Veterans Health Care" that was to review all VA hospitals and recommend needed mission changes. Instead, the so-called Mission Commission called for expanding eligibility law to enable veterans to obtain the full continuum of VA health care services. Although the commission identified the need for fundamental restructuring of the VA health care system, the subject was soon overtaken by national health reform proposals, and what role VA might have under a universal coverage system.⁷²⁰

Dr. James Holsinger, a new under secretary for health (USH), made care quality a top goal and issued a Blueprint for Quality tool in 1992, setting the stage for more far-reaching changes instituted by his successor, Dr. Kenneth Kizer. Care quality, a perennial topic, had led to the previous under secretary's resignation following reports of multiple veterans' deaths under questionable circumstances at VA's North Chicago medical center.⁷²¹ Two years later, Derwinski lost his job after creating ire among veterans' organizations in response to his proposed pilot program to open two VA hospitals to poor, rural nonveterans.⁷²²

⁷¹⁵ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 30-31.

⁷¹⁶ *Ibid.*, 33-40.

⁷¹⁷ *Ibid.*, 50.

⁷¹⁸ As the General Accounting Office reported in 1990, "The Department of Veterans Affairs (VA) faces a major challenge: planning how to meet the long-term care needs of a rapidly aging veteran population. The number of veterans 65 years old and over is projected to grow to 9 million by 2000—a 50percent increase over the 1988 level.

U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), accessed June 20, 2016, <http://www.gao.gov/assets/150/149139.pdf>.

⁷¹⁹ U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), 51, accessed June 20, 2016, <http://www.gao.gov/assets/150/149139.pdf>.

⁷²⁰ U.S. Government Accountability Office, *Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Care Reform*, GAO/HEHS-95-14 (Washington, DC, 1994), accessed June 20, 2016, <http://archive.gao.gov/f0902a/153054.pdf>.

⁷²¹ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 53.

⁷²² "Angry Veterans Groups Say They Made Bush Oust Agency's Head," Eric Schmitt, accessed June 3, 2016, <http://www.nytimes.com/1992/09/29/us/angry-veterans-groups-say-they-made-bush-oust-agency-s-head.html>.

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Transformational Leadership

VA's second secretary, Jesse Brown, brought his passion as a veterans advocate to the department's leadership.⁷²³ Among Brown's most important early acts was selecting Dr. Kenneth Kizer, a prominent California physician-administrator and educator, from among 90 candidates identified by a search committee for the USH post.⁷²⁴ With experience heading the California department of public health, Kizer saw health care as a system, and data as a tool to improve it.⁷²⁵

Kizer, in essence, launched a major reengineering of the VA health care system through better use of information technology, measurement and reporting of performance, integration of services, and realigned payment policies.⁷²⁶ His vision was large and bold, underscored by his belief that "we have to be able to demonstrate that we have an equal or better value than the private sector, or frankly we should not exist."⁷²⁷ At VA, Kizer found a workforce trapped in a micro-managerial, command-and-control system in which there was little accountability.⁷²⁸ He set the tone for what was to come at a meeting with senior managers at which he stated,

*The old culture must give way to a new culture . . . that is based on innovation and creativity; a culture based on personal initiative and individual and collective accountability; a culture that is based on outcomes and heightened productivity; and a culture that is committed to change.*⁷²⁹

Among his first steps was the development of what was to become a Vision for Change, a new organizational model to restructure both field operations and central office management. At its core was the creation of 22 veterans integrated service networks, or VISNs, (replacing four regions which had been responsible for overseeing 40 to 45 hospitals each), with decision making shifted away from VA Central Office (VACO) to the new VISN directors. VISNs were to be the basic budgetary and planning unit, and to have staffs of no more than 7 to 10 employees.⁷³⁰ Each VISN was in charge of all the care provided to veterans in that network, and each was funded on a capitated basis rather than based on historical costs.⁷³¹ The VACO structure would be marked by its *flatness*, foregoing a tiered hierarchy.⁷³²

⁷²³ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 89.

⁷²⁴ *Ibid.*, 92.

⁷²⁵ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 50-51.

⁷²⁶ Ashish K. Jha et al., "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care," *New England Journal of Medicine*, 348, no. 22, (2003): 2218-2227, accessed June 20, 2016, <http://doi.org/10.1056/NEJMsa021899>.

⁷²⁷ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 51.

⁷²⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 97-8.

⁷²⁹ *Ibid.*, 105.

⁷³⁰ *Ibid.*, 110.

⁷³¹ "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation," Ashish K. Jha, accessed June 3, 2016, <https://psnet.ahrq.gov/perspectives/perspective/31>.

⁷³² James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 111.

The system Kizer and his team inherited was characterized by a multitude of problems.⁷³³ Kizer and his team literally reengineered the veterans' health care system based on a set of transformation strategies: to create management accountability, integrate and coordinate services, improve the quality of care, align system finances with desired outcomes, and modernize information management.⁷³⁴

Kizer also launched a technological revolution in VHA with deployment of a powerful electronic medical record,⁷³⁵ and development of systems such as medication bar-coding to tackle medical errors and ensure patient safety.⁷³⁶

Some of Kizer's successes involved winning support within the administration and from Congress for bold initiatives. He won a critical concession from OMB that VA savings could be reinvested into VA, permitting his transformation efforts to be funded through internal cost-savings rather than new funding,⁷³⁷ and garnered support from Congress for a dramatic reduction of acute care beds and for closing massive regional offices.⁷³⁸ These steps and congressional passage of legislation to reform health care eligibility laws paved the way for establishing universal primary care in VA and developing community-based clinics across the country.⁷³⁹

Sweeping Reform

During a 5-year period, Kizer dramatically changed almost every major VHA management system and improved operational performance through the use of performance measures and contracts. He closed nearly 29,000 acute care beds, merged 52 medical centers into 25 multi-campus facilities, reduced staffing by almost 26,000, opened more than 300 community-based outpatient clinics, and treated 24 percent more patients. In addition to bringing measurable quality into VA health care, Kizer achieved marked reductions in waiting times and medical errors.⁷⁴⁰

Kizer's tenure brought dramatically improved quality, service, and operational efficiency to VHA yet threatened powerful interests. As he noted, "...places like Florida, Arizona, and the

⁷³³ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 316, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷³⁴ Ibid., 318-323.

⁷³⁵ VA in 2006 won the Harvard Innovations in Government Award for its VistA system. James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 211.

⁷³⁶ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 157-165.

⁷³⁷ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 323, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷³⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 128-129.

⁷³⁹ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 319-320, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷⁴⁰ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 170.

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Sun Belt States were not getting their fair share [of funds] and their elected officials were unhappy about it. People from Pennsylvania and Illinois and New York were not about to give their money away, so there was this big disconnect.”⁷⁴¹ Kizer’s team developed a capitation system to more equitably allocate funds across the system. Aware of the political ramifications, he implemented incremental changes during a 2- to 3-year period to make them as painless as possible. But the congressional goodwill he had enjoyed unraveled when Kizer and his VISN directors began cutting and consolidating facilities to accommodate VISN funding cuts. The threat of hospital mergers and consolidations ultimately led several senators to block his confirmation to a second term.⁷⁴²

Under new eligibility reform law, all veterans became *eligible* for VA health care, though its authors did not envision that the system could or would serve all eligible individuals, or even all who might someday seek VA care. The law’s priority-based enrollment system was intended to give VA a tool to align demand for care with its funding level.⁷⁴³ The law instead unleashed political pressure to expand enrollment, opening the door to an influx of veterans who historically had not been VA health care users and many of whom were already covered under military retirement benefits, private insurance, or Medicare.⁷⁴⁴ That expansion led to a tremendous demand for prescription drug benefits by new enrollees and in 2003, Secretary Tony Principi ended enrollment for higher income (category 8) veterans “to keep the system solvent.”⁷⁴⁵ At about the same time, other related pressures led Principi to establish an advisory body, the Capital Asset Realignment for Enhanced Services (CARES) Commission, to develop a comprehensive capital asset plan. Principi cited the age of VA facilities and the changes in medical practice, but also reminded a congressional oversight committee of a 1999 Government Accountability Office finding that “maintaining obsolete or duplicative structures diverts \$1 million a day, every day, every year, away from the care of veterans.” Principi did not want to repeat Kizer’s experience and hoped to avoid political backlash.⁷⁴⁶

The CARES Commission released a final report in February 2004 that recommended relatively few actual facility closures, though it proposed substantial facility mission changes at a number of facilities.⁷⁴⁷ As the then USH later recounted, “CARES, like so many things in Washington, was well-intended, but it was derailed politically once it began moving toward actual targeted action within specific congressional districts.”⁷⁴⁸

Despite such defeats, Principi and VA under secretaries following Kizer met formidable challenges, left legacies, and saw the veterans’ health care system continue to be heralded for several years.⁷⁴⁹ A cascade of other events muddled, and even blackened, VHA’s reputation:

⁷⁴¹ Ibid., 133-134.

⁷⁴² Ibid., 168-169.

⁷⁴³ Veterans Affairs Comm., Veterans’ Health Care Eligibility Reform Act of 1996, H. R. Rep. No. 104-690 (1996), accessed June 3, 2016, <https://www.congress.gov/congressional-report/104th-congress/house-report/690/1>.

⁷⁴⁴ James Rife, *Not Your Father’s VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 193.

⁷⁴⁵ Ibid., 194.

⁷⁴⁶ Ibid., 195.

⁷⁴⁷ Ibid., 196.

⁷⁴⁸ Ibid.

⁷⁴⁹ “The Best Care Anywhere,” Phillip Longman, *Washington Monthly*, accessed June 3, 2016,

accounts of veterans' suicides (and an alleged cover-up); incompetent surgeries and patient deaths at a high-visibility VA medical center (VAMC); failed software acquisitions;⁷⁵⁰ hard-hitting inspector general audit reports on issues such as system flaws, quality of care issues, and lack of timely care that fueled congressional oversight and other constraints. The 2014 scandal that erupted at the Phoenix VAMC represented a decisive turning point and set the stage once again for transforming veterans' health care.

Among initial steps on that long road to transforming the system, the Senate in July 2014 unanimously confirmed Robert A. McDonald, former chief executive officer of Proctor & Gamble, as secretary of veterans affairs. With a business career of delivering better results, McDonald, along with DEPSECVA Sloan Gibson and USH Dr. David Shulkin, has been working to improve VA's health care system and service delivery, and to set a framework for long-term reform. Days after McDonald's confirmation, Congress passed the Veterans Access, Choice, and Accountability Act of 2014, omnibus legislation to improve veterans' access to care. This legislation established the *Choice Program*, mandated an independent assessment of VHA, and established the Commission on Care.

<http://www.washingtonmonthly.com/features/2005/0501.longman.html>. "Revamped Veterans Health Care Now a Model," Gilbert Gaul, accessed June 3, 2016, <http://www.washingtonpost.com/wp-dyn/content/article/2005/08/21/AR2005082101073.html>. "The Best Medical Care in the U.S.: How Veterans Affairs Transformed Itself—and What it Means for the Rest of Us," Catherine Arnst, accessed June 3, 2016, <http://www.bloomberg.com/bw/stories/2006-07-16/the-best-medical-care-in-the-u-dot-s-dot>.

⁷⁵⁰ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 216-217.

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APPENDIX E: THE EVOLVING HEALTH CARE INDUSTRY

Health care has evolved in major ways since the federal government began providing care to veterans after the Civil War, and it will continue to evolve substantially in the future. There are a number of factors that drive evolution in health care, such as population and lifestyle changes, changes within the various health care professions, medical and information systems technology, and systems changes in management and operations.⁷⁵¹ IBM Center for Applied Insight reports that there are 18 trends to watch in health care.⁷⁵² These trends closely encompass those highlighted below. The categories in which the trends fall mirror key topic addressed in the Commission's report to include data system interoperability (10 trends), consumer technology (two trends), health care providers (two trends), government regulations (two trends), and human resources and leadership (two trends). With health care changing so rapidly, and in so many different ways, it is imperative that veterans' health care continually evolve to remain aligned with current and future trends. This section highlights key trends that, based on past experience and current practice, will likely shape health care in the future, were considerations in formulating the Commission's recommendations, and will likely affect transformation of veterans' health care.

Emergence of Large Health Care Systems

The health care industry is moving away from stand-alone community hospitals that serve the needs of a local constituency to large, multiple-campus health care systems.⁷⁵³ The industry will see more high profile mergers and acquisitions in the second half of 2016.⁷⁵⁴ The December 2015 Health Research Institute's report indicates that well-known health care systems may have a market advantage as Americans are willing to travel further for care from a well-known system. This may explain the development and affiliation for Mayo Clinic in Arizona and Florida, and Cleveland Clinic opening in Florida. The report also states that although people are willing to drive for care they are not willing to pay prices higher than the local market. Because of increasing use of outpatient services and same-day surgery, facilities within these health care systems require fewer inpatient beds.⁷⁵⁵ With the advancement of psychotropic drugs, the perceived need for large mental hospitals has declined.⁷⁵⁶ Because of shorter recovery stays, increased outpatient services, telemetry and other monitoring programs, and new medical inventions, hospitals are now built as smaller facilities with parts or sections that can be quickly

⁷⁵¹ Lynn Etheredge, Stanley B. Jones, and Lawrence Lewin, "What is Driving Health System Change?" *Health Affairs*, 15, 4, (1996): 93-104.

⁷⁵² "Healthcare Internet of Things 18 Trends to watch in 2016," Bill Chamberlain, IMB Center for Applied Insights, March 1, 2016, accessed June 20, 2016, <https://ibmcai.com/2016/03/01/healthcare-internet-of-things-18-trends-to-watch-in-2016>.

⁷⁵³ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed April 29, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

⁷⁵⁴ Ibid.

⁷⁵⁵ Ibid.

⁷⁵⁶ "How Release of Mental Patients Began," Richard Lyons, accessed May 1, 2016, <http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all>.

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modified for future changes and medical advances.⁷⁵⁷ VHA will need to consider this trend in evaluating its current physical plant and planning for future facility needs.

Management Changes

As health care systems become increasingly complex, there is a need to manage these institutions using current management theories and models.⁷⁵⁸ During the past few decades, hospital and health care management changed from being managed by a traditional top-down model to continuous quality improvement models that respond to issues such as staff satisfaction, medication errors, safety matters, and wasteful use of supplies. To address errors, hospitals have implemented Six Sigma principles. To address waste, hospitals have implemented LEAN principles. Embracing these changes in management approach and implementing Six Sigma and LEAN principles will support VHA's transformational process.

Health Care Payment

The health care industry is in the midst of transforming its payment model away from a fee-for-service model to value-based payments, a system that drives improved health outcomes.⁷⁵⁹ This transformation is tied to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which health care experts expect to shape care delivery and payment reform across the U.S. health care system over the coming decades. Congress created MACRA as a transformative law to fast track the health care system's transition from a traditional fee-for-service payment model to new risk-bearing, coordinated care models.⁷⁶⁰ Because this legislation is still in rulemaking, it is premature for the Commission to weigh in on its potential effect on VA. The MACRA legislation expands the trend toward creation of accountable care organizations (ACOs) and bundled payments for care. ACO models have been reported to drive reduced hospitalization and generate cost savings.⁷⁶¹

Specialty Care Facilities

With changes in the federal payment for hospitals, some high-cost and longer-stay care treatments have been moving out of community hospitals to specialty hospitals. For example, long-term acute care hospitals primarily treat patients on ventilators; rehabilitation facilities treat short-term, post-acute patients who need primarily physical and occupational therapy services for orthopedic or stroke incidences; and cancer hospitals provide innovative treatments for Stage 4 cancer. As a result, community hospitals may no longer need beds to take care of these special patients. VHA will need to consider this trend in planning integrated care networks and evaluating its facility needs in conjunction with these networks.

⁷⁵⁷ "The Small Hospital of the Future," Shati Matambanadzo, accessed May 3, 2016, <http://www.healthcaredesignmagazine.com/article/small-hospital-future>.

⁷⁵⁸ "How to Solve the Cost Crisis in Health Care," Robert S. Kaplan and Michael E. Porter, accessed May 2, 2016, <https://hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care>.

⁷⁵⁹ "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, <http://www.nationalpartnership.org/issues/health/macra.html>.

⁷⁶⁰ "MACRA: Disrupting the health care system at every level," Deloitte, accessed June 23, 2016, <http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/macra.html>.

⁷⁶¹ "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, Inquisitr: Medicine, accessed May 2, 2016, <http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/>.

Outpatient Care and Lifestyle-oriented Venues for Care

With improvements in surgical procedures, many surgeries that required post-surgery hospital stays are now routinely performed in outpatient settings.⁷⁶² Many nonsurgical procedures are being performed in outpatient clinics as well, such as medical imaging, cardiac catheterization, substance abuse treatment, gastrointestinal screening and cancer treatment.⁷⁶³ As care that was once provided only in hospitals is now provided in specialized medical clinics, care that was once provided only in physicians' offices is now being provided in alternative settings. As reported in Health Affairs, "another health care trend consumers are using to save both time and money is that rather than making appointments with their doctors, they are choosing to use walk-in clinics."⁷⁶⁴ Many of these clinics are located in pharmacies, retail chains, or supermarkets, allowing consumers quick, convenient, less-costly care.⁷⁶⁵ Do-it-yourself health care is also a trend, with increasingly more people taking responsibility for their health care. Consumers are using smart phone apps to monitor vital signs, medication adherence, and even urinalysis.⁷⁶⁶ As part of a commitment to continuous improvement, VHA will need to consider alternative venues as it creates integrated health care networks.

Medical Technology

Medical technology companies create life-changing innovation, and "advanced medical devices and diagnostics allow people to live longer, healthier and more productive lives."⁷⁶⁷ In fact, during the past 30 years, medical advancements helped add five years to U.S. life expectancy and reduce fatalities from heart disease, stroke, and breast cancer by more than half.⁷⁶⁸ These advancements also yield savings across the health care system by replacing more expensive procedures, reducing hospital stays, and allowing people to return to work more quickly.⁷⁶⁹ Ensuring veterans receive care that employs cutting-edge technology will be an important part of establishing integrated care networks.

Telemedicine

According to the American Telemedicine Association, "telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status."⁷⁷⁰ Telemedicine includes a growing variety of applications and

⁷⁶² Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/21183845>.

⁷⁶³ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

⁷⁶⁴ "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, accessed May 2, 2016, <http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/>.

⁷⁶⁵ Ibid.

⁷⁶⁶ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

⁷⁶⁷ "Value of Medical Technology," Advanced Medical Technology Association, accessed May 2, 2016, <http://advamed.org/page/74/value-in-medical-technology>.

⁷⁶⁸ "Value of Medical Innovation," HealthCare Institute of New Jersey, accessed May 2, 2016, <http://hinj.org/value-of-medical-innovation/>.

⁷⁶⁹ Ibid.

⁷⁷⁰ "What is Telemedicine," American Telemedicine Association, accessed May 2, 2016, <http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VwFrqfkrJaQ>.

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services using two-way video, email, smart phones, wireless tools, and other forms of telecommunications technology. The use of telemedicine has spread rapidly and is now becoming integrated into hospitals, specialty departments, home health agencies, private physician offices, as well as consumers' homes and workplaces. The following are examples of how telehealth is being used:

- A specialist assisting the primary care physician in rendering a diagnosis might use interactive video or store-and-forward transmission of diagnostic images or information.
- Home-use devices might be used to remotely collect information such as vital signs, blood glucose, or heart electrocardiogram data and transfer it in real time to a home health agency or a remote diagnostic testing facility for interpretation.
- Consumers' internet and wireless devices might be used to obtain specialized health information or participate in online peer-to-peer support groups.

VHA already excels in the use of telehealth and should expand upon its work in this area.

Midlevel Practitioners

During the past few decades, new categories of health care professionals have become increasingly commonplace in hospital settings. For example, hospitalists, physicians who specialize in the practice of hospital medicine, take over when the community-based physician admits his/her patient to the hospital.⁷⁷¹ The hospitalist does not perform the surgery but rather takes on the monitoring of the hospital services needed by the patient. Another example is medical technicians, who monitor the specialized medical equipment and devices that previously were under the purview of nurses in specialty units such as intensive care units. The growing physician shortage has led to reliance on mid-level health care providers. According to the Centers for Medicare and Medicaid Services' National Provider Identifier dataset, there were approximately 106,000 practicing nurse practitioners and 70,000 practicing physician assistants in 2010.⁷⁷² Provider trends may play into ways VHA can address its current staffing shortage.

Electronic Patient Health Information

Health records have undergone transformation from free-form physician notes of the 17th century to electronic health records (EHRs) of the 21st century. Today, providers are using clinical applications such as computerized physician order entry systems; EHRs; and radiology, pharmacy, and laboratory systems to track patient care and progress. Health plans are providing access to claims and care management, as well as member self-service applications.⁷⁷³ These advances allow the medical workforce to be more mobile and efficient (i.e., physicians can check patient records and test results from wherever they are). Though their use comes with

⁷⁷¹ "Definition of a Hospitalist and Hospital Medicine," Society of Hospital Medicine, accessed May 2, 2016, http://www.hospitalmedicine.org/Web/About_SHM/Hospitalist_Definition/Web/About_SHM/Industry/Hospital_Medicine_Hospital_Definition.aspx.

⁷⁷² "The Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the United States," Agency for Healthcare Research and Quality, accessed May 2, 2016, <http://www.ahrq.gov/research/findings/factsheets/primary/pcwork2/index.html>.

⁷⁷³ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

inherent potential security and privacy risks, they will surely play a substantial role in shaping future health care.⁷⁷⁴ Interoperability of these sources of patient information will be a continuing key issue in private-sector, military, and veterans' healthcare organizations.

Population Health

Population health refers to considering incidence and prevalence of diseases in a given area to determine if the area or the environment is contributing to the illness. Physicians and other health care providers may look at a region's demographics to determine what types of care are needed within the population. For example, if 65 percent of the region is older than age 65, then a series of wellness programs that address the chronic care concerns of this population may be needed. From a population health perspective, communities and their respective populations are as important as the individual patients who comprise them when it comes to keeping residents healthy. For VHA, population health issues may revolve around populations of veterans who served in particular wars and operations and the respective injuries and illnesses associated with them.

Geriatric Care

In the United States and Western Europe the birth rate has slowed⁷⁷⁵ and people are living longer.⁷⁷⁶ Demographic researchers report that if an American makes it to age 65, he/she should have about 17 to 20 additional years of life.⁷⁷⁷ Nursing homes and assisted living facilities are now seeing increasingly more of residents' first-time admissions occurring at age 80 or older. Some congregate care retirement facilities report that even with admission in the 80s, the average life expectancy is another 12 or 13 years.⁷⁷⁸ The aging population accounts for increasingly more hospital admissions, and as a result, hospitals rely on more revenue from Medicare.⁷⁷⁹ The VHA beneficiary population mirrors the general U.S. population, and older veterans receiving care through VHA may be sicker than their private-sector counterparts.

Chronic Disease Care

Chronic conditions now account for more than 50 percent of the death rate. Acute problems had previously been the primary causes of death.⁷⁸⁰ Even HIV/AIDS has moved away from being considered an immediate death sentence, and now, with proper treatment, is considered by

⁷⁷⁴ "Summary of the HIPAA Privacy Rule," U.S. Department of Health and Human Services, accessed May 2, 2016, <http://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/>.

⁷⁷⁵ "Fact Sheet: The Decline in U.S. Fertility," Mark Mather, accessed May 2, 2016, <http://www.prb.org/publications/datasheets/2012/world-population-data-sheet/fact-sheet-us-population.aspx>.

⁷⁷⁶ National Center for Health Statistics, *Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities*, accessed May 2, 2016, <http://www.cdc.gov/nchs/data/abus/abus15.pdf>.

⁷⁷⁷ National Center for Health Statistics, *Life Expectancy at Birth, at Age 65, and at Age 75, by Sex, Race, and Hispanic Origin: United States, Selected Years 1900-2010*, accessed May 2, 2016, <http://www.cdc.gov/nchs/data/abus/2011/022.pdf>.

⁷⁷⁸ Kathleen Harris, *CCRC Resident Demographics and Health Care Utilization: An Analysis*, accessed May 3, 2016, <http://www.avpowell.com/docs/Fall1997.pdf>.

⁷⁷⁹ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

⁷⁸⁰ "Chronic Disease Overview," Centers for Disease Control and Prevention, accessed May 2, 2016, <http://www.cdc.gov/chronicdisease/overview/>.

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most to be a chronic disease.⁷⁸¹ The Centers for Disease Control reports that since 2014, more Americans are dying as a result of chronic conditions and diseases than from acute diseases. Most chronic diseases result from lifestyle choices. Lifestyle diseases result from choices that individuals make.⁷⁸² Health care systems invest resources in addressing lifestyle-related issues caused by behaviors such as smoking, using opiates, and overeating.⁷⁸³ Lifestyle diseases such as cancer caused by smoking, addiction caused by drug use, and diabetes caused by obesity, are costly to treat.⁷⁸⁴ Because lifestyle diseases change over time, they are important to consider in thinking about the future of veterans' healthcare. Treating chronic diseases can be costly because care is ongoing, and assuming this trend continues to become more prominent, it will affect the cost of care and how it is provided.⁷⁸⁵

Needs-based Health Care

The Affordable Care Act requires all not-for-profit hospitals to complete a survey of the community (community health needs assessment, or CHNA) to show what entities in the community will address identified needs (asset mapping) and then report on how the hospital will address these needs in a community health care implementation program (CHIP).⁷⁸⁶ Starting in 2016, hospitals must post these reports on their websites and conduct these evaluations every 3 years thereafter. Monitoring community health needs can lead to preventing or stopping the spread of disease. For example, scarcity of quality food has been documented to result in poor school attendance and increased illness.⁷⁸⁷ Some Americans simply have not been exposed to how to prepare vegetables and fruits because they live in areas that are called *food deserts*, where healthy foods are not readily available. Identifying such needs and how they will be addressed can help improve health for specific populations.⁷⁸⁸ In Washington, DC, such a health assessment led to new treatments and protocols for addressing the appearance of a rare strain of tuberculosis brought in by a group of legal immigrants.⁷⁸⁹ Using CHNA and CHIP could be part of VHA's ongoing planning process.

⁷⁸¹ Steven G. Deeks, Sharon R. Lewin, and Diane V. Havlir, "The End of AIDS: HIV Infection as a Chronic Disease," *Lancet*, 382, 9903, (2013): 1525-1533.

⁷⁸² "Lifestyle Choices: Root Causes of Chronic Diseases," Cleveland Clinic, accessed May 2, 2016, https://my.clevelandclinic.org/health/transcripts/1444_lifestyle-choices-root-causes-of-chronic-diseases.

⁷⁸³ D. B. Resnik, "Responsibility for Health: Personal, Social, and Environmental," *Journal of Medical Ethics*, 33, 8, (2007): 444-445.

⁷⁸⁴ "How to Save a Trillion Dollars," Mark Bittman, accessed May 2, 2016, <http://opinionator.blogs.nytimes.com/2011/04/12/how-to-save-a-trillion-dollars/>.

⁷⁸⁵ "Why We Need Public Health to Improve Healthcare," National Association of Chronic Disease Directors, accessed May 2, 2016, <http://www.chronicdisease.org/?page=WhyWeNeedPH2impHC>.

⁷⁸⁶ "New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act," Internal Revenue Service, accessed May 2, 2016, <https://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501%28c%29%283%29-Hospitals-Under-the-Affordable-Care-Act>.

⁷⁸⁷ "Hunger In Our Schools: Breakfast Is A Crucial 'School Supply' For Kids In Need," Tom Nelson, accessed May 2, 2016, <http://blogs.usda.gov/2015/03/03/hunger-in-our-schools-breakfast-is-a-crucial-school-supply-for-kids-in-need/>.

⁷⁸⁸ "The Capital's Food Deserts," Jeremy Moorhead, accessed May 3, 2016, <http://eatocracy.cnn.com/2012/03/14/the-capitals-food-deserts/>.

⁷⁸⁹ District of Columbia Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration, *District of Columbia HIV/AIDS, Hepatitis, STD, and TB (HAHSTA) Annual Report: 2010*, accessed May 3, 2016, http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2010_Annual_Report_FINAL_0_0.pdf.

Behavioral Health

Treatment for mental health, now more commonly referred to as behavioral health, has changed dramatically since a 1968 federal law required individuals be cared for in the least restrictive environment.⁷⁹⁰ This law led to an expectation that most patients would receive care in out-patient facilities. Recently legislation was passed that requires insurance companies to increase the amount of payment for behavioral health, which could add more patients to the health care system.⁷⁹¹ VHA is a leader in mental health treatment and should continue to be a trendsetter in this regard.

Preventive Medicine

Traditionally, physicians were trained to cure illness and to restore the sick to health. The trend, however, is changing, and physicians are now trained in prevention and are more active participants in the prevention of illness.⁷⁹² Additionally, insurance and Medicare now cover preventive care and annual physicals, further supporting prevention.⁷⁹³ Preventive medicine is a key component of integrated health care and will need to be considered as VHA works to transform veterans' healthcare.

Pharmacy Changes

Health Affairs reports that "in 2015 . . . an alarming trend of new high-cost specialty pharmaceuticals entered the market. . . . Overall drug spending increased 12.2 percent last year, the highest rate of increase in more than a decade."⁷⁹⁴ Escalating drug prices account for some of this increase, including more than 3,500 generic drugs that at least doubled in price from 2008–2015 and about 400 drugs that increased in cost 1000 percent.⁷⁹⁵ Newly emerging and very expensive developments in the area of genomic medication also contribute to the increase. "One way to combat skyrocketing prices will be biosimilar drugs. These drugs are near substitutes for original brand drugs and could bring significant price discounts."⁷⁹⁶ Because many of VHA's beneficiaries seek only prescription benefits, prescription drug trends will be important to consider in the transformation process.

⁷⁹⁰ "How Release of Mental Patients Began," Richard Lyons, accessed May 2, 2016,

<http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all>.

⁷⁹¹ "Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)," Substance Abuse and Mental Health Services Administration, accessed May 2, 2016, <http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>.

⁷⁹² "Opinion 8.075 – Health Promotion and Preventive Care," American Medical Association, accessed May 2, 2016, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8075.page>.

⁷⁹³ "Preventive Services Covered Under the Affordable Care Act," U.S. Department of Health and Human Services, accessed May 2, 2016, <http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/>.

⁷⁹⁴ Anne Martin et al., "National Health Spending In 2014: Faster Growth Driven By Coverage Expansion And Prescription Drug Spending," *Health Affairs*, 35, 1, (2016): 150-160.

⁷⁹⁵ "Generic Drug Prices Quickly on the Rise," Anthony L. Komaroff, accessed May 2, 2016, <http://www.spokesman.com/stories/2016/feb/18/generic-drug-prices-quickly-on-the-rise/>.

⁷⁹⁶ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

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APPENDIX F: THE COMMISSION'S PROCESS

Commission Meetings

From September 2015 to June 2016, the Commission held convened 12 sessions of public meetings (26 days). The content addressed at each meeting is listed in the following table.

September 21-22, 2015

Assessment A: Demographics	RAND Corporation <ul style="list-style-type: none"> Christine Eibner
Assessment B: Health Care Capabilities	RAND Corporation <ul style="list-style-type: none"> Peter Hussey, PhD
VA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> Bob McDonald, Secretary Sloan Gibson, Deputy Secretary David Shulkin, MD, Under Secretary for Health
Assessment C: Care Authorities	RAND Corporation <ul style="list-style-type: none"> Michael D. Greenberg
Assessment I: Business Processes	Grant Thornton LLP <ul style="list-style-type: none"> Lane Jackson Aamir Syed Sharif Ambrose
Assessment E: Scheduling Workflow	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Alex Harris Pooja Kumar
Assessment F: Clinical Workflow	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Gretchen Berlin
Assessment G: Staffing/Productivity/Time Allocation	Grant Thornton LLP <ul style="list-style-type: none"> Peter Erwin, PhD Hillary Peabody Erik Shannon
Assessment J: Supplies	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Robin Roark, MD
Assessment K: Facilities	McKinsey & Company <ul style="list-style-type: none"> Vivian Riefberg John Means

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September 21-22, 2015 (continued)

VHA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning
Assessment Leadership	CMS Alliance to Modernize Health care <ul style="list-style-type: none"> Stephen Kirin Jay Schnitzer, PhD, MD McKinsey & Company <ul style="list-style-type: none"> Vivian Riefberg
Assessment H: Health IT	MITRE Corporation <ul style="list-style-type: none"> Aparna Durvasula Glenn Himes McKinsey & Company <ul style="list-style-type: none"> Celia Huber Vivian Riefberg

October 6, 2015

Eligibility	Veterans Health Administration <ul style="list-style-type: none"> Stephanie Mardon, Chief Business Officer Kristin Cunningham, Director, Business Policy Affairs
2014 Choice Act/2015 Enhancement to Choice/Care in the Community, Current State	Veterans Health Administration <ul style="list-style-type: none"> Stephanie Mardon, Chief Business Officer Kristin Cunningham, Director, Business Policy Affairs
Future State of VA Community Care/ Care in the Community	Veterans Health Administration <ul style="list-style-type: none"> Joe Dalpiaz, Director, VISN 17 Baligh Yehia, MD, Senior Health Advisor to the Secretary of Veterans Affairs Gene Migliaccio, Deputy Chief Business Officer, Managed Care
Academic Affiliations	Veterans Health Administration <ul style="list-style-type: none"> Robert Jesse, MD, Chief, Office of Academic Affiliations Karen Sanders, MD, Deputy Chief, Office of Academic Affiliation Long-Term Care Richard Allman, MD, Chief Consultant, Geriatrics and Extended Care Services

October 19–20, 2015

Independent Assessment, Perspective on VA Health Care, and Q&A/Panel Discussion	<ul style="list-style-type: none"> ▪ Brett Giroir, MD, Senior Fellow, Health Policy Institute, Texas Medical Center ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE ▪ Jonathan Perlin, MD, Chief Medical Officer and President, Clinical Services at Hospital Corporation of America
Women's Health	Veterans Health Administration <ul style="list-style-type: none"> ▪ Patricia Hayes, PhD, Chief Consultant, VA Women's Health Services
Mental Health	Veterans Health Administration <ul style="list-style-type: none"> ▪ David Carroll, Executive Director, Mental Health Operations ▪ Harold Kudler, MD, Chief Mental Health Consultant
Homelessness	Veterans Health Administration <ul style="list-style-type: none"> ▪ Anne Dunn, Deputy Director, VHA Homeless Program Office
Assessment D: Access	Institute of Medicine <ul style="list-style-type: none"> ▪ Michael McGinnis, MD ▪ Marianne Hamilton Lopez
VACAA Section 203	Northern Virginia Technology Council <ul style="list-style-type: none"> ▪ Ken Mullins
Scheduling	Veterans Health Administration <ul style="list-style-type: none"> ▪ Michael Davies, MD, Executive Director of Access and Clinic Administration Program
MyVA Support Services Excellence Overview	Department of Veterans Affairs <ul style="list-style-type: none"> ▪ Bob Snyder, Executive Director, MyVA Task Force ▪ Tom Muir, Director, Support Services

November 16–17, 2015

Health Care Economics/Finance	<ul style="list-style-type: none"> ▪ Mark Yow, Acting Chief Financial Officer, VHA ▪ Paul Mango, McKinsey & Company ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE
Academic Affiliations	Association of American Medical Colleges <ul style="list-style-type: none"> ▪ Atul Grover, PhD, MD, Chief Public Policy Officer ▪ John E. Prescott, MD, Chief Affiliations Officer ▪ Matthew Schick, JD, Director, Government Regulations & Regulatory Counsel
VHA Clinical Matters	Veterans Health Administration <ul style="list-style-type: none"> ▪ Lucille Beck, PhD, Deputy Chief Patient Care Services Officer, Rehab and Prosthetic Services ▪ Donna Gage, PhD, RN, Chief Nursing Officer

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December 14-16, 2015

Minority Affairs and Health Equity	Department of Veterans Affairs <ul style="list-style-type: none"> Barbara Ward, Director, Center for Minority Affairs Veterans Health Administration <ul style="list-style-type: none"> Uchenna S. Uchendu, MD, Executive Director, Office of Health Equity
Framework for the Future of Veterans Health	<ul style="list-style-type: none"> Garry Augustine, Disabled American Veterans Carl Blake, Paralyzed Veterans of America Carlos Fuentes, Veterans of Foreign Wars Ray Kelley, Veterans of Foreign Wars
Veteran Service Organizations	<ul style="list-style-type: none"> Louis Celli, The American Legion Renee Campos, Military Officers Association of America
National Health Information Operability	<ul style="list-style-type: none"> Dr. Jon White, Deputy National Coordinator, Department of Health and Human Services
DoD I Procurement: Lesson Learned/Interagency Program Office	<ul style="list-style-type: none"> Chris Miller, Program Executive Officer, Defense Health Care Management Systems, Department of Defense
Health Information Exchange	<ul style="list-style-type: none"> Elaine Hunolt, Do-Director Interoperability Office, Veterans Health Administration Dr. Harry Leider, Chief Medical Officer, Walgreens James Wood, VP-Federal, Walgreens Mariann Yeager, Chief Executive Officer, The Sequoia Project
Vision for OI&T/Collaboration with VHA	<ul style="list-style-type: none"> LaVerne Council, Chief Information Officer, Department of Veterans Affairs
Leadership and Transformation	<ul style="list-style-type: none"> Charles Rossotti, Former Commissioner, Internal Revenue Service

January 19 and 21, 2016

VHA Leadership	<ul style="list-style-type: none"> Dr. Michael Kussman, former Undersecretary for Health, Veterans Health Administration Dr. Kenneth Kizer, former Undersecretary for Health, Veterans Health Administration
Labor Perspectives	American Federal of Government Employees <ul style="list-style-type: none"> Marilyn Park National Association of Veterans Affairs Physicians and Dentists <ul style="list-style-type: none"> Samuel Spagnolo Nurses Organization of Veterans Affairs <ul style="list-style-type: none"> Joan Clifford Sharon Johnson

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January 19 and 21, 2016 (continued)

Behavioral Health	<ul style="list-style-type: none"> Association of Veterans Affairs Psychologist Leaders <ul style="list-style-type: none"> Thomas Kirchberg Russell Lemle Edgardo Padin-Rivera Antonette Zeiss American Psychiatric Association <ul style="list-style-type: none"> Jenny L. Boyer Association of Veterans Affairs Social Workers <ul style="list-style-type: none"> LeAnn Bruce Jerry Satterwhite
Homeless Veterans	<ul style="list-style-type: none"> Keith Armstrong, San Francisco Veterans Affairs Health care System
Other-Than-Honorable Discharges	<ul style="list-style-type: none"> Branford Adams

February 8-9, 2016

Construction Management	<ul style="list-style-type: none"> Lisa Freeman, Medical Center Director, Palo Alto Health care System
VISN and Field Leadership Perspectives	<ul style="list-style-type: none"> Joleen Clark, Former Network Director, VISN 8 Jon Gardner, Former Medical Center Director, Tucson VA Medical Center Lisa Freeman, Medical Center Director, Palo Alto Health care System
Implementation of the <i>Choice Program</i>	<ul style="list-style-type: none"> Billy Maynard, President HealthNet Federal Service David J. McIntyre, Jr., President and Chief Executive Officer, TriWest Healthcare Alliance
Update on VHA	<ul style="list-style-type: none"> Dr. David Shulkin, Undersecretary for Health, Veterans Health Administration
Determining Feasibility	<ul style="list-style-type: none"> Patrick Ryan, Former Staff Director and Chief Counsel, House Veterans Affairs Committee

February 29 – March 1, 2016

Economist Briefing	<ul style="list-style-type: none"> Gideon Lukens, PhD, Staff Economist Jamie Taber, PhD, Staff Economist
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March 21-23, 2016

Conversation with HVAC Chairman	<ul style="list-style-type: none"> Rep. Jeff Miller (R-FL)
Conversation with HVAC Member	<ul style="list-style-type: none"> Rep. Beto O'Rourke (D-TX)
Veterans Health Administration	<ul style="list-style-type: none"> Dr. David Shulkin, Undersecretary for Health Barbara Manning, Office of Policy and Planning Lyn Stoesen, Office of Policy and Planning

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March 21-23, 2016 (continued)

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Merideth Randles, FSA, MAAA, Milliman, Inc.
- Jamie Taber, PhD, Staff Economist

April 18-19, 2016

Veterans Service Organizations

- Garry Augustine, Disabled American Veterans
- Peter Dickinson, Disabled American Veterans
- Verna Jones, American Legion
- Rick Weidman, Vietnam Veterans of America
- Bill Rausch, Got Your 6
- Ray Kelley, Veterans of Foreign Wars
- Rene Campos, Military Officers Association of America

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Jamie Taber, PhD, Staff Economist

VA Leadership

Department of Veterans Affairs

- Bob McDonald, Secretary
- Sloan Gibson, Deputy Secretary

Community Care

- Baligh Yehia, MD, Assistant Deputy Under Secretary for Community Care, VHA

May 9-11, 2016

VA Office of General Counsel

- Leigh Bradley, General Counsel
- Jessica Tanner, Staff Attorney

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Jamie Taber, PhD, Staff Economist

June 7-8, 2016

No speakers

Commission Workgroups

The Commission on Care organized itself into workgroups in order to complete an analysis of relevant issues, consider options, and suggest recommendations to the full Commission for debate. The Commission formed five workgroups with each responsible for sections of the Independent Assessment or other topics taken on by the group. In establishing each workgroup an effort was made to balance perspectives and expertise, although Commissioners expressed interests were also taken into account in forming the membership of each group. The membership of each workgroup and the topics taken on by each is summarized in Table F-1.

Table F-1. Workgroup Structure and Topics

WORKGROUP NAME	TOPICS	MEMBERSHIP	
Health Care Alignment	<ul style="list-style-type: none"> ▪ Demographics ▪ Health care Capabilities ▪ Care Authorities ▪ Access Standards ▪ Governance 	<ul style="list-style-type: none"> ▪ Blecker ▪ Johnson ▪ Longman ▪ Selnick 	<ul style="list-style-type: none"> ▪ Gorman ▪ Khan ▪ McClenney
Health Care Operations	<ul style="list-style-type: none"> ▪ Access Standards ▪ Workflow Scheduling ▪ Workflow Clinical ▪ Staffing Productivity 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Harvey ▪ Longman ▪ Webster 	<ul style="list-style-type: none"> ▪ Gorman ▪ Hickey ▪ Taylor
Health Care Data, Tools & Infrastructure	<ul style="list-style-type: none"> ▪ Health IT ▪ Business Processes ▪ Supplies ▪ Facilities 	<ul style="list-style-type: none"> ▪ Blom ▪ Harvey ▪ Steele 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Johnson ▪ Taylor
Health Care Leadership	<ul style="list-style-type: none"> ▪ Organizational Health ▪ Leadership Systems 	<ul style="list-style-type: none"> ▪ Blecker ▪ Hickey ▪ Selnick ▪ Steele 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ McClenney ▪ Schlichting
Health Care Trends	<ul style="list-style-type: none"> ▪ Market Trends ▪ Technology ▪ Financing ▪ Vision 	<ul style="list-style-type: none"> ▪ Blom ▪ Johnson ▪ Schlichting 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Khan ▪ Webster

Each workgroup, together with any staff assigned to it, reviewed the findings and recommendations of the Independent Assessment and the Integrated Report; investigated external benchmarks and best practice models; heard testimony in public meetings (with the full Commission); met in workgroup session with VA employees, leaders, former staff and external experts to gather additional insights and explore relevant questions. Commissioners reviewed white papers and strawman proposals prepared by staff and by one another. Based on the assessments and group deliberations, each workgroup developed recommendations for consideration by the full Commission. Details of the process and outputs from each workgroup are described in the following sections.

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Health Care Alignment Workgroup

The alignment workgroup organized its work around six main topics: governance, realignment of facilities and services, medical sharing, eligibility, other than honorable discharges, and the organization of provider networks. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic was introduced through a summary paper or summary points which then were used as the basis for a conference call or a face-to-face discussion. For most topics, subsequent calls were held to discuss more detailed papers or to re-visit outstanding issues not yet resolved.

Commissioners also reviewed draft papers and provided additional feedback, revisions, and comments through written comments. The papers were finalized for inclusion in the draft Commission report for discussion on April 19. A summary of the work completed on each topic is provided in the table below.

Table F-2. Alignment Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E=email review M=face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Governance	11/17/2015	M	Vivian Riefberg	9/22/2015	F
	1/7/2016	C	Stephen Kirin	9/22/2015	F
	1/28/2016	C	Jay Schnitzer	9/22/2015	F
	2/18/2016	C	Paul Light	10/30/2015	S
	3/3/2016	C	Charles Rossotti	12/16/2015	F
	3/10/2016	C	Michael Kussman	1/19/2016	F
	3/17/2016	C	Ken Kizer	1/19/2016	F
	4/7/2016	C	Jeff Miller	3/21/2016	F
Realignment of Facilities and Services	1/7/2016	C	Vivian Riefberg	9/22/2015	F
	1/28/2016	C	John Means	9/22/2015	F
	3/10/2016	C			
	3/17/2016	C			
	4/7/2016	C			
Medical Sharing	1/28/2016	C	Atul Gover	11/16/2015	F
	3/3/2016	C	John Prescott	11/16/2015	F
	3/10/2016	C	Mathew Schick	11/16/2015	F
	3/17/2016	C			
	4/7/2016	C			
Eligibility	11/17/2015	M	Christine Eibner	9/21/2015	F
	12/10/2015	C	Michael Greenberg	9/21/2015	F
	1/28/2016	C	Pat Vandenberg	9/21/2015	F
	2/25/2016	C	Stephenie Mardon	10/6/2015	F
	3/10/2016	C	Kristin Cunningham	10/6/2015	F
	3/17/2016	C	Gail Wilensky	10/19/2015	F
	4/7/2016	C	Michael McGinnis	10/20/2015	F
			Marianne Hamilton Lopez	10/20/2015	F
			Michael Kussman	1/19/2016	F
			Jeff Miller	3/21/2106	F

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E=email review M=face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Other-Than-Honorable Discharge	1/28/2016	C	Bradford Adams	1/20/2016	F
	2/18/2016	C			
	3/10/2016	C			
	3/17/2016	C			
	4/7/2016	C			
Organization of Provider Networks	1/28/2016	C	Peter Hussey	9/21/2015	F
	2/25/2016	C	Joe Dalpiaz	10/6/2015	F
	3/10/2016	C	Baligh Yehia	10/6/2015	F
	3/17/2016	C	Gene Migliaccio	10/6/2015	F
	4/7/2016	C	Michael Kussman	1/19/2016	F
			Jon Gardner	2/8/2016	F
			Billy Maynard	2/8/2016	F
			David McIntrye	2/8/2016	F
			Jeff Miller	3/21/2016	F
			Beto O'Rourke	3/22/2016	F

Health Care Operations Workgroup

The health care operations workgroup was organized around five main topics: access standards, scheduling, clinical workflow, staffing (HR), and productivity. The workgroup (select Commissioners and support staff) first met face-to-face on October 7, 2015 to: introduce the staff, review guiding principles and business rules, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics was discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research on the four main topics; and cover other issues that may have come up during sessions (i.e., Best Practices) or from questions posed by Commissioners. To supplement the Commission conferences, the workgroup held teleconferences to cover additional research or present information from subject matter experts or emailed informational briefs and write-ups for review before a workgroup teleconference. Feedback from the Commissioners was addressed and the potential recommendations were refined. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

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Table F-3. Health Care Operations Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting	Date	Expert	Date	Type
Access Standards	10/20/2015	M	Stephanie Mardon	10/6/2015	F
	12/3/2015	C	Kristin Cunningham	10/6/2015	F
	2/25/2016	C	Institute of Medicine	10/13/2015	S
	4/27/2016	C	Institute of Medicine	10/20/2015	F
Scheduling	10/7/2015	M	McKinsey Co	9/22/2015	F
			Stephanie Mardon	10/6/2015	F
			Kristin Cunningham	10/6/2015	F
			Dr. Michael Davies	10/14/2015	S
			Gary Monder	10/14/2015	S
			Steve Green	10/14/2015	S
			Michael McGinnis	10/14/2015	S
			Ken Mullins	10/14/2015	S
			Marianne Hamilton Lopez	10/14/2015	S
			Institute of Medicine	10/20/2015	F
			Dr. Michael Davies	10/20/2015	F
			Dr. Michael Davies	11/18/2015	W
Clinical Workflow	10/27/2015	C	McKinsey & Co.	9/22/2015	F
	2/18/2016	C	Nora Socci	12/29/2015	S
	4/6/2016	C	Diane Pulphus	2/3/2016	S
			Hugh Scott	2/26/2016	S
Staffing	11/4/2015	C	McKinsey Co	9/22/2015	F
	12/3/2015	C	Dr. Jonathan Perlin	10/19/2015	F
	1/20/2016	M	Barbara Ward	12/7/2015	S
	2/18/2016	C			
	2/25/2016	C			
	4/6/2016	C			
Productivity	12/15/2015	M	McKinsey Co	9/22/2015	F
			Gene Migliaccio	10/6/2015	F
			Boston VAMC	12/7/2015:	S
			Dr. Michael Charness		
			Melanie Gilhern		
			Meredith Walker		
Best Practices	1/6/2016	C	Dr. Melanie Vielhauer		
			Rosemary Conlon		
	1/6/2016	C	McKinsey Co	9/22/2015	F
	1/20/2016	M	Dr. Theresa Cullen	12/2/2015	W
	2/25/2016	C	Dr. Daniel Bochicchio	12/3/2015	S
	3/14/2016	E	David Atkins	1/5/2016	S
			Linda Lipson	1/5/2016	S
			Amy Kilbourne	1/5/2016	S
			Bob Monte	1/5/2016	S
			Rachel Goffman	1/5/2016	S
			Dr. Daniel Bochicchio	1/20/2016	S
			Barbara Meadows	2/25/2016	W
			Barbara Meadows	3/17/2016	W

Health Care Data, Tools & Infrastructure Workgroup

The Health Care Data, Tools & Infrastructure (DTI) workgroup organized its work around four main topics: Health Information Technology, Business Processes, Supplies and Facilities. DTI first met face to face on October 7, 2015 to: introduce the staff, review the charge of DTI, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics were discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research via white papers on the four main topics; and cover other issues that may have come up during sessions or from questions posed by Commissioners. To supplement the Commission face-to-face meetings, the workgroup held teleconferences to cover additional research or present information from subject matter experts. Feedback from the Commissioners was incorporated into the white papers and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

Table F-4. Data, Tools & Infrastructure Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call		S=met with staff		
	E= email review		W=met with workgroup		
	M= face-to-face meeting		F=full Commission testimony		
	Date	Type	Expert	Date	Type
Health IT	10/7/2015	M	MITRE Co	9/22/2015	F
	11/18/2015	C	Dr. Brett Giroir	10/19/2015	S
	12/2/2015	C	LaVerne Council,	10/27/15	HVAC
	3/7/2016	C	Chris Miller, Brian Burns		Hearing
	3/14/2016	C	Brookings Institution	11/6/2015	S
	3/21/2016	M	LaVerne Council	11/25/2015	S
	4/4/2016	C & E	Dr. Theresa Cullen	12/2/2015	W
			Chris Miller	12/15/2015	F
			Chuck Hume	12/15/2015	F
			Elaine Hunolt	12/15/2015	F
			Jim Wood	12/15/2015	F
			Mariam Yeager	12/15/2015	F
			LaVerne Council	12/15/2015	F
			Jamie Bennett	3/2/2016	S
			Margaret Donahue	3/11/2016	S
			Kai Miller	4/12/2016	S
Business Processes	10/20/2015	M	SecVA Bob McDonald	9/21/2015	F
	10/26/2015	M			
	3/14/2016	C			
	3/21/2016	M			
	4/4/2016	C			

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WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting	Date	Expert	Date	Type
Supplies (Pharmaceutical & Medical Devices)	10/7/2015	M	McKinsey Co	9/21/2015	F
	10/26/2015	M	Jonathan Miller	12/4/2015	S
	2/23/2016	E	Tucker Taylor	12/4/2015	S
	2/24/2016	C			
	3/7/2016	C			
	3/14/2016	C			
	3/21/2016	M			
Facilities	10/7/2015	M	Bob McDonald	9/21/2015	F
	11/18/2015	M	Jim Sullivan	11/11/2015	S
	12/2/2015	C	Mark W. Johnson	12/21/2015	S
	12/22/2015	M	Kyle Reinhardt	12/22/2015	S
	2/16/2016	E	Thom Kurmel	12/22/2015	S
	2/17/2016	C	Rick Bond	12/22/2015	S
	2/24/2016	C & E	John Bulick	12/22/2015	S
	3/7/2016	C	John Kay	12/22/2015	S
	3/14/2016	C	Jim Sullivan	2/16/2016	S
	3/21/2016	M	Ed Bradley	2/16/2016	S
	4/4/2016	C	Jim Sullivan	2/17/2016	W
	4/11/2016	C	Jim Sullivan	3/15/2016	S
	4/27/2016	C			
Other	11/5/2015	E			
	11/6/2015	E			
	3/11/2016	E			

Health Care Leadership Workgroup

The leadership workgroup organized its work around five main topics: organizational health and cultural transformation and four leadership system issues: recruitment, retention, development and advancement; organizational structure and function; performance management and performance measurement; and human capital management. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic received an evidence review and summary which was the basis for a conference call or a face-to-face discussion. On a few topics, Commissioners or staff heard directly from VA staff or outside experts to inform the deliberation. Then, in a second meeting on the topic, the Commissioners debated a strawman proposal and alternative recommendations based on the evidence review and the prior Commission discussion. Feedback from the Commissioners was incorporated into the strawman and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. The papers were finalized and presented to the full Commission for deliberation and feedback on March 22, 2016. A summary of the work completed on each topic is provided in the table below.

APPENDIX F
THE COMMISSION'S PROCESS

Table F-5. Leadership Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting	Date	Expert	Date	Type
Organizational Health and Cultural Transformation	12/2/2015	C	Stephen Kirin	9/23/2015	F
	12/9/2015	C	Jay Schnitzer	9/23/2015	F
	2/9/2016	M	Vivian Riefberg	9/23/2015	F
	2/17/2016	C	Dee Ramsel	11/9/2015	S
	3/11/2016	E	Ashby Sharpe	11/9/2015	S
			Ken Berkowitz	11/9/2015	S
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
Recruitment, Retention, Development, and Advancement			Jon Gardner	2/8/2016	F
	11/17/2015	M	Stephen Kirin	9/23/2015	F
	11/25/2015	C	Jay Schnitzer	9/23/2015	F
	2/17/2016	C	Vivian Riefberg	9/23/2015	F
	2/24/2016	C	Volney Warner	11/9/2015	S
	3/9/2016	C	Lisa Red	11/17/2015	W
	3/11/2016	E	Payton Rica-Lewis	11/17/2015	W
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Georgia Coffey	2/22/2016	S
Organizational Structure and Function			David Perry	2/24/2016	S
			Audrey Oatis-Newsome	2/24/2016	S
	10/27/2015	C	Stephen Kirin	9/23/2015	F
	2/9/2016	M	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Charles Rossotti	12/16/2015	F
			Michael Kussman	1/19/2016	F
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
Performance Management and Performance Measurement			Jon Gardner	2/8/2016	F
			Robin Hemphill	3/4/2016	S
	11/4/2015	C	Stephen Kirin	9/23/2015	F
	11/12/2015	C	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Peter Almenoff	10/30/2015	S
			Joe Francis	1/8/2016	S
			Carolyn Clancy	1/8/2016	S
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Noel Baril	3/9/2016	S

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WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Human Capital Management	12/15/2015	M	Stephen Kirin	9/23/2015	F
	12/23/2015	C	Jay Schnitzer	9/23/2015	F
	3/11/2016	E	Vivian Riefberg	9/23/2015	F
			Sam Retherford	12/15/2015	W
			Joleen Clark	2/8/2016	F
Leadership Vision	1/6/2016	C			
	1/21/2016	M			
	2/3/2016	C			
	2/4/2016	E			
Leadership Pre-amble	3/14/2016	E			

Site Visits

Background

In the coming decades there will be increased demand for accountability in health care and increased emphasis on health care outcomes and measurements, and VHA will need to rise to meet these expectations to survive and remain competitive in the demanding and turbulent health care environment.⁷⁹⁷ The changing nature of health care organizations, including pressure to reduce costs, improve the quality of care, and meet stringent guidelines, has forced health care professionals to reexamine how they evaluate performance.⁷⁹⁸ Although many health care organizations have long recognized the need to look beyond financial measures when evaluating performance, many still struggle with what measures to select and how to use the results of those measures.⁷⁹⁹

As the nation's largest health care system in 2016, VHA employs more than 305,000 health care professionals and support staff at more than 1,000 sites of care, including hospitals, community-based outpatient clinics (CBOCs), nursing homes, domiciliaries, and 300 Vet Centers.⁸⁰⁰ Given the scope of this health care system, the Commission recognized the importance of direct lines of communication and interaction with VHA leaders, staff, and patients, to include conducting facility site visits. Commissioners conducted facility site visits to their local VA facilities to assist in the evaluation of the findings identified by the *Independent Assessment Report*, to contribute to an environmental scan of the VHA, and to inform the development of recommendations.⁸⁰¹

Scope of Site Visits

In January and February 2016, most of the 15 Commissioners conducted site visits to the VA medical centers (VAMCs) and CBOCs proximal to their respective residences. The Commissioners approached these site visits with a collaborative and information-seeking tone with the purpose of having open discussions with VAMC leadership, staff, and patients.

Individual Commissioners visited 12 VAMC facilities or CBOCs in 7 out of 19 Veteran Integrated Service Networks (VISNs). Additionally, all the Commissioners who attended the February 29, 2016, meeting in Dallas, TX, toured the Dallas VAMC.

⁷⁹⁷ Kenneth W. Kizer, M.D., M.P.H./Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation for the Veterans Healthcare System*, accessed March 1, 2016, <http://www.va.gov/healthpolicyplanning/rxweb.pdf>.

⁷⁹⁸ Kicab Castaneda-Mendez/Quality Digest, Performance Measurement in Health Care, accessed, March 1, 2016, <http://www.qualitydigest.com/magazine/1999/may/article/performance-measurement-health-care.html#>.

⁷⁹⁹ Ibid.

⁸⁰⁰ Department of Veterans Affairs, Undersecretary for Health, accessed March 1, 2016, <http://vaww.ush.va.gov/>.

⁸⁰¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, v, accessed March 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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Table F-6. VA Facility Site Visit Locations

VISN	VISN Name	VA Facility
2	VISN 2	VA Hudson Valley Health Care System (Montrose, NY)
6	VA Mid-Atlantic Health Care Network	Fredericksburg Community-based Outpatient Center, (Fredericksburg, VA)- part of Hunter Holmes McGuire VA Medical Center, Richmond, VA
7	VA Southeast Network	Ralph H. Johnson VA Medical Center (Charleston, NC) Wm. Jennings Bryan Dorn VA Medical Center (Columbia, SC)
10	VA Health Care System	VA Ann Arbor Health care System (Ann Arbor, MI) John D. Dingell VA Medical Center (Detroit, MI)
17	VA Heart of Texas Health Care System	Dallas VA Medical Center (Dallas, TX)
21	Sierra Pacific Network	Southern Nevada Health care System (Las Vegas, NV) VA Northern California Health Care System (Mather, CA) VA Palo Alto Health Care System (Palo Alto, CA)
22	Desert Pacific Health Care Network	Greater Los Angeles Health care System (Los Angeles, CA) VA San Diego Health care System (San Diego, CA)

The Commissioners were provided with a generic basic agenda as guidance, though they had the latitude to determine their own agendas as appropriate for the locations they visited. The model agenda included the following activities: a welcome and overview of the VA health care facility; tour of the facility; veteran discussion session (informal or formal); VHA employee session (e.g., informal or small group discussion); a discussion with the facility leadership, and were provided the recommended questions listed below:

- What does the medical center do well?
- What unique resources can the medical center draw on?
- What do others see as the strengths of the medical center?
- What could the medical center improve?
- Where does the medical center have fewer resources than others?
- What are others likely to see as weaknesses of medical center?
- What opportunities are open to the medical center?
- What trends could the medical center take advantage of?
- How can the medical center turn its strengths into opportunities?
- What threats could harm the medical center?
- What obstacles does the medical center face?
- What threats do the medical center's weaknesses expose it to?

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- What is the impact of MyVA?
- How do employees view working at VA compared to two or three years ago? If there is a change, what is driving it?
- In your view, what is the most important factor affecting patient satisfaction with the care you provide?
- In your view, has there been a change in the perception of the quality of care provided by the medical center? If so, what might be driving this different perception?

Once the Commissioners completed their visits, they provided the data they gathered to Commission staff to be organized in a strengths-weaknesses-opportunities-threats (SWOT) analysis framework. A SWOT analysis is a simple but useful framework for analyzing the four factors as they are faced by an organization. It helps organizations develop strengths, minimize threats, and take the greatest advantage of available opportunities.⁸⁰²

Findings

VHA leadership and staff enthusiastically shared their time, insights, perspective, and data on organizational and operational processes with the Commissioners. The site visits provided insight and reinforced the findings of the *Independent Assessment Report*.

Confirming what the *Independent Assessment Report* stated, the Commissioners found VHA facilities' staff members exhibit a deep commitment to serving veterans, but that VHA's health care facilities deliver strikingly different patient experiences, apply inconsistent business processes, and differ widely on key measures of performance and efficiency.⁸⁰³ Based on Commissioners' observations of weaknesses, challenges, and threats related to daily operations, VAMC staff members appear to be searching for suitable solutions. Anecdotal responses provided to the Commissioners illuminated the following systemic problem areas at the VAMCs:

- Care authorities: health care capabilities (i.e., purchased care)
- Staffing: productivity (i.e., human resources), health care capabilities, access standards, clinical workflow
- Leadership: staffing, productivity (i.e., human resources)
- Facilities: health care authorities (i.e., patient-centered community care)

Data from Commissioners' observation notes were organized into a SWOT analysis chart based on the common themes of the Commissioners' facility site visits. The purpose of this exercise was to gather information to inform the Commission's recommendations and to confirm or

⁸⁰² "SWOT Analysis," Mind Tools, accessed March 15, 2016, https://www.mindtools.com/pages/article/newTMC_05.htm.

⁸⁰³ "Veterans Integrated Service Networks (VISN)," Department of Veterans Affairs, VHA, accessed March 14, 2016, <http://www.va.gov/directory/guide/division.asp?dnum=1>.

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dispute the findings of the *Independent Assessment Report*. The Commissioner site visit inputs are summarized in the table below.

Table F-7. SWOT Analysis of Commissioner Site Visit Observations

Strengths	Weaknesses	Opportunities	Threats
<ul style="list-style-type: none"> ▪ VA medical center workforce customer service and dedication ▪ Research and national databases ▪ Veterans service – connected services and programs ▪ Partnerships with medical schools and training programs 	<ul style="list-style-type: none"> ▪ Inefficient/ineffective HR policies ▪ High levels of staffing vacancies ▪ Lack of clinical space; inefficient configurations of clinical space ▪ Poor access to VA care for rural veterans ▪ Lack of an effective financial system to provide real-time payment process to veterans Choice and Purchased Care Programs ▪ Lack of effective VHA leadership workforce ▪ Lack of capacity/access to appointments in VHA ▪ Insufficient federal government health care appropriation rules 	<ul style="list-style-type: none"> ▪ Modernization of VA IT ▪ Customer service training/standards ▪ Strategic focus on VHA core mission ▪ Local funding flexibility from Congress ▪ New vision and mission for VHA health care ▪ Process/systems reengineering ▪ Recruitment of outside leader candidates and retention of high-performing VHA leaders 	<ul style="list-style-type: none"> ▪ Misalignment between Congress's health care operational plans for veterans and VHA strategic health care plans ▪ Competing stakeholders health care interests ▪ Office of Personnel Management outdated standards/policies ▪ Insufficient VHA leadership development ▪ Insufficient IT funding ▪ The physician shortages around the nation has severely impacted the care of patients

Conclusions

Fundamental transformation of VHA is needed to ensure optimal delivery of veteran-centered, high-quality care. Essential to laying the path to excellence and strategic planning is a comprehensive understanding of the current state as well as the opportunities and threats facing the system. A robust connection between leaders in VHA Central Office and leaders in the field is critical to meet the needs of the veteran population served.

As part of the strategic planning process, VA/VHA leadership should make recurring site visits to VHA facilities, including VAMCs, VISN headquarters, and CBOCs to obtain current insight of the following critical areas: health care trends, health care operations, facility management and renovation/replacement, business processes and contracting, and other trends or issues affecting VAMCs. VA/VHA leaders should use performance management tools and activities to ensure the strategic goals are being met in an effective and efficient manner. It is a constant challenge to continuously and reliably measure the pulse of the organization. Site visits promote a healthy culture of sharing and building an understanding of organizational mission.

APPENDIX G: VETERAN FEEDBACK

In addition to the more than 4,000-page *Independent Assessment Report*, the Commission examined dozens of other reports, studies, and presentations as cited in the hundreds of footnotes dispersed throughout this Final Report. Collectively, these many sources provide a wealth of information on the challenges VHA confronts in realizing a vision for veterans' healthcare that leverages the strengths of VA and capitalizes on the potential non-VA providers offer.

A key source the Commission considered was the views of veterans themselves. Given the Commission's brief tenure, it was not possible to conduct a survey representative of the views of millions of veterans receiving health care from VHA. Instead, the Commission encouraged veterans to offer feedback on their health care experiences and the work of the Commission through its website. Many veterans service organizations (VSOs) also provided views representing their members in open sessions with the Commission and in formal letters and position statements directly to the Commission.

The feedback offered by veterans through the Commission's web site covered a range of health care topics, such as whether and to what extent care should be privatized, how much choice veterans should have in deciding on their care, and their assessment of the quality of care received. Not surprisingly, veterans (including a few who were also VA employees) are quite passionate about their views on health care. For the most part, veterans' feedback from the web site expressed opposition to efforts to *privatize* VHA, although a few did want more access to non-VA providers. The *Choice Program* was frequently criticized for long delays in appointments, convoluted or misapplied eligibility criteria, and issues with how providers should be reimbursed for treatment and how much the veteran should pay. When the quality of care was noted, on balance veterans praised the care received from VHA, with a few disappointed, especially when care was outsourced to non-VA providers. Because the feedback was unstructured, veterans could offer any observations they found pertinent.

The Disabled American Veterans (DAV) shared with the Commission a compendium of more than 4,000 verbatim comments on veterans' health care experiences gathered from their members during April 2016. The DAV reviewed the comments and categorized 82 percent of the comments as "overall positive experiences."⁸⁰⁴ The Commission staff reviewed the comments from DAV, with findings consistent to DAV's.

⁸⁰⁴ Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.

VA Efforts to Gather Input on Veterans Views on Health Care

Like most institutions that provide products and services to customers, VA/VHA solicits input from veterans on their health care needs and their views on specific services VA/VHA provides. Surveys, focus groups, and in-depth interviews are the more typical means for gathering input from veterans. On occasion, VA, like most agencies, encourages veterans and others to submit comments on a particular aspect of VA services and benefits.⁸⁰⁵

The following sections describe the more typical methods employed by VA/VHA to gather input from veterans.

VHA Survey of Veterans' Health and Use of VHA

Conducted by the assistant deputy undersecretary for policy and planning, the survey of veteran enrollees' health and use of health care (Survey of Enrollees) is an annual survey of more than 40,000 veterans who are enrolled in VA's health care system. The Survey of Enrollees was initially designed to give VHA the information it needed to predict the demand for services in the future. The data are used to develop health care budgets and to assist VA with its annual enrollment decisions. Over the years, the data have also been used to analyze policy decisions, provide insights into specific populations and their perspectives, and inform management decisions affecting delivery of care. In addition to collecting basic demographic information, the survey explores insurance coverage, use of health care inside and outside of VA, pharmaceutical use, attitudes and perceptions about VHA services, perceived health status, and trends in smoking among veterans enrolled in the VHA system.⁸⁰⁶

Survey of Healthcare Experiences of Patients⁸⁰⁷

The Survey of Healthcare Experiences of Patients (SHEP) program was initiated in 2002 in an effort to create standardized survey instruments administered monthly to assess ambulatory and inpatient care. In an effort to standardize its survey instruments with other health care providers, SHEP now employs the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey methodology for VHA's primary care and inpatient medical and surgical services. These surveys are supported in the public domain by the CAHPS Consortium, Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, and National Committee for Quality Assurance. Although SHEP deployed the standardized CAHPS surveys,

⁸⁰⁵ "Quality of Care Feedback Form," Department of Veterans Affairs, accessed June 20, 2016, <http://www.va.gov/QUALITYOFCARE/apps/contact.asp>. As an example, the VA web site provides a Quality of Care feedback page for veterans and others to enter comments on the care a veteran received.

⁸⁰⁶ Westat, 2015 Survey of Veteran Enrollees' Health and Use of Health Care, accessed June 6, 2016, http://www.va.gov/healthpolicyplanning/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁸⁰⁷ For more details on SHEP and VHA's recent initiatives to expand the scope of the program, see "Health Services Research & Development, Commentary: Listening to Veterans about Access to Care," Steven M. Wright, VHA Office of Analytics and Business Intelligence, U.S. Department of Veterans Affairs, accessed June 20, 2016, <http://www.hsrd.research.va.gov/publications/forum/nov15/default.cfm?ForumMenu=nov15-1>.

the access questions were limited and did not evaluate the full scope of services used by veterans.

VHA intends to expand the SHEP program with additional surveys in 2016 and beyond. These surveys will focus on satisfaction with various specialty care services and experience with community care available through the Veterans Access, Choice, and Accountability Act of 2014. VHA has also launched a survey that focuses on new veteran enrollments and their experience with first clinic appointments.

Veteran Insights Panel

VHA also established a Veteran Insights Panel, comprising more than 3,200 veterans that are representative of users of VA health care.⁸⁰⁸ VHA interacts with the panel through email notification and a special access website (mobile device enabled). This approach provides VHA an opportunity to engage panel members in direct discussions, including real time feedback via live chat, about important themes and issues, and survey development and testing. The panel can be engaged collaboratively with operational program offices and researchers to prompt direct discussions with our veterans.

Voices of Veterans: On-going Research

Initiated in the spring of 2014, the VA Center for Innovation (VACI) sponsors an on-going effort to employ human-centered design (HCD)⁸⁰⁹ concepts in a pilot to explore veterans' experience with VA through the eyes of 40 veterans across a range of demographics and locations.⁸¹⁰ The pilot had two goals:

- To test the usefulness and application of an HCD methodology within the context of VA.
- To better understand veterans' experiences interacting with VA, identify pain points in the present day service delivery model, and explore opportunities to transform these interactions into a more veteran-centered experience.

Developing Veteran Personas

As a part of this pilot, VACI set out to identify high-level trends in ways veterans seek out assistance, use technology, take advantage of services, and react to challenging interactions. Based on these patterns, VACI created a set of four profiles, or personas, that represent the

⁸⁰⁸ Ibid.

⁸⁰⁹ Human-centered design (HCD) is a discipline in which the needs, behaviors and experiences of an organization's customers (or users) drive product, service, or technology design processes. It is a practice used heavily across the private sector to build a strong understanding of users, generate ideas for new products and services, test concepts with real people, and ultimately deliver easy-to-use products and positive customer experiences. HCD is a multi-disciplinary methodology which draws from the practices of ethnography, cognitive psychology, interaction and user experience design, service design, and design thinking. It is closely tied to "user-centered design," which applies parallel processes to technology projects, and "service design" which address the service specific experiences.

⁸¹⁰ U.S. Department of Veterans Affairs, Center for Innovation, *Toward a Veteran-Centered VA: Piloting Tools of Human-Centered Design for America's Vets, Findings Report, July 2014*, accessed June 20, 2016, http://www.innovation.va.gov/docs/Toward_A_Veteran_Centered_VA_JULY2014.pdf.

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kinds of users within the set of 40 veterans engaged in the pilot (see Table G-1). Each persona is an archetype based on commonalities observed among veterans who exhibited similar behaviors and approaches to accessing VA services. They are not categorized by positive or negative experiences, but by shared expectations and needs. These personas were designed to help VHA begin to understand that it is serving users who are seeking not just different services, but also varied degrees of contact, support, information, and so forth. For this exercise, VACI assessed veterans' modes of communication, channels, frequency, stated and observed needs, reactions to service experiences, military service, and analyzed observed behavior and service experiences.

Table G-1. Veteran Profiles Developed by the VA Center for Innovation⁸¹¹

THE LIFER	THE TRANSACTIONAL
<p>Frequently use VA services and plans to continue doing so. Look to VA to play a supporting, community-building role in life. Grateful for VA benefits, but get frustrated when problems arise which break up the continuity of care—like when doctors change too frequently and when they cannot get transportation to VA facilities. Generally, try to speak highly of VA and wants to contribute to making it work better for fellow veterans.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA cares and takes the time to understand veteran's needs and story ▪ That cost of VA services won't rise ▪ That veteran can reach someone at VA anytime <p>Needs</p> <ul style="list-style-type: none"> ▪ Does not want to tell story over and over, especially after using VA for so long ▪ Wants to know what is going on with services and especially benefits ▪ Likes patient, nurturing health care 	<p>Joined the military largely based on the promise of the opportunities it would provide in life. Plan to use VA services to "get life on track" post-service. Tend to be in the younger generation of veterans (OEF, OIF, OND). Often engaged in the veteran community, see other veterans as allies, and advocates in helping folks understand and use their benefits. Will share frustrations if feels like VA is not helping as promised.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA will deliver on its promises and help veteran access the benefits earned ▪ That VA has benefits available to veterans families ▪ That it will be a headache, and veterans will have to figure it out on their own with the help of network <p>Needs</p> <ul style="list-style-type: none"> ▪ Accurate expectations ▪ Financial support at times, especially for family ▪ To feel a part of a community

⁸¹¹ Ibid.

THE JUST-IN-CASE	THE INFREQUENT
<p>Proud of service, but does not need VA and plans on using it only as a backup. Mature and organized by nature, has all papers in order with VA and have a good idea of services for which they are eligible. Grateful for the benefits available, but see working with VA as a tradeoff for time and will likely only lean on VA as a backup plan.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That will likely never need VA benefits ▪ That VA will be there if needed ▪ That there are benefits available to family ▪ That private benefits are of higher quality and greater ease <p>Needs</p> <ul style="list-style-type: none"> ▪ Peace of mind ▪ To be assured that all documents are in order ▪ To easily get in touch with one person about one question 	<p>Does not think very much about VA. Have used VA benefits in lifetime, yet often years will go by between those interactions. This might be because these veterans live in places where it is difficult to access VA services, because veterans are financially comfortable, or because it seems like too much hassle. Tend to prefer quick interaction—a short phone call or a few clicks on a website.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA is slow—like any bureaucracy ▪ That VA is for “other, injured veterans who need it more” ▪ That someone will tell veterans when and if they are eligible for something <p>Needs</p> <ul style="list-style-type: none"> ▪ To be able to quickly navigate processes ▪ To be reminded every few years of how VA might be able to help

Vantage Point: VA’s Official Blog

In addition to surveys, focus groups, and town-hall sessions, VA instituted a blog on its website and invites veterans and others interested in veterans matters to submit guest posts of potential interest to others in the community. Like most blogs, the content offered is vetted by the VA. Since 2010, Vantage Point includes hundreds of contributors with articles on various health care topics.⁸¹²

Veterans’ Views Gathered by VSOs

Like VHA, the VSOs solicit input from their membership and other stakeholders on a variety of topics and issues relevant to veterans. Occasionally surveys and polls are undertaken, but most VSO efforts to gather input take place at the grassroots level during town halls, chapter meetings and other gatherings. While these venues often suffer from self-selection bias and non- or under-represented participant samples, these are nevertheless an important source of timely information on topics of interest and concern to veterans. What follows is a selection of VSO efforts to gather input on issues important to veterans.

⁸¹² “Vantage Point: Official Blog of the U.S. Department of Veterans Affairs,” Department of Veterans Affairs, accessed June 20, 2016, <http://www.blogs.va.gov/VAntage/>.

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The DAV Veterans Pulse Survey (2015)

In mid-2015 the DAV surveyed a nationally representative sample of veterans to solicit their views on issues important to veterans.⁸¹³ The survey includes questions on various aspects of veterans' healthcare. The survey consists of a national probability sample of 1,701 veterans intended to represent the veteran population in the United States. Oversampling occurred in certain subgroups, such as female veterans and veterans age 18-40 to allow for more precision in the response estimates for these subgroups.

Veterans of Foreign Wars Our Care Veterans Survey (2015)

In the fall of 2015, the Veterans of Foreign Wars of the U.S. (VFW) published a report on its veterans 2015 Health Care Options, Preferences and Expectations Survey.⁸¹⁴ In response to the intensified debate over reform of veterans' healthcare, the VFW launched a survey in the summer of 2015 designed to evaluate veterans' options, expectations, and preferences when seeking health care. The survey did not just focus on VA services, but sought to paint a picture of how the veterans' community at large interacts within the American health care infrastructure, and the choices they make in today's health care marketplace. According to the VFW report, 1,847 veterans responded to the survey, with 92 percent eligible for care and 83 percent of those eligible reporting that they utilize VA health care.⁸¹⁵ Respondents' average age was 65, with about two-thirds Vietnam War veterans.

VFW Survey of Women Veterans (2016)

In an effort to identify barriers women veterans face when accessing their earned veterans' benefits and services, the VFW has commissioned a survey of women veterans that will guide the VFW's policy priority goals for women veterans.⁸¹⁶ Though the survey data collection phase is completed, results have not been published prior to release of the Commission's Final Report.

⁸¹³ Disabled American Veterans (DAV), *The DAV Veterans Pulse Survey: A landmark study of the attitudes and perceptions of America's veterans*, accessed June 20, 2016, <https://www.dav.org/wp-content/uploads/DAV-Pulse-Report-Final.pdf>. The survey was conducted on behalf of DAV by GfK Knowledge Networks, Inc. using their KnowledgePanel® survey participants in November 2015.

⁸¹⁴ Veterans of Foreign Wars, *Our Care: A Report on Veterans' Options, Preferences and Expectations in Health Care*, September 22, 2015, accessed June 20, 2016, http://www.vfw.org/uploadedFiles/VFW.org/VFW_in_DC/VFWOurCareReport2015.pdf.

⁸¹⁵ Ibid., 4.

⁸¹⁶ "VFW Survey of Women Veterans: Help Hold the VA Accountable," Veterans of Foreign Wars, December 22, 2015, accessed June 20, 2016, <http://www.vfw.org/News-and-Events/Articles/2015-Articles/VFW-Survey-of-Women-Veterans/>.

The American Legion Survey of Patient Health Care Experiences (2014)

This survey of 3,116 opt-in, self-reported veterans focuses on satisfaction and levels of perceived benefits with VA's posttraumatic stress disorder/traumatic brain injury (PTSD/TBI) programs, including alternative and complementary treatments.⁸¹⁷

Survey questions include veteran status; gender; era of service; number of times deployed; diagnosis of TBI and/or PTSD; availability of appointments; time and distance to care facilities; treatment type (therapy, medication and complementary and alternative medicine); reported symptoms; efficacy of treatment; and side effects.

The American Legion Women Veterans Survey Report (2011)

This survey of 3,012 women veterans, and the resulting report, was prepared by ProSidian Consulting, LLC on behalf of The American Legion. The survey assessed the perceptions of and satisfaction with women veterans' health care and other benefits delivered to women veterans through the VA system. Additionally, the survey sought to determine the factors driving women veterans' decision to use the VA system as opposed to other private or public health care systems.⁸¹⁸

Iraq and Afghanistan Veterans of America Member Survey (2015)

During the first half of 2015, 1,501 Iraq and Afghanistan Veterans of America members completed a wide-ranging on-line survey covering such issues as employment, education, GI Bill usage, health (including mental health), VA utilization, VA benefits, reintegration and more. The survey was composed of approximately 300 questions, with respondents answering only questions relevant to their experiences. Health care topics included percent enrollment in and reliance on VA care; health insurance coverage by type; and experience rating for VA care. Usage percent and experiencing rating for the VA *Choice Program* was also covered separately.⁸¹⁹

The 2015 Wounded Warrior Project® Alumni Survey

This web-enabled, opt-in survey of 23,200 Wounded Warrior Project (WWP) members measures a series of outcome domains within the following general topics about WWP Alumni: background information (military experiences and demographic data), physical and mental well-being, and economic empowerment.⁸²⁰ This WWP membership survey has been conducted annually since 2010. As it has done in prior years, Westat conducts the survey and population-

⁸¹⁷ "Legion survey to measure effectiveness of PTSD/TBI treatment," The American Legion, July 29, 2015, accessed June 20, 2016, <http://www.legion.org/pressrelease/229354/legion-survey-measure-effectiveness-ptsdtbi-treatment>.

⁸¹⁸ ProSidian Consulting, LLC, *The American Legion Women Veterans Survey Report*, March 9, 2011, accessed June 20, 2016, http://www.legion.org/documents/legion/pdf/womens_veterans_survey_report.pdf.

⁸¹⁹ "Media Advisory: IAVA to Release Groundbreaking Veterans Survey," Iraq and Afghanistan Veterans of America (IAVA), May 23, 2016, accessed June 20, 2016, <http://iava.org/press-release/media-advisory-iava-to-release-groundbreaking-veterans-survey-2/>.

⁸²⁰ Westat, *2015 Wounded Warrior Project Survey, Report of Findings*, August 14, 2015, accessed June 20, 2016, https://www.woundedwarriorproject.org/media/2118/2015_wwp_alumni_survey_full_report.pdf.

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weights the reported results, to include adjustments for potential non-response bias, to be representative of the WWP membership base (approximately 59,000).

Right to Care: Voices of Swords to Plowshares' Veteran Community (2015)

The Swords to Plowshares, Institute for Veteran Policy interviewed in-person or by phone 22 veterans.⁸²¹ Although the topics were established in advance, Swords to Plowshares characterized these interviews as individual “conversations” with a preselected group of veterans. The veterans were chosen to represent a cross-section of combat eras and VHA usage levels. The topics covered included: navigating VA care, reliance on VA and non-VA care, comprehensiveness of care, and rating quality of care. The study includes extensive verbatim comments from veterans on these topics.

Comments from Veterans About Their Experiences as Users of VHA (DAV, 2016)

During April 2016, DAV reached out to veterans around the United States and asked them to share their experiences with the VA health care system. As a result, DAV received (as of April 2016) more than 4,000 responses from veterans sharing their own stories about the care they received from VHA.⁸²² The Commission’s review of the material showed that a majority of the veterans’ comments were positive in nature. DAV’s own analysis concluded that 82 percent of the comments could be categorized as “overall positive experiences.”

Other Surveys on Veterans Issues

In addition to efforts by VA and VSOs to gather feedback from veterans on their health care, other organizations have also addressed veterans’ health care issues.

Concerned Veterans for America Survey of Veterans' Healthcare (November, 2014)

The Concerned Veterans for America commissioned The Tarrance Group to conduct a national survey of 1,000 veterans during November 2014.⁸²³ This survey used a random, demographically representative sample of veterans. Four survey items addressed health care, including: knowledge of any problems at VA; need for reform of veterans’ healthcare; importance of more choice (or options) in health care for veterans; and importance of best possible veterans care, even if outside VA.

⁸²¹ Megan Zottarelli, *RIGHT to CARE: Voices of Swords to Plowshares' Veteran Community*, Swords to Plowshares, Institute for Veterans Policy, April 2016.

⁸²² Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.

⁸²³ Concerned Veterans for America, *Fixing Veterans Health Care*, A Bipartisan Policy Taskforce, accessed June 20, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>.

Vet Voice Foundation Survey of Veterans (October, 2015)

Chesapeake Beach Consulting and Lake Research Partners conducted 800 phone (landline and cell) interviews of veterans during October 2015. The results were population weighted by demographics. Topics included rating the job VA hospitals are doing in their area and the extent they favor/oppose privatizing some of VA's health care.

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APPENDIX H: ADDITIONAL RESOURCES

The VHA health care system is immense and complex. This report provides background for the areas for which the Commission has made recommendations, yet this information is but a glimpse at the intricacies of veterans' health care. The resources below may serve as a starting point for those who would like to develop a deeper understanding of the topic than the Commission could address in this report.

Independent Assessment Report

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow – Scheduling)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow – Clinical)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

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Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

Veteran Health Competency Resources

American Nurses Foundation

The American Nurses Foundation, the philanthropic arm of the American Nurses Association, is launching an innovative web-based PTSD Toolkit for registered nurses. The toolkit provides easy to access information and simulation based on gaming techniques on how to identify, assess and refer veterans suffering from PTSD. www.nurseptsdtoolkit.org

American Osteopathic Association

The American Osteopathic Association (AOA) represents osteopathic physicians, many of whom are in primary care practice, and essentially all of whom treat America's veterans and their families. The AOA is raising awareness in the osteopathic community about the importance of having a comprehensive understanding of the unique physical and mental health care needs of our service members, veterans, and their families. The AOA is committed to ensuring that medical students, physicians, and other health care providers understand that an individual's physical and/or mental health condition may be linked to his or her military experience.

www.osteopathic.org/inside-aoa/public-policy/Pages/federal-initiatives.aspx

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Center for Deployment Psychology

The Center for Deployment Psychology of the Uniformed Services University of the Health Sciences, Department of Medical and Clinical Psychology offer a wide variety of on-line courses and other resources to help uniformed clinical providers, VHA providers, and community clinicians provide care consistent with the needs and experience of military service members, veterans and their families.

<http://deploymentpsych.org/online-courses>

<http://deploymentpsych.org/military-culture-course-modules>

Rural Clergy Training Program

The Rural Clergy Training Program, an initiative of the VHA National Chaplain Center and the Office of Rural Health, offers training and information to clergy providing pastoral services to veterans and their families.

http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December_2015.pdf

Swords to Plowshares Combat to Community Training

Swords to Plowshares is nationally recognized for its expertise in providing comprehensive services and promoting and protecting the rights of veterans. Swords to Plowshares' *Combat to Community*® training is a series of accredited cultural competency curricula developed by its Institute for Veteran Policy team with the purpose of educating the community to address the reintegration challenges veterans face and the unique skill sets they acquire in service. The training was developed for law enforcement, first responder, mental health, and service professionals to teach:

- Commonly shared attitudes, values, goals, and practice that often characterize service in the military
- Recruitment and retention strategies for veteran employment
- How deployment, combat experience, service related injuries, and disability can impact veterans
- How veteran or military family status can inform interactions and services
- Potential resources to refer veterans and families to for supportive services

The training incorporates knowledge developed by experts in the fields of veteran culture and direct services with practical tools and resources to increase understanding and improve interactions with veterans.

<https://www.swords-to-plowshares.org/combat-to-community>

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VA Military Culture Training Courses on TMS

The resources below are available to VA employees and contractors. Versions of these courses should be made available to community providers through an alternative to TMS that allows outside providers to access the training.

- **Military Culture Training for Health Care Professionals – Organization and Roles (VA 19332)**

The first module of this online course provides an overview of the differences between the explicit and implicit features of military culture and describes the characteristics of implicit military culture. The next module identifies four sources of information about implicit military culture and describes six defining characteristics of warrior ethos. The learner is provided information about the influence of military guiding ideals and values on the lives of service members and veterans. The final module offers an overview regarding the connotations of implicit military culture on the health care professional.

- **Military Culture Training for Health Care Professionals: Self-Awareness and Military Ethos (VA 19333)**

This online course, sponsored by the Department of Veterans Affairs and Department of Defense, helps health care professionals understand the role that military culture plays in the lives of those they serve. The course is comprised of four modules: 1) Self-Assessment and Introduction to Military Ethos, 2) Military Organization and Roles, 3) Stressors and Their Impact, and 4) Treatment Resources and Tools.

- **Military Culture Training for Health Care Professionals: Stressors & Resources (VA 19334)**

This online course offers the learner an explanation of how stress can be either helpful or harmful depending on the nature of the provoking stressor and the availability of resources. The four phases of modern operational deployment cycles is presented in great detail in module 3. The next two modules describe the characteristic operational stressors and the spectrum of operational stress states and outcomes experienced by service members and their families during each deployment cycle phase.

- **Military Culture Training for Health Care Professionals: Treatment Resources, Prevention & Treatment (VA 19335)**

This online course in the military culture curriculum outlines the military culture impact on patient care and the health care professional's role and explains the range of DoD and VA psychological health services. The course also provides information on interpreting military culture knowledge into patient assessment and treatment. Finally, the learner is exposed to the military culture implications of VA/DoD clinical practice guidelines relevant to the care of service members and veterans and the strategies for identifying current military culture relevant patient and health care professional resources.

- **Military Cultural Awareness (NFED 1341520)**

This military cultural awareness online course provides a common foundation for all VA employees. This course offers an overview of common military culture and courtesies, roles and ranks within the military, differences between the branches of the armed services, some of the conflicts in which veterans have served, and why this information

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is important in helping VA employees better serve the needs of veterans and their families. After taking this course, participants will understand the perspective of the veterans they serve by having a greater awareness of the military experience, and the customs and courtesies that are common in the military environment.

- **PTSD 101: Understanding Military Culture When Treating PTSD (VA 9494)**
This online web-based course is part of the PTSD 101 education series which is presented by subject-matter experts to increase provider knowledge related to the assessment and treatment issues of PTSD. Each course specifically addresses trauma events, treatments, or special population issues, not normally addressed in general therapy protocols. This course is specifically designed to familiarize clinicians with military culture, terminology, demographics, and stressors. It also provides an overview of programs offered by DoD for managing combat or operational stress, as well as implications for assessment and treatment.
- **Why Military Culture Matters (Mobile Accessible) (VA 16353)**
This independent online study activity is designed to help the learner better connect with veterans and understand how veterans' military experiences influence their health. This course is formatted to be accessible using a VA networked mobile device.

Additional Sources

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APPENDIX I: ENABLING DOCUMENTS

Veterans Access, Choice, and Accountability Act of 2014

TITLE II—HEALTH CARE ADMINISTRATIVE MATTERS

SEC. 201. INDEPENDENT ASSESSMENT OF THE HEALTH CARE DELIVERY SYSTEMS AND MANAGEMENT PROCESSES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) INDEPENDENT ASSESSMENT. —

(1) ASSESSMENT. — Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into one or more contracts with a private sector entity or entities described in subsection (b) to conduct an independent assessment of the hospital care, medical services, and other health care furnished in medical facilities of the Department. Such assessment shall address each of the following:

(A) Current and projected demographics and unique health care needs of the patient population served by the Department.

(B) Current and projected health care capabilities and resources of the Department, including hospital care, medical services, and other health care furnished by non-Department facilities under contract with the Department, to provide timely and accessible care to veterans.

(C) The authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Department facilities, including whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care.

(D) The appropriate system-wide access standard applicable to hospital care, medical services, and other health care furnished by and through the Department, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation.

(E) The workflow process at each medical facility of the Department for scheduling appointments for veterans to receive hospital care, medical services, or other health care from the Department.

(F) The organization, workflow processes, and tools used by the Department to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.

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(G) The staffing level at each medical facility of the Department and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics, which may include an assessment of any of the following:

(i) The case load of, and number of patients treated by, each health care provider at such medical facility during an average week.

(ii) The time spent by such health care provider on matters other than the case load of such health care provider, including time spent by such health care provider as follows:

(I) At a medical facility that is affiliated with the Department.

(II) Conducting research.

(III) Training or supervising other health care professionals of the Department.

(H) The information technology strategies of the Department with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by Department, especially those strategies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Department in Department or non-Department facilities.

(I) Business processes of the Veterans Health Administration, including processes relating to furnishing non-Department health care, insurance identification, third-party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows:

(i) To avoid the payment of penalties to vendors.

(ii) To increase the collection of amounts owed to the Department for hospital care, medical services, or other health care provided by the Department for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate.

(iii) To increase the collection of any other amounts owed to the Department with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate.

(iv) To increase the accuracy and timeliness of Department payments to vendors and providers.

(J) The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Department, including the following:

(i) The prices paid for, standardization of, and use by the Department of the following:

(I) Pharmaceuticals.

(II) Medical and surgical supplies.

(III) Medical devices.

(ii) The use by the Department of group purchasing arrangements to purchase pharmaceuticals, medical and surgical supplies, medical devices, and health care related services.

(iii) The strategy and systems used by the Department to distribute pharmaceuticals, medical and surgical supplies, medical devices, and health care related services to Veterans Integrated Service Networks and medical facilities of the Department.

(K) The process of the Department for carrying out construction and maintenance projects at medical facilities of the Department and the medical facility leasing program of the Department.

(L) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.

(2) PARTICULAR ELEMENTS OF CERTAIN ASSESSMENTS. —

(A) SCHEDULING ASSESSMENT. — In carrying out the assessment required by paragraph (1)I, the private sector entity or entities shall do the following:

(i) Review all training materials pertaining to scheduling of appointments at each medical facility of the Department.

(ii) Assess whether all employees of the Department conducting tasks related to scheduling are properly trained for conducting such tasks.

(iii) Assess whether changes in the technology or system used in scheduling appointments are necessary to limit access to the system to only those employees that have been properly trained in conducting such tasks.

(iv) Assess whether health care providers of the Department are making changes to their schedules that hinder the ability of employees conducting such tasks to perform such tasks.

(v) Assess whether the establishment of a centralized call center throughout the Department for scheduling appointments at medical facilities of the Department would improve the process of scheduling such appointments.

(vi) Assess whether booking templates for each medical facility or clinic of the Department would improve the process of scheduling such appointments.

(vii) Assess any interim technology changes or attempts by Department to internally develop a long-term scheduling solutions with respect to the feasibility and cost effectiveness of such internally developed solutions compared to commercially available solutions.

(viii) Recommend actions, if any, to be taken by the Department to improve the process for scheduling such appointments, including the following:

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(1) Changes in training materials provided to employees of the Department with respect to conducting tasks related to scheduling such appointments.

(II) Changes in monitoring and assessment conducted by the Department of wait times of veterans for such appointments.

(III) Changes in the system used to schedule such appointments, including changes to improve how the Department –

(aa) measures wait times of veterans for such appointments;

(bb) monitors the availability of health care providers of the Department; and

(cc) provides veterans the ability to schedule such appointments.

(IV) Such other actions as the private sector entity or entities considers appropriate.

(B) MEDICAL CONSTRUCTION AND MAINTENANCE PROJECT AND LEASING PROGRAM ASSESSMENT. – In carrying out the assessment required by paragraph (1)(K), the private sector entity or entities shall do the following:

(i) Review the process of the Department for identifying and designing proposals for construction and maintenance projects at medical facilities of the Department and leases for medical facilities of the Department.

(ii) Assess the process through which the Department determines the following:

(1) That a construction or maintenance project or lease is necessary with respect to a medical facility or proposed medical facility of the Department.

(II) The proper size of such medical facility or proposed medical facility with respect to treating veterans in the catchment area of such medical facility or proposed medical facility.

(iii) Assess the management processes of the Department with respect to the capital management programs of the department, including processes relating to the methodology for construction and design of medical facilities of the Department, the management of projects relating to the construction and design of such facilities, and the activation of such facilities.

(iv) Assess the medical facility leasing program of the Department.

(3) TIMING. – The private sector entity or entities carrying out the assessment required by paragraph (1) shall complete such assessment not later than 240 days after entering into the contract described in such paragraph.

(b) PRIVATE SECTOR ENTITIES DESCRIBED. – A private entity described in this subsection is a private entity that –

(1) has experience and proven outcomes in optimizing the performance of the health care delivery systems of the Veterans Health Administration and the private sector and in health care management; and

(2) specializes in implementing large-scale organizational and cultural transformations, especially with respect to health care delivery systems.

(c) PROGRAM INTEGRATOR. —

(1) IN GENERAL. — If the Secretary enters into contracts with more than one private sector entity under subsection (a), the Secretary shall designate one such entity that is predominately a health care organization as the program integrator.

(2) RESPONSIBILITIES. — The program integrator designated pursuant to paragraph (1) shall be responsible for coordinating the outcomes of the assessments conducted by the private entities pursuant to such contracts.

(d) REPORT ON ASSESSMENT. —

(1) IN GENERAL. — Not later than 60 days after completing the assessment required by subsection (a), the private sector entity or entities carrying out such assessment shall submit to the Secretary of Veterans Affairs, the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and the Commission on Care established under section 202 a report on the findings and recommendations of the private sector entity or entities with respect to such assessment.

(2) PUBLICATION. — Not later than 30 days after receiving the report under paragraph (1), the Secretary shall publish such report in the Federal Register and on an Internet website of the Department of Veterans Affairs that is accessible to the public.

(e) NON-DEPARTMENT FACILITIES DEFINED. — In this section, the term “non-Department facilities” has the meaning given that term in section 1701 of title 38, United States Code.

SEC. 202. COMMISSION ON CARE.

(a) ESTABLISHMENT OF COMMISSION. —

(1) IN GENERAL. — There is established a commission, to be known as the “Commission on Care” (in this section referred to as the “Commission”), to examine the access of veterans to health care from the Department of Veterans Affairs and strategically examine how best to organize the Veterans Health Administration, locate health care resources, and deliver health care to veterans during the 20-year period beginning on the date of the enactment of this Act.

(2) MEMBERSHIP. —

(A) VOTING MEMBERS. — The Commission shall be composed of 15 voting members who are appointed as follows:

(i) Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a veteran.

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(ii) Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a veteran.

(iii) Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a veteran.

(iv) Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a veteran.

(v) Three members appointed by the President, at least two of whom shall be veterans.

(B) QUALIFICATIONS. — Of the members appointed under subparagraph (A) —

(i) at least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code;

(ii) at least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000;

(iii) at least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)));

(iv) at least one member shall be familiar with the Veterans Health Administration but shall not be currently employed by the Veterans Health Administration; and

(v) at least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.

I DATE. — The appointments of members of the Commission shall be made not later than 1 year after the date of the enactment of this Act.

(3) PERIOD OF APPOINTMENT. —

(A) IN GENERAL. — Members shall be appointed for the life of the Commission.

(B) VACANCIES. — Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(4) INITIAL MEETING. — Not later than 15 days after the date on which eight voting members of the Commission have been appointed, the Commission shall hold its first meeting.

(5) MEETINGS. — The Commission shall meet at the call of the Chairperson.

(6) QUORUM. — A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(7) CHAIRPERSON AND VICE CHAIRPERSON. — The President shall designate a member of the commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.

(b) DUTIES OF COMMISSION. —

(1) EVALUATION AND ASSESSMENT. — The Commission shall undertake a comprehensive evaluation and assessment of access to health care at the Department of Veterans Affairs.

(2) MATTERS EVALUATED AND ASSESSED. — In undertaking the comprehensive evaluation and assessment required by paragraph (1), the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201, including any findings, data, or recommendations included in such assessment.

(3) REPORTS. — The Commission shall submit to the President, through the Secretary of Veterans Affairs, reports as follows:

(A) Not later than 90 days after the date of the initial meeting of the Commission, an interim report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(B) Not later than 180 days after the date of the initial meeting of the Commission, a final report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(c) POWERS OF THE COMMISSION. —

(1) HEARINGS. — The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

(2) INFORMATION FROM FEDERAL AGENCIES. — The Commission may secure directly from any Federal agency such information as the Commission considers necessary to carry out this section. Upon request of the Chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

(d) COMMISSION PERSONNEL MATTERS. —

(1) COMPENSATION OF MEMBERS. —

(A) IN GENERAL. — Each member of the Commission who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily

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equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission.

(B) OFFICERS OR EMPLOYEES OF THE UNITED STATES. — All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES. — The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(3) STAFF. —

(A) IN GENERAL. — The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(B) COMPENSATION. — The Chairperson of the Commission may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(4) DETAIL OF GOVERNMENT EMPLOYEES. — Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES. — The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals that do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(e) TERMINATION OF THE COMMISSION. — The Commission shall terminate 30 days after the date on which the Commission submits the report under subsection (b)(3)(B).

(f) FUNDING. — The Secretary of Veterans Affairs shall make available to the Commission from amounts appropriated or otherwise made available to the Secretary such amounts as the Secretary and the Chairperson of the Commission jointly consider appropriate for the Commission to perform its duties under this section.

(g) EXECUTIVE ACTION. —

(1) ACTION ON RECOMMENDATIONS. — The President shall require the Secretary of Veterans Affairs and such other heads of relevant Federal departments and agencies to

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implement each recommendation set forth in a report submitted under subsection (b)(3) that the President —

(A) considers feasible and advisable; and

(B) determines can be implemented without further legislative action.

(2) REPORTS. — Not later than 60 days after the date on which the President receives a report under subsection (b)(3), the President shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives and such other committees of Congress as the President considers appropriate a report setting forth the following:

(A) an assessment of the feasibility and advisability of each recommendation contained in the report received by the President.

(B) For each recommendation assessed as feasible and advisable under subparagraph (A) the following:

(i) Whether such recommendation requires legislative action.

(ii) If such recommendation requires legislative action, a recommendation concerning such legislative action.

(iii) A description of any administrative action already taken to carry out such recommendation.

(iv) A description of any administrative action the President intends to be taken to carry out such recommendation and by whom.

H.R. 4437: Extension of Deadline for Submittal of Final Report by Commission on Care

[114th Congress Public Law 131]

[[Page 130 STAT. 292]]

Public Law 114-131

114th Congress

An Act

To extend the deadline for the submittal of the final report required by the Commission on Care.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. 38 USC 1701; EXTENSION OF DEADLINE FOR SUBMITTAL OF FINAL REPORT BY COMMISSION ON CARE.

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Section 202(b)(3)(B) of the Veterans Access, Choice, and Accountability Act of 2014, 128 Stat. 1775 (Public Law 113-146; 128 Stat. 1773) is amended by striking “Not later than 180 days after the date of the initial meeting of the Commission” and inserting “Not later than June 30, 2016”.

Approved February 29, 2016.

DEPARTMENT OF VETERANS AFFAIRS
CHARTER OF THE
COMMISSION ON CARE

1. OFFICIAL DESIGNATION: Commission on Care
2. AUTHORITY: The Commission on Care established as required by section 202 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Public Law 113-146, and operates under the provisions of the Federal Advisory Committee Act (FACA), as amended, 5 U.S.C. App. 2.
3. OBJECTIVES AND SCOPE OF ACTIVITIES: The Commission on Care (the "Commission") is established to examine the access of Veterans to health care from the Department of Veterans Affairs (VA) and strategically examine how best to organize the Veterans Health Administration (VHA), locate health care resources, and deliver health care to Veterans during the 20-year period beginning on the date of the enactment of VACAA, August 7, 2014.
4. DUTIES OF THE COMMISSION:
 - A. Evaluation and Assessment: In accordance with section 202(b)(1), the Commission shall undertake a comprehensive evaluation and assessment of access to health care at VA.
 - B. Matters Evaluated and Assessed: In undertaking the comprehensive evaluation and assessment required by section 202(b)(1) of VACAA and paragraph (4)(A) above, the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201 of VACAA, including any findings, data, or recommendations included in such assessment.
 - C. Reports: In accordance with section 202(b)(3) of VACAA, submit an interim report not later than 90 days after the initial meeting of the Commission to the President, through the Secretary of Veterans Affairs, and a final report not later than 180 days after the initial meeting of the Commission. The reports shall include (i) the findings of the Commission with respect to the evaluation and assessment required by section 202(b)(1); and (ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through VHA.
5. OFFICIAL TO WHOM THE COMMISSION REPORTS: The Commission reports to the President, through the Secretary of Veterans Affairs.

VA is responsible for ensuring the reporting requirements of Section 6(b) of the FACA are fulfilled.

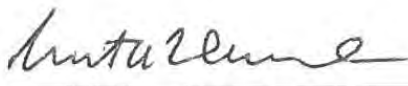
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6. OFFICE RESPONSIBLE FOR PROVIDING THE NECESSARY SUPPORT FOR THE COMMISSION: VHA is responsible for providing support to the Commission.
7. ESTIMATED ANNUAL OPERATING COSTS AND STAFF-YEARS: Annual operating cost for the Commission is estimated at \$3,600,000 per year, including compensation of members and staff, in accordance with section 202(d) of VACAA. All members will receive travel expenses and a per diem allowance in accordance with the Federal Travel Regulations for any travel made in connection with their duties as members of the Commission. Approximately 15 FTE are anticipated.
8. DESIGNATED FEDERAL OFFICER: The Designated Federal Officer (DFO) or an Alternate DFO, full-time or permanent part-time VA employees, will be present at all meetings, including subcommittee meetings. The DFO will work with the Commission Chair to schedule the meetings and develop meeting agendas. The DFO is authorized to adjourn any meeting when he or she determines it is in the public interest to do so.
9. ESTIMATED NUMBER AND FREQUENCY OF MEETINGS: The Commission will meet at the call of the Chair for the duration of the Commission. The Commission may hold such hearings, sit and act at such times and places, and take such testimony, and receive such evidence as the Commission considers advisable to carry out its duties under section 202 of VACAA. A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.
10. DURATION: The Commission is subject to the termination date as specified below in section 11.
11. TERMINATION: The Commission shall terminate 30 days after the date on which the Commission submits the final report required by section 202(b)(3)(B) of VACAA.
12. MEMBERSHIP: The Commission shall be composed of 15 voting members who are appointed as Special Government Employees and described in paragraph (A) below for the life of the Commission and have the qualifications described in paragraph (B) below:
 - A. APPOINTMENT AUTHORITY:
 - i. Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a Veteran.
 - ii. Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a Veteran.

- iii. Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a Veteran.
 - iv. Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a Veteran.
 - v. Three members appointed by the President, at least two of whom shall be Veterans.
- B. QUALIFICATIONS: Of the members appointed under 12(A) –
- i. At least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of Veterans under 38 U.S.C. 5902;
 - ii. At least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000;
 - iii. At least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined by in section 1905(1)(2)(B) of the Social Security Act (42 U.S.C. 1396d(1)(2)(B));
 - iv. At least one member shall be familiar with VHA but shall not be currently employed by VHA; and
 - v. At least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.
- C. CHAIRPERSON AND VICE CHAIRPERSON: The President shall designate a member of the Commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.
- D. VACANCIES: If a vacancy occurs, it shall be filled in the same manner as the original appointment.
13. SUBCOMMITTEES: The Commission is authorized to establish subcommittees, with DFO approval, to perform specific projects or assignments as necessary and consistent with its mission. The Commission Chair shall notify the Secretary, through the DFO, of the establishment of any subcommittee, including its function, membership, and estimated duration. Subcommittees will report back to the Commission.
14. RECORDKEEPING: Records of the Committee shall be handled in accordance with General Records Schedule 26 or other approved agency records disposition schedules. Those records shall be available for public inspection and copying, subject to the Freedom of Information Act 5, U.S.C. 552.

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15. DATE CHARTER IS FILED:

Approved:  Date 7/14/15
Robert A. McDonald
Secretary of Veterans Affairs



APPENDIX J:

COMPOSITION OF THE COMMISSION

Nancy M. Schlichting, Chairperson

Appointed by President Barack Obama

Nancy M. Schlichting is Chief Executive Officer of Henry Ford Health System (HFHS), a nationally recognized \$5 billion health care organization with 27,000 employees and recipient of the 2011 Malcolm Baldrige National Quality Award, 2011 John M. Eisenberg Patient Safety Quality Award, and 2004 Foster G. McGaw Award. She is credited with leading the health system through a dramatic financial turnaround and for award-winning patient safety, customer service and diversity initiatives.

Schlichting joined HFHS in 1998 as its Senior Vice President and Chief Administrative Officer, served as Executive Vice President and Chief Operating Officer, President and CEO of Henry Ford Hospital and was named President and CEO of the System in 2003. Her career in health care administration spans over 35 years of experience in senior level executive positions.

Schlichting serves on several national and community boards including The Kresge Foundation, Walgreens Boots Alliance, the Federal Reserve Bank of Chicago – Detroit Branch, the Detroit Regional Chamber, the Detroit Economic Club, and the Downtown Detroit Partnership. Nancy is also a Fellow of the American College of Healthcare Executives.

In 2015, Schlichting was honored as one of the 100 Most Influential People in Healthcare by Modern Healthcare magazine, the eighth time she received this recognition. She was also named to the Top 25 Women in Healthcare by Modern Healthcare, the fourth time she received this recognition and the only Michigander named to the list. Her other awards include: NCHL Gail L. Warden Leadership Excellence award, ACHE Senior-Level Healthcare Executive Regent's Award, AHA/HRET 2014 TRUST Award, Becker's Hospital Review "40 of the Smartest People in Healthcare-2014," Crain's Detroit Business "2012 Newsmaker of the Year," HealthLeaders Media "20 People Who Make Healthcare Better-2012," and most recently was named one of "Crain's 100 Most Influential Women in Michigan."

Author of the acclaimed book, *Unconventional Leadership*, Schlichting is a highly regarded expert and accomplished speaker on strategic leadership, quality, patient/family-centered care, and diversity.

Schlichting received her A.B. in Public Policy Studies, Magna Cum Laude from Duke University and her M.B.A. from Cornell University. She has also been the recipient of honorary doctoral degrees from Walsh College, Eastern Michigan University and Central Michigan University.

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Delos M. (Toby) Cosgrove, MD, Vice Chairperson*Appointed by Speaker of the House John Boehner*

Toby Cosgrove, CEO of Cleveland Clinic, presides over a \$6.2 billion health care system comprising Cleveland Clinic, eight community hospitals, 16 family health and ambulatory surgery centers, Cleveland Clinic Florida, the Lou Ruvo Center for Brain Health in Las Vegas, Cleveland Clinic Toronto, and Cleveland Clinic Abu Dhabi. His leadership has emphasized patient care and patient experience, including the reorganization of clinical services into patient-centered, organ- and disease-based institutes. He launched major wellness initiatives for patients, employees, and communities. Under his leadership, Cleveland Clinic has consistently been named among America's top four hospitals by U.S. News & World Report and is one of only two hospitals named among America's 99 Most Ethical Companies by the Ethisphere Institute.

Cosgrove was a surgeon in the U.S. Air Force and served in Da Nang, Republic of Vietnam, as the chief of U.S. Air Force casualty staging flight. He received the Bronze Star and the Republic of Vietnam Commendation Medal.

He has published nearly 450 journal articles, book chapters, one book, and 17 training and continuing medical education films. He performed more than 22,000 operations and earned an international reputation for expertise in all areas of cardiac surgery, especially valve repair. As an innovator, Cosgrove has 30 patents filed for developing medical and clinical products used in surgical environments.

Cosgrove received his medical degree from the University of Virginia School of Medicine in Charlottesville, VA, and completed his clinical training at Massachusetts General Hospital, Boston Children's Hospital, and Brook General Hospital in London. He received a BA in biology from Williams College in Williamstown, MA.

Michael A. Blecker*Appointed by House Minority Leader Nancy Pelosi*

Michael Blecker has been associated with Swords to Plowshares since 1976 and has served as Executive Director since 1982. The agency was started in 1974 by returning Vietnam veterans and VISTA volunteers assigned to the VA regional office in San Francisco.

In the 1980s, when homelessness exploded, Swords to Plowshares started a transitional housing program with funding support from VA and the city and county of San Francisco. Swords to Plowshares continues to provide housing, employment, case management, and benefits advocacy for veterans from offices in San Francisco and Oakland. In 2005, the Iraq Vet Project (IVP) was established to help veterans of those wars and to shape policies affecting them. Recognizing Swords to Plowshares' long and effective history of challenging and shaping public policy with regard to veterans, in 2011, the IVP became known as the Institute for Veterans Policy.

Under Blecker's leadership, Swords to Plowshares' annual budget has grown from \$75,000 to nearly \$16 million. He has a nationwide reputation for dedicated service and as an authority on

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veterans' services and veterans' rights. He served on the Advisory Committee on Homeless Veterans (2002-2007), which advises the Secretary of Veterans Affairs. He is cofounder of both the National Coalition for Homeless Veterans and the California Association of Veterans' Service Agencies. He has served on the Congressional Commission on Service Members and Veterans Transition Assistance, the California Senate Commission on Homeless Veterans, the San Francisco Mayor's Homeless Planning Committee, the National Agent Orange Settlement Advisory Board, The Agent Orange Information Center, and the Veterans Speakers Alliance.

Blecker served in the U.S. Army as a combat infantryman in Vietnam in 1968-69 with the 101st Airborne Division, achieving the rank of E-5. He received an AB degree in criminology from University of California, Berkeley and a JD degree from New College of California Law School.

David P. Blom

Appointed by Speaker of the House John Boehner

David Blom has been instrumental in the development and growth of the OhioHealth system. He has served as president of OhioHealth's central Ohio hospitals – Grant Medical Center, Riverside Methodist Hospital, and Doctors Hospital – while also serving as executive vice president and chief operating officer of OhioHealth. He was named president and CEO of OhioHealth in March 2002. He has a track record of achievement with a solid understanding of complex issues facing health care delivery. He has expertise in leading strategic initiatives, managing and developing human capital, improving profitability, and improving quality of care and customer experience.

Blom maintains many professional and community affiliations, currently serving as a board member of the Voluntary Hospitals of America (VHA), a member and treasurer of Columbus' Downtown Development Corporation (CDDC), member of the Columbus Partnership, and member of the local World President's Organization (WPO). In 2001, he was named a Top 100 Business Leader by Smart Business and in 2012 CEO of the Year by Columbus CEO Magazine.

He received a BA from Ohio State University and an MA in health care administration from The George Washington University.

David W. Gorman

Appointed by President Barack Obama

David Gorman is a retired, combat-disabled veteran of the Vietnam War, who was appointed executive director of the Disabled American Veterans (DAV) National Service and Legislative Headquarters in Washington, DC in 1995. His responsibilities include oversight of the DAV National Service, Legislative, and Voluntary Service Programs. He is the organization's principal spokesperson before Congress, the White House, and the U.S. Department of Veterans Affairs.

Gorman entered the U.S. Army in 1969 and served with the 173rd Airborne Brigade, the famed "Sky Soldiers" of the Vietnam War. During a campaign to secure an area in Central Vietnam

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where U.S. forces suffered extremely high casualties, Mr. Gorman was severely wounded. His wounds required amputation of both legs.

Discharged from the Army in 1970, he immediately joined the DAV and is currently a life member of the DAV's National Amputation Chapter and DAV Chapter 39 in Greer, SC.

Gorman retired from his post executive director at the Washington Headquarters for Disabled American Veterans and now resides in Simpsonville, SC. Gorman attended Cape Cod Community College.

The Honorable Thomas E. Harvey, Esq.

Appointed by Senate Majority Leader Mitch McConnell

Thomas Harvey is a Vietnam combat veteran whose decorations include the Silver Star, the Purple Heart and 12 others for valor and service. In Vietnam, he spent a year as a company commander with the 173rd Airborne brigade and a year and a half as an advisor with the Vietnamese Airborne Division.

A lawyer by training, Harvey has spent much of his professional career working with veterans and issues of concern to them. He has served as Chief Counsel and Staff Director of the Senate Veterans Affairs Committee, Deputy Administrator of the Veterans Administration, and Assistant Secretary for Congressional Affairs of the Department of Veterans Affairs. Following 5 years with a major Wall Street law firm, Harvey came to Washington, DC, in 1977 as a White House fellow, serving as an assistant to ADM Stansfield Turner, then director of the Central Intelligence Agency. He has also served in the Department of Defense and as General Counsel and Congressional Liaison of the United States Information Agency. For 5 years, he was Senior Counselor of the Institute of International Education, which administers the Fulbright Program on behalf of the U.S. Department of State, as well as a number of other international educational exchange programs.

He currently serves on the boards of the Milbank Memorial Fund, the focus of which is public health policy, and of the Art Students League of New York, where he studies watercolor painting. He holds both BA and JD degrees from the University of Notre Dame and a LLM degree from the New York University School of Law.

Maj. Stewart M. Hickey, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Since 2011, Stewart Hickey has served as American Veterans (AMVETS) National Executive Director, operating the nation's fourth largest congressionally chartered veterans service organization and its subordinate organizations, and the daily advocacy of issues affecting veterans, national security, foreign affairs, and the economy.

Previously, Hickey was chief executive officer for the Hyndman (Pennsylvania) Area Health Center, a multisite community health center providing medical and dental services to several counties of Pennsylvania, West Virginia, and Maryland. His health care administration experience includes serving as chief human resources officer and chief operating officer of

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Western Maryland Hospital Center in Hagerstown, Maryland, a 123-bed Joint Commission on Accreditation of Healthcare Organizations accredited, long-term care and sub-acute hospital with rehabilitation, occupational therapy, physical therapy, and respiratory care.

Hickey enlisted in the U.S. Marine Corps Reserve in February 1977, in Cumberland, MD, as an infantryman, and transferred to platoon leaders class in the summer of 1978. He served in Operation Desert Storm and Desert Shield and was awarded a Bronze Star Medal with Combat "V" for his achievements as commanding officer, Company D, Third Tank Battalion, Task Force RIPPER, 1st Marine Division, I Marine Expeditionary Force, Saudi Arabia from September 1990 to February 1991. His military education includes the Basic School, Armor Officer Basic, Amphibious Warfare School, Armor Officer Advanced Course, and Marine Corps Command and Staff College.

Hickey resides on his family farm in Cumberland Valley Township in McConnellsburg, PA. He and his wife, Ellen, have five children: Monroe, Ali, Charles, Andrew, and Bryce. Three of his sons, Andrew, Monroe, and Charles, followed their father's path and currently serve in the U.S. military.

Hickey received a BA in history from Penn State University and an MA in management from Webster University.

Rear Adm. Joyce M. Johnson, DO, US PHS (ret.)

Appointed by President Barack Obama

Joyce Johnson is a physician with senior public health leadership experience in civilian and military sectors.

Johnson served in the U.S. Public Health Service (Rear Admiral, Upper Half). Her last active-duty assignment was with the U.S. Coast Guard as Director, Health and Safety ("surgeon general"). She managed the Coast Guard's health care system, including 150 sickbays and clinics, and coordinated both medical and behavioral health care for the beneficiary population. She also had responsibility for the Coast Guard's safety and work-life programs. She held a Top Secret security clearance.

Other government assignments included senior scientific and management positions with the Food and Drug Administration (pharmaceutical safety and post-market surveillance) and the Substance Abuse and Mental Health Services Administration. She has held clinical positions at the National Institute of Mental Health and the Department of Veterans Affairs. At the Centers for Disease Control and Prevention, she was an Epidemiologic Intelligence Service (EIS) Officer and staff epidemiologist in the Center for Infectious Disease.

In the private sector, Johnson served as vice president, health sciences and chief medical officer for a large research organization, where she managed a portfolio of government contracts, including laboratory and social sciences research, and held a top secret security clearance.

Johnson is an osteopathic physician board certified in psychiatry and public health/preventive medicine. She is also a certified clinical pharmacologist and certified addiction specialist. In

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addition to her medical degree, she earned a master's degree in hospital and health administration. She has been conferred six honorary doctoral degrees. She is a Distinguished Life Fellow of the American Psychiatric Association.

Johnson has extensive international health experience on all seven continents. She has particular interests in global mental health, health systems development, infectious disease, and disaster relief. She has led five Flag Expeditions with the Explorers Club. For more than a decade she has been a consultant to the National Science Foundation on the health care system in Antarctica.

Johnson recently coauthored the book, *Lizard Bites and Street Riots, Travel Emergencies and Your Health, Safety and Security*, and writes a monthly medical column. She is a Clinical Professor and Adjunct Professor at Georgetown University. She has served on expert committees including the Committee on Substance Abuse in the Military, National Academy of Medicine. She is active in numerous professional associations including the American Psychiatric Association, serving on the Committee on Psychiatric Dimensions of Disasters; the American Osteopathic Association, serving on the Bureau of International Osteopathic Medicine; and the Explorers Club, serving on the Medical Committee.

The Honorable Ikram U. Khan, MD

Appointed by Senate Minority Leader Harry Reid

Ikram Khan currently, he is president and 50-percent partner of Quality Care Consultants, LLC, founded in March 1992. The company provides consultant services in health care strategy and policy development for employers and other health care organizations. The company assists clients in development and implementation of wellness and disease-management programs. The company also develops quality improvement initiatives and techniques and assists in development and implementation of programs for cost-effective utilization of medical resources. Major emphasis is on clinical outcomes and data monitoring analysis.

Khan is a member the United States Institute of Peace (USIP) Board of Directors; he was nominated by President George Bush, and confirmed by the U.S. Senate on June 5, 2008. He is also currently a member of the Nevada Homeland Security Commission, having been appointed by the Governor of Nevada.

He was nominated by President Clinton and confirmed by the U.S. Senate to serve as member of The Board of Regents Uniformed Services University of Health Sciences, an advisory board to U.S. Secretary of Defense (1999-2006).

Khan also served as Special Advisor on Healthcare to Former Nevada Governor Gibbons, was a member of the Nevada Academy of Health (appointed by Nevada Governor Gibbons), and is a past member of the Nevada Academy of Health Sciences (appointed by Nevada Governor Kenny Guinn). He is past member of Nevada Governor's Commission for Medical Education, Research and Training and was a member of the Nevada State Board of Medical Examiners for eight years. Dr. Khan received "Special Congressional Recognition" for invaluable community service in 1994 and a Congressional citation—"U.S. Senate - Honoring Dr. Ikram Khan"—on April 25, 1994.

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Khan currently serves as member on the board of trustees at Sunrise Hospital Las Vegas-a 600 bed hospital. He has received recognition as “Most Influential Man in Southern Nevada” in 2000. He is also a recipient of a Las Vegas Chamber of Commerce community achievement award (October 1999), and a “Distinguished Community Service Award” from Anti-defamation League of B’nai B’rith (1994).

November 30, 1999 was declared “Dr. Ikram U. Khan Day” by the Governor of the State of Nevada, Mayor of Las Vegas, and the Board of Commissioners of Clark County.

During the course of his practice as General Surgeon, Khan has served in multiple leadership positions at various hospitals in Las Vegas.

Ikram Khan is president of quality Care Consultants LLC in Las Vegas Nevada. He received a doctor of medicine and surgery (MBBS) degree from University of Karachi, Pakistan.

Khan received a Doctor of Medicine and Surgery (MB, BS) in August 1972 from the University of Karachi, Pakistan. He completed post-graduate surgical residency in General Surgery in New York from 1974 through 1978, and practiced as a General Surgeon in Las Vegas through 2005.

Phillip J. Longman

Appointed by Senate Minority Leader Harry Reid

Phil Longman is a director at New America, a public policy institute. He is also a senior editor at the Washington Monthly and a lecturer at Johns Hopkins University, where he teaches a course in health care policy.

Longman has written extensively on issues related to health care delivery system reform, including in his book *Best Care Anywhere* (currently in its third edition). The book chronicles the quality transformation of the Veterans Health Administration during the 1990s and applies its lessons to the broader U.S. health care system.

Longman received a BA in philosophy from Oberlin College.

Col. Lucretia M. McClenney, USA (ret.)

Appointed by House Minority Leader Nancy Pelosi

Lucretia McClenney is a consultant with the Department of Defense Vietnam War Commemoration Office and Executive Coach with the Brookings Institute Executive Education Program. Previously she served as director of the Department of Veterans Affairs Center for Minority Veterans. As director, she served as the principal advisor to the Secretary of Veterans Affairs on policies and programs affecting minority veterans. Prior to her appointment, she served as special assistant to the assistant secretary for policy, planning, and preparedness, Department of Veterans Affairs (VA). She led the department’s emergency exercise planning, training, and evaluation program, and served as liaison to other government agencies. She has served on numerous working groups to include the congressionally mandated National Commission on VA Nursing, Task Force on Employment of Women at VA, and as the Secretary

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of Veterans Affairs' representative on the American Red Cross Board of Governors and Disaster and Chapter Services Committee.

Serving 30 years in the Army, McClenney retired as a colonel in November 2001. She served in various medical treatment facilities and on staffs worldwide serving as director, population health integration team, TRICARE management activity; chief nurse, European regional medical command and deputy commander for nursing, Landstuhl Regional Medical Command; deputy commander for nursing, Moncrief Army Community Hospital, Fort Jackson, South Carolina; assistant deputy for human resources, Office Of The Assistant Secretary Of The Army for Manpower and Reserve Affairs, the Pentagon; chief ambulatory nursing, Walter Reed Army Medical Center; senior policy analyst, Office of the Secretary of Defense (Health Affairs), The Pentagon; and member of the President's National Health Care Reform Task Force.

McClenney's military and civilian awards/decorations include the Legion of Merit (two oak leaf clusters), Defense Meritorious Service Medal, Meritorious Service Medal (seven oak leaf clusters), Army Commendation Medal (two oak leaf clusters), Navy Commendation Medal, Army Achievement Medal, Army Good Conduct Medal, the Army Staff Identification Badge, Office of the Secretary of Defense Staff Identification Badge, the coveted "9A" designator, in recognition of numerous achievements at the pinnacle of nursing excellence, and The Outstanding Civilian Service Medal for her significant contribution to the mission of the United States Army and Department of Defense in assisting with the production of the book, *For Children of Valor – Arlington National Cemetery*. Her professional affiliations include the Association of Military Surgeons of the United States, Sigma Theta Tau, National Nursing Honor Society, Alpha Kappa Alpha Sorority, Inc., Top Ladies of Distinction, Inc., The ROCKS, Inc., the Order of Military Medical Merit, Past President, Federal Health Care Executives Interagency Institute Alumni Association, and former Board Member of the Bon Secours Health Care System and Chair, Quality Committee.

She is a graduate of the Command and General Staff College and the United States Army War College Fellowship Program at George Washington University, Washington, DC. She is also a graduate of the Johnson & Johnson-Wharton's Fellows Program in Management for Nurse Executives, Wharton School of Business, University of Pennsylvania; Federal Health Care Executives Interagency Institute at George Washington University, Washington, DC; Leadership VA 2004; and Brookings Institute Executive Fellowship Program. She received a BSN from Murray State University and an MS in psychiatric/mental health nursing from Catholic University.

Capt. Darin S. Selnick, USAF (ret.)

Appointed by Speaker of the House John Boehner

Darin Selnick is an independent consultant who provides a variety of services to organizations in the areas of government and community relations, business development, and veterans' issues. He is currently the senior veterans affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He also volunteers his time as Chairman of the West Los Angeles Veterans Home Support Foundation and as the Vice President of Development for the GI Film Festival.

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From 2001–2009, Selnick was an appointee at the Department of Veteran Affairs. From 2004–2009 he served as the director of the center for faith-based and community initiatives. In this role he was responsible for the management and operations of the Center and was the VA liaison to the White House Office of faith-based and community initiatives. From 2001–2004 he served as Special Assistant to the Secretary and Associate Dean, VA Learning University. In this role he was responsible for providing program and operational oversight of VA Learning University.

Selnick is a retired Air Force officer who attained the rank of Captain. He has been very active in veterans' issues and joined the Jewish War Veterans in 1994. Since that time he has taken various leadership positions and is the past department commander of the Department of California. Mr. Selnick is also a member of the American Legion, AMVETS, Air Force Association, and National Association of Uniformed Services.

Darin Selnick currently serves as senior veterans' affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He lives in Oceanside, CA. Selnick is retired from the U.S. Air Force. He received a BS in health science from California State University, Northridge and an MA in political science/public management from Midwestern State University.

Lt. Gen. Martin Steele, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Martin Steele enlisted in the Marine Corps in January 1965 and rose from private to three-star general, culminating his military career in August 1999 as the deputy chief of staff for plans, policies, and operations at Headquarters, U.S. Marine Corps, in Washington, DC. A decorated combat veteran with 34½ years of service, he is a recognized expert in the integration of all elements of national power (diplomatic, economic, informational, and military) with strategic military war plans and has served as an executive strategic planner/policy director in multiple theaters across Asia. His extraordinary career was chronicled as one of three principals in the award winning military biography, *Boys of '67*, by Charles Jones.

Upon his retirement from active duty in 1999, he served as president and CEO of the Intrepid Sea-Air-Space Museum in New York City. Currently, Steele serves as The Associate Vice President for Veterans Partnerships, the Executive Director, Military Partnerships, and Co-chair of the Veterans Reintegration Steering Committee at the University of South Florida in Tampa, Florida. Additionally, Steele is the chairman and CEO of Steele Partners, Inc., a strategic advisory and leadership consulting company. He has led a philanthropic transition program assisting exiting Marines into private-sector jobs throughout the country, at no cost to the Marine participants, the Marine Corps, or the companies that provide employment opportunities.

Steele serves proudly on several boards across the country. He is currently the Chairman of the Board, Marine Corps Scholarship Foundation. He was appointed to the Board of Directors of Florida is for Veterans, Inc., a not for profit, state legislated organization designed to assist both Veterans and businesses throughout Florida in not only hiring Veterans but also developing entrepreneurship programs designed for veterans. He is a member of Fisher House Foundation;

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chairman of the advisory committee, Stability Institute; advisory committee member, Call of Duty Endowment; advisory board member, Stay in Step Foundation; advisory council member, Operation Helping Hand; member, Veterans Advantage; board member, University of Arkansas Veterans Resource and Information Center; and advisory committee member, Jesse Lewis Choose Love Movement.

Steele is a graduate of the University of Arkansas where he obtained a bachelor's degree in history and was recognized as a distinguished graduate of the Fulbright College of Arts and Sciences. He is a recipient of the 2013 Arkansas Alumni Award Citation of Distinguished Alumni, which recognizes exceptional professional and personal achievement and extraordinary distinction in a chosen field. He also holds master's degrees from Central Michigan University, Salve Regina College, and Naval War College.

Charlene M. Taylor

Appointed by House Minority Leader Nancy Pelosi

Charlene Taylor joined Kaiser Permanente in 1997 as the director of specialty services for the Permanente Medical Group at South Sacramento. In 2002 she became the service director for Kaiser Foundation Hospitals, responsible for perioperative and perinatal services at South Sacramento. In 2008, she was promoted to chief nursing officer at the Sacramento Medical Center where she was responsible for a 287-bed tertiary acute care hospital that conducted more than 11,000 operations per year. There, she oversaw 800 full-time employees and a budget of \$150 million. Taylor was promoted to chief operating officer in 2010 and retired from Kaiser Permanente in 2013.

Before working for Kaiser Permanente, Taylor served as assistant hospital administrator for Sutter Health at the Sutter Amador Hospital from 1988 to 1997. She is a member of the Veterans of Foreign Wars, Reserve Officers Association, and the Society of Air Force Nurses.

Taylor's patriotic and adventurous nature led her to join the Air Force as a reserve officer at the age of 40, rising to the rank of Lieutenant Colonel. She was commissioned as a Captain in the United States Air Force (Reserve Command) in October 1993, earning her flight nurse wings in 1994. She subsequently was selected to be a flight nurse instructor followed by a promotion to evaluator status. Her last squadron assignment was that of chief nurse at the 349 AMDS, Travis Air Force Base.

In addition to years of experience conducting aeromedical evacuation missions throughout the world, Taylor was activated in support of Operation Enduring Freedom from March 2003 to March 2004. In January 2005 she was selected to be the chief nurse of the 379th Expeditionary Aeromedical Squadron in support of Operation Iraqi Freedom. While transporting the injured out of Mosul, Iraq in a C-130, the aircraft took enemy fire, landing without casualties. Due to the demands of her civilian position, Taylor transferred to inactive status in the Air Force Reserve Command. Taylor is the recipient of two Meritorious Service medals, Expert Marksmanship (2), and multiple other medals.

Taylor currently serves on the Veterans Board. In 2012 she was appointed to the Board by Gov. Jerry Brown and approved by the Senate. She became chair in 2014 and continues to serve

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in that role. The California Veterans Board serves as an advocate for veterans affairs, identifying needs and working to ensure and enhance the rights and benefits of California veterans and their dependents.

Taylor is a diploma nurse graduate from the Kaiser Foundation School of Nursing. She continued her education receiving a BSN from the State University of New York in Albany, New York. She earned a master's degree in nursing administration from the University of California, San Francisco.

Taylor lives in Elk Grove, CA.

Marshall W. Webster, MD

Appointed by Senate Minority Leader Harry Reid

Marshall Webster is a senior vice president of the University of Pittsburgh Medical Center (UPMC), and a distinguished service professor of surgery at the University of Pittsburgh. A graduate of Penn State University and the Johns Hopkins Medical School, he trained in surgery at the University of Pittsburgh, and subsequently served 2 years as a surgeon on active duty in the U.S. Navy.

Webster returned to the University of Pittsburgh as a faculty vascular surgeon, including initially, a part-time attending staff position at the Pittsburgh VA Medical Center for 3 years. He has held the Mark M. Ravitch Chair in Surgery, and has had a long academic career of clinical practice, research, and service in varied administrative leadership roles. From 2002–2012, he was an executive vice president of UPMC, president of UPMC's physician services division, and president of the University of Pittsburgh Physicians, the clinical practice plan of the university faculty.

His current focus is primarily strategic development: building clinical relationships and care models throughout the region with a large number of community hospitals and providers. Webster has oversight of UPMC's graduate medical education program, which sponsors a substantial number of resident rotations at the Pittsburgh VA Medical Center. He recently served for 2 years as the interim chair of the Department of Anesthesiology at UPMC. He has had a long-standing interest in patient safety and quality initiatives, and recently completed a 6-year term on the board of the Pennsylvania Patient Safety Authority.

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APPENDIX L: ACRONYM LIST

ACRONYM	DEFINITION
ACA	Affordable Care Act
ACHE	American College of Healthcare Executives
APRN	Advanced Practice Registered Nurse
BRAC	Base Realignment and Closure
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARES	Capital Asset Realignment for Enhanced Services
CDS	Community Delivered Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CITC	Care in the Community
CMD	Chief Medical Director
CMIO	Chief Medical Information Officer
CMOP	Consolidated Mail Outpatient Pharmacy
COTS	Commercial Off-The-Shelf
CPRC	Clinical Product Review Committee
CPRS	Computerized Patient Record System
CVA	Concerned Veterans for America
CVCS	Chief of VHA Care System
DAV	Disabled American Veterans
DEPSECVA	Deputy Secretary, Department of Veterans Affairs
DHP	Digital Health Platform
DM&S	Department of Medicine and Surgery
DoD	Department of Defense
DUSH	Deputy Under Secretary for Health
ECF	Executive Career Fields
EES	Employee Education System
EEO	Equal Employment Opportunity

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ACRONYM	DEFINITION
EHCPM	Enrollee Health Care Projection Model
eHMP	Enterprise Health Management Platform
EHR	Electronic Health Record
FFS	Fee-for-Service
FY	Fiscal Year
GAO	Government Accountability Office
GHATP	Graduate Health Administration Training Program
GUI	Graphic User Interface
HCD	Human-Centered Design
HEC	Healthcare Executive Council
HPDM	High Performance Development Model
HR	Human Resources
HRA	Human Resources and Administration
HSC	Health Service Category
HTM	Healthcare Talent Management
IAVA	Iraq and Afghanistan Veterans of America
IDIQ	Indefinite Delivery/Indefinite Quantity
IDN	Integrated Delivery Network
IDP	Individual Development Plan
IT	Information Technology
JC	Joint Commission
JEC	Joint Executive Committee
JLV	Joint Legacy Viewer
MSA	Medical Support Assistant
MTF	Military Treatment Facility
NAS	National Academy of Sciences
NCEHC	National Center for Ethics in Health Care
NCOD	National Center for Organization Development
NLC	National Leadership Council
NVTC	Northern Virginia Technology Council
OAA	Office of Academic Affiliations

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APPENDIX L
ACRONYM LIST

ACRONYM	DEFINITION
OEF	Operation Enduring Freedom
OGC	Office of General Counsel
OI&T	Office of Information and Technology
OIF	Operation Iraqi Freedom
OMB	Office of Management and Budget
ONC	Office of the National Coordinator
OND	Operation New Dawn
OPM	Office of Personnel Management
OTH	Other Than Honorable (Discharge)
PACT	Patient Aligned Care Team
PC3	Patient-Centered Community Care
PG	Priority Group
PHS	U.S. Public Health Service
PO	Program Office
PTSD	Posttraumatic Stress Disorder
QUERI	Quality Enhancement Research Initiative
RCLF	Relevant Civilian Labor Force
RIF	Reduction in Force
SCI	Spinal Cord Injury
SECVA	Secretary, Department of Veterans Affairs
SE	Senior Executive
SES	Senior Executive Service
SHEP	Survey of Healthcare Experiences of Patients
TBI	Traumatic Brain Injury
TMS	Talent Management System
USH	Under Secretary for Health
VA	U.S. Department of Veterans Affairs
VACAA	Veterans Access, Choice, and Accountability Act of 2014
VACI	VA Center for Innovation
VACO	VA Central Office
VAEB	VA Executive Board

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ACRONYM	DEFINITION
VAMC	VA Medical Center
VERC	Veterans Engineering Resource Center
VFW	Veterans of Foreign Wars of the U.S.
VHA	Veterans Health Administration
VHACO	VHA Central Office
VISN	Veterans Integrated Service Network
VSO	Veterans Service Organization
WWP	Wounded Warrior Project



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**A Product of the CMS Alliance to Modernize Healthcare
Federally Funded Research and Development Center**

Prepared For U.S. Department of Veterans Affairs
As Required By the Veterans Access, Choice, and Accountability
Act of 2014
Section 201

**Independent Assessment of the Health Care
Delivery Systems and Management Processes of
the Department of Veterans Affairs**

Volume I: Integrated Report

September 1, 2015
Prepared by CAMH under Contract No. HHS-M500-2012-00008I
Task Order No. VA118A14F0373

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VETERANS CHOICE ACT INDEPENDENT ASSESSMENT (SECTION 201)—INTEGRATED REPORT

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VETERANS CHOICE ACT INDEPENDENT ASSESSMENT (SECTION 201)—INTEGRATED REPORT

Preface

Congress enacted and President Obama signed into law the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146) (“Veterans Choice Act”), as amended by the Department of Veterans Affairs (VA) Expiring Authorities Act of 2014 (Public Law 113-175), to improve access to timely, high-quality health care for Veterans. Under “Title II – Health Care Administrative Matters,” Section 201 calls for an Independent Assessment of 12 areas of VA’s health care delivery systems and management processes.

VA engaged the Institute of Medicine of the National Academies to prepare an assessment of access standards and engaged the Centers for Medicare & Medicaid Services (CMS) Alliance to Modernize Healthcare (CAMH)¹ to serve as the program integrator and as primary developer of the remaining 11 Veterans Choice Act independent assessments. CAMH subcontracted with Grant Thornton LLP, McKinsey & Company, and the RAND Corporation to conduct 10 independent assessments as specified in Section 201, with MITRE conducting the 11th assessment. Drawing on the results of the 12 assessments, CAMH also produced the Integrated Report in this volume, which contains key findings and recommendations. CAMH is furnishing the complete set of reports to the Secretary of Veterans Affairs, the Committee on Veterans’ Affairs of the Senate, the Committee on Veterans’ Affairs of the House of Representatives, and the Commission on Care.

¹ The CMS Alliance to Modernize Healthcare (CAMH), sponsored by the Centers for Medicare & Medicaid Services (CMS), is a federally funded research and development center (FFRDC) operated by The MITRE Corporation, a not-for-profit company chartered to work in the public interest. For additional information, see the CMS Alliance to Modernize Healthcare (CAMH) website (<http://www.mitre.org/centers/cms-alliances-to-modernize-healthcare/who-we-are/the-camh-difference>).

VETERANS CHOICE ACT INDEPENDENT ASSESSMENT (SECTION 201)—INTEGRATED REPORT

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VETERANS CHOICE ACT INDEPENDENT ASSESSMENT (SECTION 201)—INTEGRATED REPORT

Acknowledgments

Conducting this assessment on behalf of our nation’s Veterans has been an honor. A common theme emerged as we explored data, interviewed staff, reviewed prior assessments, and assembled this report—Americans take the care of our Veterans seriously.

We would like to acknowledge those who have enabled us to complete this assessment, which carries the promise of improving Veterans health care.

First and foremost, we want to thank the leadership and staff of the Department of Veterans Affairs (VA) who routinely and unselfishly shared their time, insights, perspectives, and data. Our assessment teams visited 87 Veterans Health Administration facilities, including VA Medical Centers, Veterans Integrated Service Network headquarters, acquisition centers, construction and facilities management offices, and pharmacies, where we observed staff working diligently to provide the best possible clinical care to Veterans. During these visits, assessment teams conducted multiple interviews of VA employees, including providers, clinicians, administrators, and senior leaders. VA also provided 560 requested data sets.

Second, we are grateful to the Blue Ribbon Panel members who served as our advisers. This panel brought together individuals with years of experience in successfully transforming and running health care systems. We turned to these experts for advice and to determine if our ideas were aligned with current industry wisdom and emerging health care trends. The panel meticulously examined the materials we presented, applied their experience and industry knowledge, and shared candid recommendations. They are identified in Appendix Q.

Third, we appreciate the support of the Veterans Service Organizations (VSOs) listed in Appendix M that shared their data, reports, and surveys and their understanding of their constituents’ health care needs. They provided the invaluable “Voice of the Veteran.”

Fourth, we engaged with U.S. health care industry leaders who gave their time and provided access to their organizations and senior leadership teams. They shared their experience, perspectives, health initiatives, and viewpoints of best practices in health care that could be adopted by the Veterans health care system. Several also supported on-site visits to examine their clinical and administrative operations. These organizations are listed in Appendix M.

Finally, on behalf of the CMS Alliance to Modernize Healthcare, we would like to thank the team members from The MITRE Corporation, McKinsey & Company, RAND Corporation, Grant Thornton LLP, the Institute of Medicine of the National Academies, and numerous smaller companies and consultants who dedicated their time and energy to gather data, conduct analyses, and develop the materials that have been assembled in these Assessments and the Integrated Report. Throughout the process, it was clear that every team member shared a common commitment—to improve the health care for Veterans “who shall have borne the battle.”²

² Lincoln, A. (1865, March 4). Second inaugural address. Washington, D.C. Retrieved from <http://www.va.gov/opa/publications/celebrate/vamotto.pdf>.

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VETERANS CHOICE ACT INDEPENDENT ASSESSMENT (SECTION 201)—INTEGRATED REPORT

September 1, 2015

The Honorable Robert A. McDonald
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420-0002

Dear Secretary McDonald:

To support the Independent Assessment required by Section 201 of the Veterans Choice Act, The MITRE Corporation created a Blue Ribbon Panel, composed of experts from diverse health care and stakeholder backgrounds, to fully engage with MITRE in producing the Integrated Report and its findings and recommendations. Although the Panel was not specifically required by the Veterans Choice Act, we were fully involved by MITRE from the onset of the study, with complete access to raw data, subcontractor consulting teams, and MITRE subject matter experts and senior management.

MITRE assured the Panel of our complete independence, meaning that there would be full disclosure of data and assessments; that the Panel could meet in executive session as often as necessary; that the Panel would provide candid feedback and advice on the final findings and recommendations submitted by MITRE; and that the Panel was under no obligation to endorse the final Integrated Report. In addition, following public submission of the report to Congress and the VA, Panel members would be free to independently express their personal opinions regarding the process or findings, while protecting the confidentiality and propriety of the information.

With independence and transparency, the Panel pursued this study with extraordinary energy and commitment, because we—like everyone involved—were passionate about improving the health and quality of care for our Veterans. Over the past months, we reviewed thousands of pages of drafts, engaged in numerous conference calls, and spent four 2-day sessions in lively meetings at MITRE headquarters near Washington, D.C. We facilitated data collection, provided frequent and timely feedback, and worked collaboratively with MITRE to develop final priorities and recommendations. MITRE was consistently responsive to the Panel, and incorporated our advice at all stages.

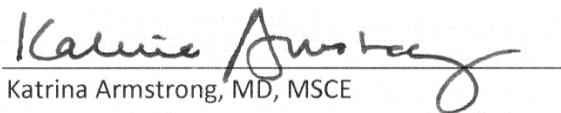
Now, we the members of the Panel unanimously endorse the Integrated Report and its findings and recommendations. The report provides not only operational, near-term strategies to improve clinical care for Veterans, but also details remedies for root-cause problems that must be addressed both by Congress and the VA before any long term, sustained improvement can be realized. Among these root issues are the need to prospectively and clearly define the role of the VHA within the modern health care ecosystem, including whether the VHA should become a comprehensive health care system for all health needs, or focus on specific areas of service-related conditions. In addition, the Congress and the VA must solve the VHA crises in leadership and culture, establish and empower the governance structure, and provide the VHA with core tools essential for any modern continuously-improving, value-based, health care system.

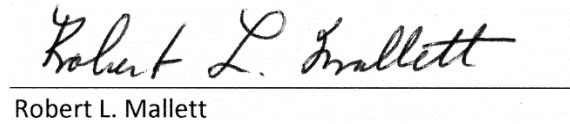
Finally, the Panel would like to express our appreciation to the hundreds of experts who have contributed to this report, and to the literally thousands of contributing Veterans and VHA employees who believed that this report would become a roadmap to achieve the highest quality of care for Veterans, at a cost we can afford, and in a culture that would be the envy of any health care system in the nation.

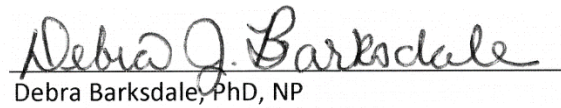
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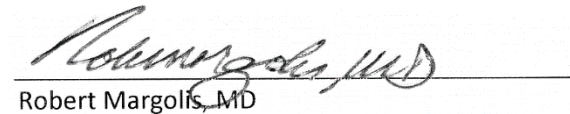
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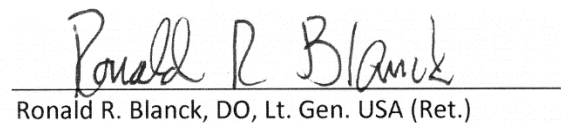
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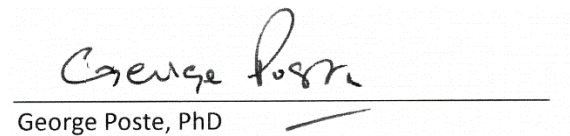

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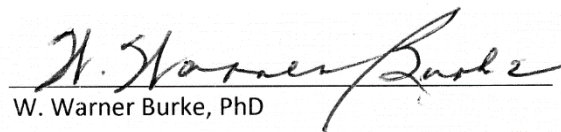

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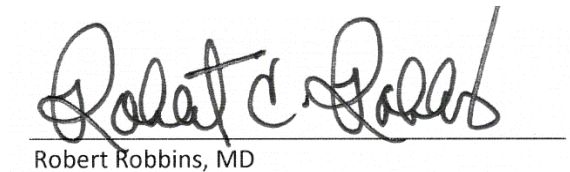

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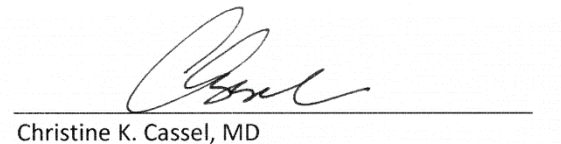

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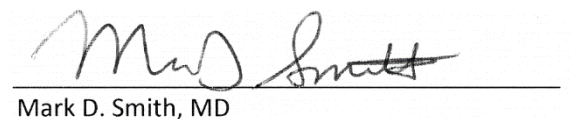

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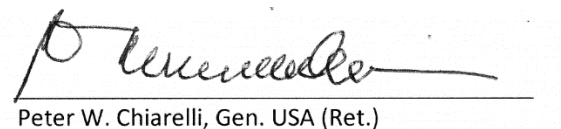

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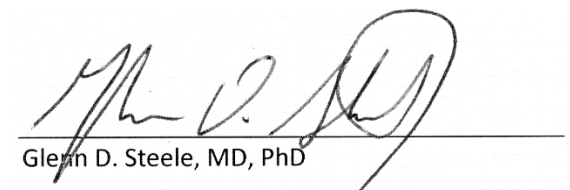

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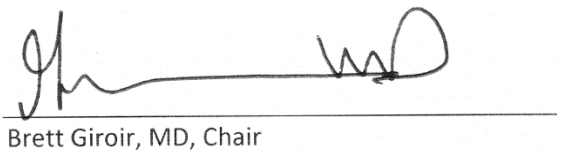

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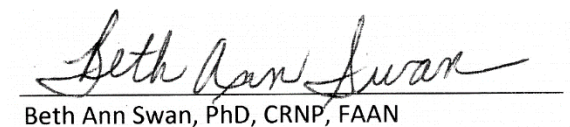

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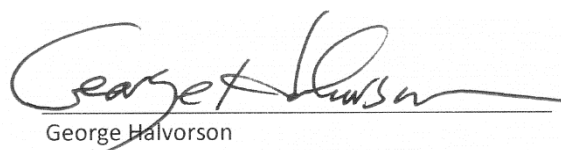

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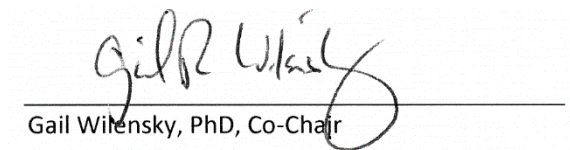

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VETERANS CHOICE ACT INDEPENDENT ASSESSMENT (SECTION 201)—INTEGRATED REPORT

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Executive Summary

Background: Section 201 of the Veterans Access, Choice, and Accountability Act of 2014 required an Independent Assessment of the hospital care, medical services, and other health care furnished in medical facilities of the Department of Veterans Affairs (VA). The Act specifically directed that assessments be conducted in 12 areas, covering a broad spectrum of Veterans Health Administration (VHA) services, operations, and support (Figure ES-1). The findings and recommendations from these assessments revealed interrelationships that demand a holistic understanding of VHA.

VHA's health care delivery system is challenged by a unique combination of factors including its significant scale and scope, unique patient population, and congressionally mandated funding, governance, and oversight. VHA operates one of the country's largest and most complex organizations, with 1,600 care sites (including 167 medical centers) across 50 states, currently staffed by approximately 300,000 employees who cared for nearly six million Veterans last fiscal year. VHA is a major research and teaching organization, with a \$1.2 billion annual research budget. Its health professional education program is the nation's largest, clinically training nearly 120,000 individuals each year via affiliations with more than 1,800 educational institutions.

ES-1. Veterans Choice Act Assessments

- A. Demographics
- B. Health Care Capabilities
- C. Care Authorities
- D. Access Standards
- E. Workflow – Scheduling
- F. Workflow – Clinical
- G. Staffing/Productivity
- H. Health Information Technology
- I. Business Processes
- J. Supplies
- K. Facilities
- L. Leadership

Approach: The Independent Assessment was performed by interviewing VA employees and outside observers, visiting 87 VA sites, conducting multiple surveys, analyzing 560 data sets provided by VHA and data from other sources, and performing literature reviews. In addition, best practices were gathered from the private sector through interviews with top health care executives, site visits to high-performing health care organizations, and consultation with an independent advisory panel of nationally recognized health executives and stakeholders (Appendix Q: Blue Ribbon Panel). This approach not only provided deep understanding of the 12 assessment areas, but additionally provided a comprehensive view of VHA. It is VHA's interdependent system that is the focus of the findings and recommendations in the Integrated Report.

The Independent Assessment: The Independent Assessment includes this Integrated Report and the 12 major assessment reports for the areas designated in ES-1. Each area is addressed in a separate assessment report that includes findings and evidence-based recommendations (Appendices A–L and Volume II). The Integrated Report builds upon the findings and recommendations of those reports and identifies the four systemic findings that must be addressed to enable a sustained transformation of VHA.

VETERANS CHOICE ACT INDEPENDENT ASSESSMENT (SECTION 201)—INTEGRATED REPORT

Significant Flaws: While VHA exhibits a deep commitment to serving Veterans, many of the assessment teams consistently found that VHA’s health care facilities deliver strikingly different patient experiences, apply inconsistent business processes, and differ widely on key measures of performance and efficiency. The assessments also provided evidence that the organization is plagued by many problems: growing bureaucracy, leadership and staffing challenges, and an unsustainable trajectory of capital costs. Other reports and assessments have pointed to local failures of access and quality. On the other hand, there are bright spots throughout VHA that illuminate best practices that work effectively within the VHA environment. Understanding the various aspects of these differences sets a context that can allow VHA to identify and act on opportunities for continuous sustained improvement.

Systems Approach: VHA must adopt systems thinking to address its most challenging problems, including access, quality, cost, and patient experience.³ Systems thinking is a framework for solving problems based on the premise that a component part of an entity can best be understood in the context of its relationships with the other components of the entity, rather than in isolation. It takes into account the interdependencies of the parts to find the best combination of strategies that meet the needs of the whole. This approach is required to address the interdependent nature of the people, processes, and technologies supporting VHA. This approach has been well established in many industries, including health care, and often enables leaders to reframe the problem into opportunities based on an appreciation of how components of the program should be working together, as opposed to how they are currently interacting. Systems thinking does not promote tackling individual problems independently because the solutions—more often than not—will be sub-optimal, non-scalable, and non-sustainable.

While complex problems benefit greatly by reframing problems in creative ways, systems solutions also work well for improving existing processes and motivating people to believe they can successfully change. Continuous improvement is one such approach that often uses a Plan-Do-Study-Act cycle that identifies, reduces, and eliminates suboptimal processes for continuous incremental or breakthrough improvements. This approach relies heavily on measuring, analyzing, and experimenting for successful innovations. The current culture in VHA would benefit greatly from instituting continuous improvement more effectively so that everyone participates, sees progress, and can build on the pride they have in being part of VHA. Some of VHA’s best performers already focus on continuous improvement, but it is not widely adopted as a standard way of operating. Transforming any organization, especially one the size of VHA, requires that everyone understands, feels accountable for, and acts daily on how to continuously improve the organization. It is as much about engaging the people as it is about fixing the processes.

Four Systemic Findings: A review of the extensive evidence, findings, and recommendations in the assessment reports—informed by an analysis of industry benchmarks and best practices, insights from health care executives and high-performing health care systems, and interactions

³ This information is informed by the Institute of Medicine Assessment D (Access Standards) in Volume II.

VETERANS CHOICE ACT INDEPENDENT ASSESSMENT (SECTION 201)—INTEGRATED REPORT

with Veterans Service Organizations—enabled the identification of four systemic findings that impact mission execution.

- A disconnect in the alignment of demand, resources, and authorities
- Uneven bureaucratic operations and processes
- Non-integrated variations in clinical and business data and tools
- Leaders are not fully empowered due to a lack of clear authority, priorities, and goals.

The recommendations that will enable VHA to address these findings are discussed below. These recommendations are interdependent and must be coordinated and implemented via a systems approach to improve the VHA system overall.

Finding 1: A disconnect in the alignment of demand, resources, and authorities

VHA’s mission—“Honor America’s Veterans by providing exceptional health care that improves their health and well-being”⁴—is inspirational and widely accepted by VHA staff, but there are significant geographic variations with respect to how the mission is translated into action for individual Veterans. Complex eligibility rules make determining which Veterans are covered and which services those Veterans receive a challenge, and navigating VHA is often difficult for Veterans—a problem exacerbated by incomplete guidance and non-standardized business processes. Furthermore, the growing role of outside providers has not been effectively integrated into VHA’s operating model, which is based on providing direct care within VHA facilities.

At present, VHA is over-committed in some geographic areas, given its broad mission, an expanding list of automatic eligibility criteria, and limited resources. Matching supply and demand at the local level is challenging because supply is relatively fixed each year once service projection models allocate resources to each facility through the appropriation and budgeting process.

Although the population of Veterans is expected to decline by 19 percent over the next decade,⁵ the demand for health care services is expected to rise before it levels off in five years, based on demographic factors (primarily aging)—and likely will rise even more if access to VHA health care is improved (Assessment B [Health Care Capabilities]). On the other hand, in some areas and for some health conditions, VHA may not have a sufficient population of patients to sustain highly specialized service lines with enough volume to achieve and maintain clinical excellence.

Recommendation 1—GOVERNANCE: Align demand, resources, and authorities.

Congress, the Commission on Care, and VA leadership should address the misalignment of demand with available resources both overall and locally. They should align VHA’s goal to

⁴ U.S. Department of Veterans Affairs. Veterans Health Administration. “About VHA.” [Website]. Retrieved from <http://www.va.gov/health/aboutVHA.asp>

⁵ This information is presented in RAND Corporation Assessment A (Demographics) in Volume II.

VETERANS CHOICE ACT INDEPENDENT ASSESSMENT (SECTION 201)—INTEGRATED REPORT

provide comprehensive health care to Veterans with VHA's capacity by adjusting capacity or reshaping the expected benefit—that is, the Veteran population to be served (eligibility) on the one hand, and the health care those Veterans will be provided (service lines) both by VHA and by community resources on the other.

Supporting Recommendations

- **Establish a governance board to develop fundamental policy, define the strategic path, insulate VHA leadership from direct political interaction, and ensure accountability for the achievement of established performance measures.**

Congress should consider the following alternatives for such a governance board:

- Charter a commission modeled after the 1955 U.S. President's Commission on Veterans' Pensions.
- Empower a board or commission to reshape geographic service areas and optimize facilities resourcing and lines of service (along the lines of the Defense Base Realignment and Closure Commission process used for military installations).
- Assign the definition of the governance board as a mission for the Commission on Care, established under Section 202 of the Veterans Choice Act.
- Whatever approach is selected, ensure that the solution focuses on governance, that members have sufficient longevity of term, and that the authorities of the board are fully endorsed by Congress.

- **Require a patient-centered demand model that forecasts resources needed by geographic location to improve access and to make informed resourcing decisions.**

VHA should:

- Effectively explore predictive tools to continually forecast local demand and fine-tune estimates of required resources.
- Reallocate and manage resources flexibly to meet national, regional, and local variations in patient-centered demand.

- **Clarify and simplify the rules for purchased care to provide the best value for patients.⁶**

VHA should:

- Develop a stronger management structure for purchased care and allocate responsibility and authority to the most appropriate levels.
- Establish an ongoing process for evaluating third-party administrator performance.
- Develop clear and consistent guidance and training on VA's authority to purchase care.
- Ensure that both new and existing purchased care contracts with outside providers and third-party administrators include appropriate requirements for data sharing, quality-of-care reporting, and care coordination.

⁶ This information is derived from RAND Corporation Assessment C (Care Authorities) in Volume II.

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Finding 2—Uneven bureaucratic operations and processes

Several centralized operational and support functions appear to have lost customer focus and do not adequately support the needs of the medical centers. In response, individual VA Medical Centers (VAMCs) have adopted local implementations of certain processes, but many of these were found to be unnecessarily complex and, not surprisingly, inconsistent across VHA. In many cases, these centralized and local process issues have become inefficient or bureaucratic and have had a direct and negative impact on the overall Veteran experience and timely access to care.

These widely varying processes highlight the complexity of VHA within the larger, equally complex VA organization. Severe problems may manifest themselves at one facility, while another constantly receives tributes from Veterans and health care experts. The oft-quoted reminder, “if you’ve seen one VA hospital, you’ve seen ONE VA hospital,” captures this reality.

Recommendation 2—OPERATIONS: Develop a patient-centered operations model that balances local autonomy with appropriate standardization and employs best practices for high-quality health care.

As Assessment L (Leadership) suggests, VA and VHA should streamline their Central Offices and strengthen poor-performing support functions. VHA should adopt systemic means to identify, assess, disseminate, adapt, and scale best practices throughout the system—whether these practices originate inside or outside of VHA.

Supporting Recommendations

- **Right size and reorient the VHA Central Office to focus on support to the field in its delivery of care to Veterans.** This implies a series of actions to include reassessing all VHA Central Office-directed metrics and policies to ensure that they add sufficient value to patient outcomes and eliminate those that do not.
- **Fix substandard processes that impede the quality of care provided to the Veteran.** This is clearly dependent on, among other efforts, implementing an operating model that provides medical centers with the autonomy and flexibility to innovate and address local needs while also providing standardization across the system.
- **Design and implement a systematic approach to identify best practices and disseminate them appropriately across the enterprise.** This approach would include defining the role of the Veterans Integrated Service Network (VISN) to lead the best-practice identification and to share ideas within and across the enterprise, working collaboratively with VAMC leaders and staff.

Finding 3—Non-integrated variations in clinical and business data and tools

A lack of common, integrated VHA enterprise systems and tools negatively impacts VHA’s operations and resulting data. Inconsistent and ineffective data collection and analysis undermines rapid, evidence-based assessment and improvement of quality and customer satisfaction. VHA lacks a holistic, enterprise approach to collecting and leveraging its data. Data interchange with the Department of Defense (DoD) and external health care providers is

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limited, which creates unnecessary clinical risk. Since newly discharged Veterans often become VA patients, interoperability with DoD is necessary and expected. These shortfalls hinder using available data to support effective decision making and performance management.

Recommendation 3—DATA AND TOOLS: Develop and deploy a standardized and common set of data and tools for transparency, learning, and evidence-based decisions.

Supporting Recommendations

- **Use standardized clinical and administrative data for accuracy and interoperability.**
- **Implement a single, integrated set of system-wide tools centered on a common electronic health record (EHR) that is interoperable across VHA and with DoD and community providers.⁷**

Specifically, VHA should implement and integrate one system-wide:

- EHR system that is interoperable across the entire system and with DoD and community providers
- Electronic claims payment system to pay for outside services
- Billing system to collect from other payers
- Patient-friendly scheduling system with modern, single toll-free-number call-center support
- Set of electronic clinical decision-support tools describing standard work, protocols, and guidelines housed in an electronic medical library.
- **Transparently share performance metrics for leadership, clinical, and business functions across VHA to identify and adopt best practices for continuous improvement.**

Finding 4—Leaders are not fully empowered due to a lack of clear authority, priorities, and goals

As Assessment L indicates, VHA leaders operate within a challenging and disempowering environment that discourages emerging leaders from seeking promotion within the organization. While VHA has seen a 160-percent growth in headquarters program office staff in the past five years, key field leadership positions throughout the organization sit vacant or are staffed with acting leaders, and more than half of executives are eligible for retirement, potentially creating a larger number of vacant positions. Further, a misalignment of accountability and authority exists within a broader VHA culture characterized by risk aversion and lack of trust. Those leaders who are effective too often achieve outcomes despite the challenges of the organization within which they operate.

⁷ This information is derived from The MITRE Corporation Assessment H (Health Information Technology) in Volume II.

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Recommendation 4—LEADERSHIP: Stabilize, grow, and empower leaders; galvanize them around clear priorities; and build a healthy culture of collaboration, ownership, and accountability.⁸

VHA must resolve the leadership crisis by putting the right leaders in the right jobs with the right skills under an appropriate governance model for the appropriate amount of time.

Supporting Recommendations

- **Push decision rights, authorities, and responsibilities to the lowest appropriate level throughout the organization.**
- **Build on Veteran-centered behaviors to drive a culture of service excellence, trust, continuous improvement, and healthy accountability.**
- **Revitalize the leadership pipeline through establishment of enterprise-wide, comprehensive succession-management and leadership-development functions.**
- **Strengthen the appeal of senior leadership positions by pursuing flexibilities in hiring and compensation.**
- **Establish sustained leadership continuity by extending tenure for key positions.**

A Call for System-Wide Change: The Independent Assessment highlighted systemic, critical problems and confirmed the need for change that has been voiced by Veterans and their families, the American public, Congress, and VHA staff. Solving these problems will demand far-reaching and complex changes that, when taken together, amount to no less than a system-wide reworking of VHA.

Several high-performing health care organizations were examined by the study team, including Kaiser Permanente, Virginia Mason, Geisinger Health System, and the Cleveland Clinic. Although all of these are of a differing scale than VHA, all overcame significant clinical or economic troubles by making consistent, organization-wide changes that enabled them to transform themselves into organizations that now excel at their specific missions. Similarly, during 1994 to 1999, sustained leadership within VHA deployed system-wide changes that effected a major transformation of the agency's operations. VHA should once again commit to that level of systemic change.

A system-wide transformation is required, based on an integrated systems approach that acknowledges the interdependence of the four systems recommendations:

- 1) **Governance:** Align demand, resources, and authorities.
- 2) **Operations:** Develop a patient-centered operations model that balances local autonomy with appropriate standardization and employs best practices for high-quality health care.
- 3) **Data and Tools:** Develop and deploy a standardized and common set of data and tools for transparency, learning, and evidence-based decisions.

⁸ This recommendation and the ideas expressed in the supporting recommendations reflect information provided in McKinsey & Company Assessment L (Leadership) in Volume II.

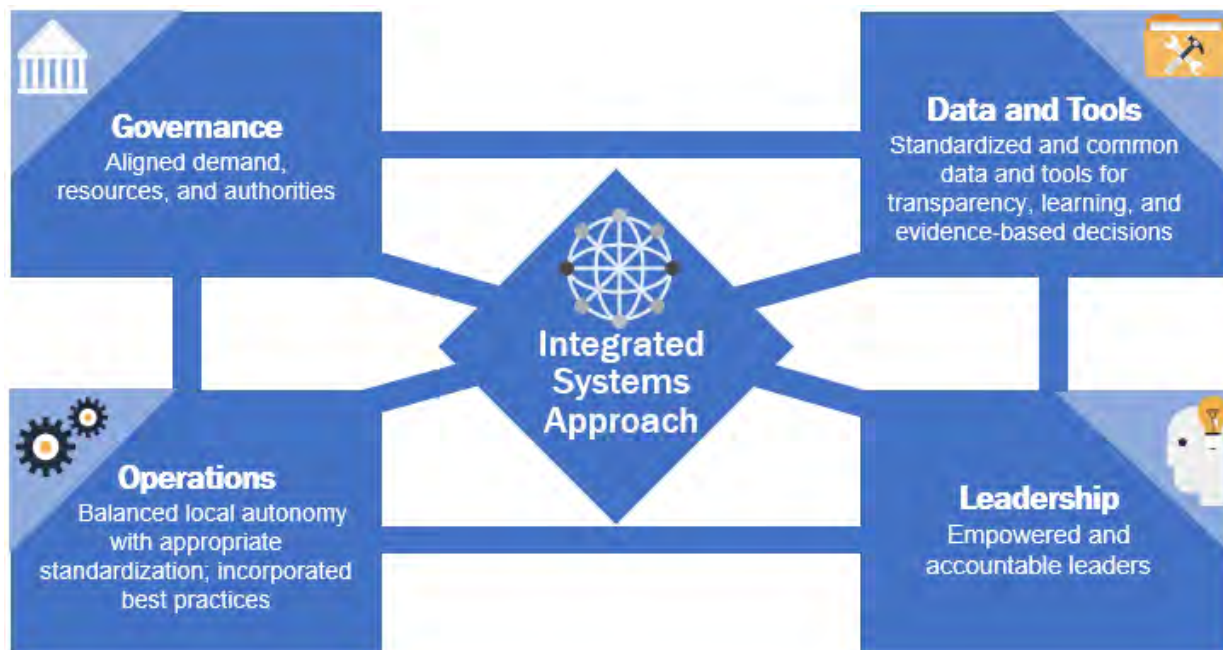
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- 4) **Leadership:** Stabilize, grow, and empower leaders; galvanize them around clear priorities; and build a healthy culture of collaboration, ownership, and accountability.

These four recommendations create the integrated systems cornerstones, as shown in Figure ES-2.

With these four interdependent systems components successfully in place, VHA will have the opportunity to achieve a place among the highest performing health care systems in the world. As an example of the value of this systems approach, consider the challenges that VA faces in managing its capital program in facilities management. As Assessment K (Facilities) highlights, provided that average funding levels remain consistent over the next 10 years, the \$51 billion capital requirement would significantly exceed the anticipated funding level of \$16–26 billion.⁹ Not only would this shortfall jeopardize the capital program, it would also threaten the financial integrity of the entire VHA health care delivery system and, in turn, significantly impact the quality of health care provided to Veterans. Viewing this primarily as a funding problem would be shortsighted. Rather there are interdependent findings in each of the four cornerstones that need to be addressed in an integrated fashion to achieve a sustainable solution. In terms of governance, external constraints limit VHA's ability to deliver and operate medical facilities at the level of private-sector benchmarks; investments in facilities are not effectively linked to workload growth; existing space is not being used at its highest efficiency; and expected funding levels do not support identified capital needs.

ES-2. Integrated Systems Cornerstones



As Assessment K also reveals, for operations, total cost of ownership is not calculated or integrated into capital planning decisions; VHA has no integrated system to manage the entire

⁹ This information comes from McKinsey & Company Assessment K (Facilities) in Volume II.

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leasing process; comprehensive tracking or measurement of the leasing program and its outcomes is precluded; and a large majority of facilities noted challenges in hiring staff and filling vacant positions. For data and tools, data capture occurs at multiple levels and through multiple tools, generating multiple sources of truth about the status of the capital program; tools for developing Strategic Capital Investment Plan business cases rely on user creativity and capabilities to consider creative alternatives to capital solutions; and systems do not consistently capture key performance indicators, and the metrics are not standardized across all stakeholders. And for leadership, there are recognized shortfalls in overall accountability, role clarity, personal ownership, internal communication, and proactive problem-solving approaches that limit VA's and VHA's ability to deliver the correct projects on time and on budget; the broader culture of facilities functions is characterized by silos and risk aversion, resulting in an inability to consistently advance projects in an efficient manner; and competition for limited funds has led leaders to make a range of choices in developing projects that favor approval strategies over efficient project delivery.

Viewing these facilities challenges through the lens of the integrated systems approach begins to reveal the complexity of the problem, the integrated nature of the required transformation, and the opportunity to reframe the facilities challenges as part of a larger set of interdependent pieces of VHA's overall health care system. Facility challenges can be significantly mitigated by a transformative realignment throughout the capital program deploying best practices in leasing and contracting; realigning the strategy of the capital program to improve project selection, optimize the infrastructure portfolio, implement innovative care delivery models, understand demand-based needs, and explore and partner with purchased-care opportunities; and reevaluating funding requirements. In short, employing the systems view could help reframe the vision for future health delivery and significantly reduce VHA's current and future capital investment issues. It also positions VHA not to be burdened long term with hospital overcapacity as the nature of health care delivery trends toward smaller inpatient facilities, increasing outpatient care, and more virtualized health care delivery.

The richness of the systems approach extends not just to facilities, but across many of VHA's biggest challenges. Patient access to clinician appointments cannot be sustainably addressed by only focusing on increasing overtime in the near term without looking at demand modeling, improving scheduling processes and tools, and a number of other dependencies. Choice Card funding is critical to increase purchased care access, but will not succeed without strong Veteran navigational aids, clearer rules of use, and a number of other cultural and leadership changes to promote using health care services outside of VHA. Prioritizing these findings and then solving them individually is tempting, but such an approach would not guarantee a sustainable solution. As H.L. Mencken stated, "For every complex problem there is an answer that is clear, simple, and wrong."

There are clear obstacles. As the assessment reports reveal, the number of issues VHA currently faces appears overwhelming. In its current state, VHA is not well positioned to succeed in the transformation that this analysis suggests. Three essential actions are required to realize the recommendations inherent in this transformation. VHA must:

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- Recognize that the four cornerstones are interdependent and the success of any one of the four overarching recommendations hinges on the implementation of the other three. These solutions must be coordinated and implemented via a systems approach to improve VHA overall.
- Establish a transformation program management office with authority and funding (redirected from current central and local funding mechanisms) to implement the system-wide reworking of VHA. This will include establishing priorities, defining timelines for execution, allocating resources, and instituting appropriate metrics for success. It should merge relevant components of MyVA, the *Blueprint for Excellence*, and other ongoing initiatives into one coherent, focused transformational approach.
- Require evidence-based systems models to inform and implement integrated solutions that balance governance, operations, data and tools, and leadership.

It will be the charge of Congress, the Commission on Care, and VA leadership to see that these recommendations and resulting transformation efforts are given the necessary attention and support that they—and our nation’s Veterans—deserve.

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Table 1. Assessment Areas

	TOPIC	FOCUS	ORGANIZATION
A	Demographics	Current and projected demographics and unique health care needs of the patient population served by the Department.	RAND Corporation
B	Health Care Capabilities	Current and projected health care capabilities and resources of the Department, including hospital care, medical services, and other health care furnished by non-Department facilities under contract with the Department, to provide timely and accessible care to Veterans.	RAND Corporation
C	Care Authorities	The authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Department facilities, including whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care.	RAND Corporation
D	Access Standards	The appropriate system-wide access standard applicable to hospital care, medical services, and other health care furnished by and through the Department, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation.	Institute of Medicine
E	Workflow – Scheduling	The workflow process at each medical facility of the Department for scheduling appointments for Veterans to receive hospital care, medical services, or other health care from the Department.	McKinsey & Company
F	Workflow – Clinical	The organization, workflow processes, and tools used by the Department to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.	McKinsey & Company
G	Staffing/ Productivity	The staffing level at each medical facility of the Department and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics.	Grant Thornton LLP
H	Health Information Technology	The information technology strategies of the Department with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by the Department.	The MITRE Corporation
I	Business Processes	Business processes of VHA, including processes relating to furnishing non-Department health care, insurance identification, third party revenue collection, and vendor reimbursement.	Grant Thornton LLP
J	Supplies	The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Department.	McKinsey & Company
K	Facilities	The process of the Department for carrying out construction and maintenance projects at medical facilities of the Department and the medical facility leasing program of the Department.	McKinsey & Company
L	Leadership	The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.	McKinsey & Company

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1 Introduction

Requirements: Several congressional hearings in the spring and summer of 2014 attempted to explore the potential uneven access and quality in the Veterans Health Administration (VHA) health care system and to identify the sources of the problems that were dominating the press. In August 2014, Congress passed the Veterans Access, Choice, and Accountability Act of 2014 (Pub. L. No.113–146, 128 Stat. 1754), also known as the Veterans Choice Act. Section 201 of the Veterans Choice Act, Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs—hereafter called the Independent Assessment—calls for a private-sector entity or entities to “conduct an independent assessment of the hospital care, medical services, and other health care furnished in medical facilities of the Department.”¹⁰ The Act specifically directed that the assessments be conducted in 12 areas, covering a broad spectrum of VHA services, operations, and support. Eleven of these assessments were conducted under the auspices of the CMS Alliance to Modernize Healthcare (CAMH), a federally funded research and development center sponsored by the Centers for Medicare & Medicaid Services (CMS) and operated by The MITRE Corporation. MITRE entered into contracts with three organizations to help execute the required assessments, with the exception of Assessment D (Access Standards), which VHA separately contracted to the Institute of Medicine (IOM). Table 1 identifies the specific assessment areas and the organizations conducting the assessments.

Activities: For the 11 CAMH assessments, the assessment teams conducted numerous activities to better understand VHA processes, functions, and operations. As Table 2 illustrates, they captured and utilized a vast amount of information gathered through site visits, surveys, data requests, and focused interviews. All of the individual assessment reports, summarized in Appendices A through L and contained in Volume II, provide a comprehensive discussion of the analytical techniques that each team used to conduct its assessment. This Integrated Report was created by applying an integrated systems perspective across all of the individual assessments’ activities, findings, and recommendations.

Table 2. Data Collection, Assessment, and Integration Activities

Conducted 87 site visits to 38 VAMCs, 16 primary care community-based outpatient clinics, 7 multi-specialty community-based outpatient clinics, 1 health care center, 13 VISN headquarters, 4 construction and facilities management offices, 2 acquisition centers, 2 consolidated mail outpatient pharmacies, 3 consolidated patient account centers, 1 health administration center, and 6 active major construction sites.
Conducted numerous interviews and workshops with VA and VHA leadership, staff, and union representatives.
Conducted extensive literature reviews that included 137 previous assessments of the Veterans health care system.

¹⁰ United States. Congress. Veterans Access, Choice, Accountability, and Transparency Act, 38 U.S.C. § 1701 (2014) (Pub. L. No.113–146, 128 Stat. 1754).

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Met with 27 leading private health care organizations and obtained information from 10 Veteran Service Organizations (VSOs). Visited four health care systems that have undergone successful major transformations in the last 10 years.

Conducted 5 individual-level surveys to include leaders at VA administrative parent organizations, schedulers, providers and administrators, inpatient clinical staff members at all VAMCs, and VHA employees about its leadership beliefs and practices.

Received 560 data sets from VHA; received and analyzed more than 20,000 files.

Created an independent Blue Ribbon Panel consisting of 16 preeminent health care industry leaders to leverage their expertise in health care industry best practices and innovative practices. The panel members (listed in Appendix Q) remained engaged throughout the assessment process and provided advice and feedback on the integrated assessment approach and this Integrated Report.

Limitations: These efforts had certain limitations:

- The assessment teams assumed that the quality, reliability, and accuracy of the data provided by VHA were acceptable. Sometimes data were unavailable, used non-standard definitions, or appeared to have inconsistencies. Conducting audits was beyond the scope of this effort.
- The assessments did not include a survey of Veterans' experiences or perceptions. The defined time frame did not permit the design and implementation of a formal survey. We engaged Veterans Services Organizations (VSOs) to gain their perspective on the viewpoints of their membership.
- The assessments did not compare costs of VA and non-VA care because the Veterans Choice Act did not require cost comparisons. The Congressional Budget Office (CBO) has previously reported to Congress on the challenges of comparing the costs of VA and non-VA care, citing the scarcity of cost-accounting data for Veterans' care and the complete absence of data on non-VA care received by Veterans who are also treated by VA.¹¹ We do recognize that the value of Veterans' health care, defined as health care outcomes relative to costs, should inform efforts for improvement.
- Due to time constraints, the assessment teams did not visit every Veterans Affairs Medical Center (VAMC). Rather, the assessment team implemented a process that defined an appropriate sample of medical facilities to visit and used data calls and surveys to cover the remaining facilities that could not be visited. The sample included representation across all (Veterans Integrated Service Networks (VISNs); satisfied assessment requirements; and 87 site visits, including visits to 38 VAMCs, were conducted. To ensure consistency across each site visit, we also ensured that the same

¹¹ Congressional Budget Office. (2014, December). *Comparing the Costs of the Veterans' Health Care System with Private-Sector Costs*. Washington, D.C.: Congressional Budget Office. Retrieved from <https://www.cbo.gov/publication/49763>

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population (i.e., roles and units) were used for observation and focus-group participation.

Organization: The results of these efforts are captured in two volumes:

- Volume I contains this Integrated Report and one appendix for each assessment, summarizing that assessment's findings and recommendations.
- Volume II contains the detailed and complete assessment reports.

Table 3 provides the major elements of this Integrated Report:

- Sections 1–3 include the Introduction, Context, and Systems and are intended to enable readers to understand the purpose of the effort, to capture VHA's state at the time of the assessment, and to introduce the need for an integrated system-level perspective to resolve identified systemic findings.
- Sections 4–7 discuss the four interrelated systemic findings of concern and respective system-wide recommendations.
- Section 8 describes the transformational journey that VHA must embark upon to become a high-performing health care system.

This Integrated Report provides an integrating perspective based on the findings and recommendations from across the independent assessment reports. It does not provide a summary of the individual findings or recommendations of the assessments; rather, readers are strongly encouraged to study those assessments in detail.

The findings and recommendations from all of the independent assessment reports revealed four systemic findings, defined in Section 3, that are clearly interrelated and underlie many of VHA's recurring problems. This Integrated Report concludes that solving VHA's more challenging problems requires VA leadership to adopt systems thinking, a framework for solving problems based on the premise that a component part of an entity can best be understood in the context of its relationships with the other components of the entity, rather than in isolation. This approach takes into account the interdependencies of the parts to find the best combination of strategies that meet the needs of the whole. Systems thinking has been well established in many industries, including health care, and requires leaders to understand how components of the system should be working together, as opposed to how they are currently interacting. Systems thinking does not promote tackling individual problems independently because the solutions, more often than not, will be sub-optimal, non-scalable, and non-sustainable. This Integrated Report also concludes that VHA should establish a transformation program management office with authority and funding necessary to effectively implement a system-wide reworking of VHA based on systems thinking and that VHA should exploit evidence-based systems models to enable informed decisions about integrated solutions.

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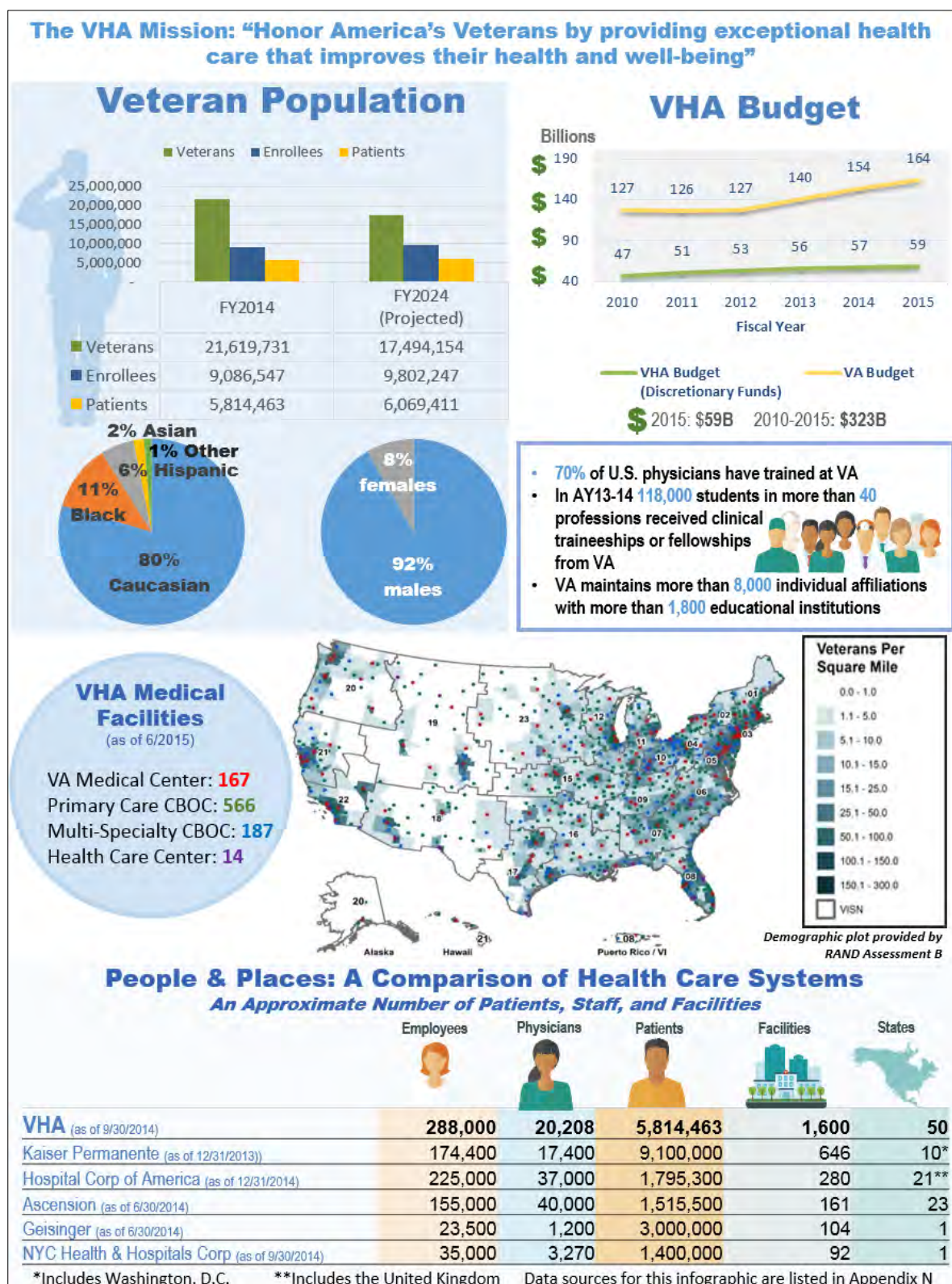
Table 3. Integrated Report Directory

SECTION	PURPOSE	PAGE NO.
I. Introduction	Explains the purpose, scope, and structure of the report	1
2. Context	Describes VHA	7
3. Systems	Introduces the systems approach to enabling transformation and identifies the four systemic findings that emerge from this assessment	13
4. Governance	Provides recommendations on how to align demand, resources, and authorities within VHA	23
5. Operations	Addresses variance in the execution of business operations across VHA, defines the need to identify and share best practices and to develop a patient centered operating model	31
6. Data and Tools	Motivates the need for common, transparent, accurate, and timely system-wide data and tools	41
7. Leadership	Discusses the impact of and solutions to the current leadership challenges	51
8. Transformation	Describes the transformation journey upon which VHA must embark	59
Appendices A–L	Provide a short synopsis of assessment reports contained in Volume II	A-1
Appendix M	Highlights the outreach efforts that were conducted with Veterans Service Organizations, high-performing health care systems, and health care executives	M-1
Appendix N	Provides the list of references that support this effort	N-1
Appendix O	Provides the list of acronyms used in the Integrated Report	O-1
Appendix P	States Section 201 of the Veterans Choice Act	P-1
Appendix Q	Identifies the Blue Ribbon Panel members	Q-1
VOLUME II	Provides background information, analytic approach, findings, conclusions, and recommendations prepared by each of the 12 assessment teams	CD

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Figure 1. Veterans' Health Care Key Metrics



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2 Context

The assessments focused on the care provided under the auspices of the U.S. Department of Veterans Affairs (VA). This care is primarily provided through the medical facilities operated by the Veterans Health Administration (VHA)—the VA organization directed by the Under Secretary for Health—and through health care funded by VA and provided outside of VHA facilities (i.e., purchased care or community care). Veterans also receive health care outside of VHA facilities that is not funded by VHA. Our focus excludes care that is not directly provided by or paid for by VHA.¹²

VHA is a multifaceted organization with several dynamics that impact how it operates. These include its mission, funding, size and scale, organizational construct, and an evolving patient population influenced by complex eligibility rules and multiple care options.

VHA Mission and Vision: VHA’s stated mission is “Honor America’s Veterans by providing exceptional health care that improves their health and well-being.”¹³ VHA aspires to the following vision:

VHA will continue to be the benchmark of excellence and value in health care and benefits by providing exemplary services that are both patient-centered and evidence-based.

This care will be delivered by engaged, collaborative teams in an integrated environment that supports learning, discovery and continuous improvement.

It will emphasize prevention and population health and contribute to the Nation’s well-being through education, research and service in national emergencies.¹⁴

Fiscal Resources: VHA estimates that its funding for fiscal year (FY) 2015 will total \$59 billion, including \$3 billion in third-party collections.¹⁵ Currently, VHA’s budget request is based on estimates developed two years prior and is constrained by overall federal budget growth. Thus, VHA may be limited in its ability to respond quickly to unexpected demand for health care, especially after changes in eligibility. This happened several times in the past: for example, after eligibility reform in 1996 and when certain diagnoses were designated presumptively service connected for Veterans who served in Vietnam, the Gulf War, and other situations.

Size and Scale: VHA has an extensive geographic presence across the United States and its territories and manages a significantly large number of facilities. It provides health care through 21 Veterans Integrated Service Networks (VISNs). In each VISN, hospitals known as VA Medical

¹² The terms VA and VHA are not interchangeable. Throughout this report, VA refers to the department and VHA refers to the administration within the department.

¹³ U.S. Department of Veterans Affairs. Veterans Health Administration. VHA Strategic Plan FY2013-2018, pg. 1. Retrieved from http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf

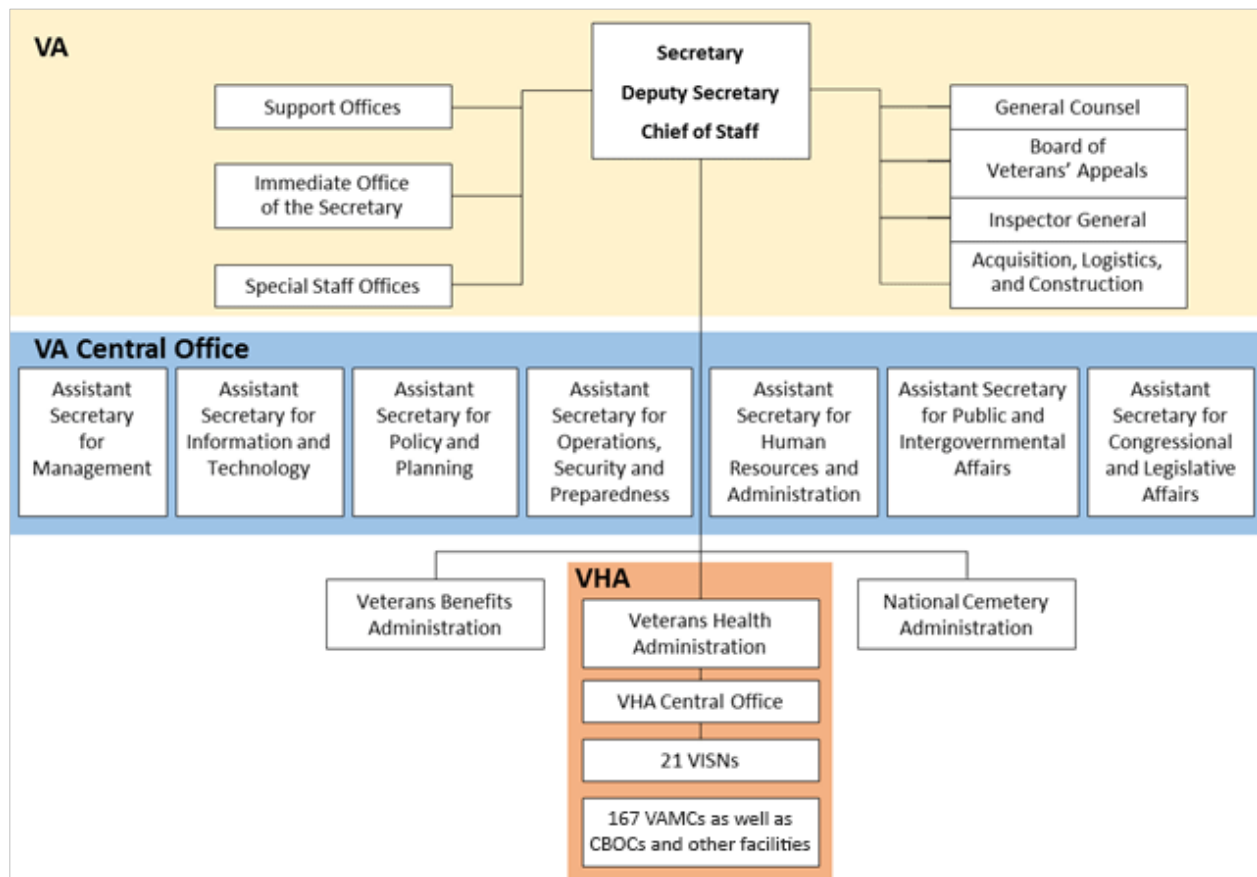
¹⁴ U.S. Department of Veterans Affairs. (2014, September 21). *Blueprint for excellence: Veterans Health Administration*. Retrieved from http://www.va.gov/HEALTH/docs/VHA_Blueprint_for_Excellence.pdf

¹⁵ U. S. Department of Veterans Affairs. Volume II: Medical programs and information technology programs; Congressional submission, FY 2016 funding and FY 2017 advance appropriations, pg. VHA-3. Retrieved from <http://www.va.gov/budget/docs/summary/Fy2016-Volumell-MedicalProgramsAndInformationTechnology.pdf>

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Centers (VAMCs) coordinate with smaller clinical sites known as community-based outpatient clinics (CBOCs) to care for Veterans in a specified geographic area. In addition to providing direct patient care to Veterans, VHA also provides medical education for physicians and other health care providers (it has been estimated that 70 percent of all U.S. physicians received some of their training from VHA),¹⁶ and conducts critical clinical, basic, and health services research.

Figure 2. U.S. Department of Veterans Affairs Organization Chart



Organization: As Figure 2 indicates, Veterans Health Administration is one of three administrations under the Secretary of Veterans Affairs. It is by far the largest administration, with 89 percent of the full-time equivalent (FTE)¹⁷ staff employed by VA and 87 percent of the fiscal year (FY) 2016 VA discretionary budget.

- All three administrations rely on the VA Central Office (VACO) to provide Information Technology (IT), Human Resources (HR), Contracting, Administration, Acquisition, Logistics, and Construction Services, among others.

¹⁶ U.S. Department of Veterans Affairs. (2015, April 14-15). MyVA Advisory Committee: Inaugural meeting [PowerPoint slides].

¹⁷ U.S. Department of Veterans Affairs. (2015, February 3). Office of Budget: President's Budget Request Fiscal Year 2016. [Website]. Retrieved from: <http://www.va.gov/budget/products.asp>

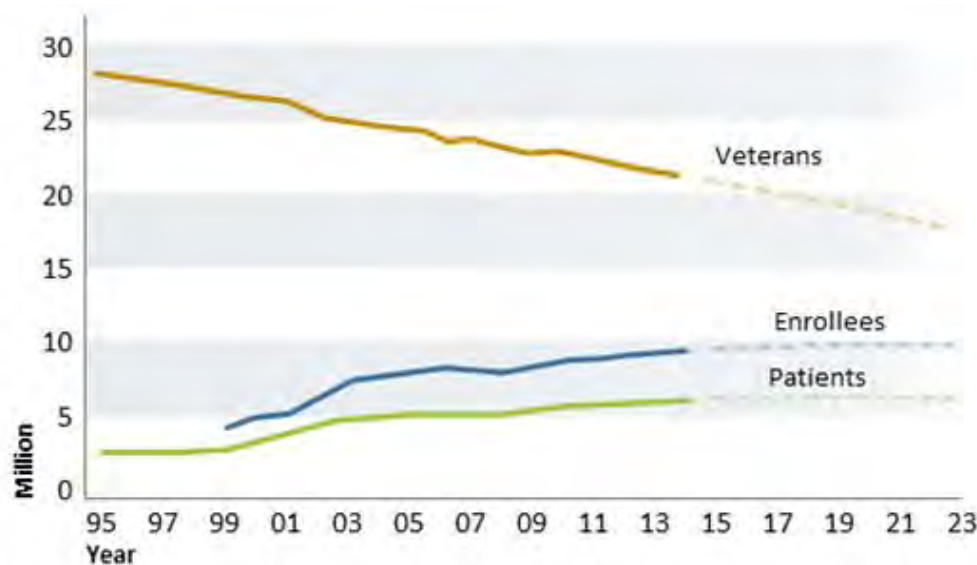
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- VHA also has a Central Office (VHACO) that includes offices for Operations and Management, Policy and Services, Nursing Services, Academic Affiliations, Business, Medical Inspector and Quality, Safety, and Value.
- The 167 VA Medical Centers (VAMCs) are distributed across 21 Veterans Integrated Service Networks (VISNs). These VAMCs and VISNs are nested within VHA under the direction of VHACO. VHA and VHACO are, in turn, nested under VA and the VA Central Office.

Evolving Population of Veterans:¹⁸ Figure 3 illustrates trends in the total Veteran population, enrollment, and use of VA care. In 2014, the Veteran population totaled 21.6 million who had served on active duty in the military; of these, 9.1 million were enrolled for VHA health care coverage. Among those enrolled, about 5.9 million Veterans used a VHA hospital or clinic at least once during the year. Historical data show that the number of Veterans peaked around 1980 at 30 million and has steadily declined since then, but the number of VHA health care enrollees and users has steadily increased over the 20 years for which data are available.

The Veteran population is projected to continue to decline over the next decade by an additional 19 percent to 17.5 million. The number of enrollees and patients is estimated to reach its peak level in 2019 before plateauing or possibly declining in future years, as the population decline begins to overtake the upward trend in use of VHA health care by eligible Veterans. Changes in access to VHA in-house or purchased care, enrollment eligibility, or external factors could result in a resumption of the upward trend or a more rapid decline.

Figure 3. Trends in the Veteran Population, Enrollment, and Use of VA Care



Source: Congressional Research Service, Assessment A Projections

¹⁸ This information is presented in RAND Corporation Assessment A (Demographics) in Volume II.

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In terms of geographic distribution, over the next decade, the Veteran population will become more concentrated in urban areas, and the relative share of the Veteran population in the Ohio River Valley region will diminish. However, migration is less frequent among Veterans than non-Veterans and will not play a substantial role in the geographic distribution of Veterans between 2014 and 2024. While migration rates vary with a range of demographic characteristics, the overall trend is one of slow decline in migration rates generally.

Health Conditions:¹⁹ Veterans are substantially older and therefore face more chronic conditions than the general civilian population. Approximately 50 percent of all Veterans are age 65 or older, compared to only 17 percent of the civilian population. Veterans report more health problems than civilians. Compared to Veterans who do not use VHA health care, VHA patients are older, less socio-economically well off, and experience a higher prevalence of common chronic conditions (such as diabetes and cancer). The prevalence of these conditions is expected to increase over the next 10 years.

The overall prevalence of mental health conditions is 56 percent higher among VHA patients than other Veterans. Twenty-five percent of all patients seen at VHA have a mental health condition, and the prevalence of post-traumatic stress disorder (PTSD) among VHA patients (at four percent) is 11 to 14 times the prevalence among Veterans not using VHA care. When combined with the otherwise rare conditions related to combat—amputation, traumatic brain injury, blindness, and severe burns—VHA handles a patient mix that is distinct from what civilian community providers typically treat. VHA also faces challenges, as do civilian providers, in treating patients who are homeless or have unstable living arrangements. An estimated 50,000 Veterans were homeless in 2014, and while overall homelessness among Veterans is declining, some areas still serve a large homeless population.

Complex Eligibility Rules: The Veterans Health Care Eligibility Reform Act of 1996 established the foundation for today's eligibility rules for Veterans' health care. The Act defined eligibility priority groups while mandating care for Veterans with service-connected health conditions, service-connected disabilities, exposure-related health conditions, and those without other means to pay for their care. However, health care for these Veterans is not an entitlement because it is limited by "the amount provided in advance in appropriations Acts for such purposes."²⁰ It is worth noting that VHA has discretion in the law over how to provide care, but it is required to maintain specialized treatment and rehabilitation programs for spinal injuries, blindness, amputations, mental illness, and other serious service-connected health conditions.

The threshold for enrollment eligibility has changed several times since 1996. After Congress expanded health care eligibility to all Veterans, the number of enrollees increased rapidly. By 2003, VHA found itself "unable to provide all enrolled Veterans with appointments within a reasonable time."²¹ To ensure quality and timeliness of care for higher priority Veterans, VHA

¹⁹ This information is presented in RAND Corporation Assessment A (Demographics) in Volume II.

²⁰ United States. Congress. H.R. 3118. Bill Summary and Status, 104th Congress 1995–1996, Veterans' Health Care Eligibility and Reform Act of 1996. Retrieved from <http://thomas.loc.gov/cgi-bin/bdquery/z?d104:H.R.3118>

²¹ Enrollment-Provision of Hospital and Outpatient Care to Veterans Subpriorities of Priority Categories 7 and 8 and Annual Enrollment Level Decision, 38 CFR 17 (2003)

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terminated the enrollment of Veterans who do not have a compensable service-connected disability and do not have incomes below the threshold used to determine which Veterans cannot pay for their care. The income threshold was relaxed in 2009, opening enrollment to Veterans whose incomes are within 10 percent of the threshold. Finally, Veterans who deployed to a combat theater after November 2009 are automatically eligible to enroll for up to five years after leaving the military without having to first establish their priority group.

Multiple Sources of Health Coverage for Veterans: Health care planning for VHA must also consider the fact that most Veterans have at least one source of health insurance coverage other than VHA health care, and Veterans with other coverage have markedly different VHA use rates than Veterans without other sources of coverage. Slightly more than half of Veterans reporting to non-VA sources of coverage have used VA health care services in the past, and 43 percent report using VA health care services in the past six months. Only eight percent of Veterans using private coverage alone report using VA health care in the past six months.

Purchased Care:²² Historically, VHA treated Veterans almost exclusively in its own facilities. In recent years, the use of purchased care has increased rapidly and now accounts for about 10 percent of expenditures. The Veterans Choice Act guaranteed purchased care for enrolled Veterans who, under certain parameters, are unable to access care in VHA facilities. VHA has begun to develop a more robust purchased-care program, relying on a network of community providers who have agreed to treat Veterans and provide information about the care provided.

Quality of Care:²³ Although Congress did not specify quality of care as a specific assessment area, one assessment did characterize current VA quality of care by including a review of previous studies and new analyses that compared VA's quality with non-VA providers on a published set of quality measures. After a careful examination of many published, peer-reviewed studies, Assessment B (Health Care Capabilities) concludes that VHA health care quality is better on many measures than non-VA providers' care, while similar or worse on other measures. In new analyses comparing VHA's quality with non-VA providers, VHA performed the same or significantly better on average than the non-VA provider organizations on 12 of 14 effectiveness measures (providing recommended care) in the inpatient setting, and worse on two measures. On average, VHA performed significantly better on 16 outpatient Healthcare Effectiveness Data and Information Set® (HEDIS) measures of effectiveness compared with commercial health maintenance organizations (HMOs); on the 15 outpatient HEDIS measures of effectiveness that were available for Medicaid HMOs; and on 14 of 16 outpatient effectiveness measures compared with Medicare HMOs. On 6 of 10 patient-centeredness measures, on average, patients in VA hospitals reported significantly less favorable experiences with the care they received than did patients in non-VA hospitals. Assessment B observed marked differences between highest and lowest performing VA facilities for most quality measures—indicative of the uneven quality of care suggested in Section 1.

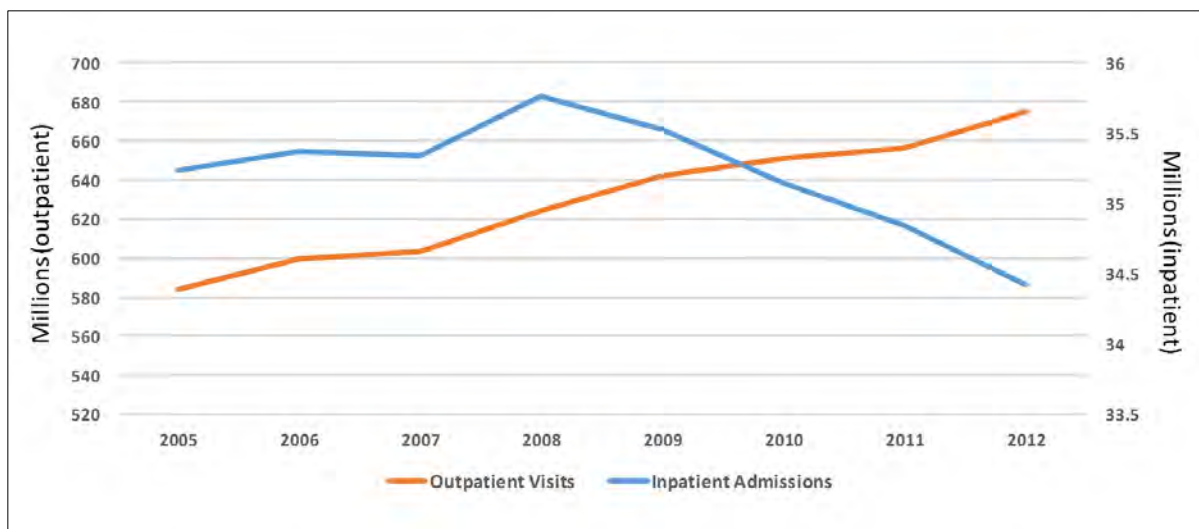
²² This information is presented in RAND Corporation Assessment C (Care Authorities) in Volume II.

²³ This information is presented in RAND Corporation Assessment B (Health Care Capabilities) in Volume II.

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Shift from Inpatient to Outpatient Care: U.S. health care has been transforming from hospital-centric sick care to an outpatient model that emphasizes primary and preventive care. Data from the American Hospital Association reveals a decline in inpatient admissions since 2008, dropping from 35.8 million community hospital admissions to 34.4 million. Outpatient visits over the same period grew from 624 million visits in 2008 to 675 million visits in 2012 (Figure 4²⁴). These trends are traced to health care reform changes and the adoption of new models of care that accommodate more patients in an outpatient setting. More hospitals are establishing medical home programs. “In 2013, 20.4% of hospitals had a medical home program compared with 14.5% in 2011.”²⁵ A review of Medicare data from 2004 to 2011 reveals that inpatient admissions per Fee for Service (FFS) beneficiary declined by 7.8 percent while the number of outpatient services per FFS beneficiary increased by 33.6 percent across all types of insurance.²⁶ Within VHA, outpatient visits are increasing while inpatient Bed Days of Care has declined, with some VISNs experiencing more dramatic swings than others. These trends will eventually impact the number, size, and configuration of the health care facilities required to provide support to Veterans.

Figure 4. U.S. Inpatient Admissions vs. Outpatient Visits



²⁴ American Hospital Association. (n.d.). Utilization and Volume. *Trendwatch Chartbook 2014*. Retrieved from <http://www.aha.org/research/reports/tw/chartbook/ch3.shtml>

²⁵ Robeznieks, A. (2015, January 27). Hospitals saw fewer admissions, more outpatients in 2013. *Modern Healthcare*. Retrieved from <http://www.modernhealthcare.com/article/20150127/NEWS/301279903>

²⁶ Medicare Payment Advisory Commission. (2013, March). Report to the Congress: Medicare payment policy. Retrieved from http://www.medpac.gov/documents/reports/mar13_ch03.pdf?sfvrsn=0

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3 Systems

Systems Thinking: A review of the findings included in the assessment reports indicates that each finding has an impact on patient care, and many findings have been recognized by previous studies.²⁷ Over the last 10 years, more than 15 studies and assessments have addressed scheduling issues alone. Prioritizing these findings and then solving them individually is tempting, but such an approach would not guarantee a sustainable solution. While focusing on one simple metric and attacking that measure is tempting, doing so may be transient and may fail to address the underlying problems. As H.L. Mencken stated, “For every complex problem, there is an answer that is clear, simple, and wrong.” Often, the simple answer is not sustainable, is not scalable, and can even create unintended consequences.

An analysis of the Veterans’ access issue illustrates this conclusion. Using wait times as the one metric for patient access, Assessment D (Access Standards) reports an average wait time of 43 days for new primary care appointments, with a range of 2–122 days across all VA facilities, based on an October 2014 VHA report. Comparison data from a review of Massachusetts physicians in the civilian sector showed average wait times of 50 days for internal medicine and 39 days for family medicine appointments. This suggests that, on average, VHA was not that different from the civilian sector. Assessment B (Health Care Capabilities) also “did not find evidence of a system-wide crisis in access to VA care.” But looking only at overall averages can mask troubling instances of poor access and can preclude the investigation of the underlying causes of those instances. Assessment D asserts that achieving sustainable access improvements requires a systems approach, incorporating multiple factors: systems strategies, supply and demand alignment, reframing the type of patient encounter, the need for standards, the need for evidence-based best practices, and leadership. Each of these will require its own evidence-based metrics and benchmarks. Taken together, they will provide a much more comprehensive and accurate assessment of access. Creating a locally tailored model of these pieces gives VHA the ability to understand how access varies from location to location. Local models can then be aggregated to provide understanding of overall system performance while still retaining local granularity to uncover previously hidden issues.

VHA must adopt a systems perspective to address its most challenging problems, including access. Systems thinking views problems within the context of the overall system and avoids isolated solutions to specific problems. It takes into account the interdependencies of the parts to find the best combination of strategies that meet the need of the whole.²⁸ This approach has

²⁷ This team reviewed 137 previous assessments of VHA, including reports by the Government Accountability Office, Veterans Administration Office of the Inspector General, and multiple other organizations. These assessments were conducted between 1998 and 2015. (Seventy-seven percent of the reports were conducted in the last five years.) They contain 790 findings about the state of VHA health care, many of which are overlapping. About 80 percent of the findings identified in this Integrated Report are aligned with or reflect those previous findings. The unique value of this report is not in the list of findings but in the recognition of the need for an integrated systems approach to address the underlying causes of those findings.

²⁸ Frank, M. (2000, March 31). Engineering systems thinking and systems thinking. *Systems Engineering*, 3(3), 163–168.

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been well established in many industries, including health care. This approach often enables leaders to exploit identified strengths and to reframe problems into opportunities based on an appreciation of how components of the program should be working together, as opposed to how they are currently interacting. As was stated in a recent Senate hearing on VHA, the tendency to chase “shiny objects”²⁹ must be avoided and replaced by focusing on an integrated process executed at the enterprise level. The Government Accountability Office (GAO) has also encouraged VA to address those systemic findings that will enhance the ability of VHA to provide high-quality health care to Veterans.³⁰

Systemic Findings: To understand the interdependence of issues and the potential causes of systemic problems in VHA, multiple reviews of all the findings across the assessment reports were conducted. Through an analysis of industry benchmarks and best practices, insights from health care executives and high-performing health care organizations, the perspective of our Blue Ribbon Panel, and interactions with Veterans Service Organizations, four systemic findings repeatedly emerged. Each of these systemic findings then motivates a cornerstone recommendation that should be integrated into a VHA systems approach.

Finding 1—A disconnect in the alignment of demand, resources, and authorities

VHA’s mission is inspirational and widely accepted by employees, but there are significant geographic variations with respect to how the mission is translated into action for individual Veterans. Complex eligibility rules make determining which Veterans are covered and what services they receive a challenge, and navigating VHA is often difficult for Veterans—a problem exacerbated by incomplete guidance and non-standardized business processes. Furthermore, the growing role of outside providers has not been integrated effectively into VHA’s operating model, which is based on providing direct care within VHA facilities.

At present, VHA is over-committed in some geographic areas, given its broad mission, an expanding list of automatic eligibility criteria, and limited resources. Matching supply and demand at the local level is challenging because supply is relatively fixed each year once service projection models allocate resources to each facility through the appropriation and budgeting process.

Recommendation 1—GOVERNANCE: Align demand, resources, and authorities.

Finding 2—Uneven bureaucratic operations and processes

Several centralized operational and support functions appear to have lost customer focus and do not adequately support the needs of the medical centers. Individual VAMCs have adopted

²⁹ Clark, C. (2015, April 30). Senators propose acting as “Board of Directors” for VA. Government Executive. Retrieved from: <http://www.govexec.com/management/2015/04/senators-propose-acting-board-directors-va/111613/>

³⁰ U.S. Government Accountability Office. (2015, February 11). *High-risk series: An update*. (GAO Publication No. 15-290). Washington, D.C.: U.S. Government Publishing Office. Retrieved from <http://www.gao.gov/assets/670/668415.pdf>

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local implementations of certain processes, but many of these were found to be unnecessarily complex and, not surprisingly, inconsistent across VHA. In many cases, these centralized and local process issues have become inefficient and bureaucratic, creating a direct negative impact on the overall Veteran experience and timely access to care.

These widely varying processes highlight VHA's complexity. Severe problems may manifest themselves at one facility, while another constantly receives tributes from Veterans and health care experts. The oft-quoted reminder, "if you've seen one VA hospital, you've seen ONE VA hospital," captures this reality.

Recommendation 2—OPERATIONS: Develop a patient-centered operations model that balances local autonomy with appropriate standardization and employs best practices for high-quality health care.

Finding 3—Non-integrated variations in clinical and business data and tools

A lack of common, integrated VHA enterprise systems and tools negatively impact VHA's operations and resulting data. Inconsistent and ineffective data collection and analysis undermines rapid, evidence-based assessment and improvement of quality and customer satisfaction. VHA lacks a holistic, enterprise approach to collecting and leveraging its data. Data interchange with the Department of Defense (DoD) and external health care providers is limited, which creates unnecessary clinical risk. Since newly discharged Veterans often become VA patients, interoperability with DoD is necessary and expected. These shortfalls hinder using available data to support effective decision making and performance management.

Recommendation 3—DATA AND TOOLS: Develop and deploy a standardized and common set of data and tools for transparency, learning, and evidence-based decisions.

Finding 4—Leaders are not fully empowered due to lack of clear authority, priorities, and roles

VHA leaders operate within a challenging and disempowering environment that discourages emerging leaders from seeking promotion within VHA. Key leadership positions remain vacant or are staffed with acting leaders, and more than half of executives are eligible for retirement, potentially creating a larger number of vacant positions. A misalignment of accountability and authority exists within a broader VHA culture that is characterized by risk aversion and lack of trust. Those leaders who are effective too often achieve positive outcomes despite the challenges of the organization within which they operate.

Recommendation 4—LEADERSHIP: Stabilize, grow, and empower leaders; galvanize them around clear priorities; and build a healthy culture of collaboration, ownership, and accountability.³¹

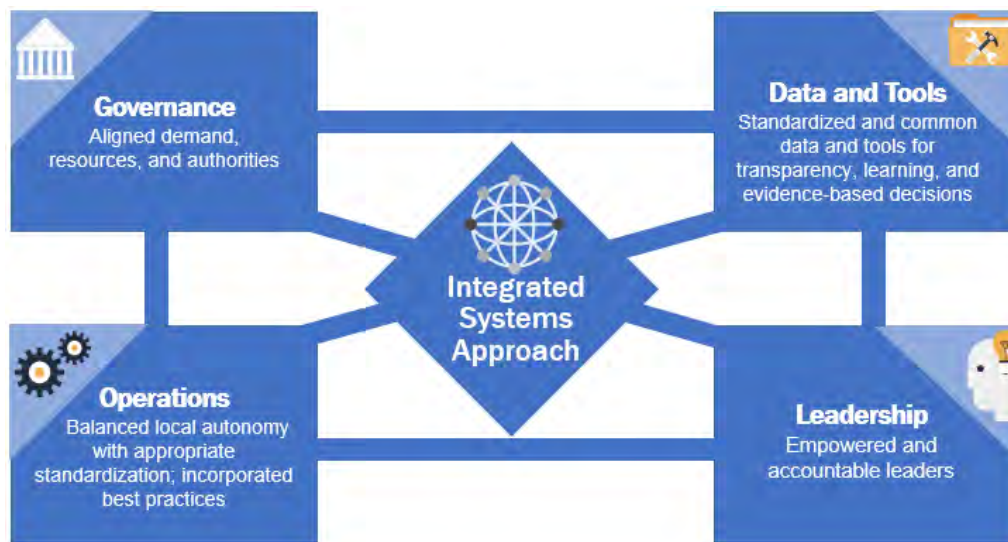
Integrated Systems Cornerstones: These four systemic findings in governance, operations, data and tools, and leadership all contribute to the critical problems that plague VHA. It should not

³¹ This information comes from McKinsey & Company Assessment L (Leadership) in Volume II.

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be surprising, then, that when addressing any one problem, the solution must integrate all of these systems cornerstones as part of a sustained solution. For example, improving access in a scalable and sustainable manner is more than just authorizing and funding temporary overtime to create more appointments; improving access must also include forecasting demand, streamlining scheduling processes, improving the efficiencies of existing hospital capacities, changing the way health delivery occurs to include telehealth, and having clarity and authority for using purchased care options. Similarly, even funding \$10 billion for Choice Cards without addressing the other parts of the system such as educating Veterans about their new options and changing the culture to embrace non-VHA providers can lead to poor results. Figure 5 illustrates the four integrated systems cornerstones that must be addressed together to enable enduring solutions in VHA.

Figure 5. Integrated Systems Cornerstones



Applications of the Integrated Systems Approach: Three examples emerge that demonstrate the value of the systems approach in addressing the significant challenges facing VA. These examples deal with facilities management, Veteran patient access, and health information technology.

Facilities³²: Consider the challenges that VA must resolve in managing its capital program in facilities management. Provided that average funding levels remain consistent over the next 10 years, the \$51 billion capital requirement would significantly exceed the anticipated funding level of \$16–26 billion.³³ Not only would this shortfall jeopardize the capital program, it would also threaten the financial integrity of the entire VHA health care delivery system and, in turn, significantly impact the quality of health care provided to Veterans. Viewing this primarily as a funding problem would be shortsighted. Rather, interdependent findings exist in each of the

³² This information comes from McKinsey & Company Assessment K (Facilities) in Volume II.

³³ This information comes from McKinsey & Company Assessment K (Facilities) in Volume II.

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four cornerstones that need to be addressed in an integrated fashion to achieve a sustainable solution, as shown in Table 4.

Table 4. Facilities Challenges Through the Lens of the Systems Approach

Governance
External and internal constraints limit VHA's ability to deliver and operate medical facilities at the level of private-sector benchmarks; to appropriately rebalance inpatient and outpatient facilities; and to accommodate future trends, including telehealth.
Investments in facilities are not effectively linked to workload growth; existing space is not being used at its highest efficiency; eliminating underutilized space is difficult.
Expected funding levels do not support identified capital needs.
Operations
Lengthy approval and funding timelines hinder VHA's ability to meet the identified space requirements to keep up with Veteran demand and invest in facilities updates that align with changing models of care.
VHA has no integrated system to manage the entire leasing process timelines, comprehensive tracking, or measurement of the impact of the leasing program.
A large majority of facilities noted challenges in hiring staff and filling vacant positions that were open and for which budget had been allocated.
Scope and design criteria for major projects are frequently subjected to major changes, especially during the design phase, affecting overall cost and schedule.
Data and Tools
Data capture occurs at multiple levels and through multiple tools, generating multiple sources of truth about the status of the capital program.
Tools for developing Strategic Capital Investment Plan business cases rely on individual effort versus a systematic process to consider creative alternatives to capital solutions.
Systems do not consistently capture key performance indicators. The metrics are not standardized across all stakeholders.
Leadership
There are recognized shortfalls in overall accountability, role clarity, personal ownership, internal communication, and proactive problem-solving approaches that limit VA's and VHA's ability to deliver the correct projects on time and on budget.
The broader culture of facilities functions is characterized by silos, risk aversion, and role ambiguity, resulting in an inability to consistently advance projects in an efficient manner.
Competition for limited funds has led leaders to make a range of choices in developing projects that favor approval strategies over efficient project delivery.

Viewing these facilities challenges through the lens of the integrated systems approach reveals the complexity of the problem; the integrated nature of the required transformation; and the

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opportunity to reframe the facilities challenges as part of a larger set of interdependent pieces of VHA's overall health care system. Facility challenges can be significantly mitigated by a transformative realignment throughout the capital program deploying best practices in leasing and contracting; realigning the strategy of the capital program to improve project selection, optimize the infrastructure portfolio, implement innovative care delivery models, understand demand-based needs, and explore and partner with purchased-care opportunities; and reevaluating funding requirements. Closing or resizing facilities to match local demand and resizing to take into account inpatient and telehealth trends will avoid significant costs. Understanding local demand can lead to a smaller facility need with overflow arrangements with local private-sector options. Other key opportunities include improving contracting and leasing processes as well as considering when to outsource construction. In short, employing the systems view could help reframe the vision for future health delivery and significantly reduce VHA's current and future capital investment issues. It also enables VHA to avoid being burdened in the long term with hospital overcapacity as the nature of health care delivery trends toward smaller inpatient facilities, increasing outpatient care, and more virtualized health care delivery.

Access: As introduced earlier in Section 3, current VHA access challenges can be viewed through a systems perspective, as shown in Table 5. Multiple findings contribute to the access problem, and they are distributed among all four cornerstones, with clear interdependencies. Taken together, they provide a much more comprehensive understanding of the access problem, and demonstrate why point solutions will fail. Initial efforts to shorten wait times focused on a long-standing shortage of physicians.³⁴ However, this addresses only one issue in an integrated set of issues. A sustainable solution depends on a systems approach to the access challenge.

Table 5. Access Challenges Through the Lens of the Systems Approach³⁵

Governance
Congress stipulates appointment wait times as the access metric
Lack of governance commitment on basic access principles
Lack of governance to ensure system-wide standards are developed, proposed, tested and appropriately applied based on local conditions
Operations
Lack of identification and use of evidence-based best practices
Approaches do not balance supply and demand, limited ability to modulate capacity, or implement surge contingencies to include technology-based alternatives to in-person visits

³⁴ Voorhees, J. (2014, November 12). Less firing, more hiring. Slate.com. Retrieved from http://www.slate.com/articles/news_and_politics/politics/2014/11/veterans_affairs_overhaul_the_va_should_worry_less_about_cleaning_house.html

³⁵ This information comes from the Institute of Medicine Assessment D (Access Standards) and McKinsey & Company Assessment E (Workflow – Scheduling) in Volume II.

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Substandard processes in patient scheduling; lack of centralized call centers
Data and Tools
Lack of patient access metrics, including data on patient and family experience, scheduling practices, patterns and wait times, cycle times, and effective care continuity
Lack of real-time capacity data
Definition of a patient encounter precludes exploiting alternative engagement approaches, including non-physician clinicians and technology mediated consultations
Leadership
Lack of employment of and commitment to systems approach
Lack of accountability that would ensure delays in access are addressed by all relevant stakeholders across care continuum, rather than with piecemeal, independent process changes
Lack of facility leadership focused on continuous assessment and adjustment at each care site

Health IT: As another example of the value of the systems approach, Assessment H (Health Information Technology) discovered that few major improvements have been implemented to the primary health care software system (VistA) in the past 10 years. Many problems undermine deployment of new capabilities. Viewed through the lens of a system approach in Table 6, issues with governance, operations, data and tools, and leadership all contribute to the inability of VA to successfully implement and modernize VistA.

Table 6. Health IT Challenges Through the Lens of the Systems Approach

Governance
Inadequate collaboration between VA's centralized IT organization and VHA results in failure to prioritize IT capabilities that will support VHA health care needs
Lack of a robust, detailed strategy and roadmap for scheduling initiatives across VA to integrate Veteran scheduling via all modalities
Lack of dedicated VHA IT executives
Operations
Document-centric, schedule-focused project management and execution processes that preclude delivery of needed capabilities
Challenges in building and maintaining a skilled health informatics workforce
Lack of technical support to Veterans for home telehealth

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Data and Tools
Lack of standard clinical documentation impedes clinical research and electronic health record exchange with DoD and private sector health care providers
Inconsistent and ineffective data collection within and across VA medical facilities prevents evidence-based assessment and improvement of quality and customer satisfaction
Overly complex processes for system development impede cost-effective delivery of new health IT capabilities and limit VA's ability to measure the value of IT investments
Leadership
Internal project-focused central IT service management philosophy vice customer focused
Turnover in the VA CIO position (four in the last 10 years) has precluded an enduring focus on a coherent approach to consolidate new infrastructure technologies, resulting in even greater software complexity
Lack of organization and staffing in the VistA Evolution program preclude successful management, development, and integration of a large complex software program

Continuous Improvement: The richness of the systems approach extends not just to facilities, access, and IT, but across many of VHA's biggest challenges. While complex problems benefit greatly by reframing problems in creative ways, systems solutions also work well for improving existing processes and motivating people to believe they can successfully change. Continuous improvement is one such approach that often uses a Plan-Do-Study-Act cycle³⁶ that identifies, reduces, and eliminates suboptimal processes for continuous incremental or breakthrough improvements. This relies heavily on measuring, analyzing, and experimenting for successful innovations. VHA's current culture would benefit greatly from instituting continuous improvement more aggressively so that everyone participates, can see progress, and can build on the pride they have in being part of VHA. Some of VHA's best performers already focus on continuous improvement, but it is not widely adopted as a standard way of operating. Transforming any organization, especially one the size of VHA, requires that everyone understands, feels accountable for, and acts daily on how to continuously improve the organization. It is as much about engaging the people as it is about fixing the processes.

In summary, Table 7 shows each systemic finding, the associated recommendations to address each finding, and a short list of early actions to turn each weakness into a strength.

³⁶ Taylor, M.J., et al. (2013, August 12). Systematic Review of the Application of the Plan-Do-Study-Act Method to Improve Quality in Healthcare. *BMJ Qual Saf* 0:1-9. doi:10.1136/bmjqs-2013-001862

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Table 7. Systemic Findings and Recommendations

Finding 1: A disconnect in the alignment of demand, resources, and authorities
Recommendation 1—GOVERNANCE: Align demand, resources, and authorities
Establish a governance board to develop fundamental policy, define the strategic direction, insulate VHA leadership from direct political intervention, and ensure accountability for the achievement of established performance measures.
Require a patient-centered demand model that forecasts resources needed by geographic location to improve access and to make informed resourcing decisions.
Clarify and simplify the rules for purchased care to provide the best value for patients.
Finding 2: Uneven bureaucratic operations and processes
Recommendation 2—OPERATIONS: Develop a patient-centered operations model that balances local autonomy with appropriate standardization and employs best practices for high-quality health care
Right size and reorient the VHA Central Office to focus on support to the field in its delivery of care to Veterans.
Fix substandard processes that impede the quality of care provided to the Veteran.
Design and implement a systematic approach to identify best practices and disseminate them appropriately across the enterprise.
Finding 3: Non-integrated variations in clinical and business data and tools
Recommendation 3—DATA and TOOLS: Develop and deploy a standardized and common set of data and tools for transparency, learning, and evidence-based decisions
Use standardized clinical and administrative data for accuracy and interoperability.
Implement a single, integrated set of system-wide tools centered on a common electronic health record (EHR) that is interoperable across VHA and with DoD and community provider systems.
Transparently share performance metrics for leadership, clinical, and business functions across VHA to identify and adopt best practices for continuous improvement.
Finding 4: Leaders are not fully empowered due to a lack of clear authority, priorities, and goals
Recommendation 4—LEADERSHIP: Stabilize, grow, and empower leaders; galvanize them around clear priorities; and build a healthy culture of collaboration, ownership, and accountability
Push decision rights, authorities, and responsibilities to the lowest appropriate level throughout the organization.
Build on Veteran-centered behaviors to drive a culture of service excellence, trust, continuous improvement, and healthy accountability.
Revitalize the leadership pipeline through establishment of enterprise-wide, comprehensive succession management and leadership development functions.
Strengthen the appeal of senior leadership positions by pursuing flexibilities in hiring and compensation.
Establish sustained leadership continuity by extending tenure for key positions.

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4 Governance

Finding 1: A disconnect in the alignment of demand, resources, and authorities
Recommendation 1—GOVERNANCE: Align demand, resources, and authorities
Establish a governance board to develop fundamental policy, define the strategic direction, insulate VHA leadership from direct political intervention, and ensure accountability for the achievement of established performance measures.
Require a patient-centered demand model that forecasts resources needed by geographic location to improve access and to make informed resourcing decisions.
Clarify and simplify the rules for purchased care to provide the best value for patients.

CURRENT STATE

VHA's primary function is clearly defined in Title 38 of the U.S. Code—to “provide a complete medical and hospital service for the medical care and treatment of Veterans.”³⁷ To implement that function, VHA has defined its mission as “Honor America’s Veterans by providing exceptional health care that improves their health and well-being.”³⁸

While this mission inspires and motivates VHA staff, it also creates a dilemma for those same individuals who are committed to its successful execution. It holds out the promise of unconstrained health care to all Veterans when, in reality, the capacity of VHA to meet that promise is constrained by the appropriated funding. While the mission captures the intent of comprehensive health care for all Veterans, VHA’s authorities, resources, and flexibility are less comprehensive. This dilemma was fueled in part by congressional actions, including the Veterans’ Health Care Eligibility Reform Act of 1996. This act mandates that VHA provides a broadly defined set of services for groups of prioritized Veteran populations, based on their eligibility, but “only to the extent and in the amount provided in advance in appropriations acts for such purposes.”³⁹

This prioritization approach was intended to provide VHA leadership with the flexibility to match the extent of care to annual budgets, and it has done just that. It has created a situation under which the organization manages to the budget, regardless of the level of demand envisioned by the aspirational mission statement. In addition, Congress appropriates VA’s budget as a nondefense discretionary program; thus, congressional priorities can influence both the level of money available and the way VA can spend the money once allocated. Funding for other large federal health programs differs in important ways. Medicare is considered an

³⁷ Title 38—United States Code Veterans’ Benefits and the Servicemembers Civil Relief Act, 38 U.S.C. § (2011) (Pub. L. No.112-7), Chapter 73, Subchapter 1, Section 7301.

³⁸ U.S. Department of Veterans Affairs. Veterans Health Administration. VHA Strategic Plan FY2013-2018, pg. 1. Retrieved from http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf

³⁹ United States. Congress. H.R. 3118. Bill Summary and Status, 104th Congress 1995–1996, Veterans' Health Care Eligibility and Reform Act of 1996. Retrieved from <http://thomas.loc.gov/cgi-bin/bdquery/z?d104:H.R.3118>

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entitlement program; funding is provided from the Medicare Trust Fund, spending is mandatory, and the program's annual cost has no formal budget constraint. TRICARE funding is included in the U.S. Department of Defense (DoD) appropriation and is therefore discretionary, but the benefit is well defined, and DoD must cover any costs incurred beyond the appropriated funding. For VHA, congressional priorities can also direct money away from the overall budget for patient care toward specific programs through the special purpose funds. According to interviewees at VA medical facilities, these silos of money can make it difficult for facilities to efficiently and effectively use their entire budgets in any given year.⁴⁰

When demand exceeds capacity to deliver care within the budget, the inevitable result is a decrease in access to care and unmet demand for some Veterans. As this report is written, VHA is facing a potential crisis in its ability to provide care as the demand for Hepatitis C therapy grows.⁴¹

This approach for funding VA complicates the development of a coherent strategic direction and has hindered a consistent

interpretation of the mission across the enterprise. Local organizations interpret their expectations locally, leading at least one VAMC to promise excellent care to “every Veteran, every time!”⁴² In an interview, one VAMC leader described the challenge in terms of “double messaging” around “managing to a budget” and “managing to the need.” At present, VHA is over-committed in some geographic areas. Matching supply and demand at the local level is challenging because supply is relatively fixed each year once service projection models allocate resources to each facility through the appropriation and budgeting process.

Although the population of Veterans is expected to decline by 19 percent over the next decade, the demand for health care services is expected to rise before it levels off in five years, based on demographic factors (primarily aging)—and likely will rise even more if access to VHA health care is improved (Assessment B [Health Care Capabilities]). On the other hand, despite this possible growth in demand, in some areas and for some health conditions, VHA may not have a sufficient population of patients to sustain highly specialized service lines with enough volume to achieve and maintain clinical excellence.

“It appears that the culture of leadership, management, and accountability is focused on making the funding fit at every level. Leadership at every level must have the confidence that if they have a need, they can ask for that need to be addressed. VA, the Administration, and Congress must resolve to make the true need the priority, not the need to make budget lines fit.”

*Deputy Director
Veterans of Foreign Wars
Before the U.S. Senate
May 15, 2014*

⁴⁰ This information is presented in RAND Corporation Assessment B (Health Care Capabilities) in Volume II.

⁴¹ Wagner, D. (2015, June 21). VA to outsource care for 180,000 vets with hepatitis C. *USA Today*. Retrieved from <http://www.usatoday.com/story/news/nation/2015/06/21/va-outsource-care-vets-hepatitis/29059755/>

⁴² U.S. Department of Veterans Affairs. (2015). About the Huntington VA Medical Center. Retrieved from <http://www.huntington.va.gov/about/index.asp>

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Congress and VA leadership must address this challenge. They must work to align VHA's promise to provide comprehensive health care to Veterans with VHA's capacity by defining the expected benefit—that is, the Veteran population to be served and the health care those Veterans will be provided. This will drive the allocation of the funding adequate to meet this demand. VHA must broadly and transparently communicate the strategy for delivering that care to Veterans, VHA employees, other stakeholders, and the public. To start, the following policy questions must be addressed:

- Who will VHA serve? Is it truly all Veterans, or a subset of Veterans whose care is mandated?
- What health care services will VHA provide, and in what settings? Will it provide all care necessary to advance population health and desired outcomes for individual Veterans? How will it address the various social needs (e.g., caring for the homeless) that can complicate the provisioning of services for some Veterans?
- How will VHA provide care? How will VHA determine the appropriate balance between provided care and purchased care? How should this care be customized at the local level to reflect local issues?

The implications of developing answers to these policy questions are significant. All eligible Veterans have not enrolled for health care. The Veteran population is aging and developing conditions and ailments that are not necessarily service related. At the same time, the health care landscape is evolving, changing the manner in which health care is being provided. To address these policy questions and to leverage the answers to those questions, three recommendations are provided.

RECOMMENDATIONS

- Establish a governance board to develop fundamental policy, define the strategic direction, insulate VHA leadership from direct political intervention, and ensure accountability for the achievement of established performance measures.
- Require a patient-centered demand model that forecasts resources needed by geographic location to improve access and to make informed resourcing decisions.
- Clarify and simplify the rules for purchased care to provide the best value for patients.

Establish a governance board to develop fundamental policy, define the strategic direction, insulate VHA leadership from direct political intervention, and ensure accountability for the achievement of established performance measures.

The fundamental policy questions about who is eligible for benefits and for which benefits are truly difficult ones that may engender heated debate and emotional responses. But these issues only represent current critical problems; moving forward, other contentious issues will need to be addressed. For example, attempts to realign resources or close facilities have been met with vehement demands that the “public input needs to carry weight with any changes in the

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system.”⁴³ Initiatives to close or eliminate older, often historic, VHA facilities can meet strong resistance from multiple groups. For example, some Veteran Service Organizations have objected to facility closures by suggesting that such closures would reduce the level of care to Veterans.

In the near term, several models could be tailored to address these policy issues in an objective and unbiased manner. Congress could charter a commission modeled after the 1955 U.S. President’s Commission on Veterans’ Pensions. This Commission studied different benefit packages that had been granted to Veterans, collected extensive information from various government agencies, and also surveyed randomly selected Veterans to develop statistical analyses of the use and effectiveness of various benefit programs. The studies compiled by the Commission were submitted to Congress and influenced subsequent legislative actions. A second model is the Defense Base Realignment and Closure (BRAC) Commission. That Commission was empowered to perform an independent analysis and evaluation of the Defense Department-proposed base closure list and present a report of its findings and its own suggestions to the President and to the American public. Once Congress received the presidentially endorsed report, it had a definitive suspense date to enact a joint resolution rejecting the report in full or the report became law. VA has already introduced this notion “in congressional hearings and has gotten very little pushback from authorizers and appropriators for a BRAC of its own.”⁴⁴

But these are short-term models that may not be able to provide the long-term oversight, guidance, and direction that is expected. VHA operates in a complex and dynamic environment, answering to a large number of stakeholders, sometimes with competing demands. It is a health care system managed as a government agency; some have suggested that Congress is VHA’s “board of directors.”⁴⁵ The long-term governance structure of a health care system can influence many aspects of that organization, to include capital investments, operations, staffing, and the definition and implementation of the strategic plan. Alternative governance models do exist. One was introduced by the Commission on the Future for America’s Veterans, which proposed that Congress “establish a new entity with characteristics not unlike a federal government ‘not for profit’ corporation” that would be empowered with “unencumbered” authority to use all the assets of VHA to “maximize benefits to Veterans.”⁴⁶ A second model, titled the “Independent Non-Taxing Unit of Government,” suggests a governance structure

⁴³ Woster, Kevin. (2011, December 13). VA proposes Hot Springs medical center closures. *Rapid City Journal*. Retrieved from http://rapidcityjournal.com/news/local/communities/hot-springs/va-proposes-hot-springs-medical-center-closures/article_56b5a98e-2545-11e1-a04d-001871e3ce6c.html

⁴⁴ Serbu, J. (2015, March 6). VA calls for its own BRAC process to close outdated facilities. *Federal News Radio*. Retrieved from <http://federalnewsradio.com/congress/2015/03/va-calls-for-its-own-brac-process-to-close-outdated-facilities/>

⁴⁵ Clark, C. (2015, April 30). Senators propose acting as “Board of Directors” for VA. *Government Executive*. Retrieved from <http://www.govexec.com/management/2015/04/senators-propose-acting-board-directors-va/111613/>

⁴⁶ Walters, H. et al. (2009, December). *Commission on the Future for America’s Veterans: Preparing for the Next Generation*. Commission on the Future for America’s Veterans.

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under which a health care board and administrative leadership “still have accountability to elected officials” but are “much more insulated” from direct political interaction.⁴⁷ The New York City Health and Hospitals Corporation (HHC), the largest municipal hospital and health care system in the United States, operates under such a model, as do other municipal and state health care systems. HHC underwent a series of transformative efforts and links the success of those efforts to “a series of successful service and clinical improvements...while also emphasizing continuity of leadership, system wide strategic planning, and board-level accountability for achieving performance objectives.”⁴⁸

Congress and VA should charter the Commission on Care to explore and identify the governance model that would best enable VHA to complete the proposed transformative efforts and sustain its ability to provide the highest quality health care to Veterans. The model that is developed should clearly focus on governance. VA currently has 25 advisory committees, some of which are mandated by Congress, to assess specific VA policies or programs. But these committees are, by title, focused on advising, not governing, and should not be considered a solution to this recommendation. Congressional endorsement is perhaps the key enabler to effectively implementing a governance board.

VHA should charter a transformation program office that has the authority and resources to implement a system-wide reworking of VHA. This office should be provided sufficient and dedicated funding to enable the envisioned transformation’s execution without having to tax other offices or borrow from other initiatives. The office should act as the “guiding team,”⁴⁹ staffed by individuals with the right emotional commitment and core competencies in executing organizational change. The office should coordinate directly with the established governance body and should focus on establishing transformation priorities, defining timelines for execution, implementing both strategic and tactical initiatives, allocating resources, and instituting appropriate metrics and processes to measure progress and success. It should replace any ongoing change initiatives and merge the relevant components of MyVA, the *Blueprint for Excellence*, and other initiatives into one coherent, focused transformational approach.

Require a patient-centered demand model that forecasts resources needed by geographic location to improve access and to make informed resourcing decisions.

Assessment D (Access Standards) states that improvements in health care access will be underpinned by continuous assessment, monitoring, and realigning of supply and demand. The assessment also states that most clinical settings do not take a sufficiently broad view of the

⁴⁷ Bharucha, F., & Oberlin, S. (2009, May). Governance Models among California Public Hospitals. California HealthCare Foundation. Retrieved from <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/G/PDF%20GovernanceModelsCAPublicHospitals.pdf/>

⁴⁸ McCarthy, D. & Mueller, K. (October 2008). The Commonwealth Fund: Commission on a High Performing Health System. The New York City Health and Hospitals Corporation: Transforming a Public Safety Net Delivery System to Achieve Higher Performance. Issues Research, Inc.

⁴⁹ Kotter, J.P. & Cohen, D.S. (2002, November 26). The heart of change. *Harvard Business Review*.

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various options to either increase supply or reduce demand, nor do they maintain the analytic capacity to observe, measure, and understand the dynamics involved. Without this information, patterns of variability will be unobserved, alternatives will go untapped, and a supply-demand mismatch—which is often unnecessary—will be inevitable and chronic.⁵⁰

VA data and analytical systems face these challenges. In addition to the need for fundamental policy guidance, VA data systems and U.S. data collection efforts have limitations that hinder planners' ability to assess how demand for VA services might change over time. For example, there has not been a full accounting of the U.S. Veteran population since the 2000 Census. Current VA data collection systems do not assess detailed information on Veterans' health care conditions and health care utilization patterns. Data are often completely unavailable for Veterans who are not currently eligible or enrolled in VHA health programs. Additional data collection would be needed to fully understand Veterans' total health care needs, including use of care currently covered by private insurance or Medicaid.

Assessment A (Demographics) also suggests the importance of developing methods and models that respond with speed and agility to policy changes. Two existing VA models—the Enrollee Health Care Projection model and the Veteran Health Care Scenario Model—can be used to estimate, for instance, how changes in demographic characteristics or economic conditions may affect demand for VA services and related costs. Expanding these models to address changes in the civilian health sector, unanticipated changes in perceptions about health care quality, and groundbreaking new technologies will enable VA to address the types of uncertainties that current models may not address.⁵¹

Other assessments identify additional demand modeling requirements that would enhance health care provided to Veterans. These requirements would address challenges in facility planning and supply-chain management. These models could answer the need for an enterprise-wide, timely, population-based ambulatory appointment demand modeling capability to forecast appointment demand. They also could provide the basis for staffing models that justify the number of resources needed to meet patient access standards and to proactively identify and forecast staffing needs.

VHA should expand its utilization of dynamic simulation modeling. The fundamental premise of the application for dynamic simulation modeling in health care is that “health care delivery systems are inherently complex, consisting of multiple tiers of interdependent subsystems and processes that are adaptive to changes in the environment and behave in a nonlinear fashion.”⁵² Traditional analytical methods might neglect the wider health system impacts that can be critical for achieving desired health system goals. VHA leadership could underestimate or ignore the interactions among the leadership, governance, operations, and data and tools. The literature is beginning to highlight the increasing application of dynamic simulation

⁵⁰ This information was presented in Institute of Medicine Assessment D (Access Standards) in Volume II.

⁵¹ This recommendation was derived from RAND Corporation Assessment A (Demographics) in Volume II.

⁵² Marshall, D.A. et al. (2015, January). Applying dynamic simulation modeling methods in health care delivery research—The SIMULATE checklist: report of the ISPOR simulation modeling emerging good practices task force. *Value Health*. 18(1):5-16. doi: 10.1016/j.jval.2014.12.001

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modeling methods to health care delivery systems. These tools enable the decision maker to better understand the dynamics and complexities of the system under analysis and the consequences, both intended and unintended, of recommended changes.

In summary, VHA should use predictive tools and dynamic simulation modeling to continually forecast local demand and underpin decisions addressing resource allocation. These patient-centered demand models should enable the management of resources to meet national, regional, and local variations in patient-centered demand.

Two examples of dynamic simulation modeling methods applied to health care delivery:

- 1) “The Mayo Clinic’s Center for the Science of Health Care Delivery applied health care delivery systems thinking to predict the minimum number of beds needed to meet quality standards of care. The model incorporated assumptions about surgery growth and new patient recovery protocols, as well as smoothing surgery schedules and transferring long-stay patients from the ICU. The model predicted 30% lower bed supply requirements than did the traditional bed planning approach. System dynamics modeling was used for high-level planning of primary care staffing; allowing for ‘what-if’ scenarios to be evaluated, and showing projected access performance measures.
- 2) “The ReThink Health model simulates the behavior of a health system, tracking changes in health status, utilization, and costs and has been used to evaluate five different health reform policy proposals. The results demonstrated that certain options would improve health status but at higher cost and greater health care inequality. Other options were found to improve health status, reduce inequalities, and lower costs. Such divergent outcomes would be extremely difficult to anticipate or quantify without the aid of a simulation model.”

Applying Dynamic Simulation Modeling Methods in Health Care Delivery Research—The SIMULATE Checklist

Clarify and simplify the rules for purchased care to provide the best value for the patients.⁵³

One of VHA’s core responsibilities involves providing health care services to eligible Veterans. Although VHA has traditionally carried out its health care role primarily by operating a national network of hospitals and other facilities, the agency also administers a purchased-care function through which it pays for health care services from outside providers (sometimes referred to as purchased care or community care). VHA purchased care has evolved primarily to address situations in which VHA’s direct-care resources are unable to offer needed services to Veterans. Although purchased care has accounted for only a small fraction of VHA’s health care budget over the past decade, that fraction is growing. In the wake of the recent crises in access to care through VHA facilities, stakeholders and policy makers are revisiting the role and performance of VHA purchased care. Specifically, they are considering whether modifications to VHA’s purchased-care approach might be desirable, given broader goals of expanding access to care,

⁵³ This information was presented in RAND Corporation Assessment C (Care Authorities) in Volume II.

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enhancing trusted partnerships, and improving VHA operations to deliver seamless and integrated support for Veterans' health.

The purchased care landscape is already in the midst of a transformation. Numerous changes to VHA's authorities and mechanisms for purchasing care are being proposed, planned, or implemented. With so many facets of purchased care authorities and practice in flux, the full landscape of VHA purchase care is not just complicated, but dynamically so. Moreover, while the proposed policy changes aim at addressing many different problems and issues, their sheer multiplicity suggests the drawbacks of a piecemeal approach, absent a guiding orientation and strategy for VHA's purchased care enterprise as a whole. To enhance the availability of purchased care to the patient, VHA should:

- Develop a stronger management structure for purchased care and allocate responsibility and authority to the most appropriate levels. VHA purchased-care activities require improved program management, with responsibilities assigned to organizations at the appropriate level of VHA's administrative hierarchy.
- Establish an ongoing process for evaluating third-party administrator performance. VHA should also assess the adequacy of the provider networks, the efficiency of claims and other processes, and Veteran experiences with the programs.
- Develop clear and consistent guidance and training on VHA's authority to purchase care. Existing VHA guidance pertaining to purchased care is scattered, sometimes outdated, and inconsistent in setting clear standards, leaving local facilities to develop their own policies and procedures.
- Ensure that both new and existing purchased-care contracts with outside providers and third-party administrators include appropriate requirements for data sharing, quality-of-care reporting, and care coordination.

"Today we have seven different programs for providing community care. Each one has its own exclusions, each one has its own payment options. It's incredibly confusing."

*Secretary Robert A. McDonald
House Veterans Affairs Committee Hearing on VA
Health Care Budget*

July 22, 2015

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5 Operations

Finding 2: Uneven bureaucratic business operations and processes	
Recommendation 2—OPERATIONS: Develop a patient-centered operations model that balances local autonomy with appropriate standardization and employs best practices for high-quality health care	
Right size and reorient the VHA Central Office to focus on support to the field in its delivery of care to Veterans.	
Fix substandard processes that impede the quality of care provided to the Veteran.	
Design and implement a systematic approach to identify best practices and disseminate them appropriately across the enterprise.	

CURRENT STATE

There is recognized variability in the execution of business operations across VHA. Many VA Medical Centers implement operations differently, resulting in widespread inconsistencies across the organization. Multiple assessments, including Assessments E (Workflow – Scheduling), F (Workflow – Clinical), G (Staffing/Productivity), I (Business Processes), and J (Supplies), found differing approaches to staff management, scheduling, quality measurement, documentation and coding, patient flow, performance management, claims, and purchased care. Multiple assessments also found support functions (e.g., HR, IT, and Contracting) that do not adequately meet the needs of the medical centers in the delivery of patient-centered care. In some cases, the lack of standardization and local variations contribute to the direct and negative impact on the overall Veteran experience and timely access to care. In 2014, the VA OIG reported that a lack of common business rules “has resulted in quality of care deficiencies.”⁵⁴ In other cases, the assessments found local implementations and best practices that are creating positive outcomes (e.g., shorter length of time to hire); however, when process improvements occur at the local level, they are often not shared or do not scale across other facilities. These widely varying processes also highlight the complexity of the VHA system. Severe problems may manifest themselves at one facility, while another constantly receives tributes from Veterans and health care experts.

To operate effectively and provide the best care to Veterans, VHA needs to increase the empowerment of local leaders while simultaneously increasing the standardization of critical operations and processes. There is a need for greater support and flexibility for those providing care at the local level as well as a need for improved processes to more reliably support Veteran care across the system. Addressing these imperatives simultaneously is not simple. As one senior leader stated, “We can’t figure out what to standardize...We tend to standardize everything and nothing at the same time.” VHA needs an operating model that will encourage

⁵⁴ U.S. Department of Veterans Affairs. Office of Inspector General. (2014). Part II: Performance section. Major management priorities and challenges. Retrieved from: <http://www.va.gov/oig/pubs/VAOIG-2014%20MMC.pdf>

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both standardization and the appropriate level of local autonomy, focusing on providing Veterans with high-quality health care.

Some observed areas in which the current VHA operating model does not support well-defined, consistent, and standard processes—causing variability in the system and possibly resulting in a negative Veteran experience—include the following:

- The length of the HR-directed hiring process for all VHA staff was cited as a challenge in 100 percent of 19 staffing workshops conducted by Assessment F (Workflow – Clinical). The VHA hiring timeline significantly exceeds private-sector benchmarks, affecting VHA's ability to fill vacancies on patient care teams. VHA targets 60 days from receiving a request for a job posting to making a tentative offer, but it does not include the steps needed and time required to make a final offer. Interviewees and workshop participants consistently reported that hiring exceeds the 60-day target, reaching approximately six months for most clinical occupations.
- As Assessment E (Workflow – Scheduling) found, many private-sector systems have adopted larger, more centralized scheduling call centers that have lower per-unit costs; put less stress on space-constrained care facilities; and are able to offer more coaching, training, and career options to schedulers. Some of these have resulted in significant improvements. Since 2008, for example, Cleveland Clinic's centralized scheduling call center has enabled a 28-percent decrease in abandoned calls, a decreased scheduling error rate, increased physician utilization of scheduling templates, and a 12-percent increase in the number of patient visits. That organization believes it was "able to capitalize on economies of scale," scale that should be available to VHA.⁵⁵ But VHA scheduling call centers, where they exist, are operated at the VAMC level to address local needs. These call centers are not tracked or coordinated on a national scale, and there is no centrally available information about VHA's scheduling call centers, including how many call centers exist, what functions they serve, or how many schedulers they employ. As one interviewee suggested, "It would be nice to know where else there are [scheduling] call centers and talk to them." Since these centers are not tracked or coordinated, there is no effort to share best practices. In response to a data call generated by Assessment E, the vast majority of schedulers operate in clinics with only a small percentage actually operating in what VHA considers call centers. The call centers that do exist tend to be fairly small, with a median size of 12 schedulers, compared to most private-sector health systems that have an average of 28 agents. In response to the same data call, VA facilities reported that the average speed of answer (ASA) was 79 seconds and the average abandonment rate was 11 percent. In comparison, average private hospital call centers achieve a 32-second ASA and a 5.15-percent abandonment

⁵⁵ Rodak, S. (2013, August 8). Cleveland Clinic's call center improves care access. *Becker's Hospital Review*. Retrieved from <http://www.beckershospitalreview.com/capacity-management/cleveland-clinic-s-call-center-improves-care-access.html>

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rate.⁵⁶ On average, Veterans are waiting longer to reach a VHA scheduler and give up at a greater rate than private-industry patients.

- Assessment J (Supplies) indicates that the organizational structure of VA's supply chain enterprise is unduly complex and duplicative. VA and VHA both contain multiple organizations that play a role in managing VA's medical supply chain and, as a result, there are areas of overlap and tension between involved groups. There is a recognized stovepiped and fragmented structure with a lack of clarity on roles and responsibilities. VA's IT and data systems in the supply management area are also antiquated, not integrated, and they do not meet the needs of a modern health system. There are multiple instantiations of the underlying architecture for VA's clinical, procurement, and inventory management systems, each with its own product nomenclature and numbering system as well as extensive free-text entries. As a result, efficient and effective cross-site comparisons or regional and national rollups are not feasible. VA's current inventory management does not have a feedback loop that links inventory to product utilization, contracting, ordering, and vice versa. This prevents optimal use of the Medical Surgical Prime Vendor program and prohibits more effective volume-based national or regional contracts. VA has not taken full advantage of its scale or potential for product standardization to achieve optimal pricing and efficiency. An analysis of unit prices for facilities across two VISNs showed significant variation in price paid for identical items.⁵⁷ For example, the highest price paid for a commonly used disposable blood pressure cuff was more than twice the lowest price. An analysis of purchase order data shows that 38 percent of purchases are made on a government contract, with the remainder through open-market purchasing. VA's supply purchasing systems are not integrated with contract or pricing catalogs, requiring the buyer to research whether an item is on contract and, if so, through which contract a purchase should be made. Several buyers reported that they bypass this step and buy products through the channel that is most familiar and convenient rather than potentially exploiting new contracts and pricing arrangements. VA also has limited ability to monitor and drive compliance with contract requirements because the required data are not captured electronically. More than 60 percent of all clinical supply items do not have a contract number listed.⁵⁸ Finally, VA does not have a mechanism to identify products for which central contracts should be established.

Exacerbating these challenges is the recognition that, as Assessment L (Leadership) identifies, VHA Central Office (VHACO)—consisting of a series of individual, highly unintegrated program offices—does not yield the coordination and collaboration required to support the field in its delivery of care to Veterans and adequately address the variability in the system. VHACO has experienced dramatic growth in the number of program offices and staff over the past five years, with VHACO program office full-time equivalent (FTE) growth vastly outpacing the

⁵⁶ Belfiore, B., et al. (2015, January 28). 41 KPI Industry Report: Health Care – Provider/Hospitals. BenchmarkPortal.com. Retrieved from <http://www.BenchmarkPortal.com>

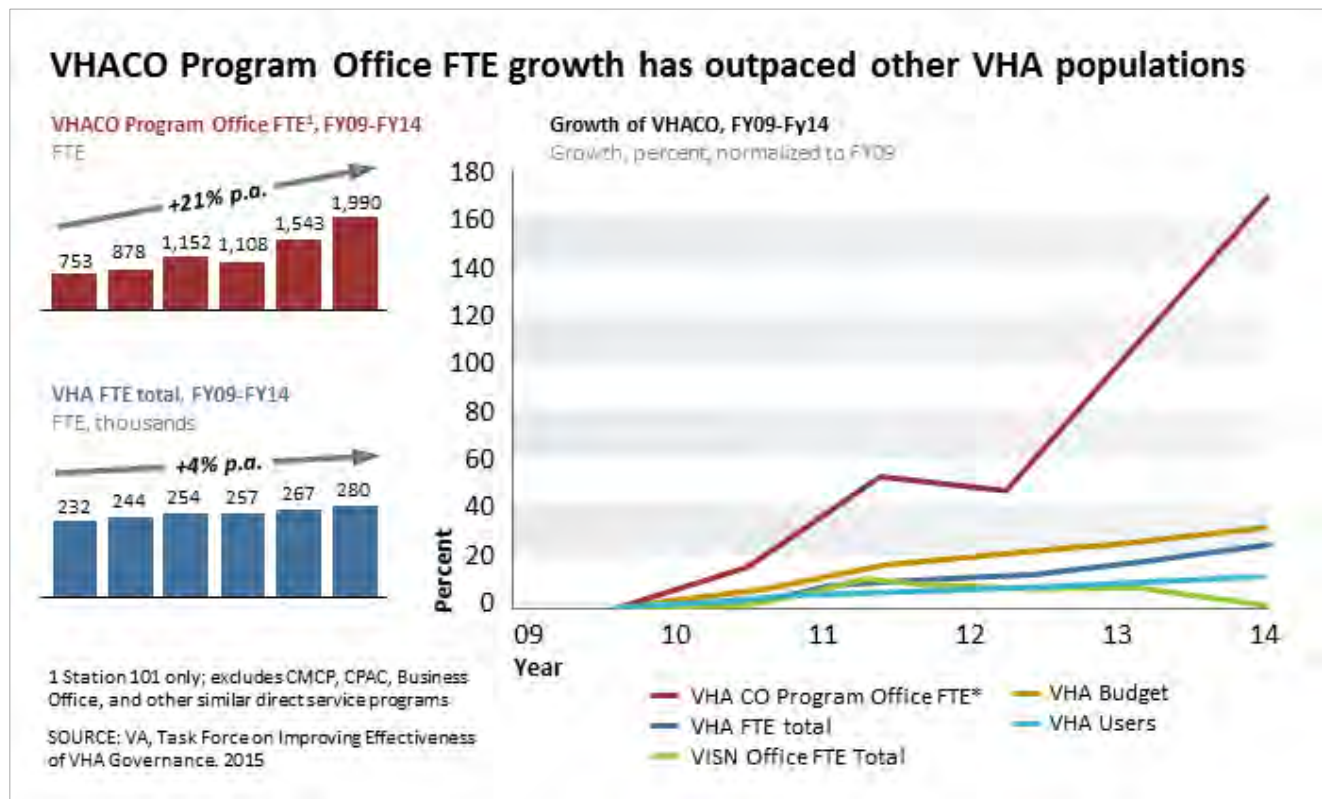
⁵⁷ U.S. Department of Veterans Affairs. (2014). IFCAP Purchase Data for Five VISNs.

⁵⁸ U.S. Department of Veterans Affairs. (2014). IFCAP Purchase Data for Five VISNs.

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growth of total VHA employee population and Veterans served (Figure 6).⁵⁹ However, in spite of program office growth, there is little systematic effort to coordinate or integrate efforts and initiatives, and there has been no discernible improvement in business or health outcomes in VHA as a result of this growth.⁶⁰ Instead of alleviating the administrative burden on the field, the growth of VHACO has had the inverse effect, creating an environment where the field is serving VHA Central Office.

Figure 6. VHACO Program Office FTE Growth



Further, the Central Offices—VACO and VHACO—are not playing a key and necessary integrator role to help spread best practices across the organization.⁶¹ While pockets of best practices and innovation exist, the assessments found the adoption of best practices to be isolated, sometimes even within the same facility. While in many cases local best practices and innovation are allowing specific VAMCs to maximize operational efficiency and positive Veteran experience, these best practices are not systematically shared and adopted across VAMCs.

⁵⁹ U.S. Department of Veterans Affairs (2015, February 28). Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health.

⁶⁰ U.S. Department of Veterans Affairs (2015, February 28). Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health.

⁶¹ The information in this section is derived from McKinsey & Company Assessment I (Leadership) in Volume II

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“As best the Task Force could determine, the addition of new program offices occurred on the basis of ad hoc decisions by VHA leadership. There was no systematic review by an internal resource committee or by NLC [National Leadership Council] committees for which they were responsible and there was no systematic review to determine if they had been successful in improving organizational outcomes. Similarly, there was no process for systematically reviewing requests for additional [full-time equivalent] or resources for a given office. Finally, there was no process at the organizational level such as review by the collective senior VHA CO leadership, by the resource committee, or by the NLC itself for formulating clear recommendations on how much funding from the VHA budget was to be set aside for VHA CO program offices versus allocated to the field for providing direct care to Veterans.”

*Task Force on Improving Effectiveness Of VHA Governance:
Report to the Under Secretary for Health*

As one previous assessment of VHA points out, “There is no mechanism for sharing scheduler tips and best practices for using the systems or to improve scheduling activities. Seasoned schedulers share their insight and lessons learned by word-of-mouth.”⁶² A recently published internal VHA report titled “Task Force on Improving Effectiveness of VHA Governance—Report to the VHA Under Secretary for Health” reached a similar conclusion. As that report suggests, “there has been little or no ongoing effort to share best practices or standardize procedures among either VHACO program offices or VISN offices.”⁶³

RECOMMENDATIONS

- Right size and reorient the VHA Central Office to focus on support to the field in its delivery of care to Veterans.
- Fix substandard processes that impede the quality of care provided to the Veteran.
- Design and implement a systematic approach to identify best practices and disseminate them appropriately across the enterprise.

“I’m shameless about stealing what works at other places. The problem is, I don’t know what other places are doing. We need a way to connect, to learn from each other.”

Associate Director of Patient Care Services

⁶² Northern Virginia Technology Council. (2014, October 29). Opportunities to improve the scheduling of medical exams for America’s veterans: A report based on a review of VA’s scheduling practices by the Northern Virginia Technology Council (NVTC). Retrieved from <http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf>

⁶³ U.S. Department of Veterans Affairs. (2015, February 28). Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health.

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Right size and reorient the VHA Central Office to focus on support to the field in its delivery of care to Veterans.⁶⁴ As Assessment L (Leadership) concludes, VHA should adjust the balance of control and empowerment across all levels of the organization by clarifying decision rights, offering greater role clarity, empowering leaders, and encouraging appropriate risk taking. VHA should refocus the role of VHA Central Office to managing outcomes and providing support to the field. Specifically, VHA should clarify the roles and responsibilities of each major operating unit: VHACO, VISNs, VAMCs, community-based outpatient clinics (CBOCs), and other organizational units. Once this clarification is achieved, the VHA Central Office should focus on enhancing collaboration, supporting resource prioritization, executing certain centralized functions, ensuring alignment with strategic direction, and, most importantly, supporting the field. The intent of this is to move from a series of individual program offices issuing independent directives and action items, with few mechanisms to encourage coordination, to a much smaller number of coordinated primary strategic priorities, or lines of business, around which supporting program offices would be organized and through which supporting program office work would be conducted.

“Program offices should be a consultancy—a small group of people. There should be more oversight of the Program Offices, because there are turf issues that leave the Field constantly answering to everyone.”

VHACO Leader

In addition, VHA should:

- Reassess all VHA Central Office-directed metrics and policies to ensure that they add sufficient value to patient outcomes and eliminate those that do not.
- Release process guidance on a regular and routine schedule to medical centers to enhance coordination and to minimize the disruptive effect of new, frequent, and duplicative directives on existing guidance.
- Create policy communication standards that require that any new policy includes a clear rationale tied to desired outcomes, recommended approach, suggested local implementation plan, and sufficient time to implement.
- Increase alignment and coordination between the offices responsible for policy and the offices responsible for operations by actively eliminating the “artificial distinction between policy and ops”⁶⁵ that exists today.
- Clarify the decision rights of VACO, VHACO, VISN, and the Medical Center, to include clearly articulating decision rights by level, organization, and role and standardizing where appropriate while allowing for local flexibility based on local needs.
- Define the role and responsibilities of the VISN (or any other local structures being considered), the balance between empowerment and support of medical facilities, and

⁶⁴ The information in this section is derived from McKinsey & Company Assessment L (Leadership) in Volume II.

⁶⁵ (2015). Choice Act assessment interviews with VHA.

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the VISN role in coordinating, translating, communicating, and innovating across the system.

- Coordinate with VACO to select a chief information officer (CIO) for VHA to identify and advocate for health IT needs and to measure the value of IT services and capabilities for health care.
- Implement a more participative management approach that engages leadership at all levels in analyzing problems, developing strategies, implementing solutions, and measuring and tracking outcomes. Doing so would create a greater sense of ownership in VHA; instill a sense of commitment, safety, and pride among VHA leaders; create more receptive conditions for implementing change across the organization; and serve as a breeding ground for future leaders. In addition, as one journal suggests, “creativity and innovation are two important benefits of participative management.”⁶⁶

Fix standard processes that currently impede the quality of care provided to the Veteran.

The independent assessments provide substantive and detailed recommendations to address many of the operational challenges that impact VHA’s ability to provide timely and consistent patient-centric health care. At an overarching level, VHA needs an operating model that provides medical centers with the autonomy and flexibility to innovate and address local needs while also providing standardization across the system to allow for more consistent and efficient delivery of Veteran care. As one VHA senior leader stated, “We need to identify key business processes that have to be standardized, such as scheduling, and standardize those things ruthlessly. We need fidelity in the system to run the business.”

In addition to the need for more consistent and efficient key processes, findings support the need for a fundamental overhaul of the core support functions of HR, IT, and Contracting to increase responsiveness and efficiency and improve customer service. These functions should be aligned with the needs of the VHA organizations delivering care to Veterans and hold those organizations accountable to outcome-based metrics to enable timely and effective care. This is consistent with the recent guidance from the Office of Management and Budget (OMB) in response to the Federal Information Technology Information Reform Act (FITARA), which enhances agency CIO authority while requiring that officer to focus on and be explicitly accountable for assuring that agency IT resources support agency mission and programs (i.e., are aligned with requirements of VHA mission and programs). While the scope of the existing statutory provisions address IT, the intent can be extended to other support functions (e.g., Contracting, HR).⁶⁷

The department has already taken some action to address the current deficiencies in VA support functions. MyVA established as one of its five focus areas “Achieving Support Service Excellence,” with a stated mission to “optimize the organization, functions, and activities of VA’s core support functions that focus on delivery of world-class services to VA facilities and

⁶⁶ McMillan, A. (n.d.). Participative management. [Website]. Reference for Business. Retrieved from <http://www.referenceforbusiness.com/management/Or-Pr/Participative-Management.html>

⁶⁷ For more information on FITARA, see The MITRE Corporation Assessment H (Health Information Technology) in Volume II.

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organizations that directly serve Veterans.” The assessments’ findings and recommendations support the following aspects of the “vision of the future” for VA support services as stated in the MyVA Transformational Plan:

- A collaborative process that produces clear business requirements and processes as well as accountable service-level agreements (SLAs) for support services.
- Integrated contracting and supply-chain activities that directly support delivery of Veteran outcomes.
- HR functions aligned to support facility directors with timely hiring, benefits, and employee relations.
- Fully integrated VA-wide information capabilities, supported by IT operational capabilities optimized to meet expectations at point of service.⁶⁸

Design and implement a systematic approach to identify best practices and disseminate them appropriately across the enterprise. To improve overall operational performance, VHA must create a systematic way to identify, share, and scale the solutions and best practices achieved by its top performers and those of other organizations. Coordinated reviews and assessments of identified best practices should be conducted to determine if the practices are scalable across the organization. The VHA Central Office should provide strategic guidance and should support establishing and implementing the approach. It would then be an appropriate role of the VISN to lead the best-practice identification and to share ideas within and across the enterprise, working collaboratively with VAMC leaders and staff. A clear example of the impact of such an approach was observed in VISN 4 as described in Figure 7.

While VHA has numerous assets in place to identify and spread innovation and best practices, these resources have not taken hold. VHA’s current culture and organizational structure, which allows for differing VISN business models, do not support standardization or effectively leveraging best practices on an enterprise basis. VHA should strive to standardize when it can and enable variation and innovation when it should. The National Leadership Council, or another identified advisory board, must be empowered by senior leadership to systematically review and consider which best-practice assets support and align to strategic outcomes such as Veteran satisfaction and access. In performing this review, the advisory board should consider the following:

- Integrating best practices with performance management and encouraging collaboration across VAMCs; those medical centers that are not performing as well as others should be encouraged to adjust their processes by leveraging others’ approaches.
- Developing an implementation strategy that migrates best practices from high-performing to lower performing facilities.

⁶⁸ U.S. Department of Veterans Affairs. (2015, April 14–15). MyVA Advisory Committee: Inaugural meeting [PowerPoint slides].

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- Evaluating the current use and efficacy of the Virtual Learning Center (VA's current online database with shared innovations, best practices, and lessons learned from VAMCs and CBOCs) for capturing and disseminating best practices.
- Developing criteria for rationalizing the best practices that should be performed at a local versus regional or enterprise level. For example, where national economies of scale can be achieved versus where local issues (e.g., demographics) prohibit broader application.

The above recommendations recognize that the best practices found in one facility or VISN will be an excellent source of inspiration and guidance for their peers, but it is important not to expect every best practice to be equally effective or implemented exactly the same way in every location.

Figure 7. VISN 4 Best Practices



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6 Data and Tools

Finding 3: Non-integrated variations in clinical and business data and tools
Recommendation 3—DATA and TOOLS: Develop and deploy a standardized and common set of data and tools for transparency, learning, and evidence-based decisions
Use standardized clinical and administrative data for accuracy and interoperability.
Implement a single, integrated set of system-wide tools centered on a common electronic health record (EHR) that is interoperable across VHA and with DoD and community provider systems.
Transparently share performance metrics for leadership, clinical, and business functions across VHA to identify and adopt best practices for continuous improvement.

CURRENT STATE

Multiple assessment efforts identified challenges in collecting, managing, and effectively using data:

- A lack of standard, interoperable enterprise VHA systems and tools negatively impacts VHA's operations and resulting data.
- The quality of data and multitude of metrics limit VHA's overall performance and continuous improvement efforts.
- VHA lacks a holistic, enterprise approach to managing, collecting, and leveraging its data.

In addition, Assessment H (Health Information Technology) identified several key challenges in VA's use of information technology. Inadequate collaboration between VA's centralized IT organization and VHA has precluded the implementation of capabilities that support VHA health care needs. Due to excessive project management overhead, a complex legacy IT infrastructure that is difficult to modernize, and more than 130 variations of the primary software system deployed across VHA medical facilities, the implementation of improved IT capabilities in the last 10 years has been extremely limited. During that time frame, VA applied the majority of its development resources to HealtheVet and the integrated EHR (iEHR) projects, both of which failed to provide the expected results. This delayed further development and improvement of VistA and CPRS so that they are no longer leading-edge products and are in danger of becoming obsolete. Scheduling, telephone, and billing systems have stagnated, and there is no strategy and roadmap for scheduling initiatives across VA that integrates Veteran access to scheduling via phone, telehealth, and mobile apps. Inconsistent and ineffective data collection across VA medical facilities has prevented evidence-based assessments that would inform capability improvements. VA is falling significantly behind the private sector in using data to improve all aspects of Veterans health care.

Enterprise Data: VHA's operational environment is plagued by a significant level of fragmentation and a lack of standards. Data aggregation across the entire VA system is problematic when each system either lacks standards or conforms to different, local data

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standards.⁶⁹ This constrains VHA's ability to recognize organizational trends, identify best practices, and assess the effectiveness of health care delivery services across the entire VHA system. Efforts to access data in support of these assessments illustrated some of the issues plaguing the operational environment. Several data discrepancies and data quality issues were noted. Some data routinely maintained by other health care systems were simply not available.⁷⁰ Three different VHA sources had to be accessed to obtain lab data. Each source resulted in a different answer, and various groups within VHA did not know how to reconcile these three sources or which source provided the most accurate information.⁷¹

The impact of these enterprise data issues was evident across various assessments.

- VHA maintains several different systems to manage access and flow; however, a lack of integration across systems, inconsistent methods for tracking data, and gaps in key flow metrics results in highly variable, non-actionable demand and capacity data. While the National Bed Control Database showed that 81 percent of one VAMC's inpatient beds were operational, that facility reported that only 51 percent of its beds were available for patients due to unreported staffing and construction-related bed closures.⁷²
- Systems limitations often demand manual processes that can obviously reduce the timeliness and accuracy of data and obscure the true state of VHA's activities. In FY2014, 28.6 percent of claims for non-VHA-provided care were submitted via Electronic Data Interchange, versus a 94-percent benchmark for commercial claims in civilian practice.⁷³ Significantly relying on manual processes slows collections and payments activities and introduces errors and waste into the process.
- There is a lack of quality, system-wide data for developing predictive models to prospectively match provider availability with patient needs.⁷⁴ Such models are built on important inputs (such as aggregated views of provider availability) and allow

"Greater issue is lack of standardization of code sets. One aspect of data standardization is in lab tests—any given site may name it any number of ways, ex. hemoglobin tests. That site may know what it means. When you roll it up nationally—have a lot of variability. Reference ranges can be different. Different sites use different lab instances."

Office of Informatics and Analytics Leader

⁶⁹ This information is presented in The MITRE Corporation Assessment H (Health Information Technology) in Volume II.

⁷⁰ This information is presented in McKinsey & Company Assessment F (Workflow – Clinical) in Volume II.

⁷¹ Decision Support System Lab data sets, Medical Statistical Analysis System data sets, and Corporate Data Warehouse inpatient and outpatient sources.

⁷² This information is presented in McKinsey & Company Assessment F (Workflow – Clinical) in Volume II.

⁷³ This information is presented in Grant Thornton Assessment I (Business Processes) in Volume II.

⁷⁴ This information is presented in McKinsey & Company Assessment E (Workflow – Scheduling) in Volume II.

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for important activities, including assessing the likelihood of patients missing appointments (so that they can be targeted for more proactive individualized appointment reminders or other interventions to increase likelihood of appointment completion); aggregated views of provider availability; and facility-centralized patient reminder systems across multiple modalities. Thus, this lack of data and data management systems compromises the ability to maximize provider availability for treating patients.

- Measuring each health care provider's productivity is challenged by several issues. First, while work Relative Value Units (wRVU) are "the current tool for physician productivity measurement in the clinical arena, a more complete productivity measurement would capture the sum total of a physician's contribution."⁷⁵ For example, the wRVU does not reflect patient satisfaction with the encounter or the provider's effectiveness in improving the patient's health outcomes. The accuracy of productivity, when measured by wRVUs, is dependent on accurate and thorough coding and documentation practices; during site visits, assessment teams observed a general lack of local infrastructure to assist providers and nurses in accurately and comprehensively documenting all encounters.⁷⁶ VHA does not capture FTE-level information for its fee-based care providers, which limits its ability to systematically track fee-based provider productivity. The proportion of clinical workload generated by fee-based physicians represents 13 percent of all physician workload and may be higher at smaller facilities where fee-based providers can be a greater proportion of specialty care provided. VHA uses multiple standards to measure its primary care panel size that rely on local interpretations of policy and a range of situational factors (for example, whether the panel is a specialized panel such as geriatric or home-based primary care, and adjustments for new providers based on start dates).
- VHA also lacks the data governance to define and implement standards and business rules to ensure consistent data definition, integrity, and documentation. During the course of our assessments, documentation related to VHA's data also presented issues. Dozens of sources of documentation describing the various types of data are scattered throughout VHA. This requires analysts to sift through many different intranet sites and encounter totally different documentation styles with varying levels of usefulness.

Enterprise Tools: Discussions with industry executives identified a number of system capabilities that are essential to operating a high-performing health care system, to include a common electronic health record (EHR) and tools that enable scheduling, billing, claims payment, and patient-centered navigational tools.⁷⁷ Standardizing these capabilities and implementing them at an enterprise level results in information and care continuity, cost

⁷⁵ Reddy, V. Seenu & Johnston, Ben. (2012). Surgeon productivity: are RVUs the end all, be all? The Society of Thoracic Surgeons. Retrieved from <http://www.sts.org/news/practice-management-pearls-surgeon-productivity-are-rvus-end-all-be-all>

⁷⁶ This information is presented in Grant Thornton Assessment G (Staffing/Productivity) in Volume II.

⁷⁷ Several health executives also highlighted the need for an Electronic Medical Library (EML) that includes a single set of clinical care protocols. VHA's EML was not assessed as part of this effort.

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savings, and consistent care delivery and business processes. The strategy should be standard across the enterprise wherever and whenever possible, and vary locally when needed. The timely and accurate enterprise data produced through these system capabilities are of particular importance as they provide the means to optimize the overall performance of the health care system. In addition, the potential of dynamic simulation modeling to underpin decisions enabling the delivery of health care is increasingly being realized and should be exploited. Our findings related to each of these important components is discussed below.

- Electronic Health Record:** An EHR represents the core of VHA's VistA system. As outlined in Assessment H (Health Information Technology), customized implementations of VistA at the VAMC level that do not all employ standard data elements and algorithms has resulted in approximately 130 instances of VistA across VHA, leading to a complex, heterogeneous mix of hardware and software, which impedes developing and deploying system changes and new capabilities and raises operations and maintenance (O&M) costs. Those instances are not well documented, further complicating efforts to upgrade and maintain the system and to conduct end-to-end testing outside of the operational environment. VHA's EHR issues stymie interoperability between VHA facilities as well as with DoD and non-VA providers. Multiple assessments noted the lack of interoperability resulted in incomplete patient records with potentially significant implications for the Veteran and VHA. This is not a trivial issue, and multiple solutions have been attempted over the last several years without success. Nevertheless, it remains a crucial issue. Incomplete records introduce unnecessary clinical risk, complicate the transition from DoD to VHA care, and inhibit VHA's ability to bill and collect revenue accurately and timely.⁷⁸
- Scheduling:** VistA is also VHA's primary scheduling tool. As highlighted in Assessment E (Workflow – Scheduling), VHA scheduling tools do not provide facility staff with the capability to effectively match patient requirements to provider availability. In addition, the tools do not provide information that allows clinic management to improve scheduling performance. For example, because providers operate across multiple and sometimes overlapping clinic schedules, also known as "profiles," calculations of aggregate appointment slot supply and therefore appointment slot utilization rates are not always correct in clinic access reports. VHA has created additional operational processes to address the recognized state of imbalance for supply and demand for appointments. Essentially, staff had to employ additional processes to work around system limitations. Current processes and infrastructure concerning the scheduling systems reduce the ability of clinics to maximize the use of provider time.
- Billing:** Assessment I (Business Processes) noted significant shortcomings in the systems and tools supporting VHA's billing and collections activities. Technical capabilities typically seen in private health care systems are lacking or absent in VHA. For example,

⁷⁸ On July 29, 2015, the Department of Defense awarded a contract to a commercial team for "an electronic health record off-the-shelf solution, integration activities and deployment across the Military Health System." See <http://www.defense.gov/News/Contracts>.

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automated tools for providing real-time estimates of out-of-pocket expenses, electronic submission of Veteran payment plan forms, and automated first-party claims matching do not exist at VHA. In addition, Assessment I lists more than 10 systems and tools used to support VHA's billing process. Lack of integration and interoperability between billing systems and tools (e.g., VistA and Nuance) slow billing activities and introduce potential errors in data as staff are required to enter redundant data into different systems. In fact, VA billing staff are manually reviewing 100 percent of claims subsequent to automated claim edits. This manual process is typically limited to 10–20 percent for industry.

- Claims Payment:** VHA's claims payment activities are similarly burdened by lack of automation, multiple systems that are not integrated, and a significant amount of manual work. Specifically, automation is lacking in VHA's primary claims system, Fee Basis Claims System (FBCS), requiring VHA staff to scan the majority of the paper claims into FBCS and manually adjudicate claims. In addition, non-VA providers do not have visibility into the status of their claims. FBCS does not support certain types of claims for non-VA care, and these claims must be processed through VistA. Overall, the high reliance on manual processes slows payments activities, introduces potential errors (e.g., lost claims and misrouting of claims), and introduces waste into the process (e.g., providers filing duplicate claims due to delays in payment and a lack of easy visibility into their status). In addition, such reliance on these manual processes reduces the timeliness and accuracy of data and obscures the true state of VHA's financial activities.

"As a service-disabled Veteran, I know first-hand the challenges women face during military service and when they return home. I, like many women who served, did not understand on leaving military service the benefits and services to which I was entitled, despite the fact that I suffered an injury during my service as an Army medic."

*Disabled American Veterans Deputy National
Legislative Director Before the Committee on
Veterans' Affairs*

U.S. House of Representatives

April 30, 2015

- Patient-Centered Navigational Tools:** The *Voices of Veterans* report, published by VA's Center for Innovation in November 2014, lists two of its key themes as "Many Veterans don't know what benefits are available to them, or how to access them" and "Utilizing VA

"Almost everything I find out is either from another Vet or by accident."

*2014 Wounded Warrior Project Survey Report of
Findings*

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technology has severe limitations with some bright spots.”⁷⁹ The benefits available to the Veteran can be complex and difficult to understand. Making matters worse, the current suite of options and the navigational tools to explore available benefit options have proven challenging. Data presented by the MyVA initiative provide some perspective on the magnitude of this challenge, identifying more than 1,000 VA websites and more than 900 1-800 numbers. Further, Assessment A (Demographics) found that “among respondents of the National Survey of Veterans who report not using VA services, 12.4 percent (1.8 million) report that the barriers to access are a reason for non-use. If these obstacles are addressed, that assessment estimates that an additional 492,000 new patients will use VA for some of their health care needs.”⁸⁰

Metrics for Performance Management: VHA lacks a clear strategy to effectively apply its data and metrics to performance improvements, including distilling and prioritizing metrics to drive patient-centered outcomes. As Assessment B (Health Care Capabilities) notes, VHA has more than 500 quality measures to monitor quality of care regionally and locally, concluding that the proliferation of measures creates burdens on staff and resources and can lead to an emphasis on the measures rather than improving areas of care that are more likely to improve patient outcomes. One VACO leader stated, “Our problem is that we’re awash in data and don’t do anything with it.”

The Centers for Medicare & Medicaid Services defines quality measures as “tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care.”⁸¹ Among quality metrics, only a subset should be considered performance measures—those quality metrics with attributes rendering them suitable for explicit comparisons of care between institutions or health care providers.⁸² Rather than adopting the practice of many high-performing health care systems—where targets are balanced in support of the mission, and a limited number of key metrics are used to measure performance and drive outcomes—VHA has adopted a catch-all approach to performance management. As Assessment L (Leadership) notes, with 382 measures today in its 10-N National Performance Measures Report provided by interviewees, VHA is not setting clear, actionable organizational targets (10N NPRM, 2015). Further, there is widespread recognition of the overabundance of metrics and the need to simplify, with one VAMC director

⁷⁹ U.S. Department of Veterans Affairs. Center for Innovation. (2014, November). *Voices of Veterans: Introducing personas to better understand our customers - Findings report*. Retrieved from http://www.innovation.va.gov/docs/Voices_Of_Veterans_11_12_4.pdf

⁸⁰ This information is presented in RAND Corporation Assessment A (Demographics) in Volume II.

⁸¹ Centers for Medicare & Medicaid Services. (2015, April 17). Quality measures. [Website]. Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html?redirect=/QualityMeasures/03_ElectronicSpecifications.asp

⁸² Bonow, R. et al. (2008, December 9). ACC/AHA Classification of Care Metrics: Performance Measures and Quality Metrics. *Journal of the American College of Cardiology* 52(24), 2113–2117. doi: 10.1016/j.jacc.2008.10.014

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describing his perception of VHA's approach to setting performance measures as, "If 50 metrics are good, 100 must be better."

Ironically, the sheer number of performance measures and the limitations of the current performance management process make effectively tracking performance difficult. One of the VISN's roles is to ensure that performance targets are negotiated with VHACO and are being met at the VAMC level. This leads to regularly scheduled meetings with VAMC leadership to review binders of performance reports and requests for detailed corrective action plans when a measure needs improvement. These progress reviews generally focus on the weakest performance measures, contributing to a commonly held perception that metrics are used to identify weak performers rather than to help drive performance excellence.⁸³

"Moving away from blame allows an organization to learn from mistakes and conduct systematic improvement efforts based on that knowledge."

Bringing a Systems Approach to Health

This emphasis on those not meeting performance targets extends to reviews conducted by multiple internal and external organizations. The bureaucratic and highly politicized environment within which VHA operates has led to a dramatic increase in the number of assessments, administrative investigation boards, and root cause analyses of VAMC performance. This focus has led many of those interviewed to describe VHA's culture as "punitive" rather than constructive or incentivizing. While understanding where VAMCs are not working well is important, this focus on poor performers is limiting from a systems perspective because it does not expose the systemic findings or potential solutions. It is equally important to understand where things are going well and the lessons that can be drawn from those high-performing sites, where successful systematic improvements and best practices are taking place.

RECOMMENDATIONS

- Use standardized clinical and administrative data for accuracy and interoperability.
- Implement a single, integrated set of system-wide tools centered on a common EHR that is interoperable across VHA and with DoD and community providers.
- Transparently share performance metrics for leadership, clinical, and business functions across VHA to identify and adopt best practices for continuous improvement.

Use standardized clinical and administrative data for accuracy and interoperability. VHA must take a more comprehensive approach toward managing its data. A key prerequisite for an effective data management strategy is clarifying the demand expectations to inform the direction and priorities of the data strategy. With that direction in place, VHA's data management strategy should include:

⁸³ This information is presented in McKinsey & Company Assessment L (Leadership) in Volume II.

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- Identifying, rationalizing, and prioritizing VHA's data needs and uses enabled by common definitions and document templates
- Identifying the internal and external data sources and analytical products required to address these needs and assessing the sources and analytical products relative to users' requirements (timeliness, accuracy, completeness, volume)
- Implementing more formal management structures and tools to bring control to VHA's data environment (governance, standards, documentation repositories)
- Identifying potential resources to support the effort (budget, staff, tools)
- Defining an implementation strategy that sets a realistic path toward improving VHA's data environment—acknowledging and working within VHA's current challenges (existing issues with enterprise data).

Implement a single, integrated set of system-wide tools centered on a common electronic health record (EHR) that is interoperable across VHA and with DoD and community providers. Specifically, VHA should implement one-system wide:

- EHR system that is interoperable across the entire system and with DoD and community provider systems, beginning with a cost-versus-benefit analysis performed by VHA between a commercial off-the-shelf (COTS) EHR and the current VistA EHR
- Electronic claims payment system to pay for outside services
- Billing system to collect from other payers
- Patient-friendly scheduling system with modern, single toll-free-number call-center support
- Set of electronic decision support tools describing standard work housed in an electronic medical library.

Along with standardizing VHA processes as discussed in Section 5, a single, integrated set of common system-wide tools centered on an EHR will substantially help address the above issues. In addition, well-designed and developed systems and tools will help VHA enforce and automate business rules, allowing for greater process standardization and reducing variation across VHA. The VA and VHA CIOs should transform the VA IT strategy to a model based on best practices for enterprise IT services that will provide the capabilities that support improved governance, operations, leadership, health care quality, and patient satisfaction. VHA should consider the following recommendations:

- **In partnership with the VA CIO, the VHA CIO should oversee a comprehensive cost-versus-benefit analysis between a COTS EHR and continued in-house custom development of the VistA EHR currently in use.** As Assessment H (Health Information Technology) noted, the analysis should take into account all the complexities of the VistA and CPRS architecture and infrastructure and known issues with performance, scalability, extensibility, interoperability, and security. It should also address full life-cycle costs, including development time (based on recent delivery trends), availability of development resources, maintenance and licensing costs, and infrastructure costs. The VA and VHA CIOs should conduct site visits and review the successful IT practices

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implemented at high-performing health care organizations (including VISN 4) to inform their strategies for effective approaches and potential contributions that IT can provide to improve the treatment of Veterans today. Those approaches would address the challenge of providing billing and claims processing capabilities beyond what the existing VistA and CPRS currently provide.

- Focus on automation, integration, and interoperability for billing and claims.** As outlined in Assessment I (Business Processes), VHA initiated its Health Care Payment System (HCPS) as a replacement for FCBS to serve as VHA's centralized claims processing system and to address many of the issues outlined above. The system is approximately two-thirds complete; however, further development has been stalled by funding issues. VHA should resolve the HCPS funding issue to ensure that this needed functionality is delivered. An effort similar to HCPS is also necessary for VHA's billing process. Assessment I identifies a number of specific capabilities required for VHA's billing system, such as integration across patient intake, medical records, coding, and billing systems; single sign-on capability; automated first-party claims matching; real-time estimate of out-of-pocket patient expenses; and automation to support algorithmic edits and claims correction.
- Align patient-centered navigation efforts to the MyVA initiative.** In November 2014, VA announced the MyVA initiative to reorganize VA to better serve its Veterans. As stated by Secretary McDonald, "The reorganization, to be known as 'MyVA,' is designed to provide veterans with 'a seamless, integrated and responsive customer service experience—whether they arrive at VA digitally, by phone or in person.'"⁸⁴ Central to this theme is enhancing the Veteran experience, approaching the Veteran holistically (e.g., as one VA organization versus three administrations, independent of the channel used) and simplifying and facilitating their use of VA services. From a technology perspective, VHA currently supports its Veterans through a variety of channels, including kiosks located at facilities, call centers, web portals such as My HealtheVet, and mobile applications. VHA must identify and review the tools and channels used to support its Veterans and determine how these tools align with the MyVA initiatives and principles. Based on this assessment, VHA may need to drop, enhance, or expand VHA systems and tools or potentially adopt systems and tools being developed as a part of MyVA.

Transparently share performance metrics for leadership, clinical, and business functions across VHA to identify and adopt best practices for continuous improvement. VHA lacks a clear strategy for its performance measures.⁸⁵ As with its enterprise data management strategy, VHA must align its performance management strategy with its clarified mission. As VHA clarifies and focuses its mission, VHA must revisit its performance management approach to ensure that metrics are strategically aligned to the organization's outcomes and that timely and accurate

⁸⁴ Daly, M. (2014, November 10). VA announces "MyVA" plan, largest reorganization in department's history. PBS. Retrieved from <http://www.pbs.org/newshour/rundown/va-announces-myva-plan-largest-reorganization-departments-history>

⁸⁵ These recommendations are derived from McKinsey & Company Assessment L (Leadership) and several other assessments.

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data are available to support those metrics. VHA should consider the following in its performance management strategy:

- Focus and simplify metrics to clarify accountability and mission alignment. VHA should develop an integrated and balanced performance scorecard for VAMCs, focusing on a smaller number of core metrics that roll up to support the broader enterprise view. These metrics should focus on the mission, encourage cross-functional collaboration, and be carefully cascaded. This requires eliminating obsolete metrics while continuing to exploit the progress achieved with the Strategic Analytics for Improvement and Learning (SAIL) initiative.
- Evolve performance management along with enterprise data improvements. Given current data limitations, an effective performance management system will be limited in its ability to support leadership. Performance management relies on data that is trusted by those being measured. As the timeliness, accuracy, and consistency of VHA's data evolves, so can VHA's performance measures.
- Monitor the impact of the performance management strategy and the behaviors it promotes. Unrealistic performance targets may disengage staff or worse—they could result in unintended consequences or undesirable behaviors. At the high-performing health care systems that were visited, the use of performance management metrics that were aggressive and frequently not being met was discussed. Rather than apply punitive measures, these health care systems focused on achieving an overall trend in increasing organizational performance or operations within a specific range. The organizational performance metrics also served as an effective means of identifying those best practices that were enabling these organizations to demonstrate continuous improvement.
- Review industry standards to provide further transparency. Ultimately, VHA is responsible to the Veterans it serves and the public that funds its operations. In developing its performance management approach, VHA must also consider how it can further its accountability and transparency. VHA's SAIL data are a positive start, as they do align with nationally accepted metrics that provide for facility-level, industry comparisons. However, VHA must go further and should review industry benchmarks with the intent of more fully aligning its metrics with industry standards. This would provide greater transparency and would highlight opportunities to adopt industry best practices.

"Performance goes down when there are more measures. We need to get away from the spreadsheet and closer to the action. Facilities need coaches—not just shaking a finger and saying, 'Can't miss this.'"

VHACO Leader

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7 Leadership⁸⁶

Finding 4: Leaders are not fully empowered due to lack of clear authority, priorities, and roles
Recommendation 4—LEADERSHIP: Stabilize, grow, and empower leaders; galvanize them around clear priorities; and build a healthy culture of collaboration, ownership and accountability
Push decision rights, authorities, and responsibilities to the lowest appropriate level throughout the organization.
Build on Veteran-centered behaviors to drive a culture of service excellence, trust, continuous improvement, and healthy accountability.
Revitalize the leadership pipeline through establishment of enterprise-wide, comprehensive succession management and leadership development functions.
Strengthen the appeal of senior leadership positions by pursuing flexibilities in hiring and compensation.
Establish sustained leadership continuity by extending tenure for key positions.

CURRENT STATE

VHA is in the midst of a leadership crisis. Through the course of more than 300 leadership-focused interviews and the analysis of multiple employee survey instruments, Assessment L (Leadership) developed a picture of an environment that is challenging and disempowering for current leaders. (A full treatment of VHA's leadership issues is provided in Assessment L.) This environment discourages emerging leaders from seeking promotion within the system. And while there are many resilient leaders working to make a positive impact on our nation's Veterans, they too often achieve desired outcomes despite the challenges of the system within which they operate. The VA staff assessment of their work environment is reflected in the federal government's "Best Places to Work Survey." Since 2010, both VA and VHA have scored lower than the large agency median and both received particularly low ratings in 2014 during the height of the scheduling crisis. Consider the following:

Mission: The lack of clarity of mission expectations, as discussed in Section 4, has resulted in confusion around leadership priorities and VHA's strategic direction. As one VHACO leader expressed, "We need to first figure out what business we want to be in...[and] choose leaders specifically for the need, change, strategy [we've] decided on." Clarifying the mission and expectations serves as a precursor to many critical leadership decisions.

Misaligned Accountability and Authority: VAMC leaders clearly understand that they are accountable for every aspect of a Medical Center as experienced by patients, employees,

⁸⁶ The information in this section is drawn primarily from McKinsey & Company Assessment L (Leadership) in Volume II.

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oversight entities, and external stakeholders; however, they do not feel they have the authority required to fully perform their role in the current environment. A standard VA Medical Center Director position description includes the provision that a

Director “operates on a broad delegation of authority with independence of action to manage the Medical Center.”⁸⁷ In both perception and practice, however, this written expectation of delegated authority does not match reality; instead, it is replaced by a fragmented environment with numerous internal and external entities possessing or competing for control. Internally, the VHA organization is viewed as being intensely, unnecessarily complex due to a lack of a clear operating model (as highlighted in Section 5), limited role clarity, fragmented authority, and overlapping responsibilities. This lack of clarity around operating model, roles, and responsibilities extends across VAMCs, the VISNs, and VHACO.

“It is very much a rule by ‘You shall’ edicts—I am told the exact number of people I will hire and the jobs that they need to do—even if I don’t have a need for the policy or the people.”

Physician Leader

“...nobody feels safe, including us. How am I supposed to role model psychological safety when I don’t feel safe myself?”

VAMC Leader

A complicated external environment exists for VHA, as the organization is treated by oversight entities and external stakeholders as both a hospital system and a traditional government agency, and Congress sees itself in the role of the VHA Board of Directors.⁸⁸ An increase in centralized control intended to mitigate risk has in fact constrained leaders’ authority. Communications from Congress, VACO, VHACO, and VISNs tend to be overly prescriptive directives governing many aspects of operating a Medical Center. A general lack of clarity around roles and responsibilities contributes to poor coordination across entities and levels, resulting in duplication, communication breakdowns, and functional responses too slow to meet mission needs.

Culture and Environment: Although the broader VHA culture includes a deep commitment to mission at all levels of the organization, it is also characterized by risk aversion and distrust, resulting in an inability to improve performance consistently and fully across the system. At almost every facility visited, at least one leader interviewed mentioned that risk aversion and a reluctance to “speak up” were a significant issue. Three out of every four leaders interviewed at

⁸⁷ U.S. Department of Veterans Affairs. Veterans Health Administration. Job Announcement: Health System Administrator (Medical Center Director) (VA Job Announcement Number: VASES151407823LR). Retrieved from <https://www.usajobs.gov/GetJob/ViewDetails/403947600>

⁸⁸ Clark, C. (2015, April 30). Senators Propose Acting as “Board of Directors” for VA. Government Executive. Retrieved from <http://www.govexec.com/management/2015/04/senators-propose-acting-board-directors-va/111613/>

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VISNs echoed this concern.⁸⁹ This culture permeates across all levels—from the front lines to Medical Center leaders to people at the VHA Central Office—and it contributes to a lack of innovation and best-practice dissemination across the organization. VHA’s *Blueprint for Excellence* lists *Provide a Psychologically Safe Environment for Employees* as a key transformational action.⁹⁰ However, although psychological safety is acknowledged as a challenge, the broader culture of distrust and risk aversion will not improve until leaders themselves feel safe and can actively demonstrate the desired behaviors.

Leader Preparation: Mission focus alone is insufficient to attract top-notch leaders to the organization or motivate high potentials to seek promotion to senior leadership positions in the current environment. In fact, many current VHA leaders perceive the risk of advancing to significantly outweigh the potential reward. The lack of a comprehensive approach to leadership development and a complete lack of formalized succession planning results in an inability to identify potential leaders and prepare them to assume their future roles.

Compensation is clearly a disincentive for many experienced senior medical health leaders to enter the VHA system,⁹¹ and it remains a point of contention among those leaders who are already in VHA. Some leaders spoke freely about their current salary and how it compares to their peers’ salaries in medical centers outside VHA. Ironically, there is a perceived disincentive for Chiefs of Staff and other clinical leaders to aspire to VAMC Director or any other Title 5 (non-clinical) leadership positions, as clinical leaders hired under existing Title 38 authority are granted more flexibility in hiring, compensation, and performance evaluation in their current positions.⁹² A VAMC Chief of Staff echoed his peers and offered, “If I became the Director, I would take a \$100K cut.”⁹³

“The salary is \$187,000 [sic] for a medical center director. In private industry, a director could get \$600,000. They don’t do it for the money, but they need some reward for doing well.”

Acting VAMC Associate Director

All of these factors have contributed to an anemic leadership pipeline that does not support VHA’s existing or future needs. Assessment L (Leadership) paints a dire picture of the current vacancy situation:

⁸⁹ This information is derived from McKinsey & Company Assessment L (Leadership) in Volume II.

⁹⁰ U.S. Department of Veterans Affairs. (2014, September 21). *Blueprint for Excellence: Veterans Health Administration*. Retrieved from http://www.va.gov/HEALTH/docs/VHA_Blueprint_for_Excellence.pdf

⁹¹ This information is derived from RAND Corporation Assessment B (Health Care Capabilities) and Grant Thornton Assessment G (Staffing/Productivity), both in Volume II.

⁹² Under the Title 38 employment system, VA has considerable hiring flexibility. It can hire professional employees directly and has flexibility to remunerate Title 38 employees at levels that are consistent with such staff’s professional qualifications. Promotions under the Title 38 system are awarded by review panels comprised principally of clinical peers having similar credentials and experience.

⁹³ The current salary cap for a VA Medical Center Director paid under the SES pay scale is \$183,300. Currently, seven Medical Center Directors are compensated under Title 38.

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- 39 percent of Quadrad or Pentad senior leadership teams⁹⁴ at VHA Medical Centers have at least one current vacancy
- 43 percent of Network Directors are fulfilling the duties of that position in an “acting” status
- 16 percent of VHA Medical Centers do not have a permanent Director (i.e., Acting, Interim, or vacant).

And VHA has been unable to fill these field leadership gaps in a timely manner. The length of time that these openings have been unfilled stretches for greater than seven months on average, with more than half currently open for longer than six months.⁹⁵ The tactical, short-term solution to filling VAMC Director positions has been to fill them with Acting or Interim Directors. However, this revolving door of Acting VAMC Directors prevents sustainable change, hurts employee morale, and compromises delivery of care to Veterans in these facilities. One VAMC leader expressed frustration with this current practice, saying “We’ve had no consistency at the top. We’ve had Acting

Directors. There is no permanent body. We need that consistency. The Directors come in with new ideas, but they don’t have the time to implement anything.”

Complicating this challenge is the realization that VHA faces a large and widespread number of potential retirements in key field leadership roles. Fifty-seven percent of leaders in key positions are eligible for retirement.⁹⁶ More than two thirds of Network Directors, Nurse Executives, and Chiefs of Staff are also eligible for retirement, as well as 47 percent of Medical Center Directors. There are indications that this retirement threat is beginning to be realized; in FY2014, retirements by VHA employees GS-13⁹⁷ and higher increased by 37 percent over the previous five-year average.⁹⁸

“Accountability is tough when the leadership is rotating (i.e., Acting Director is here 90 days to six months)...There’s a perception of ‘who’s the Director today?’”

VAMC Leader

⁹⁴ A Quadrad leadership team consists of a Medical Center Director, an Associate Director, an Associate Director for Patient Care Services/Chief Nurse Executive, and a Chief of Staff. A Pentad leadership team consists of a Medical Center Director, an Associate Director, an Associate Director of Clinical Operations, an Associate Director of Patient Care Services, and a Chief of Staff.

⁹⁵ (2015). Choice Act assessment interviews with VHA.

⁹⁶ “Key positions” are defined as VISN Network Director and Medical Center Quadrad leaders (Medical Center Director, Associate Director, Associate Director for Patient Care Services/Chief Nurse Executive, and Chief of Staff).

⁹⁷ The general schedule (GS) is the predominant pay scale within the United States civil service, with 15 levels. GS-15 has the highest base salary.

⁹⁸ U.S. Office of Personnel Management (OPM). (2015, March). FedScope database.

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RECOMMENDATIONS

As outlined in Assessment L (Leadership), VHA must stabilize, grow, and empower leaders; galvanize them around clear priorities; and build a healthy culture of collaboration, ownership, and accountability.

- Push decision rights, authorities, and responsibilities to the lowest appropriate level throughout the organization.
- Build on Veteran-focused behaviors to drive a culture of service excellence, trust, continuous improvement, and healthy accountability.
- Revitalize the leadership pipeline through establishment of enterprise-wide, comprehensive succession management and leadership development functions.
- Strengthen the appeal of senior leadership positions by pursuing flexibilities in hiring and compensation.
- Establish sustained leadership continuity by extending tenure for key positions.

Push decision rights, authorities, and responsibilities to the lowest appropriate level throughout the organization. Clarifying decision rights is a critical factor in empowering leaders in the field. VHA should articulate decision rights clearly by level, organization, and role, standardizing where appropriate while also allowing for local flexibility based on local needs. Clarifying the role of the VISN is particularly important as this role has become unclear over time. This clarification should define key roles and responsibilities, particularly with the local realignment in progress. It must address the necessary balance between empowerment and support between medical facility leaders and VISN leaders. This must be done in the context of overarching systems and clear standard performance goals and outcomes.⁹⁹

Build on the existing commitment to Veteran-centered care to drive a culture of service excellence, trust, continuous improvement, and healthy accountability. Research suggests that “most people won’t change their behaviors until they observe the role models in their organization acting differently, and when they see this new behavior positively recognized and rewarded—a clear promotion, a plum assignment, a change in authority or responsibility, or simply praise from the top of the organization.”¹⁰⁰ VHA leaders will need to demonstrate desired behaviors with the understanding that culture change will not occur until employees are motivated and feel supported to act differently.

VHA must reinvigorate its mission-driven culture through greater employee collaboration and ownership and by creating a unified organization in support of mission, strategic direction, and a goal of integrated patient care. To do this, VHA will need to foster a culture of continuous improvement and learning, spur collaboration, encourage innovation (within and across the system, and beyond), and connect all employees to the mission. Communications should make

⁹⁹ See McKinsey & Company Assessment L (Leadership) in Volume II for more detail on the role of the VISN.

¹⁰⁰ The Bridgespan Group. (2011). *Strategies for Changing Organizational Culture*. Retrieved from <http://www.bridgespan.org/Publications-and-Tools/Leadership-Effectiveness/Lead-and-Manage-Well/Strategies-for-Changing-Organizations-Culture.aspx>

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clear how activities performed by employees support the mission and strategic direction and how measures, directives, and requests directed by VHA Central Office align with and advance the mission.

Culture is often described simply as “how things are done around here,” and changing the VHA culture will need to happen at all levels—VHACO, VISN, and the VAMC level. VHACO should consider how to integrate its efforts so that the workforce is involved and experiences a coherent set of messages, policies, and support. The VISNs should support the VAMC leaders by sharing best practices, demanding steady improvement, and encouraging innovation. VAMC leaders will need to role model the change, describe why the culture must change, reinforce desired behaviors, and provide leaders and employees alike with the coaching, training, and tools they will need to succeed. As stated in Assessment D (Access Standards), leadership at every level of the health care delivery system is essential to steward and sustain cultural and operational changes needed to reduce wait times. Leadership must be devoted to reflecting, sustaining, and enhancing patient-centered care in scheduling and access, and the results must be continually gathered, assessed, made available, and deployed to drive and reward improvement.

VHA must shift its thinking to acceptance, and in fact encouragement, of risk taking and even smart failures. A cultural and leadership emphasis on healthy risk taking was adopted across all of the high-performing health care systems we studied and should be emulated by VHA. VHA should

“Cleveland Clinic has always had a high tolerance for renegades—the kind of people who are dissatisfied with the status quo and are always looking for better ways of doing things. Because no organization can be successful unless its people are free to learn from their mistakes, Cleveland Clinic allows ample room for failure.”

Toby Cosgrove
The Cleveland Clinic Way

strike a risk-reward balance that enhances the organization’s ability to reward senior leaders for the risk they assume in this increasingly politicized environment, while also making it easier to usher poor performers out of VHA. Leaders’ performance plans should not only focus on compliance requirements, administrative investigation boards, root cause analyses, and peer reviews¹⁰¹ but should also emphasize trends that are improving, best practices that are shared, risks taken, and accomplishments achieved. VHA must hold leaders accountable for rebuilding a culture of trust that is patient centered, streamlines processes, and expects best practices to be adopted.

Revitalize the leadership pipeline through establishment of enterprise-wide, comprehensive succession management and leadership development functions. As Assessment L (Leadership) concludes, a system as large, complex, and unique as VHA requires an enterprise-wide, highly coordinated succession management function, beyond traditional workforce planning. A comprehensive and enterprise-wide program to identify high-potential candidates, provide

¹⁰¹ United States. Congress. Veterans Access, Choice, Accountability, and Transparency Act, 38 U.S.C. § 1701 (2014) (Pub. L. No.113–146, 128 Stat. 1754).

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development in core health care administration competency functions, and connect these individuals with leadership opportunities is critical to moving VHA forward. A formal candidate identification, preparation, and placement program is required to identify and promote the next generation of leaders. Policy changes and congressional action, including expanding hiring authorities, should be sought to change or grant temporary exceptions to alleviate any constraints. The succession planning function should be coupled with development programs that strengthen VHA's leadership foundation. Current leadership development offerings should be rationalized, eliminating existing programs that do not reinforce or build on the behaviors expected of VHA leaders. Development programs should provide current and future leaders with the appropriate strategic, operational, and leadership skills to drive and implement change in this complex system and challenging environment. VHA should also attract and recruit leaders from outside the organization with deep health care management expertise who have demonstrated the behaviors and possess the competencies desired within VHA. These leaders would be expected to leverage and share their knowledge gained outside the organization while acting as catalysts for change within VHA.

Strengthen the appeal of senior leadership positions by pursuing flexibilities in hiring and compensation. The role of senior leaders within VHA should be strengthened by pursuing regulatory or legislative changes that expand or create a new federal classification for VHA Pentad leaders and other critically needed and vacant positions. These changes should enable the flexibility that exists in other federal positions (e.g., Title 38,¹⁰² Senior Executive Service, Excepted Service¹⁰³) to address compensation and benefits, hiring decisions, promotion process, and performance management. It should be noted that VA is pursuing a legislative remedy in its most recent federal budget request to expand Title 38 salary flexibility to non-clinical leadership positions, although at the time of this report Congress has yet to act on this request.

Establish sustained leadership continuity by extending tenure for key positions. Building sustained leadership continuity will be critical to successfully transforming culture and will give leaders the authority, accountability, ownership, and time needed to stabilize the organization, strengthen its health and performance, and shepherd change efforts. To build this continuity, VHA and Congress should consider longer terms for critical leadership positions such as the Under Secretary for Health. Extending the tenure of the Under Secretary so that it spans presidential administrations and election cycles would increase leadership stability and resilience in political headwinds. This top leadership position in one of the nation's largest health care systems could be considered akin to the Internal Revenue Service (IRS) Commissioner position. Congress passed the U.S. Internal Revenue Service Reform and Restructuring Act of 1998. That legislation allowed the IRS Commissioner a five-year term that crossed administrations and provided the opportunity to fully implement the IRS

¹⁰² Title 38 is a federal classification for health care professionals and covers a range of clinical professions at VHA.

¹⁰³ There are four schedules (A, B, C, and D) of Excepted Service that fall under OPM regulations. Agencies may make Excepted Service appointments upon specific authorization by OPM.

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transformation.¹⁰⁴ Extending the assignments of Medical Center Directors would also increase organizational stability and continuity at the facility level by ensuring that each leader is present long enough to build a rapport with the facility and his or her leadership team and see significant efforts through to completion or sustainable implementation. These extended assignments would reduce the frequency of geographic displacement, a dynamic that is becoming increasingly unattractive to many facility leaders.

¹⁰⁴ Rainey, H. & Thompson, J. (2006, July–August). Leadership and the Transformation of a Major Institution: Charles Rossotti and the Internal Revenue Service. *Public Administration Review*.

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8 Transformation

Taken together, the 12 assessments found numerous, critical shortfalls validating the many calls for change made by Veterans, the American public, Congress, and VHA staff and leaders.¹⁰⁵

These shortfalls should not be viewed as individual anomalies, but rather manifestations of the systemic findings that plague VHA:

- A disconnect in the alignment of demand, resources, and authorities that impacts mission execution
- Uneven bureaucratic business operations and processes
- Non-integrated variations in clinical and business data and tools
- Leaders are not fully empowered due to a lack of clear authority, priorities, and roles; they work in a culture of growing risk aversion and distrust.

To successfully and sustainably address these systemic findings, a system-wide transformation is required¹⁰⁶ based on an approach that acknowledges the interdependency among the four cornerstones as depicted in Figure 5 in Section 3.

Transformation is Hard but Possible. Transformation is not easy, nor is success guaranteed. Successful, sustained transformation requires unwavering persistence, enduring attention, committed leadership, and the sustained cooperation and commitment of those calling for change, as well as new approaches and capabilities. Across many industries, longitudinal research has found that only about 30 percent of attempted transformations succeed for the long term.¹⁰⁷ Employee resistance, a lack of engagement by organization leadership, scarce resources, and other organizational issues (including poor accountability and misalignment between organizational aspirations and individual and team goals and targets) are major reasons why transformational efforts fall short of their goals. Unless VHA makes major changes from its current state, it is unlikely to successfully transform.

As difficult as a major transformation is, it is still achievable. In the course of conducting the assessments and performing research for these assessments, we visited four highly regarded health care institutions that have successfully undergone transformations and emerged as high-

¹⁰⁵ A Gallup poll from June 9-10, 2014, on Americans' issue priorities found that 87 percent of Americans polled thought that improving the way in which health care services are provided to U.S. military Veterans was extremely/very important, topping the list. Retrieved from: <http://www.gallup.com/poll/171596/prioritize-improving-veterans-health.aspx>

¹⁰⁶ In his statement before the Senate Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, on April 21, 2015, Secretary of Veterans Affairs Robert A. McDonald said, "We are implementing an historic department-wide transformation, changing VA's culture, and making the Veteran the center of everything we do." Retrieved from <http://www.appropriations.senate.gov/sites/default/files/hearings/042115%20Secretary%20McDonald%20Testimony%20-%20MilCon-VA.pdf>

¹⁰⁷ Keller, S. & Price, C. (2011). *Beyond Performance: How Great Organizations Build Ultimate Competitive Advantage*. Hoboken, NJ: John Wiley & Sons.

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performing health care systems (Kaiser Permanente, Cleveland Clinic, Virginia Mason, and Geisinger). We also interviewed more than 27 health care executives and experts from industry, academia, and government. From these experiences, six themes enabling the successful transformations emerged:

- A shared sense of urgency
- Empowered leaders and new mission
- Recognition of the journey through a sustained and time-consuming process
- Patient-centric culture and value system
- Supportive and knowledgeable governance
- Transparent data-driven management system.

These themes reflect the systemic findings and recommendations provided in this report and reinforce the conclusion that a systems approach is essential to a successful VHA transformation.

VHA has also seen major transformation occur from 1994 to 1999. In 1994, care was fragmented and uncoordinated, hospital centric, specialist based, and episodic and reactionary. It was often difficult to access, with long waiting times and long distances to hospitals for some patients. The system was plagued with irregular and unpredictable quality and rapidly rising costs. Management was highly bureaucratic, centralized, and hierarchical. Organizational leadership changed frequently, and governance issues and capital investment decisions were highly politicized. Patients were unsatisfied, and staff demoralized.

After a careful, major transformational effort, there were many quantifiable examples of positive impact at the end of five years. VHA:

- Treated 24 percent more patients
- Implemented universal primary care
- Improved access with 302 new community-based outpatient clinics
- Markedly reduced waiting times
- Closed 29,000 acute-care hospital beds
- Reduced bed days of care per 1,000 patients by 68 percent
- Reduced annual hospital admissions by 350,000
- Merged 52 hospitals into 25 locally integrated multi-campus facilities
- Decreased staffing by 12 percent (25,867 FTE positions) while concomitantly increasing the number of caregivers
- Substantially decreased annual operating costs
- Decreased annual expenditures per patient by more than 25 percent in constant dollars
- Improved patient satisfaction and achieved higher aggregate patient satisfaction ratings than in the private sector (in 1998, 80 percent of patients thought that care was “definitely better” than two years before)

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- Markedly improved quality of care according to standardized performance measures for a wide array of conditions.¹⁰⁸

Transforming VHA to a High-Performing Health Care System: In its *Blueprint for Excellence*, VHA has captured its aspirations and goals citing the IOM’s “Six Aims for High Performance Healthcare” as a framework underpinning its “clinical performance improvement and measurement for comparison with non-VA care.”¹⁰⁹

“The goal of a learning health care system is to deliver the best care every time, and to learn and improve with each care experience. This goal is attainable only through system-wide changes of the sort that have been successfully undertaken in certain activities of the manufacturing sectors. In these cases significant benefits have been realized through organization wide transformations guided by principles of systems and process engineering and the practices of structured data feedback for process improvement.”¹¹⁰

Although the goals of VHA already echo many of the system findings of our assessments, the keys to future success are effective execution and implementation. All leaders and staff must be engaged and empowered to assist overcoming challenges in the transition from strategy to execution. Most transformations take at least 12 to 18 months for initial impact, and transformations of the magnitude needed at VHA may take 5 to 10 years to fully take hold. To avoid change fatigue and loss of focus, VHA leadership must set appropriate expectations with clear milestones, but also make visible early changes to demonstrate commitment and promote front-line acceptance. To this end, as Section 4 recommends, VHA must establish a new Program Management Office staffed by individuals with the right emotional commitment and core competencies in executing organizational change. This office should answer directly to the Office of the Undersecretary for Health. This team should create the strategy and roadmap for the implementation of this transformation, with the requisite

“Minor tweaks to the current system may incrementally improve health care in the near term, but the monopolistic VHA bureaucracy is likely to return to a standard operating model heavily influenced by the desires and concerns of the institution and its employees. Only fundamental reform will break the cycle and empower Veterans.”

*Fixing Veterans Health Care
Concerned Veterans for America*

February 26, 2015

¹⁰⁸ Kizer, K.W. (2012). Commentary 12-1: Lessons learned in transforming the Veterans Health System. In Levy, B. S. & Gaufin, J. R. (Eds.), *Mastering public health: Essential skills for effective practice*. Oxford University Press.

¹⁰⁹ U.S. Department of Veterans Affairs. (2014, September 21). *Blueprint for Excellence: Veterans Health Administration*. Retrieved from http://www.va.gov/HEALTH/docs/VHA_Blueprint_for_Excellence.pdf

¹¹⁰ Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*, Committee on Quality of Health Care in America. Washington, D.C.: National Academies Press.

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metrics, milestones, and timelines. This roadmap should set reasonable timelines, strive for early wins, and be willing to wait for major impact. Most importantly, VHA leadership must provide and Congress must endorse funding to enable this transformation—funding that is separate from the annual budget cycle; funding that is protected; and funding that has special rules for allocation. “A best practice is to establish an independent budget that’s distributed when—and only when—the kinds of milestones”¹¹¹ that measure success have been achieved.

With this multi-dimensional systems approach to complex problems, VHA will be able to successfully tackle its most complex problems in innovative, sustainable ways. Facility challenges can be significantly mitigated by a transformative realignment throughout the capital program deploying best practices in leasing and contracting; realigning the strategy of the capital program to improve project selection, optimize the infrastructure portfolio, implement innovative care delivery models, understand demand-based needs, and explore and partner with purchased-care opportunities; and reevaluating funding requirements. Such an integrated approach would proactively position VHA for the health care delivery model of the future. Similarly, the problems of access addressed by the Choice Card should, as noted in Appendix D, integrate multiple factors—systems strategies, supply and demand alignment, reframing the type of patient encounter, the need for standards, the need for evidence-based best practices, and leadership. This holistic approach is the heart of our proposed systems solution with its four systemic cornerstones. A systems approach to solving large scale health care delivery issues has been suggested by experts at IOM, the National Academy of Engineering, and the President’s Council of Advisors on Science and Technology.^{112,113,114} Approaching all of the recommendations in the 12 individual assessments with a systems solution that is scalable and sustainable will provide a pathway for enduring transformation.

Conclusion: Veterans, the American public, Congress, and VHA staff and leadership all want to see and support VHA returning to a high-performing health care system. Deputy Secretary Sloan D. Gibson stated, “We know that unacceptable, systemic problems and cultural issues within our health care system prevented some Veterans from receiving timely care.” We believe this Integrated Report describes a scalable and sustainable way to create the environment for enduring solutions.

¹¹¹ Harreld, J.B. & Laurie, D.L. (2013, July-August). Six ways to sink a growth initiative. *Harvard Business Review*. Retrieved from <https://hbr.org/2013/07/six-ways-to-sink-a-growth-initiative>

¹¹² Kaplan, G. et al. (2013, July 10). *Bringing a systems approach to health*. Retrieved from <http://nam.edu/wp-content/uploads/2015/06/systemsapproache>

¹¹³ National Academy of Engineering and Institute of Medicine of the National Academies. (2005). *Building a Better Delivery System: A New Engineering/Health Care Partnership*. Washington, D.C.: The National Academies Press. Retrieved from <http://www.nap.edu/catalog/11378.html>

¹¹⁴ President’s Council of Advisors on Science and Technology. (2014, May). *Better Health Care and Lower Costs: Accelerating Improvement Through Systems Engineering*. Washington, D.C. Retrieved from https://www.whitehouse.gov/sites/default/files/microsites/ostp/PCAST/pcast_systems_engineering_in_healthcare_-_may_2014.pdf

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But there are clear obstacles. The number of issues VHA currently faces appears overwhelming. The overlap of our individual assessment recommendations with those of past reports is troubling. The success rate of successful transformations is not encouraging.¹¹⁵

In its current state, VHA is not well positioned to succeed in such a transformation. As already discussed in the Integrated Report, three essential actions are required to realize the recommendations inherent in this transformation. VHA must:

- Implement a systems approach that recognizes and embraces that the four cornerstones are interdependent and the success of any one of the four overarching recommendations hinges on the implementation of the other three. These solutions must be coordinated and implemented via a systems approach to improve VHA overall.
- Establish a transformation program management office with the authority and funding (redirected from current central and local funding mechanisms) to implement the system-wide reworking of VHA. The office should be staffed by individuals with the right emotional commitment and core competencies in executing organizational change. The office should focus on confirming and communicating the aspirational state, establishing transformation priorities, defining timelines for execution, implementing both strategic and tactical initiatives, allocating resources, and instituting appropriate metrics and processes to measure progress and success. It should replace any ongoing change initiatives and merge the relevant components of MyVA, the *Blueprint for Excellence*, and other initiatives into one coherent, focused transformational approach.
- Require evidence-based systems models to inform and implement integrated solutions that balance governance, operations, data and tools, and leadership.

“Implementing systems approaches in health care, including strategies to address scheduling and access issues, requires changes not only in operational processes, but also a fundamental shift in thinking. All members of a health care organization must transition from the siloed, independent, and fragmented mentality of traditional health care culture to a culture of service excellence, an integrated approach with shared accountability in which physicians, employees, and patients treat one another with respect and as partners and patient satisfaction and employee engagement are high.”

*Institute of Medicine of the National Academies
Assessment D (Access Standards)*

VHA has the opportunity to achieve a place among the highest performing health care systems in the world. It will be the charge of Congress, the Commission on Care, and VA leadership to see that these recommendations and resulting transformation efforts are given the necessary attention and support that they—and our nation’s Veterans—deserve.

¹¹⁵ Keller, S. & Price, C. (2011). *Beyond Performance: How Great Organizations Build Ultimate Competitive Advantage*. Hoboken, NJ: John Wiley & Sons.

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**The following sections contain Appendices A through Q
as referenced throughout the Integrated Report.**

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Appendix A Demographics

Scope

Assessment A examined the “current and projected demographics and unique health care needs of the patient population served by the Department.” The assessment described characteristics of the current and projected population of U.S. Veterans and patients of the U.S. Department of Veterans Affairs (VA) health care system. In addition, the assessment examined the characteristics of Veterans who are most likely to rely on VA for their health care, described the unique health care needs of the patient population currently served by VA, and projected the health care needs of Veterans who might become patients in the future. The assessment also examined the potential impact of future policy changes, such as broader eligibility for VA care, and other events, such as a major conflict, on demand for VA health care services.

Findings

The population of U.S. Veterans will decrease by 19 percent over the next 10 years. The Veteran population has been decreasing for the past two decades, and this trend will continue. In 1990, there were 27.5 million Veterans; in 2014, there were 21.6 million. Over the next 10 years, our projections, drawing on VA and Department of Defense (DoD) data, show that the Veteran population will decline to 17.5 million, a decrease of 19 percent.

Geographically, the Veteran population will shift from the Ohio River Valley and upper Midwest to the Southwest and Mountain regions and concentrate further in urban areas. Over the next 10 years we estimate that the share of female Veterans will increase from 8 to 11 percent, while the share of non-Hispanic white male Veterans will fall from 80 to 75 percent. Mean age will increase slightly as the population will have a higher proportion of both older and younger Veterans.

Veterans generally enjoy favorable socioeconomic outcomes relative to their non-Veteran counterparts. Veterans are more likely to be employed and have health insurance, and also have higher median incomes, than non-Veterans, on average. Despite the overrepresentation of Veterans in the U.S. adult homeless population, the rate of homelessness is still low among Veterans and has been declining over time.

The VA patient population will increase through 2019 and then plateau. While the Veteran population is projected to decline by 19 percent over the next 10 years, we estimate that the number of VA patients will reach its peak level in 2019 before plateauing or possibly declining in future years. The increase in the size of the patient population relative to the Veteran population is related to recent trends in eligibility, enrollment conditional on eligibility, and use of VA health care among those eligible, particularly among younger Veterans.

The number of Veterans who use VA health care is dependent on eligibility criteria, access constraints, and other factors. For example, our scenario analysis found that expanding eligibility for VA health care to currently excluded groups of Veterans could lead to over 4.8 million newly eligible Veterans, and as many as 2.1 million new VA patients, amounting to a 35.1 percent increase in the size of VA’s patient population.

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Lower income Veterans, those in rural areas, Veterans without other access to health insurance coverage, and Veterans with poorer self-reported health status rely more on the VA than other Veterans. Most Veterans have health care options other than VA, such as employer provided health insurance or Medicare, and use VA for only part of their overall health care needs. Our estimates of the extent to which Veterans rely on VA for health care versus other sources of care are lower than VA estimates. For example, our estimates indicate that VA patients obtain 30 percent of their prescription drugs through the VA. In contrast, VA estimates that enrollees obtain 66 percent of their prescription drugs through VA. Because the VA estimates are in part based on proprietary methods, the reasons for these differences could not be fully determined.

Veterans have higher *unadjusted* rates of many key health conditions than non-Veterans. Unadjusted results show how Veterans differ from non-Veterans at the population level. Some of these differences are related to the fact that Veterans are older and more likely to be male than non-Veteran civilians, and therefore disappear when we adjust for these factors. At the population level, the prevalence of diabetes and gastroesophageal reflux disease (GERD) disorders among Veterans is substantially higher than for non-Veterans. Veterans are more likely than non-Veterans to be diagnosed with cancer, hearing loss, and posttraumatic stress disorder (PTSD). Mental health conditions, however, are equally prevalent in the Veteran and non-Veteran populations.

Veterans have a higher *adjusted* prevalence of key health conditions than non-Veterans. Adjusted results characterize how Veterans differ from non-Veterans with similar demographic characteristics, including age, sex, and race. While Veterans continue to have a higher prevalence of many chronic conditions, most differences are smaller, relative to unadjusted estimates. For example, in the unadjusted models Veterans are almost twice as likely to have diabetes; after adjusting for demographic characteristics, the relative difference is only 13 percent. An important exception is that, after adjusting for demographics, Veterans have higher prevalence of mental health conditions than non-Veterans. Differences between Veterans and non-Veterans are particularly large for PTSD, where Veterans are 13.5 times more likely than non-Veterans to be diagnosed with the condition.

VA patients are typically less healthy than Veterans who do not use VA health care. VA patients—defined as Veterans who obtained care from a VA provider or had any payment by VA for health care services used in the past year—are in poorer health than Veterans who had not used VA health care. Partly these differences in prevalence are inevitable, because Veterans with disabilities and service-connected conditions have prioritized access to VA care relative to other Veterans. Among VA patients, the unadjusted prevalence of common chronic conditions (such as diabetes and cancer) is 51 to 96 percent higher than for Veterans who do not use VA care. Approximately 25 percent of all patients who received care paid for by VA have a mental health condition and three percent have PTSD. When combined with the otherwise rare conditions related to combat—amputation, traumatic brain injury, blindness, and severe burns—VA handles a patient mix that is distinct from what community providers typically see.

The prevalence of many common conditions is projected to increase among Veterans over the next 10 years. As the Veteran population ages, they will face higher rates of conditions such

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as hypertension, diabetes, and mental health. VA patients are projected to experience relatively steeper increases in many conditions relatively to the overall Veteran population. As a result, the gap in prevalence rates between VA patients and Veterans who do not use VA health care is projected to increase over time.

In the event of a hypothetical future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients. However, previous cohorts of Veterans, especially the Vietnam cohort, were much larger than recent cohorts, so the difference would be small relative to the entire VA patient population.

Recommendations

Prepare for a changing Veteran landscape. After increasing for decades, the VA patient population is projected to level-off or even begin to decrease after 2019, a trend that is likely to continue over an even longer time horizon. While demand for VA services during this time period will be influenced by utilization patterns, there is a possibility that demand for services will decrease for the first time in several decades once the size of the Veteran population begins to plateau after 2019. The VA has been, and continues to be, responsive to increasing demand for services, but once population growth slows, VA may be left with a larger footprint than needed in the longer-term. Increasing the use of care purchased from the civilian sector may enable VA to meet short-term increases in demand without requiring costly investment in facilities, infrastructure, and personnel that could become less needed in the future.

Anticipate potential shifts in the geographic distribution of Veterans, and align VA facilities and services to meet these needs. Given projected declines in the size of the Veteran population living in the Ohio River Valley and upper Midwest, it may be possible to consolidate relatively proximal VA facilities in those regions. At the same time, some areas of projected Veteran population growth—including Montana, Wyoming, Colorado, and much of the Southwest—are not currently well covered by VA facilities. Some regions, such as Washington D.C., Los Angeles, Dallas, and northern New Jersey, may experience growth in the Veteran population under age 35.

Improve collection of data on Veterans. Because the 2010 Census did not capture information on Veteran status, there has not been a full-scale accounting of the U.S. Veteran population since 2000. Since then, there have been surveys of representative samples of Veterans that provide useful counts and information about the Veteran population, but they are only estimates. An updated census of the Veteran population would enable a definitive count of all Veterans, while also helping to refine the sampling procedures for the yearly surveys of samples of the population.

Improve collection of data on Veteran health care utilization and reliance. To gain a clearer understanding of Veterans' health care use, VA should collect data on all sources of health care that are used by Veterans—including where care is delivered, what diagnoses are recorded and procedures performed, and who pays for the services—as well as what needs for care are unmet, and why. Creating these data would enable an analysis of the extent to which Veterans currently rely on the VA for health care, and how that reliance may change as a result of internal VA policies or external factors. It would also provide insight into where the VA succeeds

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in meeting the health care needs of its patient population and what obstacles exist in delivering needed care.

Monitor use of VA health care by younger cohorts and Iraq and Afghanistan Veterans. Iraq and Afghanistan Veterans are more likely to have service-connected disabilities than other Veterans, and are automatically eligible for VA health care for five years after leaving the military. Historically, Veterans have relied less on VA health care as they age, gain access to other health insurance (e.g., through an employer), and start families. However, it is not clear the extent to which these patterns will hold for newer Veterans who have different exposures and enhanced eligibility relative to previous cohorts. Understanding how patterns for these Veterans will evolve may inform future planning.

The complete Assessment A is available in Volume II.

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Appendix B Health Care Capabilities

B.1 Scope

Access to quality health care is a central part of our nation's commitment to Veterans. However, concerns about access to VA care, including long wait times for appointments, lack of available appointments within certain clinical specialties, and problems with care transitions for patients discharged from mental health services, led to the passage of the Veterans Choice Act in 2014. Section 201 of the Veterans Choice Act includes a requirement for an independent assessment of VA health care. Assessment B provided "an independent assessment of the current and projected health care capabilities and resources of the VA, including hospital care, medical services, and other health care furnished by non-VA facilities under contract with the VA, to provide timely and accessible care to Veterans" (Veterans Choice Act, Section 201). Assessment B also explored how selected policies could affect Veterans' access to high-quality care. Volume II contains the full Assessment B report.

B.1.1 Findings

VA operates a unique health care system with broad and deep resources and capabilities. However, VA faces a number of barriers in planning for and using its resources effectively:

- **Fiscal resources:** We identified concerns about the data used for VA's budget planning, inflexibility in budgeting stemming from congressional appropriation processes, and challenges in VA's allocation processes.
- **Workforce and human resources:** VA has an extensive health care workforce, but VA capacity may not be sufficient to provide timely care to Veterans across a number of key specialties as well as primary care. VA faces shortages of physicians in some geographic areas and of certain physician specialists. These constraints are influenced by low salaries, a slow credentialing process, and infrastructure constraints. Variations in coding, inconsistently entered workload data, and incomplete physician encounter data make it difficult to measure productivity.
- **Physical infrastructure:** VA operates one of the most extensive systems of health care infrastructure in the country, but the need for additional physical space is a limiting factor in improving access, and it is sometimes difficult to update the physical space in older buildings to accommodate new technology and equipment.
- **Purchased care:** VA has many outside options for providing care to Veterans, including several programs and various types of payment or contractual arrangements, although managing these overlapping resources can be challenging.
- **Informational resources:** VA has been and continues to be an innovator and leader in IT, although there is room for improvement in some areas, including issues related to the management and planning of its IT systems. VA's electronic health record technologies suffer from aging architecture and 10 years of limited development. However, interviews suggest strong support for renewed investment in a modern, home-grown product rather than transitioning to a commercial alternative.

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VA does not currently face an overall crisis in access to care; however, we found considerable variability across the dimensions of access (geographic, timely, financial, digital, and cultural).

There is wide variation in access: For example, at 91 top-performing VA facilities, over 96 percent of new primary care patients receive appointments within 30 days of the preferred date. However, 14 VA facilities were far below this benchmark, with less than 84 percent of patients receiving appointments within 30 days of the preferred date. At top-performing VA facilities, more than 60 percent of Veterans report that they “always got urgent care appointments as soon as needed.” At the worst-performing VA facility, this rate was closer to 20 percent. On patient surveys, Veterans are substantially less likely than private-sector patients to report getting appointments, care, and information as soon as needed.

Geographic access is another challenge for VA. Veterans are highly dispersed throughout the United States, and ensuring nearby access to needed services is difficult. Many Veterans have access to VA care by a general standard of less than 40 miles distance from any facility (measured either using a straight line or driving distance), not considering the services available. Geographic access is worse when using different types of access standards. Veterans who must rely on public transportation, for example, have much lower levels of access than other Veterans. Geographic access to specialized facilities and providers is also lower.

There is substantial variation in quality measure performance across VA facilities, indicating that Veterans in some areas are not receiving the same high-quality care that other VA facilities are able to provide. For example, there was a 21-percentage-point difference in FY 2014 performance between the lowest- and highest-performing VA facilities on the rate of eye exams in the outpatient setting for patients with diabetes.

VA uses many systems for monitoring quality. On most quality measures for outpatient care, VA outperformed other health care systems, while the performance on quality measures of inpatient care was mixed, with some better and others worse. On average, VA hospitals performed the same or significantly better than non-VA hospitals on 12 inpatient effectiveness measures, all six measures of inpatient safety, and three inpatient mortality measures, but significantly worse than non-VA hospitals on two effectiveness measures and three readmission measures..

Changes in policy can help ensure continued access to VA care. If no substantial changes are made, projections indicate that it could be more difficult in 2019 for VA to provide accessible and timely care for Veterans than it was in 2014. However, we identified several policy options to ensure that Veterans have continued access to care, including formalizing full nursing practice authority, increasing the number of VA physicians, and expanding virtual access to care.

The impact and feasibility of increasing purchased care would be highly dependent on the scope of the change. Shifting a greater share of services from VA to purchased care would require more fundamental changes to VA. We did not find evidence of a current system-wide crisis in access to VA care that would indicate that such a change is necessary, but it is possible that such a reorientation would improve both access and the quality of care. However, our analyses indicate that many Veterans without access to VA health care also face significant barriers to accessing purchased care, including distance and cultural barriers. Thus, the option

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to transform VA from a provider to a purchaser of health care would not necessarily have a significant positive impact on access.

B.1.2 Recommendations

Based on the findings of Assessment B, we make several recommendations to improve access to care for Veterans:

Use a systematic, continuous performance improvement process to improve access to care.

Although many VA facilities achieve very high levels of performance on key access and quality measures, there is also a great deal of variation across the system. A systematic effort is needed to identify unwarranted variation, identify and develop best practices to improve performance, and embed these practices into routine use across the VA system. Some of the best solutions may be developed locally to reflect local needs and contexts. Solutions should be designed to be responsive to Veterans' preferences, needs, and values.

Consider alternative standards of timely access to care. Timeliness standards should be reexamined. VA should examine the utility of existing alternative benchmarks, such as same-day availability or the third next available appointment. Access standards for other dimensions, such as cultural access, should also be developed and used in performance monitoring and improvement. VA should develop methods to routinely compare the timeliness of VA care with non-VA benchmarks and publish these comparisons for transparency.

Develop and implement more sensitive standards of geographic access to care. VA should compare the "one-size-fits-all" approach of driving distance to alternative standards that are more sensitive to differences between Veteran subgroups, clinical populations, geographic regions, and individual facilities. This assessment highlighted the importance of time spent driving, mode of transportation, traffic, and availability of needed services as key considerations in assessing geographic access to care.

Continue moving toward using a smaller number of quality metrics in quality measurement and improvement activities. VA maintains an extensive set of quality measures. Although use of these measures has led to improvements in care, the proliferation of measures creates burdens on staff and resources and can lead to emphasis on the measures rather than improvement in areas of care that are more likely to improve patient outcomes. VA has already moved toward reporting systems that rely on a smaller number of measures, such as Strategic Analytics for Improvement and Learning (SAIL).¹¹⁶

Take significant steps to improve access to VA care. Our projections indicate that increases in both VA resources and the productivity of resources will be necessary to meet increases in demand for health care over the next five years. The options we considered that have the highest estimated potential impact are formalizing full nursing practice authority, increasing physician hiring, and increasing the use of virtual care. These are commonly proposed options for increasing access to VA care. In addition, new models of health care delivery are emerging

¹¹⁶ Although SAIL uses fewer measures to simplify reporting, they are composite measures which still incorporate numerous individual performance measures.

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rapidly in the U.S. health care system that could improve access to care. VA should seek to be an early adopter of these new models and should build a strategy that enables and supports such innovation.

Establish VA as a leader and innovator in health care redesign. As a large integrated delivery system, VA is well-placed to innovate in comparison with many U.S. health care delivery systems. It should endeavor to maximize this opportunity, given the constraints associated with being a public entity (for example, hiring processes, salaries, budgeting). VA should also endeavor to learn from current leaders in areas where its leadership position has eroded, particularly in health IT, and seek to reestablish its leading position.

Streamline programs for providing access to purchased care and use them strategically to maximize access. Currently available programs are overlapping and confusing to Veterans and VA employees as well as non-VA providers. VA should clearly identify the objectives of purchased care access and streamline programs to meet those objectives.

Systematically study opportunities to improve access to high-quality care through use of purchased care. Some types of care may be more effectively and efficiently delivered by non-VA providers. Identification of these types of care and the impact of shifting care to non-VA providers requires an in-depth systematic analysis that was beyond the scope of this assessment.

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Appendix C Care Authorities

Scope

Assessment C examined the “authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Department facilities, including whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care.” The Assessment C team reviewed the history of VA purchased care authorities and the programs through which VA has carried out these activities nationally and at the local level, related challenges and opportunities for VA purchased care in the future, and the ways in which varying definitions of “episodes of care” affect VA authorities and strategies for purchasing health care services.

Findings

VA has a complex set of authorities to purchase care, reflecting tension among implicit aims.

Prior to the passage of the Veterans Choice Act in 2014, the Secretary of VA had longstanding authority to furnish purchased care if VHA facilities could not provide the needed services directly. Although the basic grant of authorities to the Secretary is expansive in some respects, it is not unlimited. It involves significant controls on when, how, and for whom medical care may be purchased. These controls implicitly reflect several competing aims beyond simply making outside care available, including restricting costs and maintaining a balance between VA’s provider and payer functions. In sum, not only are VA’s authorities for furnishing purchased care complex and scattered, but they also embody more than one aim, and those aims may operate partly in tension with each other.

The episode of care defines the “unit” of VA authorization and may help shape purchased care in practice. The authorities for purchasing care tie into “episodes” primarily through program requirements for authorization (for example, as specified under the Veterans Choice Act). However, in principle, an episode conceptually bounds a clinical problem for which a Veteran might require outside services, so it might therefore make sense to outsource care as a coherent “unit.” Future refinements in defining episodes of care, and an authority framework that allows the Secretary to adopt such refinements, may be critical to supporting VA’s adoption of bundled payment and value-based purchasing mechanisms in the future.

The purchased care landscape is in the midst of transformation. Numerous changes to VA’s authorities and mechanisms for purchasing care are being proposed, planned, or implemented. These developments have included new administrative pilots for administering the Choice and Patient-Centered Community Care (PC3) initiatives, modifications to the eligibility criteria under Choice, revisions to VA’s procurement authority for purchased care, the extension of the Choice program and reallocation of funding, and the consolidation of existing purchased care mechanisms and initiatives under a unified programmatic umbrella. With these facets of purchased care authorities and practice in flux, the full landscape of VA purchase care is not just complicated, but dynamically so. Moreover, while the proposed policy changes seek to address many different problems and issues, their sheer multiplicity suggests the drawbacks of a piecemeal approach to reform and the lack of guiding orientation and strategy for VA’s purchased care enterprise as a whole.

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Recommendations

VA and Congress should articulate a clear strategy governing the use of purchased care. Such a strategy should clearly explain how purchased care fits into VA's broader health care mission and establish benchmarks for success in the adoption of purchased care reforms. The strategy should provide structure for purchased care authorities and procedures, as well as flexibility to support surge needs and Veteran-centered care.

VA and Congress should address cost control explicitly and systematically to guide consistent utilization and decision-making. Existing purchased care authorities establish an indirect set of cost controls through a discretionary health benefit funded by annual appropriations. VA should address cost control in purchased care explicitly and directly through a rigorous performance evaluation of existing purchased care contracts, better and more systematic collection of data on purchased care costs, and stronger cost-control mechanisms, such as co-pays, deductibles, and utilization reviews.

VA should collect better data to accurately estimate the demand for and use of purchased care. VA lacks systematic data on various facets of purchased care, particularly at the local facility level. It needs a strong base of data and analysis to monitor purchased care costs and processes and improve outcomes for Veterans.

VA should develop a stronger program management structure for purchased care and allocate responsibility and authority to the most appropriate levels. For example, referrals should be managed locally, while large contracts (such as those under Choice and PC3) should be managed centrally. VA leadership should issue clear policy and procedural requirements while facilitating appropriate flexibility in the field at the local level.

VA should evaluate the third-party contractors administering its managed purchased care programs. As the PC3 and Choice programs are fully implemented and continue to grow, VA should establish an ongoing process for evaluating the performance of third-party administrators. It should also assess the adequacy of the provider networks, the efficiency of claims processing and other activities, and Veterans' experiences with the programs.

VA should develop clear, consistent guidance and training on its authority to purchase care. VA should create a consolidated manual on purchased care, together with associated training and messaging that explains VHA's authority to purchase care and clarifies eligibility standards and processes.

VA purchased care contracts should include requirements for data sharing, quality monitoring, and care coordination. In its contracts with outside providers and third-party administrators, VA should require routine reporting of quality measures to ensure that the quality of care Veterans receive through non-VA providers is equivalent to the quality of care offered by VA. Such contracts should also include provisions for how non-VA providers will communicate and coordinate with VA counterparts.

VA should consider adopting innovative, but tested, ways to purchase care. TRICARE and Medicare offer useful lessons in how to purchase care. VA should incorporate some of these

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strategies, including outsourcing administrative functions and offering performance incentives to contractors.

VA and Congress should eliminate inconsistencies in current authorities and provide VHA with more flexibility to implement a purchased care strategy. There are several points of tension and confusion within existing authorities, including inconsistencies in standards for episodes of care, the subjective nature of some elements of 38 U.S.C. 1703 (the core statutory authority for VA purchased care), different definitions of geographic inaccessibility and wait times, and conflict between the language and intent of the rule specifying that the Choice program can be used if there is not a VA facility within 40 miles of the Veteran's residence. Congress and VA should also consider the more ambitious step of simplifying purchased care authorities and mechanisms generally, by seeking to consolidate and harmonize them. At least in principle, such a step could help reduce the complexity and ambiguity now associated with purchased care authorities and mechanisms.

VA and Congress should revise the definition of episode of care to better accommodate Veterans' needs. Under the Veterans Choice Act, VA must allow Veterans who use the Choice program to seek outside services through the completion of an episode of care, "but for a period not in excess of 60 days." The legal requirement for a fixed-term reauthorization of an episode runs contrary to evolving clinical practice and standards in the broader health care sector. A revision of this authority would improve monitoring of episodes of care and reduce the administrative burden on VA staff and Veterans.

VA and Congress should adopt a consistent strategy for setting reimbursement rates across purchased care initiatives. Such a strategy should balance cost and access considerations. In setting reimbursement rates, VA mechanisms and contracts for purchasing care should reflect the reality of local competitive market conditions.

The complete Assessment C report is available in Volume II.

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Appendix D Access Standards

Scope

Assessment D responded to language in Title II, Section 201, of the Veterans Choice Act of 2014 that mandated an independent assessment of “the appropriate system-wide access standard applicable to hospital care, medical services, and other health care furnished by and through the Department, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation.”

To address the requests in Assessment D, the Department of Veterans Affairs, Veterans Health Administration contracted the Institute of Medicine (IOM). The IOM formed an ad hoc Committee and instructed it to conduct a study and prepare a report directed at exploring appropriate access standards for the triage and scheduling of health care services for ambulatory and rehabilitative care settings to best match the acuity and nature of patient conditions.

Convened at the request of VA/VHA, the committee was charged with the following tasks: (1) review the literature assessing the issues, patterns, standards, challenges, and strategies for scheduling timely health care appointments; (2) characterize the variability in need profiles and the implications for the timing in scheduling protocols; (3) identify organizations with particular experience and expertise in demonstrating best practices for optimizing the timeliness of scheduling matched to patient need and avoiding unnecessary delays in delivery of needed health care; (4) consider mandates and guidance from relevant legislative processes, review wait time proposals from the VA/VHA Leading Access and Scheduling Initiative, and evaluate all evidence indicated above, along with input and comment from others in the field; (5) organize a public workshop of experts from relevant sectors to inform the committee on the evidence of best practices, their experience with acuity-specific standards, and the issues to be considered in applying the standards in various health care settings; and (6) issue findings, conclusions, and recommendations for development, testing, and implementation of standards, and the continuous improvement of their application. Throughout its work, the committee has been guided by its view that health care must always be patient and family-centered and implemented as a goal oriented partnership.

To do so, the committee:

1. Reviewed the literature assessing the issues, patterns, standards, challenges, and strategies for scheduling timely health care appointments
2. Characterized the variability in need profiles and the implications for the timing in scheduling protocols
3. Identified organizations with particular experience and expertise in demonstrating best practices for optimizing the timeliness of scheduling matched to patient need and avoiding unnecessary delays in delivery of needed health care
4. Organized and held a public workshop of experts from relevant sectors to inform the committee on the evidence of best practices, their experience with acuity-specific

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standards, and the issues to be considered in applying the standards under various circumstances

5. Issued findings, conclusions, and recommendations for development, testing, and implementation of standards, and the continuous improvement of their application.

In the course of its work, the committee considered mandates and guidance from relevant legislative processes, reviewed VA wait time proposals from the Leading Access and Scheduling Initiative, and evaluated all evidence indicated above, along with input and comment from others in the field.

Findings

The committee summarized its findings as follows:

- **Variability:** Timeliness in providing access to health care varies widely.
- **Consequences:** Delays in access to health care have multiple consequences, including negative effects on health outcomes, patient satisfaction with care, health care utilization, and organizational reputation.
- **Contributors:** Delays in access to health care have multiple causes, including mismatched supply and demand, a provider-focused approach to scheduling, outmoded workforce and care supply models, priority-based queues, care complexity, reimbursement complexity, financial barriers, and geographic barriers.
- **Systems strategies:** Although not common practice, immediate engagement for patients is achievable through queue streamlining and related systems strategies to access and scheduling.
- **Supply and demand:** Continuous assessment, monitoring, and realigning of supply and demand are basic requirements for improving health care access.
- **Reframing:** Alternatives to in-office physician visits, including the use of non-physician clinicians and technology-mediated consultations, can often meet patient needs.
- **Standards:** Standardized measures and benchmarks for timely access to health care are needed for reliable assessment and improvement of health care scheduling.
- **Evidence:** Available evidence is very limited on which to provide setting-specific guidance on care timeliness.
- **Best Practices:** Emerging best practices have improved health care access and scheduling in various locations and serve as promising bases for research, validation, and implementation.
- **Leadership:** Leadership at every level of the health care delivery system is essential to steward and sustain cultural and operational changes needed to reduce wait times.

In addition to the significant variability in wait times among care settings, among specialties, and over time, there is a lack of national standards and benchmarks for appropriate wait times. While references to timely care appear regularly in legislative proposals, a prevailing definition of timeliness has not yet emerged. While national standards for access and wait-times do not presently exist, the committee did also identify examples of organization-specific benchmarks

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within various health care settings. For example, some organizations set internal benchmarks of same-or next-day engagement for new and returning patients in primary care (Southcentral Foundation's Alaska Native Medical Center) or first time appointments of newly diagnosed cancer patients (Dana-Farber/Brigham and Women's Cancer Center in Boston); internal benchmarks guide door to provider times within emergency departments (Virginia Mason Hospital), wait times for specialty new visits (Cincinnati Children's Hospital), and primary care backup practices for urgent services (Tufts Health Plan Network Health). The Joint Commission has also developed standards pertaining to emergency department boarding times and hospital discharge risk assessments. Organization-specific benchmarks, such as these, serve as promising reference points for future research and validation.

Recommendations

The committee issued four recommendations for health care delivery systems leadership, leading to: 1) front-line scheduling practices anchored in the basic access principles, 2) governance commitment to leadership on basic access principles, 3) patient and family participation in designing and leading change, and 4) continuous assessment and adjustment at every care site.

Specifically, the committee recommended that:

1. The front-line scheduling practices of primary, specialty, hospital, and post-acute care appointments should be anchored in basic access principles, including: supply matched to projected demand, immediate engagement, patient preference, care tailored to need, surge contingencies, and continuous assessment.
2. The leadership and governing bodies at each level of the health care delivery sites should demonstrate commitment to implementing the basic access principles through visible and sustained direction, workflow and workforce adjustment, the continuous monitoring and reframing of supply and demand, the effective use of technology throughout care delivery, and the conduct of pilot improvement efforts.
3. Decisions involving designing and leading access assessment and reform should be informed by the participation of patients and their families. The potential ways that patients could provide their expertise through informal or formal channels (e.g., patient and family advisory councils, surveys, and focus groups) include contributing input on their expectations, experiences, and preferences for scheduling practices and wait times; helping representatives of health systems explore alternative access strategies; contributing to the design of pilot improvement efforts; helping to shape communication strategies; and interfacing with governance and leadership.
4. Care delivery sites should continuously assess and adjust the match between the demand for services and the organizational tools, personnel, and overall capacity available to meet the demand, including the use of alternate supply options such as alternate clinicians, telemedicine consults, patient portals, and web-based information services and protocols.

The complete Assessment D report is available in Volume II.

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Appendix E Workflow – Scheduling

E.1 Scope

Health systems across the United States have struggled with ensuring optimal patient access to the services they provide, and VHA is no exception. Although the Veterans Health Administration (VHA) has faced public concerns about access to outpatient care for several decades, many factors that influence access have been only partially analyzed to date at VHA and were called out in the Choice Act as areas for independent assessment. The Choice Act tasked Assessment E with assessing “the workflow process at each medical facility of the Department for scheduling appointments for Veterans to receive care, medical services, or other health care from the Department.” The assessment was also asked to address several supplemental areas related to provider scheduling templates, scheduler training, the use of call centers and the appointment scheduling system. All of these factors—as well as others explored in Choice Act assessments such as overall health care capabilities (Assessment B) and clinical staffing (Assessment G)—are critical to ensuring that our Veterans receive improved access to care. Volume II contains the full Assessment E report.

E.1.1 Findings

In this assessment, we have reviewed VHA performance in the scheduling workflow areas against best practices from both within VHA and across the private sector. The major finding of this assessment is that VHA is not fully leveraging provider resources, scheduling best practices, or scale to deliver the best possible scheduling experience and access for Veterans. These shortcomings have a negative impact on both patient access to outpatient appointments (in terms of total number of appointments available and the matching of patients to those available appointments) and the patient experience of scheduling an appointment with VHA. It is likely that, with improved data visibility, more streamlined processes and performance management, VHA could expand the supply of appointments even with its existing provider base, as well as improve overall utilization of appointment supply and patient experience.

More specifically, we observed the following challenges that reduce the overall effectiveness of VHA scheduling today:

- System limitations prevent accurate visibility into the supply of available appointments, inhibiting VHA’s ability to understand the gap between total appointment supply and demand and to effectively manage current performance and plan for the future.** Due to system design limitations, some providers operate across multiple, potentially overlapping, booking templates or “clinic profiles” for any given day or session. As a result, these profiles, when aggregated, provide an inaccurate picture of total available appointment supply and make it challenging to easily understand whether appointment supply matches the quantity VHA should expect given the number of providers. The issue of overlapping profiles not only affects centralized calculations of overall and provider-level appointment supply, but also makes it challenging to calculate provider utilization rate, which is an essential metric for

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managing access to care. These limitations mean VHA cannot determine how much patient demand its current provider capacity can meet in a timely manner.

- **Imbalance between supply and demand has led to policies that add responsibilities for schedulers and administrators.** Because VHA has a persistent backlog of patient demand, VHA created additional policies that do not exist in the private sector, such as the capture of patient desired date and the use of the Electronic Wait List (EWL). These policies for measuring wait times and managing waitlists have resulted in a significant number of additional activities required within the scheduler's day-to-day workflow. Further, the implementation of these policies is left largely to frontline interpretation, which may also result in inconsistent experience for patients across clinics or facilities. For example, use of the EWL varies across clinics; some clinics use it solely to measure backlog while others use it to highlight patients who may be willing to take an appointment that becomes available at the last minute (Choice Act site visits, interviews 2015). Veterans may then experience variation in when they are removed from the waitlist depending on how their clinic has implemented EWL.
- **Clinics do not consistently employ standard industry practices related to schedule setup and other scheduling processes.** VHA clinics are inconsistent in their use of industry and VHA best practices in scheduling, resulting in a fewer appointment slots available than may be possible within existing provider capacity and a significant number of booked appointments not being completed as originally scheduled. On schedule setup, examples of these practices in common use in industry and within certain services (such as Primary Care) within VHA include using standard appointment lengths within a sub-specialty and determining appointment mix (for example, number of new patient slots) based on patient demand (Institute for Healthcare Improvement (IHI), "Reduce Scheduling Complexity," n.d.; Primary Care Clinic Profile Standardization Guide, 2014). Similarly, inconsistent scheduling practices, such as the ways in which appointment reminders are used, exist across facilities and clinics. For example, a patient could expect a reminder from a clinic and not receive it (and potentially not go to the appointment as a result). Ultimately, the variability in these practices may result in reduced appointment availability and utilization as well as inconsistent patient experience.
- **Facility-level differences in performance management and accountability limit system-wide improvements in access.** VHA facilities lack consistent organizational structures for managing scheduling or access and, in many cases, lack dedicated resources to manage performance and outcomes for these activities. Given structural differences, formal monitoring of schedules is not a clearly defined duty for any staff members at the facility level, which hinders cross-system sharing of best practices, policy dissemination, and process standardization. In addition, this lack of consistency in organizational structure and accountabilities limits VHA performance management of facilities, as no one individual is specifically accountable and data analysis is

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cumbersome.¹¹⁷ The Veterans Choice Act (Section 303) identified this lack of accountability and aims to assign management of access responsibilities to a particular role within each clinic and to provide tools and processes to help perform this duty (“Veterans Access, Choice, and Accountability Act of 2014,” 2014). VHA plans to fulfill this mandate without any new facility hires; instead, the organization will designate current FTEs as owners of these responsibilities at the clinic and facility levels (Access and Clinic Administration Program [ACAP], interviews, 2015).

- VHA-specific processes paired with a scheduling system that does not simplify processes leads to a greater reported need for scheduler training.** In response to a survey, 90 percent of schedulers noted the need for additional training in at least one area (for example, wait times and wait list policies) to become proficient at executing their basic responsibilities (Assessment E VHA Employee Survey, 2015). This perceived need for enhanced training may be due to systems and processes that do not simplify scheduler responsibilities, a common focus among private sector health system executives we interviewed. For instance, scheduling systems of private sector health systems have more user-friendly interfaces, fewer unique programs, and more automated processes (Private sector health system, interviews, 2015). As a result of greater complexity, VHA schedulers must receive additional training (on wait times and wait list policies, for example) to become proficient at executing basic VHA scheduler responsibilities.
- Scheduling call centers are not maximizing their performance due to their small scale and disparate service offerings.** VHA call centers are smaller than industry standard (median size of 12 agents within VHA compared to 28 agents in private sector health systems and 110 agents across other industries) (Assessment E national data call, 2015; Belfiore et al., 2015). The scheduling call centers that do exist provide different services and support different specialties depending on the facility. Due to efficiencies in managing call demand that can lead to service improvement for patients, other provider systems have, in some cases, moved to pooling call volumes in more central locations. Larger scale call centers can also have lower per-unit costs and put less stress on space-constrained facilities than facility- or clinic-based operations. Further, larger call centers may be able to offer more coaching, training and career options to schedulers.

E.1.2 Recommendations

VHA has received significant feedback on ways to improve its scheduling and access performance. In fact, since 1999, more than 35 reports by the Government Accountability Office, VA itself, VA Office of the Inspector General (OIG), and independent contractors have commented on possible approaches for VHA to improve scheduling and access. Despite the number of reviews, there has been little articulation of the fundamental need for VHA to solve its ability to manage provider appointment slot supply until the Institute of Medicine’s February

¹¹⁷ For example, at present, there is no easy or automated way to consistently and accurately monitor provider schedules.

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2015 “Innovation and Best Practices in Health Care Scheduling” white paper, which recommended that VHA get “back to the basics” to understand provider supply vis-a-vis patient demand and ultimately design schedules that optimize the two. With the access crisis and subsequent Choice Act in 2014, VA/VHA have accelerated several efforts to address issues raised in past reports, including funding provider hiring and non-VA care, initiating the procurement of a commercial off-the-shelf (COTS) scheduling system referred to as the Medical Appointment Scheduling System (MASS), and designing a clinic manager training program to better manage the scheduling process. However, to drive overall improvement to scheduling and address the specific challenges described above, we recommend that VA and VHA successfully complete in-flight initiatives and consider additional actions, which would be most effective if executed in an integrated manner. These actions include the following:

- Address system limitations to provide visibility into aggregate appointment supply, alternative measures of wait times, and provider-level performance data.** VHA providers can operate across multiple and sometimes overlapping clinic schedules (also known as “profiles”),¹¹⁸ which can result in double-counting of appointment slots when aggregated. VHA has a current initiative to clean-up overlapping schedules and unused clinic profiles that should result in a more accurate view of each clinic’s appointment slot supply. Although this is an important first step, the effort may not eliminate all overlap in schedules and will not by itself allow understanding of appointment supply and utilization. One consolidated schedule for each provider would allow VHA to capture total appointment supply and measure the industry-standard wait time metric. With VA OI&T’s current procurement of a new scheduling system (discussed in detail in section 7, Scheduling System), VHA may be on the path to addressing system limitations. Of course, when updating or acquiring a system to support scheduling, it is important to understand the business case relative to modifying the existing system or locally sourcing solutions at the facility / regional level.
- Codify proven scheduling practices and empower clinics to improve appointment utilization and deliver a consistent patient experience.** Several pockets of scheduling best practice exist within VHA, such as the predictive missed opportunity model. However, many of the best practice VHA tools and processes are not widely disseminated nor utilized. The VHA ACAP Office reported that it is beginning to codify system-wide knowledge of scheduling best practices, but there is also an opportunity to ensure that these practices are consistently utilized in the field (ACAP, interviews, 2015). This will require addressing the lack of clinic management resourcing, addressing scheduler vacancies and ensuring that providers have an understanding of why certain practices (for example, overbooking) may be necessary to provide access.
- Streamline scheduling policy implementation with supporting tools and implementation guidance; where possible, utilize technology to support.** The current Scheduling Directive policy is designed to aid VHA facilities in managing in an environment of excess demand relative to the appointment supply it is offering. This has

¹¹⁸ Described in Provider Availability Section 5 of this report

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resulted in policy steps, such as wait time capture and wait list management being added to the scheduling process, which can result in inconsistent patient experience due to discrepancies in policy interpretation and implementation in the field. For instance, to adhere to the policy regarding the Electronic Wait List, the scheduler will place a patient scheduled outside of 90 days on a wait list, an additional step in the scheduling process (Choice Act site visits, interviews, 2015). Further, while the EWL prioritizes Veterans to be scheduled based on policy, schedulers can find it challenging to use the list in conjunction with other policies (e.g., how many times the patient should be called before moving to the next patient on the list). In contrast, an ideal system would automatically place relevant patients on the EWL, provide a manager with a comprehensive dashboard for monitoring the waitlist demand, and prioritize which patients should get the first available appointments based on additional parameters. As a result, these changes would improve schedulers' efficiency and improve consistency of policy implementation.

- Improve scheduler training by sharing local best practices and increasing experiential and on-the-job training, while also minimizing the need for training by simplifying policy implementation and improving system functionality.** Currently VHA's need for scheduler training is exacerbated by its scheduling software, policies (like EWL), and clinic- and provider-specific scheduling rules. Improvements to the scheduling systems, streamlining policy implementation, and minimizing unnecessary clinic-specific rules would reduce demands for schedulers' training and create more consistent patient scheduling experience. To optimize its training program, VHA should also leverage local best practices to create an improved and standardized curriculum for training and minimize duplication of materials development at the facility-level. In addition, training should be delivered using more experiential training methods to increase its effectiveness and information retention by schedulers.
- Design scheduling call centers that can provide expanded services for Veterans relative to current state.** Currently, VHA scheduling call centers are managed locally at the facility level. As a result, most are small (median size of 12 schedulers, based on facilities that responded to our data call) and each call center varies in regards to the responsibilities and specialties for which it is responsible (Assessment E national data call, 2015). Decentralized call centers are difficult to centrally monitor and manage with regards to patient experience. Through the new myVA effort, the organization is examining how it interacts with Veterans across various channels (such as, web, call centers, mail). This includes a VA-wide Call Center Task Force that may ultimately address scheduling; however, the scope does not yet appear to be clearly defined. VA has an opportunity to evaluate its current call center use for scheduling and develop an approach based on existing VHA call centers in other areas (like Health Resource Centers) and leading private sector scheduling call centers. VHA can then evaluate which responsibilities and specialties should be handled at larger scheduling call centers. Additionally, VHA should analyze the appropriate degree of centralization (for example, regional or virtual call center) and the call center locations.

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- Ensure that the clinic manager training program and subsequent implementation are appropriately scoped and resourced to drive access and clinic management.** Different roles, accountabilities and levels of expertise exist across facilities for managing access and scheduling, which affects how access and scheduling is managed and prioritized at different facilities. Via the Choice Act, VHA was directed to develop a clinic management training program to address these gaps within the system. While many important scheduling functions are reported to be addressed in the training curriculum as it is currently envisioned, resourcing and accountability for these activities will be equally important in ensuring that VHA is able to fully utilize its provider capacity and the appointment supply made available to Veterans. Further, tools need to be developed and distributed to ensure that these new clinic managers are successful.

Despite many of its broader organizational and operational challenges, VHA can leverage multiple positive aspects of its current scheduling and access management practices in the future. For instance, VHA's scheduling policy has created the mechanism to identify potential supply-demand imbalances by tracking patients waiting for care at the clinic level. Similarly, VHA's efforts to encourage patient appointment adherence through a multi-pronged patient reminder approach, coordination of transportation and efforts to coordinate multiple services, where possible, demonstrate a commitment to supporting Veterans receiving care. Additionally, locally developed scheduling innovations demonstrate the potential for new scheduling tools and practices within the organization. For example, several VA Medical Centers (VAMCs) have developed home-grown "best practice" tools, including the predictive missed opportunity model, aggregated views of provider availability, and facility-centralized patient reminder systems across multiple modalities. In addition, VHA can build on its early efforts to modernize its patient-facing scheduling capabilities, such as online self-scheduling. This foundation suggests that VHA can draw on experience and assets within the organization, as well as on external best practices, to improve its scheduling processes.

In summary, if VA / VHA were to continue to build on existing assets, execute on its in-flight initiatives and supplement them by executing on the recommendations above, it may be able to offer a more consistent experience across clinics and facilities, expand appointment supply with existing provider resources and ensure better utilization of its supply. The impact of this for Veterans could come in the form of both improved experience and improved access.

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Appendix F Workflow – Clinical

F.1 Scope

Assessment F (Inpatient Clinical Workflow), Section 201 of the Veterans Access, Choice, and Accountability Act of 2014 (“The Choice Act”) mandates an assessment of the “organization, workflow processes, and tools used by the Department to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.” Pursuant to this language, Assessment F focused on the organization, workflow processes, and tools (i.e., structural components and approaches) in place within acute care hospitals to facilitate the five identified sub-assessments as both individual components as well as part of the interdependent continuum of inpatient care. Comparison of current VHA practices to accepted best practices (drawn from literature and professional associations), as well as standard practices (drawn from public and private sector benchmarks) provided insight into alternative approaches and recommendations. While selected performance outcomes were used to prioritize areas of focus, a complete analysis of clinical, performance, operational, or other outcomes associated with the employed approaches was not in scope for this assessment. Volume II contains the full Assessment F report.

F.1.1 Findings

Our assessment identified both cross-cutting strengths and opportunities for improvement as well as findings and recommendations specific to each of the five sub-assessment areas reviewed.

F.1.1.1 CROSS-CUTTING FINDINGS

We observed three common themes supported by findings across sub-assessment areas.

- Ineffective data collection and management drives a lack of transparency into many key aspects of clinical operations, hindering VHA’s ability to effectively manage inpatient care.** Despite having a well-regarded EMR system and the capability of tracking extensive clinical data, poor data collection and management of operational metrics was a consistent theme heard during site visits. Furthermore, it was clearly evident from our central and local requests for specific information. Data that is standard in private sector hospitals was frequently inaccessible in a timely manner or not tracked in a usable format by VHA. For example, VHA FTE and payroll data includes information by clinical occupation but not by department, which prevented planned analysis of the appropriateness of staffing, since needed staffing levels vary considerably by department (e.g., the ICU requires more concentrated nursing attention than med/surg floors; see Volume II, Assessment F, Section 5 for more detail). We observed data integrity and availability issues significantly affecting VHA’s visibility into clinical operations in four of our five sub-assessment areas and believe that this likely affects VHA’s ability to manage operations at the local and national levels.

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- VHA resources (e.g., staff, beds) do not always match Veterans’ care needs.** The practical allocation and prioritization of resources across the VHA system may not be consistently aligned to meeting the broader health needs of the Veteran patient population. Mis-match of resources to patient care needs manifests itself in three ways: hiring that does not consistently match staffing needs; allocation of staff to tours (“shift”) that do not consistently match Veteran demand; and limited access to appropriate outpatient and post-/sub- acute care options. An example of the impact limited outpatient and post-acute care options has on Veterans can be seen in the abundance of inpatient admissions and continued stays that do not meet admission and continued stay criteria. National Utilization Management (NUMI) data¹¹⁹ indicates that 23 percent of inpatient admissions (see Volume II, Assessment F, Section 6 for more detail) and 34 percent of inpatient stays overall do not meet admission and continued stay criteria (see Volume II, Assessment F, Section 7 for more detail). Many are admitted to, or remained in the hospital, due to challenges in accessing the appropriate level or type of care (e.g., primary care, detoxification center, post-acute rehabilitation). The disconnect between resources and demand has clear implications on VHA’s ability to effectively and efficiently provide the care needed to improve the health and well-being of Veterans.
- While best practices exist in selected pockets, communication and support for implementation at scale appears to be a challenge.** Our site visits revealed several clear best practices in place at various VAMCs; however, adoption of these practices was isolated even within the facility. Case studies of particularly strong programs are included in all sub-assessments. Despite successfully adopting best practices in some units, however, facilities appeared to struggle to implement programs house-wide. Moreover, information-sharing between VAMCs appears to be limited and ad hoc. As one Assistant Director of Patient Care Services described, “I’m shameless about stealing what works at other places, the problem is, I don’t know what other places are doing. We need a way to connect, to learn from each other”¹²⁰. This sentiment was echoed by many staff across all of the facilities we visited.

SUB-ASSESSMENT FINDINGS

In addition to the broad cross-cutting findings, a review of each sub-assessment identified specific strengths and opportunities for improvement within their areas of focus.

- Clinical staffing:** Siloed resource management (e.g., limited coordination across service lines on FTE requests), poor data management, and limited guidance on staffing methodology result in staffing practices that are seldom evidence-based, outside of a few best practice areas (such as nursing). This prevents VHA from knowing whether staffing

¹¹⁹ NUMI (National Utilization Management Integration): supports national utilization management agenda by providing a common tool for tracking performance on utilization management metrics across facilities

¹²⁰ Facility interview

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allocations are appropriate. Furthermore lengthy hiring timelines and inconsistent alignment of staff to patient care needs have downstream implications.

- **Access:** Best practices exist at disparate facilities however, their lack of systemic adoption combined with an inaccurate understanding of patient demand and available capacity and inconsistent admission and bed assignment practices hinder inpatient access.
- **Length-of-stay and care transitions:** National efforts to improve length-of-stay have been hampered by challenges meeting discharge needs of patients requiring specialized post-acute care (e.g., homeless, psychiatric diagnoses), inefficiencies in care delivery practices (e.g., limited availability of weekend consults), and inconsistent approaches to discharge planning often delay care transitions and discharge beyond private sector benchmarks.
- **Patient experience:** Best practice innovations are evident at the national and local levels, but challenges with patient satisfaction data transparency and national implementation support limit system-wide adoption.
- **Documentation and coding:** Limited understanding by providers and coders of the link between coding and resource allocation, coupled with limited performance management, likely contribute to sub-optimal documentation practices yielding lost revenues and misaligned resources. Despite these challenges, coding performance is a relative strength and comparable with industry standards.

F.1.2 Recommendations

Across sub-assessments, our recommendations also fall under three major themes:

- **Improve clinical management through establishing clear operational metrics, and streamlining data collection focused on clinical priorities, monitoring, and performance management.** Appropriately defining standards for high performance and having accurate information on how departments and facilities measure against defined targets is the foundation of managing operations. Site visits, data analysis, and comparison against best and standard practices suggest that VHA lacks such visibility into clinical operations, significantly reducing its ability to address challenges and innovate (see Volume II, Assessment F, Section 3.1). We believe that improving transparency is critical to ensuring effective, timely, and efficient delivery of care to Veterans, across many of our sub-assessment areas. In part, transparency could be improved through enhanced data management, meaning both better data integrity and sharper focus on a targeted set of key metrics needed to assess performance. Equally important, VHA should ensure that facilities have clear operational guidelines on how to set and track appropriate performance goals (e.g., by providing comprehensive staffing methodologies for service lines with no national guidance).
- **Realign resourcing (for example, staff, facilities) to allow VHA to serve patients at the appropriate level of care (such as, increase Veteran access to sub-acute and post-acute care to reduce clinically inappropriate admissions and prolongation of acute inpatient stays).** We observed many instances in which VHA resources were not appropriately matched to patient demand. As described in Volume II, Assessment F, Section 3.2, there is a disconnect between resources and demand in delayed hiring of staff needed to

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support patient care, mis-allocation of staff to tours (i.e., shifts), and limited outpatient and post-acute care options needed to ensure treatment at the appropriate level of care. In order to provide high quality care that promotes the health and well-being of Veterans in a cost efficient manner, VHA should ensure that resourcing allows the system to serve patients at the appropriate level of care. Broadly, we see three categories of changes that could help effect this recommendation: improve hiring, allocate staff to match patient demand (e.g., align that staffing on weekend, holiday, and evening hours is sufficient to meet patient need), and increase access to outpatient and post-acute care options.

- Scale existing best practices and support further innovation at the local and national levels.** A consistent theme during our site visits and interviews was that the opportunity to build off of existing strengths within the system was encumbered by limited sharing of best practices across VAMCs (see Volume II, Assessment F, Section 3.3). In instances where best practices have been developed nationally, challenges appear to exist due to unclear guidance on implementation, occasional flaws in the design of programs, and lack of VAMC adoption. In instances where best practices have been developed locally, scaling seems to be inhibited by limited infrastructure for information-sharing and lack of resources. To address both sets of challenges and fully leverage and build off of institutional strengths, we suggest improving practices through a combination of targeted national guidance (e.g., streamline Veteran-centered care initiatives and mandates) and nationally-supported local best practice-sharing and innovation (e.g., build infrastructure to promote cross-facility sharing of patient flow best practices).

Several recommendations will require national coordination, while others could be implemented in the near-term at the facility level. We have provided additional tactical steps, titled near-term actions, for associated recommendations at the sub-assessment level and encourage facilities to review these and take action quickly at the local level where appropriate. Additionally, several pre-conditions for implementation (see Section II, Assessment F, Section 4.2.1) have been identified for prioritization by Congress and VACO to support a successful and sustainable system-wide transformation.

Implementing solutions to long-standing challenges will require collaboration among Congress and the Executive Branch, VA leadership (VACO, VISN, and VAMC) and staff, as well as the unions and external stakeholders. We see this assessment as an opportunity for improvement, to be achieved by all stakeholders through a combination of local, regional, and national action. Addressing these challenges will require sustained commitment as a part of an integrated transformation effort for the system as a whole.

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Appendix G Staffing/Productivity

Scope

Assessment G (Staffing/Productivity) examined “the staffing level at each medical facility of the Department and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics, which may include an assessment of the case load and number of patients treated by each health care provider, time spent by health providers on matters other than caseload, including time spent at an affiliate, conducting research, training or supervising other health care professionals of the department.”

Findings

The Assessment G team had several key findings and observations pertaining to the core assessment objectives: staffing, productivity, and time allocation.

The Assessment G team analyzed VHA provider staffing levels and compared them to the private sector (using physician per population ratio industry comparisons) and identified some of the challenges VHA faces in ensuring it has sufficient providers to meet demand. With respect to provider staffing levels, the Assessment G team found that:

- **VHA specialties with the highest provider full time equivalent (FTE) levels include medicine specialties, mental health, and primary care, consistent with VHA’s care model and the needs of the Veteran population.** Social Workers also represent a significant portion of provider FTEs. VHA does not systematically track fee-basis provider productivity, and does not capture FTE level information for fee-basis care providers.
- **VHA physician staffing levels per population are, in most specialties, lower than industry ratios.** These ratios are not sufficient to establish whether VHA is staffed to meet demand. One factor to consider is that even industry physician supply is not sufficient to meet demand in many specialties. Another factor to consider is that VHA uses Advanced Practice Providers (APPs) extensively, but APPs are not included in industry ratios.

The Assessment G team also assessed the productivity of VHA providers in comparison to providers in the private sector. With respect to provider productivity, the Assessment G team found that:

- **VHA measures the performance of its primary care providers (PCPs) using panel size.** VHA calculates a modeled panel size for providers based on a variety of factors at each facility. The model was developed based on research into the appropriate panel size for the unique needs of Veterans.
- **In accordance with policy, VHA facilities establish a maximum panel size for each primary care provider which is often lower than the modeled panel size.** The maximum figure takes into account specialized panel needs (for example, a geriatric population) and other factors deemed appropriate by the facility.
- **The actual panel size of VHA primary care providers is lower than internal and external benchmarks.** The actual panel size for VHA general practice physicians is 13 percent

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below the VHA modeled panel size, 12 percent below the external benchmark, and 5 percent below the facility maximum.

- **When compared to the private sector using wRVUs, there is a productivity gap in VHA specialty care.** When encounters (visits) are used as a measure, the gap shrinks and VHA specialty care compares more favorably to the private sector. VHA mental health providers are more productive than academic medical center (American Medical Group Management Association [AMGMA]) benchmarks, as measured by both wRVUs and encounters.
- **Overall, VHA specialty care providers are producing fewer wRVUs than private sector benchmarks; however, VHA specialty care providers at the highest complexity facilities are more productive than their peers.** Further, the most productive VHA providers (those at the 75th percentile of VHA providers) are often more productive than the private sector.
- **Productivity and access are important measures in population based health models like VHA that focus on patient outcomes, rather than volume.** VHA's Office of Productivity, Efficiency, and Staffing (OPES) reports on productivity and access offer tools for use by medical facilities. With some improvements to expedite adoption and regular use by medical centers, these tools could become key resources in optimizing productivity and maximizing access to care.
- **VHA dentists see fewer patients on average than private sector benchmarks, but serve a population with special needs.** The dentistry patient population of VHA generally has a compensable service-connected dental disability, is older, has more complex injuries, and may present for dental care following years of dental neglect.

The Assessment G team identified several barriers which limit provider productivity and may explain the differences between VHA provider productivity and that of the private sector, especially in specialty care. These include:

- A shortage of examination rooms and poor configuration of space
- Insufficient clinical and administrative support staff ratios
- Providers may not fully document and accurately code all of their clinical workload, which may impact the accuracy of wRVU productivity measurement

We noted the insufficient clinical and administrative support staff ratios as a key barrier to optimizing productivity and studied this more closely. More specifically, we found that:

- While there has been widespread implementation of the Patient Aligned Care Team (PACT) model in primary care clinics and the National Nurse Staffing Methodology in many areas of inpatient care, **there are no current VHA standards for staffing levels and/or mix in specialty clinics**, with the exception of eye clinics. Furthermore, VHA OPES has developed state of the art tools for managing staffing and productivity, but these tools will require improvements for leaders to more effectively leverage them in resource decisions.

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- **Organizational siloes and separate reporting lines exist for physicians, nurses and medical service administrators at a majority of VA Medical Centers (VAMCs).** As a result, service chiefs do not have control over the resourcing and performance of their clinical support staff (nurses) or clerical and administrative support staff.
- **Many facilities do not have a centralized staffing office or nurse float pool to address daily staff variances or absences.**

With respect to how providers spend their time, the Assessment G Team observed that:

- **VHA physicians spend a comparable proportion of total time devoted to clinical activities as private sector physicians.** There is some potential difference in the definition of direct patient care used by the private sector, specifically with respect to training, teaching and research, but we believe this represents only a small proportion of a provider's direct patient care time.
- **Across all VHA providers, less than two percent of time is devoted to research.** Since provider time spent devoted to clinical care activities is comparable to the private sector, it does not appear that research activities reduce providers' time spent treating patients. Despite the overall low proportion of time spent on research, the accomplishments of VHA's research program, and contributions to advancing care for Veterans, are numerous.

Recommendations

Taking the above findings into consideration, the Assessment G Team offers five cross-cutting recommendations:

VHA should improve staffing models and performance measurement. VHA should conduct an evaluation of the design and implementation of current VHA staffing models to determine the extent to which they are sufficient to meet the goals of VHA's population health focused model and ensure all eligible Veterans have access to high quality, timely care. VHA should conduct a program review of the implementation of the PACT staffing model in primary care to identify the causes of the gaps between actual, facility maximum, modeled and external benchmarks, the impacts of these performance gaps on access to quality care, the appropriateness of current guidelines and performance standards, and determine areas for improvement. VHA should develop and implement staffing models for outpatient specialty care services and improve existing performance measurement systems to realize the benefits of specialty care staffing models. VHA should refine and implement the National Nurse Staffing Methodology across inpatient services and improve the performance measurement system to realize the benefits of the methodology. We further recommend that VHA mandate all VAMCs adopt and report nursing quality metrics to a national database to compare VHA to other external health organizations.

To improve staffing and productivity measurement and better determine the capacity of VHA specialty clinics, this assessment recommends that VHA gather data and assess the productivity of fee-based providers, as well as conduct a work measurement study (or confirm existing workload data) to determine the volume and distribution of workload annually to better match staffing requirements to demand. For future reporting, OPES should complete the development

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of the APP productivity cube, to include completion of business rules that would allow APPs to be mapped to a specialty designation and included in OPES specialty group practice and facility productivity reports to accurately reflect care teams' overall effort and present a combined provider (doctor of medicine [MD] and APP) productivity view.

VAMCs should create the role of clinic manager and drive more coordination and integration among providers and support staff. We identify recommendations for increasing the level of teamwork and accountability among all outpatient clinic staff, especially in specialty care services. This might be achieved by creating multidisciplinary management teams for specialty clinics that include a physician leader, nurse leader, and business administrator. Alternatively, specialty clinics might establish a single or dual reporting line and operating a model for providers and their clinical and non-clinical support staff, so that all of the members of the specialty clinic team have more accountability to each other and the Service Chief of the specialty.

VA Medical Centers should implement strategies for improving management of daily staff variances, and include a replacement factor for all specialties, including PACT. With respect to managing staff absences, we make recommendations for improving the management of daily staffing variances by implementing several strategies that include intermittent float pools of support staff and the inclusion of a replacement factor across all staffing methodologies/models, to include PACT.

VA Medical Centers should implement local best practices that mitigate space shortages within specialty clinics. We identify recommendations to help VA medical facilities mitigate space shortages within specialty clinics. These include strategies such as: standardized schedule templates, expanded clinic hours, increased use of non-face-to-face encounters for follow-up consults by specialty care, and system redesign initiatives to improve patient flow within clinics.

VHA should improve the accuracy of workload capture. We recommend that VHA conduct an audit of health record documentation and current procedural terminology (CPT®) coding accuracy and reliability to validate physician productivity measurement and that if the results support it, evaluate the ability of commercially available computer assisted coding (CAC) applications to assist providers with coding. The creation of the role of clinic manager for Specialty Care clinics should also be used to improve clinic management and coding practices.

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Appendix H Health Information Technology

Scope

Assessment H responded to language in Title II, Section 201, of the Veterans Choice Act of 2014 that mandated an independent assessment of “the information technology strategies of the Department with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by the Department, especially those strategies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Department in Department or non-Department facilities.” The recognition that Veteran health and satisfaction constitute important measures of information technology (IT) effectiveness guided the assessment team’s investigations and the resulting recommendations.

To gain comprehensive insight into Department of Veterans Affairs (VA) health IT and the strategies that guide its implementation, the Assessment H team conducted 185 interviews in the course of site visits to Veterans Integrated Service Networks (VISNs), VA Medical Centers (VAMCs), and Community Based Outpatient Clinics (CBOCs), as well as VA’s Office of Information and Technology (OI&T). The team also reviewed plans, reports, audits, and protocols procured from OI&T and VHA, as well as external reports and journal articles relevant to health IT and complex system development. Further, the team compared its observations and findings against lessons learned and best practices identified by executives, administrators, clinicians, and IT professionals at high-performing private health systems. Because IT touches nearly every aspect of operations at VHA, the data gathered by Assessment H generally supports the qualitative evidence related to IT collected by the other assessments.

Findings

Several decades ago VA led the development of electronic health record (EHR) technology with its Veterans Health Information Systems and Technology Architecture (VistA) system and Computerized Patient Record System (CPRS) systems. Most VHA clinicians have a high opinion of the clinical applications and databases enabled by VistA and CPRS, as well as VA’s newer technologies such as telehealth and mobile applications (apps). Several Assessment H interviewees attributed the success of the early VistA and CPRS development efforts to the close working relationship between VistA/CPRS developers and clinicians. This collaboration seems to have disappeared with the centralization of IT in 2006, resulting in uncoordinated execution of health IT strategy and limited development of new and improved capabilities for VistA/CPRS. During the past decade, VistA and CPRS development has been confined to point solutions and minor enhancements.

Clinical users have become increasingly frustrated by the lack of any clear advances during the past decade. Numerous VHA clinicians have experience with commercial EHR systems and want the same level of features, modern clinical capabilities, integration, and mobility they see emerging in the commercial marketplace.

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VHA and OI&T do not collaborate effectively with respect to the planning and execution of IT strategies for managing and furnishing health care. Although the goals of OI&T and VHA do not conflict at the strategic planning level, the organizations often do not agree on priorities for executing the strategic plans.

During the past decade, VA's ability to deliver new capabilities for its VistA system to meet changing Veteran health care needs has stalled. As a result, VA/VHA health care systems are in danger of becoming obsolete. The VistA/CPRS systems are based on a tightly integrated, monolithic architecture and design with numerous and diverse functional components and associated interdependencies. These characteristics impose significant barriers to modernizing these systems. In addition, the high cost of infrastructure operation and maintenance (85 percent of the total IT budget) reduces funding available for new development efforts. Maintenance and data sharing are further complicated because most VAMCs have customized their local versions of VistA, leading to approximately 130 different instances of VistA across the country.

Overly demanding processes for system development, as defined by OI&T's Project Management Accountability System (PMAS), impede cost-effective delivery of new health IT capabilities and limit VA's ability to measure the value of IT investments. The PMAS process is schedule driven and risk averse, leading many project managers to limit the amount of functionality in each release, thereby increasing the total time for any useful capability to be released.

The lack of standard clinical documentation has made it harder to develop effective clinical decision support systems and hinders EHR information exchange among VAMCs, between VA and non-VA facilities (including those of the Department of Defense [DoD]), and between VA and the individual Veteran. The lack of data standards presents challenges to using comparable data for analysis and disparities among the 130 tailored local instances of VistA complicating information sharing, data aggregation, and analytics. The outdated technology underlying VistA weakens VHA's ability to leverage powerful new technologies for extracting information from free-form text, processing genomic data and images, and extracting and analyzing data from personal health monitoring devices.

While VA has successfully developed and deployed telehealth capabilities and mobile apps, it does not effectively assist end users of these technologies and it does not match the pace of the commercial marketplace. VA's support for telehealth users (patients and clinicians) is weak, understaffed, and poorly integrated with IT systems. In addition, barriers associated with providing VISN-to-VISN telehealth make optimizing the caseload across VISNs more difficult, creating unnecessarily long waits for care in certain regions. VA has the opportunity to apply mobile technology at a low price point, but until VA improves its IT development process to emphasize delivery instead of process, it cannot match the pace of the commercial marketplace with respect to delivery and improvement of mobile apps. These limitations prevent VA from realizing the strategic value of mobile technologies as an enabler of both Veteran access and Veteran satisfaction.

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Recommendations

VA/VHA must resolve IT challenges comprehensively, targeting solutions to the entire system rather than seeking to solve isolated problems. To their credit, many leaders within OI&T and VHA, as well as administrators, health information management and IT professionals, and users at the facility level, recognize the need to address these issues. This report describes a future vision for VA/VHA as a high-performing health care system and a continuously learning health system that implements enterprise IT service management best practices.

At the strategic level, VA and VHA need to transform IT strategy, planning, and execution in a systematic manner with dedicated executive-level leadership. Specifically:

The VA chief information officer (CIO) should select a CIO for VHA to manage and advocate for VHA's IT needs and assist in transforming the VA IT strategy to a model based on enterprise IT service model standards and best practices. This involves taking the following actions, explained in more detail in this report:

- Establish mutually acceptable IT service level agreements and optimize them for effectiveness.
- Refine the planning and budgeting process to ensure that business needs are effectively identified, prioritized, funded, and used to drive health IT investments.
- Develop a governance policy to ensure the strategic plans are executed well and in a timely manner.
- Establish product (capability)-focused teams to ensure delivery of needed capabilities to users.
- Refine VA's agile development process from a document-and-schedule focus to a delivery focus.

The VHA CIO, in partnership with the VA CIO, should oversee a comprehensive cost-versus-benefit analysis between a commercial off-the-shelf (COTS) EHR and continued in-house custom development of the VistA EHR currently in use. The analysis should take into account all the complexities of the VistA/CPRS architecture and infrastructure and known issues with performance, scalability, extensibility, interoperability, and security. It should also address full life-cycle costs, including development time (based on recent delivery trends), availability of development resources, maintenance and licensing costs, and infrastructure costs. VIS

The VA and VHA CIOs should conduct site visits and review the successful IT practices implemented at high-performing health care systems (including VISN4), to inform their strategies for effective approaches and potential contributions that IT can provide to improve the treatment of Veterans today.

The VA CIO and VHA CIO should report to Congress at the end of fiscal year 2016:

- Evidence that the VHA CIO serves as an effective advocate for the IT needs for health care delivery. This should include, but not be limited, to a description of the requirements for an effective health care management system to provide a basis for comparing VistA and COTS EHRs.

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- Actions taken and evidence that OI&T acts as a service provider and delivers IT capabilities and IT services that improve health care delivery to Veterans. Evidence should include results of clinician and Veteran surveys confirming the quality of and satisfaction with the newly delivered capabilities and services.
- Results of the cost-versus-benefit analysis between a COTS EHR and continued in-house custom development of the VistA EHR.

VA should implement a broad process, inclusive of clinicians, to pursue requirements that support clinical documentation best practices and improved functionality and usability while considering the positive aspects of existing systems. Although providers can continue to leverage the free text capability available in the current EHR, it must be augmented with discrete, structured data capture using industry standard definitions to increase the interoperability with other systems inside and outside of VHA. This is especially critical due to the increased use of non-VA care.

VHA should accelerate efforts to establish semantic definitions for data elements through the use of standard nomenclatures, terminologies, and code sets. By doing so, VA can ensure consistency and integration across multiple systems, leverage follow-on IT products, and facilitate analytics for clinical decision making.

VA/VHA should assess the effectiveness of analytical products in driving health and business outcomes. They should identify and recommend improvements needed in the information systems that serve as the sources of the data to improve the reporting capabilities. VA/VHA should track actions taken as a result of the analytical products and quantify how effective those actions were in improving health and business outcomes.

To reduce the number of Veterans who abandon telehealth, VA should offer technical support to Veterans, should make testing a connection between Veterans and providers easier for all parties, and should better integrate telehealth technologies across VA medical facilities and VISNs. Assisting Veterans with use of this technology should improve the Veteran experience and reduce health care costs. VA should also address the challenges that complicate telehealth appointments between VISNs.

VA should explicitly identify mobile applications as a strategic enabler to increase Veteran access and satisfaction and help VHA transition to a data-driven health system. Mobile technology could effectively leverage patient-generated data to augment the data captured in the EHR to feed the learning health system.

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Appendix I Business Processes

Scope

Assessment I reviewed the “business processes of the Veterans Health Administration, including processes relating to furnishing non-Department health care, insurance identification, third-party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows:

- To avoid the payment of penalties to vendors.
- To increase the collection of amounts owed to the Department for hospital care, medical services, or other health care provided by the Department for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate.
- To increase the collection of any other amounts owed to the Department with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate.
- To increase the accuracy and timeliness of Department payments to vendors and providers.”

I.1 Summary of Findings

VHA Revenue—VHA is Not Optimizing Revenue Due to Ineffective Veteran Insurance Identification, Clinical Documentation and Coding, and Cultural Barriers.

Ineffective Veteran-facing (front-end) VAMC processes for insurance identification, and clinical documentation, and outpatient coding issues result in CPAC staff members having to address issues “after-the-fact.” The issues correspond to \$581 million in denials from insurance companies in 2014.

For first-party (Veteran) co-payments, VAMC staff members are not collecting the co-payments at the point-of-service and CPACs must collect the co-payments weeks to months after the date of service. Further, based on feedback from VAMC leadership, Veterans do not always understand the need to provide insurance information and VHA staff can be reluctant to ask for it.

Revenue processes span across VAMCs and CPACs; however, only the CPACs are accountable for revenue collection and the associated performance outcomes. VAMC commitment is required to monitor and correct issues early in the process to reduce collections delays and denials.

Non-VA Care Payments—VHA Does Not Have Adequate Infrastructure and Streamlined Processes to Pay Non-VA Care Claims Timely and Accurately.

VHA’s complex and disparate processes for paying Non-VA Care claims are confusing to Non-VA providers and VHA staff, resulting in inconsistencies in authorization and payment practices. VHA’s mechanisms to pay Non-VA claims timely and avoid delinquent payments, particularly at

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select VISNs. However, inadequate data analytics indicate the issues could be more widespread. VHA mechanisms to avoid delinquent payments to external providers are inadequate putting VHA at risk for significant interest penalties.¹²¹

Inadequate claims submission guidance discourages widespread use of electronic claims submission. VHA receives only a small percentage of non-VA claims electronically, which increases workload, manual processing, and the likelihood for payment errors. Low staff retention and a 20 percent vacancy rate further exacerbate delays and errors in claims payments.

VHA established Patient Centered Community Care (PC3) to expand Non-VA care access by entering into national contracts with Healthnet and TriWest to provide Veteran health care on a fee for service basis. Feedback from VA employees interviewed indicate that PC3 is experiencing challenges due to gaps in the non-VA provider network.

Information Technology—Lack of Automation and Integration Prevent VHA from Optimizing Performance in both Collections and Payments.

VHA will not be able to make necessary improvements in their billing and collection processes without modern, automated technology. Antiquated systems used to support the revenue collection processes for third-party reimbursements and first-party (Veteran) co-payments do not provide needed functionality. These systems require significant manual intervention and processing that creates an environment prone to human error and delayed claims payments from insurers.

VHA software tools and functions do not interoperate across clinical and revenue management systems and their limited interoperability with other internal and external systems inhibits VHA's ability to bill and collect revenue accurately and rapidly.

Few Non-VA providers submit their claims to VHA electronically, relying instead on paper claims, which reduces payment timeliness and accuracy. In addition, staff members process claims manually compared to private-sector benchmarks of 79 percent automation.

Oversight and Metrics—VHA Lacks Certain Performance Reporting to Provide Effective Oversight and Proactive Process Improvements for Collections and Payments.

VHA lacks standard national reporting of key performance metrics for timely insurance identification and verification across VHA, inhibiting visibility into VAMC insurance capture performance of VAMCs. In addition, VHA cannot establish effective productivity standards and monitor Non-VA Care staff performance because processes are inconsistent across VAMCs and VISNs. Current decision support capabilities are not sufficient to provide oversight and management of Non-VA Care claims processing and payment. Proactive and retrospective processes are in place to find inaccurate payments, but these practices are highly manual.

¹²¹ There is an ongoing VA Office of General Counsel review of the universe of payments to which the Prompt Payment Act applies.

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I.2 Summary of Recommendations

Recommendation 1—VHA: Develop a long-term comprehensive plan for provision of and payment for non-VA health care services.

The expansion of Non-VA Care over the last decade has resulted in a combination of programs that lack sufficient infrastructure to successfully perform the business functions today or meet the demands of the future. The demand for Non-VA Care will be determined, in large part, by the decisions made regarding VHA care and, in turn, by VHA's capacity to meet demand for services. For example, decisions about VHA facilities and workforce will affect demand for Non-VA Care, as will changes in the demographics and clinical needs of Veterans. VHA should adjust the plan as necessary depending on ongoing studies regarding VHA's capacity.

Recommendation 2—VHA: Establish a formal governance model that allows CBO and VISN leadership to converge, aligning interests and accountability.

The growth of both VHA and Non-VA Care requires an increased focus on business processes to sustain care for an increasing Veteran population. An organizational structure that balances central management with local autonomy is vital to VHA. VHA must align accountability and interests at the leadership level of CBO and the VISNs. Under the current alignment, CBO is dependent upon the VAMCs and VISNs to execute core business functions. With CBO and VISNs reporting separately to the VHA Office of the Under Secretary, VAMC priorities do not always align with CBO's. Placing both organizations under a single governance structure will promote convergence of interests, accountability, cooperation, and coordination.

Recommendation 3—VHA: Standardize policies and procedures for execution of Non-VA Care, particularly the Choice Act, and communicate those policies and procedures to Veterans, VHA staff, VHA providers, and Non-VA providers.

Examination of the claims processing protocols and operations revealed opportunities to standardize the manner in which VHA implements Non-VA Care and the Veterans Choice Act across the organization. Standardization will enable VHA to communicate processes and benefits effectively to both patients and Non-VA providers.

Recommendation 4—VHA: Employ industry standard automated solutions to bill claims for VHA medical care (revenue) and pay claims for Non-VA Care (payment) to increase collections, to improve payment timeliness and accuracy.

The growth of both VHA and Non-VA Care over the last decade has produced a combination of programs that lack sufficient technology to support the execution of routine business functions. In large part, these deficiencies result in a high degree of manual intervention required to bill and pay claims. The focus on automation should expand to include integration with front-end processes such as scheduling, insurance identification and verification, medical records, and coding.

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Recommendation 5—VHA: Consider and further evaluate aligning the Patient Intake and Health Information Management Service (to include Coding) functions under CBO.

An emerging practice in private-sector health care is to align all components of the revenue cycle under the Chief Financial Officer (CFO) linking job responsibilities to financial performance. VHA's revenue cycle activities currently owned by the VAMC/VISN are Scheduling, Pre-Registration, Registration and Coding—all primary functions for identifying and verifying insurance, and ensuring accurate and timely first- and third-party collections. The private sector has recognized that aligning these functions under a single organization improves accountability and revenue cycle performance. Our findings indicate that the separation between business process and organizational structure within the VHA revenue cycle processes has resulted in a lack of coordination and consistency in these functional areas. Given the size and complexity of VHA compared to the private sector, any realignment needs to be carefully considered. Added to this, the VHA CBO recently completed a very large organizational consolidation of Non-VA Care employees and adding significantly more responsibility to the CBO at this time may be difficult for the CBO to absorb in the near-term.

Recommendation 6—VHA: Align performance measures to those used by industry, giving VHA leadership meaningful comparisons of performance to the private sector.

VHA should continue its progress toward implementation and management reporting of common industry performance measures. Once these practices are in place, VHA should identify performance standards that balance meeting VHA requirements with achievable, incremental performance improvements. This approach would immediately allow VHA to leverage common industry measures and benchmarks to conduct analysis, make informed decisions, and help to bring VHA performance into congruence with private-sector benchmarks.

Recommendation 7—VHA: Simplify the rules, policies, and regulations governing revenue, Non-VA Care, eligibility, priority groups, and service connections, educate all stakeholders, and institute effective change management.

Simplifying the rules, policies, and regulations will allow VHA to execute business processes uniformly, and to communicate clearly with all stakeholders.

Recommendation 8—VHA: Identify, share and institutionalize best practices across the agency.

There are numerous examples of business practices in VHA (as described in section 4 of this report) that produce results that significantly exceed VHA averages. VHA should develop a recurring process to examine these peer organizations' "positive deviants" and determine where successful practices apply to VHA business processes. Doing so will enable VHA to not only standardize, but also improve upon current best practices.

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Appendix J Supplies

J.1 Scope

Assessment J examined the “purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Department.” In line with the language of the legislation, pharmaceuticals, medical and surgical supplies (hereafter referred to as clinical supplies), and medical devices are considered within the scope of this assessment. In addition, services directly related to the purchasing, distribution, and use of these products are also considered, such as third party distributors and inventory management services. As the strengths and opportunities related to pharmaceuticals are quite distinct from clinical supplies and medical devices, the assessment is structured in two parts: (1) pharmaceuticals and related services, and (2) clinical supplies, medical devices and related services. Findings and recommendations are outlined below and described in more detail in the full report found in Appendix J.

J.2 Findings

J.2.1 FINDINGS RELATED TO PHARMACEUTICALS AND RELATED SERVICES

VA pays low prices for pharmaceuticals overall but several factors limit its ability to consistently access the lowest price available. Through mandated price concessions and national contracting, VA has relatively low pricing overall for pharmaceuticals. However, pharmaceuticals are not always bought at the lowest price available for a number of reasons, including inconsistencies between Federal Acquisition Regulations (FAR) and VA Acquisition Regulations (VAAR), contract lapses, national drug shortages, and requirements to buy from countries that are compliant with the Trade Agreements Act (TAA).

VA’s distribution of pharmaceuticals to Veterans and to facilities is efficient and effective:

VA’s pharmaceutical prime vendor (PPV) is a distributor that sources pharmaceuticals and delivers them to VA facilities. The PPV model ensures efficient delivery of pharmaceuticals to facilities and Consolidated Mail Order Pharmacies (CMOPs) and supports a just-in-time inventory management approach. It received unanimous support from the pharmacists, pharmacy managers, and CMOP leaders interviewed during this assessment.

Supporting distribution directly to Veterans, VA’s seven CMOPs deliver 80 percent of outpatient prescriptions directly to Veterans’ homes, and they do so efficiently and cost effectively at \$1.53 per prescription¹²². The CMOP program also achieved the highest overall customer satisfaction scores of any U.S. mail order pharmacy in a recent J.D. Power customer survey.¹²³

VA has developed effective mechanisms to drive appropriate utilization such as its formulary, clinical use guidelines, and involvement of clinical pharmacists: Physicians and pharmacists

¹²² VHA Pharmacy Benefits Management. CMOP Overview for the Secretary. Filename: CMOP Info 4-1-15.pptx

¹²³ J.D. Power (2014) U.S. Pharmacy Study

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believe the VA formulary helps guide good clinical decisions, and they express strong buy-in to the formulary process. Veterans have access to medications based on clinical need regardless of their formulary status. Standardized processes enable off-formulary prescribing, including electronic submission of clinical justification by physicians and review by clinical pharmacists. Around 80 percent of off-formulary requests are approved and five percent of outpatient prescriptions are for non-formulary drugs.¹²⁴

High generic drug use supports delivery of high quality, FDA-approved medications to Veterans while ensuring efficient use of taxpayers' dollars. While VA does not measure generic use as industry does, VA purchases 97 percent of its drugs (by volume) as a generic when a generic exists¹²⁵ – similar to health care leader Kaiser Permanente which claims 99 percent generic prescription dispensing when a generic exists¹²⁶. However, there are pockets of opportunity to use a higher share of generics within certain drug classes in some geographies.

VA has implemented policies and processes to improve patient transitions from the Department of Defense (DoD) to VA but challenges remain: Prior reports have highlighted challenges to Veterans' transitions directly from DoD to VA care, particularly related to medication continuity. VA has taken steps to improve this process in recent years, including the release and implementation of a January 2015 directive. However, three key challenges remain in the transition: timely access to primary care before existing prescriptions run out, limited mobility of health information between DoD and VA, and some differences in the DoD and VA formularies (see Appendix J, Section 3.2.4 for more detail).

VA has successfully implemented programs to reduce utilization of high-risk medications and early results are promising: For example, VA's opioid reduction program has cut the share of patients prescribed opiates by almost three percentage points since 2012. However, there are opportunities to improve the current measurement approach by taking into account the type, strength, and dosage frequency of opioids dispensed.

J.2.2 FINDINGS RELATED TO CLINICAL SUPPLIES, MEDICAL DEVICES, AND RELATED SERVICES

The organizational structure of the VA's supply chain enterprise is unduly complex and duplicative: VA and VHA both contain organizations that play a role in the management of VA's medical supply chain. There are several areas of overlap between VA and VHA overall, between national and regional contracting organizations, and between the four VA-level contracting organizations. Senior leaders in VA's and VHA's supply chain organizations who were interviewed unanimously said that the current organizational structure is too complex and should be simplified to improve collaboration, ownership and accountability.

VA's current IT systems, data systems, and analytical capabilities related to finance, inventory management, and purchasing are major impediments to effective supply chain management:

¹²⁴ VHA Pharmacy Benefits Management. 2014 Outpatient dispensing data

¹²⁵ VHA Pharmacy Benefits Management. 2014 PPV purchase data

¹²⁶ Kaiser Permanente, <http://businesshealth.kaiserpermanente.org/manage-costs/pharmacy/> accessed June 2015

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VA's IT and data systems in these areas are antiquated, not integrated, and do not meet the needs of a modern health system. Health, procurement, finance, and contracting systems do not communicate needed information seamlessly, requiring manual manipulations leading to data inaccuracies and tracking problems. VA has at least 130 separate instances of its clinical, procurement, and inventory management systems, each with its own product nomenclature and numbering for items. As entries are mainly free text, data from each instance can be quite different and cross-site comparisons or regional/national roll-ups are almost impossible. This situation is a major impediment to effective management of VA's medical supply chain.

The performance of VA's contracting organization does not meet customers' expectations, so frontline staff have developed workarounds: Users are not satisfied with the communication, responsiveness, and time it takes for contracting requests. At one facility, data showed it took on average 21-39 days from the date of initial submission to receive the first response from contracting¹²⁷ requesting, for example, additional information or paperwork. Conversely, individuals in contracting reported VAMC requests submitted to them were often incomplete or unclear, and facilities were poor at forecasting demand for items, leading to unpredictable peaks in demand for contracting services that exceeded their capacity.

Two interrelated workarounds avoid delays from contracting: (1) staff buy the majority of their clinical supplies and devices on VA-issued purchase cards to enable greater autonomy to choose products and buy through preferred suppliers; and, (2) staff mainly place orders below the \$3,000 micro purchase threshold. As a result, approximately 98 percent of VA's purchases of clinical supplies are made on purchase cards¹²⁸, which can limit VA's ability to ensure compliance with regulations because purchase card holders are responsible for identifying appropriately priced goods and contracted vendors, and VA's current systems do not support these tasks with integrated catalogs and controls. This likely leads to higher prices paid for goods. Purchase card processes are also inefficient when compared with modern alternatives, such as electronic order transmission and funds transfer.

VA has not taken full advantage of its scale or potential for product standardization to achieve optimal pricing and efficiency: Unit prices showed significant variation in the price paid for identical items. In addition, at least 27 percent of clinical supply purchases were made at open market prices¹²⁹. Unlike pharmaceutical purchasing, VA's supply purchasing systems are not integrated with contract or pricing catalogs. This results in limited ability to monitor and drive compliance with contract usage. In fact, over 60 percent of all clinical supply items have no contract number listed.¹²⁸

VA has achieved limited product standardization leading to a fragmented supplier network and a high number of items managed by the logistics organization. Despite some efforts, there is no routine mechanism to identify products for which central contracts should be established.

¹²⁷ VAMC IFCAP/eCMS communications log

¹²⁸ VHA Procurement and Logistics Office. FY2014 IFCAP purchase data for five VISNs

¹²⁹ VHA Procurement and Logistics Office. Four months FY2015 system-wide clinical supply orders with IMF numbers

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Inventory management process, practices, and systems are neither integrated nor optimized:

VA has contracts with six Medical/Surgical Prime Vendors (MSPVs) – distributors like the PPV that provide services supporting purchasing, distribution, and use of clinical supplies. To date, VA takes limited advantage of services offered such as electronic ordering platforms or lean delivery models, resulting in suboptimal utilization of the MSPV program. There is also no robust feedback loop linking inventory to product utilization, contracting, and ordering, which leads to fluctuating demand for contracting services that can overwhelm its capacity.

VA struggles to attract, hire, and retain high caliber supply chain talent: Interviewees estimated 20-30 percent of positions were currently unfilled. As an example, VA had 563 open positions for medical supply aides and technicians¹³⁰ – 20 percent of all those positions or almost four vacancies per facility. Supply chain leaders perceive three factors contribute to recruitment and retention challenges: recent position downgrades, long lead times to fill positions, and lack of a clear career path. Moreover, competition for supply chain talent in health care is also high and organizations are paying more to attract and retain the highest performers.

There are pockets of good performance and innovation across VA's supply chain that could be replicated across VA: The Denver Acquisition and Logistics Center (DALC) is a bright spot within VA's supply chain organization in its acquisition and distribution of select devices such as hearing aids to Veterans. It has developed an integrated operating model that brings together clinicians, contracting, finance, logistics, and program management to create a holistic view of what is best for Veterans. Another VA strength is the autonomy VAMCs and VISNs have to test and pilot new processes, management approaches, and technologies. Several innovations were observed during this assessment that could be scaled across VA to improve service to Veterans.

J.3 Recommendations

J.3.1 RECOMMENDATIONS RELATED TO PHARMACEUTICALS AND RELATED SERVICES

Establish mechanisms to ensure VA secures a reliable supply of pharmaceuticals and accesses the lowest possible pricing more consistently. The largest hurdle to accessing favorable pricing more consistently, is its management of suppliers and at-risk supplies. To that end, VA should improve lifecycle management of contracts to prevent lapses, and identify drugs at highest risk of shortages and price spikes, and develop specific strategies to limit impact. VAAR and FAR conflicts are also likely to cause confusion among VA contracting officers. VA should consider updating the VAAR, including options to ensure fair competitive prices are obtained when only a single supplier is on the Federal Supply Schedule.

Continue driving efficiency through VA's CMOP network. VA should drive more volume to CMOPs, increase automation of packing and shipping to improve throughput and quality, and optimize the network's footprint to improve utilization of fixed assets and reduce costs.

¹³⁰ VHA Office of Workforce Services May 2015 staffing update

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Develop strategies to improve the transition of patients from DoD to VA care. Access to primary care during a transition and better interoperability between DoD and VA are key improvements for ensuring continuity of care and clinical management. Improvements for access can be found in Assessment B and Assessment E, while recommendations for improving IT strategy can be found in Assessment H. VA should also explore opportunities to align or integrate formularies taking into account clinical evidence and economic impact. As differences are likely to remain because of different Departmental strategies, VA should develop drug-class-specific guidance for medication changes related to transitions and explore opportunities to improve communication with Veterans about their medications during transitions.

Build sophisticated approaches to drive appropriate utilization of pharmaceuticals. VA has the opportunity to be a health care leader with respect to pharmaceutical use. To that end it should incorporate evidence-based prescribing guidelines into clinical protocols and pathways, building upon recommendations in Assessment F. Enabling these developments will require investment in IT and analytic capabilities to support outcomes-based data analysis. Ensuring compliance and changing physician behaviors should be driven with appropriate data interpretation and utilization through peer review, and by building utilization rules into prescribing systems to reduce inappropriate use.

J.3.2 RECOMMENDATIONS RELATED TO CLINICAL SUPPLIES, MEDICAL DEVICES, AND RELATED SERVICES

Transform and consolidate VA's entire supply chain organization. VA should rationalize the organizational structure by consolidating VA and VHA entities into one integrated supply chain organization. Guiding principles should include a single accountable leader for policy and end-to-end effectiveness, governance including all supply chain elements, clear expectations for supporting functions and users, and alignment of personnel by product categories. In making changes, VA should ensure the pharmaceutical supply chain is not negatively impacted; rather its practices are incorporated to improve clinical supply and medical device management.

Performance management focused on Veteran outcomes should be supported by service level agreements between supply chain functions and its end users, based both on end users' expectations and what is feasible within the constraints in which VA operates. Enhancing VA's performance management system will require a level of standardized data capture and reporting that is not possible with VA's current data systems. Therefore, system upgrades and/or replacements should be considered as per the recommendation below.

Improve key enablers required to support the organizational transformation, including IT systems, data standardization, and talent management. VA should update or replace supply chain IT systems to make them fit for purpose. Any decisions made should be in line with VA's overarching IT strategy and in full consideration of the interoperability and interdependencies between supply chain, financial, and clinical systems.

VA's lack of data standardization is a major impediment to effective monitoring and management of its supply chain. It should be a high priority to standardize supply chain data and overlay user-friendly interfaces that enable robust and timely decision-making across the enterprise. As a first step, VA should evaluate near-term options to standardize critical data

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elements to enable some level of cross-comparability. This should include establishing a central item master file with standardized nomenclature and numbering of VA's commonly used items.

The future of VA's supply chain rests on the talent that can drive these changes, therefore professionalizing the supply chain workforce by creating clear opportunities for training and advancement within the organization should be a priority.

Streamline, standardize, and integrate key supply chain management processes. VA should expedite product standardization in key categories by prioritization. The approach should build upon learnings from VA's pharmacy committee structure, with its integrated cascade of testing, review, feedback, and decision-making related to selection and use of pharmaceuticals.

VA should expedite its process mapping initiative and also look holistically at acquisition policies and regulations to streamline contracting and purchasing processes. Electronic and automated purchasing processes should be improved and encouraged. Additionally, VA should build upon its ability and willingness to experiment by establishing an approach to more systematically capture, codify, prioritize, and if appropriate, scale innovations across VA.

The complete Assessment J report is available in Volume II.

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Appendix K Facilities

Scope

Assessment K examined “the process of the Department for carrying out construction and maintenance projects at medical facilities of the Department and the medical facility leasing program of the Department.” Specifically, the team was required to (i) review the processes for identifying and designing proposals for leases and capital projects, (ii) assess the process for determining the necessity and size of a lease or capital project, (iii) assess the processes and project management of the design, construction, leasing, and activation of medical facilities, and (iv) assess the medical facility-leasing program of the department. The Assessment K team also considered two additional areas that are critical to addressing VHA’s facility needs, facility management and the long term capital funding needs of VHA.

Findings

We have found that VHA is expected to face accelerating and likely unfunded capital requirements driven by maintenance to aging infrastructure, projected workload needs to serve the Veteran population, and inefficient capital management. Moreover, we observed that VA performance in capital management, design and construction, leasing, and facilities management is on par with public sector performance in most cases, yet well below private sector performance, particularly in the cost to deliver major construction projects. Consistently deploying world class practices in capital management has the potential to improve performance significantly and address some of the capital constraints VA faces, but would require a further overhaul of VA’s capital program and supporting organization. However, even if VA is able to meet the significant challenge of achieving best practice performance in capital management, VA would still likely experience a significant capital funding gap that will require strategic changes in operations and additional funding to close the gap.

The capital requirement for VHA to maintain facilities and meet projected growth needs over the next decade is two to three times higher than anticipated funding levels, and the gap between capital need and resources could continue to widen.

VA has identified more than \$51 billion in total capital needs over the next 10 years through its capital planning methodology.¹³¹ These requests cover current ten-year projections; however, new projects may be added as needs change and could change the total capital requirement. Provided that average funding levels remain consistent over the next 10 years, the \$51 billion

¹³¹ The \$51 billion capital requirement combines \$46 billion in projects submitted through the Strategic Capital Investment Plan (SCIP) and \$5 billion in anticipated outstanding funding needs for on-going major projects projected in the FY2016 VA Budget Submission. While our team did not independently verify the cost estimates for the 8,038 capital requests that make up the \$46 billion requests through SCIP, we did review the process by which these requests are identified and developed. See Section 3.1 and Appendix B.3 for additional detail.

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capital requirement would significantly exceed the anticipated funding level of \$16–26 billion.¹³²

Multiple factors drive the scale of the capital need. VHA facilities are older buildings, with significant repair needs, and some are poorly suited to emerging models of care. The average VHA building is 50 years old, five times older than the average building age for not-for-profit hospital systems in the United States.¹³³ While many facilities have been extensively renovated, the renovations themselves have aged, and the condition of buildings shows this strain. Independent assessments of infrastructure and facilities through the VHA Facilities Condition Assessment (FCA) found that VHA facilities average a “C minus” score, meaning that much of the total facilities portfolio is nearing the end of its useful life.¹³⁴ More than 70 percent of VHA facilities correction costs result from infrastructure and facilities that are D rated, meaning that they are at the end of their useful life.

Current facilities, whether they have been maintained adequately or not, often do not match current models of care. The overwhelming majority of VHA hospitals were designed when care was focused more heavily around inpatient hospital treatments. Over the past eight years, Veteran inpatient bed days of care have declined nearly ten percent while outpatient clinic workload has increased more than 40 percent.¹³⁵ Space for outpatient care is typically housed in converted inpatient spaces or VHA’s growing number of clinics. As a result, VHA’s capital needs fall into a broad range of categories, including ensuring adequate facility condition, providing sufficient and appropriate space for Veteran care, and upgrading infrastructure. As facilities age further and care continues to shift to the outpatient setting, the size of the capital need could continue to grow.

Shortfalls in overall accountability, role clarity, personal ownership, internal communication, and proactive problem solving approaches limit the ability of VA and VHA to deliver the correct projects consistently on time and on budget. Facilities functions are dispersed through VA, resulting in a lack of accountability for facilities outcomes, a mismatch between planning efforts and funding decisions, and the separation of project execution and facilities management. Additionally, internal VA directives, federal procurement requirements, and stakeholder involvement impact VHA’s ability to deliver and operate medical facilities at the level of private sector benchmarks.

¹³² Over the last four years, VA’s capital funding budget has ranged from \$1.6 billion to \$2.6 billion each year, averaging \$2 billion.

¹³³ The age of VHA facilities is calculated by taking the year built recorded in the Capital Asset Inventory and weighting it by the gross square footage of each property. 2013 analysis of 139 not-for-profit hospital systems in US, encompassing 1,362 hospitals (Soule & Keller, 2013). See Section 5.2.1.4 for additional detail.

¹³⁴ FCA assessments are conducted by independent evaluators at each facility every three years. More than 180,000 individual items are scored across VHA facilities, using a scale of A (like new) to F (critical condition) scale. Average score was calculated using the aggregated reports in VA’s Capital Asset Database, accessed March 2015.

¹³⁵ Workload reported by VAMCs in the 2015 VSSC Trip Packs, aggregated by VISN.

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Capital is not being consistently allocated to projects that address the greatest areas of Veteran need in the most cost effective and timely manner. Lengthy approval and funding timelines hinder the ability of VHA to meet the identified space requirements to keep up with Veteran demand and invest in facilities updates that align with changing models for care. VA has recently established the Strategic Capital Investment Plan (SCIP), a systematic approach to approve capital projects and allocate funding. However, the process does not yet ensure full alignment with VA strategy, include rigorous business case scrubbing, or incorporate feedback on past project outcomes into the capital program assessment.

VA construction costs are similar to other public agencies in most cases, but double private industry best practice, and VA time-to-complete exceeds both public and private peers. Increased design requirements resulting from resilience, energy, security and community mandates increase the initial cost of projects over the private sector. Frequent design changes driven by users before construction contract award and during construction further increase the costs of projects and contribute to construction delays. Additionally, project teams are designed and staffed to support compliance requirements but these structures have resulted in reduced accountability for project delivery outcomes and a limited ability to develop solutions to manage cost overruns and schedule delays.

The leasing program is not effectively enabling VHA to provide facilities where and when they are required or at a reasonable cost for major leases. Lease timelines preclude VHA from benefitting from the speed and flexibility that leasing typically provides, often taking more than twice as long as private sector benchmarks. The leasing program typically achieves per square foot costs comparable to market prices for small and medium sized facilities, however, for larger build-to-suit facilities which are impacted by the same type of design and construction challenges seen in owned facilities we observed rents clustered at 40 to 50 percent higher than private sector benchmarks.

Facility management costs across VHA exceed those at comparable medical facilities. Facility management costs, including recurring maintenance and environmental services, are on the average two to three times higher than comparable private medical facilities, largely due to in-house management of these services rather than utilization of lower cost external service contracts. Facility management costs and practices are also highly variable across VHA facilities, with little incentive for individual stations to adopt cost effective measures.

Recommendations for consideration

Achieving best practice levels of performance in each of the assessment areas would require an overhaul of VA's capital program and supporting organization. Through our research, we have identified best practices from capital management organizations around the world that could be deployed to improve the total performance of capital programs of the scale and complexity of VA's. The cumulative improvement value of deploying all of these best practices in a single

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organization could result in savings up to 40 percent.¹³⁶ However, even world class capital management organizations do not succeed in deploying all of these best practices consistently across their organizations, which illustrates the scale of the challenge. Shifts in the model of care delivery, lengthy approval processes, organizational health concerns, and strained budgets have combined to make capital management and delivery a formidable task for VA, and even the most ambitious transformation effort at VA may not achieve this total potential. As a result, we have estimated the total potential improvement opportunity for VA to be up to 25–35 percent.

Detailed recommendations for improving the capital program can be found in Sections 5 through 9, for each of the deep dives on core assessment areas. These recommendations fall into the following main opportunity areas:

VA should improve project selection and refine its project portfolio. VA should refine the SCIP process to rationalize and prioritize capital requirements by ensuring that space, energy, and condition criteria are reflective of the most critical items that contribute to Veteran care. The SCIP process, initiated four years ago, advanced VA capital project selection by creating a standardized methodology to review and approve projects which did not previously exist, but further steps are needed to improve the approach. These include a careful assessment of standards and a modification of the criteria for project selection. By focusing the criteria and approval processes for capital projects, VA could concentrate capital spending on strategic priorities and accelerate approval timelines. Capital project planning should also incorporate feedback on performance and outcomes from past projects to determine which capital programs respond to Veteran needs in the most cost effective manner possible. This would help enable a vital link between portfolio planning, project execution, and achievement of the desired outcomes in Veteran care.

VA should streamline project delivery across all construction types and leasing. VA should comprehensively address the root causes (for example, specifications, approval processes, project governance structures, team capabilities and composition) currently leading to consistent overruns in cost and schedule for construction projects and lengthy timelines for leases. This begins with modernizing and rationalizing design standards in keeping with current innovations in health care. A clear stage-gate process should be implemented to manage scope and design changes in the planning and design phases of projects and to limit scope and design changes that occur after a project receives funding and during construction. The recently launched Capital Program Requirements Management Process (CPRMP) introduced reviews during the design process to manage scope changes, another positive step which should be further developed and rolled out. To increase ownership and accountability, project delivery teams should be restructured with clear roles and responsibilities, well-defined handoffs, and adequate staffing levels. Additionally, contracting and other supporting entities should be

¹³⁶ “Infrastructure Productivity How to save \$1 trillion a year,” by McKinsey & Company (January 2013). This report includes more than 400 case examples from around the world. For this assessment, estimated savings have been adjusted to reflect requirements and constraints specific to VA.

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accountable and equipped to support a fast-paced project environment and facilitate the needs of construction projects and leases.

VHA should ensure proposed projects make the most of existing infrastructure. VHA could improve the effectiveness of its infrastructure through incorporating a total cost of ownership assessment approach into design, capital planning, and facility management. This requires evaluating the operational cost implications of design choices and pursuing opportunities to optimize capital and operating costs simultaneously. Space planning programs should regularly evaluate underutilized and vacant space to identify opportunities for increased utilization or to actively divest unusable properties.

In addition to taking steps to address the above recommendations, VHA should consider more transformative options as needed to address the remaining unfunded capital requirement. If VA is able to successfully implement current improvement initiatives, act on the additional recommendations listed above, and demonstrate best practice performance, VA could potentially reduce its total capital need to \$33 to \$38 billion over the next 10 years. Based on average funding of \$16–26 billion over 10 years, an unfunded gap of \$7 to 22 billion would still exist. To close this remaining gap, funding would have to increase and VA will need to consider more transformative options. When other institutions have faced similar capital shortfalls, they have considered a range of strategic and business model redesign options in addition to implementing best practices in capital project delivery. This report lays out several strategic approaches for further consideration by VHA, including:

- *Maximize operational efficiency.* Operating improvements, such as extending operating hours, improving scheduling efficiency, increasing tele-health options, and reducing average length of stay, can provide non-capital solutions to meeting workload needs. The operating recommendations in Assessments E, F, G, and H may contribute to addressing VHA's capital need.
- *Reassess how and where to best serve Veterans.* When facing similar circumstances to VA, other health care organizations have considered strategic operating changes that result in a realignment in their capital portfolios. This could potentially include geographic realignment, community partnerships, or a shift in service offerings. Assessments B and C may offer some further insights.
- *Explore alternative vehicles for capital delivery.* Alternative models of providing facilities have proved productive for some organizations. These models include contracting out capital investment, outsourcing facility management, and establishing innovative public-private partnerships.

In summary, VA has taken steps to improve its capital program, but much more is required given the scale of the capital need and the gap between current performance and best practice. Even with the most ambitious expectations for improving the capital program, VA will likely face a major funding gap over the next decade that will require a combination of additional funding and transformative changes to operations in order to ensure that Veterans receive the level and quality of care VA has committed to provide.

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Appendix L Leadership

L.1 Scope

Part L (“Assessment L”), Section 201 of the Veterans Access, Choice, and Accountability Act of 2014 (“The Veterans Choice Act”) required an independent assessment of how leadership influences the Veterans Health Administration’s (VHA’s) ability to accomplish its mission. The law required an assessment of:

“(L) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.”

Congress has thus directed that VHA leadership be viewed in the context of the eight separate but related elements of leadership, each of which is addressed in detail in the assessment, as summarized below.

The broad scope of the law’s mandate represented an important opportunity to understand leadership at VHA, including its executive organization, Medical Center facility leaders, and regional network administrators. The scope of this assessment focuses on the senior leadership of VHA at each VA Medical Center (VAMC), Veterans Integrated Service Network (VISN), VA Central Office (VACO), and VHA Central Office (VHACO). The senior leadership at the VAMC and VISN are defined as the “Quadrad” or “Pentad” leaders: Director, Associate Director, Chief of Staff, Associate Director for Patient Care Services, and Assistant Director for Operations, if applicable.¹³⁷

The assessment utilizes data and analysis from a survey of all VHA employees about its leadership beliefs and practices, 39 site visits and more than 300 interviews with VHA leaders across the country and analysis of existing VHA and other federal data. We then synthesized the findings and recommendations across the eight elements to identify patterns, points of interaction, and interdependencies, resulting in seven cross-cutting themes and six overarching recommendations.

L.1.1 Findings

Reviewing all eight elements described in Section 201 Assessment L provides an opportunity to create an integrated perspective of leadership at VHA. The scale of VHA is vast, and it is difficult to fully capture all the nuances and variability that exist throughout the system. Areas of excellence exist across the system, including some inspiring and resilient leaders, front-line systems redesign teams, and homegrown innovation. We touch on these throughout the full report. However, most areas of the organization show a highly risk-averse culture; lack of role clarity; fragmentation and organizational silos; and breakdowns in communication, accountability, and key processes that impair the organization’s ability to deliver the mission.

¹³⁷ The terms Quadrad and Pentad are used interchangeably throughout this report as they are at VHA.

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Our efforts have yielded a complex portrait of leadership practices reflecting leaders at VHA who are diverse in their approach, experience, skill, and effectiveness. They are operating in a system without common agreed upon leadership goals, methods and processes. Examining each of the eight elements, we identified the following seven themes about leadership today at VHA:

1. **An expanding scope of VHA activities has led to confusion around leadership priorities and the strategic direction of VHA.** The organization's focus has expanded and shifted over time, and it is unclear what the priorities are, and unclear when they will shift again. Over time, VHA has expanded into the delivery of a wide range of clinical services, as well as various social pursuits. The organization is not configured or resourced to deliver this expanding scope of activities, and it is unclear where the boundaries of the mission lie. VHA is also treated by oversight entities and external stakeholders as both a hospital system and a traditional government agency. This unique complexity of VHA is not supported by equally unique performance expectations, operational flexibility, and supporting tools.
2. **From the point of view of leaders and employees, the VHA organization is intensely, unnecessarily complex due to lack of a clear operating model, limited role clarity, fragmentation of authority, and overlapping responsibilities.** This lack of clarity around operating model, roles and responsibilities extends across VAMCs, the VISNs, and Central Office. The issue is exacerbated by a cultural context that is often unable to work effectively across chains of command, except where all parties concur. Fragmentation and silos exist across the system and within each tier of the organization. Many key support functions, such as human resources or contracting, suffer from this, resulting in service too slow to meet the needs of the mission. Meanwhile, the sheer number of operational performance measures in many cases overwhelms and makes it difficult to know and focus on what is most important.
3. **The broader VHA culture is characterized by risk-aversion and distrust, resulting in an inability to improve performance consistently and fully across the system.** At almost every facility visited, at least one leader interviewed mentioned that risk-aversion and a reluctance to "speak up" were significant issues. Three out of every four leaders interviewed at VISNs in which site visits were conducted echoed this concern (VHA interviews, 2015). A general aversion to speak up or take risks originates from: a) trying to perform in a heavily siloed organization; b) fear that raising issues will result in punitive actions toward the individual or addition of significant workload with no additional support; and c) insufficient reward for those trying to make improvements. This culture permeates across all levels of the organization – from the front-lines, to Medical Center leaders, to people at Central Office. This culture of risk aversion also hinders great ideas from spreading. A lack of enterprise-wide incentives and mechanisms for knowledge-sharing within or across the system yields pockets of innovation but not broader system-wide adoption (VHA interviews, 2015; VHA OHI survey, 2015).

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4. **VHA leadership faces a workforce that appears to be steadily losing its motivation.** Caring for Veterans is a value that powerfully motivates VHA leaders and employees alike – however, this commitment alone is insufficient to fuel the organization’s motivation and performance. Other sources of motivation such as a great work environment, job satisfaction, or working with an inspiring team have eroded in recent years (VHA interviews, 2015). Physicians are only partially aligned with the various demands put on them. In a changing environment in which VHA competes with other health care organizations for top talent, a value proposition that relies primarily on the intrinsic reward of caring for Veterans cannot make up for the erosion of other sources of employee motivation to meet the VHA mission.
5. **The performance of a particular VAMC hinges to a large degree on the capability of its Director and the executive leadership team; yet these leaders are “on their own” in many ways.** VAMC Directors often lack competent and timely assistance from support functions (including HR for disciplining, hiring employees, planning for succession; construction; IT; and contracting). Support from VISN and VHACO is variable and often limited. Directors are left to navigate their own career progression and development (VHA interviews, 2015).
6. **VHA leadership attention is consumed by addressing crises that have occurred in the past, at the expense of preparing for tomorrow’s opportunities.** The number of directives for which leaders are accountable, coupled with heightened scrutiny from internal and external sources, compels leaders to spend much of their time reacting to crises and completing action items from above. Bottom-up innovation and consultative leadership are not well-developed, and there is a heavy reliance on top-down directives, exacerbated by the growth of Central Office Program Offices (VHA OHI survey, 2015; VHA interviews, 2015).
7. **The leadership pipeline is not robust enough to meet VHA’s current and future needs, a function both of inadequate succession planning and unfocused leadership development efforts.** As of March 2015, 16 percent of VAMC Quadrad and VISN Network Director positions are vacant or have acting leaders. Twenty-three VA Medical Centers (16 percent) do not have a permanent Director. Nine VISN Network Directors (43 percent) are Acting (VHA Office of Workforce Services, 2015). Leadership positions are increasingly unattractive to the next generation of VHA leaders, which contributes to the difficulty in filling leadership openings (VHA interviews, 2015). VHA is currently experiencing a large and widespread number of current vacancies and upcoming retirements in key leadership roles, and open positions remain unfilled due to a lack of qualified candidates. Meanwhile, VHA’s lack of a comprehensive approach to leadership development—experiential, relational, and training—has resulted in leaders with uneven preparation for their future roles. Multiple competency models and frameworks are in use, and VHA’s formal programs are not linked to career paths, not well-coordinated, and thus do not effectively bolster VHA’s talent pipelines (VHA Office of Workforce Services, 2015; VHA interviews, 2015).

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This report's findings indicate that immediate action is required. The challenges of the current culture and operating environment, the deteriorating atmosphere for leaders, and the intense public scrutiny suggest that sustaining an effective operation and an engaged employee and leadership base to serve six million Veteran enrollees each year will require a fundamental shift achieved through a bold, integrated, multi-year transformation.

L.1.2 Recommendations

The scale of the transformation needed to address the findings above has few precedents in the private or public sector. VHA employs one in nine federal civilian employees (OPM, Historical Federal Workforce Tables and FedScope, 2015). It is both the largest hospital system and the largest training ground for health care providers in the country, training tens of thousands of clinicians each year (VA, Office of Academic Affiliations, 2015). And the nature of the current system – with hundreds of unique locations, partnerships, and performance measures – only increases the complexity of the opportunity.

Given this challenge, the recommendations summarized below should not be approached like a checklist of individual and incremental performance improvements. Most transformations treated in this manner fail (Keller and Price, 2011). Instead, VHA should systematically implement these recommendations in a comprehensive, multi-year transformation program. The transformation program needs to clearly define its aspiration state, determine what is needed to meet this state, be housed in a formal change program, protect or build on best practices and high performing pockets, and ensure timely implementation faithful to the original aspiration.

These recommendations fall into six main opportunities:

1. **Galvanize VHA leaders around a clear strategic direction.**

Decide and communicate the strategic direction of VHA going forward. The strategy could take a variety of forms, but there needs to be clarity within VHA of where the organization is headed, and this needs to be communicated throughout the organization and understood by all leaders and employees. We do not seek to define the strategic direction here, but clear strategic direction will be critical as the organization moves forward and works to implement the recommendations laid out herein.

2. **Stabilize, grow, and empower leaders.**

VHA should strengthen its leadership foundation, both today's and tomorrow's. VHA should focus in the near term on increasing leadership stability and readiness by filling vacancies with high-quality leaders, improving the attractiveness of the role to prospective leaders, and ensuring leaders are ready to assume their roles. In the medium term they should build a coordinated people development strategy that connects top performers with the right opportunities and generates a robust pipeline of leaders through a formal succession planning program and a coordinated set of development opportunities. Efforts should be made to build sustained leadership continuity across the system, including considering longer tenures for key leaders, such as Medical Center Directors and select roles at VHACO. This is necessary to have the

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authority, accountability, ownership and time needed to stabilize the organization, strengthen its health and performance, and shepherd the transformation.

3. Redesign VHA's operating model to create clarity for decision-making authority, prioritization, and long-term support.

VHA should immediately lead an effort to clearly define roles and decision rights at each level and increase coordination within Central Office, refocusing the role of Central Office to managing outcomes and providing “corporate center”-like support to the field. The Central Office should prioritize, integrate, and actively provide support to the various initiatives and policies being implemented by the field. The net effect of the redesign should be a Central Office that is highly valued by the field for the expertise, services, and strategic direction it provides.

4. Focus and simplify performance management to clarify accountability and actively support the mission.

Within six months, VHA should complete an effort to develop an integrated and balanced performance scorecard for VAMCs focusing on a smaller number of core metrics that roll up to support the broader enterprise view. These metrics should be designed to focus more on the mission and encourage cross-functional collaboration and should be carefully cascaded. This requires moving from hundreds today (over 382 alone in the National Performance Measures Report) to no more than 20 that cover quality, safety, patient experience, operational efficiency, finance, and human resources. The resulting data should be made readily available and accessible agency-wide with proper procedures in place to ensure quality.

5. Rebuild a high-performing, healthy culture by cultivating greater employee collaboration, ownership, and accountability to accomplish the mission.

Culture is often described simply as “how things are done around here,” and changing the VHA culture will need to happen at all levels of VHA: VHACO, VISN, and the VAMC level, as well as within the context of VA broadly. VHACO should consider how to integrate their efforts so the workforce is involved and experiences a coherent set of messages, policies, and support from VHACO. The VISNs should lead the VAMC leaders by sharing best practices, demanding steady improvement, and encouraging innovation. VAMC leaders will need to role model the change, describe why the culture must change, reinforce desired behaviors (and discourage unhelpful ones), and provide leaders and employees alike with the coaching, training and tools they will need to succeed. In our experience this is feasible, but there is no simple or fast way, and it will require a dedicated performance transformation effort.

6. Redesign the human resources function as a more responsive customer service-focused entity.

VHA, with the full support and backing of VA, should begin an effort in the next 12 months to transform the human resources (HR) function to be more responsive to meeting the needs of VAMC leadership, more efficient, and more customer service-

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focused. Although a comprehensive examination of HR was not within scope of Assessment L, systematic HR challenges were identified that need to be addressed through a transformation of the HR function. Such a transformation will likely require redesigning key processes (e.g., hiring), shifting the mindsets of HR cadre from compliance to effectiveness, training HR and its customers on key roles and responsibilities, and rationalizing its technology systems.

The complete Assessment L report is available in Volume II.

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Appendix M Outreach

Over the past 10 years, many assessments of VHA have been conducted from different points of view, and many thoughtful solutions by experts from inside and outside the department have been provided. However, while some incremental changes may have been made, the real desired impact of a highly coordinated, enterprise-level, successful transformation of VHA has not been achieved.

MITRE conducted an analysis of selected health care systems that successfully transformed into high-functioning and performing health care systems. This effort included interviews with executive teams from 27 large U.S. health systems and also included visits to selected health systems.

Some of the lessons learned from these engagements include:

A sense of urgency: Many of the largest health systems faced financial crises in the late 1990s and early 2000s due to a dramatically changed medical payment landscape. Several leaders of the selected health care systems found their institutions were not profitable, and they faced a critical decision: either change management models from a fee-for-service model or go out of business. Within this crucible, new leaders often emerged. They recognized both the need for change and the importance of communicating the urgency of that change to all levels of the organization and to organizational stakeholders.

Empowered visionary leaders and new missions: The individuals who emerged to lead these institutions had similar characteristics. They were visionary and charismatic leaders who were fully committed to the new mission and exemplified the behaviors required to achieve that mission. Their leadership teams described them as actively shaping the culture, and they provided focus on change and freedom to fundamentally alter processes. They consistently were “hard on processes, not on people,” meaning they built a culture that was developmental and transparent rather than punitive. Employee morale, motivation, and retention improved as they were empowered to remove non-mission essential burdens and increase time and resources for core mission activities. Leaders were routinely seen on the front lines of care and in regular meetings with cross-functional teams to resolve barriers to mission success and reinforce the vision and culture.

Sustained and time-consuming process: The institutions that were visited consistently pointed out that what they are doing to realize change is not a special project; rather, it is a management system. Each found that it took about three years for physicians and staff to recognize that the changes occurring were not the “change du jour.” They also shared that after five to six years, staff and providers within the health systems felt the changes were successful and enduring. Along the way, it was important to experiment, tolerate mistakes, and learn from them and encourage employee engagement to instill a new culture within the organization.

A new management system that adheres to a patient-centric culture and value system: The new management models were patient centered and required working with physician leadership and payers to reshape clinical and operational processes around the patient. Leaders were selected carefully for performance, not on résumés. Leadership and staff were

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empowered, recognized, and rewarded for challenging care decisions and modifying processes that did not add value to patients care.

Supportive and knowledgeable governance: The leaders of these high-performing systems often had a supportive and knowledgeable Board of Trustees. Some trustees had led similar successful transformations in other industries. This type of governance structure ensured adherence to a single clear architecture and the ongoing integrity of the health care system’s mission and operating principles. The board also often had compacts with practicing physicians, leadership, and management. In addition, the leaders were given a wide berth and sufficient time (more than five to seven years) to execute needed reforms.

Transparent data-driven management system: The systems consistently demonstrated transparent use of data that was shared from the chief executive officer to front-line staff, clarifying how performance is measured and ensuring that everyone worked from the same accurate information. Many compared the performance data of similar teams and staff members to promote sharing best practices. Most health care systems focused on continuous improvement that originated within teams rather than setting team targets from higher levels in the organization. Lastly, “red” metrics were used as an opportunity for management to focus and fix, rather than blame and punish.

Methodology: In January 2015, CAMH gathered publicly available listings of the largest U.S. health care systems (by number of employees), health insurers (by market share), and organizations representing medical device manufacturers and pharmaceutical companies. CAMH leveraged its network of health care executives to add additional prominent health care systems with national reputations and then generated a convenience sample of 37 private-industry institutions to use for data collection. Upon inquiry, executive leaders from 27 of the selected U.S. health care organizations were available to be interviewed.

MITRE Officers and leaders conducted 30–60 minute interviews with the executives from selected health care systems to inform them of the Veterans Choice Act 201 assessments and to gain their insight, experience, and recommendations of best practices that, if adopted, would positively impact the Veterans health care delivery system. An interview guide was developed for each institution that targeted the Veterans Choice Act 201 assessment topic areas and was tailored to center on strengths (by reputation) of the institution being interviewed.

From March to June 2015, CAMH Choice Act Program Teams conducted site visits to selected health systems. Teams of 5–18 members from CAMH’s Choice Act Program attended these one-to three-day site visits; participated in the discussions with executive leaders, administrators, and clinicians; and completed facility tours and observations. These site visits have included:

- Kaiser Permanente
- Cleveland Clinic
- Virginia Mason Hospital and Medical Center
- Geisinger Health System.

U.S. Health Care Industry Leaders: The following organizations gave freely of their time and provided access to their systems and their senior leadership teams for in-depth discussions.

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During those conversations, they shared their experience, perspectives, health initiatives, and viewpoints of best practices in health care that could be adopted by the Veterans health care system. Several also provide on-site visits to examine their clinical and administrative operations. Many spoke of their thankfulness for our nation's Veterans and their pleasure to support the VA in making improvements to Veterans' care.

- Adventist Health System
- Aetna, Inc.
- American Pharmacists Association
- Anthem, Inc.
- Ascension Health
- Blue Cross Blue Shield of Massachusetts
- Blue Shield of California
- Cleveland Clinic
- Geisinger Health System
- Hospital Corporation of America, Inc.
- Humana Subsidiaries: Government Business - Humana Veterans (subsidiary of Humana Government Business) and Concentra
- Intermountain Health care
- Independence Blue Cross Group
- New York City Health and Hospital Corporation
- Johns Hopkins Medicine
- Kaiser Permanente
- Medical Device Manufacturers Association
- New York-Presbyterian Health care System
- NYU Langone Medical Center
- Partners Health care, including executives from Brigham and Women's Hospital and Mass General Hospital System
- Pharmaceutical Research and Manufacturers of America
- Providence Health & Services
- Tenet Health care Corporation
- ThedaCare Center for Health care Value
- University of California Health Sciences and Services
- University of Texas System
- Virginia Mason Hospital & Medical Center

Veterans Service Organizations (VSOs): The VSOs listed below shared with us data, reports, surveys, and their understanding of their constituents' health care needs. They provided the voice of the Veterans that the health care system serves. We are grateful to them for their support and for their daily commitment and service to Veterans.

- The American Legion
- American Veterans
- Disabled American Veterans
- Iraq and Afghanistan Veterans
- Military Officers Association of America
- Military Order of the Purple Heart of the U.S.A., Inc.
- Paralyzed Veterans of America
- Veterans of Foreign Wars of the United States
- Vietnam Veterans of America
- Wounded Warrior Project

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Appendix O Acronyms

ACAP	Access and Clinic Administration Program
APP	Advanced Practice Providers
ASA	Average Speed of Answer
BRAC	Base Realignment and Closure
CAMH	CMS Alliance to Modernize Healthcare
CBO	Congressional Budget Office
CBOC	Community-Based Outpatient Clinic
CIO	Chief Information Officer
CMOP	Consolidated Mail Order Pharmacies
CMS	Centers for Medicare & Medicaid Services
COTS	Commercial Off-the-Shelf
CPAC	Consolidated Patient Account Center
CPRS	Computerized Patient Record System
CPT	Current Procedural Technology
DoD	U.S. Department of Defense
EHR	Electronic Health Record
EWL	Electronic Wait List
FBCS	Fee Basis Claims System
FFS	Fee for Service
FITARA	Federal Information Technology Reform Act
FTE	Full-Time Equivalent
FY	Fiscal Year
GAO	General Accountability Office
HCPS	Health Care Payment System
HEDIS®	Healthcare Effectiveness Data and Information Set
HHC	New York City Health and Hospitals Corporation
HMO	Health Maintenance Organization
HR	Human Resources
IOM	Institute of Medicine of the National Academies
IRS	Internal Revenue Service

The views, opinions, and/or findings contained in this report are those of The MITRE Corporation and should not be construed as an official government position, policy, or decision.

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IT	Information Technology
MASS	Medical Appointment Scheduling System
MSVP	Medical/Surgical Prime Vendors
NLC	National Leadership Council
O&M	Operations and Maintenance
OI&T	Office of Information & Technology
OIG	Office of the Inspector General
OMB	Office of Management and Budget
OPES	Office of Productivity, Efficiency, and Staffing
PCC	Patient-Centered Community Care
PMAS	Project Management Accountability System
PPV	Pharmaceutical Prime Vendor
PTSD	Post-Traumatic Stress Disorder
SAIL	Strategic Analytics for Improvement and Learning
SCIP	Strategic Capital Investment Plan
SES	Senior Executive Service
SLA	Service-Level Agreement
U.S.	United States
VA	U.S. Department of Veterans Affairs
VACO	VA Central Office
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VHACO	Veterans Health Administration Central Office
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture
VSO	Veterans Service Organizations
wRVU	Work Relative Value Unit

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Appendix P Section 201 of the Veterans Choice Act

Section 201: Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs.

(a) INDEPENDENT ASSESSMENT.—

(1) ASSESSMENT.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into one or more contracts with a private sector entity or entities described in subsection (b) to conduct an independent assessment of the hospital care, medical services, and other health care furnished in medical facilities of the Department. Such assessment shall address each of the following:

(A) Current and projected demographics and unique health care needs of the patient population served by the Department.

(B) Current and projected health care capabilities and resources of the Department, including hospital care, medical services, and other health care furnished by non-Department facilities under contract with the Department, to provide timely and accessible care to veterans.

(C) The authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Department facilities, including whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care.

(D) The appropriate system-wide access standard applicable to hospital care, medical services, and other health care furnished by and through the Department, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation.

(E) The workflow process at each medical facility of the Department for scheduling appointments for veterans to receive hospital care, medical services, or other health care from the Department.

(F) The organization, workflow processes, and tools used by the Department to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.

(G) The staffing level at each medical facility of the Department and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics, which may include an assessment of any of the following:

(i) The case load of, and number of patients treated by, each health care provider at such medical facility during an average week.

(ii) The time spent by such health care provider on matters other than the case load of such health care provider, including time spent by such health care provider as follows:

(I) At a medical facility that is affiliated with the Department.

VETERANS CHOICE ACT INDEPENDENT ASSESSMENT (SECTION 201)—INTEGRATED REPORT

(II) Conducting research.

(III) Training or supervising other health care professionals of the Department.

(H) The information technology strategies of the Department with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by the Department, especially those strategies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Department in Department or non-Department facilities.

(I) Business processes of the Veterans Health Administration, including processes relating to furnishing non- Department health care, insurance identification, third-party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows:

(i) To avoid the payment of penalties to vendors.

(ii) To increase the collection of amounts owed to the Department for hospital care, medical services, or other health care provided by the Department for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate.

(iii) To increase the collection of any other amounts owed to the Department with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate.

(iv) To increase the accuracy and timeliness of Department payments to vendors and providers.

(J) The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Department, including the following:

(i) The prices paid for, standardization of, and use by the Department of the following:

(I) Pharmaceuticals.

(II) Medical and surgical supplies.

(III) Medical devices.

(ii) The use by the Department of group purchasing arrangements to purchase pharmaceuticals, medical and surgical supplies, medical devices, and health care related services.

(iii) The strategy and systems used by the Department to distribute pharmaceuticals, medical and surgical supplies, medical devices, and health care related services to Veterans Integrated Service Networks and medical facilities of the Department.

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(K) The process of the Department for carrying out construction and maintenance projects at medical facilities of the Department and the medical facility leasing program of the Department.

(L) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.

(2) PARTICULAR ELEMENTS OF CERTAIN ASSESSMENTS.—

(A) SCHEDULING ASSESSMENT.—In carrying out the assessment required by paragraph (1)(E), the private sector entity or entities shall do the following:

(i) Review all training materials pertaining to scheduling of appointments at each medical facility of the Department.

(ii) Assess whether all employees of the Department conducting tasks related to scheduling are properly trained for conducting such tasks.

(iii) Assess whether changes in the technology or system used in scheduling appointments are necessary to limit access to the system to only those employees that have been properly trained in conducting such tasks.

(iv) Assess whether health care providers of the Department are making changes to their schedules that hinder the ability of employees conducting such tasks to perform such tasks.

(v) Assess whether the establishment of a centralized call center throughout the Department for scheduling appointments at medical facilities of the Department would improve the process of scheduling such appointments.

(vi) Assess whether booking templates for each medical facility or clinic of the Department would improve the process of scheduling such appointments.

(vii) Assess any interim technology changes or attempts by Department to internally develop a long-term scheduling solutions with respect to the feasibility and cost effectiveness of such internally developed solutions compared to commercially available solutions.

(viii) Recommend actions, if any, to be taken by the Department to improve the process for scheduling such appointments, including the following:

(I) Changes in training materials provided to employees of the Department with respect to conducting tasks related to scheduling such appointments.

(II) Changes in monitoring and assessment conducted by the Department of wait times of veterans for such appointments.

(III) Changes in the system used to schedule such appointments, including changes to improve how the Department—

(aa) measures wait times of veterans for such appointments;

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(bb) monitors the availability of health care providers of the Department; and

(cc) provides veterans the ability to schedule such appointments.

(IV) Such other actions as the private sector entity or entities considers appropriate.

(B) MEDICAL CONSTRUCTION AND MAINTENANCE PROJECT AND LEASING PROGRAM ASSESSMENT.—In carrying out the assessment required by paragraph (1)(K), the private sector entity or entities shall do the following:

(i) Review the process of the Department for identifying and designing proposals for construction and maintenance projects at medical facilities of the Department and leases for medical facilities of the Department.

(ii) Assess the process through which the Department determines the following:

(I) That a construction or maintenance project or lease is necessary with respect to a medical facility or proposed medical facility of the Department.

(II) The proper size of such medical facility or proposed medical facility with respect to treating veterans in the catchment area of such medical facility or proposed medical facility.

(iii) Assess the management processes of the Department with respect to the capital management programs of the Department, including processes relating to the methodology for construction and design of medical facilities of the Department, the management of projects relating to the construction and design of such facilities, and the activation of such facilities.

(iv) Assess the medical facility leasing program of the Department.

(3) **TIMING.**—The private sector entity or entities carrying out the assessment required by paragraph (1) shall complete such assessment not later than 240 days after entering into the contract described in such paragraph.

(b) **PRIVATE SECTOR ENTITIES DESCRIBED.**—A private entity described in this subsection is a private entity that—

(1) has experience and proven outcomes in optimizing the performance of the health care delivery systems of the Veterans Health Administration and the private sector and in health care management; and

(2) specializes in implementing large-scale organizational and cultural transformations, especially with respect to health care delivery systems.

(c) **PROGRAM INTEGRATOR.**—

(1) **IN GENERAL.**—If the Secretary enters into contracts with more than one private sector entity under subsection (a), the Secretary shall designate one such entity that is predominately a health care organization as the program integrator.

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(2) RESPONSIBILITIES.—The program integrator designated pursuant to paragraph (1) shall be responsible for coordinating the outcomes of the assessments conducted by the private entities pursuant to such contracts.

(d) REPORT ON ASSESSMENT.—

(1) IN GENERAL.—Not later than 60 days after completing the assessment required by subsection (a), the private sector entity or entities carrying out such assessment shall submit to the Secretary of Veterans Affairs, the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and the Commission on Care established under section 202 a report on the findings and recommendations of the private sector entity or entities with respect to such assessment.

(2) PUBLICATION.—Not later than 30 days after receiving the report under paragraph (1), the Secretary shall publish such report in the Federal Register and on an Internet website of the Department of Veterans Affairs that is accessible to the public.

(e) NON-DEPARTMENT FACILITIES DEFINED.—In this section, the term “non-Department facilities” has the meaning given that term in section 1701 of title 38, United States Code.

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Appendix Q Blue Ribbon Panel

The Blue Ribbon Panel members are listed here, along with their biographies.

Dr. Brett Giroir (Panel Chair)	
Dr. Gail Wilensky (Panel Co-Chair)	
Dr. Katrina Armstrong	Dr. Debra Barksdale
Dr. Ronald R. Blanck	Prof. W. Warner Burke
Dr. Christine Cassel	GEN(R) Peter W. Chiarelli
Mr. George Halvorson	Mr. Robert L. Mallett
Dr. Robert Margolis	Dr. George Poste
Dr. Robert C. Robbins	Dr. Mark D. Smith
Dr. Glenn D. Steele, Jr.	Dr. Beth Ann Swan

Dr. Katrina Armstrong

Katrina Armstrong, M.D., MSCE, a world-renowned investigator in the areas of medical decision-making, quality of care, and cancer prevention and outcomes, is Physician-in-Chief of the Massachusetts General Hospital Department of Medicine, and Professor of Medicine at Harvard Medical School. Focusing at the interface of genomics, cancer and social policy, she has translated genomics advances into improvements in cancer control and identified novel mechanisms underlying cancer disparities. She leads one of the premier departments of medicine in the U.S. today, and has a deep understanding of what is needed to deliver exemplary clinical care.

Dr. Debra Barksdale

Dr. Debra J. Barksdale is Professor and Director of the DNP program at the University of North Carolina at Chapel Hill (UNC-CH). She is certified as a family nurse practitioner (NP), an adult NP, and a nurse educator. She is a Fellow of the American Academy of Nurse Practitioners and the American Academy of Nursing. She has over 20 years of NP experience and has been a NP in urgent care, primary care, home care and care of the underserved. On September 23, 2010, Dr. Barksdale was one of 19 members appointed to the 21 member Board of Governors for the new Patient-Centered Outcomes Research Institute (PCORI) by the U.S. Government Accountability Office under the Obama Administration. She is the only nurse appointed to the PCORI Board.

Dr. Ronald R. Blanck

Lt. Gen. Ronald R. Blanck, D.O., USA (Ret.), was the 39th Surgeon General of the United States Army, from 1996–2000. He was president of the University of North Texas Health Science

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Center at Fort Worth from 2000 to 2006. He currently serves as Chairman of the Board of Regents of the Uniformed Services University of the Health Sciences. He began his military career in 1968 as a medical officer and battalion surgeon in Vietnam. He retired 32 years later as the Surgeon General of the U.S. Army and commander of the U.S. Army Medical Command, with more than 46,000 military personnel and 26,000 civilian employees throughout the world.

Prof. W. Warner Burke

Warner Burke, Ph.D., is the E. L. Thorndike Professor of Psychology and Education and Editor of the Journal of Applied Behavioral Science at Teachers College, Columbia University. A social-organizational psychologist (Ph.D., University of Texas, Austin), Dr. Burke is currently engaged in teaching, research, and consulting. He teaches leadership and supervision and organization change. His research focuses on leadership, multirater feedback, organization change, and learning agility. Prof. Burke co-directs the Eisenhower Leader Development Program, an MA degree for Army officers jointly sponsored by Teachers College, Columbia University and the US Military Academy at West Point. He is the former Chair of the Department of Organization and Leadership at Teachers College, Columbia University. Among his many awards is the Public Service Medal from the National Aeronautics and Space Administration.

Dr. Christine Cassel

Christine K. Cassel, M.D., President and CEO of the National Quality Forum, is a leading expert in geriatric medicine, medical ethics, and quality of care. She is one of the world's leading experts on clinical quality. Dr. Cassel previously served as President and CEO of the American Board of Internal Medicine (ABIM), the ABIM Foundation, and Dean of the School of Medicine at Oregon Health Sciences University. Dr. Cassel is one of 20 scientists (and the only M.D.) chosen by President Obama to serve on the President's Council of Advisors on Science and Technology (PCAST), which advises the President in areas where an understanding of science, technology, and innovation is key to forming responsible and effective policy. She is the co-chair and physician leader of PCAST working groups that have made recommendations to the President on issues relating to health information technology and ways to promote scientific innovation in drug development and evaluation. In addition to having chaired influential Institute of Medicine (IOM) reports on end-of-life care and public health, she served on the IOM's Comparative Effective Research Committee mandated by Congress to set priorities for the national CER effort (PCORI).

Gen. Peter W. Chiarelli

Peter W. Chiarelli is a retired United States Army general who served as the 32nd Vice Chief of Staff of the U.S. Army from August 4, 2008 to January 31, 2012. As former vice chief of staff of the Army, Gen Chiarelli understands the needs of the Veteran, understands the issues of the hand-off from DoD care to VHA care for the Veterans, and has a deep personal interest in improving care for those Veterans who have experienced traumatic brain injury and post-traumatic stress.

Dr. Brett Giroir (Panel Chair)

The views, opinions, and/or findings contained in this report are those of The MITRE Corporation and should not be construed as an official government position, policy, or decision.

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Brett Giroir, M.D., is currently Senior Fellow at the Health Policy Institute of the Texas Medical Center, and former CEO of the Texas A&M Health Science Center, a premier assembly of colleges devoted to educating health professionals and advancing research in medicine, dentistry, public health, nursing, and pharmacy. He is a global authority on health care and life sciences innovation, having served diverse roles including Director of the Defense Science Office at DARPA, Principal Investigator of the DHHS Center for Innovation responsible for producing 50 million doses of vaccine against pandemic influenza, and Director of the Texas Task Force on Infectious Diseases chartered to lead the state's Ebola response and recommend policy changes within the state.

Mr. George Halvorson

Mr. George Halvorson served as chairman and chief executive officer of Kaiser Permanente from 2002–2013. Prior to serving as Kaiser Permanente CEO, Mr. Halvorson was the president and CEO of Health Partners in Minnesota for 17 years. He brings world-class leadership experience and expertise to the Panel, particularly in terms of leading a very large vertically integrated health care delivery system. He also brings connectivity to, and relationships with, many other expert health care leaders.

Mr. Halvorson currently serves as the Chair and CEO for the Institute of InterGroup Understanding and has a four year appointment to Chair the State of California Commission for Children and Families.

Mr. Robert L. Mallett

Robert L. Mallett is currently a board member and President and CEO of Accordia Global Health Foundation, an organization dedicated to health systems strengthening in Sub-Saharan Africa. For much of his professional career, Mr. Mallett has served in the health sector as a board member of health centered nonprofit organizations and at industry-leading health care companies. He is formerly Executive Vice President & General Counsel, Public and Senior Markets Group, a division of United Health Group. Immediately prior to joining United Health Group, Mr. Mallett served as Senior Vice President, Worldwide Policy & Public Affairs, Pfizer Inc. At Pfizer, among other things, he co-led the company's efforts on enhancing global access to medicines and served as President of the Pfizer Foundation. Mr. Mallett has also enjoyed a stimulating career as a chief operating officer in both federal and local government. During the Clinton Administration, he served as Acting Secretary and Deputy Secretary of the U.S. Department of Commerce, and he was City Administrator and Deputy Mayor for Operations for the District of Columbia. He has been the Peter P. Mullen Visiting Professor of Law at Georgetown University, and a Visiting Professor at the John F. Kennedy School of Government at Harvard University. Mr. Mallett is a member of the Council on Foreign Relations and an elected Fellow of the National Academy of Public Administrators.

Dr. Robert Margolis

Robert Margolis, M.D., is former Co-Chairman of the Board, DaVita HealthCare Partners and CEO Emeritus of HealthCare Partners, LLC. Dr. Margolis served as the managing partner and CEO of HealthCare Partners from the formation of the company in 1992 through February 2014. Under Dr. Margolis' leadership, HealthCare Partners became a highly respected and innovative

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physician-owned and operated medical group, independent physician association, and management services organization. Dr. Margolis has been on the leading edge of the managed care industry for more than 30 years.

Dr. George Poste

Dr. George Poste is the Del E. Webb Professor of Health Innovation and Chief Scientist of the Complex Adaptive Systems Initiative (CASI) at Arizona State University (ASU). This program integrates research in genomics, synthetic biology and high performance computing to study the altered regulation of molecular networks in human diseases to develop new diagnostic tests for precision (personalized) medicine and the remote monitoring of health status using miniaturized body sensors and mobile devices. From 1992–1999, he was Chief Science and Technology Officer and President, R&D, of SmithKline Beecham (SB). During his tenure at SB, he was associated with the successful registration of multiple drug, vaccine, and diagnostic products. He has served as a member of the Defense Science Board of the U.S. Department of Defense and currently serves on advisory committees for several U.S. government agencies in defense, intelligence, national security and health care.

Dr. Robert C. Robbins

Robert C. Robbins, M.D., became President and Chief Executive Officer of Texas Medical Center on November 5, 2012. Prior to that, he was professor and chairman of the Department of Cardiothoracic Surgery at Stanford University School of Medicine, where he served as a member of the faculty since 1993. He served as director of the Stanford Cardiovascular Institute, of the Heart- Lung and Lung Transplantation Programs, and of the Cardiothoracic Transplantation Laboratory. Dr. Robbins is an internationally recognized cardiac surgeon who has focused his clinical efforts on acquired cardiac diseases with a special expertise in the surgical treatment of congestive heart failure. His research work includes the investigation of stem cells for cardiac regeneration, cardiac transplant allograft vasculopathy, bioengineered blood vessels, and automated vascular anastomotic devices. As the CEO of the largest medical complex in the world, he brings world class expertise from a senior leadership perspective for all of the areas covered by the 12 assessments.

Dr. Mark D. Smith

Mark D. Smith, M.D., is founder and former President and Chief Executive Officer of the California HealthCare Foundation, an independent philanthropy in Oakland California, dedicated to improving the health of the people of California, particularly the underserved. He chaired the IOM's Committee on the Learning Healthcare System, which produced the widely publicized 2012 report Best Care at Lower Cost.

Dr. Glenn D. Steele, Jr.

Glenn D. Steele, Jr., M.D., Ph.D., is Chairman of xG Health Solutions and immediate past President and Chief Executive Officer of Geisinger Health System. Under his leadership from 2001–2015, this vertically integrated health care system has risen to be one of the most cost-effective, high quality provider organizations in the country. Prior to Geisinger, he was at the University of Chicago, where he served as Richard T. Crane Professor in the Department of

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Surgery, Vice President for Medical Affairs, and Dean of the Biological Sciences Division and the Pritzker School of Medicine. Prior to that, he was the William V. McDermott Professor of Surgery at Harvard Medical School, President and Chief Executive Officer of Deaconess Professional Practice Group and Chairman of the Department of Surgery at New England Deaconess Hospital. Widely recognized for his investigations into the treatment of primary and metastatic liver cancer and colorectal cancer surgery, Dr. Steele is past Chairman of the American Board of Surgery. He serves on the editorial board of numerous prominent medical journals. His investigations have focused on the cell biology of gastrointestinal cancer and pre-cancer. Most recently, he has concentrated on innovations in health care delivery and financing.

Dr. Beth Ann Swan

Beth Ann Swan, Ph.D., CRNP, FAAN, is Dean and Professor, Jefferson College of Nursing, Thomas Jefferson University. An acknowledged leader in nursing and ambulatory care, she has deep expertise and research experience in technology applications for practice-based research; client outcomes, especially symptom distress and functional status following ambulatory surgery; post-acute care coordination and transition management; and dissemination of evidence, based on accessibility and usability of web-based evidence resources.

Dr. Gail Wilensky (Panel Co-Chair)

Gail Wilensky, Ph.D., is an economist and senior fellow at Project HOPE, an international health foundation. She directed the Medicare and Medicaid programs from 1990–1992 and served in the White House as a senior health and welfare adviser to President GHW Bush. Dr. Wilensky currently serves as a trustee of the Combined Benefits Fund of the United Mine Workers of America and the National Opinion Research Center, is on the Board of Regents of the Uniformed Services University of the Health Sciences (USUHS), the Visiting Committee of the Harvard Medical School, and the Geisinger Health System Foundation. She recently served as president of the Defense Health Board, a Federal advisory to the Secretary of Defense, was a commissioner on the World Health Organization's Commission on the Social Determinants of Health, and co-chaired the Dept. of Defense Task Force on the Future of Military Health Care. She is an elected member of the Institute of Medicine and has served two terms on its governing council. She is a former chair of the board of directors of Academy Health, a former trustee of the American Heart Association and a current or former director of numerous other non-profit organizations.

VETERANS CHOICE ACT INDEPENDENT ASSESSMENT (SECTION 201)—INTEGRATED REPORT

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From: Blackburn, Scott R. </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Wright, Vivieca (Simpson) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: MVAC ideas
Date: Sun Feb 19 2017 10:31:47 CST
Attachments: 170219 MVAC ideas v1.docx

David / Vivieca – for our next generation MVAC, I've included a document with a several names/ideas. This is meant to be notional for brainstorming. If we like a handful of these names, we can start recruiting them and get them on board for an early April meeting.

Let me know what you think.

Scott

Owner: Blackburn, Scott R. </o=va/ou=exchange administrative group (fydibohf23spdl)
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Filename: 170219 MVAC ideas v1.docx
Last Modified: Sun Feb 19 10:31:47 CST 2017

MVAC: ideas for reconstituting

Principles for choosing members:

Embrace critics – make sure we have differing points of views

Mix of VSOs/advocates, people that are influential on Capitol Hill and media, cutting-edge thinkers with big ideas, and people who have specific skillsets/experiences that could be valuable (healthcare transformation, healthcare IT, customer service, driving government transformation)

Diversity of gender, ethnicity, generation (e.g. post 9/11, Vietnam Veterans), and perspectives

Perhaps start with a smaller group and then ask them for ideas on who else should be included.

Notional slate (thought starters for brainstorming):

1. Traditional VSO – (b) (6), American Legion (already on the committee)
2. Traditional VSO – (b) (6), DAV; (b) (6), PVA; or (b) (6) VVA
3. Post 9/11 VSO/influencer – (b) (6), IAVA
4. Veteran thought leader – (b) (6), CNAS; (b) (6) IVMF
5. Iconic military leader (possibly pick 2) – **Stanley McCrystal**; **Mike Mullen**; David Petraeus; Martin Dempsey; Richard Myers; John Abrams; Pete Charelli
6. Influential Republican – **Jeff Miller**; Steve Buyer; Newt Gingrich; Scott Brown
7. Influential Democrat - ???
8. Healthcare leaders (possibly pick 2 or 3) – (b) (6), Cleveland Clinic; (b) (6) Mayo Clinic; (b) (6), Virginia Mason; (b) (6), Henry Ford
9. Experienced government change leader – **Robert Mueller**, FBI; Charles Rossotti; Tom Ridge
10. Former VA leaders – Leo McKay; Scott Gould; **Anthony Principi**

Other ideas

1. CVA – Pete Hegseth, Dan Caldwell
2. DoD health care connections - Patty Horoho; Doug Robb
3. Post 9/11 influencer - (b) (6), Team Rubicon (I might suggest him for Suicide Prevention)

From: Shulkin, David J., MD </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: Lee, Jennifer S. (VACO) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: FW: LPMHC's in the VA
Date: Wed Feb 22 2017 18:05:33 CST
Attachments: Commission-on-Care_Final-Report_063016_FOR-WEB.pdf
LCPC Questions.docx
Letter to Shulkin.docx
RAND_RR806.pdf

Who might be able to look at this?

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6)
Sent: Wednesday, February 22, 2017 03:19 PM Eastern Standard Time
To: Shulkin, David J., MD
Subject: LPMHC's in the VA

Good afternoon Dr. Shulkin,

I watched your confirmation and the Town Hall this afternoon. I hope that you will read my letter and help get the answers I would like to have regarding the use of Licensed Professional Mental Health Counselors and Licensed Marriage and Family Therapists in the VA. The letter and the questions documents pertain to my concerns. The RAND report and Commission on Care are supplemental evidence to support my argument. Thank you for your consideration.

Regards,

(b) (6), M.S., L.C.P.C.

Licensed Professional Mental Health Counselor

Substance Abuse Rehabilitation Program

VA Illiana Health Care System

1900 East Main Street Building 103/Ward 2

Danville, IL 61832

(b) (6) @va.gov

Office: (217) 554-(b) (6)

Fax: (217) 554-(b) (6)

“Genius is 1% inspiration and 99% perspiration” –Thomas Edison

Owner: Shulkin, David J., MD </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6)
Filename: Commission-on-Care_Final-Report_063016_FOR-WEB.pdf
Last Modified: Wed Feb 22 18:05:33 CST 2017

Commission on Care

Final Report

COMMISSION ON CARE

June 30, 2016

VA-18-0457-A-001615

2638

COMMISSION ON CARE

Final Report of the Commission on Care

June 30, 2016

Commission on Care
1575 I Street, NW
Washington, DC 20005



commissiononcare.sites.usa.gov

COMMISSION ON CARE

1575 I Street, NW ▪ Washington, DC 20005

June 30, 2016

We are honored to submit to the President, through the Secretary of Veterans Affairs, in accordance with the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), the enclosed recommendations for transforming veterans' health care. We believe these recommendations are essential to ensure that our nation's veterans receive the health care they need and deserve, both now and in the future.

We worked with an absolute commitment to putting veterans at the heart of our deliberations, and believe our recommendations will create an integrated, community-based health care system for veterans that will be sustainable for the long term. During the term of the Commission on Care, we evaluated the 4,000-page *Independent Assessment Report*; held public meetings; listened to a broad range of stakeholders, including veterans and leaders of veterans service organizations; made site visits to Veterans Health Administration (VHA) facilities; and exchanged ideas with individual veterans, VA and VHA leaders, VHA employees and health care providers, members of Congress, economists, and health care experts.

Overall, the Commissioners agree with the findings of the *Independent Assessment Report*, which are consistent with the expansive body of other evidence the Commissioners have reviewed. This evidence shows that although care delivered by VA is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes. The Commissioners also agree that America's veterans deserve much better, that many profound deficiencies in VHA operations require urgent reform, and that America's veterans deserve a better organized, high-performing health care system.

The most public and glaring deficiency was access problems. Congress attempted to solve this problem through a provision in VACAA that directed VHA to implement a temporary program allowing for greater choice. The Commission finds, however, that the design and execution of the *Choice Program* are flawed. In its place, we offer specific recommendations for standing up integrated veteran-centric, community-based delivery networks that will optimize the balance of access, quality, and cost-effectiveness.

The Commission also finds that the long-term viability of VHA care is threatened by problems with staffing, facilities, capital needs, information systems, health care disparities and procurement. Fixing these problems requires deliberate, concurrent, and sequential actions. It also requires fundamental changes in governance and leadership of VHA to guide the organization during the next two decades through the rapid changes coming in demographics, technology, and in the structure of the overall U.S. health care system.

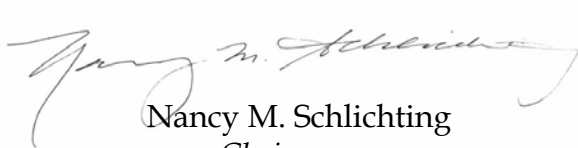
VHA has many excellent clinical programs, as well as research and educational programs, that provide a firm foundation on which to build. As the transformation process takes place, VHA must ensure that the current quality of care is not compromised, and that all care is on a trajectory of improvement. VHA has begun to make some of the most urgently needed changes outlined in the *Independent Assessment Report*, and we support this important work.

Implementing the recommendations in this report will greatly enhance VHA's ongoing reform efforts by providing both a systems-oriented framework and vitally needed changes in organizational structure. Foundational among these changes is forming a governing board to set long-term strategy and oversee the implementation of the transformation process, and building a strong, competency-based leadership system.

The remaining recommendations work in harmony to ensure veterans receive timely access to care, have options for where and how they receive care, are cared for in an environment that embraces diversity and inclusion, and are supported in making informed decisions about their own health and well-being. These recommendations are

not small-scale fixes to finite problems. Instead, they constitute a bold transformation of a complex system that will take years to fully realize, but that our country must undertake to provide our veterans with the high-quality health care they richly deserve.

Respectfully Submitted,



Nancy M. Schlichting
Chairperson



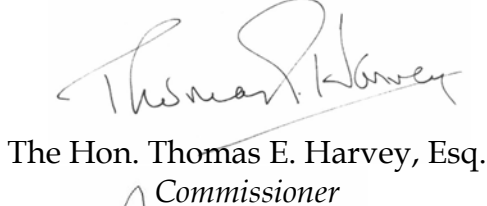
Delos M. Cosgrove, MD
Vice Chairperson



David P. Blom
Commissioner



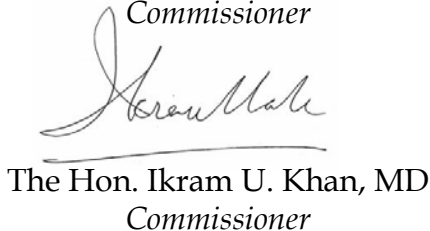
David W. Gorman
Commissioner



The Hon. Thomas E. Harvey, Esq.
Commissioner



Rear Adm. Joyce M. Johnson, DO, USPHS (ret.)
Commissioner




The Hon. Ikram U. Khan, MD
Commissioner



Phillip J. Longman
Commissioner



Col. Lucretia M. McClenney, USA (ret.)
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EXECUTIVE SUMMARY

Two years ago, a scandal over VHA employees' manipulation of data systems to cover up long appointment scheduling delays made headlines and left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. The White House appointed new leadership, including the secretary of veterans affairs (SECVA) and the undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program*, to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The independent assessment included an examination of the hospital care, medical services, and other health care provided in VA medical facilities.¹ The legislation identified 12 specific areas for in-depth evaluation:

- Demographics
- Health Care Capabilities
- Care Authorities
- Access Standards
- Workflow–Scheduling
- Workflow–Clinical
- Staffing/Productivity
- Health Information Technology
- Business Processes
- Supplies
- Facilities
- Leadership

The *Independent Assessment Report* provided a detailed analysis of the assessment and associated findings. The Commission work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

In an effort to focus the Commission's recommendations and set the tone for subsequent change, the Commissioners developed a vision, a mission, and a set of values to drive reform as shown below. The vision provides the conceptual framework for the model of veterans' health care put forth in this report, and the mission and values shape the content of the recommendations.

Vision

Transforming veterans' health care to enhance quality, access, choice, and well-being.

- *Quality: Provide community-based, innovative care that drives improved outcomes.*
- *Access: Ensure timely access to the best providers for meeting veterans' health care needs.*

¹ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113–146, § 201(a)(1).

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- *Choice: Integrate health care within communities to foster convenience and efficiency.*
- *Well-Being: Support veterans in achieving optimal physical and mental health.*

Mission

Provide eligible veterans prompt access to quality health care.

Values

- Provide veteran-centric care.
- Involve all stakeholders, and especially veterans and their families, in designing the evolving future health care for veterans.
- Assimilate veterans into the greater community.
- Create community-based integrated networks to improve health care access and choice for veterans.

The recommendations in this report acknowledge that although VHA provides health care that is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes.

Some of these challenges are not exclusive to VHA, and reflect large-scale problems in the U.S. health system in general, such as acute shortages of primary care doctors and lack of health care capacity in poor and rural areas. Other challenges reflect deficiencies within VHA itself, in areas such as staffing, facilities, capital needs, information systems, healthcare disparities and procurement.

It is important to understand VA's long history as a health care provider, which has included previous cycles of crisis and renewal that offer lessons for the present. It is also important to consider how VHA can implement major reform in a manner that is sustainable. This report addresses both of these issues.

The Commission's focus on access to care clearly highlighted the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The report begins with an *Introduction* that addresses the controversy over veterans' health care and gives a brief description of the Commission's vision for improving it. There are three main recommendation sections: *Redesigning the Veterans' Health Care Delivery System*; *Governance, Leadership, and Workforce*; and *Eligibility*. Each section includes detailed discussions of the high-level areas in which change must occur in the respective areas to facilitate bold reform. The format for each discussion includes identification of the problem, the Commission's recommendations for addressing the problem, background information, analysis, and implementation steps for Congress, VA, and other agencies. This executive summary provides a brief overview of each of the recommendations.

For the ease of our readers, the appendices contain all additional content. Of particular interest are appendices on *Financing the Vision and Model*, *Leadership Implementation*, *History as a Context for Systemic Transformation*, *Veteran Feedback*, and *Additional Resources*. These and other appendices provide policymakers and those charged with implementing the plan with a clear picture of the rationale for the recommendations and the context that frames them.

Recommendations

The Commission does not intend for these recommendations to be piecemeal fixes to everyday problems. Instead, they are presented as the foundation for far-reaching organizational transformation that adheres to a systems approach. The Commission's recommendations comprise the essential elements for such transformation.

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Due to changing veteran demographics, increasing demand for VHA care in some markets and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Congress tasked VHA with creating the temporary *Choice Program*. It was designed to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

The Commission Recommends That . . .

- VHA Care System governing board (see recommendation on p. 94) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.

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- Integrated community-based health care networks be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.
- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

The recommendations above work together to support the VHA Care System, as outlined in Table 1 below.

Table 1. VHA Care System Operations

Key Component	Expectations
Choice	<ul style="list-style-type: none"> ▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	<ul style="list-style-type: none"> ▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.²

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.³ For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified “not working to top of provider licensure” as a barrier in health care provision.⁴

² RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

³ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁴ Ibid., 95.

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VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

The Commission Recommends That. . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally supported programs.

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.⁵ Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).⁶

As part of the MyVA initiative, the Secretary of Veterans Affairs has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.⁷ The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.⁸

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a revised clinical-appeals process.

⁵ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

⁶ VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷ "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, <http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx>.

⁸ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.⁹

VHA has a program of system engineering — Veterans Engineering Resource Center (VERC) — that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to identify proactively problem areas within the system and offer assistance.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*, Assessment F (Workflow—Clinical), 14 and A-2, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

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A systematic review of VHA in 2007 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.¹⁰ VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues – the Health Equity Action Plan (HEAP) – but it has not been fully implemented.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.¹¹

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

Veterans who turn to VHA to meet health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of those barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks holds the promise of markedly improving veterans' access to care. That promise cannot be realized without transformative changes to VHA's capital structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of building out the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as

¹⁰ Somnath Saha et al., *Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review*, U.S. Department of Veterans Affairs, Health Services Research & Development Service, June 2007, accessed June 22, 2016, <http://www.hsrd.research.va.gov/publications/esp/RacialDisparities-2007.pdf>.

¹¹ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

much control as possible to drive the process to ensure that all facility plans are fully integrated with the strategic vision for the VHA Care System.

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meets its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission (BRAC) process to be implemented as soon as practicable. The Commission recommends the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems; enables scheduling, billing, claims, and payment, and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.¹² VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, VHA lacks an experienced senior health care IT leader focusing on the strategic health care IT needs of veterans.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing

¹² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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and implementing a comprehensive health IT strategy and developing and managing the health IT budget.

- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.¹³

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.

¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

Governance, Leadership, and Workforce

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center, and similar problems at multiple other VA medical centers, had both direct and indirect causes. Weak governance was found to be among those indirect causes.¹⁴ As the authors of a root-cause analysis of the Phoenix scandal highlighted, “a governance gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed to the wait-time problems.¹⁵ The report authors observed, “Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors.”¹⁶ The governance limitations made evident in the Phoenix scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration’s expectations for short-term results,¹⁷ and VHA’s operating in a “dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with competing demands”¹⁸ offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act (FACA) and be structured based on the key elements included in Table 5.

¹⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁵ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

Leadership

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

High-performing organizations have healthy cultures in which diverse staff feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government. For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

The Commission Recommends That . . .

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report on it to the CVCS and the new VHA Care System board of directors (see governance discussion in the previous section).

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and

promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an OMB management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and the functions overlap or are duplicated. The role of the VISN is not clear, and the delegated responsibilities of the medical center director are not defined.

The Commission Recommends That . . .

- VHA redesign VHACO to create high-performing support functions that serve VISNs and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the CVCS with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report.

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Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

To achieve the Commission’s vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set—identical to private-sector standards—will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes to veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders’ performance not just on *what* they achieve but *how* they achieve it.

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Personnel Performance Management System

- VHA create a new performance management system appropriate for health care executives, tied to health care executive competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of

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these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veterans' care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does all of the following:
 - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
 - Promotes veteran preferences and hiring.

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- Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, due process) through simplified, sensible processes that work for managers and employees.
 - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
 - Provides due process and appeals standards to adverse personnel actions.
 - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
 - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
 - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
 - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
 - Grandfathers current employees with respect to pay and benefits.
- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

Recommendation #16: Require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Effective planning for and management of human capital are core enabling requirements for any business: If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

The Commission Recommends That . . .

- VHA hire a chief talent leader who holds responsibility for the operation's entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the chief of VHA Care System.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.

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- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

In some cases, individuals have been dismissed from military services with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury [TBI], posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

The Commission Recommends That . . .

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an OTH discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Although VHA continues to offer the promise of health care to all eligible veterans, its capacity to meet that promise is constrained by appropriated funding.¹⁹

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use

¹⁹ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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underutilized VHA providers and facilities, providing payment through private insurance.

- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

Conclusion

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, though, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient-provider engagement and in where and how care is delivered. VHA must keep pace with, and even be a leader in, these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand access to reflect not only timeliness, but care quality, and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone: Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report* emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The Commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term transformation, the Commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the nation's obligation to those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission fully acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the Commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For

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example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net. Even considering these strengths, some may question how a system beleaguered with the problems VHA faces can achieve lofty transformation goals. This is not the first time VHA has faced challenges; however, and history has demonstrated that with appropriate structure and strategies in place, transformation can be achieved and sustained.

Transformation is a difficult process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. The Commission's recommendations in some areas acknowledge VHA's efforts to begin the transformation process and suggest that where these efforts align with the Commission's recommendations, they should be sustained. Reaping the fruits of transformation will take more than a single Congress or a single 4-year administration. For this reason, the Commission strongly recommends a new governance model and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission's recommendations, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

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INTRODUCTION

Two years ago, a scandal over VHA employees manipulating data systems to cover up long delays in scheduling care left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. In response, the White House appointed new leadership, including the secretary of veterans affairs (SECVA) and undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program*, to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The Commission on Care's work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

The charge given this Commission, with its emphasis on access to care, reflects the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the Commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, however, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient-provider engagement, and in where and how care is delivered. VHA must keep pace with, and even be a leader, in these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand *access* to reflect not only timeliness, but care quality and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone; Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report*

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emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term *transformation*, the commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the obligation owed those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net.

Others may question how a system with the range of problems VHA faces can meaningfully improve, let alone realize a transformation. Mindful of its 20-year charge, the Commission notes that VA health care faced similar challenges 20 years ago and underwent a historic transformation. The long history of the VA health care system has seen highs and lows. Among the lessons in that history is that the mission—to care for those who have borne the battle—is not only powerful, but enduring. History has demonstrated that transformation can be achieved, but also that structures and strategies for sustainability must be built into the framework.

As the commission report emphasizes, transformation is difficult. It is a process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. VHA has begun some of this work; our recommendations in some areas acknowledge VHA's efforts and suggest that where they are aligned with the Commission's recommendations, they should be sustained. The fruits of the transformation, though, will not be realized over the course of a single Congress or a single 4-year administration. For this reason, the Commission, strongly recommends a new form of governance and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission recommends, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

COMMISSION RECOMMENDATIONS

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Problem

Due to changing veteran demographics, increasing demand for VHA care in some markets, and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With the passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACA), Congress tasked VHA with creating the temporary *Choice Program*. It was intended to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

The Commission Recommends That . . .

- VHA Care System governing board (see Recommendation #9) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.
- Integrated, community-based health care networks be developed with *local* VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.

Recommendations continue on next page. =>

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Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

Background

VHA has long had authority to purchase hospital care and medical services based on geographic inaccessibility or VHA's lack of a required service.²⁰ In 2013, VA moved beyond the use of individual purchased-care authorizations to regional contracting under the Patient-Centered Community Care (PC3) Program.²¹ In all cases, purchased care was a secondary means of providing care, to be used "when VA health care facilities are not feasibly available."²² Even before the creation of the *Choice Program* in 2014, some 10 percent of VHA medical spending went for purchased-care services.

When Congress enabled what became known as the *Choice Program*, it tasked VHA with implementing a fundamentally new mechanism for purchasing care. Unlike traditional purchased-care authority (which still exists), the *Choice Program* promises veterans who meet specific geographic or wait-time-related criteria that they can elect to receive treatment from within a network of a community providers.²³

Under the current *Choice Program*, however, most VHA patients are promised little or no actual choice of providers outside VHA. To be eligible for the program, VHA patients must meet the following criteria:²⁴

The Commission Recommends That . . .

<= Recommendations continued from previous page.

- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- The VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

²⁰ Contracts for Hospital Care and Medical Services in Non-Department Facilities, 38 U.S.C. § 1703(a).

²¹ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, 37, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

²² Non-VA Medical Care Program, VHA Directive 1601, (2013).

²³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014).

²⁴ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014), as amended by Construction Authorization and Choice Improvement Act, Pub. L. No. 114-19, 129 Stat. 215, (2015). The Independent Assessment proposed that VA should "Develop and implement more sensitive standards of geographic access to care. VA should compare the 'one-size-fits-all' approach of driving distance to alternative standards that are more sensitive to differences between Veteran subgroups, clinical populations, geographic regions, and individual facilities. This

- Live more than 40 miles from the closest VHA facility with a full-time primary care provider
- Cannot be seen within 30 days of the date veterans' providers indicate they need to be seen.
- Cannot be seen within 30 days of veterans' preferred appointment date if providers have not provided a specific appointment date.

This standard is difficult to reconcile with other statutory priorities for VA care.²⁵ For example, under the *Choice Program*, a veteran with severe service-incurred health conditions may have no access to providers outside VHA, yet a veteran with no service-related disabilities does have such a choice.²⁶ Implementing the *Choice Program* has posed challenges, including difficulties arising from overlapping, but fundamentally different, care-purchasing authorities. Veterans, VHA staff, and community providers²⁷ have been confused because of conflicting requirements and processes in eligibility rules, referrals and authorizations, provider credentialing and network development, care coordination, and claims management.²⁸

Adding to the confusion is the fact that VHA, facing a 90-day deadline for implementing the program, outsourced the creation and management of its provider networks to two private contractors, thus blurring lines of responsibility and leaving both patients and providers confused about who exactly holds responsibility for what. In execution, the program has aggravated wait times and frustrated veterans, private-sector health care providers participating in networks, and VHA alike.²⁹

In October 2015, VA submitted a report to Congress that proposed legislation to harmonize the different purchased-care authorities into a single approach.³⁰ VA's report also set out a plan for establishing high-performing networks. The report acknowledged that "[n]o organization can excel at every capability," and that "[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers."³¹ As further articulated by Dr. David Shulkin, USH:

assessment highlighted the importance of time spent driving, mode of transportation, traffic, and availability of needed services as key considerations in assessing geographic access to care."

²⁵ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705.

²⁶ Ibid.

²⁷ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, 43, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf. Pete Henry, retired VA medical center director, response to questions about the challenges facing field officials, email to Commission on Care staff, January 18, 2016.

²⁸ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

²⁹ "Despite \$10B 'Fix,' Veterans are Waiting Even Longer to See Doctors," Quil Lawrence, Eric Whitney, and Michael Tomsic, accessed May 16, 2016, <http://www.npr.org/sections/health-shots/2016/05/16/477814218/attempted-fix-for-va-health-delays-creates-new-bureaucracy>.

³⁰ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

³¹ Ibid., 18.

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It's become apparent that the VA alone cannot meet all the health care needs of U.S. veterans. The VA's mission and scope are not comparable to those of other U.S. health systems. Few other systems enroll patients in areas where they have no facilities for delivering care. Fewer still provide comprehensive medical, behavioral, and social services to a defined population of patients, establishing lifelong relationships with them. These realities, combined with the wait-time crisis, have led the VA to reexamine its approach to care delivery . . . [A]ddressing veterans' needs requires a new model of care: rather than remaining primarily a direct care provider, the VA should become an integrated payer and provider. This new vision would compel the VA to strengthen its current components that are uniquely positioned to meet veterans' needs, while working with the private sector to address critical access issues.³²

Analysis

VHA needs systemic transformation, and merely clarifying and simplifying the rules for purchased care, as proposed in the *Independent Assessment Report*, is not sufficient to achieve that goal. VHA must replace the arbitrary eligibility requirements and unworkable clinical and administrative restrictions of current purchased programs with the new VHA Care System, available to all enrolled veterans.

The VHA Care System is defined as VHA employed providers and facilities; Department of Defense (DoD) and other federally-funded providers and facilities; and community-based, VHA-credentialed community providers and facilities, forming integrated networks to deliver high-quality and high-access care to enrolled veterans across the United States. VHA may establish the networks with the use of national contractors or with internal resources, but networks should be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.

This new delivery model must preserve critical VHA programs and competencies that are unique to VHA or that are of higher quality or greater scope than is available in the private sector, either locally or nationally³³ They include specialized behavioral health care programs, integrated behavioral health and primary care (in patient-aligned care teams), specialized rehabilitation services, spinal cord injury centers, and services for homeless veterans.³⁴ These and similar programs and services are core competencies and special capabilities that serve the needs of combat veterans, veterans with conditions incurred or aggravated in service, and veterans reliant on safety-net services and supports.³⁵ Because of its unique capabilities and competencies, VHA should play an important role in expanding and enhancing the care of veterans across the United States by collaborating with local network providers to improve the

³² David J. Shulkin, "Beyond the VA Crisis — Becoming a High-Performance Network," *New England Journal of Medicine*, 374, (2016): 1003-1005, accessed June 15, 2016, <http://doi.org/10.1056/NEJMp1600307>.

³³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

³⁴ Special capabilities like spinal cord injury care, which draw from specialty care available in the full-service hospitals in which they are currently provided, merit continued support and investment. Thus, in instances where VHA might no longer operate a full-service hospital that had once housed a spinal cord injury center, it would need to establish community partnerships to assure veterans would continue to receive the same high quality care.

³⁵ David J. Shulkin, "Why VA Health Care Is Different," *Federal Practitioner*, 33, no. 5 (2016): 9-11, <http://www.fedprac.com/home/article/why-va-health-care-is-different/c8da5ba1261bdb726bdddcbceea81f27.html>.

availability and quality of care in areas especially needed by veterans, such as mental health and rehabilitation.

Management and Oversight

VHA Care System networks will be built out in a well-planned, phased approach overseen by the new governing board, which will determine the criteria and sequencing for the phases, to ensure effective execution of the strategy. The timing and phasing criteria may include veteran service needs, access issues, quality issues, facility issues, and IT capabilities.

The networks within the VHA Care System will require ongoing management and evaluation of their performance. This process will be the responsibility of VHA management and board, with board oversight of network performance.

The governing board will oversee the budget for the VHA Care System. Local leadership will provide input on funding, and the local networks will determine their funding needs and submit their respective requests to the chief of VHA Care System (CVCS), formerly the undersecretary of health for VHA. The governing board will recommend to Congress the budget required to implement the VHA Care System, with multiyear appropriations. The local network leaders will have the flexibility to manage their respective network budgets based upon local needs. A key element of the new system will be combining a national strategy and local flexibility for managing the budget to allow for effective decision making to ensure veterans' needs are met.

Provider Payment

Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS). MACRA is intended to move the health care industry away from a fee-for-service model to value-based payments.³⁶ Such a system is expected to drive improved quality and lower costs.³⁷

Care Administration

From a strategic perspective, service-connected disabled veterans should receive the highest priority access to the VHA Care System. This principle should guide access to all types and points of care. Veterans with limited financial means should also have high priority. If needed, cost sharing (applicable only to those who are non-service-connected disabled and not financially needy) can provide a means for offering broader choice. The current time and distance criteria for community care access (30 days and 40 miles) should be eliminated. VISN geography should also be eliminated as a factor in determining where veterans can access care. Eligible veterans should be permitted to receive care at any facility and by any provider in the VHA Care System, whether in a veteran's home VISN or not.

Choice and Care Coordination

The topic of choice was the most contentious issue considered by the Commission. Some Commissioners advocated complete choice of providers for veterans, with no requirement for

³⁶ "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, <http://www.nationalpartnership.org/issues/health/macra.html>.

³⁷ Ibid.

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care coordination by primary care physicians. Others advocated for a tightly managed model with VHA controlling access to community providers, as is done today. After considering the costs of various design options, the importance of care coordination, and the need for greater veteran access to both primary care and specialty care services, the Commission agreed to the following design principles:

- VHA will establish and credential community networks with a focus on quality of providers, access to comprehensive services, and utilization of VHA resources.
- Veterans will have complete choice of primary care providers within the VHA Care System.
- All primary care providers in the VHA Care System (including VHA providers, DoD and other federally funded providers, and community providers) will coordinate veterans' care.
- Specialty care will require a referral from a primary care provider.
- VHA will assume overall responsibility for care coordination and navigation for all enrolled veterans.

Quality of care must be a core element of network design and consistently monitored with metrics that are routinely used by the private sector. Accordingly, VHA must adopt standards that both ensure networks are composed of high-quality providers and set appropriate expectations of those providers. Critically, all providers in the networks must have fully interoperable IT platforms to allow for complete data exchange. Providers must work together to maximize patients' well-being using evidence-based protocols of care.

Lack of coordination among providers is a major quality and patient-safety issue throughout the U.S. health care system. It is important for VHA to coordinate the care it provides because it serves an especially vulnerable population that has more chronic medical conditions, behavioral health conditions, and individuals of lower socioeconomic status than the general medical population.³⁸ Veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers.³⁹

³⁸ Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, <http://doi.org/10.1001/jama.2012.196>.

³⁹ "The Impact of the Affordable Care Act on VA's Dual Eligible Population," Patricia Vandenberg et al., Department of Veterans Affairs, accessed June 2, 2016, <http://www.hsrd.research.va.gov/publications/forum/apr13/apr13-1.cfm>. Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, <http://doi.org/10.1001/jama.2012.196>. Brigham R. Frandsen et al., "Care Fragmentation, Quality, and Costs Among Chronically Ill Patients," *American Journal of Managed Care*, 21, no. 5, (2015): 355-362, accessed June 20, 2016, <http://www.ajmc.com/journals/issue/2015/2015-vol21-n5/care-fragmentation-quality-costs-among-chronically-ill-patients>. Chuan-Fen Liu et al., "Use of Outpatient Care in Veterans Health Administration and Medicare among Veterans Receiving Primary Care in Community-Based and Hospital Outpatient Clinics," *Health Services Research*, 45, no. 5 part 1, (2010): 1268-1286, accessed June 20, 2016, <http://doi.org/10.1111/j.1475-6773.2010.01123.x>.

VHA Care System will operate as outlined in Table 2 below.

Table 2. VHA Care System Operations

Key Component	Expectations
Choice	<ul style="list-style-type: none"> ▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	<ul style="list-style-type: none"> ▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Scope of Provider Networks

In setting up networks within the VHA Care System, VHA must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans' choice, yet would also consume far more financial resources (i.e., taxpayer dollars) due to increased utilization or cost shifting. Currently, money VHA spends on expanding choice is not available to spend on other programs and services vital to its mission.⁴⁰

Health plans commonly limit the size and scope of networks as a cost-management tool, offering insurance products with narrow networks (managed care plans) or more open networks (preferred provider plans). Well-managed, narrow networks can maximize clinical quality by requiring participating clinicians to adhere to evidence-based protocols of care.⁴¹ Achieving high quality and cost effectiveness may constrain consumer choice. A patient's preferred doctor, clinic, or hospital may not be part of that smaller network or the narrow network may not offer sufficient geographic access for some patients.⁴²

VHA must balance these competing considerations. In doing so, it faces a variety of options. In addition to the scope of networks, for example, is the question of whether and how VHA will play a role in steering patients to different providers within the networks. This is another area involving tradeoffs among competing values and considerations. Private-sector health plans

⁴⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 23 accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴¹ "What Tier Networks Will Mean to You," Ken Terry, accessed June 2, 2016, <http://medicaleconomics.modernmedicine.com/medical-economics/content/what-tiered-networks-will-mean-you>.

⁴² Ibid. U.S. Congress, House of Representatives, Committee on Ways and Means, Subcommittee on Health, *Hearing on "Health Care Consolidation"*, 112th Congress, 1st Session, (2011), (Statement of Paul B. Ginsburg, President, Center for Studying Health System Change, Research Director, National Institute for Health Care Reform), accessed June 2, 2016, http://waysandmeans.house.gov/UploadedFiles/Ginsburg_Testimony_9-9-11_Final.pdf.

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often require all specialty care to be preapproved through a referral from a primary care physician. Managed care plans may also use prospective and concurrent utilization review and care management for hospitalization. For prospective reviews, patients must receive approval from their health plan before being admitted to the hospital to ensure the admission is clinically appropriate. Plans may also use concurrent utilization or case management for inpatient care to ensure the care and tests ordered and the length of stay in the hospital are appropriate.⁴³

The Commission carefully weighed these issues in recommending an approach. The Commission considered the effect of cost using various configurations of VHA services and community delivered services (CDS). Options considered by the commission include the following:

- **Recommended Option:** This option provides an integrated network of VHA, DoD and other federally funded providers, and community providers, credentialed by VHA. It requires veterans to attain a referral from their primary care provider to access specialty care.
- **CDS Alternative 1:** The main difference between this option and the *Recommended Option* is primary care, inpatient medical and surgical care, and some standard specialty care would not be eligible for CDS networks and would be accessed within VHA unless the *Choice Program* distance exception applies.
- **CDS Alternative 2:** The division of care between VHA providers and CDS network providers would be the same as for *CDS Alternative 1*; however, veterans would only need to consult their primary care provider before seeking specialty care, rather than obtaining a referral.
- **CDS Alternative 3:** This option would combine the broad network in the *Recommended Option*, but would have no referral or consultation requirement; thus, it would be an extremely generous benefits package.
- **Premium Support:** Under this scenario, enrollees who are younger than 65 would choose a subsidized insurance premium with cost sharing. Access to VA services, including special services, would be eliminated.
- **Eligibility Expansion:** Under this scenario the VA health care system would expand to allow all veterans, regardless of priority group.
- **Other-Than-Honorable Discharges:** A policy change for which individuals with other-than-honorable (OTH) discharge is outlined in Recommendation #17. This option would allow temporary eligibility for VA health care to those with an OTH discharge until the adjudication process to determine long-term eligibility took place.

⁴³ Paul B. Ginsburg, "Achieving Health Care Cost Containment Through Provider Payment Reform that Engages Patients and Providers," *Health Affairs*, 32, no. 5, (2013): 929-934, accessed June 20, 2016, <http://doi.org/10.1377/hlthaff.2012.1007>. While these approaches can help keep costs down, patients, doctors and hospitals can experience the process as bureaucratic interference in clinical care. To implement utilization management, health plans usually include a strong clinical appeals process that both doctors and patients can access to question the decisions made by administrators.

Below is a more detailed summary of the Commission's *Recommended Option*. Additional information, including cost projections for all of the options above, can be found in Appendix A.

Cost Model for Commission Recommended Option

This option would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VHA. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in a substantially different way than by VHA).⁴⁴ In 2014, 68 percent of care would have been eligible for CDS networks at current VHA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network (i.e., from any provider in the VHA Care System). In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

Both CDS networks and traditional Care in the Community (CITC) are priced at Medicare allowable rates by matching Medicare fee schedule data to VA Health Service Categories.⁴⁵ A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities. For care shifting into the CDS networks, we assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance; those costs are not modeled.

We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a provider in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and

⁴⁴ Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health, and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

⁴⁵ Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

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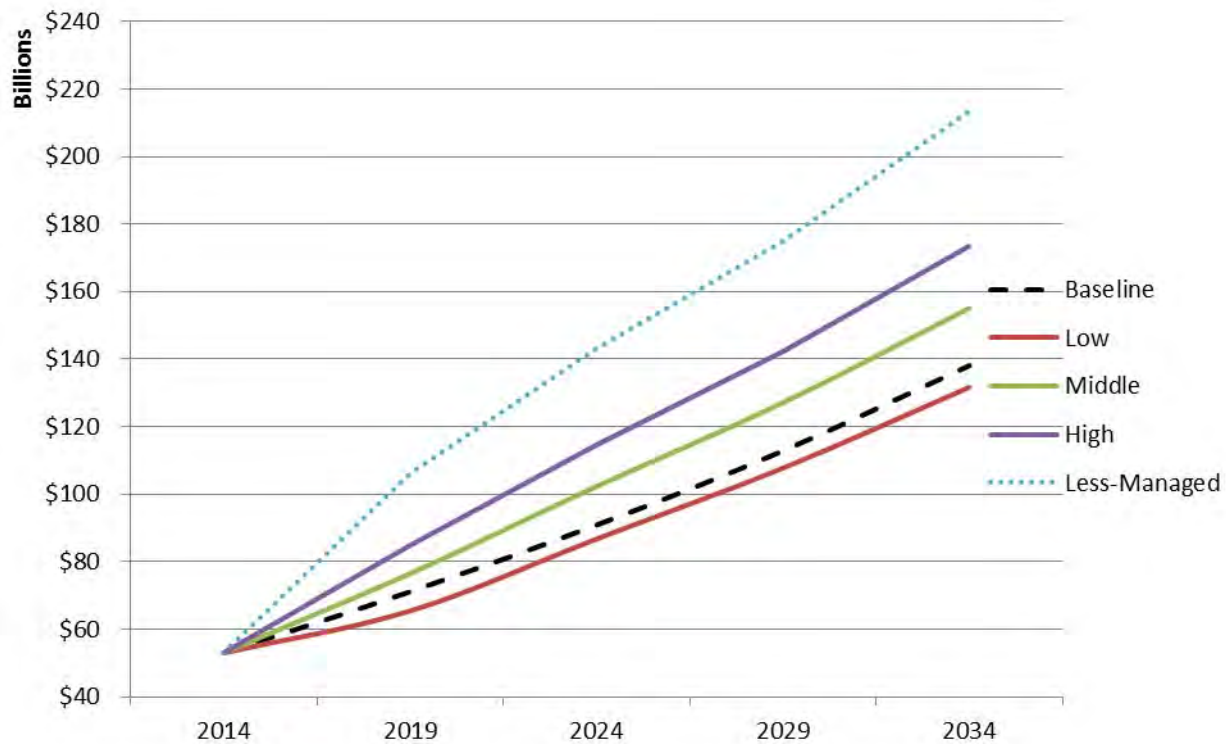
20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was formerly subject to sizable cost sharing with private insurance or Medicare and now would be subject to little, if any, cost sharing associated with VA-financed care.

There are a number of caveats associated with our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects on quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. Finally, estimates do not include administrative costs associated with CDS networks; these costs could be substantial.

Figure 1 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from \$65 billion to \$85 billion in 2019, with a middle estimate of \$76 billion. The middle estimate is moderately above the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is \$106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

This model is described more fully in Appendix A, along with models for a range of other options, some of which are previously described in this section. Consult Appendix A for more details on the technical assumptions necessary to understand the results presented here. The assumptions and caveats detailed in Appendix A play a critical role in our estimates, and any deviation from these assumptions could substantially affect the estimates.

Figure 1. Projected Costs of Recommended Option



Mitigating Risks

Choice involves tradeoffs. Reducing drive times to see a doctor may lead to longer wait times, for example, if it induces substantially more veterans to seek more care.⁴⁶ VHA reliance on contracting could also have unintended consequences for already underserved communities. Providers in such communities who join the local VHA network may decide to limit the number of Medicare and Medicaid patients they accept into their practices. In other, highly concentrated health care markets, which are increasingly common throughout the United States, VHA may not be able to contract for care in the community except at higher prices.⁴⁷ Such circumstances underscore the importance of VHA retaining the option of building its own capacity.

Policymakers must also carefully weigh concerns that leaders of seven major veterans organizations expressed in a recent joint letter in which they warned “choice should never be the ultimate goal of a health care system designed to meet the unique needs of veterans.”⁴⁸ These organizations do not support providing unfettered choice, and the VSO leaders stated that “any health care reform proposal that elevates the principle of ‘choice’ above all other clinical considerations would have severe consequences for veterans who rely on VA, resulting

⁴⁶ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 284, accessed May 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁴⁷ David M. Cutler and Fiona Scott Morton, “Hospitals, Market Share, and Consolidation,” *Journal of the American Medical Association*, 310, no. 18, (2013): 1964-1970, accessed June 20, 2016, <http://doi.org/10.1001/jama.2013.281675>.

⁴⁸ Garry J. Augustine, Disabled American Veterans et al., letter sent to Commission on Care, April 29, 2016.

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in less ‘choice’ rather than the intended desire for more health care options for many disabled veterans.”⁴⁹

The Commission has addressed this concern in several ways, including the following:

- recommendations to substantially improve VHA operations, thereby enhancing the attractiveness of using VHA providers and facilities by enrolled veterans
- VHA control of network design
- VHA Care System governing board oversight of network execution and phasing
- high standards for community provider participation, including credentialing, military competence, and quality and utilization performance
- VHA oversight of care coordination and navigation
- requirement of primary care referral for specialty care

The Commission recognizes that greater choice of provider can result in higher utilization of health care services, which increases costs. This risk can be mitigated by recommendations in this report that will produce cost savings. To incentivize cost mitigation, all cost savings associated with improved efficiency and operations should be reinvested into the VHA Care System. Examples of cost mitigation strategies include the following:

- recovering third-party payments owed to VHA more effectively
- maintaining VHA as a secondary payer when veterans have other health insurance and treatment is for non-service-connected care
- increasing cost-sharing or changes in eligibility and/or benefit design could also substantially contain the projected costs of increasing provider-choice
- reducing fixed costs of underutilized facilities and services
- managing the supply chain to produce cost savings
- improving facilities to increase provider productivity (e.g., increase in outpatient exam rooms)
- adopting information technology that improves the quality and efficiency of care

Effectively implementing and managing integrated networks will require extensive changes in the governance and leadership of VHA, as well as flexible and smart procurement policies and

⁴⁹ Ibid.

contracting authorities, as discussed elsewhere in this report. The highest priority for standing up networks should be locations where VHA quality of care is deficient or capacity is strained.⁵⁰

Where capacity constraints exist within networks, first priority for care should go to those veterans with greatest medical need, followed by service-connected disabled veterans and indigent veterans.⁵¹ VHA should develop processes and procedures for insuring that veterans have the knowledge and assistance they need to make informed health care decision and to navigate effectively through the expanding health care networks. By employing strategies proven by other managed care plans, VHA will find administrative means to guard against inappropriate treatment, wasteful spending, and fraud.

As many surgical and medical procedures that previously required inpatient hospital stays have routinely become outpatient procedures, there continues to be a substantial shift from inpatient to outpatient care.⁵² Consequently, to ensure improved access to care for veterans, the VHA Care System and long-term plans for facilities should focus on creating a robust ambulatory network and reshaping inpatient resources to match expected demand. Additionally, to inform veterans' and providers' decisions and create increased accountability for performance, all VHA and community network providers and facilities must provide transparent information on inpatient and outpatient quality, service, and access using the same performance metrics, including those used by Medicare.

Implementation

Legislative Changes

- Enact legislation amending 38 U.S. Code, Chapter 17 to consolidate existing purchased-care authorities and authorize the SECVA to furnish enrolled veterans needed hospital care and medical services through agreements with providers the SECVA deems meet quality standards the SECVA will establish. Veterans would be eligible for community care on the same basis as for VHA-furnished care, and current wait time and geographic distance criteria should no longer be applicable.

VA Administrative Changes

- Develop national policy to govern local establishment of networks, and in doing so, focus its design and long-term planning on creating a robust ambulatory capability and reshaping inpatient resources to match expected demand.
- Establish standards that community providers must meet to qualify for participation in community networks, to include becoming fully credentialed, meeting patient-access criteria, demonstrating high-quality clinical outcomes and appropriate use decisions, demonstrating military cultural competency, and having capability for interoperable data exchange.

⁵⁰ Information on what medical centers are deficient in their care is available, for example, from the VHA's own Strategic Analytics for Improvement and Learning (SAIL) data.

⁵¹ It would seem prudent to begin such phased development by piloting that effort, and limiting the scope of unfettered choice to service-connected veterans.

⁵² Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/21183845>.

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- Establish systems to ensure that all primary care providers in the VHA Care System can effectively coordinate veterans' care.
- Provide veterans navigation services for complex care needs, including information needed by patients and their families for informed decision making about treatments and providers. Navigation services should assist veterans and their families with eligibility, cost-sharing, and other administrative issues.
- Establish policies and procedures to ensure that VHA provider as well as community providers within each network, provide transparent information (using the same metrics) on care-quality, service, and access.
- Eliminate the practice of cross-country referrals if quality care is available locally.
- Employ the most current payment approaches that incentivize quality and appropriate use of health care services.

Other Department and Agency Administrative Changes

- None required.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

Problem

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.⁵³

The Commission Recommends That . . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.⁵⁴ For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified “not working to top of provider licensure” as a barrier in health care provision.⁵⁵

VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

Background

A large part of the VHA’s problem with inadequate clinical support staff derives from its difficulties in hiring, retaining, and training medical support assistants (MSAs). These individuals answer phones, schedule care, and verify health care eligibility, among other duties.

⁵³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁵⁴ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵⁵ *Ibid.*, 95.

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Congress has recently given VHA the flexibility to offer MSAs market-based pay rates.⁵⁶ VHA is changing cumbersome rules that have made hiring new MSAs exceptionally time-consuming.⁵⁷

VHA is working to resolve its problems with resource allocation in clinics. For example, the agency has committed to increasing use of clinical managers to help medical centers better match resources to patient demand. Widely used by other health care systems, clinic managers enhance operations by ensuring that telephone protocols, scheduling, and clinic workflow are operating at peak efficiency. They also ensure that staff members are assigned appropriate caseloads and are meeting productivity standards and wait time targets and that administrative staff has appropriate training in scheduling, coding, and/or documentation.

Many states have already taken the steps to ensure APRNs have full practice authority. VHA is working to do the same, which will allow a vast increase in the number of VHA clinicians available to treat patients independently.⁵⁸

To effectively manage clinician supply for the inpatient setting, administrators require accurate bed count data. Currently in VHA, data integrity of bed counts is compromised as a consequence of disclosure requirements of Congress. VHA is required by statute to complete a complicated reporting, approval, and notification process when it closes hospital beds.⁵⁹ To avoid the reporting requirements some VA medical centers count beds as unavailable indefinitely. This action can skew occupancy rates and thwart planning activities. VHA developed its guidance in part to satisfy the Millennium Act⁶⁰ and other requirements that essentially froze beds at FY 1998 levels.⁶¹

Analysis

VHA has taken a number of measures to address data integrity issues. VHA has started hiring clinical managers to assist in managing resources for effective performance. VHA has made efforts to address problems affecting supply and training of MSAs. Additionally, VHA has recently proposed a rule that would authorize full practice for APRNs working within the agency.⁶²

These measures by themselves, however, will not be sufficient to solve the current problems. VHA must ensure all facilities have enough support positions—both clerical and clinical—to

⁵⁶ Sloan D. Gibson, Deputy Secretary, Department of Veterans Affairs, presentation to Commission on Care, April 18, 2016.

⁵⁷ 38 U.S.C. § 7401(3)(A)(iii).

⁵⁸ Establishing Medication Prescribing Authority for Advanced Practice Nurses, VHA Directive 2008-049, (2008).

⁵⁹ Inpatient Bed Change Program and Procedures, VHA Handbook 1000.01, (2010).

⁶⁰ The Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545, Sec. 301. Title III of the Millennium Act prohibits the secretary from closing in any fiscal year more than 50 percent of the beds within a department medical center unless the secretary first submits to the veterans' committees a justification for such closure and waits to take action on a closure until 21 days after the submission of the report. It also requires the secretary to report annually to the veterans committees on bed closures during the preceding fiscal year.

⁶¹ Extended Care Services, 38 U.S.C. § 1710B(b) requires staffing for extended care to remain at FY 1998 levels.

⁶² "VA Proposes to Grant Full Practice Authority to Advanced Practice Registered Nurses," Department of Veterans Affairs, accessed June 3, 2016, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2793>.

enable all clinicians to work at the top of their licenses and to avoid problems with turnover, unexpected staff absences, and surges in patient demand.⁶³

VHA must have authority to pay competitive rates for the personnel it needs. This goal would be accomplished in part by adopting Recommendation #15 of this report for creating a new personnel system under Title 38 for all VHA employees. Currently, for example, clinical managers and practitioners earn far more in the private sector.⁶⁴

As VHA develops improved clinic management tools such as the Health Operations Dashboard, these tools draw from clinical data, patient data, and other sources to allow managers to make decisions using real-time data.⁶⁵ To be effective tools, the data fed into them must be accurate. Relieving VHA from some of the reporting requirements of the Millennium Act will help accomplish effective use of the dashboard for inpatient management.

Implementation

Legislative Changes

- Create a new alternative personnel system under Title 38 authority as mentioned in Recommendation #15.
- Eliminate bed reporting requirements under the Millennium Bill, and require VHA to report new beds as closed, authorized, operating, staffed, or temporarily inactive within 90 days of enactment.

VA Administrative Changes

- Develop policy to allow full practice authority for APRNs.
- Develop leadership tracks, including clinical and group practice managers, for ambulatory settings.
- Develop training programs for medical support assistants (MSAs).
- Modify policy in VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, as appropriate.

Other Department and Agency Administrative Changes

- None required.

⁶³ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 17-18, accessed June 3 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

⁶⁴ For example, Salaries.com listed a median salary for Clinic Manager III (a manager of a clinic with more than 50 physicians) in Dallas, TX, as \$94,000.⁶⁴ The pay grade assigned for this position is GS-13, which pays about \$73,800 in the first step and increases up to \$96,000. Office of Personnel Management, *Schedule 1 General Schedule*, accessed March 31, 2016, <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/pay-executive-order-2016-adjustments-of-certain-rates-of-pay.pdf>.

⁶⁵ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, presentation to Commission on Care, April 18, 2016.

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Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-supported programs.

Problem

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.⁶⁶ Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).⁶⁷

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a national revised clinical-appeals process.

As part of the MyVA initiative, the SECVA has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.⁶⁸ The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.⁶⁹

Background

VHA policy has long required medical centers to operate a patient advocate program to address patient complaints.⁷⁰ In 1996, Congress enacted an eligibility reform statute that, for the first time, gave enrolled veterans access to a uniform benefits package.⁷¹ In implementing that law, VHA conducted a systemwide review of how clinical disputes were handled and consequently instituted an external appeal system in FY 2000. The policy, as outlined in a subsequent directive, allowed VISNs to request external professional boards to conduct impartial reviews of clinical determinations.⁷² That directive also addressed a process for internal clinical appeals. It stated as policy that patients or their representatives who have disputes regarding clinical determinations or services pertaining to provision or denial of care that are not resolved at the facility level must have access to a fair and impartial review of those disputes that could result in a different and/or improved clinical outcome. That policy requires VISN directors to have written policy and procedures in place for how internal appeals are to be handled. Under this policy, VISNs still have authority to request an external review at any time during the clinical

⁶⁶ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

⁶⁷ VHA Clinical Appeals, VHA Directive 2006-057, (2006).

⁶⁸ "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, <http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx>.

⁶⁹ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷⁰ VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁷² VHA Clinical Appeals, VHA Directive 2006-057 (2006).

appeals process.⁷³ Although the directive itself expired in 2011, it continues to serve as guidance because it has not been renewed or replaced.

VHA policy directs that all facilities have a patient advocate office to manage and attempt to resolve complaints. That office, which can serve as the liaison between patients and clinicians, is generally the first stop for veterans who are dissatisfied with a clinical decision.⁷⁴ If a clinical issue is not resolved at the point of the service, it generally goes to the facility director, who is to provide veterans written notification of the facility's decision and inform veterans about the VISN's appeals process. Under the same policy directive, veterans may appeal the facility decision to the VISN director. That official, or a clinical review panel that he or she establishes, is to render a decision within 30 days (or 45 days if the director requests an external clinical review).⁷⁵ Should the VISN director agree with the facility, he or she must notify the veteran that the decision is final or may refer the matter to a VACO office to arrange for an external review.⁷⁶

The VHA process does not appear fully comparable to procedures required under other federal and federally-supported health care programs. For example, under the Affordable Care Act, health care plans are required to provide external reviews to beneficiaries whose internal appeals have been denied.⁷⁷ Unlike those and other appeals processes, veterans have no right to external review; such review is at the discretion of the VISN director. Medicare has an extensive review process for clinical disputes between its managed care organizations and beneficiaries. Beneficiaries have the right to an internal appeal with an option for an expedited review, an internal reconsideration of the initial review, an independent review, a hearing with an administrative law judge, a review by the Medicare Appeals Council and, finally, a federal district court review.⁷⁸ Medicaid has requirements for localities to review appeals from its beneficiaries and for states to offer timely access to fair hearings to determine whether managed care organizations have denied or terminated medically necessary care.⁷⁹ Although VHA's timeframe for decision making seems reasonable, the national policy makes no provision for an expedited review, unlike Medicare managed care organizations and plans providing health benefits to federal employees. VHA's policy is also silent on meeting with veterans to hear their cases much less hold hearings during any point of the appeal. Unlike Medicaid, VHA also lacks any provision for service-continuity while the matter is being appealed. The Commission recommends that VHA develop a revised clinical-appeals process that provides veterans protections at least comparable to those afforded patients under other federal and federally-supported programs, including, at a minimum, a right to an external review at the veteran's discretion.

⁷³ Ibid.

⁷⁴ VHA Patient Advocacy Program, VHA Handbook 1003.4, (2005).

⁷⁵ VHA Clinical Appeals, VHA Directive 2006-057, (2006).

⁷⁶ Ibid.

⁷⁷ "Appealing Health Plan Decisions," Department of Health & Human Services, accessed June 1, 2016, <http://www.hhs.gov/healthcare/about-the-law/cancellations-and-appeals/appealing-health-plan-decisions/index.html>.

⁷⁸ Centers for Medicare & Medicaid Services, *Managed Care Appeals Flowchart CY2016*, accessed May 26, 2016, <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Managed-Care-Appeals-Flow-Chart.pdf>.

⁷⁹ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

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Implementation***Legislative Changes***

- None required.

VA Administrative Changes

- Convene an interdisciplinary panel to assist in developing a revised clinical-appeals process and policy that includes all care provided within the VHA Care System, to include representation from Patient Care Services, MyVA's Patient Advocates and Veterans Experience Program, the Office of Equity, the National Center for Ethics in Health Care, and the Office of Access and Clinical Administration. VHA should have that panel examine and offer recommendations regarding the following:
 - Each level of review in the clinical-appeals process – from the facility's initial reconsideration to a final decision by the VISN director to assess the fairness and impartiality in those processes compared to Medicare Managed Care and Medicaid appeals processes and private-sector managed care providers' best practices.
 - Whether VHA should establish a uniform national clinical appeals process.
 - The advisability of requiring review panels consisting of individuals such as attorneys, clinicians, case managers, patient advocates, and administrators to review clinical appeals.
 - Whether hearings or judicial reviews are appropriate at any level of the appeals process.
 - Whether resolutions of clinical appeals are equitable for all types of veterans (service-connected or non-service-connected, by racial or ethnic group, by age, or gender).
 - Options for increasing veterans' awareness of the clinical-appeals process.
- Publish the new clinical appeals policy and process for comment and input by veterans, VHA business partners, and other stakeholders.
- Once the new policy is finalized, VHA must train staff on the new process.

Other Department and Agency Administrative Changes

- None required.

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

Problem

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.⁸⁰

VHA has a program of systems engineering — the Veterans Engineering Resource Center (VERC) — that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to proactively identify problem areas within the system and offer assistance.

Background

To become a truly veteran-centric care provider, VHA is working to become a learning organization.⁸¹ Learning organizations focus on worker competency rather than on rules compliance. Instead of using results to identify high- and low-performers, VHA will use this information to identify opportunities to intervene with training or other resources to improve employees' performance universally. Employees and patients should benefit from this approach because it values listening and encourages risk taking and innovation.

VA and VHA have adopted the tenets of LEAN Six Sigma as a systemic change approach to move the system forward. This methodology employs a rigorous define, measure, analyze, improve, and control approach to systemic change. LEAN, initially used by manufacturers, has been used successfully by many health care organizations.⁸² The goal of implementing LEAN practices is to eliminate waste, ensuring that any work done adds value. The MyVA plan calls for MyVA districts and the Office of Policy and Planning to ensure the transmission of best practices and the adopting of LEAN throughout the enterprise to provide a more comprehensive view of quality that balances a results-oriented approach with more process-

⁸⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow—Clinical)*, 14 and A-2 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁸¹ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.

⁸² MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 12, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

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oriented practice.⁸³ So far these efforts have been guided by trial and error, rather than directives and adopting a LEAN, process-driven model.⁸⁴ VHA must sustain its commitment to LEAN Six Sigma as a continuous improvement methodology.

VHA will have to use VERC staff and other trained staff members to ensure that principles of LEAN Six Sigma are applied at every level of the system. VERC has the mission to propose, develop, and facilitate innovative solutions to challenges within VHA health care delivery through the integration of systems engineering principles.

With VERC's reach already extending into access to care, health policy, population health, LEAN management, business systems, clinical systems, safety systems, and innovation, all other programs and initiatives become redundant or ancillary. VHA must assess its new system for best practice diffusion to ensure that selected practices are being appropriately scaled. This goal can best be achieved by collapsing all related efforts into VERC.

There are a number of emerging best practices within the health care sector that apply to all aspects of VHA – health care capabilities, staffing, access, supplies, and facilities – and involve the testing, dissemination, and application of procedures or systems that have been shown to improve approaches, processes, or systems.⁸⁵ VHA needs to have the opportunity to fully leverage and build on institutional strengths by implementing best practices.

VHA has recently developed the Diffusion of Excellence Initiative, which is designed to serve as the mechanism for improving practice through a combination of targeted national guidance and nationally-supported local best practice sharing and innovation.⁸⁶ Its organizational structure includes a governance board chaired by the USH, a Diffusion Council, and action teams responsible for implementing promising practices.

VHA also has many business lines charged with disseminating best practices information, including VERC, Systems Redesign SharePoint – Center for Improvement Education, VA Center for Innovation, MyVA – Best Practices in LEAN, MyVA Blog, MyVA Performance Improvement Hub, Knowledge Management System–Improvement in Action (I-ACT), VA Idea House, VA Pulse: Promising Practices Consortium, Evidence-based Synthesis Program (ESP), Quality Enhancement Research Initiative (QUERI), the Annual Conference on the Science of Dissemination and Implementation, and the Diffusion of Excellence Initiative.

Analysis

LEAN Six Sigma offers VHA a methodology to effect change and VERC offers VHA the agents to lead its implementation. VHA must consolidate its transformational tools, including its best

⁸³ MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 21, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

⁸⁴ The MITRE Corporation, Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow—Clinical), viii accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁸⁵ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 41, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁸⁶ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.

practice repositories within VERC. The VERC uses a systemic change process to streamline workflow and procedures by eliminating waste and redundancy to ensure that every step in the process adds value. The VERC offers services to VHA health care facilities upon request, but VHA would substantially benefit if the service was authorized to perform outreach to ensure awareness across the VHA Care System.⁸⁷

Until developing the Diffusion of Excellence Initiative, VHA lacked a uniform way to scale and optimize best practices throughout the enterprise. Although the Diffusion Initiative is initially targeting best practices from within VHA, to be successful, a long-term plan should also allow for the adoption of best practices from the private sector and other government sectors (e.g., the Medicare program related to pricing, contracting, privatization, value-based purchasing, management, and oversight). Plans should also allow for adaptation at the local and regional levels to reflect respective differences in provider supply, veteran needs, and marketplace characteristics.⁸⁸

VHA has multiple offices and sites invested in system reengineering, continuous process improvement, and best practices implementation. Repositories of best practices do not get information to the intended person or group that could benefit from the information and are dependent upon VHA employees knowing they exist.⁸⁹

VHA's National Leadership Council has proposed consolidating these best practice repositories under the VERC, which now serves within the Office of Organizational Excellence. Until recently, VERC has been underutilized because it is not known throughout the enterprise.⁹⁰

QUERI is a system that identifies evidence-based care practices that may be scaled for systemwide implementation. QUERI was integrally involved in the transformation of VHA from a largely hospital-based system to one centered on primary care⁹¹ and is now integral to the collaborative endeavor to transform VHA into a learning organization. QUERI recently released a policy brief that indicated veterans' reliance on VHA was strongly correlated to economic factors such as unemployment rates and availability of other health care coverage.⁹²

VA should use a systematic, continuous performance improvement process to improve access to care. Although many VA facilities achieve very high-performance ratings on key access and quality measures, a systematic effort is needed to improve performance. These efforts need to

⁸⁷ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

⁸⁸ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, 28, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf

⁸⁹ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

⁹⁰ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 27, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁹¹ "HSR&D Perspectives Blog, QUERI Corner: Surviving and Thriving," Amy Kilbourne, QUERI Program Director, January 20, 2015, accessed from VA Intranet, April 4, 2016, <http://vaww.blog.va.gov/hsrd/category/queri-corner/>.

⁹² Christine Yee, Austin Frakt, and Steven Pizer, U.S. Department of Veterans Affairs, "Economic and Policy Effects on Demand for VA Care," Partnered Evidence-based Policy Resource Center, Policy Brief, March 2016, accessed June 21, 2016, http://www.queri.research.va.gov/partnered_evaluation/YeeFraktPizer.pdf.

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be embedded into routine use across the VA system. The best solutions should be adjusted to reflect local needs and designed to respond to veterans' preferences, needs, and values.⁹³

A systems approach to health care is “one that applies scientific insights to understand the elements that influence health outcomes, models the relationships between those elements, and alters design, processes, or policies based on the resultant knowledge in order to produce better health at lower cost”⁹⁴ and would benefit VA greatly, especially with resources like VERC to serve as a guide.

Emerging best practices have improved health care access and scheduling in various locations and serve as promising bases for research, validation, and implementation.⁹⁵ A variety of quality improvement organizations are involved in establishing and maintaining standards in health care as well as developing measures for the monitoring and assessment of these standards, including The Centers for Medicare & Medicaid Services, the Joint Commission, the National Committee for Quality Assurance, and the National Quality Forum.⁹⁶

The tools of operations management, industrial engineering, and systems approaches are successful in increasing process gains and efficiencies. In particular, a wide range of industries have employed systems-based engineering approaches to address scheduling issues, among other logistical challenges.⁹⁷

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Consolidate all best practices and continuous improvement portals under VERC to provide a more accessible and comprehensive approach to best practice sharing and adoption.

Other Department and Agency Administrative Changes

- None required.

⁹³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 110 and 297 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁹⁴ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 27 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁹⁵ Ibid., 15.

⁹⁶ Ibid., 60.

⁹⁷ Ibid., 27-28.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

Problem

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.⁹⁸

A systematic review of VHA in 2015 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.⁹⁹ VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues—the Health Equity Action Plan (HEAP)—but it has not been fully implemented.

Background

It is time to refocus, reinforce, and repeat the message that health disparities exist and that health equity benefits everyone.¹⁰⁰

Across the nation, health care systems are raising awareness about health care equity, inequality, and disparities.¹⁰¹ The growing incidence of health care disparities and inequities is said to be ascribed to individual and collective cultural indifference on the part of health care

⁹⁸ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

⁹⁹ Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, accessed May 19, 2016, <http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf>.

¹⁰⁰ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

¹⁰¹ Centers for Disease Control and Prevention, *CDC Health Disparities and Inequalities Report – United States, 2013*, accessed April 5, 2016, <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>.

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providers and the health care system as a whole.¹⁰² A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on racial or ethnic group, gender, age, sexual orientation, military era, geographic location, religion, socioeconomic status, mental health, cognitive/sensory/physical disability, and other characteristics historically linked to discrimination or exclusion.¹⁰³

The United States is becoming increasingly diverse, with racial and ethnic minorities making up more than 36 percent of the population.¹⁰⁴ Indicators of overall health, such as life expectancy and infant mortality, have improved for most Americans; however, some minorities still face comparatively greater likelihood of preventable disease, death, and disability.¹⁰⁵

Although the country's veteran population is projected to decline from 22 million to 14.5 million by 2040, the percentage of minority veterans will increase from 20 percent to 34 percent during the same period.¹⁰⁶ Currently, African Americans make up 11 percent of the veteran population, and Hispanics, 6 percent.¹⁰⁷

Survey data show that minority veterans use VA health care more than White veterans, as shown below:¹⁰⁸

- African American: 38 percent
- Hispanic: 34 percent
- American Indian/ Alaska Native: 38 percent
- White: 32 percent

¹⁰² G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," *JHSA* (2011), 146.

¹⁰³ "Office of Health Equity," U.S. Department of Veterans Affairs, accessed June 12, 2016, <http://www.va.gov/HEALTHY/index.asp>.

¹⁰⁴ "Minority Health and Health Equity – CDC," Centers for Disease Control and Prevention (CDC), accessed March 28, 2016, <http://www.cdc.gov/minorityhealth/index.html>.

¹⁰⁵ *Ibid.*

¹⁰⁶ National Center of Veterans Analysis and Statistics, *Minority Veterans 2011 Report*, May 2013, accessed April 6, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf.

¹⁰⁷ U.S. Census Bureau, *American Community Survey, Public Use Microdata Sample (PUMS)*, 2011. Department of Defense, *Population Representation in the Military Services Fiscal Year 2011 Report*, accessed April 5, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf

¹⁰⁸ Reliance projections here are based on ambulatory care utilization. Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 82, accessed May 19, 2016,

http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

Survey data on racial and ethnic minority veterans' use of VHA health care offer revealing insights on current equity issues:¹⁰⁹

- Fifty-seven percent of African Americans indicated they are more likely to use VA as their primary source of health care as compared to 45 percent of Whites.¹¹⁰
- The percentage of African Americans who reported they use VA for all or most of their care needs is 18 percent higher than the percentage of Whites who do so.¹¹¹
- A higher percentage of Whites assessed their health to be good or excellent than did African Americans.¹¹²

Analysis

VHA Office of Health Equity

VA created the OHE in 2012 to identify health care inequities, understand the cause of them, and bring to clinical practice interventions intended to reduce disparity drivers within VA. OHE partners with other VA offices, federal government offices, and nongovernment institutions with missions aimed at promoting health equity.¹¹³ OHE has substantial stakeholder involvement from minority veterans groups, including the Advisory Committee on Minority Veterans (ACMV), rural veterans groups, women veterans, and the Office of Diversity and Inclusion (ODI).¹¹⁴ A staunch internal partner and stakeholder of OHE, ODI's mission is to foster a diverse workforce and an inclusive work environment. The OHE and ODI missions intersect with ODI's special emphasis programs, intended to engage affinity groups and agencies to raise the awareness of the importance of diversity and demonstrate VA's commitment to a diversity model.¹¹⁵

OHE's foundational work included updated systematic reviews and data analyses that not only revalidated VA's previous findings on health care inequities, but also identified more areas of health care disparity among veterans. For instance, hepatitis C virus (HCV) was noted to have disparate effect on racial/ethnic minority veterans and Vietnam-era veterans. Additionally, OHE convened stakeholders and worked with the Health Equity Coalition to develop the VHA Health Equity Action Plan (HEAP), which aligns with the VHA Strategic Plan Objective 1e: Quality & Equity, which states, "Veterans will receive timely, high quality, personalized, safe effective and equitable health care irrespective of geography, gender, race, age, culture or sexual

¹⁰⁹ Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.

¹¹⁰ Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, 85, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.

¹¹¹ Ibid.

¹¹² Ibid.

¹¹³ Department of Veterans Affairs, Office of Health Equity, *US Department of Veterans Affairs Office of Health Equity Mission and Accomplishments*, accessed March 30, 2016, http://www.va.gov/HEALTHEQUITY/docs/OHE_Mission_and_Accomplishments_November_2015.pdf.

¹¹⁴ "Office of Diversity and Inclusion (ODI)," Department of Veterans Affairs, accessed May 13, 2016, <http://www.diversity.va.gov/>.

¹¹⁵ "Office of Diversity and Inclusion (ODI), Special Emphasis Programs," Department of Veterans Affairs, accessed May 17, 2016, <http://www.diversity.va.gov/programs/default.aspx>.

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orientation.”¹¹⁶ HEAP aims to address five strategic areas: awareness, leadership, health system and life experience, cultural and linguistic competency, and data that are vital for effectively implementing its mission. HEAP implementation strategies are conceptually modeled after the goals and strategies of the National Partnership for Action to End Health Disparities’ National Stakeholder Strategy for Achieving Health Equity sponsored by the U.S. Department of Health and Human Services.¹¹⁷

Despite OHE’s best efforts, HEAP was not fully implemented because VHA leadership failed to establish it as a strategic priority with adequate staffing, resources, and support, and the departure of the then USH, a champion for health equity. These factors led to the reduction of OHE staffing from 8 to 2 FTEs in FY 2013 and a realignment of OHE to several layers down in the organization. As a result of an FY 2015 budget reduction, OHE continues to operate with a two-person staff.¹¹⁸ The reduced staffing level is inadequate to meet the requirements and mission of the office.

OHE has a broad and challenging mission, particularly given the number of minority veterans who rely on VA health care, the health risks in those populations, and the health care disparities those populations experience.¹¹⁹ OHE faces serious challenges in its efforts to carry out its action plan and to realize its broad and critical mission, challenges intensified by its limited staffing and the downgrade of this office within VHA’s organization structure. These include the following:¹²⁰

- lack of quality data on vulnerable populations and disparate health outcomes
- health equity projects that have been delayed or halted due to staff and resource limitations
- lack of data on the overall impact of existing health equity initiatives at facilities
- lack of common definitions on vulnerable populations and health equity concepts

Notwithstanding its limited staffing, OHE has compiled a substantial record of accomplishments. Among its initiatives, OHE embarked in 2015 on a strategy of working collaboratively with the Quality Enhancement Research Initiative (QUERI) to advance health equity. The two collaborative efforts focus on using a population health approach to examine the distribution of diagnosed health conditions, mortality, and health care quality across the VA health care system. A fully staffed OHE would have the capability of creating additional

¹¹⁶ Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018*, accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.

¹¹⁷ “National Partnership For Action (NPA), National Stakeholder Strategy for Achieving Health Equity,” U.S. Department of Health & Human Services, accessed May 16, 2016, <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286>

¹¹⁸ Uche S. Uchendu, Executive Director, OHE, briefing to Commission on Care, December 14, 2015.

¹¹⁹ “Management Brief no. 99,” Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=eBrief-no99. Somnath Saha et al., “Racial and Ethnic Disparities in the VA Health Care System: A Systematic Review,” *Journal of General Internal Medicine*, 23, no. 5, (2008): 654–671.

¹²⁰ Uche S. Uchendu, Executive Director, Office of Health Equity, briefing to Commission on Care, December 14, 2015.

analytical tools to manage the daily health care equity program and provide needed services to advance health equity.¹²¹

Health Care Disparities Among Minority Veterans

Minority groups are at increased risk of major, life-threatening health conditions, as documented in a substantial body of research¹²² and illustrated in the table below:¹²³

Table 3. Major Health Conditions in Racial/Ethnic Minority Groups

Major Health Conditions Identified and Examined in Racial/Ethnic Minority Groups		
African Americans	Hispanics	American Indian or Alaska Natives
<ul style="list-style-type: none"> ▪ Colon Cancer ▪ HIV ▪ Chronic Kidney Disease ▪ Diabetes ▪ Stroke ▪ Venous Thromboembolism (VTE) ▪ Cancer ▪ Heart Disease 	<ul style="list-style-type: none"> ▪ Hepatitis C ▪ Cancer ▪ Heart disease 	<ul style="list-style-type: none"> ▪ Major Non-cardiac Surgery ▪ Pregnant Women with PTSD

HCV is more prominent among some racial and ethnic minority veterans and they are less likely to receive treatment for HCV. In VHA, some racial and ethnic minorities diagnosed with HCV are disproportionately more at risk for having associated liver disease (ALD). Disparities among veterans in the incidence of HCV, illustrated in the graphs below, show the important policy and resource implications for VA.¹²⁴

¹²¹ Ibid.

¹²² Andy I. Choi et al., “White/Black Racial Differences in Risk of End-Stage Renal Disease and Death,” *The American Journal of Medicine*, 122, no. 7, (2009): 672-678. Andy I. Choi et al., “Racial Differences in End-Stage Renal Disease Rates in HIV Infection with Diabetes,” *Journal of the American Society of Nephrology*, 18, no. 11 (2007): 2968-2974. Hashem B. El-Serag et al., “Racial Differences in the Progression to Cirrhosis and Hepatocellular Carcinoma in HCV-Infected Veterans,” *The American Journal of Gastroenterology*, 109, no. 9, (2014): 1427-1435. Cleo A. Samuel et al., “Racial Disparities in Cancer Care in the Veterans Affairs Health Care System and the Role of Site of Care,” *American Journal of Public Health*, 104, Supplement 4, (2014): S562-571.

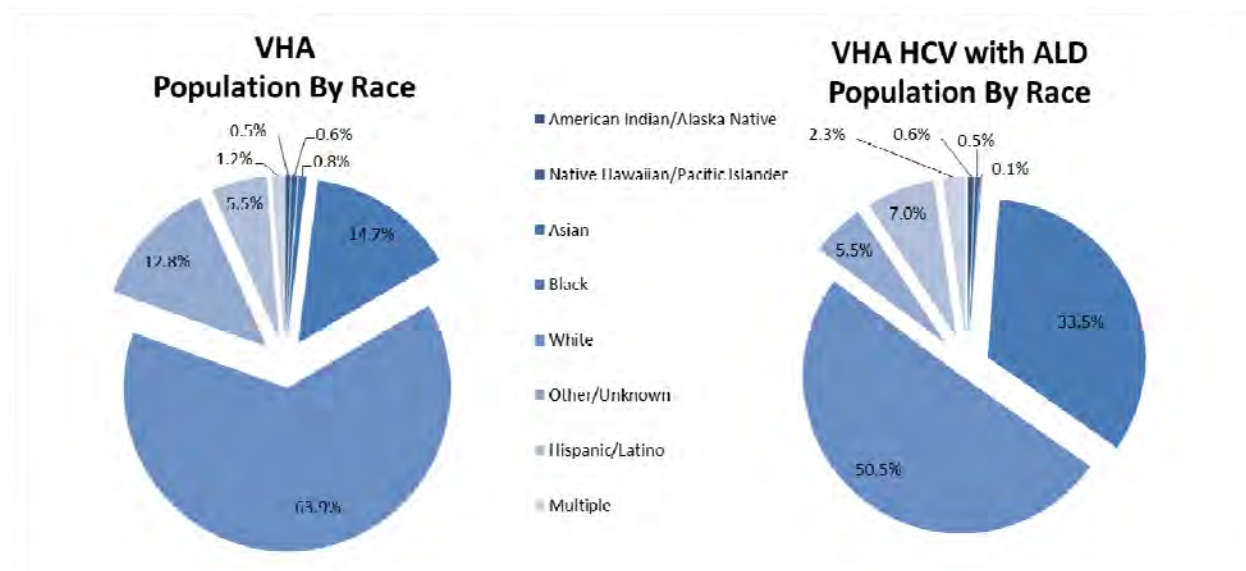
¹²³ Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, accessed May 19, 2016,

<http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf>.

¹²⁴ Department of Veterans Affairs, Office of Health Equity, *Hepatitis C Factsheet, Hepatitis C, Advanced Liver Disease & Health Care Disparities*, accessed May 25, 2016, <https://github.com/departement-of-veterans-affairs/VHA-Asset/raw/master/Hep%20C%20FACT%20SHEET%20FINAL%2010162015.pdf>.

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Figure 2. Disparities Among Veterans in the Incidence of Hepatitis C Virus



A recent review of evidence related to racial and ethnic differences in outcomes for VA patients showed moderate- and low-strength evidence suggestive of gaps in morbidity and mortality outcomes among vulnerable veteran populations with major health conditions. These data, presented in the table below, highlight targets for further research.¹²⁵

Table 4. Comparison of Health Outcomes by Race

Comparison		Worse Health Outcomes For Racial Minority Group Relative to Reference Population (usually White)
Moderate-Strength Evidence		
(based on VA data from the early 2000s)		
African American v. White	Increased end-stage renal disease among chronic kidney disease patients	
	Increased end-stage renal disease among HIV patients (with or without diabetes)	
	Decreased colon cancer survival 3 years after diagnosis	
Hispanic v. White	Increased cirrhosis and hepatocellular carcinoma among hepatitis C patients	
Low-Strength Evidence		
(each finding supported by only a single retrospective study with important methodological limitations)		
African American v. White	Increased mortality among diabetes patients	
	Increased risk of preterm birth among PTSD patients	
	Increased mortality at 2 years post-hospitalization among stroke patients	
	Decreased survival 3 years after diagnosis of rectal cancer	
American Indian or Alaskan Native v. White	Increased risk of 30-day post-op mortality after major noncardiac surgery	
	Increased risk of preterm birth among PTSD patients	
Combined other racial/ethnic minority groups v. African American	Increased injury-related death among alcohol use disorder patients	

¹²⁵ "Management Brief no. 99," Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=ebrief-no99.
VA-18-0457-A-001680

OHE's focus, health equity, is intended to combat health care disparities, namely, the differences in the preventive, diagnostic, or treatment services offered to veterans with similar health conditions. Health care disparities stem from a combination of complex factors occurring at the level of the health system, provider, and patient.¹²⁶ Health care disparities can result from biological differences among various racial/ethnic groups as well as from social disparities,¹²⁷ also termed social determinants, which stem from such factors as socioeconomic status, discrimination, education levels, housing, transportation, and crime and violence, and are causally linked to subsequent adult disease.¹²⁸ For example, poor-quality housing poses a risk of exposure to many conditions that can contribute to poor health, such as indoor allergens that can lead to and exacerbate asthma, injuries, and exposure to lead and other toxic substances.¹²⁹ Social determinants that drive health disparities among African Americans, Hispanics, American Indians, and Alaska Natives include race/ethnicity; gender; age; geographic location; religion; socio-economic status; sexual orientation; military era; disabilities, including cognitive, sensory, or physical; and other characteristics historically linked to discrimination or exclusion. Positioned in a department that also provides benefits that fall within the social determinants of health, OHE is in a unique position to improve veterans' health.

The Henry Ford Health System (HFHS) is an example of a health system that is committed to health equity and one VHA can emulate as it works to improve health equity. HFHS is a nonprofit, vertically integrated health care organization that serves the primary and specialty health care needs of residents in southeastern Michigan, including Detroit and its surrounding metropolitan area.¹³⁰ HFHS's comprehensive health equity staff has a health care equity campaign with a goal of increasing knowledge, awareness, and opportunities to ensure health care equity is understood and practiced by HFHS providers and other staff, the research community, and the community-at-large.¹³¹ The campaign is also intended to make health care equity a key, measurable aspect of clinical quality.¹³² A similar effort by VHA would create a system for tracking improvement of health equity over time and holding the organization accountable for ongoing efforts in this regard.

The VHA strategic plan for FY 2013–2018 states that veterans will receive timely, high quality, personalized, safe, effective, and *equitable* health care, irrespective of geography, gender, race, age, culture, or sexual orientation.¹³³ Although that statement signals a sensitivity to health equity, the level of funding support for the VHA office with the lead role in promoting health equity and reducing disparity calls into serious question the leadership priority and commitment to that strategic goal. VHA leadership must make health care equity a strategic

¹²⁶ Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, <http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf>.

¹²⁷ James H. Price, Molly A. McKinney, and Robert E. Braun, *Social Determinants of Racial/Ethnic Health Disparities in Children and Adolescents*, accessed April 1, 2016, <http://www.sophe.org/Sophe/PDF/Webinars/20120416151902.pdf>.

¹²⁸ Ibid.

¹²⁹ "What Drives Health," Robert Wood Johnson Foundation, Commission to Build a Healthier America, accessed April 1, 2016, <http://www.commissiononhealth.org/WhatDrivesHealth.aspx>.

¹³⁰ Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, <http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf>.

¹³¹ Ibid.

¹³² Ibid.

¹³³ Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018*, accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.

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priority by directing and funding the implementation of VHA HEAP nationwide and designating a leader and clinical champions within each VISN and VAMC, as a designated full-time equivalent (FTE), providing OHE budgetary support in FY 2017 and beyond to fully staff the office so that it can successfully achieve its mission and goals, to include providing additional needed funding to support implementation of the VHA HEAP; and ensuring OHE reports to the chief of VHA Care System (CVCS).

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Make health equity a strategic priority by directing the implementation of the VHA HEAP nationwide and designating a leader and health equity clinical champion within each VISN and VAMC for whom part of their respective FTE position descriptions includes focusing on health equity issues.
- Reestablish OHE staffing based on the 2011 VHA Health Care Equality Workgroup recommendations to enable OHE to fulfill VHA's vision to provide appropriate individualized health care to each veteran in a method that eliminates disparate health outcomes and assures health equity. Action required includes, but is not limited to, funding FTE staffing levels commensurate with the scope and size of other federal offices of health equity.
- Reinstate OHE within the office of the CVCS to underscore health equity as a priority and to position the office to champion successfully the advancement of health equity for all veterans.¹³⁴
- Monitor and evaluate the department's success in implementing HEAP.

Other Department and Agency Administrative Changes

- None required.

¹³⁴ Department of Veteran Affairs, Health Equity Coalition Request for VHA Commitment, February 2016. Principal Deputy Under Secretary of Health Memorandum, Health Equity Coalition, March 21, 2013.

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

Problem

Veterans who turn to VHA to meet their health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern ambulatory health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of these barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks, as proposed in

Recommendation #1 holds the promise of markedly improving veterans' access to care.

That promise cannot be realized without transformative changes to VHA's capital

structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of the build out of the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as much control as possible to drive the process so that all facility plans are fully integrated with the strategic vision for the VHA Care System.

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meet its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission process to be implemented as soon as practicable. The Commission recommends that the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

Background

Most VHA health care centers were designed when care was focused on inpatient hospital treatment. VA acquired some of these facilities nearly a century ago from the Public Health Service; many others were transferred from the War Department shortly after World War II.¹³⁵ The average VHA building is 50 years old – five times older than the average building age of not-for-profit hospital systems in the United States.¹³⁶ Most of its facilities were designed to meet markedly different needs than today's health care facilities. Some were tuberculosis

¹³⁵ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

¹³⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, vi, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

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sanatoriums, others for years primarily housed patients with mental health conditions.¹³⁷ Although many have been extensively renovated, the renovations themselves are now outdated, and the condition of buildings shows this strain. Independent assessments of infrastructure and facilities showed that VHA facilities average a *C minus* score,¹³⁸ meaning much of the total facilities portfolio is nearing the end of its useful life, and 70 percent of facility correction repairs are being made on Grade D facilities.¹³⁹

During the past 8 years, veteran inpatient bed days of care have declined nearly 10 percent as outpatient clinic workload has increased more than 40 percent.¹⁴⁰ Current facilities, whether they have been maintained adequately or not, often do not support contemporary ambulatory care needs, with outpatient care often housed in converted inpatient spaces.

Through its capital planning methodology, VA has identified more than \$51 billion in total capital needs during the next 10 years.¹⁴¹ Capital funding during the past 4 years has averaged just \$2 billion annually.¹⁴² If funding levels remain consistent during the next 10 years, anticipated funding would be \$25 billion to \$35 billion less than the \$51 billion capital requirement.¹⁴³ VA planning must also take account of demographic changes and population migration that have led to underutilized medical centers in some areas of the country, and a need for new capacity in others.¹⁴⁴

Analysis

New Planning Paradigm

As the department acknowledged, “VA’s health care delivery model must . . . change.”¹⁴⁵ Importantly, it recognizes that “No organization can excel at every capability,” and stated “[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers.”¹⁴⁶ The acknowledgement that VHA can best serve veterans by focusing on its core competencies and unique capabilities, while relying more heavily on purchased care holds important implications for VHA’s capital needs and capital asset management. Rather than assessing VHA’s capital needs by reference to an expectation that each VA medical center, or constellation of medical centers, must provide virtually all needed hospital and medical services, capital needs must be redefined within the framework of the VHA Care System’s high-performing integrated community health care networks. VHA must determine what services it will continue to provide directly in a given community before it can determine its respective infrastructure needs. In identifying its core competencies, unique

¹³⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

¹³⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 27, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹³⁹ *Ibid.*

¹⁴⁰ *Ibid.*, 46.

¹⁴¹ *Ibid.*, 17.

¹⁴² *Ibid.*, 18.

¹⁴³ *Ibid.*, 18.

¹⁴⁴ *Ibid.*, 59-61.

¹⁴⁵ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 18, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

¹⁴⁶ *Ibid.*

capabilities, and needed ancillary services, VHA would be setting at least a general framework through which network and local planners could assess where and how needed services would be delivered, including which would be provided directly by VHA and which through purchased care. Such a mapping exercise would be a first step in developing the integrated community health care networks.

The shape of an integrated delivery network will take different forms in each service-area, and planning and developing those local networks will necessarily require assessing VHA's physical plant and capacity in a new light. That reassessment process would inform capital planning, and must take account of at least three distinct needs: capital needs associated with buildings VA would retain; meeting new or replacement space needs; and the disposal of unused, unneeded property.

Property Divestiture

VHA's principal mission is to provide health care to veterans, yet over time it has acquired an ancillary mission: caretaker of an extensive portfolio of vacant buildings. As recently as October 2015, VA reported that its inventory includes 336 buildings that are vacant or less than 50 percent occupied, requiring it to expend patient-care funds to maintain more than 10,500,000 square feet of unneeded space.¹⁴⁷ The SECVA recently testified that it costs VA an estimated \$26 million annually to maintain and operate vacant and underutilized buildings.¹⁴⁸

VA's authority to carry out property-management is circumscribed in law,¹⁴⁹ and the department at times faces insurmountable challenges in either attempting to repurpose or divest itself of underutilized or vacant property.¹⁵⁰ In contrast to more rigid property-divestiture provisions, VA has had success in using a flexible authority to enter into long-term leases of VA property for *enhanced use*.¹⁵¹ This authority allows VA to lease underutilized capital

¹⁴⁷ Ibid., 92.

¹⁴⁸ "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, <https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2>.

¹⁴⁹ Authority for Transfer of Real Property; Department of Veterans Affairs Capital Asset Fund, 38 U.S.C. § 8118 Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122. For example, under section 8118, VA must receive at least full market value in transferring property, unless the property is transferred to an entity that provides services to homeless veterans, and any proposed transfer is subject to the requirement in section 8122 that VA first hold hearings, notify Congress in advance, and not proceed for a specified period. VA property can be determined to be "excess," though under 38 U.S.C. § 8122(d)(1), VA may not make such a declaration unless the property is not suitable for use for provision of services to homeless veterans and reviewed for possible disposal under the Property Act Disposal, administered by the General Services Administration (GSA) (40 U.S.C., subchapter III). GSA employs a rigorous, multistep process to assure that the asset is not needed by any other Federal agency. Under the Act, the agency disposing of the asset is responsible for funding disposal costs, including environmental remediation. GAO has testified that properties remain in an agency's possession for years and continue to accumulate maintenance and operations costs because of the legal requirements agencies must meet and the length of the process. (U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain*, GAO-11-520T (Washington, DC, 2011), 5, <http://www.gao.gov/products/GAO-11-520T>).

¹⁵⁰ With many properties under the protection of the National Historic Preservation Act (16 U.S.C. § 470h-3), VA faces obstacles and delays in efforts to divest itself of these properties; VACO staff report that stakeholder concerns have been obstacles.

¹⁵¹ Enhanced-Use Leases of Real Property, 38 U.S.C. §§ 8161-8169, as amended by Veterans Millennium Health Care and Benefits Act, Section 208, Pub. L. No. 106-117, 113 Stat. 1545 (1999), as in effect when GAO testified on this successful program (U.S. Government Accountability Office, *VA Real Property: VA Emphasizes Enhanced-Use Leases to* VA-18-0457-A-001685

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assets to private-sector entities for up to 75 years to develop housing for homeless and at-risk veterans and their families. Most recently, however, Congress imposed severe limits on that leasing authority.¹⁵²

Ongoing Capital Needs

Establishing a transformative new health care delivery model that relies more on purchased care will not eliminate the need for new clinics, facility renovations, and remedying VHA space deficiencies. The scope of those needs must still be determined in light of a proposed new delivery system, but they cannot be ignored. The *Independent Assessment Report* catalogued the challenges of managing and operating VA's capital program and the need to deploy best practices to improve total performance, and clearly address the importance of more modern facilities for delivering high quality care.¹⁵³

Of particular concern is an apparent breakdown in the process of bringing new clinics online and renewing the leases of existing clinics. With current law requiring congressional approval of any lease with an average annual rental of more than \$1 million,¹⁵⁴ a Congressional Budget Office (CBO) ruling¹⁵⁵ has upended the approval process and halted the leasing program.¹⁵⁶ Indicative of the scope of the problem, VHA's then USH testified in 2013 that VA, since 2008, had opened 180 leased medical facilities, 50 of which required authorization as major leases.¹⁵⁷ Currently, 24 major VA leases are in limbo.¹⁵⁸

Manage its Real Property Portfolio, GAO-09-776T (Washington, DC, 2009), <http://www.gao.gov/assets/130/122697.pdf>. For example, VA has authority to outlease its facilities for up to 3 years, but may not retain the proceeds of any such leasing (Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122(a)(1)). U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain*, GAO-11-520T (Washington, DC, 2011), 5, <http://www.gao.gov/products/GAO-11-520T>.

¹⁵² Before the sunset of that authority in 2011, VA could enter into such a long-term lease if (1) at least part of the property's use would contribute to VA's mission, (2) the lease would not be inconsistent with that mission; and (3) the lease would enhance the use of the property (Enhanced-Use Leases, 38 U.S.C. § 8162(a)(2)). Congress reauthorized enhanced-use leasing, but limited it to a single use: the development of supportive-housing for veterans who are homeless or at risk of homelessness (Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Sec. 211, Pub. L. No. 112-154, 126 Stat. 1165 (2012).)

¹⁵³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁵⁴ Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104.

¹⁵⁵ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., 42 (June 27, 2013) (Statement of Robert A. Sunshine, Deputy Director, Congressional Budget Office), accessed June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

¹⁵⁶ *Ibid.* CBO maintains that the structure of VHA's lease transactions—the lease of a facility, designed by and built for VHA, and for which payments retire most or all of the debt over the life of the lease—is in the nature of a governmental purchase, and, as such, the full cost of acquiring the facility should be budgeted up front, rather than spread over the duration of the lease. As budget rules generally require that Congress offset that aggregate cost, CBO's position has had the effect of blocking what had previously been a manageable funding process.

¹⁵⁷ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., 44 (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

¹⁵⁸ "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, <https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2>.

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One of the primary benefits of leasing is that it can provide flexibility and speed.¹⁵⁹ But the time VHA has required to execute a lease, from planning through to activation, has taken almost 9 years in the case of a major lease,¹⁶⁰ in contrast with private-sector expectations of build-to-suit leases that often take fewer than 3 years.¹⁶¹

In acknowledging the magnitude of the challenges associated with VA's capital program and the budget constraints within which VA is operating, the *Independent Assessment Report* includes a suggestion that transformative options be considered, to include alternative vehicles for capital delivery such as public-private partnerships.¹⁶²

Capital Asset Management

Capital asset management itself requires reengineering. Facilities-related functions are dispersed through VA, resulting in a lack of accountability for outcomes, a mismatch between planning efforts and funding decisions, and separation of project execution and facilities management,¹⁶³ suggesting a need for transformative changes in operations.¹⁶⁴

In its work to foster transformation, department officials have recognized many organizational and process challenges that require priority attention, including the need to realign its infrastructure, identify new (private) sources of financing, streamline investment decision making and contracting, and improve the management of capital projects.¹⁶⁵ Organizational change aimed at streamlining and better aligning core processes is vital to effective operation of VA's facilities programs.

Capital-Asset Imperatives

The planning and development of a new delivery model centered on establishing integrated networks of care has major implications for identifying, planning for, and realizing VHA's capital needs. Greater reliance on community care, inherent in that model, establishes a new set of imperatives, specifically, a need for

- facility realignment
- more effective means of repurposing or other divestiture of unneeded buildings and land
- new, more effective tools to meet VHA's need for new clinic capacity and major construction
- more effective management of VHA's capital needs

¹⁵⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 159, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁶⁰ Ibid., 159-160.

¹⁶¹ Ibid., 160.

¹⁶² Ibid., vii-ix, 34.

¹⁶³ Ibid., vi, 20.

¹⁶⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, K-5, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁶⁵ Interviews of VA staff by Commission on Care staff, April 2016.

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Facility Realignment

VA planning must closely examine the role of, and future for, individual facilities, in light of a transformative new delivery model. For more than a quarter century, VHA leaders have cited the need for medical center mission changes, realignments, disposal of unneeded buildings, and where indicated, hospital closures.¹⁶⁶ The critical importance of transforming VA health care delivery gives new urgency to providing tools to realign VHA's care-delivery infrastructure. The Commission recognizes that the SECVA does have authority to "consolidate, eliminate, abolish, or redistribute the functions of . . . [VA] facilities, and to carry out an administrative reorganization" of a field facility.¹⁶⁷ But that authority may generally not be unilaterally exercised.¹⁶⁸ In addition, despite VA's having established two previous commissions to address the need for facility realignment, leaders have had only limited success in achieving that objective. The exercise of SECVA's broad authority to reorganize is tempered by the prerogatives and fiscal authority held by Congress. Congress has rejected legislation that proposed a process to reassess the future of individual VA facilities,¹⁶⁹ reflecting concerns over veterans losing access to care and the potential of constituents losing employment. Such concerns can be addressed. To be successful, a capital asset realignment process must be conducted on a systemwide basis within a framework that provides for sound planning; the exercise of objective, independent expertise; and a reliable mechanism for implementation. Congress can look to and adapt a proven model¹⁷⁰ — the military base realignment and closure (BRAC) process — to meet those objectives and achieve marked improvements in access to care.

Congress should enact legislation, based on DoD's BRAC model, to establish a VHA capital asset realignment process to more effectively align VHA facilities and improve veteran's access to care. Creating a robust capital asset realignment process is vital because previous capital divestiture efforts have failed.¹⁷¹ This process should offer a level of rigor far beyond what currently exists for repurposing and selling capital assets. It should require VHA to employ criteria set by the VHA Care System governing board (see Recommendation #9) to conduct locally-based analyses of capital assets, based on national process criteria. Information generated would be used to assist an independent commission, established under the

¹⁶⁶ "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com*, accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578>.

¹⁶⁷ Authority to Reorganize Offices, 38 U.S.C. § 510.

¹⁶⁸ Authority to Reorganize Offices, 38 U.S.C. § 510(c). In instances where a reorganization would reduce employment by 15 percent or more at a facility, VA must provide Congress a detailed plan and justification, and must defer implementation for at least 45 days.

¹⁶⁹ Veterans Millennium Health Care and Benefits Act, H.R. 2116, 106th Cong. (1999). Section 107 of House-passed H.R. 2116 would have established a mechanism for VA to cease providing hospital care at medical centers which were no longer providing high quality, efficient hospital care because of factors such as aging physical plant, functional obsolescence, and low utilization, and to redirect funds instead toward establishment of enhanced-service programs. In taking up H.R. 2116, the Senate did not adopt that provision, and it was not included in the Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545 (1999), accessed January 12, 2016, <https://www.gpo.gov/fdsys/pkg/PLAW-106publ117/html/PLAW-106publ117.htm>

¹⁷⁰ Defense Base Closure and Realignment Commission, *Defense Base Closure and Realignment Act of 1990 (as amended through FY 05 Authorization Act)*, accessed June 23, 2016, <http://www.brac.gov/docs/BRAC05Legislation.pdf>.

¹⁷¹ "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com*, accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578>.

legislation, in making recommendations regarding realignment and capital asset needs.¹⁷² The independent commission would conduct a thorough, one-time process, to include making site visits and holding hearings to inform recommendations that would constitute a proposed national realignment plan. The VHA Care System governing board would review, and adopt or make recommendations to revise, the independent commission's recommended realignment plan. The commission would then empower the VHA Care System governing board to implement the recommendations unless, within a specified timeframe, Congress disapproves the entire plan on an up or down vote. The Commission on Care envisions that after the completion of a realignment carried out under such proposed legislation and in the course of ongoing VHA transformation, the VHA Care System governing board would make all additional facility alignment decisions, to meet veterans' needs and to fully integrate with the strategic vision for the VHA Care System.

Repurposing and Divestiture of Unneeded Buildings and Land

Maintaining health care facilities to provide state-of-the-art care requires ongoing financial support. Bearing the additional cost of maintaining outdated, vacant, and unused buildings diminishes operating funds needed for patient care, and yields no benefit. Even taking unused buildings offline and placing them in *mothball status*, requires tens of millions of dollars in basic building maintenance.¹⁷³ If VA could sell, repurpose, or otherwise divest itself of unused or underutilized buildings in a timely, cost-effective manner, it would free funds for the purposes for which they are appropriated.¹⁷⁴

Enhanced-use leasing authority has in the past provided VHA a viable tool that prevents the need for such unnecessary spending, while permitting development of vacant property for uses compatible with VHA's mission, and effective use of the proceeds, whether in cash or in kind.¹⁷⁵ This leasing mechanism has been put to particularly effective use in leveraging an asset that VHA can no longer use, but which has development potential, as consideration for an asset it may need, such as clinic space. But limiting enhanced-use leasing to a single use that may not be feasible in many locations precludes effective use of a valuable capital-alignment tool.

In many instances, however, the condition or remote location of VHA buildings does not lend itself to enhanced-use leasing. Given the need to dispose of a large inventory of vacant

¹⁷² The process should take into account the community health needs assessments (CHNA) that not-for-profit hospitals are required to carry out under current law, (Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat.119, sec. 9007(a) (2010)) and opportunities to engage community providers in collaborative partnerships. This provision requires tax-exempt hospitals to create a hospital community health needs assessment every three years. This hospital CHNA is developed alongside community stakeholders. The community health needs assessment requirements include: demographic assessment identifying the community the hospital serves; a community health needs assessment survey of perceived healthcare issues; quantitative analysis of actual health care issues; appraisal of current efforts to address the healthcare issues; and formulation of a 3-year plan under which the community comes together to address those remaining issues collectively.

¹⁷³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 49, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁷⁴ *Ibid.*, B-13.

¹⁷⁵ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), accessed June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

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buildings for which there is no realistic prospect of their being repurposed, a streamlined divestiture process is needed.

Meeting Clinic Capacity and Other Infrastructure Needs

Developing a new delivery model and establishing a thorough realignment process may shrink VHA's future capital needs but will not eliminate them. As congressional budget rules have frustrated VHA efforts to lease needed clinic space, it is critical that VHA and Congress find models or remedies to establish new ambulatory care space and renew leases of existing clinics. Congress and VHA should work together to find the means to meet VHA's need for new clinic capacity. Given an impasse in congressional authorization of VA clinic leasing based on build-to-lease contracts, VA should explore the feasibility of restructuring those arrangements. VA should explore an arrangement that remedies the concern that it is entering into capital leases. Such an approach, for which VA provides the builder with space needs rather than a complete design, would have the additional benefit of bringing projects on line much sooner. Absent an effective solution to meeting VA's ongoing need for clinic space, Congress must be willing, as it was in passing VACAA, to take extraordinary steps¹⁷⁶ to overcome a funding challenge, and, in this instance to waive, or suspend for at least 5 years, the operation of current congressional authorization and scorekeeping requirements governing major medical leases.

In addition to severe leasing challenges, current statutory spending limits make it difficult for VHA to modernize and renovate its aging facilities.¹⁷⁷ Notably, minor construction funds, available for "constructing, altering, extending, and improving"¹⁷⁸ any VA facility, are limited to \$10 million,¹⁷⁹ yet such projects may require substantially more given the age and condition of many VA buildings. Congress last lifted the threshold of what constitutes a major medical facility project – the amount above which a project requires specific authorization – more than a decade ago.¹⁸⁰ The Commission believes that with the tight controls a governing board would exercise, that threshold should be lifted substantially, providing needed flexibility to carry out minor construction projects.

As VHA works more closely with community providers and participates in discussions regarding community health needs, it should be open to opportunities to discuss and potentially work toward joint efforts at meeting infrastructure needs.¹⁸¹

¹⁷⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 stat. 1754, sec. 803 (2014).

¹⁷⁷ VA Office of Inspector General, *Veterans Health Administration: Review of Minor Construction Program*, 8, accessed June 3, 2016, <http://www.va.gov/oig/pubs/VAOIG-12-03346-69.pdf>.

¹⁷⁸ Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242 Div. J., Title II, Department of Veterans Affairs (2015).

¹⁷⁹ A major medical facility project is one involving a total expenditure of more than \$10 million. Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(a)(3)(A).

¹⁸⁰ Sec. 812 of the Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. No. 109-461, 120 Stat. 3403 (2006), raised the threshold as to what constitutes a major medical facility project from more than \$7 million to more than \$10 million.

¹⁸¹ One such public-private model, such as under discussion in Omaha, NE, where talks have centered on private donors' partially funding construction of a replacement medical center, necessarily poses challenges, but merits exploration and support. ("VA Exploring Public-Private Plan for New Facility," Lincoln Journal Star, accessed June 3, 2016, http://journalstar.com/news/state-and-regional/nebraska/va-exploring-public-private-plan-for-new-facility/article_6a90778e-6962-545f-a86a-3f27930bd84e.html.) Although Congress must ultimately provide apt facilities for VA care-delivery, the law has long authorized the SECVA to accept gifts or donations, for purposes of facility

Capital Asset Management

The Commission fully recognizes that VHA has much to do on its own to more effectively meet its capital asset needs. At the core, leaders must strengthen and streamline the capital asset programs' management and operation, to include better aligning the component elements; streamlining the leasing program, contracting, and investment decisions; managing and streamlining project delivery for construction and renovation; and adopting a facility (or building) life-cycle-model planning tool. These are all important elements of needed system transformation.

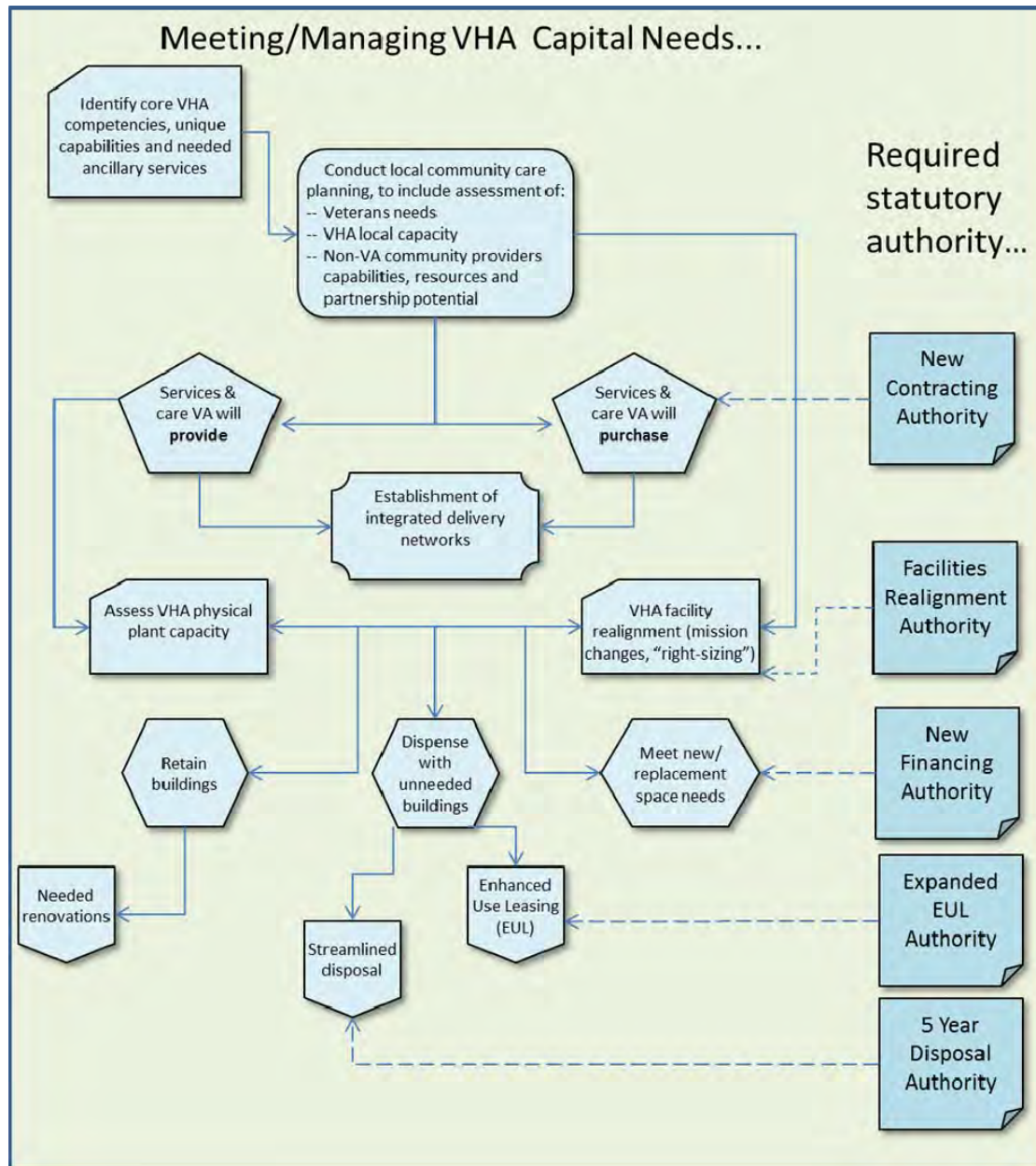
As depicted in Figure 3, meeting and managing VHA's capital-asset needs require an integrated approach that requires congressional support to tackle the multiple capital-asset challenges facing VHA. The Commission's recommendations for meeting and managing those interrelated capital-asset needs are set forth in the *Implementation* section following Figure 3.

construction. (Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(e)) Nevertheless, new legislative authority would almost assuredly be needed to permit development of public-private partnerships that provide new platforms for the construction of new or replacement medical facilities. For example, H.R. 5099 would establish a pilot program permitting VA to enter into public-private partnership agreements to plan, design, and construct new VA facilities using private donations. To Establish a Pilot Program on Partnership Agreements to Construct New Facilities for the Department of Veterans Affairs, H.R. 5099, 114th Cong. (2016), <https://www.congress.gov/bill/114th-congress/house-bill/5099>.

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Figure 3. The Complicated Process of Meeting and Managing VHA's Capital Needs

**Implementation****Legislative Changes**

- Provide VA new, more flexible authorities to realign facilities, meet capital-asset needs, and divest itself of unneeded buildings.
- Establishing a VHA capital asset realignment process that provides (notwithstanding any other law) for more effectively aligning VHA facilities with the objective of improving the access, quality, and cost-effectiveness of VA care, and provides for:

- Establishing an independent commission (empowered to hold public hearings, make site visits, and have full access to VHA analyses and data) charged with developing a national capital asset realignment plan that would include recommendations to the VHA Care System governing board (see Recommendation #9) for systemwide facility realignment (to include changes in facility mission, facility downsizing, integration of facilities, and closures), with the rationale for each recommended change.
- The proposed plan would identify (a) the criteria used in developing realignment recommendations, (b) proposals for reinvestment and savings/cost avoidance resulting from the realignment, (c) the projected care improvements that would result, and (d) mechanisms to minimize the adverse effects on displaced employees, to include assuring that, to the extent feasible, VA retrain and reemploys displaced employees.
- The VHA Care System governing board would be empowered to adopt or alter the proposed realignment plan, and to implement the final plan unless, within a specified timeframe, Congress disapproves the plan as a whole on an up-or-down vote.
- Waive or suspend for at least 5 years current authorization and scorekeeping requirements governing major medical facility leases under 38 U.S.C. § 8104.
- Amend 38 U.S.C. § 8104 to lift the threshold of what constitutes a major medical facility project from \$10 million to \$50 million.
- Amend pertinent provisions of 38 U.S.C. § 8161, and what follows, to reinstate and extend for 10 years the authority in prior law (as in effect on December 30, 2011) for VHA to enter into enhanced-use leases for any use that is not incompatible with VA's mission.
- Provide the VHA Care System governing board authority to promulgate regulations that for a period of not more than 5 years, and notwithstanding any other law, would ease the divestiture of unneeded vacant VHA buildings, to include (a) shifting to a third party the cost of meeting environmental requirements, (b) allowing VHA to retain the proceeds of any property sale, and (c) creating a streamlined process to address historic preservation considerations.

VA Administrative Changes

- None required.

Other Department and Agency Administrative Changes

- None required.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

Problem

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems and other health care providers; enables scheduling, billing, claims, and payment; and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.¹⁸²

VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, currently within VHA, there is no experienced senior health care IT leader focusing on the strategic health care IT needs of veterans and VHA staff.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing and implementing a comprehensive health IT strategy and developing and managing the health IT budget.
- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Background

A fully functional electronic health record (EHR) can improve the quality of patient care, help avert medical errors, and improve communication among providers and with patients.¹⁸³ Starting in the 1970s, VHA became a leader in the development of EHR technology with VistA and a computerized patient record system (CPRS).¹⁸⁴ Full implementation of the EHR, together with other reforms, helped improve the quality of care at VHA.¹⁸⁵ During the last decade, VHA has not been able to maintain an IT advantage.¹⁸⁶ Although in the past most VHA clinicians

¹⁸² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁸³ "Does health information technology improve quality of care?" Robert Wood Johnson Foundation, accessed May 20, 2016, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71333.

¹⁸⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 29-30, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

¹⁸⁵ Phillip Longman, *Best Care Anywhere: Why VA Care Is Better Than Yours* (3rd ed., Berrett-Koehler Publishers, Inc., 2012). Jonathan B. Perlin, Robert M. Kolodner, and Robert H. Roswell, "The Veterans Health Administration: Quality, Value, Accountability, and Information as Transforming Strategies for Patient-Centered Care," *The American Journal of Managed Care* (November 2004), 828-836, accessed June 3, 2016, <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.476.450&rep=rep1&type=pdf>.

¹⁸⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, vi, accessed April 5, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

have had a high opinion of the clinical applications and databases enabled by VistA and CPRS, a lack of upgrades has put VHA's EHR at risk of becoming obsolete.¹⁸⁷ Many large U.S. health care systems that were early adopters of homegrown EHR systems found themselves in similar circumstances and have since purchased and migrated to commercial off-the-shelf (COTS) products.¹⁸⁸ DoD recently made the same choice.¹⁸⁹

To achieve the Commission's vision of a health care system that delivers quality, access, choice, and veteran well-being, VHA requires effective, robust, and modern information technology systems. A robust EHR system would allow veterans and clinical providers to send, receive, find, and use electronic health information in a manner that is appropriate, secure, timely, and reliable. It would be seamlessly interoperable with other systems including DoD, private-sector providers, and with other VA enterprise systems such as those in the Veterans Benefits Administration (VBA). It would support VHA clinical workflow, evidence-based practice, and patient safety. It would provide clinicians, patients, and administrators the data, analytic power, and user interfaces required to monitor the effectiveness of care and improve it over time. A robust IT system for VHA should include more than just the EHR, however, extending to all the systems and tools required to facilitate and automate business processes that support access and veterans' care. These capabilities include an effective scheduling system, telephone systems, mobile applications, telehealth, financial management systems, human resources systems, and other systems that enable community care.

To realize such a transformation of IT in a system as complex as VHA requires exceptional leadership and staff, sufficient budget, a robust change management plan, effective systems for accountability and quality control, and efficient and agile contracting.¹⁹⁰ Presently, VHA appears to lack a majority of these factors required for success.¹⁹¹

Analysis

Leadership and Staff

Prior to 2006, VHA had a chief health informatics officer responsible for the VHA electronic record system and for coordinating with VA on IT systems. The programmers in VHA worked closely with the clinicians who used the tool to create a system that met their needs.¹⁹² VHA was able to prioritize clinical needs and patient safety requirements within its overall budget and plan for IT spending; however, there was no specific budget line item for the electronic health

¹⁸⁷ Ibid., 29-30.

¹⁸⁸ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

¹⁸⁹ "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

¹⁹⁰ LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

¹⁹¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 41, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁹² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

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record system or related technology, and there was limited central oversight or accountability for information technology infrastructure.

VA's IT budget was centralized in 2006, and the Office of Information and Technology (OIT) was assigned to deliver, operate, and manage IT and its budget, across the department. With this change, VHA's needs became only one of the priorities that OIT has had to accommodate and VHA's priorities have not always prevailed.¹⁹³

To ensure that clinical needs and patient safety are a priority, many large health care systems, such as DoD, Cleveland Clinic, Geisinger, and Kaiser Permanente, have a medical CIO (i.e., CMIO) who manages and advocates for the clinical IT needs of the organization. A CMIO ensures that clinicians are involved in the selection of any IT systems they use to perform their job functions and provide patient care, including EHRs. Clinicians involved in the selection and deployment of an IT system are more likely to feel ownership of it and fully adopt its use. The CMIO usually reports to the health system's CEO or CMO, and working in concert with these individuals and the organization's CIO, makes sure that health information needs are prioritized and funded.¹⁹⁴

VA does not have staff with the necessary expertise to execute large-scale IT projects. Previous system implementations have failed because VA did not have individuals with adequate experience to effectively plan and manage system development and deployment. If VA had an adequate system and skilled staff to monitor and identify program and contracting problems affecting the progress of prior IT implementations, effective and timely decisions could have been made to either redirect or terminate VA IT projects that ultimately failed. To avoid repeating these previous IT implementation failures, VA needs to develop effective oversight systems and develop in-house staff with the expertise to oversee, fully support, manage, and execute complex integrated IT programs.¹⁹⁵

Given all of these critical needs, the Commission believes that it is essential for VHA to have a CIO with health care expertise and substantial experience, reporting to the chief of VHA Care System. The VHA CIO will be responsible for managing the complex implementation of a state-of-the-art comprehensive information system platform to support the new integrated VHA Care System, with the functionality, interoperability, and data management capabilities to support the delivery and coordination of high-quality health care for veterans. The CIO will need to work closely with clinical and operational leaders on the effective execution of the new system, and will also need to collaborate with the VA CIO to ensure the integration and coordination of the health care information system and the Veterans Benefit Administration system.

¹⁹³ Ibid., 10.

¹⁹⁴ "CMIOs Help Hospitals Make Tech Transitions," Naseem S. Miller, accessed May 13, 2016, <https://www.acep.org/content.aspx?id=79744>.

¹⁹⁵ Department of Veterans Affairs Office of the Inspector General, *Review of the Awards and Administration of Task Orders Issues by the Department of Veterans Affairs for the Replacement Scheduling Application Development Program*, accessed May 25, 2016, <http://www.va.gov/oig/52/reports/2009/VAOIG-09-01926-207.pdf>.

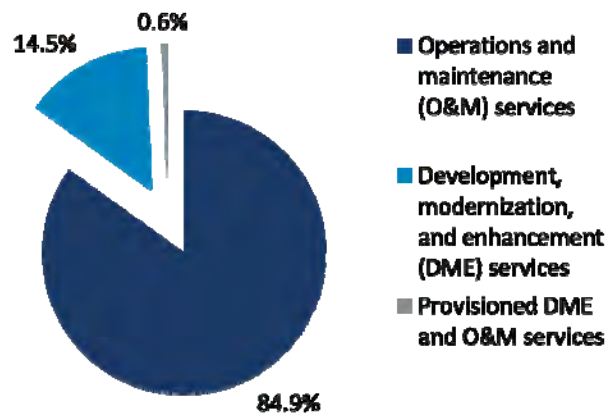
Budget

The 1-year budget appropriations cycle makes it difficult to secure multiyear funding for long-term development and important IT projects.¹⁹⁶ The budget process is disconnected from total lifecycle IT costs.¹⁹⁷ That disconnect has grown wider with a change in law¹⁹⁸ under which Congress provides VHA advanced medical care appropriations—in effect a 2-year budget—while health IT funding remains 1-year money.¹⁹⁹ As the Congressional Research Service (CRS) testified,

*providing an advance appropriation for some VHA accounts and funding IT accounts under a regular appropriation act could create a situation whereby, for example, VHA could not purchase computer software although it has procured medical equipment that needs software. Another example would be the difficulty of procuring IT infrastructure to support opening of a new community-based outpatient clinic (CBOC).*²⁰⁰

Spending on new systems and upgrades to existing systems now represents only 15 percent of VA's total IT budget (see Figure 4),²⁰¹ meaning that essential upgrades like a new scheduling package and EHR modernization have not had the funding or focus required to succeed. Clinical users have become increasingly frustrated by the lack of any clear advances with VistA during the past decade. Numerous VHA clinicians have experience with commercial EHR systems and want the same level of features, modern clinical capabilities, integration, and mobility they see emerging in the commercial marketplace.²⁰²

Figure 4. VA IT Spending



In July 2015, DoD awarded a \$4.3 billion, 10-year contract to overhaul the Pentagon's electronic health records for millions of active-duty military members and retirees. Officials estimate that

¹⁹⁶ "Coming in 2016: Cloud Legislation," Aisha Chowdhry and Adam Mazmanian, accessed January 12, 2016, <https://fcw.com/articles/2015/12/22/cloud-bill-2016.aspx>.

¹⁹⁷ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.

¹⁹⁸ Veterans Health Care Budget Reform and Transparency Act of 2009, Pub. L. No. 111-81, 123 Stat. 2137 (2009).

¹⁹⁹ With the Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235 (December 16, 2014), Congress expanded advanced appropriations to additional VA program accounts.

²⁰⁰ U.S. Congress, House of Representatives, Committee on Veterans Affairs, *Funding the U.S. Department of Veterans Affairs of the Future: Hearing before the Committee on Veterans Affairs U.S. House of Representatives*, 111th Congress, 1st Sess., April 29, 2009, 60, accessed June 3, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-111hhrg49914/pdf/CHRG-111hhrg49914.pdf>.

²⁰¹ Department of Veterans Affairs, *Information Technology Agency Summary*, accessed May 25, 2016, <https://itdashboard.gov/drupal/summary/029>.

²⁰² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

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during its potential 18-year life, the contract could be worth just less than \$9 billion.²⁰³ The recent Senate appropriations bill for VA OIT allots \$63 million toward development and modernization of VA's existing EHR (i.e., VistA Evolution).²⁰⁴ Assuming that VA's implementation of a new COTS EHR would be similar in size and scope to DoD's EHR implementation, VA would be short \$3.67 billion in funding for a new COTS EHR, given the current funding amount of \$63 million per year. VA will require a substantial increase in IT funding to support the successful implementation of a new comprehensive COTS EHR.

Robust Change Plan

Because VistA has been customized at each medical center, there are few standard data elements. The varied algorithms lead to a complex, heterogeneous mix of hardware and software that impedes system changes and new capabilities and raises operations and maintenance costs.²⁰⁵ Due to excessive project management overhead, a complex legacy IT infrastructure that is difficult to modernize, and more than 130 variations of the primary software system deployed across VHA medical facilities, the implementation of improved IT capabilities in the last 10 years has been extremely limited.²⁰⁶ VA is currently weighing whether to continue to modernize VistA or purchase a COTS health information technology platform. The Commission recommends moving to a COTS program.

Whether VHA moves forward with the purchase of a COTS product, as recommended by the Commission, or continues attempting to modernize VistA, VHA must effectively manage the change process. At present, a lack of standard clinical documentation has made it harder to develop effective clinical decision-support systems and hinders EHR information exchange among VA Medical Centers (VAMC), between VA and non-VA facilities (including those of DoD), and between VA and individual veterans. Shared data must be well labeled in a way that the receiving system can identify and properly ingest such data. An electronic medical record can contain as many as 100,000 different data fields. The lack of data standards presents challenges to using comparable data for analysis and disparities among the 130 tailored local instances of VistA, complicating information sharing, data aggregation, and analytics.²⁰⁷ VHA has not established comprehensive semantic definitions for data elements through the use of standard nomenclatures, terminologies, and code sets. Doing so is required to ensure consistency and integration across multiple systems, leverage follow-on IT products, and facilitate analytics for clinical decision making.²⁰⁸

The Office of the National Coordinator (ONC) for Health IT, under HHS, is responsible for advancing national connectivity and interoperability of health information technology. The

²⁰³ "Cerner wins \$4.3 billion DoD contract to overhaul electronic health records," Amy Brittain, *The Washington Post*, accessed May 25, 2016, https://www.washingtonpost.com/national/health-science/cerner-wins-dod-contract-to-overhaul-electronic-health-records/2015/07/29/7fbfccfa-35f5-11e5-b673-1df005a0fb28_story.html.

²⁰⁴ S. Rept. 114-237 – Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, 2017, accessed May 25, 2016, <https://www.congress.gov/congressional-report/114th-congress/senate-report/237/1>.

²⁰⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²⁰⁶ *Ibid.*, 41.

²⁰⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, vi, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁰⁸ *Ibid.*, viii.

ONC developed the National Interoperability Roadmap with the goal of being able to use electronic health information exchange, so information can follow a patient where and when it is needed, across organizational, health IT developer, and geographic boundaries. The roadmap lays out a clear path to catalyze the collaboration of stakeholders who are going to build and use the health IT infrastructure.²⁰⁹ VA's intent to expand veteran care to more community providers through the creation of locally-integrated health care networks will mean that it is important for VHA to follow the ONC roadmap and standards. Following this roadmap includes using the continuity of care document to exchange data, which was established by ONC and is followed by community health care providers. VA OIT is currently collaborating with the ONC on VA's plans for interoperability and has committed VA to following the roadmap.²¹⁰

VHA does not yet have a robust, detailed strategy and roadmap for IT initiatives across VHA that integrates veteran access to scheduling via phone, telehealth, and mobile apps.²¹¹ National deployment of the VistA Scheduling Enhancement and the veteran mobile scheduling Veteran Appointment Request app, are initial steps to prepare for the implementation of new COTS electronic medical system with a scheduling package.

To resolve the underlying systemic issues with VistA scheduling, VA awarded a contract for the implementation of VA's new COTS medical appointment scheduling system in August 2015.²¹² This system is a COTS scheduling solution that, when implemented, is expected to move VHA from primarily a face-to-face appointment model to a coherent, resource-based system with broad opportunities for improved services for VA stakeholders.²¹³ Deployment is awaiting the final decision on whether VHA will continue with VistA or purchase a full COTS product.

COTS Solution

The current VistA/computerized patient records systems are based on a tightly integrated, monolithic architecture and design with numerous and diverse functional components and associated interdependencies. These characteristics impose barriers to modernizing the respective systems. In addition, the high cost of infrastructure operation and maintenance (85 percent of the total IT budget) reduces funding available for new development efforts.²¹⁴ Maintenance and data sharing are further complicated because most VAMCs have customized their local versions of VistA, leading to approximately 130 different versions of VistA across the country.²¹⁵

²⁰⁹ "A Shared Nationwide Interoperability Roadmap Version 1.0," HealthIT.gov, accessed March 29, 2016, <https://www.healthit.gov/policy-researchers-implementers/interoperability>.

²¹⁰ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²¹¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 44, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²¹² "\$623M Medical Appointment Scheduling System (MASS) Contract," G2Xchange, accessed May 3, 2016, <https://www.g2xchange.com/statics/623m-medical-appointment-scheduling-system-mass-contract>.

²¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 40, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²¹⁴ *Ibid.*, vi.

²¹⁵ *Ibid.*, vi.

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VHA relies on a VistA scheduling package to provide veterans with access to health care. The system is antiquated, highly inefficient, does not optimally support processes or allow for efficient scheduling of appointments. A report on scheduling published by the Northern Virginia Technology Council (NVTC) in October 2014, showed that VA's exam-scheduling processes are not enabled by state-of-the-art technologies or consistently applied standard operating procedures.²¹⁶ To improve this situation, VHA has developed, and is in the process of a national roll out of, VistA scheduling enhancements, which provides an improved user interface (i.e., graphic user interface or GUI). Although the new GUI will help veterans gain access to care by implementing better scheduling procedures, it does not address the need that managers, planners, and administrators have for accurate and timely data on clinic use.²¹⁷ For instance, VHA's new health care operations dashboard shows that more than 55 percent of clinic slots in VHA go unused each day.²¹⁸ However when questioned about this data, VHA notes that it is not correct.²¹⁹ The underlying VistA scheduling software does not allow accurate representation of clinician time toward each clinic stop. As a result, whether data is presented in a dashboard or a new GUI tool, as long as the underlying data cannot be captured accurately, then VHA will not have the information it needs to effectively manage the supply of clinic slots.²²⁰

VA's financial management information technology system is woefully outdated and VA has previously wasted approximately \$500 million in two failed attempts to replace it. Given VA's lack of an integrated finance and logistics IT system, VA has no method to perform commitment accounting.²²¹ VA's current financial management system does not support streamlining and automation of VA's revenue cycle.²²²

Community care processes currently include eligibility determinations, referrals and authorizations, care coordination, network management, claims, and customer service.²²³ VA's information technology systems limitations often demand manual processes to support community care that can reduce the timeliness and accuracy of data and obscure the true state of VHA's activities. Relying on manual processes slows collections and payment activities and introduces errors and waste into the process.²²⁴ Barriers to automation are multifactorial,

²¹⁶ Ibid., 39-40.

²¹⁷ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

²¹⁸ Crystal Wilson, Office of Analytics and Business Intelligence, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.

²¹⁹ Joe Francis, Director of Clinical Analytics and Reporting, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.

²²⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

²²¹ Jan R. Frye, *Letter to Secretary McDonald, March 19, 2015*, accessed May 17, 2016, http://extras.mnginteractive.com/live/media/site36/2015/0522/20150522_025126_WhistleblowerMemo.pdf.

²²² Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, 24, accessed May 24, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf.

²²³ Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.

²²⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 42, accessed March 28, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

including confusing eligibility rules governing which veterans may receive care outside VHA and for what conditions, in what circumstances, and which services may be billed to third-party insurers.²²⁵ In addition, there are multiple authorities for purchasing community care—all with different business rules²²⁶ and reimbursement rates, as well as antiquated financial management information systems that are not standardized to private-sector processes. All of these impediments are exacerbated by workers throughout the revenue cycle who are poorly compensated and marginally trained, experience high turnover, and work in environments with a continuous 20 percent vacancy rate;²²⁷ thus, they cannot effectively manage certain business practices such as insurance verification and ensuring clinicians complete necessary coding documentation.²²⁸

Many large U.S. health care systems that originally developed in-house EHRs have since purchased and migrated to COTS EHRs.²²⁹ DoD recently made the same choice, deciding to replace its homegrown EHR with a COTS product to take advantage of private-sector innovation and have an EHR that communicates with private-sector systems. For a system in which 60 to 70 percent of military health care takes place outside the DoD,²³⁰ this was an important business consideration that is also consistent with VHA's long term direction. Very large IT programs with purpose-built systems and labor-driven business models are shifting rapidly toward more open source, COTS systems. Large proprietary IT solutions are increasingly being replaced by less risky, agile, and open-source solutions or IT as-a-service models, and getting away from client-server models.²³¹

Interoperability

VHA's EHR issues stymie interoperability among VHA facilities as well as between VHA and DoD and other non-VHA providers. Multiple assessments noted the lack of interoperability resulted in incomplete patient records with potentially substantial implications for veterans and VHA. Incomplete records introduce unnecessary clinical risk, complicate the transition from

²²⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I (Business Processes)*, 19-20, accessed April 26, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²²⁶ Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.

²²⁷ Healthcare Talent Management, Veterans Health Administration, email to Commission on Care, April 11, 2016. Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America's Veterans*, accessed April 25, 2016, <http://www.va.gov/opa/choiceact/documents/NVTCTFinalReporttoVA-revised3.pdf>.

²²⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I, Business Processes*, I3-I4, accessed November 24, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²²⁹ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

²³⁰ "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

²³¹ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

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DoD to VHA care, and inhibit VHA's ability to bill and collect revenue in an accurate and timely manner.²³²

As GAO reported in August 2015, VA and DoD have taken initial steps to increase interoperability between their existing electronic health record systems.²³³ They have deployed the Joint Legacy Viewer (JLV), which provides a patient-centric, integrated view of a patient's health data from VA, DoD, and community health partners on one screen. It has been available at all VA medical centers since October 2014 and currently has more than 70,000 users.²³⁴ The JLV is a positive step in supporting coordination of care among VA, DoD, and community partners, but it only allows for providers to view veterans'/service members' medical records and does not yet allow for the other agencies' medical records to be updated by providers.²³⁵

VA's next evolution in interoperability with DoD and community partners is the deployment of their Enterprise Health Management Platform (eHMP). eHMP is intended to provide VA streamlined access to complete patient history from VA, DoD, and community health partners in a single, reliable, customizable, and secure interface that is easy to use. It is reported to deliver a modern, web-based user interface and supporting infrastructure and is intended to replace the Computerized Patient Record System (CPRS) as VA's primary point-of-care application. The national rollout of eHMP is expected to be completed by December 2017.²³⁶

VHA does not have everything that is needed in an IT system to manage the business and clinical aspects of care in the community and support the overall veteran experience in an expanded community network. To address these gaps and provide health care well into the future, VA intends to develop in house a comprehensive and interoperable digital health platform (DHP). The DHP is intended to seamlessly integrate all of VHA's core processes, including scheduling, supply chain management, billing, and claims. Through consolidation of more than 40 contact center systems and more than 130 versions of the VistA EHR and clinical procurement/inventory systems, the DHP is designed to enable VHA's operation as a holistic, platform business and greatly reduce the cost of system maintenance across the IT enterprise.²³⁷

Because there is no unique patient identifier, problems exist with "1) accessing and integrating information from different providers and provider computer systems, 2) aggregating and providing a lifelong view of a patient's information, and 3) supporting population-based research and development."²³⁸ To accurately match veteran patient data that is exchanged between VA and non-VA providers, both organizations need to use the same unique patient

²³² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 44, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²³³ "Electronic Health Records: VA and DOD Need to Establish Goals and Metrics for Their Interoperability Efforts," U.S. Government Accountability Office, accessed April 1, 2016, <http://www.gao.gov/products/GAO-16-184T>.

²³⁴ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²³⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, A-35, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²³⁶ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²³⁷ LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²³⁸ "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPVU-508.pdf>.

identifier. This practice is currently not used.²³⁹ Each health care system uses a unique patient identifier number, but it is specific to that system.²⁴⁰ VA uses patients' social security numbers as unique identifiers; whereas, due to stricter security standards required by HIPPA privacy laws that community providers must adhere to, many non-VA providers use other personally identifiable information (e.g., first name, last name, date of birth, and phone number) to match patient identities between record systems. Studies have shown that patient identification error rates range from 7-20 percent.²⁴¹ For VA to accurately identify patients and their records, a unique national patient identifier is essential.

The security of electronic records is an ongoing concern. One in three Americans had health care records breached in 2015.²⁴² Recent hacks of U.S. hospital health care systems through the use of ransomware, viruses that hold systems hostage until victims pay for a key to regain access, further highlight the need for enhanced VA cybersecurity.²⁴³ VA's OIG has repeatedly identified the same weaknesses and deficiencies in VA's information security program in its annual FISMA audit reports.²⁴⁴ Although VA has recently made some progress in developing policies and procedures to address current security gaps, OIG's FY 2015 audit concluded that information security is still a *material weakness* for VA and that VA must take comprehensive measures to mitigate security vulnerabilities affecting VA's mission-critical systems.²⁴⁵ For sharing of veteran data to be secure, only the designated correct parties can have access to patients' data.²⁴⁶ Interoperability increases the risk to veterans' health records.²⁴⁷ Cybersecurity guidelines and best practices are being developed by HHS in response to the requirements in the recently enacted Cybersecurity Information Sharing Act;²⁴⁸ however, security protocols also cannot impede health information exchange with VA community providers and health systems. VA OIT needs to be involved in the health information exchange planning discussions, which

²³⁹ "Interoperability 2015: Current State and Next Steps", Kent Gale, KLAS Research, accessed March 9, 2016, <http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0>.

²⁴⁰ "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPAVU-508.pdf>.

²⁴¹ "The Right Fit: How We Solve the Puzzle of Interoperability," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, <http://www.futureofhealthcarenews.com/telemedicine/the-right-fit-how-we-solve-the-puzzle-of-interoperability>.

²⁴² "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, <http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records>.

²⁴³ "Virus Infects Medstar Health System's Computers, Forcing an Online Shutdown," John Woodrow Cox, Karen Turner and Matt Zapotosky, accessed March 28, 2016, https://www.washingtonpost.com/local/virus-infects-medstar-health-systems-computers-hospital-officials-say/2016/03/28/480f7d66-f515-11e5-a3ce-f06b5ba21f33_story.html?hpid=hp_local-news_medstar-health-virus-345pm%2Fstory.

²⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, A-24, accessed May 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁴⁵ Department of Veterans Affairs, Office of the Inspector General, *Federal Information Security Modernization Act Audit for Fiscal Year 2015*, accessed May 25, 2016, <http://www.va.gov/oig/pubs/VAOIG-15-01957-100.pdf>.

²⁴⁶ "Interoperability 2015: Current State and Next Steps; Market Immaturity Highlights Opportunity," Kent Gale, KLAS Research, accessed March 9, 2016, <http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0>.

²⁴⁷ Jon White, M.D., The Office of the National Coordinator for Health Information Technology, briefing to Commission on Care, December 15, 2015.

²⁴⁸ "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 17, 2016, <http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records>.

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are currently handled solely within VHA, so that VA OIT can assist in removing impediments to health information exchange.²⁴⁹

Veterans currently have to opt in (i.e., provide consent) to allow VA to share their health information with non-VHA/community care providers. Although the technology is in place for VA to exchange patient health information with more than 100 health information exchange partners, only a fraction of data can be exchanged in these networks because, due to lack of awareness, only 3 percent of veterans have opted in to allow VA to share their health information.²⁵⁰ The standard industry policy is to have patients opt out of having their health data shared with their other health care providers. VA is prohibited from taking this approach because statutory language in 38 U.S.C. § 7332 prohibits VA from disclosing information relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia, except when required in emergencies, without written authorized consent from the patient.²⁵¹

In response to this limitation, VA approved and submitted Legislative Proposal VHA-10 (10P-07), Authority for the Department of Veterans Affairs (VA) to Release Patient Information under 38 U.S.C. § 7332 to Health Care Providers for Treatment of Shared Patients in 2013. The proposal allows veterans to opt out of sharing their data with VA community providers instead of having to opt in. The proposal was approved by OMB and was included in the president's 2015 Budget. VHA provided a briefing to a Senate Veterans Affairs Committee staff in April 2015 on this legislative proposal. A House Bill was introduced, but it limited the opt-out option to the *Choice Program*. VA's Office of Congressional and Legislative Affairs responded back to Congress that the bill should be expanded to include all external purchased care options (i.e., community providers) thus directly supporting more veterans.²⁵²

Collaboration between VA OIT and VHA is paramount to transforming VHA's health IT infrastructure. Such collaboration would be most effectively achieved by establishing an IT leader for VHA who is focused on ensuring that the strategic and operational IT needs of VHA clinicians, staff, and veterans are met. Current OIT leadership is in the process of modernizing VA's IT management processes, to include putting in place IT account managers (ITAMs) for each of the agency's departments, including VHA.²⁵³ An account manager is neither senior enough, nor has the level of expertise and experience, to manage the complexity of the VHA IT system. VHA's extensive IT needs require a VHA CIO with authority over the health IT budget and the execution of the health IT strategy. VA needs a robust process for IT investment decisions, especially those relating to VHA's health strategy. The VHA CIO would work with the CVCS and the VA CIO to define the health IT strategy and key IT acquisitions/projects and ensure that health IT funding is aligned and committed to the execution of VHA's health IT

²⁴⁹ Jamie Bennett, VLER Health Program Manager, phone call with Commission on Care Staff, March 2, 2016.

²⁵⁰ Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015

²⁵¹ 38 U.S.C. § 7332 Subchapter III - Protection of Patient Rights Sec. 7332 - Confidentiality of certain medical records.

²⁵² Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015.

²⁵³ "OI&T Enterprise Strategy: Putting Veterans First," LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.

strategy. Rolling out a new system takes multiple years, and VA must commit to funding system deployments to completion.

The modernization of VHA's IT infrastructure requires a substantial increase in and reallocation of VA's IT budget to implement it. The budget process for VA health care IT funding should be the same as the process for VHA medical care funding. That shift can be accomplished by establishing a separate line item for *health* IT within VA's IT appropriation, and providing for advanced appropriations for that account. In addition, there is also a potential supplementary role for government-wide IT legislation. For example, H.R. 4897, the Information Technology Modernization Act of April 2016, would create a \$3.1 billion revolving fund for upgrading outdated federal IT systems.²⁵⁴

The Commission strongly recommends that VA purchase a comprehensive COTS health IT platform, and implement all information systems with minimal customization. VHA leadership is in the process of assessing whether VistA is the best solution to support veterans' future health care needs or whether a new EHR, such as a COTS product or open-source EHR, should be used.²⁵⁵ The decision to choose a COTS product would be consistent the approach adopted by DoD and by other large health systems that have moved away from homegrown solutions to commercial and open-source products. It would allow VHA to focus energy on excellent patient care as a core competency and shift the IT development and maintenance risk of software products to external vendors with more expertise in this area.²⁵⁶ It is also likely to accelerate interoperability as vendors continue to offer IT solutions that meet meaningful use standards and the roadmap published by ONC.

A COTS product must be able to execute key functionalities required by VHA. These requirements include one standard version of an EHR across all VHA sites of care; interoperability within VA, such as with Veterans Benefit Administration (VBA), and between VHA and DoD, and community providers; robust security; and the ability to accommodate a national unique patient identifier. This system must also be a robust clinical management tool that supports VHA clinical workflow and has a customizable interface for clinical users, allows for evidence-based clinical order sets and patient safety features like automated medication reconciliation, has robust analytic capability for both clinical and administrative functions, and enables automated abstraction and reporting of performance measures.

The system must also seamlessly support administrative functions like scheduling, patient intake, eligibility determination, referrals, and patient out-of-pocket expense determination. The system must enable effective business operations in billing coding, automated claims processing, and all aspects of supply chain management. This COTS purchase should include a scheduling package. Improvements in scheduling should dramatically increase access and satisfaction, as well as data quality, productivity, and operational reporting capabilities.

²⁵⁴ "Two IT Modernization Bills Could See Movement in Congress," Aisha Chowdhry, accessed April 28, 2016, <https://washingtontechnology.com/articles/2016/04/22/it-bills-congress.aspx>.

⁷³ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²⁵⁶ "DoD awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

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Broadening and improving scheduling capabilities will provide more opportunities for veterans to become active partners in their own care.²⁵⁷

For VHA to transition to a COTS product, the new VHA CIO must develop and implement a strategy that will allow the current nonstandard data to effectively roll into a new system, engage clinical-end users and internal experts in the procurement and transition process, ensure effective cybersecurity, and limit spending on the current systems to fund only critical changes required for continued operations. Finally, this plan should be coordinated with ONC and DoD.

Implementation

Legislative Changes

- Provide a specific appropriation to fully fund the complete development and deployment of the comprehensive COTS electronic health platform, recognizing this will require significant resources above the current annual appropriation and funding to support VHA's IT transformation; including funds that ensure appropriate training of all staff, recognize loss of staff productivity during implementation, and provide proper maintenance and upgrades of VA IT infrastructure in preparation for new and successor technologies.
- Establish within the Department's IT appropriation a line item for health IT, and provide for advanced appropriations for that account, consistent with the overall VHA IT strategy.
- Amend section 38 U.S.C. §7332, to authorize VA to share protected health information under the same rules as all other HIPAA protected information.

VA Administrative Changes

- Hire a CIO for the VHA IT transformation. The CIO should report to the CVCS, with secondary reporting responsibility to VA CIO.
- Establish a transformation strategy that addresses all of the following needs (as directed by the VHA CIO):
 - standardizes data elements in the current IT systems through the use of standard nomenclatures, terminologies and code sets in order to promote the transition to a COTS EHR and to support interoperability²⁵⁸
 - develops a robust cybersecurity plan for VHA IT infrastructure, in coordination with VA CIO and Chief Information Security Office, which addresses both current systems and defines
 - the requirements for new systems

²⁵⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 46, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁵⁸ *Ibid.*, 55.

- collaborates with the Office of the National Coordinator for Health IT on national interoperability standards and implementation
- limits any continued VistA development and associated spending to only those upgrades required to keep VistA functioning until a new system is in place
- Plan and implement procurement of a comprehensive COTS electronic health platform that executes all of the following requirements:
 - establishes one logical version of an electronic health record platform in VHA²⁵⁹
 - standardizes evidenced-based, best practice clinical order sets across VHA
 - incorporates effective analytic capabilities to drive health and business outcomes and offers the ability to interface with other tools for data management and presentation²⁶⁰
 - modernizes appointment scheduling so that it accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veterans²⁶¹
 - accomplishes a coordinated IT infrastructure for appointment scheduling, coding, billing, claims payment, third party collections, and other core VHA business processes, including the following specific capabilities: integration across patient intake, medical records, coding, and billing systems; single sign-on capability; automated first-party claims matching; real-time estimate of out-of-pocket patient expenses; and automation to support algorithmic edits and claims correction²⁶²
 - supports the business processes required to implement integrated community care networks, including eligibility determinations, referrals and authorizations, care coordination, network management, claims and customer service
 - promotes full interoperability with IT systems across VA (including VBA and National Cemetery Administration) and between VA and DoD
 - supports the development of full interoperability with integrated community care network facilities and providers

²⁵⁹ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²⁶⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, viii, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁶¹ The Independent Budget, *The Independent Budget—Veterans Agenda for the 114th Congress: Policy Recommendations for Congress and the Administration*, accessed May 17, 2016, http://www.independentbudget.org/2016/IB_FY16.pdf.

²⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 49, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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- enables automated abstraction and reporting of quality performance measures including process and outcome measures of clinical quality, access measures, and cost effectiveness that are the same as the private sector
- includes functionality to use a national unique patient identifier
- integrates supply chain and financial systems with the electronic health records to provide accurate operational data²⁶³
- Streamline its current IT procurement processes so that IT procurement is expeditious, including lengthier contract vehicles with more options, the use of indefinite delivery indefinite quantity vehicles, blanket purchase agreements, time and material contracts, and flexible contract structures to allow for the onboarding of emerging technologies in a competitive fashion.
- Increase health IT expertise within VHA.

Other Department and Agency Administrative Changes

- CMS and federal health care providers should collaborate to develop a national unique patient identifier standard. CMS should require health care providers to use these identifiers as a condition of participation in Medicare and HHS should require federally qualified health centers to use them as a condition of participation. The President should require all federal health care providers to adopt the standard.

²⁶³ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Problem

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.²⁶⁴

Background

Health systems nationwide, under pressure from reforms driven by the Affordable Care Act, are looking at every aspect of their business to maximize cost savings, while maintaining quality services.²⁶⁵ This effort includes examining the supply chain for ways to save money.²⁶⁶

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.
- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

²⁶⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁶⁵ Bob Kehoe, "Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness," *Health Facility Management Magazine*, 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.

²⁶⁶ "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, <http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends>. "5 Ways Supply Chain Can Reduce Rising Health Care Costs," Jasmine Pennie, accessed April 28, 2016, <http://hitconsultant.net/2013/05/13/5-ways-supply-chain-can-reduce-rising-health-care-costs/>.

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Price competition achieved through technology and aggressive management of supply chain efficiencies by retailers such as Walmart and Amazon are held up as just the kind of disruption that health care requires.²⁶⁷ Health care organizations as diverse as Kaiser Permanente, Cleveland Clinic, Stanford Medicine, and Johns Hopkins Health System have taken on the challenge of transforming their supply chains, realizing savings of as much as hundreds of millions of dollars.²⁶⁸ VHA, which in FY 2014 spent approximately \$3.4 billion on clinical supplies, medical devices, and prosthetic appliances, has an opportunity to realize similar savings.²⁶⁹

Opportunities for efficiency in the supply chain include reducing pricing for purchases and lowering operating costs of procurement processes. To achieve price savings, organizations must have detailed information on what products they use, understand and reduce variability in the products purchased, and aggressively negotiate pricing, usually by consolidating purchases to a small number of preferred vendors who are willing to offer volume discounts and improve service delivery. On the operations side, cost savings are achieved by managing inventory lifecycle and restocking processes; order management; and the logistics of shipping, receiving, and transportation to drive down costs and lower waste and breakage. In health care, it also pays to ensure that clinical staff, both nurses and doctors, are treating patients rather than conducting inventory checks or ordering and collecting supplies.²⁷⁰ To be successful in managing the supply chain in health care, a partnership with clinical staff is key. Variability in device and supply purchases can be driven by clinician preferences and thus, to reduce variability, clinicians must be engaged in analyzing product options and examining data on product effectiveness to determine what products to use with patients.²⁷¹

VHA has a successful internal model of aggressive supply chain management that can serve as a model for improving the management of medical, surgical and other supplies: the VHA Pharmacy Benefits Management Service (PBM). PBM has taken a systems approach to

²⁶⁷ John Agwunobi and Paul London, "Removing Costs from the Health Care Supply Chain: Lessons from Mass Retail," *Health Affairs*, 28, no 5, (2009): 1336-1342, accessed April 26, 2016, <http://content.healthaffairs.org/content/28/5/1336>.

²⁶⁸ "In Age of Mergers, Hospitals Get Strategic with Medical Supply Purchasing," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/age-mergers-hospitals-get-strategic-medical-supply-purchasing>. "Supply Chain Management," Cleveland Clinic, accessed April 27, 2016, <http://my.clevelandclinic.org/services/supply-chain-management>. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering>.

²⁶⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 47, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁰ "EY Provider Post: Choosing Your Innovation Pathway," EY, accessed April 26, 2016, <http://www.ey.com/US/en/Industries/United-States-sectors/Health-Care/Provider-Post--Choosing-your-innovation-pathway>.

²⁷¹ "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, <http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends>. "Strategic Supply Chain Management," Lee Ann Jarrow, accessed April 28, 2016, <http://www.hhnmag.com/articles/4522-strategic-supply-chain-management>. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering>.

managing pharmaceutical supplies, logistics, and prescribing.²⁷² PBM has largely solved the internal contracting deficiencies in VA by consolidating its activities under just two contracting organizations that oversee all national-level contracts for pharmaceuticals. PBM also applies effective mechanisms to drive standardization of supplies through a national formulary, clinical guidelines for prescribers and utilization review, and feedback to help clinicians identify outlier prescribing practices.²⁷³ Vital to the success of this program is the involvement of clinicians and pharmacists in a vertically integrated model of engagement and decision making through facility-level, Veterans Integrated Service Network (VISN)-level, and national-level PBM committees that contribute to formulary and clinical guideline decisions and manage utilization review with local clinicians.²⁷⁴ PBM also has a sophisticated web of communications, education, and engagement efforts to ensure clinical leaders across the system are helping drive PBM policy and practices.²⁷⁵ As a result, 90 percent of purchases are acquired through pharmaceutical prime vendor contracts.²⁷⁶

PBM, taking advantage of standardized industry nomenclature and bar codes for pharmaceuticals, has implemented automated dispensing, distribution, and ordering processes, including VA's Consolidated Mail Outpatient Pharmacy (CMOP).²⁷⁷ The use of CMOP, a system of seven highly automated pharmacies that process more than 460,000 prescriptions every work day, results in exceptional accuracy and lower processing costs than would result if filling prescriptions at each VAMC.²⁷⁸ Eighty percent of prescriptions in VHA are filled through CMOP,²⁷⁹ which has been recognized for the last 6 years as the best or one of the best mail order pharmacies in the country meeting or exceeding customer satisfaction scores of health care systems like Kaiser Permanente and on-line pharmacies like Express Scripts and Walgreens Online Pharmacy.²⁸⁰ Customer service, veteran satisfaction, and patient safety delivered through team-based care are a hallmark of the mission of PBM,²⁸¹ and are a useful reminder of the principles that must drive any successful transformation of supply chain management in VHA.

²⁷² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 19, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷³ *Ibid.*, 20.

²⁷⁴ VHA Formulary Management Process, VHA Handbook 1108.08 (2009).

²⁷⁵ Clinical Pharmacy Services, VHA Handbook 1108.11, 28-30 (2015). The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 32-34, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁷ *Ibid.*

²⁷⁸ "VA Mail Order Pharmacy," U.S. Department of Veterans Affairs, accessed April 29, 2016, http://www.pbm.va.gov/PBM/CMOP/VA_Mail_Order_Pharmacy.asp.

²⁷⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁸⁰ "U.S. Pharmacy Study – Mail Order (2015)," J.D. Power, accessed April 29, 2016, <http://www.jdpower.com/ratings/study/U.S.-Pharmacy-Study-Mail-Order/631ENG2>.

²⁸¹ "Pharmacy Benefits Management Services," U.S. Department of Veterans Affairs, accessed April 29, 2016, <http://www.pbm.va.gov/PBM/index.asp>.

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Analysis

VHA's supply chain for clinical supplies, medical devices, and related services is inadequate compared to the agency's pharmacy organization or to best practices in leading hospital systems.

*Its contracting processes are bureaucratic and slow, which can delay veterans access to care. Purchasing processes are cumbersome which has driven VHA staff to work arounds and exacerbates the variation in prices VA pays for products. Utilization is difficult to measure or manage given a lack of data which likely leads to significant avoidable expense for VA.*²⁸²

Leadership and Organizational Structure and Function

Best-in-class supply chain organizations typically have a single group responsible for the strategy, sourcing, procurement, and logistics of clinical supplies and medical devices. The organization is typically led by an executive-level leader, such as a chief supply chain officer (CSCO), and personnel are aligned along product categories to develop and use deep expertise in the products and suppliers they manage.²⁸³ In contrast, the organizational structure for contracting, logistics, and supply management in VA and VHA is complex and duplicative.²⁸⁴ Four contracting entities are located within VA central office but report to two different management offices within VA's office of acquisition, logistics, and construction (OALC).²⁸⁵ Procurement personnel within VHA's regional contracting and VISN offices report to VHA's national office of procurement. In contrast, facility-based and VISN logistics personnel report to their local VAMC or VISN director and not to the national VHA logistics office.²⁸⁶ To further complicate the management picture, clinical supplies are managed by the logistics organization, yet medical devices are managed by the Prosthetics and Sensory Aid Service (PSAS)²⁸⁷ (see Figure 5). In most health care organizations, the supply chain chief operating officer and their integrated supply chain group manages the procurement and distribution of all clinical supplies and medical devices.²⁸⁸ This is not the case in VA. Senior leaders in VA's and VHA's supply chain organizations and field-based supply chain personnel indicate current organizational structure is too complex and should be simplified.

*National supply chain leaders expressed lack of clarity regarding the scope of responsibilities of the entities for which they are responsible, which has led to some tension and what one leader described as a 'turf war.' Others described a vacuum of ownership and accountability, and lack of clarity on roles and responsibilities.*²⁸⁹

²⁸² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, v, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁸³ Ibid., 57-58.

²⁸⁴ Ibid., ix.

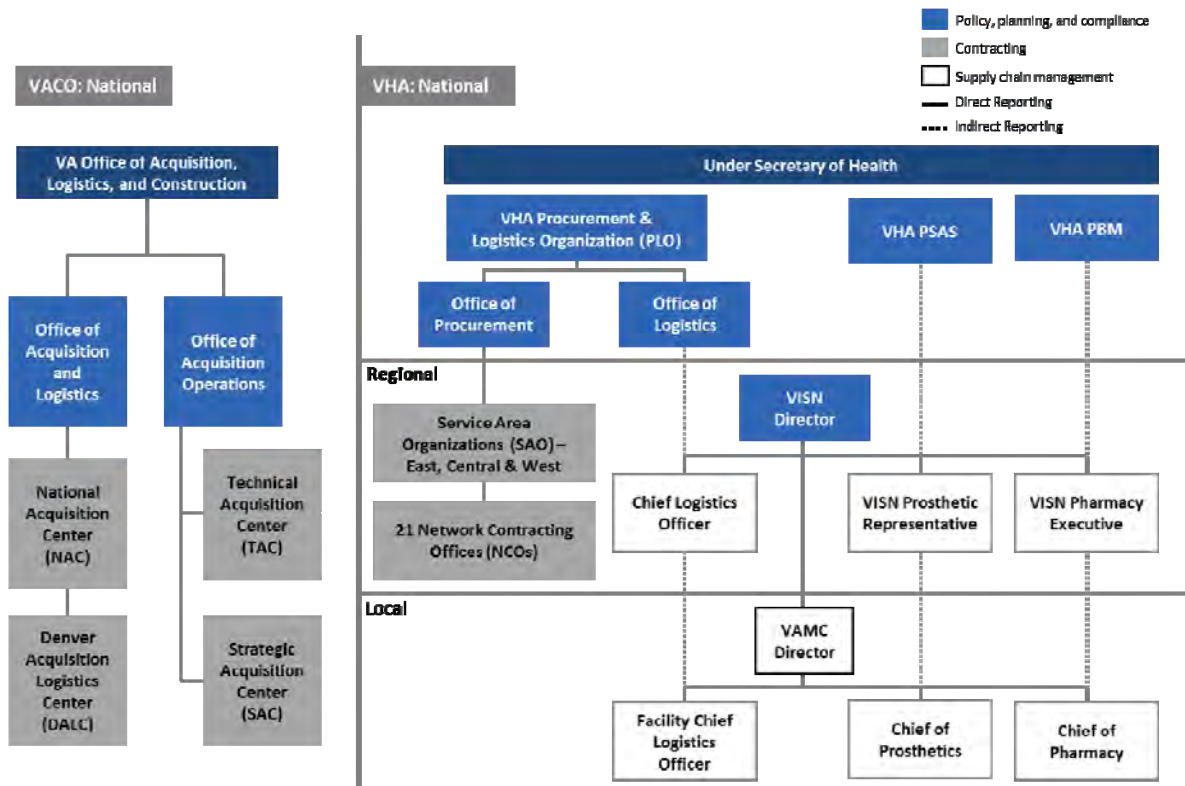
²⁸⁵ Ibid., 96-97.

²⁸⁶ Ibid., 47-50.

²⁸⁷ Ibid., 58.

²⁸⁸ Ibid.

²⁸⁹ Ibid., 55.

Figure 5. Organizations Comprising VA's Supply Chain²⁹⁰

Notes: Some VISNs may have different reporting relationships with facility prosthetics staff.

The separation of clinical supplies and prosthetics/medical devices causes issues in coordinating products needed for procedures. Frontline staff members indicate the time it takes to procure simple items through contracting (1 to 3 months) is problematic. For example, heart valve surgery may be delayed because some heart valves cost more than the micro-purchase threshold (\$3,000), thus the purchase must be made through the contracting process.²⁹¹ Medical center staff consistently expressed concern that VHA procurement offices are not responsive to the needs of a health care organization and do not communicate effectively with them,²⁹² findings borne out by low customer satisfaction scores given to these organizations.²⁹³

There is great overlap and redundancy in procurement and logistics functions in VA and VHA and the reporting structures are not aligned to ensure that the needs of veteran patients and their clinical providers are met. In an environment with limited sharing of best practices and a lack of transparent, open communications, the current complicated reporting structures impede customer-service quality and effectiveness. The original intent behind the current structure was to consolidate and strengthen purchasing power through the establishment of national contracts; however implementation of the vision has been poor and the result has been a

²⁹⁰ Ibid., 49.

²⁹¹ Ibid., 67.

²⁹² Ibid., 68.

²⁹³ Ibid., 69.

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complicated, bureaucratic system filled with redundancies.²⁹⁴ These broken processes serve as a precursor for catastrophic systems failures.²⁹⁵

There is an immediate need to consolidate and streamline procurement and logistics for medical and surgical supplies under one leader in VHA, the VHA chief supply chain officer (CSCO), who would be accountable for transforming VHA supply chain management. As identified under MyVA, medical and surgical supply chain management is the first priority but the rest of the supply chain needs to be addressed by the CSCO in a staged approach. The VERC or other experts in business process engineering must be engaged to create a vertically aligned organizational structure with clear delegated responsibilities at each level of the organization to create an efficient and responsive procurements and logistics process which the VHA CSCO would lead.

Clinical Engagement and Value Analysis

*In contrast to pharmaceuticals, usage of clinical supplies and medical devices is not strictly monitored or managed in VA. In general, physicians and nurses can choose whichever products they believe are best for patients and the supply chain organization's role is to make those items available.*²⁹⁶

VHA does not have a means to determine what supplies should be standardized or a feedback loop administrators and staff use to assess whether standards were being used when they did exist.²⁹⁷ As a result, limited product standardization has been achieved across VHA, despite VHA establishment of national standardization user groups in 2001 responsible for identifying items for standardization based on national procurement data.²⁹⁸ To date, national product standardization has been achieved in only a limited number of categories.²⁹⁹ Since 2011,

*VHA required that medical centers establish Clinical Product Review Committees (CPRCs) to: (i) review and approve the use of new clinical items and reusable medical equipment (RME) at each medical center; (ii) maintain a list of approved expendable clinical supplies and RME by establishing and maintaining a Medical/Surgical Supply Formulary; and (iii) ensure compliance with nationally standardized contracts and blanket purchase agreements. In all sites visited, CPRCs exist and meet regularly but reviews were generally formalities.*³⁰⁰

²⁹⁴ Ibid., 47-50.

²⁹⁵ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

²⁹⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 54, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁹⁷ Ibid., xii.

²⁹⁸ VHA Handbook 1761.1, Standardization of Supplies and Equipment Procedures, July 2003.

²⁹⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 81, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁰ Ibid., 82.

Under this 2011 policy, the establishment of VISN oversight committees was also required to provide accountability and feedback to the local committees, but these committees were apparently never established.³⁰¹

VHA, with the engagement of the Veterans Engineering Resource Center (VERC), is making progress on clinician alignment to accomplish value-based purchasing decisions for medical and surgical supplies. VERC has recently rolled out a national clinical product review committee (CPRC-E) e-portal to better organize this function. This portal provides a central system and standard processes for all new product requests and approvals to inform the procurement processes.³⁰²

In the area of medical and surgical supplies, clinician preference can drive variability in procurement and utilization. As has been done in VHA for pharmaceutical prescribing, a similar system to engage and align clinicians must be undertaken for medical devices and surgical supplies. VERC has started this process, but requires further funding and leadership support to fully implement a clinician-driven sourcing process. Current and future leaders of VA and VHA must ensure that VERC continues to receive the funding support and leadership engagement it needs to fully accomplish this transformation with support and direction from a VHA CSCO.

Information Technology, Data Standards, and Analytics

Information technology systems, data systems, and analytical capability for finance, inventory management, and purchasing impede VHA's ability to effectively manage its supply chain.³⁰³ VHA needs greater "end-to-end visibility into the operational and financial performance of their supply chain" and more effective means to accomplish supply chain budgeting, forecasting, inventory management and automation of at least some key supply chain functions.³⁰⁴

*VA lacks visibility into supplies and devices spending at the level of granularity usually seen in the private sector. For example, in the private sector, it is typically possible to measure clinical supply spend and utilization at the service, patient, or physician level. However, this is not possible in VHA because it does not capture such data. Therefore, supplies spend per case can only be calculated in aggregate, which is relatively meaningless and does not allow for fair comparison across hospitals, services, or physicians. This inhibits VA's ability to manage utilization and to understand fully the impact of product standardization efforts.*³⁰⁵

VERC is working to reduce the more than 130 versions of VistA in place across the country so that the same data sets can be tracked and reported.³⁰⁶ Funding was approved by OIT for the Future Transformation Tool (FTT) graphical user interface that will standardize product names

³⁰¹ Ibid., 54.

³⁰² Heather Woodward-Hagg, PhD, email to Commission on Care, March 17, 2016.

³⁰³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁴ Ibid.

³⁰⁵ Ibid., 60.

³⁰⁶ Ibid.

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and provide data integration across all of VHA. Point of Use Solution, a commercial off the shelf supply management software product, has been purchased to achieve better inventory and demand management control and has been deployed to 32 percent of facilities, as of April 2016.³⁰⁷

True sustainment of a clinician driven process cannot be achieved with fragmented information systems that do not communicate. Leaders at all levels of the organization are not able to effectively identify and manage procurement requirements or provide effective feedback to clinicians on utilization. Similarly, automated inventory control, ordering, billing, and payment cannot occur without a seamless information technology infrastructure. With a current IT system in which fiscal, supply chain, and clinical informatics systems do not interface, the hopes of moving to automated processes for supply ordering, equipment life cycle management, and vendor communications cannot be realized. A plan for the transformation of supply chain management, developed by a VHA CSCO with support from VERC, must be fully integrated with planning and procurement within OI&T and fully financed to accomplish these important goals.

Policy and Procedures

Ninety-eight percent of all clinical supplies are acquired using purchase cards³⁰⁸ and 75 percent of what VHA spends on clinical supplies is made through this purchase mechanism.³⁰⁹ This is not a surprise given that the standard contracting process can take anywhere from 150 to 180 days to complete,³¹⁰ yet use of purchase cards is inefficient as this mechanism does not take advantage of economies of scale and potential cost savings an organization the size of VHA can achieve through price negotiations and strategic sourcing.³¹¹ It can also be contrary to law, as use of purchase cards often necessitates orders be split to remain under the \$3,000 purchase card limit.³¹² An analysis of purchase records showed that 38 percent of supply orders were made through standing vendor contracts which is in stark contrast to the private sector benchmark of aiming to complete 80-90 percent of supply purchases from master contracts with negotiated price discounts.³¹³ Indeed, the private sector trend in health care has been for hospitals and health care systems to form alliances in “group purchasing organizations” to achieve the scale that VHA naturally enjoys.³¹⁴ Weaknesses in logistic management have been recognized in VHA for some time and still remain.³¹⁵ For instance, a review of logistics business

³⁰⁷ Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.

³⁰⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁹ Ibid., xii.

³¹⁰ Ibid., x.

³¹¹ U.S. Government Accountability Office, *Strategic Sourcing: Improved and Expanded Use Could Save Billions in Annual Procurement Costs*, accessed April 28, 2016, <http://www.gao.gov/assets/650/648644.pdf>.

³¹² U.S. Department of Veterans Affairs, Office of Inspector General, *Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System*, accessed April 28, 2016, <http://www.va.gov/oig/pubs/VAOIG-11-00826-261.pdf>.

³¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xii, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³¹⁴ Bob Kehoe, “Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness,” *Health Facility Management Magazine*, 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.

³¹⁵ U.S. Government Accountability Office, *Veteran’s Health Care: VHA Has Taken Steps to Address Deficiencies in Its Logistics Program, but Significant Concerns Remain*, accessed April 28, 2016, <http://www.gao.gov/assets/660/653886.pdf>.

practices at 17 VHA medical facilities in 2014 showed that none of the facilities achieved 100 percent compliance on the factors assessed, and the rate of noncompliance ranged from 53 to 88 percent, depending on the business metrics examined.³¹⁶

VA is inhibited by a failure to update its acquisition regulations to take advantage of modernization made in 2014 to the governmentwide regulations to promote simplified purchasing procedures.³¹⁷

VERC initiatives to improve VHA supply chain are intended to standardize business processes and address the great price variations for the purchasing of medical and surgical supplies. A national medical surgical prime vendor (MSPV) contract has been established. This development has several advantages to include (a) increased ability to leverage pricing negotiations; (b) standardized pricing; (c) elimination of redundant contract development, bidding, and selection; and (d) future ability to integrate with CPRC E-Portal.³¹⁸ VA has established a goal for 85 percent of all orders in FY 2016 be made under the prime vendor contract and has made 1,100 contracting officers available to meet demand against the contract.³¹⁹ As of April 2016, an estimated \$24.4 million in supply chain costs had already been avoided since January.³²⁰

The establishment of a new MSVP contract in April 2016, the assignment of 1,100 staff to support its use, and the expectation communicated to the field that 85 percent of all purchases be made from the contract are important steps in the right direction. For efficient ordering processes to take hold and be sustained across VHA, all of the policies and procedures from the bedside (or surgical suite) to the head contracting office must be reworked to align with the desired business outcomes. Reworking policies and procedures must occur together with appropriate training and communication at all levels of the organization. Each staff member involved in the procurement process must be held accountable for meeting the new requirements and expectations assigned to them. Updating the VA Acquisition Regulation (VAAR) is just one small piece of such a transformational change. The VERC or others with appropriate experience in aligning business processes within government should be assigned responsibility to finish developing and implementing plans for such a transformation under the direction of a VHA CSCO.

Contracting

Analysis of the *Independent Assessment Report* confirmed issues with the responsiveness of contracting. For example, at one facility, if a request was submitted to contracting that was incomplete or inaccurate, it took on average 21 to 39 days from the date of initial submission to

³¹⁶ U.S. Department of Veterans Affairs, *VA Supply Chain News*, Issue 13, Jan/Feb 2015.

³¹⁷ Jonathan Miller, Director of Logistics Operations, VHA Procurement & Logistics Office, phone call with Commission on Care, December 9, 2015.

³¹⁸ Heather Woodward-Hagg, PhD, Acting Director, Veterans Engineering Resource Center, phone call with Commission on Care, March 18, 2016.

³¹⁹ Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.

³²⁰ Ibid.

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receive the first response from contracting requesting, for example, additional information or paperwork.³²¹ This problem appears to be a widespread.

In another instance, interviews conducted as part of the independent assessment showed that VA vendor contracting processes to order equipment valued at less than \$3,000, for example, scalars for dentistry, can be confusing and lengthy, leading to shortages in equipment and delays in clinic as equipment is located. Delays in sterile processing were also indicated by providers as an issue pertaining to equipment availability.³²²

Communication with contracting is another substantial challenge within VHA. In surveys that assessed the effectiveness of VA's contracting organization, VHA employees' customers rated the communications received from contracting officials the lowest of all contracting dimensions that were evaluated.³²³ Several interviewees recommended that VA provide more clarity on the status of contracting requests to help them plan and schedule care.³²⁴

Individuals in contracting believed that VAMC staff members were responsible for some of the delays in the contracting process. They reported that requests submitted to them from VAMCs were often incomplete or unclear and that facilities were poor at forecasting demand for items, leading to unpredictable peaks in demand for contracting services that exceeded their capacity. The VHA Procurement and Logistics Organization (PLO) and facilities are seeking to address these challenges by placing contract liaisons in facilities to better support contracting officer representatives throughout the process.³²⁵

Contracting compliance analysis showed substantial opportunity for improvement. Analysis of purchase order data showed that 38 percent of purchases were made on a government contract, 27 percent were made at open-market prices, and 34 percent did not have a source type specified.³²⁶ Private-sector organizations typically aim to buy 80 to 90 percent of their clinical supplies and medical devices on some type of negotiated contract.³²⁷

Interviews and observations undertaken as part of the independent assessment revealed that there are two primary reasons for VHA's relatively high share of open-market purchasing. First, in contrast to pharmaceutical purchasing, VHA's supply purchasing systems are not integrated

³²¹ The consulting team based this on an IFCAP/eCMS transmission log received during a VAMC site visit (2015). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²² Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 91, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

³²³ The consulting team derived this from a VHA procurement metrics book. McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 69, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²⁴ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²⁵ Ibid.

³²⁶ Ibid., xii.

³²⁷ Ibid.

with contract or pricing catalogs. Therefore, the purchasing process relies on buyers (often clinical staff) to research whether an item is on contract and through which contract a purchase should be made. Because of that complexity, several buyers reported that they bypass this step and buy products through the channel that is most familiar and convenient, for example, by replicating previous orders to their usual supplier, despite changes that may have occurred (new contracts and pricing arrangements, for example). Second, VHA has limited ability to monitor and drive compliance with the contract hierarchy because the required data are not captured electronically. In fact, more than 60 percent of all clinical supply items do not have a contract number listed.³²⁸

VHA's fragmented inventory management systems and processes also create challenges. VHA's current inventory management does not have a feedback loop to link inventory to product use, contracting, ordering, and vice versa. This lacking information prevents optimal use of the MSPV contract program and creates missed opportunities to establish more effective volume-based national or regional contracts. It also leads to peaks and troughs in demand for contracting services, which can overwhelm contracting's capacity.³²⁹

There are pockets of good performance and innovation in VHA that could be replicated across its supply chain. The *Independent Assessment Report* notes that the Denver Acquisition and Logistics Center (DALC) is a bright spot within VHA's supply chain organization in its acquisition and distribution of select devices such as hearing aids to veterans. It has developed an integrated operating model that brings together clinicians, contracting, finance, logistics, and program management. That integrated team makes decisions around product and supplier selection based on a holistic view of what is best for veterans and for VHA.³³⁰

Talent Management

VHA is unable to hire good talent to manage its supply chain. In 2014, 20 to 30 percent of logistics positions were unfilled, and 20 percent of medical supply aide jobs were vacant.³³¹ The causes were identified as lengthy time-to-hire, nonexistent internal career progression ladders for these individuals, and inability to provide competitive pay due to position downgrades made by OPM under Title 5.³³² Examples of recent downgrades include supply technician, mail manager, administrative officer, and materials handler.³³³

*It is well known in the health care industry that there is a shortage of supply chain talent currently. The private sector organizations interviewed during this assessment stated that they are recruiting more highly trained individuals than they did in the past and, because of competition for talent, are paying them more than they used to. This may be contributing to VHA's recruitment and retention challenges.*³³⁴

In Recommendation #15, the application of the more than 60-year old standards and processes used in the Title 5 personnel system does not serve the needs of a modern health care delivery

³²⁸ Ibid.

³²⁹ Ibid.

³³⁰ Ibid., xiii.

³³¹ Ibid.

³³² Ibid.

³³³ Ibid., 87.

³³⁴ Ibid., 88.

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organization. Health care supply chain management is a recognized field of study and a valued component of leadership teams at the highest performing health care organizations. For VHA to compete for top leadership talent in this field and frontline staff, logistics and procurement personnel must be included in a new excepted personnel system for VHA under Title 38 (see Recommendation #15).

To address talent management issues, VERC has established a new VA Acquisition Academy (VAAA) Supply Chain Management School.

*The mission of the Supply Chain Management School is to provide best-in-class education, training, professional development, and certification of the VA supply chain workforce. VAAA's competency-based curriculum addresses general and technical skills, VA-specific functional areas, and core activities for VA logistics professionals. Emphasis is on translating theory, fundamentals, and concepts to practical application with realistic VA-based scenarios utilizing hands-on application of problem-solving skills.*³³⁵

The supply chain management school is organized under VAAA which has been recognized by external organizations to offer high quality training.³³⁶

Implementation

Legislative Changes

- Establish a new excepted personnel system under Title 38 to permit VHA to compete effectively with the private sector for personnel required to run a complex health care system, including staff to manage and operate a modern supply chain system.

VA Administrative Changes

- Establish an executive position for supply chain management, a VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- Transform policy and procedures for supply chain management in parallel with identification and procurement of new management software: new software should support the new processes and not the existing, poorly organized business processes and requirements.
- Establish a staged process for the transformation of all supply chain operations in VHA under the direction of a VHA CSCO, with support from VERC.
- Reconcile the VAAR with the Federal Acquisition Regulation (FAR) to ensure the VAAR aligns with recent updates to the FAR to permit streamlined acquisition processes.
- Provide consistent and standardized training to ensure those developing and administering contracts have updated information regarding FAR and VAAR

³³⁵ "Message from the Vice Chancellor," Veterans Affairs Acquisition Academy, accessed April 28, 2016, <http://www.acquisitionacademy.va.gov/schools/scm/message.asp>.

³³⁶ "VA Acquisition Academy Recognized as a 2016 Learning Elite Organization," U.S. Department of Veterans Affairs, accessed May 13, 2016, <http://www.acquisitionacademy.va.gov/rss/index.xml#20160413b>.

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regulations as well as a thorough understanding of their responsibilities under the new approach to supply chain management and how to carry out these duties.

Other Department and Agency Administrative Changes

- None required.

Governance, Leadership, and Workforce

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

Problem

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center (VAMC), and similar problems at multiple other VAMCs, had both direct and indirect causes. Weak governance was found to be among those indirect causes.³³⁷ As the authors of a root-cause analysis of the Phoenix scandal highlighted, “a governance gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed to the wait-time problems.³³⁸ The report authors observed, “Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors.”³³⁹ The governance limitations made evident in the Phoenix scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration’s expectations for short-term results,³⁴⁰ and VHA’s operating in a “dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act and be structured based on the key elements included in Table 5.
- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term to allow for continuity and to protect the CVCS from political transition. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

³³⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³³⁸ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.

³³⁹ Ibid.

³⁴⁰ Ibid.

competing demands”³⁴¹ offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

Background

VHA, as an agency within a cabinet department, is accountable to the secretary of Veterans Affairs (SECVA) and to the President. This framework, when it works well, can provide VHA access to, and support from, the President and White House staff. Like other executive branch agencies, VA and VHA undergo Office of Management and Budget (OMB) oversight; must win OMB approval of proposed rulemaking, budgets, IT development, and performance plans; and are also subject to governmentwide regulation of such areas as procurement, personnel, and property management. VHA health care and operations are subject to close congressional scrutiny.³⁴² VHA undergoes oversight from several independent bodies, including the internal Office of the Inspector General audits and external Government Accountability Office audits.

Within VA, VHA participates in the VA Executive Board (VAEB) and Senior Review Group, which are designated as the principal governance bodies of the department.³⁴³ VAEB serves as the department’s risk-governance board and determines VA’s strategic direction. VAEB oversees the department’s planning, programming, budgeting, and execution. Notwithstanding certain strengths inherent in this framework, VHA governance can be paralyzed by bureaucratic decision-making processes and competing stakeholder concerns.³⁴⁴

Among its principal recommendations, the *Independent Assessment Report* calls for “establishing a governance board to develop fundamental policy, define the strategic direction, insulate VHA leadership from direct political intervention, and ensure accountability for the achievement of established performance measures.”³⁴⁵

Analysis

In recent years, VHA leadership priorities and strategic direction have been unclear. Leaders have been consumed by crisis and by responding to congressional demands, creating a reactive, rather than proactive environment.³⁴⁶ Additionally, the leadership vision has lacked continuity.³⁴⁷ The SECVA and deputy secretary of Veterans Affairs may exercise oversight of

³⁴¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³⁴² “Legislation,” U.S. House of Representatives, House Committee on Veterans’ Affairs, accessed June 15, 2016, http://veterans.house.gov/legislation?type=hearing&tid=All&tid_1=All&page=3. Over the course of calendar year 2015, the House Veterans Affairs Committee and its subcommittees alone held 18 oversight hearings relating to the Veterans Health Administration, with VHA and/or VA officials testifying as often as three times in a month.

³⁴³ Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014).

³⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 26, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³⁴⁵ *Ibid.*, 23.

³⁴⁶ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 52-54.

³⁴⁷ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, vi-viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Linda Belton, former VHA VISN Director and Director of National Center for Organizational Development, written submission to the Commission on Care Staff, January 19, 2016.

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VHA and try to impose accountability, but incumbents do not necessarily have experience in federal health care administration or delivery.³⁴⁸ The SECVA has often lacked independent information and metrics on VHA performance, and the oversight, risk management, and compliance functions of VHA report to the undersecretary for health (USH) or to lower officials in VHA.³⁴⁹

Previous studies, dating back 20 years,³⁵⁰ have proposed fundamental change in VHA's governance and government structure, to include a proposal that it be restructured as a government corporation.³⁵¹ The earliest rationale for making VHA a government corporation was based on the view that the system needed a new service-delivery strategy,³⁵² and envisioned specific legislation to permit the corporation to operate more expansively under a wide range of reforms.³⁵³ Although the authors of the 1996 report presented a VHA government

³⁴⁸ Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Under Secretary of Health, 38 U.S.C. § 305. While statute requires the USH of VHA to be appointed “solely on the basis of demonstrated ability in the medical profession, in health-care administration and policy formulation, or in health-care fiscal management; and on the basis of substantial experience in connection with the programs of the Veterans Health Administration or programs of similar content and scope” there is no such selection criteria for the VA Secretary or VA Deputy Secretary. Of the eight men to hold the position of Secretary of Veterans Affairs, only one, James Peake would qualify to be USH (“United States Secretary of Veterans Affairs,” Wikipedia, accessed June 15, 2016, https://en.wikipedia.org/wiki/United_States_Secretary_of_Veterans_Affairs#List_of_Secretaries_of_Veterans_Affairs) and of the six men to hold the position of DEPSECVA, none would qualify to be USH.

³⁴⁹ Department of Veterans Affairs, *2014 Functional Organizational Manual v2.0: Description of Organization Structure, Missions, Functions, Tasks, and Authorities*, 57-58, accessed June 15, 2016, http://www.va.gov/ofcadmin/docs/va_functional_organization_manual_version_2.0a.pdf.

³⁵⁰ Veterans Benefits Improvement Act of 1994, Pub. L. No. 103-446, 108 Stat. 4645 (1994). In 1994, Congress in sec. 1104 of Public Law 103-446 called for an independent examination of the justifiability of establishing an alternative government structure to provide health care services for veterans, culminating in the 1996 report.

³⁵¹ Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. A government corporation has been described as “a government agency that is established by Congress to provide a market-oriented public service and to produce revenues that meet or approximate its expenditures.” Kevin R. Kosar, Congressional Research Service, *Federal Government Corporations: An Overview*, 2, accessed June 15, 2016, <https://fas.org/sgp/crs/misc/RL30365.pdf>. Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report* September 22, 2015. Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce*, accessed June 15, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>. Commission on the Future for America's Veterans, *Preparing for the Next Generation*, 3, accessed June 15, 2016, http://s3.amazonaws.com/siteninja/site-ninja1-com/1438121489/original/2014-05_Commission-Report-on-America-Veterans.pdf. That task force study, for example, called for an independent governance model and stated that “the operational structure of VHA does not lend itself to progress. Due to its size, governmental structure and geographic extension it does not readily foster innovation and faces challenges in addressing the politics of changing demographics and ancient facilities.” The study report states, “VHA provides excellence in care in spite of its operations/governance structure, not because of it.”

³⁵² Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. The strategy was premised in part on the view that VHA would be operating in a resource-constrained environment and lacked the resources it would need to invest in making significant changes.

³⁵³ Ibid. The 1996 report proposed such measures as providing VHA authority to seek additional revenue streams, to include billing and keeping funds from Medicare, Medicaid, and other government sources; authorizing it to invest nonappropriated funds; developing a trust fund for deposit of Medicare taxes by active-duty personnel; incorporating VHA as a Federal Employee Health Benefits Plan selection; allowing it to become part of health maintenance organization (HMO) networks and open HMO enrollment to veterans; changing appropriation law to create

corporation as a means of achieving specific objectives, those objectives were largely met (though ultimately not fully sustained) by reforms within existing government structures and processes set in place by former USH Kenneth W. Kizer.³⁵⁴

Nearly 20 years later, the report analyzing the root causes of delayed care at the Phoenix and other VA centers proposed creation of “governance mechanisms to bridge ‘Secretary suite’ leadership transitions and provide more stable strategy, oversight, and stewardship.”³⁵⁵ Explaining that “the study team feels that the complexity of this organization requires a more stable and professionalized governance model that more closely resembles the governance of large health care systems in the private sector,”³⁵⁶ the study authors proposed the creation of a board-of-directors-type oversight board to set the strategy for the organization, define priorities, provide operational oversight, and review budget requests. “The board would . . . create a body that would be the steward of the organizational vision, providing institutional memory and continuity as senior political appointees transition.”³⁵⁷

Frequent turnover of the USH is a critical problem. Recently, each USH has served for only a relatively short period, leaving office with a change in administration or sooner. This pattern has deprived VHA of vitally needed sustained leadership and has likely contributed to short-term decision making. VHA history shows a connection between longer tenure and transformative accomplishment.³⁵⁸ As testimony to the Commission from three former USHs would indicate, brevity of tenure tends to limit leaders’ strategic horizon and create a pattern of leadership discontinuity. Because transformative change can only be realized through many years of focused leadership, VHA and those who depend on it cannot afford the senior leadership turnover routinely associated with a change in administration.

The complex, sustainable transformation VHA needs will take years to implement. To succeed, VHA needs strong, consistent leadership and a governance framework that can assure effective development and execution of transformation plans over time. The current governance structure emphasizes operational, rather than strategic priorities; experience has shown it to be incapable of sustaining transformational change. Establishing a well-designed, overarching-governance model would provide an opportunity to achieve objectives shared by both the executive and legislative branches.

To be effective, a VHA Care System governance model should be empowered with a governing board that exercises fiduciary-like responsibilities (not subject to the Federal Advisory Committee Act) to carry out the following key functions:

multiyear/no-year appropriations; reforming human resources management practices for increased flexibility in hiring and firing, compensation, leave, and other functions; and reforming; and reforming procurement and contracting.

³⁵⁴ Ibid., 46, 48. The Klemm report saw a VHA corporation as having greater capacity to focus on strategic as well as short term goals; greater results orientation; greater flexibility; greater capacity to replicate and develop best practices; upgraded staff competence and expertise at senior levels; and greater political independence.

³⁵⁵ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 59.

³⁵⁶ Ibid.

³⁵⁷ Ibid.

³⁵⁸ See Dr. William S. Middleton, Chief Medical Director (1955-1963) and Dr. Kenneth W. Kizer, Under Secretary for Health (1994-1999).

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- select the chief of VHA Care System (CVCS) and recommend the appointment of the CVCS to the President
- provide long-term, strategic direction for VHA Care System and establish priorities, milestones, and timelines
- oversee, direct, and make critical decisions regarding the transformation process
- review and approve major operational, business, and organizational plans
- set VHA Care System performance objectives and provide annual reports to Congress and the President on VHA Care System performance
- review and make decisions regarding VHA's budget request, and independently assess and report to Congress on the adequacy of VHA budgets

New governance and changes to assure continuity of leadership are critical to meeting the needs of VHA and veterans who depend on it. At the core of this foundational recommendation, the Commission calls for establishing a VHA board of directors,³⁵⁹ referred to as the VHA Care System governing board, which is independent of department leadership to provide governance, strategic direction, decision making, and oversight of VHA Care System's operations and transformation. Table 5 provides details regarding the governing board.

Table 5. Overview of VHA Care System Governing Board

Detailed Outline for VHA Care System Governing Board	
Voting Members	The President, the majority leader of the Senate, speaker of the House, the minority leaders of the Senate and House would each appoint two members. In addition, the SECVA would serve on the Board as a voting member.
Qualifications	Members would be selected to achieve collectively broad experience, expertise, and leadership, such as experience in senior management of large, private, integrated health care systems; clinical expertise; extensive experience with federal government health care systems; extensive experience with (though not current employment in) VHA; expertise in federal medical facility construction and leasing, and commercial property transactions; expertise in government contracting; expertise in federal health care budgeting and finance; expertise in health equity and disparities; and veterans' representation. Because of the importance of veterans' representation, at least one of each congressional leader's two appointees would be a veteran; at least one of the appointees of the President would be a veteran who receives VHA care.

³⁵⁹ Michael A. Froomkin, "Reinventing the Government Corporation," *University of Illinois Law Review*, (1995): 543, accessed June 15, 2016, <http://osaka.law.miami.edu/~froomkin/articles/reinvent.htm>. Congress need not create a government corporation to meet VHA's governance needs. The Commission notes that Congress has created entities it has called government corporations that are not predominantly commercial enterprises, rely on appropriations, and do not have the potential to become self-sustaining. A principal intention behind assigning this status and title has been to provide insulation from central management oversight agencies and the application of general management laws. When the corporation relies in whole or in part on appropriations, Congress retains the power of the purse, and the means of exercising it on matters large and small, and through formal and informal means.

Detailed Outline for VHA Care System Governing Board	
Terms	Governing board members would serve staggered terms of up to 7 years, with the governing board members electing a chair and vice chair from among the membership (other than the SECVA, who would not be eligible to serve as the chair) for 3-year terms.
Personnel Matters	Compensation would be at a rate equal to the daily equivalent of annual pay prescribed for level IV of the executive level. ³⁶⁰
Funding	Congress would provide a specific budget for the operation of the governing board as a separate account within VA's appropriations.
Relationship to the CVCS	Relationship to the CVCS: The governing board would provide the President its recommendation for a chief of VHA Care System (CVCS); the President would appoint that executive to a 5-year term; the governing board would annually review the CVCS's performance and be empowered to reappoint that official to a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. The CVCS can be removed by mutual agreement of the President and the governing board.
Staff	The chairperson would determine the size and compensation of the permanent staff of the board, including an executive director responsible for governing board operations and a chief of staff. The director of the proposed transformation office within VHA would report to the chairperson through the CVCS.
Powers	<p>The board would have the power to do the following:</p> <ul style="list-style-type: none"> ▪ Select the CVCS and recommend the candidate to the President. ▪ Review the performance of the CVCS on an annual basis. ▪ Reappoint the CVCS to a second 5-year term. ▪ Remove the CVCS with the mutual agreement of the President. ▪ Direct and exercise decision-making authority regarding the transformation process and operations related to the transformation process. ▪ Establish priorities, milestones, and timelines for the transition process. ▪ Review and approve major new initiatives; major operational and organizational plans (including plans regarding capital asset and facility management); strategic and business plans; and goals and metrics for operational performance and established priorities. ▪ Oversee and manage facility and capital asset strategies and operations. ▪ Review, approve, and/or amend VHA's budget requests, and independently assess and comment on pertinent elements of the President's budget, as deemed appropriate.
Reporting	The board would report annually to the President and Congress on VHA's progress toward transformation.

Navigating transformation of one of the largest agencies in the federal government requires not only extraordinary leadership, but steady, sustained, long-range-focused governance. A governing board structured to provide continuity of membership—as the Commission proposes through staggered terms among members—is vital. A second critical step toward assuring such continuity would be to address the tenure of the CVCS and the process for selecting candidates for that position.³⁶¹ VHA, Congress, and the President would be better served by a VHA leader who holds a 5-year term of office, with the governing board empowered to reappoint that leader to a second 5-year term.

³⁶⁰ The rate of compensation provided for members of the Commission on Care.

³⁶¹ Under Secretary of Health, 38 U.S.C. § 305. Current law provides that the Under Secretary is appointed by the President with the advice and consent of the Senate. When a vacancy in that position occurs or is anticipated, the Secretary is to convene a commission (the composition of which is set forth in the statute) which is to recommend at least three individuals to the Secretary, who is to forward those names, with any comments the Secretary considers appropriate, to the President.

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It is important that that the CVCS report to the board and function as a chief executive officer of VHA. Although the Commission envisions that the President would appoint this official, it is critical that the governing board be empowered to recommend to the President an individual for appointment when the office becomes vacant. This would replace the framework in current law that requires the establishment of a new commission convened solely to carry out the task of recommending candidates to the President.³⁶²

A governing board must be tailored to the unique needs of VHA.³⁶³ It should include members of appropriate expertise and experience to provide strategic guidance and continuity of leadership and it should possess authority to exercise the powers needed to realize and sustain a VHA transformation.³⁶⁴

Although some might consider Congress to be VA or VHA's board of directors and might question the appropriateness of establishing a VHA board of directors, this governance model does not diminish Congress's role. Instead, a board that would report periodically to congressional committees would provide a level of close oversight and health care expertise that would complement, and in many ways enhance, Congress's work.

A change in governance alone will not bring about successful transformation. This recommendation must be instituted in concert with many other Commission recommendations. For example, a board will require data, and data systems, to carry out its responsibilities, and establishing these and other appropriate systems, as addressed throughout this report, is key to empowering a board to drive and sustain transformation.

Implementation

Legislative Changes

- Amend 38 U.S.C., Chapter 3 to establish a VHA Care System governing board.
 - Amend 38 U.S.C. § 305 – which currently provides in subsection (a) for the President to appoint the USH by and with the advice and consent of the Senate, and subsection (c) for the establishment of a commission to provide recommendations for appointees for USH when a vacancy is expected or has occurred – as follows:
 - Amend subsection (a) to provide for the President to appoint the CVCS to a 5-year term of office.
 - Repeal subsection (c) of that section.
 - Provide instead for the governing board to recommend a CVSC candidate.
 - Authorize the governing board to reappoint the CVSC to a second 5-year term.

VA Administrative Changes

- None required.

³⁶² Under Secretary of Health, 38 U.S.C. § 305.

³⁶³ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 60.

³⁶⁴ The Board is not an advisory body, and as such would not be subject to the Federal Advisory Committee Act.

Other Departments and Agency Administrative Changes

- None required.

Leadership

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

Problem

High-performing organizations have healthy cultures in which diverse staff members feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government.³⁶⁵ For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

The Commission Recommends That . . .

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report to the chief of the VHA Care System and the new VHA Care System governing board (also included in Recommendation #12).

Background

Healthy organizations successfully align, execute, and renew themselves through learning and innovation.³⁶⁶ They are characterized by a high level of trust, accountability, and ownership among staff; high functioning, empowered teams; and an environment that provides psychological safety and open communication, focuses on the needs of customers, and instills pride in performance.³⁶⁷ An inclusive workplace where diversity is valued, staff feel empowered and supported, are treated with fairness, and cooperation and open communication helps engage employees and drive organizational performance.³⁶⁸ Engaged

³⁶⁵ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 56, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

³⁶⁶ "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, <http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage>.

³⁶⁷ [http://organizationalhealth.vssc.med.va.gov/Resource percent20Library/Forms/AllItems.aspx](http://organizationalhealth.vssc.med.va.gov/Resource%20Library/Forms/AllItems.aspx)

³⁶⁸ "Diversity & Inclusion; Federal Workforce At-A-Glance," U.S. Office of Personnel Management, accessed May 13, 2016, <https://www.opm.gov/policy-data-oversight/diversity-and-inclusion/federal-workforce-at-a-glance/>.

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employees who are dedicated to their work and attached to the organization and its mission support a healthy organization.³⁶⁹

Companies that have a healthy organizational culture or engaged staff outperform those that do not. Companies that score in the top 25 percent of organizational health metrics outperform comparable companies in the bottom 25 percent by more than two-fold.³⁷⁰ Similarly, high employee engagement is correlated with better staff and customer experiences that include higher patient satisfaction, higher staff retention, better safety and quality, higher productivity and lower absenteeism.³⁷¹ Companies with engaged employees outperform those without by more than 200 percent.³⁷² Leaders and supervisors play a key role in establishing and sustaining employee engagement and in establishing a positive environment and culture that supports a healthy organization.³⁷³

Analysis

VHA staff and leaders are highly dedicated to the mission of VA and to serving veterans.³⁷⁴ This dedication is arguably VHA's greatest strength, and it can be leveraged to create and sustain positive change.³⁷⁵ There are substantial impediments to moving VHA forward, however, as noted in the *Independent Assessment Report*. There is a pervasive lack of trust throughout the organization.³⁷⁶ Staff perceives VHA to be bureaucratic and political and to lack a systems orientation.³⁷⁷ Employees want to work for an organization that is accountable and efficient, but instead they operate in a bureaucratic, siloed, and political organization.³⁷⁸ The culture creates risk aversion in staff, and when cultural factors are measured in VHA, none of the metrics align with the definition of a healthy organization.³⁷⁹ Staff find the work environment at VA challenging, with no connection to leadership, and feel they receive little positive

³⁶⁹ U.S. Office of Personnel Management, *Strategic Plan FY2014-2018: Recruit, Retain, and Honor*, 22, accessed January 25, 2016, <https://www.opm.gov/about-us/budget-performance/strategic-plans/2014-2018-strategic-plan.pdf>. Office of Management and Budget, *Memorandum for Heads of Executive Departments and Agencies: Strengthening Employee Engagement and Organizational Performance*, M-15-04, December 23, 2014, accessed May 16, 2016, <https://www.whitehouse.gov/sites/default/files/omb/memoranda/2015/m-15-04.pdf>.

³⁷⁰ "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, <http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage>.

³⁷¹ U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015, 4. Melissa Bottrell, *Ethics Quality Helps Build Healthy Organizations*, VHA Organizational Health, Volume 19, Summer 2013, 4-5, accessed January 25, 2016, http://www.ethics.va.gov/docs/integratedethics/art_bottrell_orghealth_v19_2013.pdf.

³⁷² U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015, 4. Dee Ramsel, *Improving VHA's Culture: A Presentation Before the National Leadership Council*, Veterans Health Administration, December 2015, 7-9. U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change*, 6, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.

³⁷³ Dee Ramsel, "Improving VHA's Culture. A Presentation Before the National Leadership Council, Veterans Health Administration," December 2015, 7-9.

³⁷⁴ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 43, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

³⁷⁵ *Ibid.*, 44.

³⁷⁶ *Ibid.*, 47.

³⁷⁷ *Ibid.*, 46.

³⁷⁸ *Ibid.*, 46.

³⁷⁹ *Ibid.*, 49-51.

reinforcement or clear feedback on performance.³⁸⁰ As demonstrated in the Federal Employee Viewpoint Survey for 2015, VHA staff does not believe top leaders lead (only 47 percent positive³⁸¹) and only 65 percent have a positive view of their immediate supervisor compared to 70 percent in other large federal agencies.³⁸²

Through the review of available documents and briefings from key staff, the Commission found VA and VHA have a number of activities intended to support a positive environment and culture in VHA (see Table 6), but the efforts are not systematic, integrated, or broadly deployed.³⁸³ The efforts are under-resourced to achieve success. Specifically, the effort lacks mandatory positions at the facilities to lead these efforts and has no requirements on the VHA Central Office (VHACO) program offices to participate in the efforts.³⁸⁴ At the same time, the efforts are duplicative in that multiple offices communicate similar, but distinct messages to field staff and leaders. VHA appears to lack systematic mechanisms to ensure leaders at all levels of the organization have the knowledge, skills, and ability to create an effective culture; metrics are not comprehensive or aligned with a single-change model; and leaders in VHACO and the field are not consistently held accountable for their actions in support of a positive organizational culture.³⁸⁵

*Table 6. Cultural Transformation Efforts in VA and VHA*³⁸⁶

Program/Initiative	Responsible Office
Servant Leadership	VHA National Center for Organizational Development
Leaders Developing Leaders	MyVA
Just Culture	VHA National Center for Patient Safety
Civility, Respect, and Engagement in the Workplace (CREW)	VHA National Center for Organizational Development
Organizational Transformation Pilot	MyVA
Employee Engagement Playbooks	MyVA
VHA Voices	VHA Office of Patient Centered Care and Cultural Transformation

³⁸⁰ Ibid., 53 and 60.

³⁸¹ U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change*, 47, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.

³⁸² Ibid.

³⁸³ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 29-31. Dee Ramsel, Virginia Ashby Sharpe, Veterans Health Administration, conference call with staff of the Commission on Care, November 9, 2015.

³⁸⁴ See “Ethical Leadership, Fostering an Ethical Environment and Culture,” National Center for Ethics in Health Care, U.S. Department of Veterans Affairs, accessed June 22, 2016, <http://www.ethics.va.gov/integratedethics/elc.asp>. “Stop the Line for Patient Safety Initiative,” U.S. Department of Veterans Affairs, accessed June 22, 2016, <http://www.qualityandsafety.va.gov/StoptheLine/StoptheLine.asp>. “VHA Center for Organizational Development,” U.S. Department of Veterans Affairs, accessed from VA Intranet, May 16, 2016, http://vaww.va.gov/NCOD/Organizational_Health.asp. U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015.

³⁸⁵ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 13-14. Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan, Network Director and Medical Center Director*, November 20, 2015.

³⁸⁶ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 29-31.

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VHA must rebuild a high-performing, healthy culture by cultivating greater employee collaboration, ownership, and accountability to accomplish its mission.³⁸⁷ This cultural transformation needs to occur at all levels of the organization (VA, VHACO, veterans integrated service network [VISN], VA medical center, and community-based outpatient clinic). To achieve transformation in VHA, create a healthy environment and culture, and sustain staff engagement, the solution must start with leaders. Leaders must understand and believe in the powerful effect they have on the climate and culture in their organization. Change occurs one employee at a time. Leaders at all levels must commit to this change process. They must be inspired by top executives and embrace the values and mission of VHA and then, in turn, inspire their teams, engaging with individual employees to make change. Leaders must be given the roadmap and tools to make such change and then be supported with training, coaching, and feedback to achieve success. They must also be held accountable for their personal behavior and for the actions they take to positively influence the environment and culture of their unit or facility. Leaders should not be on their own in this transformation. Fellow leaders, outside experts, national program offices, and VA and VHA top executives must provide them with incentives, support, feedback, coaching, and, when needed, admonishment to support this cultural transformation.

To align leaders at all levels with expectations for the cultural transformation, all leaders must understand the role they play in the process. VHA must create standards for the behavior and actions leaders adopt to accomplish the transformation and widely publicize the standards among leaders and staff to establish uniform expectations across the organization and a single vision of cultural transformation. The CVCS and other senior leaders must model and reinforce these behaviors to further embed expectations. These behaviors and actions should be integrated into leadership assessment tools such as a 360 evaluation, performance management frameworks, and coaching guides to ensure expected behaviors and actions are reinforced across the leadership development and advancement system. The strategy must include the development of tools, training, guidelines, and operating procedures that create a living curriculum to support leaders in developing and deploying these new skills and behaviors. Finally, to ensure leaders at all levels implement the behaviors and actions, the strategy must establish both explicit rewards and sanctions. The rewards and recognition (nonmonetary) should liberally acknowledge and publicize leaders and staff who embody the very best standards of behaviors and actions that support a positive organizational culture. At the same time, leaders and staff at all levels must clearly understand what behavior and actions are not acceptable and be held accountable through disciplinary action if they cross these boundaries. Expectations and repercussions should be clearly articulated.

VA and VHA have a number of competing models of organizational health and staff engagement. The models are not integrated with one another or with an overall leadership competency model. Some models are robust, coupling abundant resources and training, while others are not. To create a clear focus for engagement and organizational health and guide

³⁸⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 55 accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

transformation effectively, one model must be selected for use in VHA. To do so, VHA must establish a cross functional executive team to make this decision. The team should include all of the stakeholder offices involved in current efforts, but none of them should lead the effort, to avoid parochial interests driving decisions. Once a single model is selected, the executive team must then outline a clear strategy, involving and engaging the offices in VHA with relevant expertise and resources to support the execution, and put forward a single strategic plan. Consequently, each of those offices must also be required to stand down its own efforts that are not part of this new model going forward and align its work and budget behind a single focused model and strategy. Tools, training, and communication to support broad deployment must be part of the strategy, and the CVCS and the executive team must present a compelling, transparent rationale for what the model is, why it was selected, and how it is to be deployed. All leaders and staff members in the organization must understand their roles in cultural transformation and what is expected of them.

The strategy must establish and articulate a clear set of behaviors and actions expected of staff to ensure their alignment around the transformation. The standards should be incorporated into the hiring process to ensure that VHA is hiring into the new culture and avoids a poor fit from the start. These behavioral expectations must be articulated clearly in the on-boarding process and reinforced on an ongoing basis in performance evaluations, reviews, and individual development plans. Leaders at all levels of the organization must also reinforce these behavioral expectations with staff and be provided with tools, messages, and communication support to accomplish this. Leaders must also recognize and reward the positive examples of the desired behaviors and sanction the worst examples, up to and including discipline and removal.

The change strategy should also recognize that cultural transformation and staff engagement go beyond individual leader and staff behaviors. Systems and processes at both the local and national level can impede the realization of the positive organizational culture desired. As such, the transformation strategy must also anticipate changing systems and processes as an explicit component of transformation. Leaders at all levels must establish mechanisms to elicit staff concerns and have quality improvement tools in place to address them, such as LEAN Six Sigma. Line staff must be engaged as part of the solution to these system issues. Leaders should be transparent about these issues and publicly track and report on progress.

To ensure the effective execution of this strategy, specific responsibilities must be assigned to program offices. The program offices must also support the VISN and facilities in their transformation effort by developing the standards and guidance for them to use and making program office expertise available to support coordination, coaching, and sharing of best practices across the institution. The program offices must be held accountable for supporting the application of these same standards and process within VHACO.

Standards for facility implementation must include a funded, full-time equivalent employee to support each major facility director³⁸⁸ and be the point person to coordinate efforts with VHACO and other facilities. Facilities may take the opportunity to consolidate related functions that currently exist in the facility. Each facility must have a local mechanism, such as an organizational health council, to integrate and drive transformation locally. But this does not

³⁸⁸ This equates to one person at each of the approximately 141 VHA health care systems led by a facility director.

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mean the facility should create yet another committee or oversight group to accomplish the transformation. Instead, facilities must look to existing leadership structures and activities, consolidating similar efforts to create an efficient process.

Finally, the executive team must oversee the development of a consolidated and meaningful set of metrics, using community standards where available, to track cultural transformation, organizational health and staff engagement. The metrics should not only measure the desired outcomes but also provide insights to leaders on how to fix problems by providing sufficient detail and specificity to offer this insight. Once deployed, the metrics should be used by the executive team and responsible program offices to identify under-performing facilities and to provide additional expertise, resources, and support to help those facilities improve. If, after much support, the continuing behavior and actions of the leaders at the under-performing facility are identified as the cause of the long-term culture problem, these individuals must be removed from leadership positions in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Develop and implement a strategy for cultural transformation.
- Establish a cross-functional senior executive team reporting directly to the CVCS with long-term responsibility for creating, executing, and tracking the cultural transformation.
- Align frontline staff in support of the cultural transformation strategy.
- Require standards and a strategy for execution of the cultural transformation from every program office and facility and these efforts must be fully funded.
- Develop consolidated, meaningful metrics for organizational health and staff engagements with input from experts and field users.

Other Department and Agency Administrative Changes

- None required.

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

Problem

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an Office of Management and Budget management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Background

*Our Corps does two things for America: We make Marines and we win our nation's battles. Our ability to successfully accomplish the latter depends upon how well we do the former.*³⁸⁹

Effective leaders are required for organizational success. Thus, attracting, growing, and advancing leaders is a key business imperative across all sectors.³⁹⁰ The most urgent human capital management need worldwide, according to one survey, is the development of leadership talent.³⁹¹ This need is driven by a changing workforce that is motivated more by passion than by monetary incentives, a rapid advance in knowledge that quickly creates obsolescence, and technology drivers that change business practices over months instead of years.³⁹² Investing in new supervisors and emerging leaders is critically important because

³⁸⁹ U.S. Marine Corps, *Sustaining the Transformation*, Foreword, accessed June 9, 2016, [http://www.marines.mil/Portals/59/Publications/MCRP percent206-11D percent20Sustaining percent20the percent20Transformation.pdf](http://www.marines.mil/Portals/59/Publications/MCRP%20206-11D%20Sustaining%20the%20Transformation.pdf).

³⁹⁰ Jim Collins, *Good to Great: Why Some Companies Make the Leap . . . And Others Don't* (New York, NY: HarperCollins Publishers, Inc., 2001), 17-40. Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015).

³⁹¹ Deloitte Consulting LLP and Bersin by Deloitte, *Global Human Capital Trends 2014: Engaging the 21st Century Workforce*, 25, accessed June 10, 2016, http://dupress.com/wp-content/uploads/2014/04/GlobalHumanCapitalTrends_2014.pdf.

³⁹² *Ibid.*, 3.

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employees report that when they quit a job they leave their supervisors and not their organization.³⁹³ In an organization like VHA, with more than 300,000 employees but only a bit more than 200 executives, VHA's 28,000 supervisors are responsible for leading the staff.³⁹⁴

Going back to at least 1998, the federal civilian sector has had difficulty identifying and promoting individuals with leadership skills.³⁹⁵ Staff members who can produce results and meet organizational objectives are promoted into supervisory and leadership positions.³⁹⁶ Yet, the skills needed to be a successful leader are different than those needed to be a successful technical expert. Today, soft skills such as empathy, effective listening, and team coaching are valued in leaders.³⁹⁷ The most effective leaders are those who consistently display integrity, high moral character, and the ability to inspire others.³⁹⁸ An effective leadership system develops leaders at all levels, from frontline supervisor to executives, and does so in all dimensions of leadership: "knowing, doing, and being."³⁹⁹

Analysis

In a review of VHA's approach to leadership development, the *Independent Assessment Report* noted the current system was not sufficient to meet VHA's need for high-quality, prepared leaders.⁴⁰⁰ VHA lacks a comprehensive approach to leadership development that would include formal structured programs such as networking, reflection, goal setting, learning, mentoring, experiential learning, and a clear career ladder. As a result, leaders are unable to fully prepare

³⁹³ "People Leave Managers, Not Companies," Victor Lipman, accessed June 10, 2016, <http://www.forbes.com/sites/#/sites/victorlipman/2015/08/04/people-leave-managers-not-companies/#78b15df216f3>.

³⁹⁴ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 21-23, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

³⁹⁵ U.S. Merit Systems Protection Board, Office of Policy and Evaluation Perspectives, *Federal Supervisors and Strategic Human Resources Management*, accessed June 10, 2016, <http://www.mspb.gov/netsearch/viewdocs.aspx?docnumber=280538&version=280868&application=ACROBAT>.

³⁹⁶ Ibid. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

³⁹⁷ Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. "Creating and Retaining Great Leaders," Dominique Jones, accessed June 10, 2016, <http://www.hrreview.co.uk/analysis/analysis-hr-news/dominique-jones-creating-and-retaining-great-leaders/60419>. "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, <http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success>.

³⁹⁸ Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015). "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, <http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success>. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

³⁹⁹ Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. U.S. Marine Corps, *Sustaining the Transformation*, accessed June 9, 2016, [http://www.marines.mil/Portals/59/Publications/MCRP percent206-11D percent20Sustaining percent20the percent20Transformation.pdf](http://www.marines.mil/Portals/59/Publications/MCRP%20percent206-11D%20Sustaining%20the%20Transformation.pdf).

⁴⁰⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

for future roles.⁴⁰¹ Although VHA does have some components of a development program, the activities are not connected to a career path and not well coordinated. Comprehensive development efforts are impeded by the use of multiple competing competency models in VA that make it impossible to align assessment and development with a cohesive standard. Emerging leaders are left to navigate career progression largely on their own and may be stymied because development opportunities are cancelled due to budget restrictions. Even when promising young leaders complete the current activities, gaps remain in their experience and training because the training programs are not coordinated.⁴⁰² As a result, VHA does not have a robust pipeline of young leaders ready to take on higher-level responsibilities.⁴⁰³

Included in the *Independent Assessment Report* is a recommendation that VA stabilize, grow, and empower leaders. This recommendation includes suggestions to fill current vacancies with high-quality leaders, improve the attractiveness of the roles, ensure leaders are prepared to assume their roles, and create a comprehensive strategy that connects top performers to leadership opportunities and development plans.

There is little concrete information in the assessment to suggest how VA and VHA should accomplish these objectives. The commission examined VA's and VHA's current work to assess whether they have created plans to operationalize the leadership development recommendations articulated in the *Independent Assessment Report*.

Neither VA nor VHA has rationalized the multiple competency models within the department. A competency model is the core driver informing recruitment, development, assessment, and advancement in any comprehensive approach to leadership development and management.⁴⁰⁴ Having a cogent competency model is a prerequisite to a coherent strategy.⁴⁰⁵ Leading a health care organization requires specialized knowledge and skills not required of leaders in other fields.⁴⁰⁶ Thus, any competency model applied in VHA must include health care specific components. Health care executive competencies embrace such topics as an understanding of ethics in health care, management of self-governing professionals (e.g., physicians, nurses), the technical knowledge of health care regulation and operational management, and leading change, in addition to other leadership skills and knowledge.⁴⁰⁷

The current models used in VHA do not reference external benchmarks, and they are not health care specific. VHA plans to continue to use the High Performance Development Model (HPDM) as its competency model.⁴⁰⁸ HPDM was developed by VHA and is not benchmarked to private-sector competency models for health care executives. VHA plans to use the model to drive

⁴⁰¹ Ibid.

⁴⁰² Ibid., 38.

⁴⁰³ Ibid., 37.

⁴⁰⁴ The American College of Healthcare Executives, *ACHE Healthcare Executive: 2016 Competencies Assessment Tool*, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf.

⁴⁰⁵ Ibid.

⁴⁰⁶ Ibid.

⁴⁰⁷ Ibid. "Joint Medical Executive Skills," Joint Medical Executive Skills Program, U.S. Department of Defense, accessed May 16, 2016, http://www.au.af.mil/au/awc/awcgate/leadership/med_exec_skills.htm. "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁰⁸ "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

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position requirements, performance management, and training content.⁴⁰⁹ The plan mentions coordination with VA Learning University but provides no detail.⁴¹⁰ The plan also does not provide specific information about how the use of HPDM will link to formal recruitment, performance assessment, and advancement of leaders.⁴¹¹

VHA is working to understand the current career progression of candidates who move into field-based executive positions. VHA field leaders are cultivated from within VHA with about 98 percent advancing from lower-level field positions such as associate director, service chief, or chief of staff.⁴¹² As a result, field senior executives often lack outside experience and first-hand knowledge of alternative management methods.⁴¹³ Most companies look for a mix of internal and external hires, and the circumstances of the organization often drive the mix.⁴¹⁴ For instance, Henry Ford Health System, a successful growing company with a robust internal leadership development program has set a target of 70 percent internal promotions and 30 percent external hires.⁴¹⁵

The VHA pool of internal candidates is also deficient in racial and ethnic diversity with striking under-representation of women of color in all of the positions that constitute the pipeline for medical center director positions (see Figures 6 and 7).⁴¹⁶ VHA leadership development programs have failed to effectively recruit and advance under-represented minorities with a striking over-representation of White men in the leadership class that feeds the senior executive service (see Table 7).⁴¹⁷ Minority women shoulder the biggest burden of formal mentoring within the organization.⁴¹⁸ VHA also has the lowest representation of veterans among its staff (31 percent) compared to Veterans Benefit Administration (52 percent) and National Cemetery Administration (74 percent). The number of veterans among doctors and dentists in VHA is only about 14 percent of the employees.⁴¹⁹ Among leaders, 22 percent of senior executives are veterans and a similar number (23.8 percent) populate the leadership pipeline.⁴²⁰

⁴⁰⁹ Ibid.

⁴¹⁰ Ibid.

⁴¹¹ Ibid.

⁴¹² Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A*, November 23, 2015.

⁴¹³ Ibid.

⁴¹⁴ Eric Krell, "Staffing Management: Look Outside or Seek Within?" *HR Magazine*, January/February 2015.

⁴¹⁵ "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

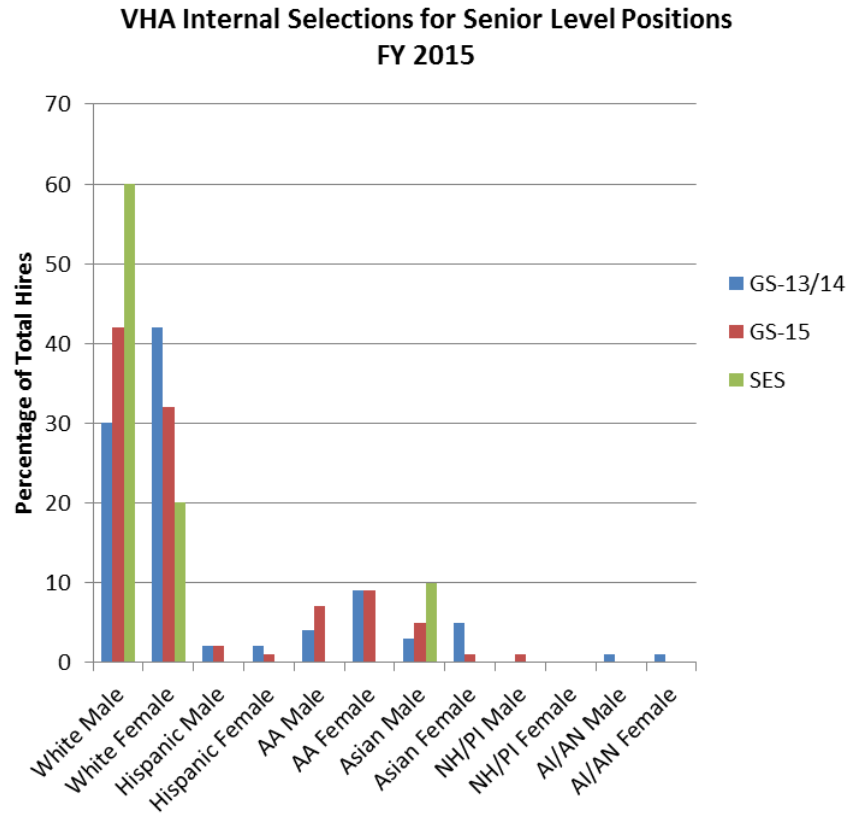
⁴¹⁶ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

⁴¹⁷ Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A*, November 23, 2015.

⁴¹⁸ Ibid.

⁴¹⁹ Health Care Talent Management Office from PAID and NOA, September 17, 2015: Path to Medical Center Director, Healthcare Leadership Talent Institute.

⁴²⁰ VHA Health Care Talent Management Office, provided to Commission on Care for employees in VHA as of September 30, 2015 by request, March 8, 2016.

Figure 6. Diversity of Senior-Level Hires in VHA

AA = African American

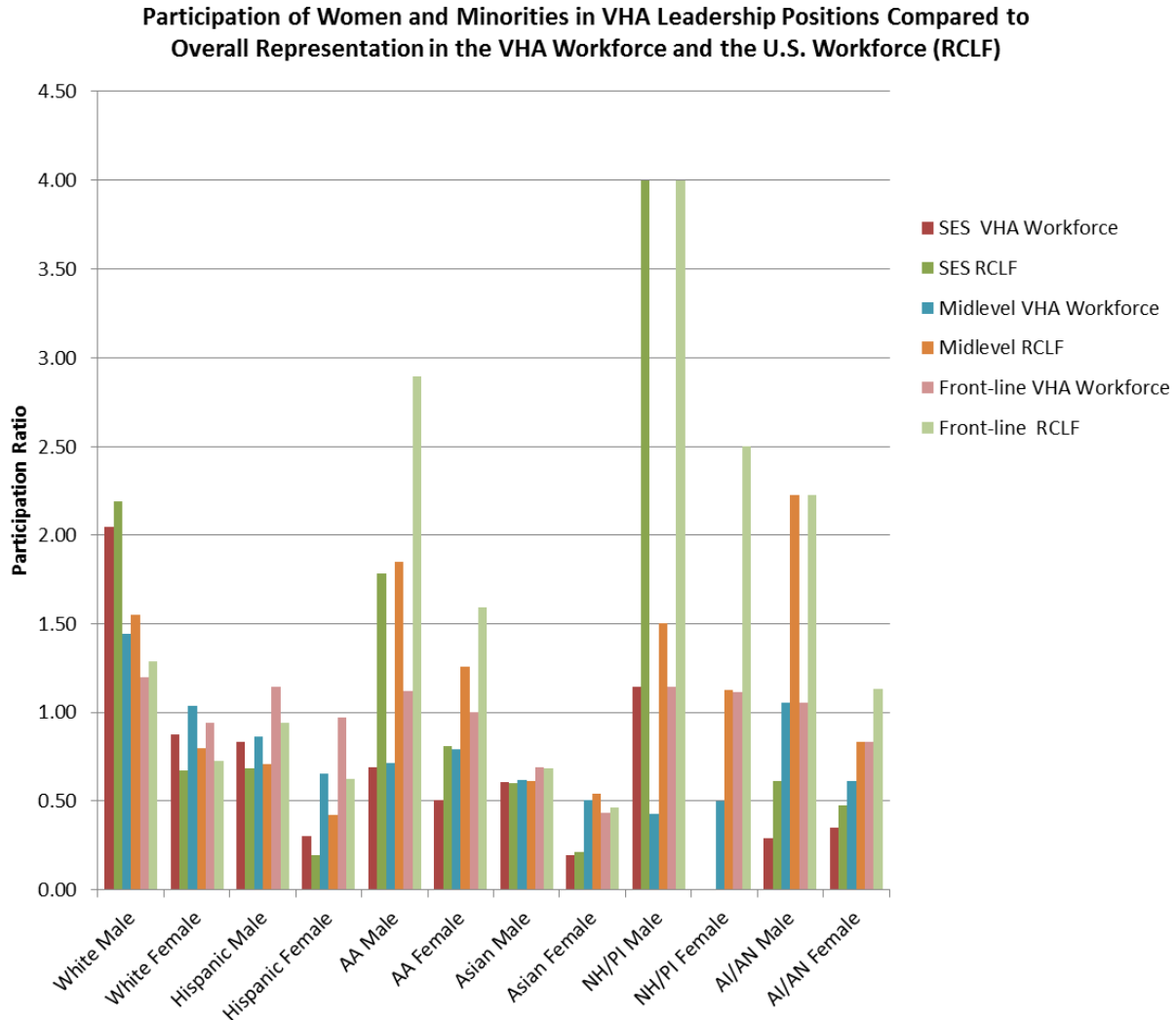
NH/PI = Native Hawaiian/Pacific Islander

AI/AN = American Indian/Alaska Native

Note: In FY 2015, VHA failed to select many candidates from diverse racial and ethnic backgrounds for senior executive positions. These data were drawn from the VHA annual equal employment opportunity (EEO) report.

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Figure 7. Minority Women are Under Represented in Higher-Level Positions in VHA



AA = African American

NH/PI = Native Hawaiian/Pacific Islander

AI/AN = American Indian/Alaska Native

Note: Women and particularly minority women are under-represented in comparison to their participation in the U.S. workforce (relevant civilian labor force [RCLF]) and their participation in the VHA workforce at higher levels in the organization. Some minority men are also under-represented in high-level positions. These data were derived from the VHA annual EEO report.

Table 7. White Males are Over Represented in VHA SES Development Program, HCLDP

	TCF 2015 (N)	GHATP 2014 (N)	Facility LEAD 2015 (N)	VISN/CO LEAD 2015 (N)	HCLDP 2015 (N)	VHA Workforce
White Male	35% (78)	30% (14)	19% (160)	22% (69)	41% (151)	23%
White Female	16% (35)	28% (13)	41% (342)	41% (127)	39% (144)	36%
African American Male	15% (33)	9% (4)	8% (66)	8% (24)	4% (14)	9%
African American Female	19% (42)	15% (7)	22% (180)	16% (50)	6% (23)	15%
Hispanic/Latino Male	4% (10)	4% (2)	3% (23)	4% (11)	1% (5)	3%
Hispanic/Latina Female	3% (7)	2% (1)	3% (29)	3% (10)	1% (4)	4%
Asian Male	4% (9)	2% (1)	1% (9)	>1% (2)	2% (7)	3%
Asian Female	2% (5)	9% (4)	2% (16)	4% (13)	3% (12)	5%
Native Hawaiian/Pacific Islander Male	0% (0)	0% (0)	>1% (3)	0% (0)	0% (0)	>1%
Native Hawaiian/Pacific Islander Female	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	>1%
American Indian/Alaska Native Male	2% (4)	0% (0)	>1% (1)	>1% (2)	1% (3)	1%
American Indian/Alaska Native Female	0% (0)	0% (0)	1% (7)	1% (4)	1% (3)	1%

Note: VHA offers career development opportunities from entry-level programs (TCF and GHATP) to an SES preparatory curriculum (HCLDP). Overall, White men make up about 23% of VHA employees but are over-represented in the HCLDP program at 41%. African American and Hispanic men and women are under-represented in the same program.

TCF= Technical Career Field; GHATP=Graduate Healthcare Administration Training Program; LEAD=Leadership, Effectiveness, Accountability, and Development; HCLDP=Health Care Leadership Development Program.

No evidence was presented to indicate that career progression mapping is occurring for positions within VHA central office, where high-quality leaders are also required.⁴²¹

⁴²¹ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

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VHA has much work to do to produce an effective leadership management system. Recruitment, retention, development and advancement are key processes that require immediate and sustained attention from VHA leaders. Without substantial changes, high-potential staff will continue to struggle to understand their career trajectory. Without a driving competency model and coordinated training to guide advancement, hiring decisions will continue to be made without uniform standards against which to measure applicants and new executive hires will continue to struggle to understand VHA and their role in leading it. Without the committed engagement and support of the chief of VHA Care System (CVCS) and the other top VHA executives for the leadership management system and their direct communications about and modeling of the leadership competencies, VHA will continue to flounder. As a result, veterans will be denied the high-performing health system they deserve.

Executive Commitment

The long-term success of any enterprise rests on having excellent leaders in key positions and sustaining them over time. To accomplish this goal, leadership management, development, and recruitment must be a core responsibility and a priority for VHA senior executives. To start, VA must include the goal of achieving an effective leadership management system in VHA as a component of the department's management agenda in the annual budget. The goal is a robust, high-quality, diverse leadership team in VHA. VA needs to establish a credible operational plan and accountability mechanisms for meeting this goal. Executive leaders are then held accountable for attaining the leadership management goals, including personally investing time in meeting diversity targets, recruitment plans, and succession planning objectives. These targets are to be reviewed in the individual performance of top leaders as well as in the Office of Management and Budget's ongoing review of the department's management objectives. Executive leaders need to also set and communicate clear expectations for the behavior of leaders and staff and to invest their own time in mentoring, coaching, and developing subordinate leaders and promising staff, including under-represented populations. They must be visible and role-model leadership competencies in meetings, training, and new-hire orientations. They must take an interest in developing leaders and help create opportunities for them to gain leadership experience and competencies. The CVCS and senior executives must keep in mind that their sole role is not to manage crises or to oversee a process or to manage up. Rather, their primary role is to lead their people. Their time and attention must reflect that priority.

Leadership Model

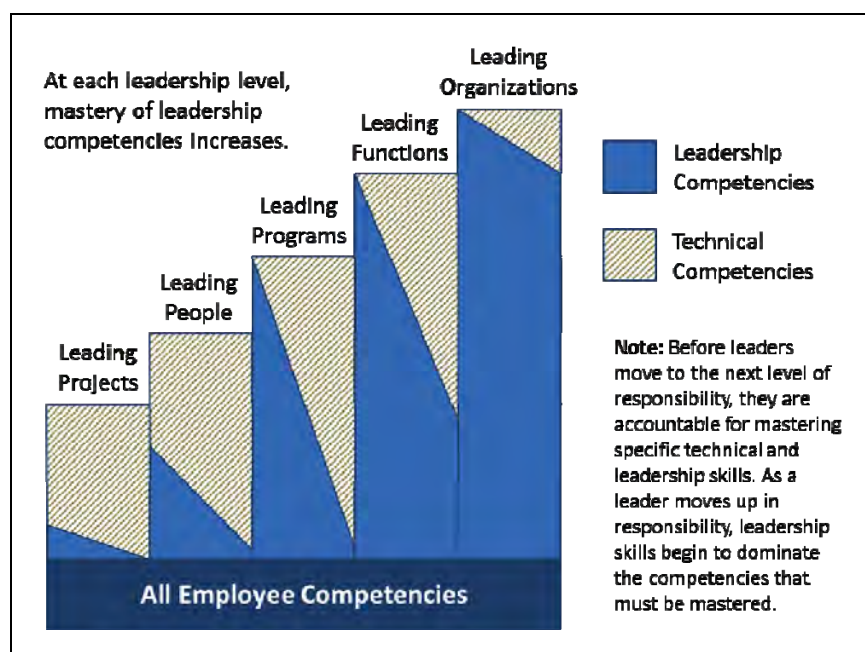
To establish clear leadership standards to guide hiring, development, and the advancement of leaders, VHA needs to adopt one benchmarked health care competency model. Currently, VHA is subject to the Office of Personnel Management executive core qualifications, HPDM, and standards for servant leadership. Although all of the models have value, none provide a clear trajectory for high-potential staff to follow, and they do not provide opportunities for VHA to intersect with leaders in the private sector. VHA must stop using these varied competency models and instead adopt a single model that is benchmarked to private-sector standards. The Commission is not making a recommendation about which model VHA should choose. Rather VHA should apply the criteria below to select a model around which to base its leadership development program:

- The standard must embrace leading through ethics and values, demonstrating character and concern for others, and creating a strong organizational culture.
- The standard must be health care based and describe the knowledge, skills, ability, and leadership bearing and behaviors that health care leaders must master to be effective.
- The standard must be a robust competency model including aligned training and tools to permit quick implementation.
- The model must describe different career tracks and the mastery requirements for key points in each career track. Key career tracks such as VISN director, facility director, and VHA Central Office (VHACO) program executive should fit into the competency model.
- A career path must specify the competencies that require mastery before moving to a higher position.
- VHA may need to enhance the model with competencies in care and services to Veterans and knowledge of military occupational health.

Training and Assessment

VHA needs to develop assessment tools based on the competency model, including 360, 180, self-assessment, and supervisory review processes. Leaders and developing leaders should be required to use at least one of the assessments each year and to apply the results to identifying their training and development needs. Findings from the assessments should be rolled into an individual development plan (IDP) for each leader or developing leader and enrollment in a leadership course should require a documented need from one of these assessments.

Figure 8. At Each Leadership Level, Mastery of Leadership Competencies Increases



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Training must be mapped against the competency model career track. All current leadership training should be mapped against the model. Gaps should be identified and filled with commercially available, or where needed, internally developed training. This training should include leadership competencies for the care of veterans, including an understanding of military occupational health, combat injuries and exposure, combat readjustments, and military sexual trauma. (See Appendix H for descriptions of such training material.) VHA should look for opportunities to partner with Department of Defense and the private sector to provide joint training and development opportunities to fill some of the identified gaps. VHA must develop one or more face-to-face training series that allow high-potential candidates to complete all the competencies required to move to the next career stage. As VHA strengthens its partnership with community providers and health systems, executive and high-potential training resources from VHA should be made available to community health care leaders and VHA should join training offered by these private-sector partners.

Based on the benchmarked competency model, VHA should collaborate with Academic Affiliates to establish two new programs. The first is to create opportunities for VHA physicians to gain masters-level training in health care management to prepare them to lead a medical facility. Second, VHA should work to create rotations in VHA for external physicians who are completing graduate health care management programs. Like academic affiliate residency training programs, VHA should collaborate with academic medicine to establish, fund, and run these programs with the goal that all participants rotate in management positions in VHA or VHA-partnered private-sector systems for six or more months during their training. Graduates of such programs would be candidates for recruitment into the VHA leadership pipeline and would encumber a pay-back commitment to VHA for any direct funding provided.

All training should include formal assessment to assure that learners have mastered the material and this mastery should be noted in their IDPs and training record.

As part of the leadership development model, experiential learning opportunities and formal coaching are critical to executive learning. Individual and group coaching standards and programs must be established for all developing and new leaders. A program for senior leaders to pair them with private-sector health care leaders must also be supported. VHA must establish rotation opportunities for developing leaders to rotate for substantial periods (e.g., 3 to 18 months) in not-for-profit hospital systems. This program could be structured as a certificate program that the employee and VHA jointly fund and include a payback commitment on the part of the trainee. Similar rotations from the private sector into VHA should be developed with health care system partners to help develop private-sector competencies in care for veterans and inject private-sector approaches into VHA.

Apply the Leadership Model

VHA is required to apply the competency model in all hiring decisions for executive career field positions. Thus all functional statements must be based on the model, all interview protocols must incorporate the competencies, and all candidates who are not internally certified to the standard of the job must undergo an assessment by a board to ensure they meet the position requirements. Conversely, internal candidates must be required to demonstrate mastery of the competencies before qualifying to apply for a position. VHA must adopt the strategies of executive recruiters to identify and recruit needed experts outside of government with the

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competencies VHA seeks. Recruiters can look to the pipelines the Commission has recommended building to bring military treatment facility commanders and other senior leaders and private sector experts into VHA as a network for identifying additional recruits. Executive recruiters can particularly help ensure diverse candidates are identified for open positions.

VHA will require competency assessments and IDPs for all existing executives, potential executives, and new hires. Current leaders and new hires who have an identified gap in any competency must have it included in their IDP and be required to fill these deficiencies by a specific deadline or face demotion or dismissal. Completion of IDP development opportunities is required for advancement in grade or promotion to higher position within the leadership pipeline.

VHA will aggressively manage its leadership candidate pool by identifying and tracking all high-potential individuals. Diversity statistics should be tracked and diversity in this pool actively managed. This pool of candidates derives from annual ratings as well as leadership development program graduates. Supervisors and executive leaders must provide ongoing coaching for higher positions to this pool of developing leaders. VHA must identify anticipated succession needs and offer development opportunities that would help prepare candidates for these anticipated openings. Once the positions are open, individuals in the high-potential pool must receive notices of new job postings and detail opportunities that provide experience into higher positions. Candidates who agree to be in this pool should be required to enter into formal mentoring relationships with leaders outside their chain of command to further advance their career development. For highest-level positions (VISN director, facility director, VHACO chief officer) a formal pool of approved or precertified candidates should be established.

To expand the perspectives and management experience in its leadership pipeline, VHA must develop explicit strategies to on-ramp diverse candidates at critical midcareer transition points. This process includes creating pathways for retiring commanders and other senior officers of military treatment facilities to compete effectively for leadership positions in VHA. To increase VHA understanding of private-sector health care, VHA must develop midcareer entry points for private-sector candidates. This could be accomplished through the use of temporary hiring authority and the ability to convert these positions to permanent staff positions if leadership competencies standards have been met by the candidates. Such opportunities can be modeled on efforts recently announced by DoD and, wherever practicable, should be developed collaboratively with DoD to establish the legal and policy requirements for implementing these programs. Finally, the current graduate health administration training program (GHATP) program should be expanded to include more schools and programs with diverse trainees. This expansion must allow high-performing residents to continue to convert to full time positions.

On-boarding

A formal on-boarding process should be instituted for all new executive hires. In addition to the transactional knowledge the individual will need, on boarding should establish the expectations for what it means for that executive to be successful in VHA. The values of the organization and the expectations for ethical practice must be conveyed by the CVCS and the top leadership team. A formal assessment of knowledge and skills should be made during on-boarding and an IDP established to cover the probationary period of new hires if any deficiencies are identified.

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Completion of the IDP is required for continued employment. All new leadership hires should be assigned a coach based on their individual needs. Within their first 6 months of employment, the undersecretary for health and Secretary should meet with these new executives to build a relationship with them and hear their fresh perspectives on the performance of VHA.

Stabilize Leadership

VHA should immediately stabilize its leadership ranks by authorizing VA medical center and veterans integrated services network (VISN) director details to last up to a year with no restrictions on an acting leader competing for the permanent position. VHA should also create flexible capacity by creating more assistant-level positions (e.g., assistant director, assistant VISN chief medical officer, assistant nurse executive, deputy chief officer). These individuals would comprise the pool of potential leaders and also allow for cross filling positions that are empty due to development assignments, training, or other leadership development opportunities.

Implementation

Legislative Changes

- Establish direct-hire authority from the graduate health care administration training program, military treatment facility, and private-sector fellow pools, clarifying application of merit-system principles, including approaches to managing veterans' preference in these programs.
- Establish Intergovernmental Personnel Act authority for VHA to include the for-profit private sector; this could be done as a pilot program with a report to Congress before considering whether to make the authority permanent.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.
- Aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: All hires and promotions are required to demonstrate these competencies.
- Require a formal on-boarding process for HPDM 3 and 4 leaders at all levels that reinforces the leadership competency model.
- Take immediate steps to stabilize the continuity of leadership by extending the length of authorized details to extend the continuity of leadership at medical centers and allow leaders detailed to a position to compete for a permanent appointment to the position by removing the non-compete requirements.

COMMISSION RECOMMENDATIONS

- Establish the competency model in regulation and include requirements for its use in hiring, promotion and dismissal and clarify the application of veterans' preference in executive development.

Other Department and Agency Administrative Changes

- None required.

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Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Problem

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and their functions overlap or are duplicative. The role of the Veterans Integrated Service Network (VISN) is not clear, and the delegated responsibilities of the medical center director are not defined.

Background

A prerequisite of a successful, high-performing system is having strong leaders and a strong leadership system.⁴²² An organization's leadership system is "the way leadership is exercised, formally and informally, throughout the organization; the basis for key decisions and the way they are made, communicated, and carried out."⁴²³ It includes "structures and mechanisms for making decisions; ensuring two-way communication; selecting and developing leaders and managers; and reinforcing values, ethical behavior, directions, and performance expectations."⁴²⁴ In an organization the size of VHA, with a budget of \$69 billion,⁴²⁵ more than 300,000 employees, and more than 1,000 sites of care,⁴²⁶ strong leadership systems are essential.

The Commission Recommends That . . .

- VHA redesign VHA Central Office (VHACO) to create high-performing support functions that serve Veterans Integrated Service Networks (VISNs) and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the chief of VHA Care System with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report (also included in Recommendation #10).

⁴²² Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 50.

James Collins, *Good to Great: Why Some Companies Make the Leap and Others Don't*, (New York, NY: HarperCollins, 2001), 17-64.

⁴²³ Ibid.

⁴²⁴ Ibid.

⁴²⁵ Department of Veterans Affairs, *VA 2017 Budget Request: Fast Facts*, accessed March 10, 2016, <http://www.va.gov/budget/docs/summary/FY2017-FastFactsVAsBudgetHighlights.pdf>.

⁴²⁶ "About VHA," Department of Veterans Affairs, accessed February 5, 2016, <http://www.va.gov/health/aboutVHA.asp>.

In the last successful reorganization of VHA in 1995,⁴²⁷ the organizational design and functional roles of the leadership system were organized into clear structures with clear functions. The VISNs were responsible for operations⁴²⁸ and VHACO program offices were responsible for policy, guidelines, and outcomes.⁴²⁹ The National Leadership Board (made up of VISN directors and all program office leaders) was responsible for collective, fact-based decision making and the Friday Hotline call was used to communicate leadership priorities and decisions directly to VA medical center (VAMC) leadership. A negotiated performance measurement system based on consistent, benchmarked, outcome-focused metrics⁴³⁰ was also established that was supported by centralized functions that benefit from economies of scale.⁴³¹ As part of the reorganization, VHA experienced a reduction in staff and consolidation of VHACO offices to create a flat, agile leadership system.⁴³² Because this functional matrix was not sustained, VHA now faces the challenge of reinstituting an effective leadership system.

Analysis

Twenty years after the Kizer reorganization, VHA has a very different leadership system, under which it “is intensely, unnecessarily complex due to a lack of clear operating model, limited role clarity, fragmentation of authority, and overlapping responsibilities.”⁴³³ The *Independent Assessment Report* included the following findings about the VHA operating model:⁴³⁴

- VHACO has grown rapidly since 2009 from 753 in FY 2009 to 1,990 in FY 2014.
- The VISNs’ ability to manage and support their regions is heavily hampered by resourcing restrictions and direct VHACO control over VAMC operations.
- The VAMCs’ operating model suffers from powerful silos, which prevent an effective end-to-end mission focus.
- VA’s increasingly top-down management style, coupled with poor prioritization and the external political environment, result in a lack of clarity around strategic direction, reactivity to external headwinds, and flawed efforts to standardize.

VHACO has grown rapidly in the past few years.⁴³⁵ The growth in central office was driven in part by new ideas, new priorities, and new crises being addressed through the creation of new

⁴²⁷ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco, CA: Berrett-Koehler Publishers, Inc., 2012), 54.

⁴²⁸ Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 35. Kizer, Kenneth W and Ashish Jha, “Restoring Trust in VA Health Care,” *New England Journal of Medicine*, 371, (2014): 295-297.

⁴²⁹ Ibid.

⁴³⁰ Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 61-72.

⁴³¹ Ibid., 33.

⁴³² Ibid., 60. Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation of the Veterans Healthcare System*, Objective 3 and 17, 1996.

⁴³³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 95, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁴³⁴ Ibid.

⁴³⁵ Ibid., 98.

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offices and new staff infrastructure to support it.⁴³⁶ A portion of the growth came from the centralization of functions that were previously managed in the field such as business office functions. The final component has come from the duplication in VHA of offices in which decision-making authority rests with VA, such as communications and regulatory management. VHA has also duplicated functions and responsibilities between two or more offices in VHA, such as primary care, surgery, mental health, and geriatrics and extended care. This increased growth in staff and offices has resulted in more complex and lengthy decision processes, often with little clarity as to whom ultimate responsibility for decisions or follow up falls.⁴³⁷

One symptom of the top-down management is VHACO control of budgeting and resource management. “Support funding is outside local control” and the “increasing share of Specific Purpose funding hinders” local leaders in their ability to use resources effectively.⁴³⁸ In FY 2015, specific-purpose funds were spread across more than 450 line items,⁴³⁹ taking money away from general purpose funding and restricting how this money can be used. Both VHACO and Congress have been complicit in taking control away from medical center directors through these budget controls.⁴⁴⁰ For instance, the congressional appropriation to fund VHA for 1998 included only five appropriation line items; medical care, medical administration, construction major, construction minor, and medical and prosthetic research.⁴⁴¹ In contrast, the budget request to Congress for FY 2016 included 12 budget categories relevant to VHA with some of those accounts having four or five subcategories.⁴⁴² In his testimony before the Commission and Congress, Secretary McDonald made the point that such fragmentation of the VHA budget and the prohibition to reallocate across budget categories without first receiving Congressional approval was an impediment to effective and agile management of the department.⁴⁴³ Greater Congressional control of VHA spending is understandable in light of VA’s lack of adequate management systems and data analytic capabilities to track expenditures in real time⁴⁴⁴ and report them to Congress and central office. The only means available to hold the medical centers

⁴³⁶ Ibid., 96-99.

⁴³⁷ Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health*, (Washington, DC, Veterans Health Administration, February 2015), 7-9.

⁴³⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership)*, 102, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴³⁹ Ibid., 107.

⁴⁴⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership)*, 102-108, accessed June 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴⁴¹ PL 105-65, October 27, 1997.

⁴⁴² Department of Veterans Affairs Fiscal Year 2016 Budget Submission, Volume II Medical Programs and Information Technology, Accessed June 10, 2016, <http://www.va.gov/budget/products.asp>.

⁴⁴³ On January 21, 2016, Secretary of Veterans Affairs, Robert A. McDonald, provided the following testimony before the U.S. Senate Committee on Veteran’s Affairs “Flexible Budget Authority: We need flexible budget authority to avoid artificial restrictions that impede our delivery of care and benefits to Veterans. Currently, there are over 70 line items in VA’s budget that dedicate funds to a specific purpose without adequate flexibility to provide the best service to Veterans. These include limitations within the same general areas, such as health care funds that cannot be spent on health care needs and funding that can be used for only one type of Care in the Community program, but not others. These restrictions limit the ability of VA to deliver Veterans with care and benefits based on demand, rather than specific funding lines.” accessed June 10, 2016,

<http://www.veterans.senate.gov/imo/media/doc/VA%20Sec%20Testimony%2001.21.2016.pdf>

⁴⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 105, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

accountable was to fund the priority initiatives as separate budget lines or indicate allocations to be made under the specific-purpose process.

To fix the overly complex and bureaucratic structure of VHA, the *Independent Assessment Report* suggests that VHA “redesign (its) operating model to create clarity for decision-making authority, prioritization, and long-term support.”⁴⁴⁵ VHA must take a systems approach to reorient its leadership operations, restructuring and re-orienting VHACO program offices to ensure all of the following:⁴⁴⁶

- fact based, innovative decision making that is responsive to the field, other offices, and external stakeholder requirements
- feedback mechanisms to incorporate system learning into policy development and operational guidance
- communication mechanisms to effectively share information across offices and reach VISN and facilities to explain expectations and tie decisions to organizational values and goals
- effective execution of policy decisions through expert coaching, deployment of resources, and guidance based on external benchmarks and sharing of internal best practices
- analytic capability and infrastructure to effectively monitor progress and outcomes of all organizational priorities

Such a reorientation will involve a different skill set and expertise than currently required in VHACO. Transformation will call for recruiting new expertise, making advancement decisions based on these new competencies, reinforcing them through recognition and performance assessment, and developing new skills in current staff through training and coaching. This skill set includes a high level of technical expertise relevant to the program office; the ability to build relationships with external stakeholders; demonstrated skills in coaching, staff development, and training; certification in quality improvement methodologies; analytic capabilities to develop and track metrics; and the ability to lead transformational change. VHA must fully fund the retraining and the hiring of skilled staff in VHACO to accomplish this transformation.

For the VHACO program offices to work effectively with one another and with the field, the specific authority of each office must also be defined. Where overlap and confusion exists between offices, programs must be combined and streamlined or eliminated with a corresponding reduction in force. In changing the structure and orientation of VHACO program offices, VHA leadership can take the opportunity to align functions to achieve its stated priority of patient-centered care. In a fully aligned operating structure, business processes from the VAMC front line to central office must be organized to deliver important

⁴⁴⁵ Ibid., ix.

⁴⁴⁶ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 7, 34, and 50.

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patient outcomes rather than aligned in professional silos. For instance, instead of having an office of nursing, one for social work, and a lead for physician assistants, business offices should be aligned around the work they do together, like patient aligned care teams, to deliver positive outcomes for veterans.

The administrative operations of VHACO should also be flattened. Senior staff should be speaking directly to other senior staff to discuss and make decisions rather than relying on bureaucratic, paper-based processes as a means of negotiation: It is neither a healthy culture nor an efficient process. At the same time, VHACO needs to take full advantage of being a large-scale enterprise by centralizing functions such as acquisition package development, recruitment package development, and account reconciliation so that staff is not required in each program office to take on these occasional but complex activities. The net savings resulting from this reorganization and delayering of the bureaucracy must be reinvested in the transformation process.

VISNs must also examine the skills needed to take on an expanded role as facilitators, coaches, and guides in improving services and sharing best practices across facilities. VISNs are critical players in the feedback loop between service delivery and VHACO to identify ineffective processes, problems, and emerging issues that need to be raised to VHACO for help in clearing away barriers to effective operations. Similar to VHACO, VISNs must define the new skill set required by their staffs and establish these requirements in hiring, promotion, and performance evaluation as well as training and coaching staff to develop these competencies. Finally, the chief of VHA Care System (CVCS) should establish a required staffing ratio for the VISN office and reduce the staffing in VISNs that exceed this standard.

A new operating model also means that medical center directors must control the budget, staff, supplies, and infrastructure required to deliver needed health care. This model includes consolidation of budget lines and new authority and expanded authority to reallocate funds across the remaining budget categories. To manage the new VHA Care System and ensure that facility and network directors have the local control needed to make decisions about how to deliver services, fewer restrictions should be placed on the VHA budget. To start, specific-purpose funds must no longer be used to direct obligations at facilities. Congress should also work with the administration to reduce the number of budget lines and specific spending authorities back to a simpler system like that used in 1998. To support these changes and create transparency, medical centers should be accountable for their expenditure of funds by ensuring accurate, complete, and timely cost accounting. This last requirement, however, can only be met if it is supported by effective financial management data systems and fully trained staff and leadership who understand how to use such systems.

To support the leaders, program offices, and the field in this transformation, the CVCS must establish a transformation office that has appropriate expertise in business process reengineering and is fully funded to conduct this work. Existing offices with the requisite expertise, including the Office of Strategic Integration and the Veterans Engineering Resource Center (VERC), should be rolled into the transformation office. This office would oversee transformation and incubate new initiatives with the goal of incorporating them into regular work of other program offices once the new initiative is established. This mechanism, if used consistently, would prevent VHA from growing new offices as new priorities arise.

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Finally, as part of cultural change within the leadership system, the CVCS, VISN directors, and program office leaders must promote open and productive dialogue among themselves about problems and solutions. To accomplish this goal, leaders must address both the culture within the leadership ranks, as well as establish systems and processes that support identification and discussion of problems. The CVCS must model this behavior by inviting input on problems and rewarding leaders when they bring issues forward, including rewarding them with access to expertise, staff, and money; removing barriers; and aligning other leaders in support of solutions.

In its work to oversee change in VHA, the transformation office will create an implementation plan for transformation, identifying key strategies and milestones. This plan will drive data collection, development of strategic goals and supporting objectives to encourage effective planning, accountability, and the ability to unearth critical gaps that need to be addressed. The transformation office will require each new initiative to establish a project plan and provide periodic reports that include all of the following components: tactic/action, initiative owner, cost (i.e., operational, equipment, contracts), number of FTEs, start and completion dates, outcome measures, strategic drivers, and milestone.⁴⁴⁷ The President's Management Agenda Scorecard will serve as the evaluation model. The Office of Management and Budget created this tool to evaluate new initiatives and track progress on outcomes over time with regular spotlight reports (red, yellow, green) to leadership.⁴⁴⁸

Implementation

Legislative Changes

- Simplify the VHA budget to include fewer accounts while at the same time requiring more transparent and detailed accounting of VHA expenditures.

VA Administrative Changes

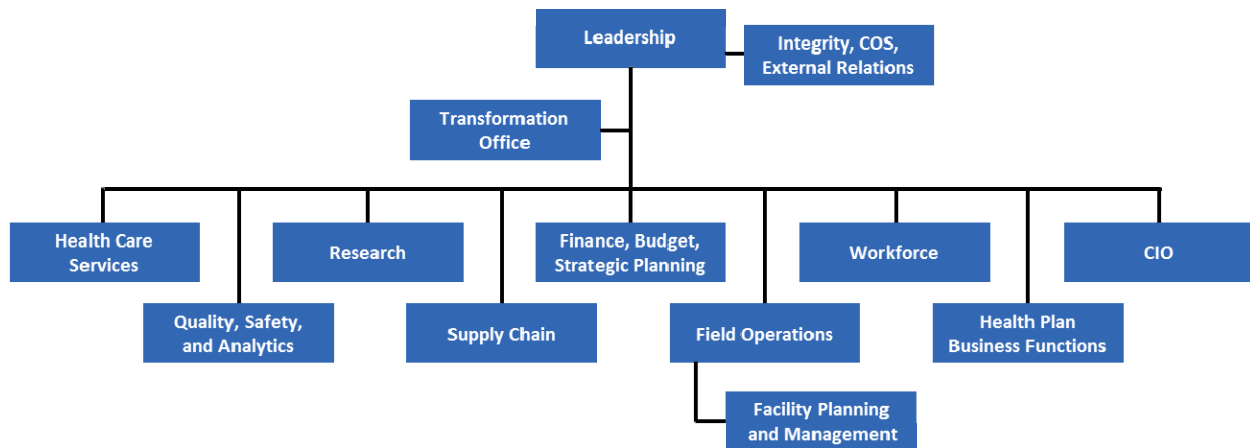
The following administrative changes are a priority during the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B. Responsibility for establishing a transformation plan with milestones, timelines, and evaluation of outcomes is assigned to the transformation office that the Commission recommends be established in VHA.

- Eliminate duplication within VHA and consolidate program offices to create a flat structure. Figure 9 is one model of an organizational chart for accomplishing this goal. This organizational chart shows how VHA can be streamlined to mirror the structure of large private-sector hospital systems. Figure 10 is the current VHA organizational chart, provided as a point of comparison and to emphasize the cumbersome nature of the current structure.

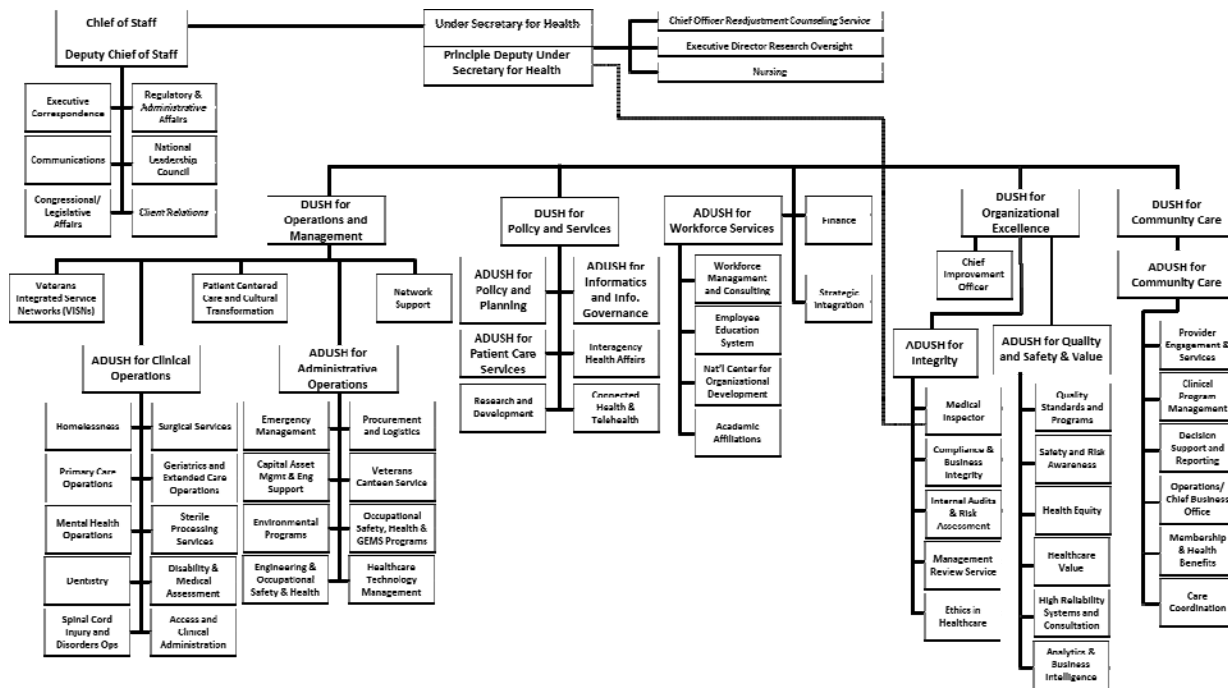
⁴⁴⁷ For example, see "VA Faith-based and Community Initiative President Management Agenda Scorecard," September 30, 2008,

⁴⁴⁸ "Office of Federal Financial Management President's Management Agenda," Office of Management and Budget, accessed June 15, 2016, https://www.whitehouse.gov/omb/financial_fia_pma/.

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Figure 9. Proposed VHA Organizational Chart⁴⁴⁹

Note: This organizational chart is an example of how to align VHA functions to create a flatter organization, remove duplication, and streamline decision making as discussed throughout this section of the report. Of note, the placement of the Transformation Office, CIO, and supply chain in this diagram is consistent with recommendations made by the Commission elsewhere in this report. In this chart, COS is chief of staff.

Figure 10. Current VHA Organizational Chart⁴⁵⁰

⁴⁴⁹ Modified from Appendix C, Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health*, (Washington, DC, Veterans Health Administration, February 2015), 41.

⁴⁵⁰ Ibid.

COMMISSION RECOMMENDATIONS

- Eliminate the duplication of functions between VHA and VA by closing VHA offices as needed.
- Create innovative organizational structures that are aligned to patient's needs rather than professional silos, to support clinical care.
- Undertake a reduction-in-force in VHACO that facilitates delayering and efficiency in communication and decision making.
- Establish a transformation office implementation plan to ensure effective and comprehensive implementation of the transformation across VHA. The transformation plan is to capture all of the transformation activities recommended in the Commission report, establish specific timelines and milestones for accomplishing each objective, and report on both progress and outcomes at least quarterly to VHA leadership and the governing board. Periodic evaluation of the effect of these change initiatives on internal and external stakeholders would also be appropriate.
- Clarify the roles and responsibilities of VISNs and facilities and implement a change strategy to orient staff and leaders to these new expectations. Establish effective leadership communication mechanisms to promote transparency, dialogue, and collaboration among VHACO offices and with the field.

Other Department and Agency Administrative Changes

- None required.

Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

Problem

To achieve the Commission's vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set, identical to private-sector standards, will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes for veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders' performance not just on *what* they achieve but *how* they achieve it.

Background

One of the criteria for performance excellence in health care is the measurement, analysis, and improvement of organizational performance.⁴⁵¹ Performance measurement is used to track daily operations, overall organizational performance, and progress in achieving organizational objectives and action plans. Performance measurement is also used to benchmark organizational performance against internal and external standards.

Organizational performance measurement is not the same as workforce performance management.⁴⁵² Workforce performance management is intended to reinforce intelligent risk taking, help focus the workforce on the needs of patients and other customers, and support

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Workforce and Leadership Performance Management System

- VHA create a new performance management system appropriate for health care leaders, tied to health care leadership competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

⁴⁵¹ Baldrige Performance Excellence Program, 2015-2016 *Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.

⁴⁵² *Ibid.*, 20.

health care delivery and the achievement of action plans.⁴⁵³ Although there is a relationship between organizational performance measurement and workforce performance management, they are not synonymous processes.

Workforce performance management is made up of much more than just clinical outcome measures. As noted by the American College of Healthcare Executives (ACHE), performance evaluations of hospital CEOs must also evaluate leadership traits such as judgment, communication, and diplomacy.⁴⁵⁴ Furthermore, ACHE emphasizes the inclusion of individual professional objectives in performance plans, such as promoting ethical behavior, supporting diversity and inclusion within the organization, or fostering effective medical staff relationships.⁴⁵⁵ ACHE and other leading practitioners⁴⁵⁶ emphasize that performance management is not a plan or an event, but rather a continuous, ongoing process and conversation among the leaders and their reviewers. A workforce performance management system must also make meaningful distinctions among individuals⁴⁵⁷ and promote high performance through rewards, recognition, and incentive practices.⁴⁵⁸ Ideally, when coupled with a leadership competency model and development program, workforce performance management should also help to identify high-performing potential leaders and provide guidance to the workforce on how to move up in the leadership ranks.⁴⁵⁹ As deployed in FY 2015 and evaluated by the *Independent Assessment Report*, VHA's performance management system failed to effectively achieve any of these objectives.⁴⁶⁰

Analysis

One of the findings in the *Independent Assessment Report* was that “hundreds of operational performance measures overwhelm leaders and this, combined with limited transparency and inconsistent data availability, makes it difficult to focus on what is most important.” More than 300 measures spanned everything from critical clinical metrics to political priorities introduced to address the most recent crisis. VHA reports that it was tracking approximately 500 measures,

⁴⁵³ Ibid.

⁴⁵⁴ “Policy Statement: Evaluating the Performance of Hospital or Health System CEO,” November 2013 (revised), American College of Healthcare Executives, accessed February 18, 2016, <https://www.ache.org/policy/ceo-perf.cfm>.

⁴⁵⁵ Ibid.

⁴⁵⁶ Ibid. NeuroLeadership Institute’s “Reengineering Performance Management: How Companies are Evolving Beyond Ratings” webinar, scheduled on January 14, 12-1.

⁴⁵⁷ “Implementing FCAT-M Performance Management Competencies: Differentiating Performance,” Office of Personnel Management, Performance Management: Performance Management Cycle, accessed June 10, 2016, <https://www.opm.gov/policy-data-oversight/performance-management/performance-management-cycle/developing/differentiating-performance/>.

⁴⁵⁸ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization’s Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.

⁴⁵⁹ Office of Personnel Management. Proficiency Levels for Leadership Competencies. <https://www.opm.gov/policy-data-oversight/proficiencylevelsforleadershipcompetencies/>. “Joint Medical Executive Skills Institute,” Health.mil: The official website of the Military Health System and the Defense Health Agency, accessed June 13, 2016, <https://www.jmesi.army.mil/documents.asp>, National Center for Healthcare Leadership. NCHL Healthcare Leadership Competency Model. <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁶⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 78-79, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

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including 156 related to access, 29 measuring employee engagement, 18 on high-performing networks, 250 best practice measures, and seven related to trust.⁴⁶¹

Distinct from performance measurement, the performance management process⁴⁶² is a cycle that begins with clear input from top leadership on the priorities of the organization, followed by clear targets, performance tracking, reviews, and rewards. The *Independent Assessment Report* noted that, “Individual performance management processes are hindered by targets inconsistent with the VHA mission, delayed implementation, lack of meaningful performance dialogue, and limited rewards.”⁴⁶³ Many of the same system flaws that impede effective organizational performance also impede individual success. Performance plans are released late in the performance cycle,⁴⁶⁴ metrics are hard to track in real time and lack the detail required for individual performance assessment,⁴⁶⁵ and few plans are written to support shared accountability and team-based solutions. In addition, participants observed that the current senior executive performance agreements and rating process (a) do not result in meaningful distinctions in performance between individuals, (b) do not drive meaningful conversations about individual performance, (c) and do not consistently focus on key health care metrics of quality, safety, patient experience, operational efficiency, finance, and human resources.⁴⁶⁶ The *Independent Assessment Report* notes that the rewards currently offered to employees do not motivate them to work toward exceptional performance.⁴⁶⁷

Information provided to the Commission indicates that VHA has taken action to address some of these findings. First, the USH has reestablished a performance accountability workgroup (absent for a number of years) comprising leaders from the field and VHACO to provide oversight and direction to the performance measurement process.⁴⁶⁸ The workgroup has been charged with aligning metrics to each level of VHA, dramatically simplifying metrics, and increasing the capacity of the organization to focus on measures that truly matter.⁴⁶⁹ The group has created an aspirational vision of a performance measurement system that describes cascading accountability from the top of the organization with health system outcomes (reported annually) through strategic measures (reported quarterly), to tactical measures (reported monthly) to transactional measures (reported in real time).⁴⁷⁰ It is critical that these aspirations become policy.

⁴⁶¹ Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.

⁴⁶² McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 78, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁴⁶³ Ibid., 82.

⁴⁶⁴ Ibid., 82.

⁴⁶⁵ Ibid., 84.

⁴⁶⁶ Ibid., 84.

⁴⁶⁷ Ibid., 87.

⁴⁶⁸ David Shulkin, *Charter of the Performance Accountability Workgroup*, (Washington, DC, Veterans Health Administration, September 22, 2015).

⁴⁶⁹ Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.

⁴⁷⁰ Ibid.

Starting in the 1990s, VHA has used performance measurement, benchmarking, and reporting internally to motivate higher clinical quality performance by individuals and teams.⁴⁷¹ As a large, national health care system, internal benchmarking can be a valid method to drive change, yet both internal and external audiences may ask how well VHA performance compares to that of private-sector providers. VHA currently posts some patient quality, safety, and outcome measures on both its website and on the Department of Health and Human Services (HHS) Hospital Compare website.⁴⁷² These measures allow patients to evaluate the quality of care they receive from VA and make informed health care decisions. They include measures of timely and effective health care; measures of readmissions; complications of death, surgical complication measures and health-care related infection measures; survey data of patient experiences; and other measures required of hospitals participating in Medicare.⁴⁷³ Former USH Kizer believes this reporting is insufficient, noting

*the VA health care system has become increasingly insular and inward-looking. It now has little engagement with private-sector health care, and too often it has declined to make its performance data public. For example, it contributes only a small proportion of its data to Hospital Compare and has declined to participate in other public performance reporting forums such as the Leapfrog Group's efforts to assess patient safety.*⁴⁷⁴

The Commission has reviewed VHA's principal measurement approach, Strategic Analytics for Improvement and Learning Value Model (SAIL) and has determined that although it is modelled on private-sector approaches to measurement and rating, measures are not exactly the same as those reported in the private sector and consequently impede direct benchmark comparisons of VHA to the private sector. Updating these measures so they are consistent with the private sector will be especially important as integrated delivery networks are established and more care is received in the community, as they will allow for making objective comparisons.

Measurement, analysis, and improvement of organizational performance work together as a key system.⁴⁷⁵ The USH has signed a new organizational chart for VHA that acknowledges the interconnection of these elements by establishing an office for organizational excellence that encompasses all of these functions.⁴⁷⁶ To be effective, not only must all of the various units within this office work together but also they must work with personnel in the field to coach and develop their ability to effectively apply performance measurement and improve organizational performance.

⁴⁷¹ "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation?" Ashish K. Jha, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, September 2006, accessed April 21, 2016, <https://psnet.ahrq.gov/perspectives/perspective/31/what-can-the-rest-of-the-health-care-system-learn-from-the-vas-quality-and-safety-transformation>.

⁴⁷² "Quality of Care: How Does Your Medical Center Perform?" Medical Center Performance Search (MCPS), U.S. Department of Veterans Affairs, accessed May 16, 2016, <http://www.va.gov/qualityofcare/apps/mcps-app.asp>.

⁴⁷³ Title XVIII of the Social Security Act 42 U.S.C. § 1395 et seq.

⁴⁷⁴ Kenneth Kizer and Ashish Jha, *Restoring Trust in VA Health Care*, N Engl J Med 2014; 371:295-297, July 24, 2014

⁴⁷⁵ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.

⁴⁷⁶ See the proposed organizational chart at end of Recommendation #12.

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These improvements in performance measurement do not appear to be mirrored on the performance management side of the equation. The draft FY 2016 performance plan template for network directors and medical center directors,⁴⁷⁷ although more streamlined than in previous years, continues to reflect confusion of performance measurement and performance management. It also continues to distribute all of the organization's key (and not so key) priorities under OPM executive core qualifications of leading change, leading people, business acumen, building coalitions, and results driven. The new, streamlined performance measures described above could be considered results-driven; however, the rest of the plan continues to be a confusing presentation of instructions to field leaders, restatements of policy, and performance objectives for action plans. Only the last category is appropriate for workforce performance management.⁴⁷⁸ The Corporate Senior Executive Management Office has implemented a new online performance management data tool that allows for tracking and assessment of the performance management process for senior executive service and equivalent leaders in VA.⁴⁷⁹

To improve performance measurement and organizational performance, the *Independent Assessment Report* recommends that VHA focus and simplify organizational performance measurement to clarify accountability, actively support the mission, and promote continuous improvement. Specifically, VHA must create a simplified, focused, balanced scorecard that reduces the total number of metrics to about 20; establish metrics that support cross-functional collaboration; cascade metrics down the organizational hierarchy; and make data tracking transparent, timely, broadly available, credible, reliable, and meaningful down to the lowest level of the organization. Furthermore, leaders should support continuous improvement, problem-solving, and the exchange of best practices across the organization rather than focusing on only correcting poor performance.⁴⁸⁰ The Commission broadly agrees with this approach to performance measurement. In addition, the Commission emphasizes that VHA customers and stakeholders require public reporting of clinical quality measures that are the same as, and therefore directly comparable to, measures used by the private sector. Although VHA may require an enhanced set of measures that reflects services not broadly deployed in the private sector, or for which measures do not yet exist, a minimum set that are the same as private-sector measures must be used by VHA. As VHA expands integration of care with the community, the use of the same measures as the private sector will be important so that direct comparisons can be made of care delivered inside VHA and that delivered under contract or partnership agreement by the VHA community care network.

VHA also requires a cohesive, integrated personnel performance management system that is specific to the knowledge, skills, and abilities required of health care leaders; includes

⁴⁷⁷ Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan Template*, Network Directors and Medical Center Director, November 20, 2015.

⁴⁷⁸ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.

⁴⁷⁹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁴⁸⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 81, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

accountability to key organizational outcomes; but also assesses organizational and professional objectives. A new personnel performance management system must be free of OPM requirements for executive core qualification and certification process and instead be benchmarked to the private sector⁴⁸¹ and consistent with the new leadership competency model. Congress required DoD to establish independent competency standards for the Commanders of Military Treatment Facilities (MTFs) and should consider doing the same for VHA.⁴⁸² This new performance management model must be based on both evaluation of leadership competencies and demonstrated success in delivering on strategic priorities. To break with current perceptions of the rating scales, it would be helpful to establish a new rating scale for the performance management system. Once the new system is developed, VHA must conduct training to describe the system, rating process, and expectations for both participants and raters.

A performance management system must also address the responsibilities of the rater. This includes clearly establishing written performance requirements for subordinates that are both timely (i.e., prior to the start of the rating period) and meaningful. Raters must be required to provide continuous feedback and assessment throughout the year to recognize and reward progress and outstanding achievements as well as to coach and trouble shoot when needed. The CVCS must establish this expectation by clearly communicating what is required of raters, and most importantly, by modeling the behavior. Finally, raters must provide meaningful ratings that distinguish achievement based on objective performance and demonstrated leadership skills. For instance, the Cleveland Clinic has moved to a system of forced rankings for which the top 10 percent of performers are celebrated and the bottom 10 percent are given intensive coaching or, if justified, sanctioned.⁴⁸³ To accomplish the last point, raters themselves must be given feedback and oversight to understand how their approach to rating compares to other leaders in the organization. If raters' assessments are not consistent with rating standards, their supervisor must bring this issue to their attention and include it in the performance assessment they receive.

The newly established performance management data tool can be used to support the performance management process. The submission of written performance plans (or failure to do so) can be tracked and reported; and the quality of those plans can be audited to provide feedback to raters. Final ratings and a comparison of raters can be conducted and provided to all of the executive raters in the organization. Finally, such a tool can also be used to identify and track high performers who deserve further investment and development as leaders from VHA.

⁴⁸¹ The American College of Healthcare Executives, *2016 Competencies Assessment Tool*, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf. "NCHL Health Leadership Competency Model™," National Center for Healthcare Leadership, accessed May 16, 2016 <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁸² Department of Defense Appropriations Act of 1999, Pub. L. No 105-262, Section 8052 (1998): "None of the funds appropriated in this Act may be used to fill the commander's position at any military medical facility with a health care professional unless the prospective candidate can demonstrate professional administrative skills."

⁴⁸³ Delos M. (Toby) Cosgrove, MD, CEO, Cleveland Clinic, statement during Commission on Care public meeting, March 22, 2016.

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Implementation***Legislative Change***

- Obtain legislative relief from the requirement to use the OPM executive core qualifications system of competencies and ratings and tied to new Title 38 pay authority for health care leaders (see Recommendation #15).

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Establish a workgroup and engage outside experts to create a new performance management system for VHA leaders that is appropriate for health care executives.
- Establish standards and processes to hold raters accountable for creating meaningful distinctions in performance between subordinate leaders.
- The new Office for Organizational Excellence should work with experts to reorganize their internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Other Department and Agency Administrative Changes

- None required.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

Problem

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans, and must become a strategic priority throughout the organization, because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veteran's care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Background

Cultural competence is the ability of health care organizations and their providers to understand and respond effectively to the cultural, language, and in VA's case, military service experience brought by the patient to the health care encounter. It has been endorsed as a viable skill set to reduce, if not eliminate, the rate at which health care disparities occur. VHA has recognized the problem of health disparities among its patient population and has taken steps to address it by tasking certain internal offices with building cultural and military competence throughout the organization. For example, VHA established the Office of Health Equity (OHE) and charged it with championing the efforts to identify, understand, and address health care disparities among veterans.

Analysis

There are seven essential strategies for promoting and sustaining organizational and systemic cultural competence. These strategies include the following:⁴⁸⁴

- Provide executive-level support and accountability.
- Foster patient, community, and stakeholder participation and partnerships.
- Conduct organizational cultural competence assessments.
- Develop incremental and realistic cultural competence action plans.

⁴⁸⁴ Miriam E. Delphin-Rittmon et al., "Seven Essential Strategies for Promoting and Sustaining Systemic Cultural Competence," *Psychiatric Quarterly*, 84, (2013), 53-64.

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- Ensure linguistic competence.
- Diversify, develop, and retain a culturally competent workforce.
- Develop an agency strategy for managing staff and patient grievances.

VA has taken some steps to address cultural and military competence strategies, but these programs are not sufficient to address the breadth and depth of the problem. These strategies will not take hold and become fully ingrained in VHA's culture unless VHA leadership makes them a key priority and commits the resources and on-going, comprehensive training required to build cultural competencies across the entire VHA workforce.

Military Competency

In addition to addressing the needs of minority veterans and vulnerable veterans populations, VA must address military-specific needs and ensure that all providers in the VHA Care System have sufficient military competency (i.e., knowledge of specific issues and health care needs of those who served in the military). VHA's Office of Academic Affiliations developed a *Clinician Pocket Card* for providers that includes questions for clinicians to ask veterans about their military health history.⁴⁸⁵ The *Pocket Card* and similar resources should be given to all VHA and community providers to leverage during veteran patient medical assessments and appointments. In addition, VA's Office of Public Health (OPH) provides information on VA health care programs for veterans who were exposed to environmental and occupational hazards during military service, such as Agent Orange, chemicals leading to Gulf War veterans' illnesses, and Camp Lejeune water contamination.⁴⁸⁶ This military exposure information should be leveraged in VA's cultural competency strategy.

Health care disparities often result from patients' lack of trust in their health care provider; therefore, enhancing the patient-provider relationship is paramount in overcoming these disparities. Stereotypical thinking on the part of providers about certain patient groups, including veterans, may unwittingly influence their prognosis.⁴⁸⁷ Specific reasons for the increase of health care disparities in the military population include the following:

- the cultural norms of the military are such that to admit or display any signs of perceived weakness, especially related to mental health issues, discourages military personnel and veterans from seeking medical care and treatment
- changes in the demographical makeup of the civilian population result in similar changes to the military population
- a small but gradual increase in the number of foreign born personnel who have joined the ranks of the military

⁴⁸⁵ Department of Veterans Affairs, Office of Academic Affiliations, *Military Health History: Pocket Card for Health Professions Trainees and Clinicians*, accessed June 12, 2016, <http://www.va.gov/oaa/archive/Military-Health-History-Card-for-print.pdf>.

⁴⁸⁶ "Public Health: Military Exposures," U.S. Department of Veterans Affairs Intranet, accessed June 12, 2016, <http://vaww.publichealth.va.gov/exposures/index.asp>

⁴⁸⁷ G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," JHHSA (2011), 148.

- a disengaged provider culture that may have become more immersed in the medical culture than the military culture

VA must make cultural and military competence a strategic priority, provide the resources needed to execute the strategy, and hold leadership and providers, both within VHA and community partners, accountable for strategy implementation and integration into VA's culture.

Women

Women are the fastest growing group within the veteran population.⁴⁸⁸ As of 2011, approximately 1.8 million (8 percent) of the 22.2 million veterans were women. Data indicate that by 2020 women veterans will comprise nearly 11 percent of the total veteran population. As the number of women veterans increases, VHA continues to prepare for an increasing demand for women veterans' health care needs.⁴⁸⁹ To address the health disparities affecting women veterans, VHA must provide high-quality, equitable care on par with that of men, deliver that care in a safe and healing environment, provide seamless coordination of services, and actively recognize women as veterans.⁴⁹⁰

In the past, VHA found gaps in its ability to provide comprehensive primary care for women veterans because many primary care providers had little or no exposure to women patients and women were often referred outside of primary care for gender-specific care. To close these gaps, VHA has implemented women's health comprehensive primary care clinic models with the goal of providing complete primary care from one designated women's health provider (DWHP) at one site. An analysis of FY 2012 data revealed that women assigned to DWHPs had more positive overall experiences with care and were more satisfied on six composite scores including access, communication, shared decision making, self-management support, comprehensiveness, and office staff.⁴⁹¹ VA has substantially reduced gender gaps in care,⁴⁹² but women veterans still encounter challenges when accessing care. VHA leadership must support the future planning of women's services and programming so that women veterans receive the highest quality health.⁴⁹³

LGBT Equity

In its systemwide implementation of cultural competency, VHA should leverage best practices from an area in which the agency is already an equity leader: treatment of LGBT patients. Every year since 2007, the Human Rights Campaign has published a Health Equality Index (HEI) report that aims to measure the quality of health care for LGBT patients based on core criteria

⁴⁸⁸ "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, <http://www.womenshealth.va.gov/>.

⁴⁸⁹ U.S. Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care*, April 2015, accessed June 12, 2016, http://www.womenshealth.va.gov/WOMENSHEALTH/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf.

⁴⁹⁰ Patricia M. Hayes, Chief Consultant Women's Health Services, VHA Office of Patient Services, briefing to the Commission on Care, October 19, 2015.

⁴⁹¹ Ibid.

⁴⁹² Ibid.

⁴⁹³ "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, <http://www.womenshealth.va.gov/>.

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that require health care systems to couple strong policies with appropriate training.⁴⁹⁴ In 2016, VAMCs made up 20 percent of all HEI participants. Among participating VAMCs, 84 percent were designated with *Leader* status.⁴⁹⁵ VHA hospitals publicize that discrimination against LGBT patients and employees is prohibited. Senior managers are registered for HEI training. And equal visitation rights are granted to families and friends of LGBT patients. VHA hospitals play a critical role in promoting patient care equality in states where VHA is the only Equality Leader.⁴⁹⁶ VHA should create strong policies and mandatory training, like that used to promote health equity for LGBT patients, to address equity issues for racial and ethnic minorities and women.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- VHA Care System providers should be required to ask patients about their military health history and incorporate veterans' responses into patients' treatment plans.
- VHA leadership should support the future planning of women's services and programming so that women veterans receive the highest quality health care.
- VHA should leverage the best practices developed in support of LGBT equity and implement them across VHA.
- VHA Care System providers should be required to attend comprehensive, on-going cultural and military competency training.

Other Department and Agency Administrative Changes

- None required.

⁴⁹⁴ "How the VA is leading the way on LGBT patient care," Andrew Park, The Week, February 25, 2014, accessed June 12, 2016, <http://theweek.com/articles/450361/how-v-a-leading-way-lgbt-patient-care>.

⁴⁹⁵ "Office of Health Equity: Healthcare Equality Index," U.S. Department of Veterans Affairs, accessed June 15, 2016, http://www.va.gov/HEALTHYEQUITY/Healthcare_Equality_Index.asp

⁴⁹⁶ "How the VA is leading the way on LGBT patient care," Andrew Park, The Week, February 25, 2014, accessed June 12, 2016, <http://theweek.com/articles/450361/how-v-a-leading-way-lgbt-patient-care>.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

Problem

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

Background

During the 1990s, Congress passed the Government Performance and Results Act⁴⁹⁷ to correct shortcomings in the way government was managed and assessed in an effort to bring modern business management practices into the federal government. The law was updated in 2011,⁴⁹⁸ yet one essential

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does all of the following:
 - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
 - Promotes veteran preferences and hiring.
 - Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, due process) through simplified, sensible processes that work for managers and employees.
 - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
 - Provides due process and appeals standards to adverse personnel actions.
 - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
 - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
 - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
 - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
 - Grandfathers current employees with respect to pay and benefits.
- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

⁴⁹⁷ Government Performance and Results Act of 1993, Pub. L. No. 103-62, 107 Stat. 285 (1993).

⁴⁹⁸ GPRA Modernization Act of 2010, Pub. L. No. 111-352, 124 Stat. 3866 (2011).

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component of modernizing the management of federal programs is still missing: reform of human capital management.⁴⁹⁹

The Civil Service Act was initially passed in 1883 and revised in 1978.⁵⁰⁰ The *general schedule*, which governs the pay and job classification process, was codified by regulation in 1949. The U.S. workforce, including the federal workforce, has changed dramatically since these laws and regulations were implemented. As noted in a recent report from the Partnership for Public Service, “the personnel system, designed more than 60 years ago, now governs more than 2 million workers and is a relic of a bygone era, reflecting a time when most federal jobs were clerical and required few specialized skills.”⁵⁰¹ As of 2013, nearly two-thirds of federal employees work in professional or administrative positions focused on knowledge-based work, with the Department of Veterans Affairs accounting for the largest percentage of such workers.⁵⁰²

The Partnership for Public Service calls for broad reform of the civil service system, noting that the

*the federal workforce has become an island disconnected from the larger talent market for knowledge-based professional and administrative occupations that are mission critical. . . . Federal employee pay . . . is not tied to the broader labor market, making it harder to compete with the private sector for talent. That disconnect is exacerbated by a job classification system that describes a workplace from the last century.*⁵⁰³

This system lacks mechanisms for rewarding top performers, demoting or firing poor performers, and holding managers accountable.⁵⁰⁴ The unnecessarily complex hiring system is difficult for applicants to navigate and makes it challenging for hiring managers to identify the most qualified candidates, hindering the ability to bring in experienced candidates from the private sector.⁵⁰⁵

*The civil service system has become a maze of rules and procedures that are not perceived as rational by the people who serve in government or by the general public. . . . Rigid policies . . . are now a burden on a government that needs to encourage flexibility and innovation to meet rapidly changing and difficult challenges.*⁵⁰⁶

⁴⁹⁹ U.S. General Accountability Office, Office of the Comptroller General, *Human Capital – A Self-Assessment Checklist for Agency Leaders*, accessed April 11, 2016, <http://www.gao.gov/assets/80/76520.pdf>. U.S. General Accountability Office, *Transforming the Civil Service: Building the Workforce of the Future – Results of a GAO Sponsored Symposium*, accessed April 11, 2016, <http://www.gao.gov/assets/200/197256.pdf>.

⁵⁰⁰ The Pendleton Civil Service Reform Act of 1883, Pub. L. No. 16, 22 Stat. 403 (1883).

⁵⁰¹ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵⁰² Ibid. The Department of Defense in total has more knowledge workers but the numbers for each service are reported independently and are below the total for the VA workforce.

⁵⁰³ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵⁰⁴ Ibid.

⁵⁰⁵ Ibid.

⁵⁰⁶ Ibid.

The General Accounting Office (GAO) also continues to point to human capital management as a high-risk area across government.⁵⁰⁷ DoD has proposed walking away from the Title 5 civil service system to support modernization of human capital management,⁵⁰⁸ President Barack Obama has repeatedly called for a commission to overhaul and modernize the civil service,⁵⁰⁹ and Congress is considering whether the time is right for civil service reform.⁵¹⁰

VHA currently uses three different personnel systems: Title 5 (the civil service/general schedule system) for senior executive service (SES) and other, mostly nonclinical, employees; Title 38 for physicians, dentists, and other specified health care professionals;⁵⁰⁹ and Title 38 Hybrid for allied health professionals such as pharmacists and licensed physical therapists.⁵¹⁰ Each system has its own set of requirements, procedures, and rules for the employees under its respective authority.⁵¹³ Currently, about two-thirds of VHA employees serve in the Title 38 Hybrid occupations.⁵¹⁴

VHA is not alone in having an excepted service system. More than a dozen agencies have special legislative authority to create a personnel system to fit their particular needs, including the Federal Bureau of Investigation, National Institutes of Health, National Security Agency, U.S. Public Health Service, Defense Intelligence Agency, U.S. Nuclear Regulatory Commission, and National Aeronautics and Space Administration.⁵¹¹ In an acknowledgement of the failure of the general schedule process to meet the needs of certain professions, OPM has also instituted governmentwide direct hiring authority for difficult-to-recruit positions, including medical officer, nurse, pharmacist, radiologic technician, and information technologist – all positions critically important to VHA’s mission success.

Modernizing human capital management is a global imperative for the private sector as well, with 92 percent of participants in one assessment of 7,000 businesses noting that a new approach to human resources is a critical organizational priority in 2016.⁵¹² According to a report from Deloitte, which examined broad human resource (HR) trends, “HR is redesigning almost everything it does – from recruiting to performance management to onboarding to reward systems” to learning and development.⁵¹³ Younger workers are driving many of these

⁵⁰⁷ U.S. GAO, *Federal Workforce—Human Capital Management Challenges and the Path to Reform, Testimony Before the Subcommittee on Federal Workforce U.S. Postal Service and the Census, Committee on Oversight and Government Reform, House of Representatives, Statement of Robert Goldenkoff*, GAO-14-723T, July 15, 2014, Washington, DC, 2014, accessed June 12, 2016, <http://www.gao.gov/assets/670/664772.pdf>.

⁵⁰⁸ “Draft Proposal Calls for Major Revamp of DoD Civilian Personnel System,” Jared Serbu, Federal News Radio, accessed April 8, 2016, <http://federalnewsradio.com/defense/2015/09/draft-proposal-calls-major-revamp-dod-civilian-personnel-system/>.

⁵⁰⁹ “Obama’s Budget Touts Progress Within Federal Workforce, but Offers It Nothing New,” Eric Katz, Government Executive, accessed April 8, 2016, <http://www.govexec.com/management/2016/02/obamas-budget-touts-progress-within-federal-workforce-offers-it-nothing-new/125815/>. The Office of Management and Budget, *Fiscal Year 2016 Budget of the U.S. Government*, accessed May 13, 2016, <https://www.whitehouse.gov/sites/default/files/omb/budget/fy2016/assets/budget.pdf>.

⁵⁰⁹ “Brace Yourselves: Congress Preps Civil Service Reform,” Andy Medici, Federal Times, accessed April 8, 2016, <http://www.federaltimes.com/story/government/management/oversight/2015/01/19/congress-civil-service-reform/21458717/>.

⁵¹⁰ Ibid.

⁵¹¹ See, e.g., 38 U.S.C. § 7401(1).

⁵¹² See, e.g., 38 U.S.C. § 7401(3).

⁵¹³ Joleen Clark, Jack Hetrick, and Donna Schroeder, “Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers,” Alternative Personnel System (2014).

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changes with expectations for meaningful work, learning opportunities, and career progression.⁵¹⁴ These workers have been choosing the federal government in diminishing numbers, with only 6 percent of federal employees currently younger than 30 years of age (compared to 23 percent of the civilian workforce).⁵¹⁵ In VHA, millennials (those 34 and younger) make up only 15 percent of the workforce, but are disproportionately over-represented among staff that quit VHA, at 20 percent.⁵¹⁶

As of January 2016, VHA had a vacancy rate of 16 percent for all positions, despite filling more than 40,000 positions in FY 2015.⁵¹⁷ VHA faces the additional challenge that 40 percent of its overall workforce is eligible for retirement in the next few years.⁵¹⁸ This problem occurs in the face of acknowledged national shortages of physicians⁵¹⁹ and geographic misalignment of the current health care workforce that leaves many localities short of needed providers.⁵²⁰ Taken together, this information makes clear that excellence in human capital management continues to be a business imperative for VHA.

Analysis

The human resource function within VHA needs a fundamental overhaul to increase responsiveness, efficiency, and customer service, as well as to align its orientation to the business needs of VHA.⁵²¹ Medical center directors do not receive the support they need from HR to accomplish hiring, disciplining, and planning for succession of employees.⁵²² During exit interviews, staff members who leave VHA cite barriers to career growth, insufficient professional development, a lack of promotions, and poor on-boarding and training as reasons for departing.⁵²³ In a recent national survey of VA employees, improving end-to-end hiring, recognizing stellar job performance, and providing professional development and career

⁵¹⁴ U.S. GAO, *The Excepted Service: A Research Profile*, GAO/GGD-97-92, accessed April 12, 2016, <http://www.gao.gov/assets/80/79968.pdf>.

⁵¹⁵ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 12, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵¹⁶ Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.

⁵¹⁷ “VA Struggles to Fill Medical Center Positions in Arizona, Across Nation,” Danika Worthington, Arizona Daily Sun, accessed April 5, 2016, http://azdailysun.com/news/local/va-struggles-to-fill-medical-center-positions-in-arizona-across/article_a14e6937-ecc1-5415-9391-7a6d759e5025.html.

⁵¹⁸ Joleen Clark, Jack Hetrick, and Donna Schroeder, *Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers, Alternative Personnel System* (2014).

⁵¹⁹ IHS Inc., *The Complexities of Physician Supply and Demand: Projections from 2013-2025*, accessed April 12, 2016, <https://www.aamc.org/download/426242/data/ihsreportdownload.pdf>.

⁵²⁰ “Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations,” U.S. Department of Health and Human Services, Health Resources and Services Administration, accessed April 12, 2016, <http://www.hrsa.gov/shortage/>.

⁵²¹ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, x, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵²² Ibid., vii.

⁵²³ Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.

planning ranked, numbers one, six, and nine respectively as top priorities for improving the employee experience at VA.⁵²⁴

The Civil Service System Does Not Support a High-Performing Health System.

Recruitment in VHA operates in an incredibly complex environment. Federal rules and regulations make HR more challenging than it is in the private sector.⁵²⁵ For example, interviews in 2014 with more than 500 VHA hiring managers and HR staff members pointed to the top problems with Title 5 recruitments as OPM classification standards, grading of position descriptions, position characterization, and the ranking and rating process.⁵²⁶ The group specifically noted that there are many staff positions required in a health care delivery system that do not translate into a general schedule occupational series; therefore, when the positions are graded, the grade and salary is too low to compete with the private sector. Examples of such positions are custodial workers (hospital employees need to apply antiseptic cleaning techniques, but general custodians do not) and general facilities and equipment maintenance (hospital employees need to understand the maintenance of such items as specialized medical equipment, positive pressure rooms, and sterile plumbing systems that are not requirements for general plant maintenance at an office building).⁵²⁷ In another example, VHA managers noted that the OPM classification standard for supply chain positions rendered VHA unable to compete for local talent because the assigned grade was too low.⁵²⁸

The general schedule system also has been identified as a barrier to career advancement.⁵²⁹ Clerical staff members in particular often cannot advance in pay and responsibility without leaving their positions and moving into a different job series.⁵³⁰ Similarly, frontline customer service staff under the general schedule cannot receive advanced steps within the grade for better performance or completing job-related certifications or degrees, unlike nurses and allied health professionals who can receive advances in pay for these accomplishments.⁵³¹

The hiring process in VHA is acknowledged to take too long.⁵³² “HR is expected to fill a position within 60 calendar days . . . but process requirements, even if perfectly executed, take about 49

⁵²⁴ “MyVA, Putting Veterans First,” MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.

⁵²⁵ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵²⁶ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People. Powerpoint of findings, July 29, 2014.

⁵²⁷ Veterans Health Administration, “Leading Access Scheduling Initiative – People, Assessment of Hiring Barriers,” VHA Classification Workgroup, 2014.

⁵²⁸ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xiii, accessed December 28, 2015, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

⁵²⁹ Ibid.

⁵³⁰ “Classification and Qualification: Classifying General Schedule Positions,” U.S. Office of Personnel Management, accessed November 24, 2015, <https://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/>.

⁵³¹ Pay Administration, VA Directive 5007 (2002). Staffing, VA Directive 5005 (2002).

⁵³² McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 109, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

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to 62 days.” Hiring timelines can span 4-8 months compared to private-sector hiring that takes between 0.5 and 2 months.⁵³³

This finding was echoed in a Northern Virginia Technology Council report on information technology challenges in VA that indicated across the board hiring of needed staff proceeds too slowly. “The causes are complex, but much of the delay can be traced to redundant, inconsistent, and inefficient hiring processes.”⁵³⁴ One driver of extended VHA hiring times is the government background checks and the licensing and credential review for clinical staff that is managed through VetPro, an internet-enabled data bank for credentialing VHA personnel.⁵³⁵

Although addressing recruiting and hiring problems will not be easy, doing so is essential to maintaining VHA’s workforce.⁵³⁶ An internal VHA workgroup that examined HR concluded that a complete break with Title 5 and a reworking of current Title 38 hiring authority is required, stating:

*The existing Personnel system does not meet today’s market or demand. With VHA’s tremendous volume of occupations to hire and significant turn-over rate in critical positions, it is necessary to promote an efficient organizational system to be able to hire qualified candidates as quickly as possible. The current classification system led to disparity across the systems and only looks at the duties of the position versus the qualifications of the person. The VHA hiring system must be agile and attractive to recruit those that just graduated or are entering the workforce... An agency specific excepted employment system would allow VHA to meet the unique staffing demands that are required of a complex health care organization.*⁵³⁷

VHA is Not Competitive in Pay for Many Positions

Many VHA staff have substantially lower earning potential than their private-sector counterparts. Despite a generous benefits package and the possible opportunities for greater work-life balance, and for research and teaching in a system that serves the important role of caring for the nation’s veterans, lower salaries reduce VHA’s competitive edge in the marketplace when trying to attract top talent.⁵³⁸ For example, although VHA is often able to provide physicians an entry salary that is comparable or better than industry standards, physicians’ long-term earning potential is dramatically less in VHA than that of their private-sector peers. “At the top of the salary ranges, VHA providers made less than their counter parts

⁵³³ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow-Clinical)*, 45-49, accessed May 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁵³⁴ Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America’s Veterans*, 12, accessed April 25, 2016, <http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf>.

⁵³⁵ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 37, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵³⁶ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵³⁷ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report*, August 2014.

⁵³⁸ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 39, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

by up to \$310,000 and on average, \$74,631. The only specialties for which VHA physicians made equal to or more than industry averages were anesthesiology, nephrology, ophthalmology, and psychiatry.”⁵³⁹ In another example of barriers to competitive pay, current provisions in law limit VA to a 60 percent level of market pay compensation for allied health professionals, even when recruitment failures demonstrate the need to offer higher salaries.⁵⁴⁰ As noted above in the discussion on classification, failure to appropriately classify positions also leads to a salary that is not competitive with private-sector health care organizations for positions such as customer service personnel.

In the area of educational debt repayment relief, VHA lags behind other federal and state agencies that use such programs to fill critical physician shortages in medically under-served areas.⁵⁴¹ VHA can offer up to a maximum of \$60,000 for 2 years (\$30,000 per year). HRSA National Health Service Corps (NHSC) runs three programs: the NHSC loan repayment program that provides up to \$50,000 in loan payments, the Student-to-Student Loan Repayment Program for up to \$120,000, and the State Loan Repayment Program with each state establishing loan amounts that are administered by HRSA.⁵⁴² These amounts range broadly from \$80,000 in Arizona and Arkansas, \$90,000 in Colorado, \$100,000 in Georgia and Alabama, and \$190,000 in California.⁵⁴³

Clinic Staffing Is Impaired by Current Law, Regulation, and Policy

Successfully reallocating staff to meet veterans’ needs in a rapidly evolving health care environment is difficult in VHA. The *Independent Assessment* recommended that VHA use extended clinic hours and weekend clinics to better optimize space and increase access to care for veterans.⁵⁴⁴ VA policy currently prohibits full-time VA physicians from receiving fee-basis compensation from the same VA facility in which they are salaried, although they can, under certain circumstances, receive fee-basis appointments at other VA facilities.⁵⁴⁵

These restrictions can make it hard to meet policy requirements for night and weekend schedules⁵⁴⁶ without reducing staffing on inpatient units or under-resourced primary care clinics. Use of alternative work schedules and overtime pay for physicians to meet local patient demands should be under control of local medical center directors.

⁵³⁹ Ibid., 40.

⁵⁴⁰ Increases in Rates of Basic Pay, 38 U.S.C. § 7455.

⁵⁴¹ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report*, August 2014.

⁵⁴² “Loan Repayment Program,” U.S. Department of Health and Human Services, National Health Service Corps, accessed June 9, 2016, <http://nhsc.hrsa.gov/loanrepayment/>.

⁵⁴³ “Physician Loan Repayment Guide,” Jimmy Karnezis, accessed April 13, 2016, <https://www.credible.com/blog/physician-loan-repayment-guide/>.

⁵⁴⁴ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 136, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵⁴⁵ VA Handbook 5005, pt. II, ch. 3, § A, para. 3b.

⁵⁴⁶ Extended Hours Access for Veterans Requiring Primary Care Including Women’s Health and Mental Health Services at Department of Veterans Affairs Medical Centers and Selected Community Based Outpatient Clinics, VHA Directive 2013-001 (2013).

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VHA Staff Receive Inadequate Training Including at Initial Hire

Leading practices include providing mandatory onboarding training that introduces policies, procedures, and necessary skills. Onboarding programs include various activities that expose new hires to the culture of the organization and expectations based on roles and responsibilities. A report released by the Society for Human Resources Management suggests, “Formal orientation programs help new employees understand many important aspects of their jobs and organizations, including the company’s culture and values, its goals and history and its power structure.”⁵⁴⁷ To make up for inadequate on-boarding and to fill current staff’s understanding of VA, VHA is providing VA 101 training for current employees, with 60 facilities having completed the training in FY 2015.⁵⁴⁸ Employees in VA continue to desire a wide array of training, including customer service training, professional development, peer-to-peer training, hands-on training, and role-specific training.⁵⁴⁹

HR Professionals Must Focus on People and Business Priorities Not Compliance

VHA job candidates indicate they have unsatisfactory recruiting experiences, noting failures in timely follow-up and communication.⁵⁵⁰ VA human resources management and administration indicate that VA HR professionals do not exhibit a uniform level of competency, frequently do not understand the employee recruitment process end-to-end, and fail to provide high quality consultative support to managers with respect to all HR functions, but particularly in the area of progressive discipline and firing of employees.⁵⁵¹ Currently HR professionals in VA are largely focused on compliance with a complex set of rules,⁵⁵² rather than adding true value to the organization and being able to be full partners in accomplishing VHA business objectives. Resolving these staffing issues would render the overall HR function more effective.

VHA must become the employer of choice to attract and retain the very best health care workforce. To help it accomplish this goal, VHA requires competitive pay and flexible hiring and talent management processes. VHA cannot achieve that goal within its current personnel systems. A uniform alternative personnel system under Title 38 for all VHA human capital management would accomplish all of the following:

- Meet the unique staffing demands of a health care delivery organization.
- Allow market-based compensation and pay-setting latitude using broad pay bands to support staff growth and progression within their job. VHA must consider total compensation (with benefits), as compared to market rates because the government provides many more benefits than private-sector organizations. Consequently, VA may

⁵⁴⁷Talya Bauer, Society for Human Resource Management, *Onboarding New Employees: Maximizing Success*, 2010, 9-10, accessed May 13, 2016, <https://www.shrm.org/about/foundation/products/documents/onboarding-percent20epg-percent20final.pdf>.

⁵⁴⁸ Veterans Health Administration, *Blueprint for Excellence: Fiscal Year 2015 Results: Communicating Accomplishments*, presented to the National Leadership Committee, March 22, 2016.

⁵⁴⁹ “MyVA, Putting Veterans First,” MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.

⁵⁵⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁵¹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁵² Ibid.

pay less than private-sector employers for a position, but the total compensation (with benefits) may end up being equivalent to private-sector total compensation.

- Allow flexibility in the processes used to hire staff including direct hiring when needed.
- Support career planning and professional development through the application of competency models and training specific for health care as part of position management.
- Simplify the management tasks for supervisors and hiring managers who will only need to know one set of rules and processes instead of four.
- Simplify the job of HR professionals who will only need to know one set of rules and processes instead of four.
- Allow development and training of the HR workforce in VHA to focus on only one personnel system to create true end-to-end hiring expertise.
- Reduce competition within government where shortages of HR professionals create competition for Title 5 trained HR professionals.
- Create streamlined and uniform standards and approach to discipline and dismissal.
- Create fairness among staff in sick leave, vacation pay, salary, awards and bonuses, and compensatory time off.
- Support flow of staff between the field and VHA Central Office (VHACO) under a single personnel system.

Establishing a new human capital management system in VHA will neither be easy nor quick, nor will it be a panacea that alone will fix all that is wrong with recruitment, retention, development, and advancement. In designing and implementing a new system, VHA must take full advantage of private-sector resources and expertise in human resource management and ensure that the new system is built to be compatible with the private-sector. As VHA moves toward greater integration of care delivery, with networks of community providers, compatibility in personnel systems and a resulting greater flow of employees between VHA and community sites can help create closer linkages between the two parts of the care delivery system.

Implementation

Legislative Changes

- Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.
- Update student loan reimbursement limits to be competitive with other federally administered programs and market conditions.

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- Establish an appeals process that provides staff appropriate due process that is based on the regulatory standards for the new alternative personnel system.

VA Administrative Changes

- Eliminate barriers to creating hiring pools for positions with frequent turnover (e.g., extend the length of time over which candidates can continue to be hired from a completed certification until all of the qualified candidates are hired or have declined offers).
- Eliminate barriers to initiating a recruitment process when vacancies are anticipated; positions need not be empty before recruitment ensues. In some cases, hires should also be made before the departure of key personnel to allow for on-the-job training and mentoring of the replacement.
- Benchmark credentialing to private-sector processes and consider outsourcing the process as much as practicable through centralized mechanisms.
- Release market pay and total compensation information to the field for all job categories using commercially available data and information, at least every 2 years.

Other Department and Agency Administrative Changes

- OPM should continue to oversee and administer benefits for VHA but not impose any of the other existing conditions or requirements on the management of the new alternative personnel system. The new personnel system should be governed by the new legislative requirements and those established during the anticipated rulemaking process in VA. These requirements include market-based pay, performance awards, or performance and disciplinary processes other than those imposed under Title 38.

Recommendation #16: Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Problem

Effective planning for and management of human capital are core enabling requirements for any organization. If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

Background

As recognized by GAO, “to attain the highest level of performance and accountability, federal agencies depend on three enablers: people, process, and technology. The most important of these is people, because an agency’s people define its character and its capacity to perform.”⁵⁵³ Human capital management, although often viewed as a cost, must be viewed as an investment in business success.⁵⁵⁴ For too long, VA human capital management has been undervalued and under resourced. A 1993 report from GAO outlined many of the same deficiencies found in 2016: a focus on compliance instead of outcomes, a lack of proactive human capital planning and management, and a weak system of rewards and incentives to attract and retain qualified personnel.⁵⁵⁵

Today, VA Human Resources and Administration (HRA) shares responsibility for human capital management with VHA. Neither organization has been able to establish a high-performing, effective, human capital management system. For VHA to transform to a high-performing organization, human capital management must do the same.

Analysis

VA “needs a fundamental overhaul of the core support functions (including human resources) . . . to increase responsiveness and efficiency and improve customer service. These functions should be aligned with the needs of the VHA organizations delivering care to

The Commission Recommends That . . .

- VHA hire a chief talent leader who holds responsibility for the operation’s entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the CVCS.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.
- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

⁵⁵³ U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders*, GAO/OCG-00-14G, version 1, September 2000, 3, accessed June 10, 2016, <http://www.gao.gov/assets/80/76520.pdf>.

⁵⁵⁴ Ibid.

⁵⁵⁵ U.S. General Accountability Office, *Management of VA: Improved Human Resource Planning Needed to Achieve Strategic Goals*, GAO/HRD-93-10, March 1993, accessed June 10, 2016, <http://www.gao.gov/assets/220/217512.pdf>.

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Veterans.”⁵⁵⁶ Governance and responsibility for human capital management is fragmented and complicated.⁵⁵⁷ Medical center directors appear to be largely on their own in addressing human capital management needs, without competent and timely assistance to support hiring employees, planning for succession, and taking disciplinary actions.⁵⁵⁸ Recruiting takes too long and is cumbersome because information is not shared freely among the various organizational components.⁵⁵⁹ Candidates are not treated with respect, experience lengthy intervals between contacts from VA, fail to receive timely follow-up once candidates are selected, and experience a lengthy on-boarding process.⁵⁶⁰ Human capital management also fails to effectively support the disciplinary process, which is perceived as too long and too difficult.⁵⁶¹ Insufficient resources are devoted to training,⁵⁶² leaving VHA vulnerable to failure.

VA requires a comprehensive redesign of the human resources function to be more responsive, more efficient, and more focused on customer service.⁵⁶³ Transforming HR will require “redesigning key processes, shifting the mindset of [human resources] staff from compliance to effectiveness, training [human resources] and its customers on key roles and responsibilities, and rationalizing its technology systems.”⁵⁶⁴

Some progress has been made in updating human capital management functions. VA is in the process of implementing new talent management software to provide better process management and analytics.⁵⁶⁵ HRA has also started a new HR Academy.⁵⁶⁶ The academy is intended to demonstrate alignment between training resources and competency requirements⁵⁶⁷ and to describe the experience needed to advance to the next position level in human resources.⁵⁶⁸ VA instituted a new online senior executive service performance management system that permits real-time tracking of the performance management process and analysis of

⁵⁵⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁵⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁵⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, L3, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁵⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 109, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁶⁰ *Ibid.*, 110.

⁵⁶¹ *Ibid.*, 61.

⁵⁶² *Ibid.*, 67.

⁵⁶³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, L5, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁶⁴ *Ibid.*

⁵⁶⁵ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁶⁶ *Ibid.*

⁵⁶⁷ Department of Veterans Affairs, HR Academy, *TMS User eIDP Checklist*, accessed January 25, 2016, www.vahracademy.va.gov/docs/TMSUserIDPChecklist.pdf.

⁵⁶⁸ “VA HR Academy: Resources,” Department of Veterans Affairs, accessed January 25, 2016, www.vahracademy.va.gov/resources.asp. Department of Veterans Affairs, *VA HR Competency Model Reference Guide*, accessed January 25, 2016, www.vahracademy.va.gov/docs/VAHRCompetencyModelReferenceGuide.pdf.

performance outcomes;⁵⁶⁹ however, HR specialists must still use as many as 30 different IT systems that do not communicate with each other to do their work.⁵⁷⁰ Although some new systems have been purchased, life cycle funding for them is not guaranteed by the Office of Information and Technology and no concrete plan has been approved to replace and consolidate the many current systems that are not interoperable. In addition, funding support for HRA initiatives overall are not planned, allocated, and maintained at consistent levels year-to-year in the departmental budget, impeding long term transformation.⁵⁷¹

A VHA workgroup was formed with HR subject matter experts and leadership to identify hiring barriers and develop recommendations for improvements. The workgroup fielded a survey in July 2014 to gather broad input from VHA on the deficiencies in the management of human capital in VHA. These experts concluded that VHA should move to a new alternative personnel system under Title 38.⁵⁷² (See Recommendation #15.)

Substantial deficiencies in human capital management still remain in VA. The funding mechanism to support the departments' human capital management does not support long-range planning and effective program implementation. The lines of authority and management for human capital management professionals do not permit consistency in the quality and skill of the human capital management professionals hired and promoted, nor does the reporting structure allow HRA to hold human capital management staff accountable for effective service delivery. The investment in human capital management information technology systems has been inadequate for decades.⁵⁷³

Top leadership, including the SECVA, DEPSECVA, and CVCS, must make the transformation of human resources a top priority as demonstrated by investing their personal time in human capital management transformation; reviewing and endorsing a transformation plan including the funding required to accomplish it; receiving regular progress updates; and engaging in problem-solving sessions with human capital management leaders to refine and advance transformation efforts. Top leadership must demonstrate to other leaders that human capital management transformation is an organizational priority by disseminating clear goals for transformation in planning documents, communicating expectations for change that are clear to all key employees, and sharing successes with subordinate leaders and employees. The CVCS must ensure that the executive who leads the human capital management function has the demonstrated knowledge, skills, and experience in human capital management to competently lead the function and make this individual part of the executive leadership team on par with other key functions like finance and clinical operations. (See suggested organization chart in Recommendation #12.)

⁵⁶⁹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁷⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 24, 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁷¹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁷² Ibid.

⁵⁷³ Ibid.

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The SECVA, DEPSECVA, and CVCS must engage subordinate leaders in the transformation process by ensuring the needs of these leaders have informed the transformation solutions; that subordinate leaders are assigned specific responsibilities under the transformation plan; and they are held accountable by the CVCS for outcomes. They must also ensure that the HR transformation and ongoing HR function is adequately resourced to be successful.

The VA HRA and VHA Workforce Management Office must engage change management experts to undertake a review of human resource business processes, management structures, funding, and technology needs to create a transformation agenda and human capital management plan. As VHA is shifting to a new alternative personnel system under Title 38, the human capital management plan should consolidate in VHA the HR functions, responsibility, and authority required to hire, manage, develop, reward, and discipline staff and consider whether functions such as benefit management remain with HRA or move to VHA. Furthermore, the plan should address all of the following issues:

- need for a chief of talent management
- consistency with benchmark standards of private-sector health care systems
- key organizational structures and roles and responsibilities of VA and VHA in human capital management that are clearly defined and consistent with benchmark organizations
- the full life cycle of human capital management (i.e., planning, recruitment, hiring, retention, development, performance management, and discipline), which should be supported effectively by human capital management and fully meet the needs of managers and staff
- federal sharing authority and the ability to outsource human capital management functions to the private sector are addressed
- IT investments and analytical capability to provide meaningful, timely data to managing staffing, performance tracking, and accountability
- meaningful performance metrics and risk management indicators that are established for human capital management⁵⁷⁴
- funding and full-time equivalent employee staffing for human capital functions that meet private-sector benchmark standards for health care
- knowledge, skills, and ability required of human capital management professionals at each grade and within each series, which should be clearly defined, and a requirement to assess current staff, new hires, and promotions against this standard, which should include procedures for dismissal

⁵⁷⁴ U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders*, GAO/OCG-00-14G, version 1, September 2000, 34, accessed June 10, 2016, <http://www.gao.gov/assets/80/76520.pdf>.

Once completed, this analysis and draft plan must be shared widely within the department to gain feedback and input, and it must be shared with OPM, OMB, and Congress. After incorporating feedback and finalizing the plan, HRA should engage change management experts to fully implement the transformation agenda and new human capital management plan. Implementation will require funding contributions from VA and VHA that the SECVA must mandate.

HRA must develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 Hybrid, Title 38 7306, and SES). This process must include clear standards, guidelines, and training for supervisors and managers on how to implement the new progressive discipline process. All managers and supervisors and human capital management professionals must complete the training, and VA must establish a process for ensuring that new supervisors and managers complete the training on an ongoing basis. HRA must develop HR staff to be effective coaches so they can provide the coaching and support that managers need as they embark on disciplinary procedures to ensure timely and effective interventions.

VHA supervisors and managers must be held accountable for applying these procedures when poor performance or conduct occurs. To enable accountability, VHA must have a technology infrastructure to actively track and manage poor performance (annual ratings and disciplinary actions) that both human capital managers and supervisors can use to keep track of issues.

The Commission notes GAO is launching a comprehensive audit of human capital management functions in VA to be delivered to Congress in September 2016.⁵⁷⁵ The review and resulting recommendations will provide further insights to promote meaningful transformation of human capital management in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Employ HR and change management experts to undertake a review of its business processes, management structures, funding, technology, and the legal authority needed in HR to create a transformation agenda and human capital management plan.
- Require VHA to allocate budget to fully support the change plan and ongoing HR operations.

⁵⁷⁵ Ms. Frieda Stenzel, lead investigator, U.S. Government Accountability Office, during an initial meeting with VACO HR&A about a new study being undertaken by GAO, December 18, 2015. The study is intended to 1) assess VHAs capacity to perform its workforce planning and talent management, and 2) evaluate the effectiveness of VHAs human capital functions.

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- Develop and implement an effective progressive discipline process for all staffing authorities.

Other Department and Agency Administrative Changes

- None required.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

Problem

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

The Commission Recommends That . . .

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an other-than-honorable discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

In some cases, individuals have been dismissed from military service with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury, posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

Background

Veteran status is the basis for eligibility for all VA benefits,⁵⁷⁶ and under law a veteran is a person who has met three criteria: active-duty military service (subject to specified exceptions), 2 years of continuous service, and discharge or separation from the military under conditions other than dishonorable.⁵⁷⁷ The military characterizes discharges into one of five categories: honorable, general (under honorable conditions), OTH, bad conduct (adjudicated by a general court or special court-martial), and dishonorable.⁵⁷⁸

Congress has established specific bars to VA benefits. Those barred by statute include deserters, individuals sentenced by a general court-martial, and conscientious objectors who refused to perform military duty.⁵⁷⁹ VA regulations interpret the phrase "discharged or released . . . under conditions other than dishonorable" to mean that a discharge or release because of one of the following offenses is considered to have been issued under dishonorable conditions:

(1) acceptance of an OTH discharge to escape trial by general court-martial, (2) mutiny or

⁵⁷⁶ Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁷⁷ Veterans Benefits, 38 U.S.C. § 101(2).

⁵⁷⁸ Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁷⁹ Certain Bars to Benefits, 38 U.S.C. § 5303(a).

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spying, (3) an offense involving moral turpitude, (4) willful and persistent misconduct, and (5) certain homosexual acts involving aggravating circumstances.⁵⁸⁰

Limited exceptions to those statutory and regulatory bars permit VA to award of benefits. A claimant may be granted benefits if VA determines that the claimant was insane at the time of the offense leading up to discharge.⁵⁸¹ Benefits may be granted based on a prior period of other-than-dishonorable service for individuals with two or more periods of service.⁵⁸²

Former service members with an OTH discharge as a result of a regulatory (rather than a statutory) bar are eligible for VA care for service-incurred conditions.⁵⁸³ Former service members with OTH discharges are not recognized as veterans, so they will be routinely denied treatment unless they initiate, and prevail in, an adjudication conducted by the Veterans Benefits Administration as to the character of their discharge. No routine mechanism exists to trigger adjudication to determine if such a discharge is not dishonorable. In many instances, the character of an individual's discharge is predicated on behaviors that resulted from, or are linked to, behavioral health conditions that had their origin in service, yet VA regulation bars the individual from receiving benefits.⁵⁸⁴

Analysis

Veterans' benefits are understood to be earned. The principle has been described as follows: In harsh environments in which lives may be on the line, serious breaches of conduct that interfere with the military mission should rightfully brand the offender for life and should likewise prohibit them from being eligible for the special military benefits and entitlements reserved for honorable and meritorious service.⁵⁸⁵

Some argue the offender's mental state at the time of the misconduct must be taken into account when considering veteran status.⁵⁸⁶ For example, many service members have experienced combat and sustained psychological wounds of war that manifest behaviors that lead to military discipline.⁵⁸⁷ VA regulations not only fail to account for the role of those psychic wounds, but are themselves overbroad, weak discriminators as to what is truly dishonorable service. To illustrate, commentators have identified two regulatory bars as particularly problematic: those based on moral turpitude,⁵⁸⁸ and willful and persistent misconduct.⁵⁸⁹ Neither of those two regulatory terms, which originated in 1944,⁵⁹⁰ are defined; neither provides

⁵⁸⁰ Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸¹ Certain Bars to Benefits, 38 U.S.C. § 5303(b).

⁵⁸² Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁸³ Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).

⁵⁸⁴ Certain Bars to Benefits, 38 U.S.C. § 5303(a). Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸⁵ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 12-13, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁸⁶ *Ibid.*, 13.

⁵⁸⁷ *Ibid.*

⁵⁸⁸ Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸⁹ *Ibid.*

⁵⁹⁰ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the

criteria or examples of what is or is not covered. Both are ambiguous and susceptible to subjective judgment,⁵⁹¹ with great potential for different VA regional offices reaching different outcomes on the same facts.⁵⁹² VA officials have acknowledged that these terms are broad and imprecise,⁵⁹³ and advocates have documented the resultant disparities in VA adjudicative decisions.⁵⁹⁴

The only specific mental-health exception to the bar-to-benefits rules — that the person was insane at the time of the commission of offense⁵⁹⁵ — is very limited. VA regulations define the term *insane*, as follows:

*An insane person is one who, while not mentally defective or constitutionally psychopathic, except when a psychosis has been engrafted upon such basis condition, exhibits, due to disease, a more or less prolonged deviation from his normal method of behavior; or who interferes with the peace of society; or who has so departed (become antisocial) from the accepted standards of the community to which by birth and education he belongs as to lack the adaptability to make further adjustments to the social customs of the community in which he resides.*⁵⁹⁶

VA's Office of General Counsel (OGC), in a now almost 20-year old precedential opinion, has construed that regulation narrowly. Responding to a request for an opinion regarding the parameters for behavior that would constitute insanity under the regulation, the General Counsel advised, as follows:

*The question of insanity arises in numerous legal proceedings, and its meaning may vary according to the jurisdiction and the object or purpose of the proceeding. However, in all contexts, the term indicates a condition involving conduct which deviates severely from the social norm. Black's Law Dictionary, at 794, states that '[t]he term is more or less synonymous with . . . psychosis, which itself has been defined as "a mental disorder characterized by gross impairment in reality testing' or, in a more general sense, as a mental disorder in which 'mental functioning is sufficiently impaired as to interfere grossly with the . . . capacity to meet the ordinary demands of life.'"*⁵⁹⁷

Armed Forces," *Military Law Review*, 214, Winter, (2012): 160-192, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁹¹ Ibid., 164, 186.

⁵⁹² Ibid., 10, 172. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable*, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁵⁹³ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 67, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁹⁴ Ibid., 68-70.

⁵⁹⁵ Characters of Discharge, 38 C.F.R. 3.12(b).

⁵⁹⁶ Determinations of Insanity, 38 C.F.R. 3.354(a).

⁵⁹⁷ "Office of General Counsel: Opinions Year 1997," U.S. Department of Veterans Affairs, accessed June 15, 2016, <http://www.va.gov/ogc/opinions/1997precedentopinions.asp>. Vet. Aff. Op. Gen Couns. Prec. 20-97, VAOPGCPREC 20-97, 1997, accessed June 15, 2016, <http://www.va.gov/ogc/docs/1997/Prc20-97.doc>.

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As understood by VA OGC at the time, *insanity*, with its emphasis on gross impairment, and as reflected in practice,⁵⁹⁸ is a highly restrictive standard. That narrow standard is also limiting with respect to the range of symptoms that could be considered under the *insanity* exception: gross cognitive impairment or gross impairment in capacity to function in daily life. That limited range effectively excludes behaviors associated with a widely prevalent service-related condition, PTSD. Those behaviors, which often lead to disciplinary actions, include aggressive behavior, substance-abuse,⁵⁹⁹ impulsivity, and risk-taking (including sensation seeking, aggressive driving, interpersonal violence, and self-injurious or suicide-related behavior).⁶⁰⁰ Research has shown that combat veterans with PTSD and other psychiatric diagnoses have a heightened risk of misconduct outcomes.⁶⁰¹ Other than its *insanity* rule, the regulations provide no specific opportunity to consider mental health as a likely cause of, or mitigating factor in, disciplinary issues leading to an individual's discharge.

The following are illustrative examples of how these regulations have worked in practice:

- John, a service member with multiple deployments to Iraq and Afghanistan and 7 years of service, received an OTH discharge after self-medicating with marijuana. He was denied VA treatment for PTSD.⁶⁰²
- Tim, a rifleman with two purple hearts and four campaign ribbons for service in Vietnam, was sent to combat while still 17 years old, and had a nervous breakdown and suicide attempt before his 18th birthday. He was sent back to Vietnam involuntarily for a second tour, and had a third nervous breakdown that led to an AWOL and OTH discharge. He was denied service connection for PTSD because the nature of his discharge.
- Tom, a combat infantryman in the first Gulf War, on his return, started experiencing symptoms of PTSD and attempted suicide. He was denied leave to be with his family,

⁵⁹⁸ Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable,"* accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁵⁹⁹ Deirdre MacManus et al., "Aggressive and Violent Behavior Among Military Personnel Deployed to Iraq and Afghanistan: Prevalence and Link with Deployment and Combat Exposure," *Epidemiologic Reviews*, 37, no. 1, (2015): 196-212, <http://doi.org/10.1093/epirev/mxu006>.

Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, <http://dx.doi.org/10.1186%2F1471-244X-10-88>.

⁶⁰⁰ Lisa M. James, Thad Q. Strom, and Jennie Leskela, "Risk-Taking Behaviors and Impulsivity Among Veterans With and Without PTSD and Mild TBI," *Military Medicine*, 179, no. 4, (2014): 357 – 363, <http://publications.amsus.org/doi/pdf/10.7205/MILMED-D-13-00241>.

⁶⁰¹ Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, <http://dx.doi.org/10.1186%2F1471-244X-10-88>.

⁶⁰² Swords to Plowshares, presentation to Commission on Care, January 21, 2016, accessed June 25, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former service members.

but left anyway. After a 60-day absence, he returned and was given an OTH discharge. He was denied services for 20 years.⁶⁰³

In short, the VA regulation used to determine whether the character of a veteran's OTH discharge is disqualifying does not take into account behavioral health problems associated with military service. As a result, former service members who were discharged for disciplinary problems that cannot be disassociated from PTSD or other behavioral health disorders are routinely barred from VA treatment for those disorders.

Individuals with PTSD and traumatic exposure are at heightened risk of substance abuse,⁶⁰⁴ depression,⁶⁰⁵ homelessness,⁶⁰⁶ premature mortality,⁶⁰⁷ and suicide.⁶⁰⁸ Access to VA health care is vital to successful reintegration of combat-traumatized veterans into society because it provides "the only reservoir of combat PTSD expertise."⁶⁰⁹

The importance of early access to needed treatment for behavioral health conditions like PTSD cannot be overstated,⁶¹⁰ yet many former service members are reluctant to seek treatment for behavioral health problems.⁶¹¹ Those with unfavorable discharge records who finally come forward to seek medical care must not only initiate a request for a character of discharge adjudication, but be prepared to confront a lengthy process if they elect to do so.⁶¹²

⁶⁰³ Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁶⁰⁴ Kipling M. Bohnert et al., "The Association Between Substance Use Disorders and Mortality among a Cohort of Veterans with Posttraumatic Stress Disorder: Variation by Age, Cohort, and Mortality Type," *Drug and Alcohol Dependence*, 128, no. 1-2, (2013): 98-103, <http://www.sciencedirect.com/science/article/pii/S0376871612003328>.

⁶⁰⁵ Leo Sher, Maria Dolores Braquehais, and Miquel Casas, "Posttraumatic Stress Disorder, Depression, and Suicide in Veterans" *Cleveland Clinic Journal of Medicine*, 79, no. 2 (2012): 92-97, <http://doi.org/10.3949/ccjm.79a.11069>.

⁶⁰⁶ Eve B. Carlson et al., "Traumatic Stressor Exposure and Post-Traumatic Symptoms in Homeless Veterans," *Military Medicine*, 178, no. 9, (2013): 970-973, <http://doi.org/10.7205/MILMED-D-13-00080>.

⁶⁰⁷ Joseph A. Boscarino, "Posttraumatic Stress Disorder and Mortality Among U.S. Army Veterans 30 Years After Military Service," *Annals of Epidemiology*, 16, no. 4 (2005): 248-256, <http://www.sciencedirect.com/science/article/pii/S1047279705001109>.

⁶⁰⁸ Holly J. Ramsawh et al., "Risk for Suicidal Behaviors Associated with PTSD, Depression, and their Comorbidity in the U.S. Army," *Journal of Affective Disorders*, 161, no. 1, (2014): 116-122, <http://www.sciencedirect.com/science/article/pii/S0165032714001189>.

⁶⁰⁹ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 14, accessed June 20, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁶¹⁰ Ronald C. Kessler, "Posttraumatic Stress Disorder: The Burden to the Individual and to Society," *Journal of Clinical Psychology*, 5, Suppl. 5, (2000): 4-12, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/10761674>.

⁶¹¹ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶¹² Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 74-78, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

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Several generations of former service members were exposed to combat trauma and continue to live with the psychological wounds of war. Lack of access to treatment for those who sustained psychological wounds that went untreated and were manifest in undesirable behavior in service is concerning. Although Congress could address this concern, VA has the means to remedy the problem without congressional action by amending its own regulations. VA could afford former service members needed treatment for their conditions when they are able to establish that their health problems were incurred in service.⁶¹³ In other circumstances, when it is likely an individual could establish eligibility for VA care, current regulation permits the individual to receive the care on the basis of a tentative eligibility determination.⁶¹⁴ This regulation permits VA to provide treatment without prior adjudication of the character of discharge.

VA should revise its regulations to lift the immediate bar to health care for former service members who have an OTH discharge. VA should award tentative eligibility for health care to at least some former service members who have an OTH discharge. The criteria for awarding tentative eligibility for care could include service in a combat theater, more than a single enlistment, duration of service, or some combination thereof. This approach would allow VA to provide meaningful access to treatment without delay for those likely to be granted eligibility. For health care purposes, VA should also revise its regulations by recognizing that the severe punishment of characterizing a person's service as OTH is not justified when extenuating circumstances (to include behavioral health issues at the time) explain or mitigate that misconduct that resulted in the OTH discharge.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Amend 38 C.F.R. 17.34 to provide for tentative eligibility determinations applicable to individuals with OTH discharges who have had substantial honorable service, including service in a combat theater.
- Amend of 38 C.F.R. 3.12(d) to provide for recognition of extenuating circumstances that show, for purposes of health care eligibility, that service was not OTH.

Other Departments and Agency Administrative Changes

- None required.

⁶¹³ Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).

⁶¹⁴ Tentative Eligibility Determinations, 38 C.F.R. 17.34.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Problem

Although VHA continues to offer the promise of health care to all veterans, its capacity to meet that promise is constrained by appropriated funding.⁶¹⁵ Congress and VA leadership must work to identify who VHA will serve, and what services it will provide, yet eligibility criteria have not been examined in 20 years.⁶¹⁶

Background

VHA's core mission is to care for veterans who has borne the battle. But its secondary mission of caring for veterans' non-service-connected health care needs is longstanding, dating back to Civil War origins. Congress has included veterans without service-connected needs among those eligible as highlighted below:

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use underutilized VHA providers and facilities, providing payment through private insurance.
- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

- In March 1865, Congress incorporated the National Home for Disabled Volunteer Soldiers and Sailors, originally intended for Union veterans who suffered economic distress from disabilities incurred during the Civil War. The National Home constructed the first hospitals for Civil War veterans in 1866, and after a series of acts of Congress, those hospitals were opened in 1887 to veterans suffering economic distress from disabilities not incurred in military service.⁶¹⁷
- The World War Veterans Act of 1924, which established the Veterans Bureau⁶¹⁸ (the predecessor to the Department of Veterans Affairs), authorized its director to provide hospitalization and related travel expenses to veterans whose services dated back as far as 1897, regardless of the type or cause of their disabilities, as long as those veterans who were unable to pay received preferential admission.⁶¹⁹
- Public Law 85-56 (1957), which codified prior VA laws and regulations, effectively expanded eligibility to veterans of future wars, providing needed hospital care for veterans with service-connected disability incurred or aggravated during war, or for any other disability if the veteran is unable to pay for hospital care.⁶²⁰

⁶¹⁵ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶¹⁶ *Ibid.*, 25.

⁶¹⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

⁶¹⁸ The Veterans Bureau consolidated the National Home and other veterans-related functions housed in different government bureaucracies.

⁶¹⁹ World War Veterans Act, 1924, Pub. L. No. 68-242, (1924).

⁶²⁰ Veterans Benefits Act of 1957, Pub. L. No. 85-56, 71 Stat. 83 (1957). That law provided separate authority in section 512 for outpatient medical treatment, which was limited to treatment for a service-connected disability.

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- In 1966, Congress expanded eligibility for hospital care to *peacetime* veterans (of service after January 1955).⁶²¹
- In 1970, Congress extended eligibility for hospital care to veterans 65 and older for a non-service-connected disability,⁶²² exempting that group of veterans from taking the then-required oath affirming their inability to defray the expense of care for non-service-connect ailments.⁶²³
- With the Veterans Health Care Expansion Act of 1973, Congress eliminated the distinction between wartime and peacetime veterans for purposes of eligibility for outpatient care, and further expanded eligibility to outpatient care. It granted veterans who are 80 percent or more service-connected disabled eligibility for treatment of any condition, and authorized others eligible for hospital care to receive outpatient care to prepare for or preclude a need for hospitalization or to complete treatment initiated during hospitalization.⁶²⁴
- Congress expanded eligibility again in 1976, authorizing hospital care for treating a non-service-connected condition of any veteran 65 or older (without regard to ability to pay), authorizing outpatient care for any disability to any veteran 50 percent or more service-connected disabled, and directing VA to ensure, by regulation, special treatment priority to service-connected veterans and others receiving benefits because of a need for aid and attendance, or being permanently housebound.⁶²⁵

Eligibility laws for veterans' health care have changed substantially during the past century, yet the commitment to serving service-connected veterans and veterans in financial need has remained constant.

Prior to enactment of the Veterans' Health Care Eligibility Reform Act of 1996,⁶²⁶ VHA was a hospital-based model with entirely different eligibility rules for hospital care than for outpatient care. The eligibility reform law was aimed at transforming access to VA care from a 1950s hospital-based model to one that erased distinctions between eligibility for hospital and outpatient care.⁶²⁷ It essentially provided that all veterans are eligible for VA hospital care and *medical services*.⁶²⁸

⁶²¹ Veterans Readjustment Benefits Act of 1966, Pub. L. No. 89-358, 80 Stat. 12 (1966).

⁶²² Pub. L. No. 91-500.

⁶²³ S. Rep. No. 91-481.

⁶²⁴ Veterans Health Care Expansion Act of 1973, Pub. L. No. 93-82, 87 Stat. (1973).

⁶²⁵ Veterans Omnibus Health Care Act of 1976, Pub. L. No. 94-581, 90 Stat. 2842 (1976). The patchwork of eligibility provisions resulting from a succession of incremental changes set the stage for development and enactment of the Veterans' Health Care Eligibility Reform Act of 1996, Pub. Law 104-262.

⁶²⁶ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁶²⁷ *Ibid.*

⁶²⁸ The term "medical services" was broadly defined to include in addition to medical examination and treatment, preventive health services; surgical services; wheelchairs, artificial limbs, and similar appliances; optometric and podiatric services; noninstitutional extended care services; and rehabilitative services (including services to restore physical, mental, and psychological functioning. Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C.

§ 1701(6),(8). VA regulations more fully set out the "medical benefits package" that VA is to provide patients, as needed; VA regulations detail that the benefits package includes services ranging from emergency care and prescription drugs to

Recognizing there could be circumstances in which VHA might lack capacity to provide timely care, Congress noted in the reform act that the requirement to provide care would be in effect only to the degree to which there were appropriated funds to pay for such care.⁶²⁹ This qualified availability of care clearly indicated veterans' health care is not an entitlement. Congress went further, though, and established a statutory patient enrollment mechanism for VA to manage access.⁶³⁰ The law specifically requires VA to establish and operate a patient enrollment system managed in accordance with statutory priorities and within any additional priority classifications established by VA. The eligibility reform act gave VA tools both to limit demand consistent with available funding and to discourage veterans from seeking VA care simply to fill an occasional need not met by a private health plan.⁶³¹ The act also requires the SECVA to manage the enrollment system such that care is timely and of acceptable quality.⁶³²

The enrollment system the department established is not being used today to calibrate supply and demand as envisioned.⁶³³ Although law and VA regulation require a system of annual patient enrollment,⁶³⁴ VHA last curtailed enrollment in 2003, and then only for veterans who were deemed eligible based on the category 8 criteria (see Table 8) that include those with higher-level incomes who lack any higher priority. In 2009, the Obama administration eased access for higher income veterans. Under that policy, veterans whose gross household income exceeds VA's current geographic income limit by 10 percent or less may enroll for VA care, subject to cost-sharing requirements.⁶³⁵ In 2014, Congress established the *Choice Program* to expand availability of care through contracts with community providers. Veterans' choice was limited by reference to distance and wait-time issues, but was otherwise broadly open to any enrolled veterans.⁶³⁶

comprehensive rehabilitative services, home health services, noninstitutional extended care services, hospice care, and pregnancy and delivery services and newborn care. Medical Benefits Package, 38 C.F.R. 17.38.

⁶²⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General 38 U.S.C. § 1710(a)(4).

⁶³⁰ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705. As explained in the report of the House Committee on Veterans Affairs which developed the legislation, "[T]he Act would...provide the VA with an important tool, the authority to design and manage access to care through a system of patient enrollment...Enrollment...would help the VA plan more effectively, so that facilities can better calculate and dedicate the resources needed to provide the care its enrollees require. The Act would direct the Secretary...to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment (or registration) system would operate. For example, the VA would be able to establish a system which simply registers patients throughout all or part of a fiscal year, or could employ a time-limited registration period. Significantly, the Act would permit the Secretary to set priorities within the specified priority classifications established in the Act. The Secretary could, for example, establish a policy which, within any priority classification, gives veterans who have previously been "enrolled" as VA patients priority over new applicants. However, the Committee expects any enrollment system to be designed and administered to assure that any veteran with a service-connected condition would receive priority treatment for that condition whether or not that veteran had enrolled for VA care." H. Rep. No.104-690, 6-7.

⁶³¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262; 110 Stat. 3177 (1996).

⁶³² Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705(b).

⁶³³ H. Rep. No. 104-690, 16.

⁶³⁴ Enrollment, 38 C.F.R. sec. 17.36(c). VA regulations state that "[i]t is anticipated that that each year the Secretary will consider whether to change the categories and subcategories of veterans eligible to be enrolled."

⁶³⁵ Enrollment, 38 C.F.R. 17.36(b)(8)(ii),(iv).

⁶³⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014). Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, Pub. L. No. 114-41 (2015).

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Table 8. Priority Groups

Priority Group	Definition
1	<ul style="list-style-type: none"> Veterans with VA-rated service-connected disabilities 50% or more disabling Veterans determined by VA to be unemployable due to service-connected conditions
2	<ul style="list-style-type: none"> Veterans with VA-rated service-connected disabilities 30% or 40% disabling
3	<ul style="list-style-type: none"> Veterans who are former prisoners of war Veterans awarded a Purple Heart medal Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty Veterans with VA-rated service-connected disabilities 10% or 20% disabling Veterans awarded special eligibility classification under Title 38, U.S.C. § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation" Veterans awarded the Medal of Honor
4	<ul style="list-style-type: none"> Veterans who are receiving aid and attendance or housebound benefits from VA Veterans who have been determined by VA to be catastrophically disabled
5	<ul style="list-style-type: none"> Non-service-connected veterans and noncompensable service-connected veterans rated 0% disabled by VA with annual income below VA's and geographically (based on resident zip code) adjusted income limits Veterans receiving VA pension benefits Veterans eligible for Medicaid programs
6	<ul style="list-style-type: none"> Compensable 0% service-connected veterans Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki Project 112/SHAD (shipboard hazard and defense) participants Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975 Veterans of the Persian Gulf War who served between August 2, 1990 and November 11, 1998 *Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987 Veterans who served in a theater of combat operations after November 11, 1998 as follows: <ul style="list-style-type: none"> Currently enrolled veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge. **Combat veterans who were discharged between January 2009 and January 2011, and did not enroll in the VA health care during their five-year period of eligibility have an additional one year to enroll and receive care. The additional one-year eligibility period began February 12, 2015 with the signing of the Clay Hunt Suicide Prevention for America Veterans Act. <p>Note: At the end of this enhanced enrollment priority group placement time period veterans will be assigned to the highest Priority Group (PG) their unique eligibility status at that time qualifies for.</p> <p>*Note: While eligible for PG 6; until system changes are implemented you would be assigned to PG 7 or 8 depending on your income.</p> <p>*Note: While eligible for PG 6; due to system limitations, veterans will be manually assigned to PG 8c, yet eligible for the enhanced benefits</p>
7	<ul style="list-style-type: none"> Veterans with gross household income below the geographically-adjusted income limits for their resident location and who agree to pay copays

Priority Group	Definition
8	<ul style="list-style-type: none"> ▪ Veterans with gross household income above VA and the geographically-adjusted income limits for their resident location and who agrees to pay copays <p>Veterans eligible for enrollment:</p> <p>Noncompensable 0% service-connected:</p> <ul style="list-style-type: none"> – Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA or geographic income limits by 10% or less <p>Non-service-connected and:</p> <ul style="list-style-type: none"> – Subpriority c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority d: Enrolled on or after June 15, 2009, whose income exceeds the current VA or geographic income limits by 10% or less <p>Veterans not eligible for enrollment:</p> <p>Veterans not meeting the criteria above:</p> <ul style="list-style-type: none"> – Subpriority e: Noncompensable 0% service-connected (eligible for care of their service-connected condition only) – Subpriority g: Non service-connected

Analysis

Two decades have passed since Congress last reexamined VHA eligibility and benefits, and many far-reaching changes that affect veterans' health care have occurred in that time. In more than a decade of war, 2.75 million troops have deployed to Iraq and Afghanistan⁶³⁷ where many have faced long and repeated deployments; constant risk of injury and death; and high levels of psychological disorders, substance abuse issues, and physical health problems.⁶³⁸ Post-9/11-era veterans are enrolling for VA care at historically high levels.⁶³⁹

Under current law and VA policy, enrollment is open to a relatively broad spectrum of veterans, though some veterans with higher incomes are not eligible to enroll.⁶⁴⁰ As discussed above, the law draws distinctions between those whose health problems have been adjudicated as service-connected and those whose problems are deemed non-service-connected. If Congress substantially reduced funding for VA medical care, the distinction would be important because those with service-connected issues have higher priority for enrollment. Under VA's current enrollment policy, which bars only veterans with higher incomes from receiving care, the

⁶³⁷ Defense Manpower Data Center, *Contingency Tracking System (CTS) Deployment File*, (Dec. 31, 2015).

⁶³⁸ Institute of Medicine of the National Academies, *Returning Home from Iraq and Afghanistan: Readjustment Needs of Veterans, Service Members, and Their Families*, (Washington, DC: The National Academies Press, 2013), accessed June 25, 2016, <http://www.nationalacademies.org/hmd/Reports/2013/Returning-Home-from-Iraq-and-Afghanistan.aspx>.

⁶³⁹ Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *Profile of Post-9/11 Veterans: 2014*, accessed May 27, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Post_911_Veterans_Profile_2014.pdf.

⁶⁴⁰ Veterans Health Administration, *Enrollment Determinations*, VHA Handbook 1601A.03, 9-10 (2015). Veterans with gross household income that do not exceed VA's means test threshold and a geographic means test by more than 10 percent may enroll for care, while those with higher income and no other special eligibility may not.

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statutory service-connected enrollment priority has little practical significance.⁶⁴¹ Future budget constraints could result in more restrictive enrollment criteria⁶⁴² or recurrence of lengthy wait times that hinder service-connected, disabled veterans' ability to receive timely care.

Current eligibility law does afford special status to veterans who deployed to a combat theater. It grants a 5-year window of eligibility for care to those veterans who are not otherwise eligible.⁶⁴³ All combat veterans are also eligible for readjustment counseling services at VHA Vet Centers without needing to enroll in VHA care and without time limitation.⁶⁴⁴ It is questionable, however, if the 5-year time limit takes sufficient account of continued reluctance of some veterans to seek care for behavioral health problems⁶⁴⁵ or of the difficulties of establishing service-connection years later for conditions that may be linked to wartime exposures to toxic substances.⁶⁴⁶ It is challenging for veterans to establish service-connection for health conditions that may have been caused by or associated with a long-distant exposure for which there may be no documentation. Given emerging evidence that combat exposure should be considered a risk factor for coronary heart disease,⁶⁴⁷ it has been suggested that combat exposure may not only take a toll on psychological health, but may exert a physiologic toll as well.⁶⁴⁸

Congress has attempted to remedy the challenge of documenting toxic exposures and establishing that particular illnesses are linked to wartime or other service exposure. It has, for example, enacted statutes that provide certain veterans eligibility for health care on the presumption that they were exposed to particular toxic substances.⁶⁴⁹ Congress went a step further in the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 which provided eligibility for care for several types of cancer and other specified conditions for family members of veterans who had been exposed to drinking water contaminated with industrial solvents and other toxic chemicals at the Marine Corp base.⁶⁵⁰

Congress has made only limited provision for VA to cover care for family members of certain veterans,⁶⁵¹ but with research suggesting that long combat deployments can take a

⁶⁴¹ Prior to 1996, provisions of law required VA to ensure special priority to service-connected veterans in furnishing outpatient care. 38 U.S.C. § 1712(i), repealed by § 101(c), Pub. L. No. 104-262.

⁶⁴² Enrollment, 38 C.F.R. 17.36(c)(1).

⁶⁴³ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(3), as amended by Sec. 7, Pub. L. No. 114-2 (2015), accessed June 20, 2016, <https://www.govtrack.us/congress/bills/114/hr203/text>.

⁶⁴⁴ Readjustment Counseling Service, 38 U.S.C. § 7309.

⁶⁴⁵ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶⁴⁶ Matthew S. King et al., "Constrictive Bronchiolitis in Soldiers Returning from Iraq and Afghanistan," *New England Journal of Medicine*, 365, no. 10 (2011): 222-230, accessed June 20, 2016, <http://doi.org/10.1056/NEJMoa1101388>.

⁶⁴⁷ Nancy F. Crum-Cianflone et. al., "Impact of Combat Deployment and Posttraumatic Stress Disorder on Newly Reported Coronary Heart Disease Among US Active Duty and Reserve Forces," *Circulation*, 129, (2014), accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.113.005407>.

⁶⁴⁸ Rachel Lampert, "Veterans of Combat: Still at Risk When the Battle is Over," *Circulation*, 129, (2014): 1797-1798, accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.114.009286>.

⁶⁴⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(10).

⁶⁵⁰ Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Pub. L. No. 112-154, 126 Stat. 1165 (2012).

⁶⁵¹ Health Care of Persons Other Than Veterans, 38 U.S.C. §§ 1781-1787.

psychological toll on family members,⁶⁵² there may be circumstances under which it might be argued that VA should afford such family members behavioral health services. Studies indicate that longer deployments, deployment extensions, and posttraumatic stress disorder in military personnel are associated with psychological problems for the spouse.⁶⁵³ Long-term effects are unknown, yet studies suggest children may have heightened risk for psychosocial issues during a parent's deployment.⁶⁵⁴

The experience of the nation's longest war and increased options available under the Affordable Care Act (ACA), particularly to previously uninsured non-service-connected veterans, may raise new questions for policymakers.⁶⁵⁵ VHA's most recent survey of enrollees showed that 20 percent of enrollees reported that they were uninsured, down from 22 percent in 2014.⁶⁵⁶ Enrollment in VHA-provided care meets the ACA requirement for health care coverage, creating pressure to continue to provide care to those enrolled.⁶⁵⁷ Given that VHA serves large numbers who are poor or near poor and have chronic medical conditions and behavioral health problems,⁶⁵⁸ it is important to note that receiving care under an ACA plan would not necessarily be a substitute for the rich benefits afforded through VHA. In addition, adults in this population are only eligible for coverage under ACA through state expansion of Medicaid that 19 states have elected not to accept, making this option unavailable to poor or near poor veterans in many parts of the country.⁶⁵⁹

Over time Congress has expanded VA health care eligibility to increasingly more cohorts of non-service-connected veterans. There is wide variability among different cohorts in the extent to which veterans rely on VA care. Those at the higher-income levels (priority categories 7 and 8) who were generally not eligible for ambulatory care prior to 1996, for example, rely on VA for

⁶⁵² Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, accessed June 20, 2016, <http://dx.doi.org/10.1186%2F1471-244X-10-88>. Swords to Plowshares, presentation to Commission on Care, January 21, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former servicemembers. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁶⁵³ H. Thomas De Burgh et al., "The Impact of Deployment to Iraq or Afghanistan on Partners and Wives of Military Personnel," *International Review of Psychiatry*, 23, no. 2 (2011): 192-200, <http://www.ncbi.nlm.nih.gov/pubmed/21521089>.

⁶⁵⁴ Gregory H. Gorman, Matilde Eide, and Elizabeth Hisle-Gorman, accessed June 20, 2016, "Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints," *Pediatrics*, 126, no. 6 (2010): 1058-1066, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-2856>. Anita Chandra et al., "Children on the Homefront: The Experience of Children from Military Families," *Pediatrics*, 125, no. 1 (2010): 16-25, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-1180>.

⁶⁵⁵ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁶ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁵⁷ "Affordable Care Act & Veterans," Department of Veterans Affairs, accessed May 27, 2016, <http://explore.va.gov/health-care-affordable-care-act?show=all>.

⁶⁵⁸ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁹ "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update," Rachel Garfield and Anthony Damico, Kaiser Family Foundation, accessed March 29, 2016, <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/>.

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less than 22 percent of their outpatient care-needs, based on VA's most recent survey of veteran enrollees' health and use of care.⁶⁶⁰

One consideration, as suggested by a few Commissioners, is the feasibility of allowing veterans' family members and currently ineligible veterans to purchase VHA care through their health plans in areas where VHA hospitals and other facilities might otherwise need to close. In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. A related challenge is maintaining safe volume of care when patient loads decline. As an extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁶¹ Similarly, VHA may be unable to continue offer specialty care in certain areas if it forced to close facilities. Patients in a polytrauma unit for example, require a full spectrum of routine and nonroutine health care.

Closing a low-volume hospital may be the answer in some instances. But closing VHA facilities reduces the choices available to veterans. Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. See Appendix C for a further discussion of the challenge of future VHA hospital closures and an outline of suggested pilot programs.

Substantial changes have occurred since Congress last comprehensively examined eligibility for VHA care. These changes merit a reexamination of VA health care eligibility.⁶⁶² The Commission did not, however, view its charge of examining veterans' access and how best to organize VHA, locate health care resources, and deliver care in the years ahead⁶⁶³ as calling for it to make recommendations on this fundamental policy issue, and recommends that the President or Congress consider tasking another body to develop recommendations for VA care eligibility and benefit design. The Commission's work, however, has illuminated the fact that nothing in law or regulation assures a service-connected, disabled veteran of priority for care. VA can and should amend its regulations to provide for such priority, subject to a necessarily higher priority for urgent and emergent care.

Implementation

Legislative Changes

- Task another body to examine the need for changing eligibility for VA care and benefits design, which would include simplifying eligibility criteria, and may include exploring

⁶⁶⁰ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 75, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁶¹ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

⁶⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 25, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶⁶³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

COMMISSION RECOMMENDATIONS

pilots for expanding eligibility for nonveterans to use underutilized providers and facilities when paid for through private insurance.

VA Administrative Changes

- SECVA should amend 38 C.F.R., chapter 17 to establish that veterans with service-connected disabilities shall be afforded priority for access to care, subject to the priority dictated by clinical care needs.

Other Departments and Agency Administrative Changes

- None required.

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APPENDIX A: FINANCING THE VISION AND MODEL

Estimating the Cost of Alternative Policy Proposals

This chapter presents estimates of the costs of allowing veterans access to expanded community care through integrated networks, as well as a range of other options. In the *Recommended Option*, the one chosen by the Commission and described in Recommendation #1, veterans would be eligible to receive community care for primary and standard specialty care with a referral from any primary care doctor in the VHA Care System. Special emphasis care, care provided in a distinctive fashion by VHA, is not included in community networks.

In addition to the *Recommended Option*, we considered three alternatives that are based on a similar concept of integrated networks, but which have potential costs that could vary dramatically due to differences in the openness of access to community care and the breadth of services eligible. We also estimated the costs of three options that differ in focus from the integrated network options, including options that move selected services entirely to the community, set up a premium support model, and expand access to all Priority 8 veterans. Finally, we estimated costs for two additional policies: expanding nurse navigator/care coordinator staff to help guide and coordinate veterans' care in the integrated networks of expanded community care and granting temporary eligibility for VA health care to those with other-than-honorable discharges.

Baseline Projections

We used projections from the Enrollee Health Care Projection Model (EHCPM) produced by VHA and Milliman as the baseline upon which to build our estimates. However, with the exception of the options involving premium support and an expansion of Priority 8 enrollment, we use separate analyses and not the EHCPM to derive the estimates. Costs of VA care are modeled as the product of utilization and cost per unit of care (unit cost). Utilization is dependent on both enrollment in, and reliance on, the VA health care system, total demand for health care, and other factors. Enrollment measures how many people enroll to receive VA health care, and reliance is the percentage of their medical care that enrollees receive through VA or VA-financed community care. Unit costs measure the cost of each health care service. Unit costs can be calculated for care in VA facilities, for care outside of VA facilities, or for both, depending on the scenario being estimated.

Utilization

Utilization depends on enrollment, reliance, total demand for health care, and characteristics of the health care system, such as medical technology and practice patterns. We discuss enrollment and reliance in further detail below, but overall demand for health care is similarly important. Enrollment, reliance, and overall demand each have a multiplicative effect on

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utilization and total costs. For example, if enrollment increases by 10 percent, costs will increase by 10 percent (assuming new enrollees have the same characteristics as existing enrollees). Thus, it is important to consider carefully the effect of any policy change on enrollment, reliance, and overall demand for health care. Each of these factors is subject to effects by policies that make care more convenient, less expensive, or less restricted.

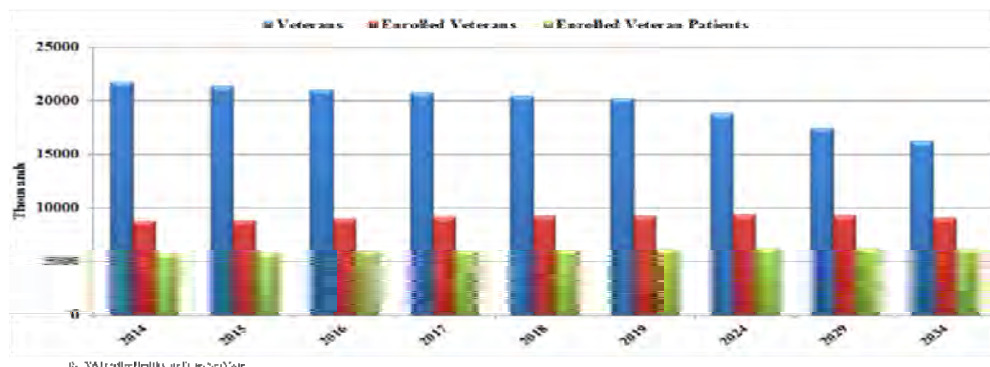
Enrollment

Currently there are 22 million veterans, 9 million of whom have enrolled and 7 million of whom are eligible to enroll but have not done so. Even though the number of veterans is decreasing, projected numbers of enrollees and patients should remain relatively stable during the next 20 years. Younger veterans enroll at particularly high rates, and once enrolled, they remain continuously enrolled until death.

This enrollment trend is subject to change based on various inputs. Enrollment rates are projected based on current policy, and if policy changes, the number of enrollees and patients will change. For example, an increase in cost sharing would likely decrease enrollment and the number of patients, yet easing access to care would likely increase enrollment and the number of patients. Changes to other health insurance policies outside of VA can also affect enrollment and the number of patients (for example, changes to the Affordable Care Act).

Figure A-1. Changes in Number of Veterans, Enrollees over a 20-year Period

Veterans, Enrollees, and Patients FY 2014-2034



Reliance

On average, enrolled veterans receive 34 percent of their health care through VHA, and approximately 80 percent of enrollees have other health insurance in addition to VA health care. Many factors affect reliance rates including, age, income, service-connected disabilities, distance from VA facilities, cost-sharing levels, and characteristics of other insurance options. Any policy that affects the cost of receiving VA care, the convenience of receiving VA care, the cost or convenience of other health insurance held by enrollees, or demographic or health characteristics of enrollees, is likely to change reliance. Any increase in reliance will increase

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costs to VHA, and the effect can be very large. In the absence of a policy change, VHA predicts that reliance will decline slightly from 34 percent to 32 percent during the next 20 years.

Unit Cost

Unit cost measures how much a particular service, procedure, or drug costs to provide. Unit costs can measure the cost of the unit of care in the VHA system or in the community, depending on where veterans receive care. We used unit cost projections from the EHCPM for 78 Health Care Service Categories (HSCs). The unit of measurement depends on the service. Examples include office visits, pathology procedures, vision exams, and inpatient surgical days. Unit cost projections reflect anticipated changes in price inflation and health care practice patterns, as well as historical trends. EHCPM projects separate unit costs, depending on whether veterans receive a service in a VA facility, in the community at historic Care in the Community (CITC) rates, or in the community at Medicare allowable rates. Any policy that affects the quantity of care provided in VA facilities, as opposed to the community, will have an effect on the total cost of care. If veterans receive care in the community, the rate of provider reimbursement will also affect costs.

Baseline Cost Projections

The baseline cost projections, produced by the EHCPM, show how cost will change in the future. They incorporate projected changes in enrollment, reliance, unit costs, and other factors. The projections reflect current policy with regard to enrollment eligibility and VA health care benefits, with the exception of the *Choice Program*, which is assumed to continue for veterans living more than 40 miles away from a VA medical care facility.⁶⁶⁴

We based the projections on assumptions about inflation and anticipated effects of changes in health care practice on the cost of VA health care in the next 20 years. New military conflicts, policies, legislation, regulations, and external factors, such as economic recession, can occur and change projected demand for VA health care during this period. The projections do not include requirements for several activities/programs not projected by the VA EHCPM, including nonrecurring maintenance; readjustment counseling; state-based, long-term services and support programs; and some components of the CHAMPVA program.

In the absence of any policy changes, costs increase from \$53 billion in 2014 to \$125 billion in 2032. This growth is largely due to inflation and how health care practices are expected to change over time, which reflects factors that affect the cost of both VA and non-VA health care. These trends increase the cost of VA health care regardless of changes in enrollment growth and demographics. Within enrollment, the increasing number of enrollees adjudicated for service-connected disabilities by the Veterans Benefit Administration (VBA) is the most significant driver of cost increases. Enrollees will likely increase their reliance to reflect the substantially higher reliance of enrollees in the service-connected Priorities 1-3.

These baseline estimates, along with our scenario estimates presented below, carry some key limitations. First, the EHCPM does not track capacity at VA facilities. We assume health care

⁶⁶⁴ Veterans qualifying based on wait times or excessive travel burdens are not included.

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utilization will increase or decrease at the average unit cost, when in fact it is the marginal cost that would be relevant for cost estimates. This marginal cost could be smaller or larger than the average cost, depending on existing capacity. Although we did make some assumptions about fixed and variable unit costs when care leaves VA facilities in our policy estimates below, precise estimates are not possible given data availability. Second, the EHCPM does not consider health care capacity in local communities. For these and other reasons, the EHCPM is best for the near future and for policy scenarios that do not stray dramatically from current policy. A 2008 RAND review of the EHCPM highlighted these limitations, which are particularly important for analyzing policy changes such as expanded community care.⁶⁶⁵ In light of the types of policy choices VHA is likely to consider in the future, it would be particularly beneficial for VHA to collect and incorporate the data necessary to mitigate these limitations. Due both to these limitations and to the general uncertainty regarding any long-term changes in the health care system, we suggest focusing attention on the 2019 estimates of the scenarios below, as 2019 is the first year to incorporate the fully phased-in effects of the scenarios.

Policy Estimates

In this section, we present results for the *Recommended Option* and three alternative options for expanding access to providers outside of VA through integrated networks. These options expand community care for different categories of care and vary by whether referrals are required to receive specialty care. We present estimates for several other scenarios we examined, each with a design or focus that differs from the integrated network options. Finally, we estimate costs for two other policies discussed in this report: (1) expanding the use of nurse navigators to help patients coordinate their care in VA and in the community, and (2) expanding eligibility to all veterans with an other-than-honorable (OTH) discharge until the adjudication process is complete to determine whether they will remain eligible.

Community-Delivered Services Networks

This section describes the *Recommended Option* and the first three alternative options. At least initially, all care currently provided by VA would continue to be provided by VA. In addition, expanded community care, also called Community-Delivered Services (CDS), will be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA. CDS will focus on tertiary and quaternary care, and may include primary care and all standard specialty care, depending on the scenario considered. CDS will not include special-emphasis care and some types of specialty care provided in a distinctive fashion by VHA. The network of CDS providers that VA will coordinate varies by community. To make the flow of service both appropriate and smooth in operation, there will be navigators who will help guide veterans to the best and most appropriate providers inside and outside VA.

The Commission's recommendation to create the VHA Care System (see Recommendation 1) considers the ways in which health plans can vary the size and scope of networks as a means of managing costs. It highlights that broad, open networks offer greater choice, but narrow, well-

⁶⁶⁵ Katherine M. Harris, James P. Galasso, and Christine Eibner, "Review and Evaluation of the Enrollee Health Care Projection Model," RAND Corporation, Santa Monica, CA, 2008.

managed networks potentially result in lower costs. It discusses ways in which, after networks are designed, VHA could exercise additional cost controls by steering patients to different providers within the networks. Finally, the recommendation regarding the VHA Care System emphasizes that access and local needs are important considerations in setting up the integrated networks, and that governance of the networks should be a process of ongoing management and evaluation.

In the estimates that follow, we assume that networks are designed and governed in a way that gives major consideration to cost, choice, and access. We assume that management of the integrated networks would be an iterative process that involves continual evaluation of resulting outcomes, including cost outcomes, and that networks would be adjusted in light of those outcomes. We also assume that local communities and services with poor access would require more community providers and/or expanded capacity within VHA than those that already have adequate access. Finally, we assume that the networks will be integrated, relatively narrow, and well-managed with the aim of controlling costs effectively. One exception is that for the *Recommended Option*, we added an estimate that assumes less-managed, broader networks to illustrate that costs are sensitive to network size and management.

Technical Assumptions for Community-Delivered Services Options

We based our estimates on utilization and unit cost data and projections for 78 HSCs that we obtained from the VHA Office of Policy and Planning. Starting from a base year of 2014, we projected utilization and unit costs through 2034. For HSCs that are eligible for CDS networks, we assume a certain fraction of care, depending on the option, shifts from VA facilities to the networks. We assume traditional CITC will be offered and used at baseline levels.⁶⁶⁶ We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks. All effects are phased in during the first 5 years.

Both CDS networks and CITC are priced at Medicare allowable rates by matching Medicare fee schedule data to VA HSCs.⁶⁶⁷ A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities.

For care shifting into the CDS networks, we use data on the components of HSC unit costs that we obtained from the VA Allocation Resource Center. We assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. These portions, which together averaged approximately 10 percent of care in 2014, form our proxy for the portion of unit costs that VA will not be able to shed in scenarios for which, on net, care leaves VA facilities for CDS networks. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance. These costs are not part of the EHCPM, and costs and/or savings associated with changes to facilities and nonrecurring maintenance are not included in our estimates.

⁶⁶⁶ CITC accounted for approximately 11 percent of modeled expenditures in the base year 2014.

⁶⁶⁷ Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

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Improving access, choice, and/or quality of services is likely to induce greater reliance and enrollment in the VA system. Although reliance and enrollment increases result in greater budgetary costs for VA, it is important to note that these increases do not represent societal costs or costs to the government. The VA budgetary cost increases may be associated with reductions in out-of-pocket expenses and improved health care benefits for patients, as well as savings to Medicare, Medicaid, and other government programs. Our cost estimates are confined solely to the VA budget.

Approximately 52 percent of eligible veterans have enrolled in VA health care, and enrolled veterans receive 34 percent of health care through VA. There is little data from which to anticipate how reliance and enrollment might change under the scenarios, and our estimates use wide ranges of assumptions for these parameters. In forming our assumptions, we consider a variety of factors, such as insurance coverage and other characteristics of eligible veterans (both enrolled and unenrolled), survey responses of veterans (both enrolled and unenrolled) on use and reasons for lack of use of VA health care, and research on take-up of health insurance coverage.⁶⁶⁸ We are confident that enrollment and reliance would increase more with greater patient choice and access. For all options, we present low, middle, and high estimates.

In addition to increases in reliance and enrollment, reduced cost sharing, increased convenience of receiving community care, and the removal of a requirement to get a referral for specialty care can increase the total amount of medical care that a patient receives. Depending on the option considered, some health care is subject to reduced cost sharing from levels typical of private insurance coverage and Medicare to the very small levels of cost sharing found in the VA system. We assume utilization increases for health care subject to lower cost sharing and/or removal of a requirement to get a referral, with our estimates based in part on the literature examining how cost sharing affects health care demand.⁶⁶⁹

Caveats

There are a number of caveats associated with all of our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. New enrollees are assumed to cost slightly less than existing enrollees for *CDS Alternative 3* and the

⁶⁶⁸ Examples of sources include: the 2014 American Community Survey; the 2010 National Survey of Veterans; the 2015 Survey of Veteran Enrollees' Health and Use of Health Care; Katherine Baicker, William J. Congdon and Sendhil Mullainathan, "Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics," *The Milbank Quarterly*, 90(1) (2012), 107-134.

⁶⁶⁹ Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," Washington, DC, 2008. Willard G. Manning, Joseph P. Newhouse, Naihua Duan, Emmett B. Keeler, Arleen Leibowitz, and M. Susan Marquis, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review* 77(3) (1987), 251-77.

same as existing enrollees in the *Recommended Option* and *CDS Alternatives 1 and 2*.⁶⁷⁰ Finally, we do not estimate any administrative costs associated with CDS networks other than the additional RN care managers hired to handle the increased clinical and administrative burden of expanded community care. These additional, nonmodeled administrative costs could be substantial.

Commission Recommended Option

The *Recommended Option* would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA or a third-party administrator. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in VA in a distinct fashion).⁶⁷¹ In 2014, 68 percent of care would have been eligible for CDS networks at current VA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network. In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a doctor in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and 20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was

⁶⁷⁰ Assumptions based on previous analysis by VHA and Milliman.

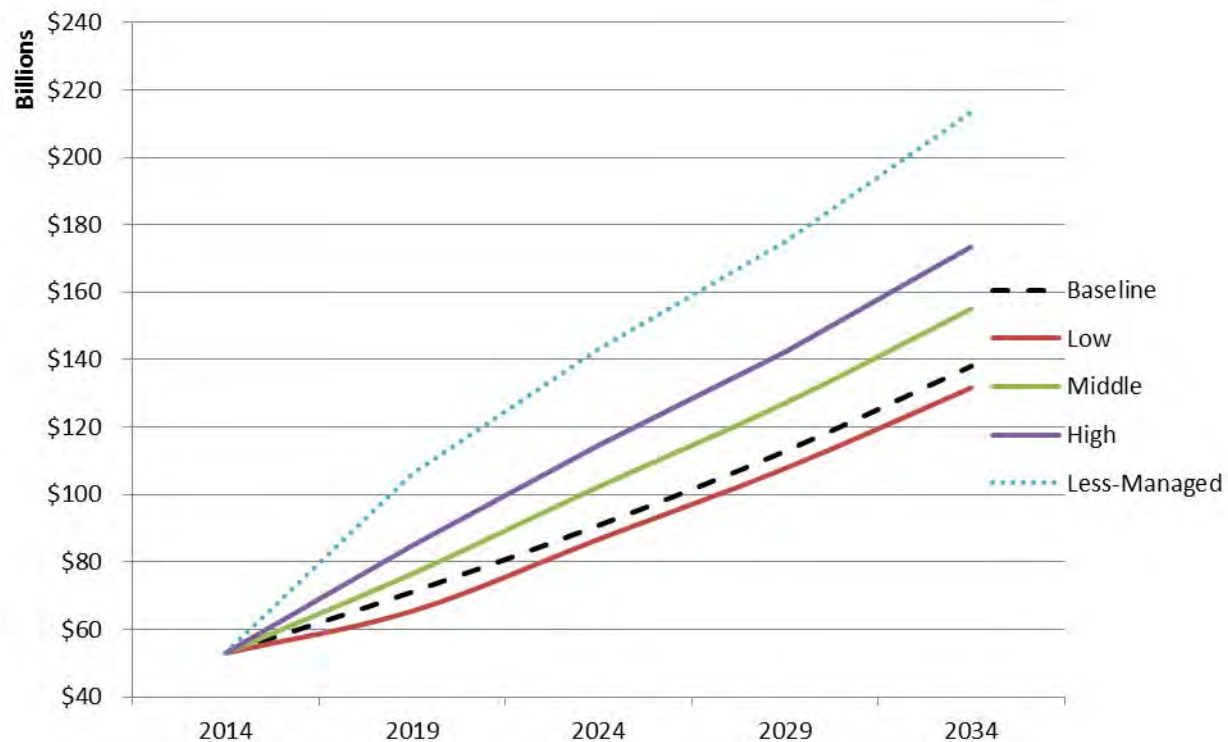
⁶⁷¹ Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

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formerly subject to sizable cost sharing with private insurance or Medicare, and now it would be subject to little if any cost sharing associated with VA-financed care.

Figure A-2 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from \$65 billion to \$85 billion in 2019, with a middle estimate of \$76 billion. The middle estimate is moderately above the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is \$106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

Figure A-2. Projected Costs of Recommended Option



APPENDIX A

FINANCING THE VISION AND MODEL

COST ESTIMATES Commission on Care Scenarios							
	Brief Description	Utilization Increase	Enrollment Increase (low, middle, high)	Reliance (low, middle, high)	Cost FY 2014 Actual (billions)	Cost FY 2019 Projected (billions)	Cost FY 2034 Projected (billions)
Baseline	2014 Actual		9,078,615	34%	\$53	\$ 71	\$ 138
Recommended (low)	Referral Based Care in VHCS (68% of current VHA care eligible as CDS)	+20% of new demand in CDS Care	5%	40%	\$	65	\$ 132
Recommended (middle)	same	same	15%	50%	\$	76	\$ 155
Recommended (high)	same	same	20%	60%	\$	85	\$ 173
Recommended (less-managed)	same	same	50%	60%	\$	106	\$ 213
Alternative 1 (low)	Similar to Recommended but primary care, inpatient med and surg and some standard specialty care not eligible for CDS remain in VHA (47% of care eligible for CDS)	+20% of new demand in CDS Care	0%	10%	\$	66	\$ 128
Alternative 1 (middle)	same	same	5%	35%	\$	73	\$ 140
Alternative 1 (high)	same	same	10%	50%	\$	78	\$ 151
Alternative 2 (low)	Similar to Alternative 1 but primary care coordinator must only be consulted; no referral required (47% of care eligible for CDS)	+20% CDS eligible Care	5%	60%	\$	97	\$ 191
Alternative 2 (middle)	same	same	10%	80%	\$	123	\$ 243
Alternative 2 (high)	same	same	20%	100%	\$	154	\$ 307
Alternative 3 (low)	Similar to Alternative 2 but primary care, inpatient med/surg and specialty care eligible for CDS and no consult required	+20% CDS eligible Care	75% (level)	80%	\$	167	\$ 320
Alternative 3 (middle)	same	same	85% (level)	90%	\$	206	\$ 395
Alternative 3 (high)	same	same	95% (level)	100%	\$	250	\$ 479
Keep Selected Services (low)	Move most standard ambulatory specialty care to community	+20% of new demand in CDS Care	0%	10%	\$	64	\$ 128
Keep Selected Services (middle)	same	same	4%	25%	\$	70	\$ 136
Keep Selected Services (high)	same	same	8%	40%	\$	75	\$ 145
Premium Support	Enrollees under age 65 can choose a subsidized insurance premium with cost sharing in lieu of VHA care	42% of enrollees <65 choose premium support	6%		\$	82	\$ 158
Eligibility Expansion	Allow all eligible veterans to enroll	increase to 30% market share among priority 8	5%		\$	72	\$ 140
Initiatives	Nurse navigators for CDS care				\$	71	\$ 138
	Make veterans with Other than Honorable Discharges Temporarily Eligible for VA Health Care While Claims are Adjudicated				\$	72	\$ 139

Additional Sample Cost Models

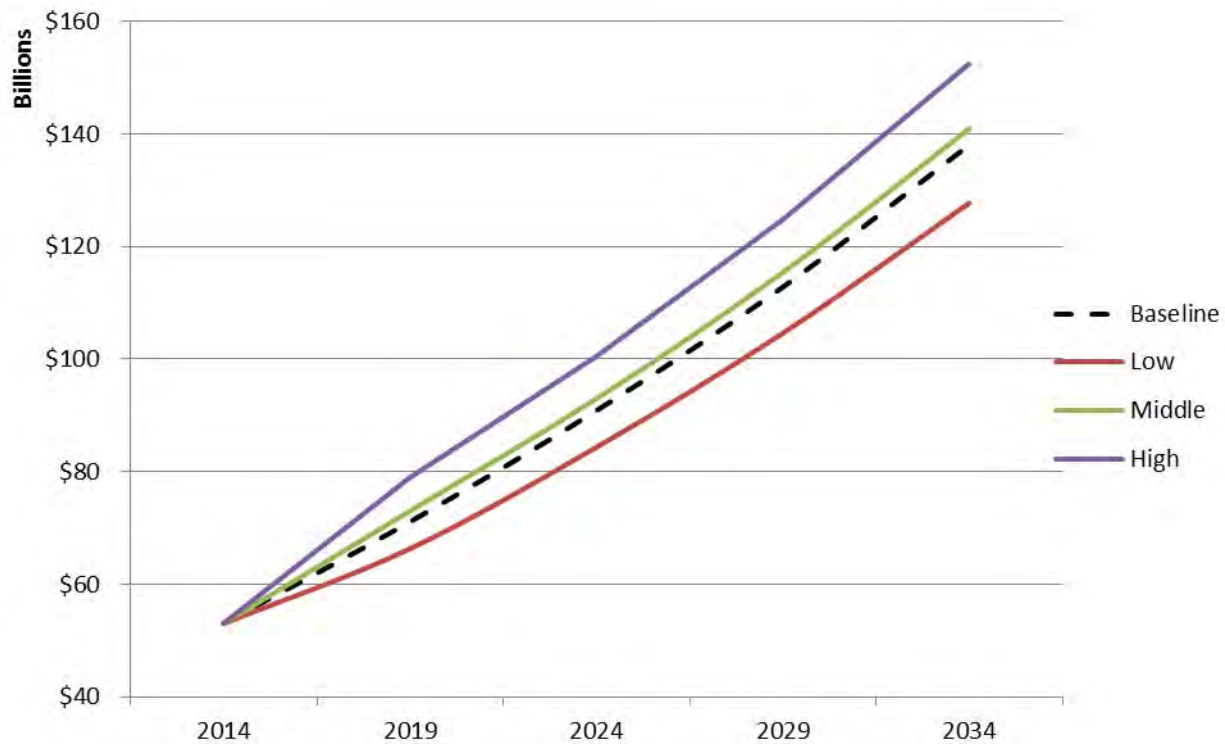
CDS Alternative 1

CDS Alternative 1 is similar to the Commission's *Recommended Option* above. The main difference is that a narrower subset of services is available in the CDS networks. Primary care, inpatient medical and surgical care, and some standard specialty care are not eligible for CDS networks and must be accessed within VA. The CDS network for *CDS Alternative 1* would focus on tertiary and quaternary care; it would not include primary care, some specialty care, inpatient medical and surgical care, and special-emphasis care (care that is provided in VA in a distinct fashion). In 2014, 47 percent of care would have been eligible for CDS networks.

Because less care is eligible for CDS networks than in the *Recommended Option*, less care will shift to CDS networks, reliance increases will be smaller, and enrollment increases will be smaller. We assumed that 50 percent of eligible care shifts from VA facilities to CDS networks. We modeled increases in reliance of 10, 35, and 50 percent, which correspond to reliance rates of approximately 37, 46, and 51 percent. These reliance increases pertain only to CDS care, not CDS-eligible care provided in VA facilities. We modeled enrollment increases of 0, 5, and 10 percent. As in the *Recommended Option*, we assume newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks.

Figure A-3 displays estimates for CDS Alternative 1. Estimates range from \$66 billion to \$78 billion in 2019, with a middle estimate of \$73 billion. As in the *Recommended Option*, the middle estimate is close to the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to Medicare allowable rates for CDS networks and CITC offsets these effects.

Figure A-3. Projected Costs of CDS Alternative 1



CDS Alternative 2

Like *CDS Alternative 1*, CDS care in *Alternative 2* would focus on tertiary and quaternary care. CDS networks would not include primary care, special-emphasis care, inpatient medical and surgical care, and some types of specialty care.

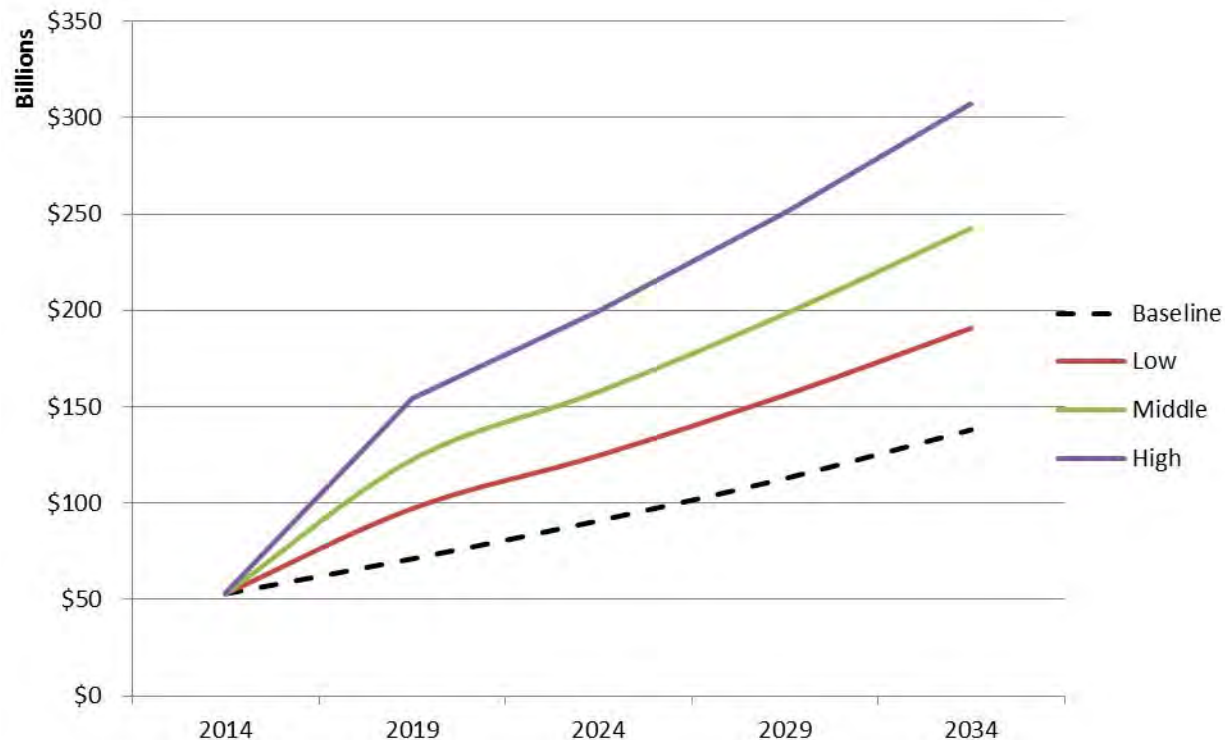
This option differs from the *Recommended Option* and *CDS Alternative 1* in that veterans must consult their VHA primary care provider in some way before seeking specialty care, but they *do not* need a referral to receive CDS eligible care whether they receive it in or out of VA. Some specialty care, all primary care, and all special-emphasis care are only provided in VA unless the veteran is eligible for traditional CITC. However, after the primary care consultation, the choice of whether to seek eligible care in CDS networks is entirely up to the veteran. As in *CDS Alternative 2*, the care eligible for CDS networks comprised 47 percent of total modeled expenditures in 2014.

We expect reliance increases to be relatively high, and we apply these reliance increases to CDS eligible care regardless of where veterans receive it because referrals are not required for any CDS eligible care. Further, we expect enrollment increases to be higher than the *Recommended Option* and *CDS Alternative 1* because the absence of a referral requirement makes this a more attractive policy for potential enrollees. We model reliance rates of 60, 80, and 100 percent for care eligible for CDS networks; enrollment increases of 5, 10, and 20 percent; 70 percent of VA facility care shifting into CDS networks; and a 20 percent utilization increase for CDS eligible care.

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Estimates are displayed in Figure A-4. In 2019, the baseline projection is \$71 billion. *CDS Alternative 2* estimates range from \$97 billion to \$154 billion, with a middle estimate of \$123 billion. The potential for considerable reliance and enrollment increases could push costs substantially higher than the baseline.

Figure A-4. Projected Costs of CDS Alternative 2



CDS Alternative 3

CDS Alternative 3 differs from *Alternative 2* in two main ways. First, a broader array of care is eligible for CDS networks. CDS would include primary and standard specialty care, including inpatient medical and surgical care. It would not include special-emphasis care (care that is provided in VA in a distinct fashion). This array of eligible care is the same as that for the *Recommended Option*, and comprised 68 percent of total modeled expenditures in 2014. Second, enrollees do not need to consult with a primary care doctor in order to access CDS eligible care.

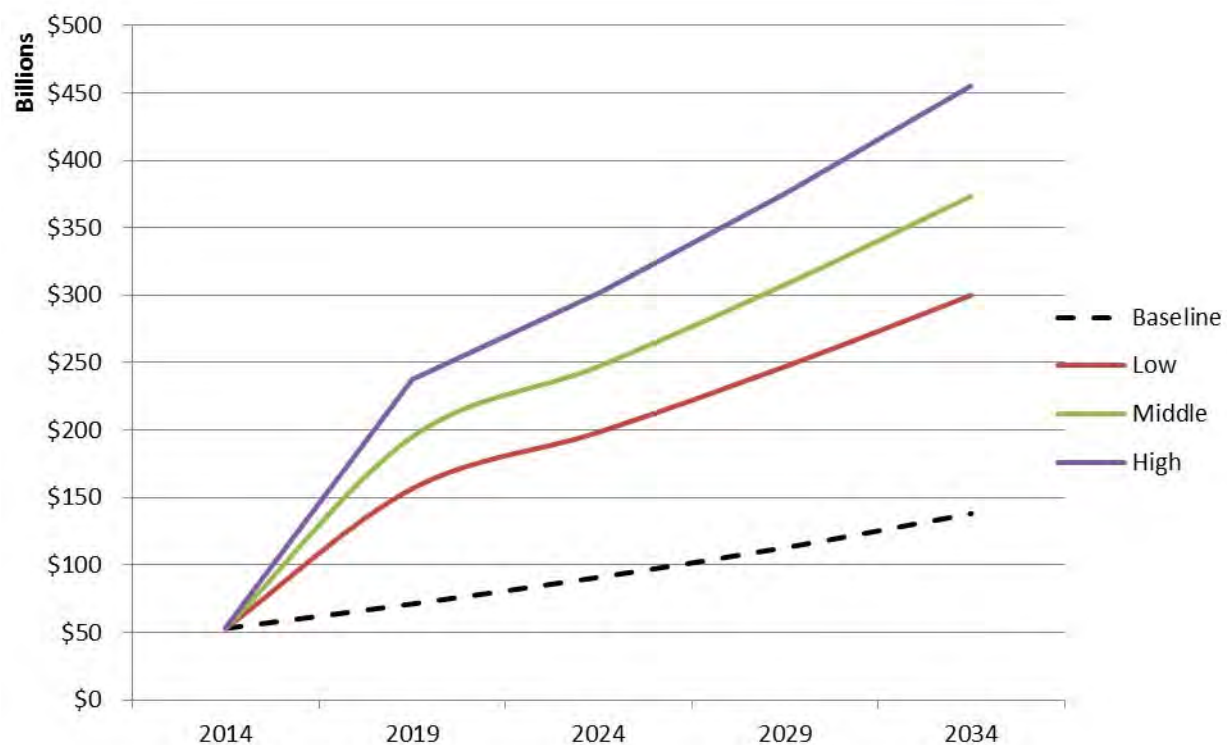
CDS Alternative 3 would offer an extremely generous benefits package for patients. With no referral or consultation, no premiums, and little if any copayments, patients would have access to a robust network of high-quality providers in their area. Although care within VA facilities would be available, no clinical contact would be necessary for those seeking care in CDS networks. Even within VA facilities, care is more attractive because patients would no longer need to consult their primary care doctors to receive specialty care. The benefits of this option contrast with the 10 to 30 percent cost sharing typical in Medicare and private coverage, the low

provider reimbursements, stigma and access barriers often associated with Medicaid,⁶⁷² and the requirements for referrals and/or prior authorizations that are widespread among health insurance plans. Few veterans would have reason to turn down such an attractive option.

Consequently, we model high ranges for reliance, enrollment, and care shifting into CDS networks. We model reliance rates of 80, 90, and 100 percent for all CDS eligible care; enrollment shares of 75, 85, and 95 percent; and a 70-percent rate of eligible care shifting from VA facilities to CDS networks. We apply the reliance increases to all care eligible for CDS networks, even if the care is provided in VA facilities or traditional CITC, because this option eliminates the need for consultations with primary care doctors for all CDS eligible care. Additionally, we assume that the total amount of CDS eligible care received by veterans from any provider and payer increases by 20 percent due to the lack of a referral requirement and/or reduced cost sharing.

Estimates are displayed in Figure A-5. In 2019, when effects are fully phased-in, estimated costs range from \$156 billion to \$237 billion, with a middle estimate of \$195 billion. This compares to a baseline projection of \$71 billion. Although estimates are highly uncertain, a key takeaway is that this option could result in very large cost increases relative to the baseline scenario, *Recommended Option*, and *CDS Alternatives 1 and 2*.

Figure A-5. Projected Costs of CDS Alternative 3



⁶⁷² Yu-Chu Shen and Stephen Zuckerman, "The Effect of Medicaid Payment Generosity on Access and Use among Beneficiaries," *Health Services Research* 40, no. 3 (2005), 723-44. Jennifer Stuber and Karl Kronebusch, "Stigma and Other Determinants of Participation in TANF and Medicaid," *Journal of Policy Analysis and Management* 23, no. 3 (2004), 509-530.

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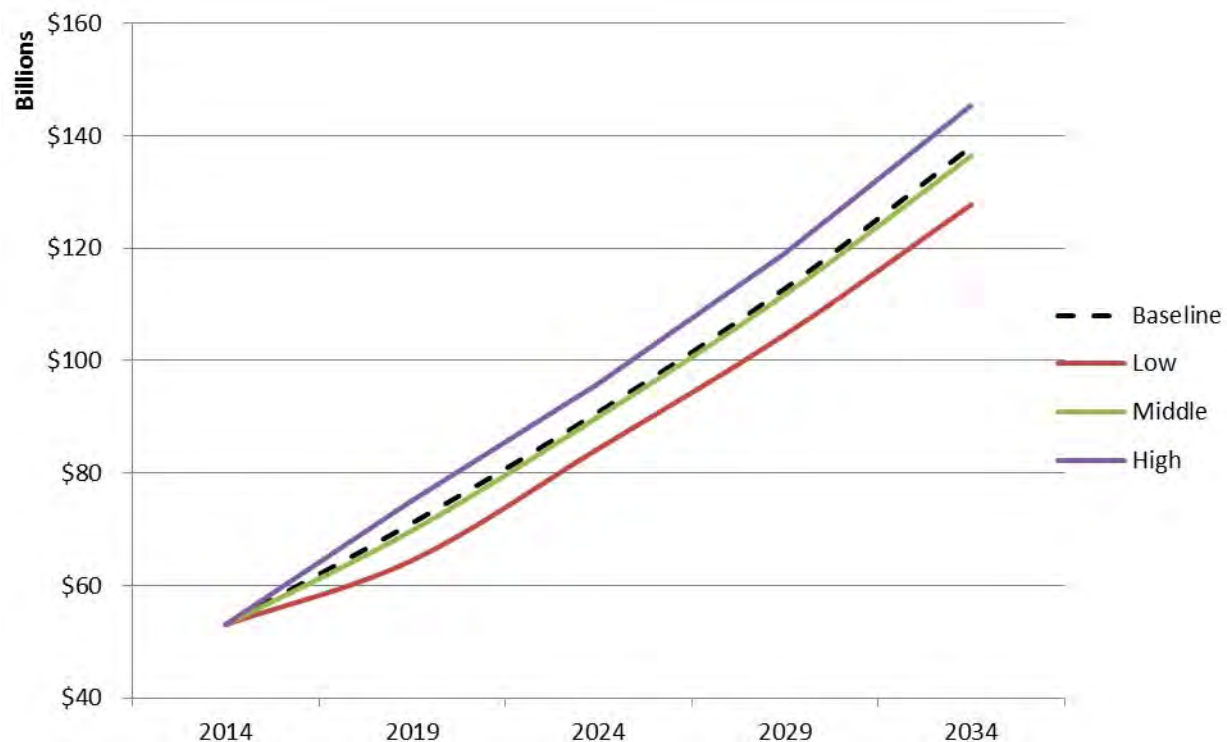
Keep Selected Services

The *Keep Selected Services (KSS)* scenario would move most standard ambulatory specialty care entirely into the community, yet keep the remainder of care entirely within VA facilities or traditional CITC. Although VA would no longer provide most standard ambulatory specialty care in VA facilities, it would continue to provide primary care, inpatient care, and special-emphasis care in VA facilities, including long term services and supports, prosthetics and orthotics services, inpatient and outpatient mental health and substance abuse, inpatient medical and surgical care, prescription drugs, medication management, recreational therapy, and immunizations. Under this scenario, approximately 35 percent of the cost of care currently provided in VA would be provided solely in the community. Providers in the community would receive Medicare rates.

We modeled increases in reliance of 10, 25, and 40 percent, which correspond to reliance rates of approximately 37, 43, and 48 percent. These reliance increases pertain only to care that moves into the community. We modeled enrollment increases of 0, 4, and 8 percent.

Estimates are displayed in Figure A-6. In 2019, when effects are fully phased-in, estimated costs range from \$64 billion to \$75 billion, with a middle estimate of \$70 billion. This estimate compares to a baseline projection of \$71 billion. Although estimates are highly uncertain, a key takeaway is that even with expanded community care, cost increases are constrained when veterans cannot choose whether they receive care in VA facilities or in the community.

Figure A-6. Projected Costs of Keep Selected Services Scenario



Premium Support⁶⁷³

Under the *Premium Support* (PS) scenario, all current and future enrollees younger than age 65 can choose a subsidized insurance premium with cost sharing (for some priorities) in lieu of their current VHA benefit. Enrollees electing the premium and cost sharing subsidy no longer have access to any VA services, including the special services VA offers. Under this scenario, there is an annual election period, and VA actively engages with enrollees to make a decision. Enrollees ages 65 and older receive no additional benefit options.

For those enrollees choosing the subsidized insurance program, the cost sharing varies by priority level: 10 percent for priorities 1 and 2; 20 percent for priorities 3 and 4; 30 percent for priorities 5 and 6; and 40 percent for priorities 7 and 8. Veterans would buy *Silver* policies on the state individual insurance exchanges, and VA would provide additional cost sharing assistance to meet the target subsidy. If enrollees purchased plans offered with lower cost sharing, such as *Gold* (20 percent cost sharing) or *Platinum* plans (10 percent cost sharing), the additional premium costs would likely exceed the cost of purchasing a Silver plan and subsidizing the cost sharing. The cost estimates did not consider the potential effect of adding a large number of veterans on exchange plans. Were VA to do this, considerations for veteran morbidity as well as the proposed cost sharing subsidies would need to be accounted for within the purchase of state exchange plans from commercial insurers.

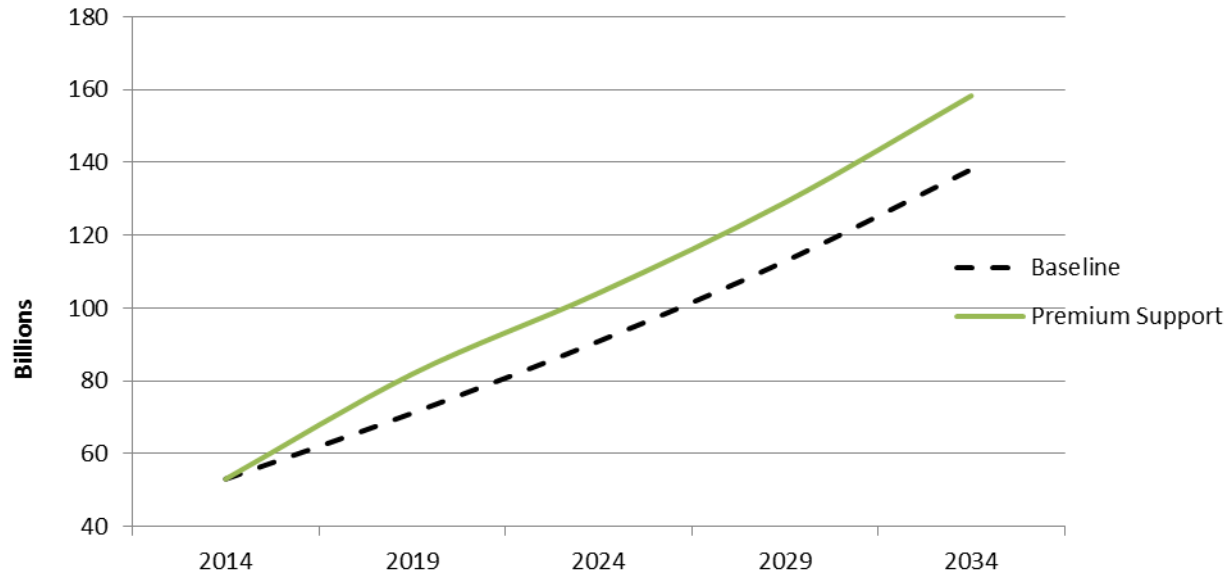
To determine participation rates in the subsidized premium program, we summarized enrollees' FY 2014 baseline data into cost brackets by attaching 2015 EHCPM unit costs to workload and then summarizing the total cost of workload provided to each enrollee. Overall, 42 percent of enrollees younger than age 65 were assumed to select the subsidized premium option, but the model assigned different rates of participation depending on enrollees' priority level and historical VA utilization. Enrollees with little to no costs were assumed to participate in the program at a higher rate as compared to those who had larger levels of VA costs. Participation rates for priority 5 veterans were assumed to be half the rates set for other priority levels. This assumption was made because many of these lower-income enrollees already have the option of participating in a highly subsidized state exchange plan with low cost sharing. It is also assumed that offering this option will motivate additional nonenrolled veterans to enroll to receive the subsidized premium plan. To estimate this effect, we analyzed the proportion of veterans by priority level with either no insurance or individual insurance plans, as reported in recent years of data captured by the American Community Survey (ACS). We estimated that this potential subsidy would lead to an additional 577,000 enrollees over the projection period.

Finally, it is assumed that the subsidized premium plan serves as a primary payer and does not supplement other coverage available to the enrollee, such as Medicare or employer sponsored insurance.

⁶⁷³ Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.

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Figure A-7. Projected Costs of Premium Support Scenario



Eligibility Expansion⁶⁷⁴

Under the *Eligibility Expansion* (EE) scenario, the VA health care system expands to allow all veterans to enroll in VA health care. In 2014, half of veterans eligible under priorities 1-7, 8b,⁶⁷⁵ and 8d were enrolled, representing a 50 percent *market share*,⁶⁷⁶ with the highest market share among those with service-connected priorities. The market share among Priorities 8a and 8c was an estimated 21 percent, reflecting enrollment from before suspension began in January 2003 and from enrollees who initially enrolled in another priority and later transitioned to Priorities 8a and 8c. If the suspension of new priority 8 enrollment had never occurred, we estimate that the market share would be 28 percent in 2014 and 30 percent in 2021 under natural growth and priority transition rates.

Under a scenario of lifting priority 8 enrollment suspension beginning in FY 2017, we estimate that the market share would climb steadily during a 5-year phase-in period to reach 30 percent in 2021, which equates to 464,000 new priority 8 enrollees. The market share is not expected to reach the level observed among other priorities because Priority 8 veterans have higher incomes, are not service-connected disabled, are more likely to have employer-sponsored coverage and individually purchased health plans, and are less likely to be uninsured relative to other priorities. Further, regression analysis of market shares among veterans in census data demonstrated that higher income veterans, nondisabled veterans and veterans with employer-sponsored health insurance are all less likely to enroll. To develop the cost estimates, newly

⁶⁷⁴ Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.

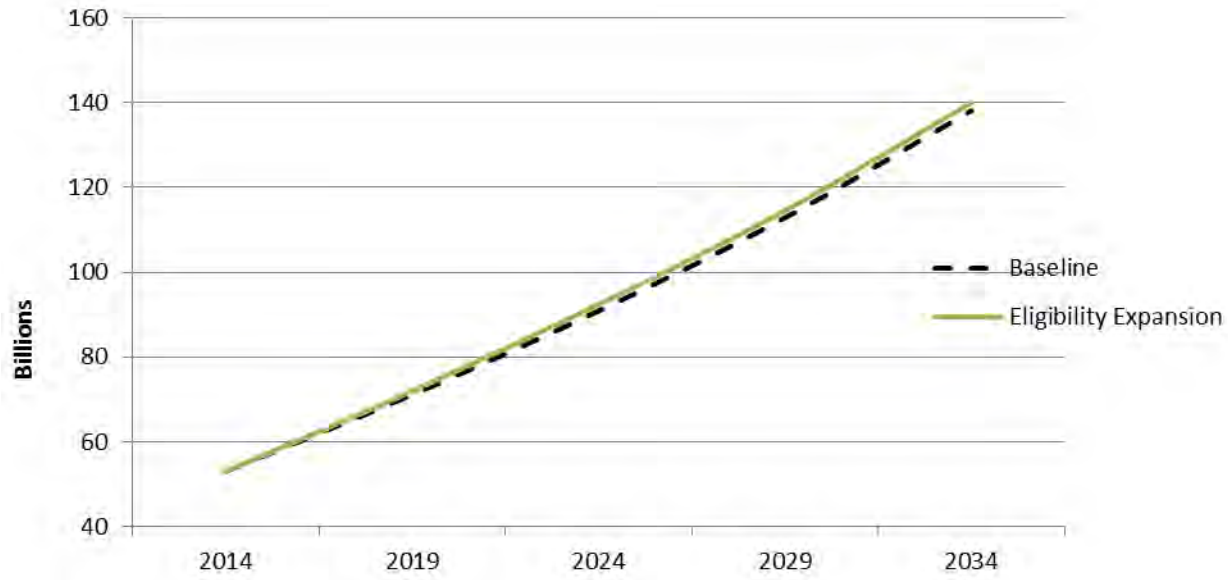
⁶⁷⁵ Priority 8b and 8d were enrolled on or after June 15, 2009 and have incomes that exceed the current VA or geographic income limits by 10 percent or less.

⁶⁷⁶ Market share is the percentage of veterans who are enrolled in VHA out of all veterans. This differs from the enrollment share, which is the percentage of eligible enrollees who are enrolled.

eligible priority 8 veterans are assumed to have the same morbidity and reliance as current priority 8 enrollees.

By 2032, based on the estimated market share, we project an additional 368,000 priority 8 enrollees with an additional \$1.8 billion in costs.

Figure A-8. Projected Costs of Eligibility Expansion Scenario



Additional Cost Factors

Nurse Navigators

VHA already has a robust care manager program that largely overlaps with the proposed nurse navigators in the CDS scenarios. VHA patient aligned care teams (PACTs) were created to coordinate care and maintain long-term relationships with patients. Most PACTs exist in a primary care setting, but there are also special-emphasis PACTs, such as those for spinal cord injury and disorders, geriatrics, and HIV care. All patients may choose to be assigned to a primary care PACT, and the vast majority do so: There are approximately 5.3 million unique patients in primary care PACTs out of a total of 5.8 million.

The primary care PACT typically consists of a provider, an RN care manager, a clinical associate, and a clerk. This team is assigned to a panel of approximately 1,200 patients. There are also expanded team members who are assigned to multiple panels, such as clinical pharmacy specialists, nutritionists, and behavioral health professionals. The RN care manager is the lynchpin of the primary care PACT.

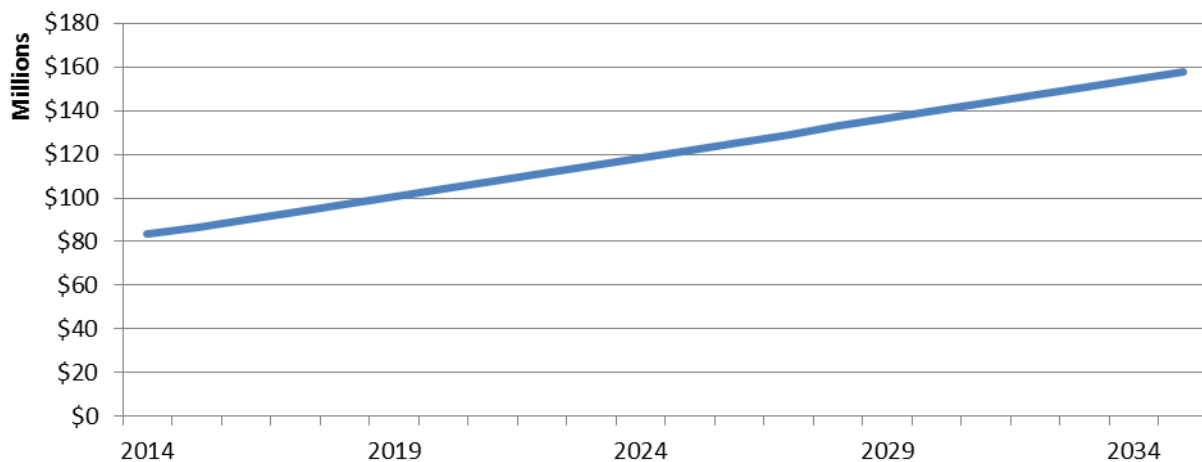
One of the tasks of the care manager is to coordinate care received in VHA facilities with care received in the community. Because this coordination role would increase with the CDS scenarios, we provide a notional estimate for expanding the number of care managers to account for the additional administrative and clinical burden of an increase in community care.

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Based on discussions with VHA primary care operations and policy staff, we assume that one additional RN care manager per five panels would be necessary to handle a substantial increase in community care such as that associated with the CDS scenarios.⁶⁷⁷ Based on 2014 data on the number of patients in PACTs and the recommended panel size, we estimate that 882 RN care managers would need to be hired if the CDS scenarios were fully phased in. Incorporating the average total compensation of RN care managers (\$94.4 thousand in FY 2014) and inflating costs using the projected patient population and personnel inflation trend from the EHCPM, we generate the following cost estimates. These estimates are assumed to be fully phased in. The cost of this policy is \$100 million in 2019 and rises to \$158 million in 2034.

Figure A-9. Cost of Hiring Additional RN Care Managers



Other-than-Honorable Discharges

We also consider a policy for which those with an OTH discharge are made temporarily eligible for VA health care while their claims are adjudicated. The adjudication process would determine whether these individuals would remain eligible for care or would lose eligibility. Adjudication would be based on the reason for the discharge. For example, if the discharge were due to behavior associated with a mental health condition caused by serving in the military, that person would likely be positively adjudicated. However, the specific criteria for adjudicating cases still needs to be determined.

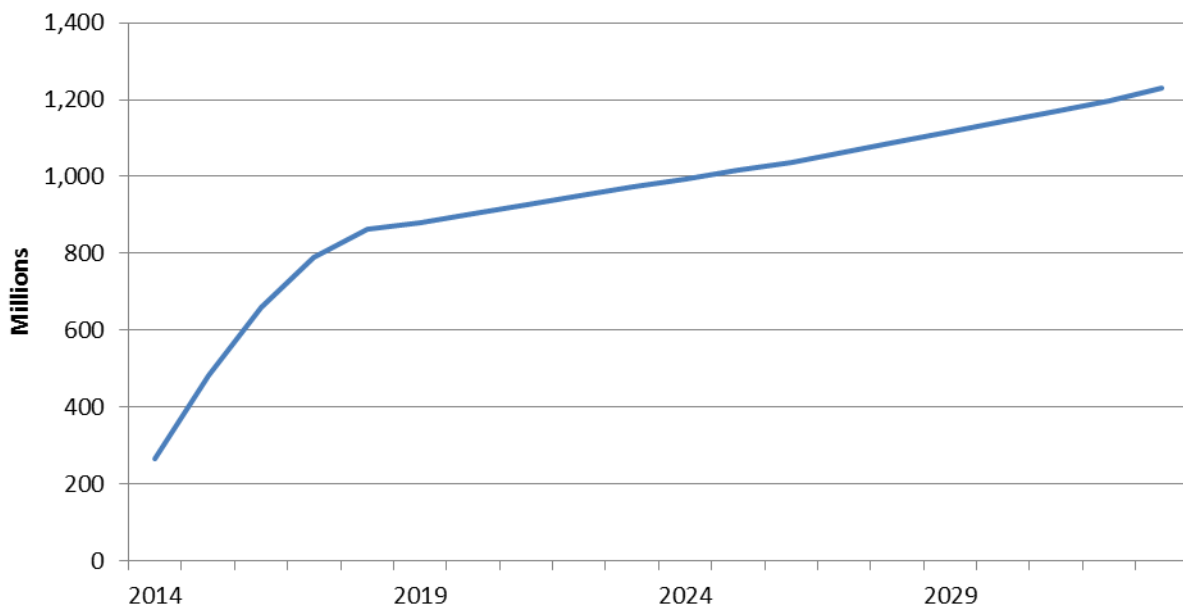
To model the cost of this proposal, we assume all people with an OTH discharge who would otherwise be eligible for VHA care are initially eligible. We assume that, consistent with the rest of the population, 73 percent of veterans with an OTH discharge are eligible for VA health care based on income and disability criteria. During a period of 5 years, their cases are examined, and 50 percent are positively adjudicated. Whether this number is actually higher or lower than 50 percent will depend on the exact details of the policy as well as the specific circumstances of veterans with an OTH discharge. In our model, the number of eligible veterans with an OTH discharge who enroll increases during the first 5 years as they become aware of the new rules. It

⁶⁷⁷ These estimates would differ depending on the CDS option pursued, but we provide a single notional estimate to give a sense of the magnitude of costs involved.

increases to 52 percent, which is the enrollment share of veterans who are currently eligible. In reality, this rate could be higher or lower for those with an OTH discharge if they are different from those who are already eligible. We assume costs per patient are similar to other veterans of the same age.

The cost of this policy increases from \$264 million in 2014 to \$1.23 billion in 2033. Fully phased-in, the cost is \$864 million in 2019. The shape of the cost curve reflects increasing enrollment during the first 5 years as veterans learn about the new rule and sign up. It also reflects adjudications as all enrolled veterans are initially eligible and then their eligibility is adjudicated during the 5 years. These calculations reflect estimates that the number of veterans with an OTH discharge for active duty military has fallen from a high of 8.8 percent in 2002 to 2.1 percent in 2015. We assume that the rate continues at 2.1 percent of discharges throughout the projection window.

Figure A-10. Projected Costs of Temporarily Covering Veterans with OTH Discharges



Conclusion

The estimated cost of allowing veterans to receive expanded community care through integrated networks varies dramatically depending on the specifics of the policy, including which categories of care are eligible for the community and whether referrals are required to access specialty care. We estimate that the *Recommended Option*, which provides increased community care that is reimbursed at Medicare allowable rates but maintains referrals for specialty care, increases costs modestly, assuming that networks are narrow and well-managed with cost as a major consideration. *CDS Alternative 1*, which offers a more restricted array of services eligible for CDS care, yet maintains a referral requirement, does not substantially increase costs. However, *CDS Alternative 3* and to a lesser degree *Alternative 2*, which eliminate the need for referrals for standard specialty care, potentially lead to very high costs. The estimated costs of the other scenarios range from small to substantial, though these costs would

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ultimately depend on the details of the proposals (e.g., the premium support schedule). Finally, we find that the costs of introducing expanded nurse navigators/care coordinators and making those with OTH discharge temporarily eligible are comparatively modest.

APPENDIX B: LEADERSHIP IMPLEMENTATION

Table B-1. Organizational Health and Cultural Transformation

Action	Responsible	Timeline
That VHA create a comprehensive, coordinated, sustainable cultural transformation effort by aligning programs and activities around a single, benchmarked concept.		
Establish the charter for the cross-functional SE team responsible for cultural transformation.	SECVA/DEPSECVA or CVCS depending on level	Now (0-6 mos)
Assess cultural transformation models and decide on a single model.	Chartered SE team	Now (0-6 mos)
Create an execution strategy for cultural transformation.	Chartered SE team	Now (0-6 mos)
Develop communication strategy and materials and release.	Chartered SE team	Near (18 mos)
That VHA aligns leaders at all levels in support of the cultural transformation strategy.		
Establish a subcommittee under the SE team to drive leadership transformation.	Chartered SE team	Near (6 mos)
Establish leadership standards for behaviors and actions.	Chartered SE team Subcommittee	Near (6-9 mos)
Publicize the standard.	Chartered SE team Subcommittee/CVCS/HTM	Near (12 mos)
Develop assessment tools.	SE Subcommittee/NCOD, NCEHC, HTM	Near (12-24 mos)
Establish expectations (in policy) for use of leadership standards in IDPs, performance review, hiring, promotions.	HTM/CVCS	Near (12-36 mos)
Provide coaching to the standard.	(Current HCM office responsible)	Near (24 mos)
Collect standards, training, support materials into a living curriculum for leaders.	EES/HTM	Near (24 mos)
Modify VA Directive 5021 (Employee/Management Relations) to include unacceptable behavior and unacceptable performance standards related to organizational transformation responsibilities of leaders and update table of penalties to correspond.	HRA/HTM	Future (36 mos)
That VHA align frontline staff in support of the cultural transformation strategy.		
Establish subcommittee to support staff transformation.	Chartered SE team	Near (9 mos)
Establish behavioral expectations/requirements for staff.	Subcommittee	Near (9-18 mos)
Develop hiring tools against the staff standard.	Subcommittee	Near (18-36 mos)
Establish requirements (in policy) for use of the standard for IDP, performance reviews, advancement in grade/promotions.	HTM/HRA/nursing and similar/unions	Near (18-36 mos)

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Action	Responsible	Timeline
Support leaders and supervisors at all levels of the organization to communicate and reinforce these standards with staff (see align leaders, above).	(Policy owner)	Near (18 mos)
Establish program office and VAMC standards and strategy for execution.		
Establish subcommittee to develop VAMC and PO execution standards.	Chartered SE team	Near (18 mos)
Establish execution strategy and policy requirements.	Chartered SE team Subcommittee/NCEHC/ NCOD	Near (18-36 mos)
Develop consolidated, meaningful metrics with input from experts and field users.		
Assign responsibility for metric development.	Chartered SE team/CVCS	Near (6 mos)
Develop and test metrics.	Organizational Excellence	Near (6-18 mos)
Deploy metrics.	Chartered SE team/CVCS/ (policy owner)	Near (18 mos)
Identify outliers and intervene.	SE team/CVCS/(policy owner)	Near (24 mos)

Table B-2. Recruitment, Retention, Development, and Advancement

Action	Responsible	Timeline
VHA executives are required to make the leadership system a top priority for funding, strategic planning, and investment of their own time and attention.		
Establish a VHA leadership management goal for inclusion in the 2018 budget with specific targets, including diversity targets.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (3 mos)
Submit the leadership management goal to VA for inclusion in the budget submission for 2018.	VHA OPP and CVCS	Now (3 mos)
Adopt VHA leadership management goal and submit to OMB/White House.	VA OPP and SECVA	Now (3 mos)
Establish an operational plan and accountability mechanisms for meeting these goals.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (4 mos)
Include yearly targets in the performance plan of the CVCS and SES members.	VHA NLC subcommittee on performance planning	Now (4 mos)
Schedule regular communication (at least quarterly) to the field that speaks to mission, vision, values, and expectations for ethical behavior.	CVCS	Now – ongoing
Schedule regular meetings with VHACO and field senior staff that allows for a discussion of mission, vision, values and expectations for ethical behavior.	CVCS	Now – ongoing
Develop opportunities for developing leaders to participate in the leadership and management decisions and processes of VHA.	CVCS /ask NLC executive committee to develop and implement a plan	Now (6 mos)
Adopt and implement a comprehensive system for leadership development and management.		
Convene a group to review ACHE and the National Center for Health Care Executives and devise a benchmarked model that meets the needs of health care executives in VHA as well as the private sector.	NCEHC with NCOD, & Human Capital Management; report to the NLC subcommittee for leadership development	Now (6 mos)
Create career tracks for key positions based on this new competency model.	HTM	Near (within 12 mos)
Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.		
Develop assessment tools (360, 180, self-assessment, supervisory) to support the competency model.	HTM with support as required from other offices, e.g., NCOD, EES	Near (within 18 mos)
Assess existing training against the model and identify gaps.	EES	Near (18 mos)
Develop and implement a plan to fill these gaps.	EES/reporting to NLC to ensure funding	Near (plan 20 mos – fill gaps 36 mos depending on \$)

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Action	Responsible	Timeline
Assess opportunities to share additional leadership training with DoD and create a plan to implement it.	HEC/JEC	Near (9 mos)
Develop and fund a face-to-face training to fulfill competencies for critical career positions.	EES	Near (24 mos)
Develop a masters level training program for clinical leaders in partnership with academic medicine.	EES/Academic Affiliations	Near (36 mos)
Establish sharing agreements with non-profit institutions to permit the exchange of executives for extended rotations.	EES/Academic Affiliations	Near (18 mos)
Create an experiential learning program to parallel the competency model.	EES, HTM reporting to the leadership development subcommittee of the NLC	Near (24 mos)
Establish a coaching program.	HTM/EES	Near (18 mos)
Incorporate tracking of competency assessment, training, coaching, and IDP completion into an appropriate IT platform (e.g., TMS).	HRA/EES/Workforce Management and Consulting	Near (18 mos)
VHA is required to aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: all hires and promotions are required to demonstrate these competencies.		
Create functional statements for all key positions based on the competency model.	HTM	Near (18 mos)
Create interview questions incorporating competencies for all key positions.	HTM	Near (12 mos)
Establish a process for certifying internal candidates for advancement to the next position.	Human Capital Management	Near (18 mos)
Incorporate the tracking of competency achievement with performance ratings and create a tracking mechanisms and pool of high potential candidates.	Human Capital Management	Near (18 mos)
Create regulatory requirements for the use of the competency model in hiring, promotion, development opportunities, and discipline; and incorporate procedures for veterans preferences.	Human Capital Management in VHA	Near (36 mos)
Establish an IDIQ, PBA or similar contract for executive recruitment.	Human Capital Management	Now (6 mos)
Establish requirement in policy for all ECF, SES / SES equivalent to complete IDP.	Human Capital Management	Future (following regulatory change)
Create on-ramp for retiring MTF.	Human Capital Management / DoD Coordination	Now (6 mos)
Expand (GHATP) program.	EES	Now (6 mos)
Establish a plan for developing and managing the candidate pool.	NLC subcommittee for leadership	Now (6 mos)
Require a formal on boarding process for leaders at all levels that re-enforces the leadership competency model.		
Establish an onboarding curriculum and process.	Human Capital Management, EES, HTM	Now and Near (18 mos)

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APPENDIX B
LEADERSHIP IMPLEMENTATION

Action	Responsible	Timeline
VHA is required to take immediate steps to stabilize the continuity of leadership.		
Extend authority for length of details and ability to compete for the detail position.	Human Capital Management	Now (6 mos)
Establish and fund assistant level positions in all key career development tracks.	CVCS	Now (18 mos)

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Table B-3. Organizational Structure and Function

Action	Responsible	Timeline
Eliminate duplication within VHA and consolidate program offices to create a flat structure.		
Eliminate the duplication of functions between VHA and VA by closing VHA offices.		
Create innovative organizational structures to support clinical delivery that are aligned to patient's needs rather than professional silos.		
Undertake a reduction-in-force (RIF) in VHACO that promotes delayering and efficiency in communication and decision making.		
Publish a new organizational chart consistent with Figure 9.	CVCS	Now (1 mos)
Prepare an initial RIF for offices eliminated.	VHA Human Capital Management	Now (3 mos)
Engage VERC (or other resources with expertise in business process reengineering) to re-design the processes and structures with remaining offices to ensure end-to-end support for field function and to further reduce duplication; including clinical function re-organization.	Transformation Office/ VERC	Near (3-12 mos)
Each program office in collaboration with VERC or other transformation resources identifies areas of "stop work" with staffing and budget savings.	Transformation Office/ PO/ CVCS	Near (3-12 mos)
Publish clear roles, responsibilities and expectations that apply to all VHACO offices.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VHACO staff to the new expectations for the role of VHACO.	Transformation Office/ EES	Now (1 mos)
Develop training curriculum to support VHACO staff in developing the skills and competencies required.	Transformation Office/ EES	Near (18 mos)
Develop an engagement strategy to inspire VHACO staff to embrace their new role and tie to in-service training roll out.	Transformation Office/ CVCS	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VHACO employees.	Transformation Office/ EES	Now (6 mos)
Adopt customer service training in VHACO and roll it out; include as part of new employee on-boarding in VHACO.	Transformation Office/ EES	Near (12 mos)
Draft basic competencies for VHACO program staff (e.g., customer service, quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ Each PO	Near (18 mos)
Acquire, configure, and train PO staff on data analytics infrastructure to support program office and field tracking of key performance metrics.	Office of Organizational Excellence/OIT	Near (18 mos)

APPENDIX B
LEADERSHIP IMPLEMENTATION

Action	Responsible	Timeline
Clarify and specifically define the roles and responsibilities of the VISNs and facilities, pushing decision making down to the lowest level.		
Publish clear roles, responsibilities and expectations that apply to the VISNs.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VISN staff to the new expectations for the role of VISN.	Transformation Office/ EES	Now (1 mos)
Develop an engagement strategy to inspire VISN staff to embrace their new role and tie to in-service training roll out.	VISN directors	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VISN employees.	Transformation Office/ EES	Now (6 mos)
Draft basic competencies for VISN staff (e.g., quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ each PO	Near (18 mos)
Gain agreement from Congress to institute three appropriation lines only: medical, major construction, research.	CVCS/SECVA/OMB	Near (12 mos)
Eliminate segregation of specific-purpose funds to the VISNs and facilities.	CVCS/Office of Finance	Now (6 mos)
Modernize financial management system (FMS) to permit effective cost accounting and tracking of priority spending.	OIT/Office of Finance	Future (36 mos)
Develop training to support effective use of FMS to permit effective account tracking and reporting and roll it out.	Finance/EES	TBD post procurement
Establish quarterly spend reports covering all priority areas (e.g., NRM, IT, facility minor, purchased care, mental health, women's health, administration) by facility and release to Congress and the public.	Finance Office	TBD post procurement
Delegate decisions in recruitment, retention and advancement (e.g., hiring bonus, retention bonus, market pay) for staffing to the facility.	CVCS/HCM	Now (1 mos)
Delegate training and travel decisions.	CVCS/EES/OAA	Now (1 mos)
The USH establishes leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue and collaboration.		
Improve communication with field leadership and frontline employees through the liberal use of social media, town halls and other direct engagement channels with a dedicated champion to help the USH and senior staff in this endeavor.	CVCS	Now (3 mos)
Reestablish in-person leadership conferences, at least semi-annually, to foster communication and relationship building between VHACO, VISN and facility leadership.	CVCS/EES/NLC	Now (6 mos)
Add behavioral competencies to performance plans that promote effective communication amongst leaders.	CVCS	Near (12 mos)

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Action	Responsible	Timeline
Establish expectations and requirements for program office leaders to communicate the USH leadership messages, coordinate PO communications with the USH and with one another.	CVCS	Now (3 mos)
Establish a transformation office with broad authority and a supporting budget to accomplish the change.		
Establish the new transformation office in the organizational chart, populate with expertise in business process re-engineering, and fund initially using savings from closure and consolidation of offices in VHACO and a budget reduction to all other VHACO offices.	CVCS	Now (6 mos)
Create a Transformation Office strategic plan to educate and provide guidance to the new initiatives and support the goals of VA and VHA.	Transformation Office	Near (3-6 mos)
Create a new initiative implementation plan to include follow-on priorities, tasks and milestones. The Transformation Office will support the operation and the plan moving forward.	Transformation Office	Near (3-6mos)
The Transformation Office will be responsible for evaluating all new initiatives and programs using the President's Management Agenda Scorecard or a model that emulates its rating standards of Green represents success; yellow for mixed results; and red for unsatisfactory. These ratings are indicative of standards of success or failure.	Transformation Office	Near (3-6mos)

Table B-4. Performance Metrics and Management

Action	Responsible	Timeline
Create a new performance management system for VHA leaders appropriate for health care executives.		
Establish a workgroup and engage outside experts to create the new performance management system that is benchmarked to private-sector models, is consistent with the new leadership competency model, and recognizes both leadership competencies and success in delivering strategic priorities. The model should include a new rating scale.	Transformation Office/Human Capital Management	Now (6 mos)
Develop and conduct training on the new performance management system for all participants to describe the system, rating process, and expectations.	Human Capital Management	Near (6-12 mos)
Establish a mechanism to capture performance assessment outcomes and track and manage high-potential staff.	Human Capital Management/HRA	Now (3 mos)
Establish a project plan to deliver annual guidance on performance plans at least a month in advance of the new fiscal year (i.e., at the start of the new rating period).	Human Capital Management/CVCS/Sec/OMB	Now (3 mos)
Hold raters accountable for creating meaningful distinctions between leaders.		
Provide training to raters on the application of the new performance management system and expectations for ratings.	Human Capital Management	Future (12 mos)
Require raters to establish plans for subordinates that are timely and meaningful; track and provide feedback on meeting this goal.	Human Capital Management/HRA	Now (3 mos)
By modeling the behavior and communicating the requirement, establish expectations that raters, and secondary-level raters, engage in continuous dialogue and coaching with subordinates about performance throughout the year, not just at mid-year and at the end of the rating period.	CVCS	Now (3 mos)
Establish oversight and feedback process for raters and incorporate this into the raters performance evaluation.	Human Capital Management/CVCS	Now (12 mos)
Provide coaching to raters and focused reviews if their rating profile doesn't provide meaningful distinctions in performance.	Supervisors	Near (12 mos)

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Table B-5. Leadership Implementation: Human Capital Management

Action	Responsible	Timeline
VA re-align HR functions and processes to be consistent with best practice standards of high-performing health care systems.		
Charge HRA to undertake an HR transformation study and ensure budget and solicitation of customer requirements.	SECVA/DEPSECVA	Now (0-6 mos)
Engage HR and change management experts to develop a benchmark human capital management plan for VA.	HRA	Now (0-6 mos)
Circulate new human capital plan for feedback and finalize.	HRA with input from VHA, Congress, OPM, OMB, SECVA/DEPSECVA, CVCS	Now (6 mos)
That VA and VHA leaders make transformation of Human Capital management a priority, with adequate attention, funding and continuity of vision.		
Endorse human capital management plan and ensure alignment of budget, IT system funding, training resources, and accountability mechanisms to support it.	SECVA/DEPSECVA and CVCS, as applicable	Near (9 mos)
Employ HR and change management experts to fully implement the transformation agenda and the new human capital management plan.	HRA	Near (12-30 mos)
Create an HR IT technology plan.	HRA & OIT	Near (9 mos)
Establish meaningful measures and risk indicators for VA human capital management.	HRA	Future (24 mos)
Incorporate HR measures into systematic reporting to leadership; and as appropriate into performance plans for key subordinate leaders.	HRA, DEPSECVA, CVCS as appropriate	Near (18 mos)
VA develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 Hybrid, Title 38 7306, and SES).		
Develop clear standards, guidelines, and training on progressive discipline.	HRA (with support from OPM)	Now (6 mos)
Managers, supervisors and HR professionals complete training.	SECVA/ DEPSECVA and CVCS (HTM office)	Near (12 mos)
Train HR staff to be coaches in progressive discipline.	HRA	Now (6-12 mos)
Establish performance metrics for HR professionals and client feedback mechanisms to ensure effective coaching and support for progressive discipline process.	HRA	Near (12 mos)
Establish performance expectations for VA supervisors and managers to apply the progress discipline process.	SECVA/ DEPSECVA, CVCS	Near (12 mos)

APPENDIX C: PILOT PROJECTS FOR EVALUATING EXPANDED CARE

As discussed in Recommendation #18, some Commissioners support the idea of developing pilot programs to test the feasibility of avoiding VA hospital closures by allowing veterans' spouses and currently ineligible veterans to purchase VA care in selected areas.

Problem

In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. This trend is driven by four main factors: (a) the overall decline in the size of veterans population, (b) the migration of veterans away from some parts of the country, such as New England and the Upper-Midwest, (c) the general trend in health care toward less intensive use of acute-care hospital beds, and (d) increased use of purchased care, which now accounts for 27 percent of all appointments.

A related challenge is maintaining safe volume of care when patient loads decline. As extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁷⁸

Simply closing a low-volume hospital is sometimes the answer. But closing a local VA hospital may mean that area veterans will have reduced access not only to routine, but also to specialty care related to their military service, such as for spinal cord or traumatic brain injuries. In many areas, such care is not available or is in short supply outside VHA.

At the same time, it may not be clinically feasible for VHA to engage in highly specialized care if it lacks the ability to offer other forms of care in the same setting. Patients in a polytrauma unit for example, require a full-spectrum of routine and nonroutine health care.

Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. Toward that end, VHA could develop pilot programs to test the feasibility of enabling veterans' spouses and currently ineligible veterans in these areas to purchase VHA care through their health plans. These pilots could be tested in conjunction with the growth of the high-performance, integrated VHA networks recommended elsewhere in this report. These networks will allow VHA far more flexibility than in the past to expand or contract its local capacity in different markets as appropriate.

⁶⁷⁸ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

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Background***Current Nonveteran Access to VHA Care***

VHA already treats many nonveterans. VHA estimates it treated 694,120 unique nonveteran patients at a total cost of \$1.9 billion in 2015,⁶⁷⁹ or 3.6 percent of total VHA obligations.⁶⁸⁰

By far the largest subgroup within the nonveteran patient population are participants in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA beneficiaries are the dependents of permanently and totally disabled veterans, survivors of veterans who died from service-connected conditions or while on active duty, or spouses of veterans who at the time of death were rated permanently and totally disabled from a service-connected condition.

Congress authorized CHAMPVA in 1973. The authorization specifies that VHA is the secondary payer for those with Medicare Part A and B coverage. In cases for which VA medical facilities are equipped to provide the care, VA may use facilities not being used for the care of veterans to provide services to the dependent or survivor.

Congress has also directed VHA to offer specific health care services to many other classes of nonveterans. These include mental health and counseling services for family caregivers of seriously injured veterans of post-9/11 service. Several provisions of law also authorize VA care for certain family members of veterans who were exposed to toxic substances. In the case of veterans with 50 percent or more service-connected disability, VHA must provide by law “consultation, professional counseling, marriage and family counseling, training and mental health services as are necessary in connection with” the veteran’s treatment.⁶⁸¹

Analysis

Others who have developed strategic plans for the long-term future of VA health care have recommended expanding upon these precedents, specifically by allowing currently ineligible veterans and the spouses of veterans to purchase VHA care.⁶⁸² In effect, providing such care would allow VHA to operate as an accountable care organization, capable of receiving reimbursement from patients covered by Medicare, Medicaid, as well as by private insurance plans. Among the potential benefits envisioned are the following:

- optimizing patient safety, productivity, and cost-effectiveness by ensuring sufficient patient volumes in currently under-utilized facilities
- preserving mission critical veterans’ programs that would otherwise need to be terminated in many parts of the country
- optimizing the integration of VHA and non-VHA care within communities

⁶⁷⁹ Allocation Resource Center, information provided to Commission on Care, December 8, 2015.

⁶⁸⁰ Department of Veterans Affairs, “Volume II: Medical Programs and Information Technology Programs, Congressional Submission, FY 2016 Funding and FY 2017 Advance Appropriations,” accessed May 27, 2016, <http://www.va.gov/budget/products.asp>.

⁶⁸¹ Counseling, Training, and Mental Health Services for Immediate Family Members and Caregivers, 38 U.S.C. § 1782.

⁶⁸² Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce*, accessed May 27, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>.

APPENDIX C
PILOT PROJECTS FOR EVALUATING EXPANDED CARE

- providing a *public option* for health care to a wider range of veterans as well as nonveterans in communities where health care choices are currently limited
- bringing in new sources of revenue to contribute to the funding for veterans' healthcare

The pilot projects described below would specifically evaluate whether such a strategy will allow VHA to optimize the quality and cost-effectiveness of its health care system by avoiding low volumes of routine and specialty care in certain sections of the country. These pilot projects would also allow VHA to evaluate whether such a strategy could provide new revenues for sustaining the VA health system while providing other benefits to veterans and the public at large.

The chart below sketches six possible pilot projects designed to test different specific policy configurations. The configurations include projects in which VA care is marketed to health care plans on fee-for-service (FFS) basis, and plans in which VA facilities are markets to health care plans as Accountable Care Organizations that provide integrated health services to a fixed population of insured patients for a fixed cost.

*Demonstration Projects to Assess VHA's Capability to Treat
Nonveteran Spouses and Ineligible Priority 8 Veterans*

	Eligibility	Capitation/Fee For Service	Timing
Demonstration 1: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) With Private Insurance	FFS	Years 2-7
Demonstration 2: FFS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance	FFS	Years 2-7
Demonstration 3: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) with private insurance	FFS	Years 3-8
Demonstration 4: FSS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance and/or Medicare	FFS	Years 3-8
Demonstrations 5 and 6: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses	Enrollment: May choose higher cost plan with more coverage and less copayment; lower cost option with less coverage and higher copayments.	Years 4-9

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	Eligibility	Capitation/Fee For Service	Timing
Demonstrations 7 and 8: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses with private insurance and/or Medicare	Enrollment: May choose higher cost plan with more coverage and less copayment; or lower cost option with less coverage and higher copayments. Pilot sites would be deemed Accountable Health Care Organizations for Medicare Advantage plans.	Years 5-10

Certification of Access: Any participating VHA facility must certify that its waiting times for primary care, specialty care and behavioral health are less than 30 days.

Site selection: Sites should include facilities in different regions with various population densities (urban, suburban, rural) and levels of service complexity. VHA may also consider such factors as stability of medical center leadership, and whether local markets are underserved or subject to high degrees of market concentration among either providers or payers.

Assumptions

- Many provisions are subject to Congressional authorization.
- Participating VHA facilities will be able to retain any “profit” associated with treatment of new users without offset;
- Congress will (preferably) waive the current prohibition on Medicare funding federal health care programs,
- VHA will not be subject to proving “level of effort” in order to receive Medicare funds

Assessment

After the first year of operations, VHA will assess these projects according the following criteria:

- Was access to care or patient satisfaction among veterans already enrolled in the system affected by the demonstration?
- What was the level of patient satisfaction among new users purchasing VA care?
- Did VHA cover the costs of delivering care to its patients purchasing care? If so, what were its net revenues and how were they used?
- If VHA collected Medicare funds, did funding cover costs of delivering care?

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- Were there administrative challenges in opening the VHA to new users? If so, what lessons were learned?
- How did VHA promote the demonstration project to those eligible?
- What are the recommended strategies for further implementation?
- Were there non-financial benefits to treatment of new users, such as diversifying case mix, providing sufficient volume to allow certain VHA services to remain available, or keeping scarce health professionals employed in an area that is medically underserved?
- How did the demonstrations affect the overall quality of care, market structure, pricing, and range of health care options available to both veterans and nonveterans in the surrounding community?

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APPENDIX D: HISTORY AS A CONTEXT FOR SYSTEMIC TRANSFORMATION

History provides opportunities to see the problems and challenges facing VHA today through the lens of recurring themes from the past. Veterans' health care has, over the course of its history, been marked by periods of both progress and problems. Understanding the challenges of the past and the solutions used to address them provides context for building a plan for reforming veterans' health care in a manner that is flexible and sustainable.

Challenges and Growth

The federal government's role as a care provider for veterans has evolved, paralleling, to some extent, medicine's evolution. Prior to World War I, the only benefits afforded then-eligible veterans were pensions and domiciliary care (which involved only incidental medical treatment), provided under the National Home for Disabled Volunteer Soldiers and Sailors established after the Civil War.⁶⁸³

World War I brought real change. At the time, no single agency was responsible for the anticipated deluge of sick and wounded soldiers. The more than 200,000 wounded who returned home from battle quickly exceeded capacity of the U.S. Public Health Service (PHS), the National Home, and other agencies. According to one account of the period, "[c]haos and confusion reigned for more than two years . . . [n]ew hospital construction languished," and "[b]y 1921, veterans' care had become a national embarrassment."⁶⁸⁴ At the recommendation of a presidential committee, Congress passed legislation in 1921 to consolidate the several veterans-related bureaucracies into a single Veterans Bureau, to which the President Warren Harding transferred 57 PHS hospitals. A new administrator, Frank T. Hines, proposed care and treatment of veterans' non-service-connected ailments when facilities and bed space were available. Congress adopted the proposal in the World War Veterans Act of 1924.⁶⁸⁵

Under Hines' tenure, VA grew from 64 to 91 hospitals, nearly doubling bed capacity. Civil Service Commission personnel rules and low pay led to generally poor quality VA physicians, yet Congress rebuffed VA proposals to set up a VA Medical Corps.⁶⁸⁶ With many physicians having left VA to serve in World War II or for more lucrative practice, the VA health care system was left critically understaffed.⁶⁸⁷

⁶⁸³ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 4.

⁶⁸⁴ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 13-14.

⁶⁸⁵ *Ibid.*, 19.

⁶⁸⁶ *Ibid.*, 21.

⁶⁸⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 149.

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World War II and the need to care for millions of service members, including 671,000 wounded, highlighted the problems facing VA. Scathing reports of shoddy veterans' care, including an exposé characterizing veterans' hospitals as backwaters of medicine, magnified the problems.⁶⁸⁸

Congressional hearings led to a shakeup in leadership and General Omar Bradley was appointed to head the agency, with its network of 97 hospitals, and a need for more.⁶⁸⁹ Dr. Paul Magnuson, who served as VA's chief medical director (CMD) from 1948 to 1951, later described the conditions at the time:

The majority of Veterans Administration hospitals were stuck in far off places, some of them on Indian reservations, others as much as fifty miles from the nearest through-line railway stop. The doctors were all full-time Civil Service employees, hemmed in by regulations and practically forbidden to do any research, attend any medical meetings or otherwise keep in touch with scientific progress. Operating rooms closed at noon so everybody could spend the afternoon happily doing required paperwork, while patients waited days and weeks for surgery.⁶⁹⁰

With President Harry Truman's statement that "the Veterans Administration will be modernized," new VA leadership worked with Congress to pass far-reaching legislation, Public Law 293, which created a VA Department of Medicine and Surgery (DM&S), and freed VA physicians, dentists, and nurses from the Civil Service Commission and its rules.⁶⁹¹ Within weeks, the chief medical director of the new DM&S issued a policy memorandum that outlined a cooperative affiliation agreement between VA and medical schools under which deans' committees would recommend consultants and attending physicians for appointment to VA, and residency-training programs would be established at VA hospitals. The law, and Policy Memorandum #2, broke a recruitment logjam and enabled the short-staffed department to hire medical professionals needed for the dozens of new VA hospitals being built. Soon after, medical students and residents began working in 32 VA hospitals. The reforms instituted under Bradley and his team were palpable,⁶⁹² with the physician staff at VA hospitals increasing from 2,300 (1,700 of whom were detailed by the military) in June 1945 to 4,000 full-time staff a year later.⁶⁹³ By 1948, VA had 125 hospitals in operation with 60 medical school affiliations and 2,000 residents.⁶⁹⁴

After this turn-around, Bradley left to become Army Chief of Staff, and under his successor, "who did not enjoy the same level of prestige and support that Bradley did . . . VA quickly

⁶⁸⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 22.

⁶⁸⁹ Ibid., 23-25.

⁶⁹⁰ Ibid., 22.

⁶⁹¹ "31: The President's News Conference," Harry S. Truman Library & Museum, accessed June 3, 2016, <http://trumanlibrary.org/publicpapers/viewpapers.php?pid=38>.

⁶⁹² James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 27.

⁶⁹³ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 214.

⁶⁹⁴ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 28.

reverted to its pre-Bradley ways and remained that way for the next forty years,”⁶⁹⁵ according to one account.

By the early 1950s, the veteran population had grown to more than 20 million.⁶⁹⁶ VA was operating 162 hospitals, with an average census of more than 104,000 patients.⁶⁹⁷ A VA historian observed that “waiting lists contained 22,613 applicants awaiting admission, none of whom were service-connected, although some of the latter were hospitalized in other than VA hospitals.”⁶⁹⁸ At the time, non-service-connected veterans seeking care had to state under oath that they could not afford to pay for hospitalization, and admission was granted only when beds were available in VA or other federal hospitals.⁶⁹⁹ Critics called for reducing free medical care of non-service-connected veterans, and questioned whether some were getting care that they could afford. This issue led VA to institute a policy of formal counseling under which hospitals would supply the veterans with an estimated cost of care to assist them in determining their ability to pay.⁷⁰⁰

In contrast to the generous Bradley-era funding, the 1950s funding cuts necessitated layoffs, bed-closures, and moth-balling of newly constructed hospital wards.⁷⁰¹ During this period, annual debates over the DM&S budget centered on the number of beds VA should operate. VA leaders contended that the number should be 125,000, yet the director of the Bureau of the Budget (the predecessor to the Office of Management and Budget [OMB]) asserted 87,000 was sufficient.⁷⁰²

The expiration of the incumbent CMD’s term led to the appointment in 1955 of medical educator Dr. William Middleton, dean of the Wisconsin Medical School, and a long-time member of a VA special medical advisory group. One of his first acts as CMD was to champion medical research in VA and broaden its scope to include geriatric research. Soon after, Congress began earmarking funds for VA research, and expanded DM&S’ statutory role to include medical research.⁷⁰³ During Middleton’s tenure, from 1955 to 1963, VA research funding grew from some \$6 million to more than \$30 million.⁷⁰⁴ Middleton’s work laid the foundation for a research program long recognized for pioneering important medical technologies, including medical use of radioisotopes, dialysis, cardiac pacemakers, liver transplantation, as well as seminal studies that documented the benefits of coronary artery bypass surgery and drug treatment of hypertension.⁷⁰⁵ The program also stood out for its capacity to design and rapidly implement large-scale cooperative trials, first mounted in the 1950s with successful evaluation

⁶⁹⁵ Ibid., 29.

⁶⁹⁶ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 254.

⁶⁹⁷ Ibid.

⁶⁹⁸ Ibid.

⁶⁹⁹ Ibid., 253.

⁷⁰⁰ Ibid., 253-254.

⁷⁰¹ Ibid., 256.

⁷⁰² Ibid., 258.

⁷⁰³ Ibid., 262-263.

⁷⁰⁴ Ibid., 263-264.

⁷⁰⁵ Stanley Zucker et al., “Veterans Administration Support for Medical Research: Opinions of the Endangered Species of Physician-Scientists,” *The FASEB Journal*, 18, no. 13, (2004): 1481-1486, <http://doi.org/10.1096/fj.04-1573lfe>.

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of chemotherapy for tuberculosis.⁷⁰⁶ Working on issues relevant to veterans, VA researchers developed functional electrical stimulation systems to allow patients to move paralyzed limbs, helped develop the first ankle-foot prosthesis, and launched the largest-ever trial of psychotherapy to treat posttraumatic stress disorder.⁷⁰⁷

Middleton expanded the VA educational program. In addition to growing the number of medical residents it helped train, VA provided training to a large share of clinical psychologists, graduate dentists, student nurses, occupational and physical therapists, social work students, and dietetic interns. Middleton instituted numerous advances in VA care such as introducing outpatient care for preadmission workups and post-hospital treatment that allowed earlier release from inpatient stays. He moved VA away from operating hospitals for specific diseases (as had been done for tuberculosis and mental illness).⁷⁰⁸

The enactment of Medicare in 1965 raised questions about the effect that program would have on the VA health care system. The House Veterans Affairs Committee sent a questionnaire to a group of 10,000 veterans explaining the new program and asking the veteran to if they preferred VA care or treatment in a community hospital under Medicare.⁷⁰⁹ Some 59 percent responded, and nearly two-thirds of respondents preferred VA.⁷¹⁰ At the time, the policy governing those eligible for VA care based on financial need was that Medicare benefits were to be considered in determining an individual's ability to pay for needed care.⁷¹¹

The enactment of Medicare and other changes in health care in 1977, led to a commission being established by the National Academy of Sciences (NAS) which issued a report pursuant to a congressional directive to evaluate the VA health care system. Among its findings, the commission reported that VA had a surplus of acute beds and recommended that new facilities be constructed only after examining bed availability in the community. It also recommended that underutilized VA hospitals be closed or converted to long-term care facilities, and resources redistributed to permit a shift from inpatient to outpatient care. The NAS commission also recommended that VA experiment with models for community-based integrated care.⁷¹² The commission's recommendation for integrating the VA system into the nation's civilian health care program⁷¹³ provoked objection, particularly in Congress.⁷¹⁴ Hearings produced sharp rejections of the NAS commission findings and its call to end VA's role in providing health care to veterans.

⁷⁰⁶ Ibid.

⁷⁰⁷ Veterans Health Administration, *History of VA Research Accomplishments*, accessed June 3, 2016, http://www.research.va.gov/researchweek/press_packet/Accomplishments.pdf.

⁷⁰⁸ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 265-267.

⁷⁰⁹ Ibid., 390.

⁷¹⁰ Ibid.

⁷¹¹ Ibid.

⁷¹² *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs*, 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.

⁷¹³ J. William Hollingsworth and Philip K. Bondy, "The Role of Veterans Affairs Hospitals in the Health Care System," *New England Journal of Medicine*, 322, no. 10, (1990): 1851-1857, <http://doi.org/10.1056/NEJM199006283222605>.

⁷¹⁴ *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs*, 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.

The VA of the 1970s and 1980s is remembered as bureaucratic, reliant on paper health care records, and driven by patient admissions (on which budgets were based).⁷¹⁵ The quality of VA care was also an issue. Complaints from Vietnam veterans and critical media accounts fueled outrage, and led to the view that the system was broken. The question, how to fix it, reopened an earlier dialogue around making VA a cabinet-level department, a view strongly supported by veterans service organizations (VSOs) and veterans' leaders in the House of Representatives. In 1988, after years of debate, and opposition from administration offices and advisors, President Reagan signed legislation creating a Department of Veterans Affairs.⁷¹⁶ The new department, with DM&S now renamed the Veterans Health Services and Research Administration (to emphasize its research legacy in such fields as infectious disease, pacemaker technology, and prosthetics), employed some 194,000 people with a \$12 billion budget.⁷¹⁷

Facing an aging veteran population⁷¹⁸ expected to overwhelm the system by 2010, the new secretary, Edward Derwinski, in 1989 requested Congress establish an independent commission to review the alignment and mission structure of VA's hospitals. Congress rebuffed the request after VSOs, suspecting a plan to close hospitals, lobbied against it.⁷¹⁹ Derwinski created his own "Commission on the Future Structure of Veterans Health Care" that was to review all VA hospitals and recommend needed mission changes. Instead, the so-called Mission Commission called for expanding eligibility law to enable veterans to obtain the full continuum of VA health care services. Although the commission identified the need for fundamental restructuring of the VA health care system, the subject was soon overtaken by national health reform proposals, and what role VA might have under a universal coverage system.⁷²⁰

Dr. James Holsinger, a new under secretary for health (USH), made care quality a top goal and issued a Blueprint for Quality tool in 1992, setting the stage for more far-reaching changes instituted by his successor, Dr. Kenneth Kizer. Care quality, a perennial topic, had led to the previous under secretary's resignation following reports of multiple veterans' deaths under questionable circumstances at VA's North Chicago medical center.⁷²¹ Two years later, Derwinski lost his job after creating ire among veterans' organizations in response to his proposed pilot program to open two VA hospitals to poor, rural nonveterans.⁷²²

⁷¹⁵ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 30-31.

⁷¹⁶ Ibid., 33-40.

⁷¹⁷ Ibid., 50.

⁷¹⁸ As the General Accounting Office reported in 1990, "The Department of Veterans Affairs (VA) faces a major challenge: planning how to meet the long-term care needs of a rapidly aging veteran population. The number of veterans 65 years old and over is projected to grow to 9 million by 2000—a 50percent increase over the 1988 level.

U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), accessed June 20, 2016, <http://www.gao.gov/assets/150/149139.pdf>.

⁷¹⁹ U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), 51, accessed June 20, 2016, <http://www.gao.gov/assets/150/149139.pdf>.

⁷²⁰ U.S. Government Accountability Office, *Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Care Reform*, GAO/HEHS-95-14 (Washington, DC, 1994), accessed June 20, 2016, <http://archive.gao.gov/f0902a/153054.pdf>.

⁷²¹ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 53.

⁷²² "Angry Veterans Groups Say They Made Bush Oust Agency's Head," Eric Schmitt, accessed June 3, 2016, <http://www.nytimes.com/1992/09/29/us/angry-veterans-groups-say-they-made-bush-oust-agency-s-head.html>.

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Transformational Leadership

VA's second secretary, Jesse Brown, brought his passion as a veterans advocate to the department's leadership.⁷²³ Among Brown's most important early acts was selecting Dr. Kenneth Kizer, a prominent California physician-administrator and educator, from among 90 candidates identified by a search committee for the USH post.⁷²⁴ With experience heading the California department of public health, Kizer saw health care as a system, and data as a tool to improve it.⁷²⁵

Kizer, in essence, launched a major reengineering of the VA health care system through better use of information technology, measurement and reporting of performance, integration of services, and realigned payment policies.⁷²⁶ His vision was large and bold, underscored by his belief that "we have to be able to demonstrate that we have an equal or better value than the private sector, or frankly we should not exist."⁷²⁷ At VA, Kizer found a workforce trapped in a micro-managerial, command-and-control system in which there was little accountability.⁷²⁸ He set the tone for what was to come at a meeting with senior managers at which he stated,

*The old culture must give way to a new culture . . . that is based on innovation and creativity; a culture based on personal initiative and individual and collective accountability; a culture that is based on outcomes and heightened productivity; and a culture that is committed to change.*⁷²⁹

Among his first steps was the development of what was to become a Vision for Change, a new organizational model to restructure both field operations and central office management. At its core was the creation of 22 veterans integrated service networks, or VISNs, (replacing four regions which had been responsible for overseeing 40 to 45 hospitals each), with decision making shifted away from VA Central Office (VACO) to the new VISN directors. VISNs were to be the basic budgetary and planning unit, and to have staffs of no more than 7 to 10 employees.⁷³⁰ Each VISN was in charge of all the care provided to veterans in that network, and each was funded on a capitated basis rather than based on historical costs.⁷³¹ The VACO structure would be marked by its *flatness*, foregoing a tiered hierarchy.⁷³²

⁷²³ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 89.

⁷²⁴ *Ibid.*, 92.

⁷²⁵ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 50-51.

⁷²⁶ Ashish K. Jha et al., "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care," *New England Journal of Medicine*, 348, no. 22, (2003): 2218-2227, accessed June 20, 2016, <http://doi.org/10.1056/NEJMsa021899>.

⁷²⁷ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 51.

⁷²⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 97-8.

⁷²⁹ *Ibid.*, 105.

⁷³⁰ *Ibid.*, 110.

⁷³¹ "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation," Ashish K. Jha, accessed June 3, 2016, <https://psnet.ahrq.gov/perspectives/perspective/31>.

⁷³² James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 111.

The system Kizer and his team inherited was characterized by a multitude of problems.⁷³³ Kizer and his team literally reengineered the veterans' health care system based on a set of transformation strategies: to create management accountability, integrate and coordinate services, improve the quality of care, align system finances with desired outcomes, and modernize information management.⁷³⁴

Kizer also launched a technological revolution in VHA with deployment of a powerful electronic medical record,⁷³⁵ and development of systems such as medication bar-coding to tackle medical errors and ensure patient safety.⁷³⁶

Some of Kizer's successes involved winning support within the administration and from Congress for bold initiatives. He won a critical concession from OMB that VA savings could be reinvested into VA, permitting his transformation efforts to be funded through internal cost-savings rather than new funding,⁷³⁷ and garnered support from Congress for a dramatic reduction of acute care beds and for closing massive regional offices.⁷³⁸ These steps and congressional passage of legislation to reform health care eligibility laws paved the way for establishing universal primary care in VA and developing community-based clinics across the country.⁷³⁹

Sweeping Reform

During a 5-year period, Kizer dramatically changed almost every major VHA management system and improved operational performance through the use of performance measures and contracts. He closed nearly 29,000 acute care beds, merged 52 medical centers into 25 multi-campus facilities, reduced staffing by almost 26,000, opened more than 300 community-based outpatient clinics, and treated 24 percent more patients. In addition to bringing measurable quality into VA health care, Kizer achieved marked reductions in waiting times and medical errors.⁷⁴⁰

Kizer's tenure brought dramatically improved quality, service, and operational efficiency to VHA yet threatened powerful interests. As he noted, "...places like Florida, Arizona, and the

⁷³³ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 316, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷³⁴ Ibid., 318-323.

⁷³⁵ VA in 2006 won the Harvard Innovations in Government Award for its VistA system. James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 211.

⁷³⁶ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 157-165.

⁷³⁷ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 323, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷³⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 128-129.

⁷³⁹ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 319-320, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷⁴⁰ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 170.

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Sun Belt States were not getting their fair share [of funds] and their elected officials were unhappy about it. People from Pennsylvania and Illinois and New York were not about to give their money away, so there was this big disconnect.”⁷⁴¹ Kizer’s team developed a capitation system to more equitably allocate funds across the system. Aware of the political ramifications, he implemented incremental changes during a 2- to 3-year period to make them as painless as possible. But the congressional goodwill he had enjoyed unraveled when Kizer and his VISN directors began cutting and consolidating facilities to accommodate VISN funding cuts. The threat of hospital mergers and consolidations ultimately led several senators to block his confirmation to a second term.⁷⁴²

Under new eligibility reform law, all veterans became *eligible* for VA health care, though its authors did not envision that the system could or would serve all eligible individuals, or even all who might someday seek VA care. The law’s priority-based enrollment system was intended to give VA a tool to align demand for care with its funding level.⁷⁴³ The law instead unleashed political pressure to expand enrollment, opening the door to an influx of veterans who historically had not been VA health care users and many of whom were already covered under military retirement benefits, private insurance, or Medicare.⁷⁴⁴ That expansion led to a tremendous demand for prescription drug benefits by new enrollees and in 2003, Secretary Tony Principi ended enrollment for higher income (category 8) veterans “to keep the system solvent.”⁷⁴⁵ At about the same time, other related pressures led Principi to establish an advisory body, the Capital Asset Realignment for Enhanced Services (CARES) Commission, to develop a comprehensive capital asset plan. Principi cited the age of VA facilities and the changes in medical practice, but also reminded a congressional oversight committee of a 1999 Government Accountability Office finding that “maintaining obsolete or duplicative structures diverts \$1 million a day, every day, every year, away from the care of veterans.” Principi did not want to repeat Kizer’s experience and hoped to avoid political backlash.⁷⁴⁶

The CARES Commission released a final report in February 2004 that recommended relatively few actual facility closures, though it proposed substantial facility mission changes at a number of facilities.⁷⁴⁷ As the then USH later recounted, “CARES, like so many things in Washington, was well-intended, but it was derailed politically once it began moving toward actual targeted action within specific congressional districts.”⁷⁴⁸

Despite such defeats, Principi and VA under secretaries following Kizer met formidable challenges, left legacies, and saw the veterans’ health care system continue to be heralded for several years.⁷⁴⁹ A cascade of other events muddled, and even blackened, VHA’s reputation:

⁷⁴¹ Ibid., 133-134.

⁷⁴² Ibid., 168-169.

⁷⁴³ Veterans Affairs Comm., Veterans’ Health Care Eligibility Reform Act of 1996, H. R. Rep. No. 104-690 (1996), accessed June 3, 2016, <https://www.congress.gov/congressional-report/104th-congress/house-report/690/1>.

⁷⁴⁴ James Rife, *Not Your Father’s VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 193.

⁷⁴⁵ Ibid., 194.

⁷⁴⁶ Ibid., 195.

⁷⁴⁷ Ibid., 196.

⁷⁴⁸ Ibid.

⁷⁴⁹ “The Best Care Anywhere,” Phillip Longman, *Washington Monthly*, accessed June 3, 2016,

accounts of veterans' suicides (and an alleged cover-up); incompetent surgeries and patient deaths at a high-visibility VA medical center (VAMC); failed software acquisitions;⁷⁵⁰ hard-hitting inspector general audit reports on issues such as system flaws, quality of care issues, and lack of timely care that fueled congressional oversight and other constraints. The 2014 scandal that erupted at the Phoenix VAMC represented a decisive turning point and set the stage once again for transforming veterans' health care.

Among initial steps on that long road to transforming the system, the Senate in July 2014 unanimously confirmed Robert A. McDonald, former chief executive officer of Proctor & Gamble, as secretary of veterans affairs. With a business career of delivering better results, McDonald, along with DEPSECVA Sloan Gibson and USH Dr. David Shulkin, has been working to improve VA's health care system and service delivery, and to set a framework for long-term reform. Days after McDonald's confirmation, Congress passed the Veterans Access, Choice, and Accountability Act of 2014, omnibus legislation to improve veterans' access to care. This legislation established the *Choice Program*, mandated an independent assessment of VHA, and established the Commission on Care.

<http://www.washingtonmonthly.com/features/2005/0501.longman.html>. "Revamped Veterans Health Care Now a Model," Gilbert Gaul, accessed June 3, 2016, <http://www.washingtonpost.com/wp-dyn/content/article/2005/08/21/AR2005082101073.html>. "The Best Medical Care in the U.S.: How Veterans Affairs Transformed Itself—and What it Means for the Rest of Us," Catherine Arnst, accessed June 3, 2016, <http://www.bloomberg.com/bw/stories/2006-07-16/the-best-medical-care-in-the-u-dot-s-dot>.

⁷⁵⁰ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 216-217.

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APPENDIX E: THE EVOLVING HEALTH CARE INDUSTRY

Health care has evolved in major ways since the federal government began providing care to veterans after the Civil War, and it will continue to evolve substantially in the future. There are a number of factors that drive evolution in health care, such as population and lifestyle changes, changes within the various health care professions, medical and information systems technology, and systems changes in management and operations.⁷⁵¹ IBM Center for Applied Insight reports that there are 18 trends to watch in health care.⁷⁵² These trends closely encompass those highlighted below. The categories in which the trends fall mirror key topic addressed in the Commission's report to include data system interoperability (10 trends), consumer technology (two trends), health care providers (two trends), government regulations (two trends), and human resources and leadership (two trends). With health care changing so rapidly, and in so many different ways, it is imperative that veterans' health care continually evolve to remain aligned with current and future trends. This section highlights key trends that, based on past experience and current practice, will likely shape health care in the future, were considerations in formulating the Commission's recommendations, and will likely affect transformation of veterans' health care.

Emergence of Large Health Care Systems

The health care industry is moving away from stand-alone community hospitals that serve the needs of a local constituency to large, multiple-campus health care systems.⁷⁵³ The industry will see more high profile mergers and acquisitions in the second half of 2016.⁷⁵⁴ The December 2015 Health Research Institute's report indicates that well-known health care systems may have a market advantage as Americans are willing to travel further for care from a well-known system. This may explain the development and affiliation for Mayo Clinic in Arizona and Florida, and Cleveland Clinic opening in Florida. The report also states that although people are willing to drive for care they are not willing to pay prices higher than the local market. Because of increasing use of outpatient services and same-day surgery, facilities within these health care systems require fewer inpatient beds.⁷⁵⁵ With the advancement of psychotropic drugs, the perceived need for large mental hospitals has declined.⁷⁵⁶ Because of shorter recovery stays, increased outpatient services, telemetry and other monitoring programs, and new medical inventions, hospitals are now built as smaller facilities with parts or sections that can be quickly

⁷⁵¹ Lynn Etheredge, Stanley B. Jones, and Lawrence Lewin, "What is Driving Health System Change?" *Health Affairs*, 15, 4, (1996): 93-104.

⁷⁵² "Healthcare Internet of Things 18 Trends to watch in 2016," Bill Chamberlain, IMB Center for Applied Insights, March 1, 2016, accessed June 20, 2016, <https://ibmcai.com/2016/03/01/healthcare-internet-of-things-18-trends-to-watch-in-2016>.

⁷⁵³ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed April 29, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

⁷⁵⁴ Ibid.

⁷⁵⁵ Ibid.

⁷⁵⁶ "How Release of Mental Patients Began," Richard Lyons, accessed May 1, 2016, <http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all>.

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modified for future changes and medical advances.⁷⁵⁷ VHA will need to consider this trend in evaluating its current physical plant and planning for future facility needs.

Management Changes

As health care systems become increasingly complex, there is a need to manage these institutions using current management theories and models.⁷⁵⁸ During the past few decades, hospital and health care management changed from being managed by a traditional top-down model to continuous quality improvement models that respond to issues such as staff satisfaction, medication errors, safety matters, and wasteful use of supplies. To address errors, hospitals have implemented Six Sigma principles. To address waste, hospitals have implemented LEAN principles. Embracing these changes in management approach and implementing Six Sigma and LEAN principles will support VHA's transformational process.

Health Care Payment

The health care industry is in the midst of transforming its payment model away from a fee-for-service model to value-based payments, a system that drives improved health outcomes.⁷⁵⁹ This transformation is tied to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which health care experts expect to shape care delivery and payment reform across the U.S. health care system over the coming decades. Congress created MACRA as a transformative law to fast track the health care system's transition from a traditional fee-for-service payment model to new risk-bearing, coordinated care models.⁷⁶⁰ Because this legislation is still in rulemaking, it is premature for the Commission to weigh in on its potential effect on VA. The MACRA legislation expands the trend toward creation of accountable care organizations (ACOs) and bundled payments for care. ACO models have been reported to drive reduced hospitalization and generate cost savings.⁷⁶¹

Specialty Care Facilities

With changes in the federal payment for hospitals, some high-cost and longer-stay care treatments have been moving out of community hospitals to specialty hospitals. For example, long-term acute care hospitals primarily treat patients on ventilators; rehabilitation facilities treat short-term, post-acute patients who need primarily physical and occupational therapy services for orthopedic or stroke incidences; and cancer hospitals provide innovative treatments for Stage 4 cancer. As a result, community hospitals may no longer need beds to take care of these special patients. VHA will need to consider this trend in planning integrated care networks and evaluating its facility needs in conjunction with these networks.

⁷⁵⁷ "The Small Hospital of the Future," Shati Matambanadzo, accessed May 3, 2016, <http://www.healthcaredesignmagazine.com/article/small-hospital-future>.

⁷⁵⁸ "How to Solve the Cost Crisis in Health Care," Robert S. Kaplan and Michael E. Porter, accessed May 2, 2016, <https://hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care>.

⁷⁵⁹ "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, <http://www.nationalpartnership.org/issues/health/macra.html>.

⁷⁶⁰ "MACRA: Disrupting the health care system at every level," Deloitte, accessed June 23, 2016, <http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/macra.html>.

⁷⁶¹ "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, Inquisitr: Medicine, accessed May 2, 2016, <http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/>.

Outpatient Care and Lifestyle-oriented Venues for Care

With improvements in surgical procedures, many surgeries that required post-surgery hospital stays are now routinely performed in outpatient settings.⁷⁶² Many nonsurgical procedures are being performed in outpatient clinics as well, such as medical imaging, cardiac catheterization, substance abuse treatment, gastrointestinal screening and cancer treatment.⁷⁶³ As care that was once provided only in hospitals is now provided in specialized medical clinics, care that was once provided only in physicians' offices is now being provided in alternative settings. As reported in Health Affairs, "another health care trend consumers are using to save both time and money is that rather than making appointments with their doctors, they are choosing to use walk-in clinics."⁷⁶⁴ Many of these clinics are located in pharmacies, retail chains, or supermarkets, allowing consumers quick, convenient, less-costly care.⁷⁶⁵ Do-it-yourself health care is also a trend, with increasingly more people taking responsibility for their health care. Consumers are using smart phone apps to monitor vital signs, medication adherence, and even urinalysis.⁷⁶⁶ As part of a commitment to continuous improvement, VHA will need to consider alternative venues as it creates integrated health care networks.

Medical Technology

Medical technology companies create life-changing innovation, and "advanced medical devices and diagnostics allow people to live longer, healthier and more productive lives."⁷⁶⁷ In fact, during the past 30 years, medical advancements helped add five years to U.S. life expectancy and reduce fatalities from heart disease, stroke, and breast cancer by more than half.⁷⁶⁸ These advancements also yield savings across the health care system by replacing more expensive procedures, reducing hospital stays, and allowing people to return to work more quickly.⁷⁶⁹ Ensuring veterans receive care that employs cutting-edge technology will be an important part of establishing integrated care networks.

Telemedicine

According to the American Telemedicine Association, "telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status."⁷⁷⁰ Telemedicine includes a growing variety of applications and

⁷⁶² Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/21183845>.

⁷⁶³ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

⁷⁶⁴ "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, accessed May 2, 2016, <http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/>.

⁷⁶⁵ Ibid.

⁷⁶⁶ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

⁷⁶⁷ "Value of Medical Technology," Advanced Medical Technology Association, accessed May 2, 2016, <http://advamed.org/page/74/value-in-medical-technology>.

⁷⁶⁸ "Value of Medical Innovation," HealthCare Institute of New Jersey, accessed May 2, 2016, <http://hinj.org/value-of-medical-innovation/>.

⁷⁶⁹ Ibid.

⁷⁷⁰ "What is Telemedicine," American Telemedicine Association, accessed May 2, 2016, <http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VwFrqfkrJaQ>.

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services using two-way video, email, smart phones, wireless tools, and other forms of telecommunications technology. The use of telemedicine has spread rapidly and is now becoming integrated into hospitals, specialty departments, home health agencies, private physician offices, as well as consumers' homes and workplaces. The following are examples of how telehealth is being used:

- A specialist assisting the primary care physician in rendering a diagnosis might use interactive video or store-and-forward transmission of diagnostic images or information.
- Home-use devices might be used to remotely collect information such as vital signs, blood glucose, or heart electrocardiogram data and transfer it in real time to a home health agency or a remote diagnostic testing facility for interpretation.
- Consumers' internet and wireless devices might be used to obtain specialized health information or participate in online peer-to-peer support groups.

VHA already excels in the use of telehealth and should expand upon its work in this area.

Midlevel Practitioners

During the past few decades, new categories of health care professionals have become increasingly commonplace in hospital settings. For example, hospitalists, physicians who specialize in the practice of hospital medicine, take over when the community-based physician admits his/her patient to the hospital.⁷⁷¹ The hospitalist does not perform the surgery but rather takes on the monitoring of the hospital services needed by the patient. Another example is medical technicians, who monitor the specialized medical equipment and devices that previously were under the purview of nurses in specialty units such as intensive care units. The growing physician shortage has led to reliance on mid-level health care providers. According to the Centers for Medicare and Medicaid Services' National Provider Identifier dataset, there were approximately 106,000 practicing nurse practitioners and 70,000 practicing physician assistants in 2010.⁷⁷² Provider trends may play into ways VHA can address its current staffing shortage.

Electronic Patient Health Information

Health records have undergone transformation from free-form physician notes of the 17th century to electronic health records (EHRs) of the 21st century. Today, providers are using clinical applications such as computerized physician order entry systems; EHRs; and radiology, pharmacy, and laboratory systems to track patient care and progress. Health plans are providing access to claims and care management, as well as member self-service applications.⁷⁷³ These advances allow the medical workforce to be more mobile and efficient (i.e., physicians can check patient records and test results from wherever they are). Though their use comes with

⁷⁷¹ "Definition of a Hospitalist and Hospital Medicine," Society of Hospital Medicine, accessed May 2, 2016, http://www.hospitalmedicine.org/Web/About_SHM/Hospitalist_Definition/Web/About_SHM/Industry/Hospital_Medicine_Hospital_Definition.aspx.

⁷⁷² "The Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the United States," Agency for Healthcare Research and Quality, accessed May 2, 2016, <http://www.ahrq.gov/research/findings/factsheets/primary/pcwork2/index.html>.

⁷⁷³ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

inherent potential security and privacy risks, they will surely play a substantial role in shaping future health care.⁷⁷⁴ Interoperability of these sources of patient information will be a continuing key issue in private-sector, military, and veterans' healthcare organizations.

Population Health

Population health refers to considering incidence and prevalence of diseases in a given area to determine if the area or the environment is contributing to the illness. Physicians and other health care providers may look at a region's demographics to determine what types of care are needed within the population. For example, if 65 percent of the region is older than age 65, then a series of wellness programs that address the chronic care concerns of this population may be needed. From a population health perspective, communities and their respective populations are as important as the individual patients who comprise them when it comes to keeping residents healthy. For VHA, population health issues may revolve around populations of veterans who served in particular wars and operations and the respective injuries and illnesses associated with them.

Geriatric Care

In the United States and Western Europe the birth rate has slowed⁷⁷⁵ and people are living longer.⁷⁷⁶ Demographic researchers report that if an American makes it to age 65, he/she should have about 17 to 20 additional years of life.⁷⁷⁷ Nursing homes and assisted living facilities are now seeing increasingly more of residents' first-time admissions occurring at age 80 or older. Some congregate care retirement facilities report that even with admission in the 80s, the average life expectancy is another 12 or 13 years.⁷⁷⁸ The aging population accounts for increasingly more hospital admissions, and as a result, hospitals rely on more revenue from Medicare.⁷⁷⁹ The VHA beneficiary population mirrors the general U.S. population, and older veterans receiving care through VHA may be sicker than their private-sector counterparts.

Chronic Disease Care

Chronic conditions now account for more than 50 percent of the death rate. Acute problems had previously been the primary causes of death.⁷⁸⁰ Even HIV/AIDS has moved away from being considered an immediate death sentence, and now, with proper treatment, is considered by

⁷⁷⁴ "Summary of the HIPAA Privacy Rule," U.S. Department of Health and Human Services, accessed May 2, 2016, <http://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/>.

⁷⁷⁵ "Fact Sheet: The Decline in U.S. Fertility," Mark Mather, accessed May 2, 2016, <http://www.prb.org/publications/datasheets/2012/world-population-data-sheet/fact-sheet-us-population.aspx>.

⁷⁷⁶ National Center for Health Statistics, *Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities*, accessed May 2, 2016, <http://www.cdc.gov/nchs/data/abus/abus15.pdf>.

⁷⁷⁷ National Center for Health Statistics, *Life Expectancy at Birth, at Age 65, and at Age 75, by Sex, Race, and Hispanic Origin: United States, Selected Years 1900-2010*, accessed May 2, 2016, <http://www.cdc.gov/nchs/data/abus/2011/022.pdf>.

⁷⁷⁸ Kathleen Harris, *CCRC Resident Demographics and Health Care Utilization: An Analysis*, accessed May 3, 2016, <http://www.avpowell.com/docs/Fall1997.pdf>.

⁷⁷⁹ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

⁷⁸⁰ "Chronic Disease Overview," Centers for Disease Control and Prevention, accessed May 2, 2016, <http://www.cdc.gov/chronicdisease/overview/>.

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most to be a chronic disease.⁷⁸¹ The Centers for Disease Control reports that since 2014, more Americans are dying as a result of chronic conditions and diseases than from acute diseases. Most chronic diseases result from lifestyle choices. Lifestyle diseases result from choices that individuals make.⁷⁸² Health care systems invest resources in addressing lifestyle-related issues caused by behaviors such as smoking, using opiates, and overeating.⁷⁸³ Lifestyle diseases such as cancer caused by smoking, addiction caused by drug use, and diabetes caused by obesity, are costly to treat.⁷⁸⁴ Because lifestyle diseases change over time, they are important to consider in thinking about the future of veterans' healthcare. Treating chronic diseases can be costly because care is ongoing, and assuming this trend continues to become more prominent, it will affect the cost of care and how it is provided.⁷⁸⁵

Needs-based Health Care

The Affordable Care Act requires all not-for-profit hospitals to complete a survey of the community (community health needs assessment, or CHNA) to show what entities in the community will address identified needs (asset mapping) and then report on how the hospital will address these needs in a community health care implementation program (CHIP).⁷⁸⁶ Starting in 2016, hospitals must post these reports on their websites and conduct these evaluations every 3 years thereafter. Monitoring community health needs can lead to preventing or stopping the spread of disease. For example, scarcity of quality food has been documented to result in poor school attendance and increased illness.⁷⁸⁷ Some Americans simply have not been exposed to how to prepare vegetables and fruits because they live in areas that are called *food deserts*, where healthy foods are not readily available. Identifying such needs and how they will be addressed can help improve health for specific populations.⁷⁸⁸ In Washington, DC, such a health assessment led to new treatments and protocols for addressing the appearance of a rare strain of tuberculosis brought in by a group of legal immigrants.⁷⁸⁹ Using CHNA and CHIP could be part of VHA's ongoing planning process.

⁷⁸¹ Steven G. Deeks, Sharon R. Lewin, and Diane V. Havlir, "The End of AIDS: HIV Infection as a Chronic Disease," *Lancet*, 382, 9903, (2013): 1525-1533.

⁷⁸² "Lifestyle Choices: Root Causes of Chronic Diseases," Cleveland Clinic, accessed May 2, 2016, https://my.clevelandclinic.org/health/transcripts/1444_lifestyle-choices-root-causes-of-chronic-diseases.

⁷⁸³ D. B. Resnik, "Responsibility for Health: Personal, Social, and Environmental," *Journal of Medical Ethics*, 33, 8, (2007): 444-445.

⁷⁸⁴ "How to Save a Trillion Dollars," Mark Bittman, accessed May 2, 2016, <http://opinionator.blogs.nytimes.com/2011/04/12/how-to-save-a-trillion-dollars/>.

⁷⁸⁵ "Why We Need Public Health to Improve Healthcare," National Association of Chronic Disease Directors, accessed May 2, 2016, <http://www.chronicdisease.org/?page=WhyWeNeedPH2impHC>.

⁷⁸⁶ "New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act," Internal Revenue Service, accessed May 2, 2016, <https://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501%28c%29%283%29-Hospitals-Under-the-Affordable-Care-Act>.

⁷⁸⁷ "Hunger In Our Schools: Breakfast Is A Crucial 'School Supply' For Kids In Need," Tom Nelson, accessed May 2, 2016, <http://blogs.usda.gov/2015/03/03/hunger-in-our-schools-breakfast-is-a-crucial-school-supply-for-kids-in-need/>.

⁷⁸⁸ "The Capital's Food Deserts," Jeremy Moorhead, accessed May 3, 2016, <http://eatocracy.cnn.com/2012/03/14/the-capitals-food-deserts/>.

⁷⁸⁹ District of Columbia Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration, *District of Columbia HIV/AIDS, Hepatitis, STD, and TB (HAHSTA) Annual Report: 2010*, accessed May 3, 2016, http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2010_Annual_Report_FINAL_0_0.pdf.

Behavioral Health

Treatment for mental health, now more commonly referred to as behavioral health, has changed dramatically since a 1968 federal law required individuals be cared for in the least restrictive environment.⁷⁹⁰ This law led to an expectation that most patients would receive care in out-patient facilities. Recently legislation was passed that requires insurance companies to increase the amount of payment for behavioral health, which could add more patients to the health care system.⁷⁹¹ VHA is a leader in mental health treatment and should continue to be a trendsetter in this regard.

Preventive Medicine

Traditionally, physicians were trained to cure illness and to restore the sick to health. The trend, however, is changing, and physicians are now trained in prevention and are more active participants in the prevention of illness.⁷⁹² Additionally, insurance and Medicare now cover preventive care and annual physicals, further supporting prevention.⁷⁹³ Preventive medicine is a key component of integrated health care and will need to be considered as VHA works to transform veterans' healthcare.

Pharmacy Changes

Health Affairs reports that "in 2015 . . . an alarming trend of new high-cost specialty pharmaceuticals entered the market. . . . Overall drug spending increased 12.2 percent last year, the highest rate of increase in more than a decade."⁷⁹⁴ Escalating drug prices account for some of this increase, including more than 3,500 generic drugs that at least doubled in price from 2008–2015 and about 400 drugs that increased in cost 1000 percent.⁷⁹⁵ Newly emerging and very expensive developments in the area of genomic medication also contribute to the increase. "One way to combat skyrocketing prices will be biosimilar drugs. These drugs are near substitutes for original brand drugs and could bring significant price discounts."⁷⁹⁶ Because many of VHA's beneficiaries seek only prescription benefits, prescription drug trends will be important to consider in the transformation process.

⁷⁹⁰ "How Release of Mental Patients Began," Richard Lyons, accessed May 2, 2016,

<http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all>.

⁷⁹¹ "Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)," Substance Abuse and Mental Health Services Administration, accessed May 2, 2016, <http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>.

⁷⁹² "Opinion 8.075 – Health Promotion and Preventive Care," American Medical Association, accessed May 2, 2016, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8075.page>.

⁷⁹³ "Preventive Services Covered Under the Affordable Care Act," U.S. Department of Health and Human Services, accessed May 2, 2016, <http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/>.

⁷⁹⁴ Anne Martin et al., "National Health Spending In 2014: Faster Growth Driven By Coverage Expansion And Prescription Drug Spending," *Health Affairs*, 35, 1, (2016): 150-160.

⁷⁹⁵ "Generic Drug Prices Quickly on the Rise," Anthony L. Komaroff, accessed May 2, 2016, <http://www.spokesman.com/stories/2016/feb/18/generic-drug-prices-quickly-on-the-rise/>.

⁷⁹⁶ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

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APPENDIX F: THE COMMISSION'S PROCESS

Commission Meetings

From September 2015 to June 2016, the Commission held convened 12 sessions of public meetings (26 days). The content addressed at each meeting is listed in the following table.

September 21-22, 2015

Assessment A: Demographics	RAND Corporation <ul style="list-style-type: none"> Christine Eibner
Assessment B: Health Care Capabilities	RAND Corporation <ul style="list-style-type: none"> Peter Hussey, PhD
VA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> Bob McDonald, Secretary Sloan Gibson, Deputy Secretary David Shulkin, MD, Under Secretary for Health
Assessment C: Care Authorities	RAND Corporation <ul style="list-style-type: none"> Michael D. Greenberg
Assessment I: Business Processes	Grant Thornton LLP <ul style="list-style-type: none"> Lane Jackson Aamir Syed Sharif Ambrose
Assessment E: Scheduling Workflow	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Alex Harris Pooja Kumar
Assessment F: Clinical Workflow	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Gretchen Berlin
Assessment G: Staffing/Productivity/Time Allocation	Grant Thornton LLP <ul style="list-style-type: none"> Peter Erwin, PhD Hillary Peabody Erik Shannon
Assessment J: Supplies	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Robin Roark, MD
Assessment K: Facilities	McKinsey & Company <ul style="list-style-type: none"> Vivian Riefberg John Means

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September 21-22, 2015 (continued)

VHA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning
Assessment Leadership	CMS Alliance to Modernize Health care <ul style="list-style-type: none"> Stephen Kirin Jay Schnitzer, PhD, MD McKinsey & Company <ul style="list-style-type: none"> Vivian Riefberg
Assessment H: Health IT	MITRE Corporation <ul style="list-style-type: none"> Aparna Durvasula Glenn Himes McKinsey & Company <ul style="list-style-type: none"> Celia Huber Vivian Riefberg

October 6, 2015

Eligibility	Veterans Health Administration <ul style="list-style-type: none"> Stephanie Mardon, Chief Business Officer Kristin Cunningham, Director, Business Policy Affairs
2014 Choice Act/2015 Enhancement to Choice/Care in the Community, Current State	Veterans Health Administration <ul style="list-style-type: none"> Stephanie Mardon, Chief Business Officer Kristin Cunningham, Director, Business Policy Affairs
Future State of VA Community Care/ Care in the Community	Veterans Health Administration <ul style="list-style-type: none"> Joe Dalpiaz, Director, VISN 17 Baligh Yehia, MD, Senior Health Advisor to the Secretary of Veterans Affairs Gene Migliaccio, Deputy Chief Business Officer, Managed Care
Academic Affiliations	Veterans Health Administration <ul style="list-style-type: none"> Robert Jesse, MD, Chief, Office of Academic Affiliations Karen Sanders, MD, Deputy Chief, Office of Academic Affiliation Long-Term Care Richard Allman, MD, Chief Consultant, Geriatrics and Extended Care Services

October 19–20, 2015

Independent Assessment, Perspective on VA Health Care, and Q&A/Panel Discussion	<ul style="list-style-type: none"> ▪ Brett Giroir, MD, Senior Fellow, Health Policy Institute, Texas Medical Center ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE ▪ Jonathan Perlin, MD, Chief Medical Officer and President, Clinical Services at Hospital Corporation of America
Women's Health	Veterans Health Administration <ul style="list-style-type: none"> ▪ Patricia Hayes, PhD, Chief Consultant, VA Women's Health Services
Mental Health	Veterans Health Administration <ul style="list-style-type: none"> ▪ David Carroll, Executive Director, Mental Health Operations ▪ Harold Kudler, MD, Chief Mental Health Consultant
Homelessness	Veterans Health Administration <ul style="list-style-type: none"> ▪ Anne Dunn, Deputy Director, VHA Homeless Program Office
Assessment D: Access	Institute of Medicine <ul style="list-style-type: none"> ▪ Michael McGinnis, MD ▪ Marianne Hamilton Lopez
VACAA Section 203	Northern Virginia Technology Council <ul style="list-style-type: none"> ▪ Ken Mullins
Scheduling	Veterans Health Administration <ul style="list-style-type: none"> ▪ Michael Davies, MD, Executive Director of Access and Clinic Administration Program
MyVA Support Services Excellence Overview	Department of Veterans Affairs <ul style="list-style-type: none"> ▪ Bob Snyder, Executive Director, MyVA Task Force ▪ Tom Muir, Director, Support Services

November 16–17, 2015

Health Care Economics/Finance	<ul style="list-style-type: none"> ▪ Mark Yow, Acting Chief Financial Officer, VHA ▪ Paul Mango, McKinsey & Company ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE
Academic Affiliations	Association of American Medical Colleges <ul style="list-style-type: none"> ▪ Atul Grover, PhD, MD, Chief Public Policy Officer ▪ John E. Prescott, MD, Chief Affiliations Officer ▪ Matthew Schick, JD, Director, Government Regulations & Regulatory Counsel
VHA Clinical Matters	Veterans Health Administration <ul style="list-style-type: none"> ▪ Lucille Beck, PhD, Deputy Chief Patient Care Services Officer, Rehab and Prosthetic Services ▪ Donna Gage, PhD, RN, Chief Nursing Officer

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December 14-16, 2015

Minority Affairs and Health Equity	<p>Department of Veterans Affairs</p> <ul style="list-style-type: none"> Barbara Ward, Director, Center for Minority Affairs <p>Veterans Health Administration</p> <ul style="list-style-type: none"> Uchenna S. Uchendu, MD, Executive Director, Office of Health Equity
Framework for the Future of Veterans Health	<ul style="list-style-type: none"> Garry Augustine, Disabled American Veterans Carl Blake, Paralyzed Veterans of America Carlos Fuentes, Veterans of Foreign Wars Ray Kelley, Veterans of Foreign Wars
Veteran Service Organizations	<ul style="list-style-type: none"> Louis Celli, The American Legion Renee Campos, Military Officers Association of America
National Health Information Operability	<ul style="list-style-type: none"> Dr. Jon White, Deputy National Coordinator, Department of Health and Human Services
DoD I Procurement: Lesson Learned/Interagency Program Office	<ul style="list-style-type: none"> Chris Miller, Program Executive Officer, Defense Health Care Management Systems, Department of Defense
Health Information Exchange	<ul style="list-style-type: none"> Elaine Hunolt, Do-Director Interoperability Office, Veterans Health Administration Dr. Harry Leider, Chief Medical Officer, Walgreens James Wood, VP-Federal, Walgreens Mariann Yeager, Chief Executive Officer, The Sequoia Project
Vision for OI&T/Collaboration with VHA	<ul style="list-style-type: none"> LaVerne Council, Chief Information Officer, Department of Veterans Affairs
Leadership and Transformation	<ul style="list-style-type: none"> Charles Rossotti, Former Commissioner, Internal Revenue Service

January 19 and 21, 2016

VHA Leadership	<ul style="list-style-type: none"> Dr. Michael Kussman, former Undersecretary for Health, Veterans Health Administration Dr. Kenneth Kizer, former Undersecretary for Health, Veterans Health Administration
Labor Perspectives	<p>American Federal of Government Employees</p> <ul style="list-style-type: none"> Marilyn Park <p>National Association of Veterans Affairs Physicians and Dentists</p> <ul style="list-style-type: none"> Samuel Spagnolo <p>Nurses Organization of Veterans Affairs</p> <ul style="list-style-type: none"> Joan Clifford Sharon Johnson

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January 19 and 21, 2016 (continued)

Behavioral Health	<ul style="list-style-type: none"> Association of Veterans Affairs Psychologist Leaders <ul style="list-style-type: none"> Thomas Kirchberg Russell Lemle Edgardo Padin-Rivera Antonette Zeiss American Psychiatric Association <ul style="list-style-type: none"> Jenny L. Boyer Association of Veterans Affairs Social Workers <ul style="list-style-type: none"> LeAnn Bruce Jerry Satterwhite
Homeless Veterans	<ul style="list-style-type: none"> Keith Armstrong, San Francisco Veterans Affairs Health care System
Other-Than-Honorable Discharges	<ul style="list-style-type: none"> Branford Adams

February 8-9, 2016

Construction Management	<ul style="list-style-type: none"> Lisa Freeman, Medical Center Director, Palo Alto Health care System
VISN and Field Leadership Perspectives	<ul style="list-style-type: none"> Joleen Clark, Former Network Director, VISN 8 Jon Gardner, Former Medical Center Director, Tucson VA Medical Center Lisa Freeman, Medical Center Director, Palo Alto Health care System
Implementation of the <i>Choice Program</i>	<ul style="list-style-type: none"> Billy Maynard, President HealthNet Federal Service David J. McIntyre, Jr., President and Chief Executive Officer, TriWest Healthcare Alliance
Update on VHA	<ul style="list-style-type: none"> Dr. David Shulkin, Undersecretary for Health, Veterans Health Administration
Determining Feasibility	<ul style="list-style-type: none"> Patrick Ryan, Former Staff Director and Chief Counsel, House Veterans Affairs Committee

February 29 – March 1, 2016

Economist Briefing	<ul style="list-style-type: none"> Gideon Lukens, PhD, Staff Economist Jamie Taber, PhD, Staff Economist
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March 21-23, 2016

Conversation with HVAC Chairman	<ul style="list-style-type: none"> Rep. Jeff Miller (R-FL)
Conversation with HVAC Member	<ul style="list-style-type: none"> Rep. Beto O'Rourke (D-TX)
Veterans Health Administration	<ul style="list-style-type: none"> Dr. David Shulkin, Undersecretary for Health Barbara Manning, Office of Policy and Planning Lyn Stoesen, Office of Policy and Planning

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March 21-23, 2016 (continued)

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Merideth Randles, FSA, MAAA, Milliman, Inc.
- Jamie Taber, PhD, Staff Economist

April 18-19, 2016

Veterans Service Organizations

- Garry Augustine, Disabled American Veterans
- Peter Dickinson, Disabled American Veterans
- Verna Jones, American Legion
- Rick Weidman, Vietnam Veterans of America
- Bill Rausch, Got Your 6
- Ray Kelley, Veterans of Foreign Wars
- Rene Campos, Military Officers Association of America

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Jamie Taber, PhD, Staff Economist

VA Leadership

Department of Veterans Affairs

- Bob McDonald, Secretary
- Sloan Gibson, Deputy Secretary

Community Care

- Baligh Yehia, MD, Assistant Deputy Under Secretary for Community Care, VHA

May 9-11, 2016

VA Office of General Counsel

- Leigh Bradley, General Counsel
- Jessica Tanner, Staff Attorney

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Jamie Taber, PhD, Staff Economist

June 7-8, 2016

No speakers

Commission Workgroups

The Commission on Care organized itself into workgroups in order to complete an analysis of relevant issues, consider options, and suggest recommendations to the full Commission for debate. The Commission formed five workgroups with each responsible for sections of the Independent Assessment or other topics taken on by the group. In establishing each workgroup an effort was made to balance perspectives and expertise, although Commissioners expressed interests were also taken into account in forming the membership of each group. The membership of each workgroup and the topics taken on by each is summarized in Table F-1.

Table F-1. Workgroup Structure and Topics

WORKGROUP NAME	TOPICS	MEMBERSHIP	
Health Care Alignment	<ul style="list-style-type: none"> ▪ Demographics ▪ Health care Capabilities ▪ Care Authorities ▪ Access Standards ▪ Governance 	<ul style="list-style-type: none"> ▪ Blecker ▪ Johnson ▪ Longman ▪ Selnick 	<ul style="list-style-type: none"> ▪ Gorman ▪ Khan ▪ McClenney
Health Care Operations	<ul style="list-style-type: none"> ▪ Access Standards ▪ Workflow Scheduling ▪ Workflow Clinical ▪ Staffing Productivity 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Harvey ▪ Longman ▪ Webster 	<ul style="list-style-type: none"> ▪ Gorman ▪ Hickey ▪ Taylor
Health Care Data, Tools & Infrastructure	<ul style="list-style-type: none"> ▪ Health IT ▪ Business Processes ▪ Supplies ▪ Facilities 	<ul style="list-style-type: none"> ▪ Blom ▪ Harvey ▪ Steele 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Johnson ▪ Taylor
Health Care Leadership	<ul style="list-style-type: none"> ▪ Organizational Health ▪ Leadership Systems 	<ul style="list-style-type: none"> ▪ Blecker ▪ Hickey ▪ Selnick ▪ Steele 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ McClenney ▪ Schlichting
Health Care Trends	<ul style="list-style-type: none"> ▪ Market Trends ▪ Technology ▪ Financing ▪ Vision 	<ul style="list-style-type: none"> ▪ Blom ▪ Johnson ▪ Schlichting 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Khan ▪ Webster

Each workgroup, together with any staff assigned to it, reviewed the findings and recommendations of the Independent Assessment and the Integrated Report; investigated external benchmarks and best practice models; heard testimony in public meetings (with the full Commission); met in workgroup session with VA employees, leaders, former staff and external experts to gather additional insights and explore relevant questions. Commissioners reviewed white papers and strawman proposals prepared by staff and by one another. Based on the assessments and group deliberations, each workgroup developed recommendations for consideration by the full Commission. Details of the process and outputs from each workgroup are described in the following sections.

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Health Care Alignment Workgroup

The alignment workgroup organized its work around six main topics: governance, realignment of facilities and services, medical sharing, eligibility, other than honorable discharges, and the organization of provider networks. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic was introduced through a summary paper or summary points which then were used as the basis for a conference call or a face-to-face discussion. For most topics, subsequent calls were held to discuss more detailed papers or to re-visit outstanding issues not yet resolved.

Commissioners also reviewed draft papers and provided additional feedback, revisions, and comments through written comments. The papers were finalized for inclusion in the draft Commission report for discussion on April 19. A summary of the work completed on each topic is provided in the table below.

Table F-2. Alignment Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E=email review M=face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Governance	11/17/2015	M	Vivian Riefberg	9/22/2015	F
	1/7/2016	C	Stephen Kirin	9/22/2015	F
	1/28/2016	C	Jay Schnitzer	9/22/2015	F
	2/18/2016	C	Paul Light	10/30/2015	S
	3/3/2016	C	Charles Rossotti	12/16/2015	F
	3/10/2016	C	Michael Kussman	1/19/2016	F
	3/17/2016	C	Ken Kizer	1/19/2016	F
	4/7/2016	C	Jeff Miller	3/21/2016	F
Realignment of Facilities and Services	1/7/2016	C	Vivian Riefberg	9/22/2015	F
	1/28/2016	C	John Means	9/22/2015	F
	3/10/2016	C			
	3/17/2016	C			
	4/7/2016	C			
Medical Sharing	1/28/2016	C	Atul Gover	11/16/2015	F
	3/3/2016	C	John Prescott	11/16/2015	F
	3/10/2016	C	Mathew Schick	11/16/2015	F
	3/17/2016	C			
	4/7/2016	C			
Eligibility	11/17/2015	M	Christine Eibner	9/21/2015	F
	12/10/2015	C	Michael Greenberg	9/21/2015	F
	1/28/2016	C	Pat Vandenberg	9/21/2015	F
	2/25/2016	C	Stephenie Mardon	10/6/2015	F
	3/10/2016	C	Kristin Cunningham	10/6/2015	F
	3/17/2016	C	Gail Wilensky	10/19/2015	F
	4/7/2016	C	Michael McGinnis	10/20/2015	F
			Marianne Hamilton Lopez	10/20/2015	F
			Michael Kussman	1/19/2016	F
			Jeff Miller	3/21/2106	F

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E=email review M=face-to-face meeting	Date	Expert	Date	Type
Other-Than-Honorable Discharge		1/28/2016	Bradford Adams	1/20/2016	F
		2/18/2016			
		3/10/2016			
		3/17/2016			
		4/7/2016			
Organization of Provider Networks		1/28/2016	Peter Hussey	9/21/2015	F
		2/25/2016	Joe Dalpiaz	10/6/2015	F
		3/10/2016	Baligh Yehia	10/6/2015	F
		3/17/2016	Gene Migliaccio	10/6/2015	F
		4/7/2016	Michael Kussman	1/19/2016	F
			Jon Gardner	2/8/2016	F
			Billy Maynard	2/8/2016	F
			David McIntrye	2/8/2016	F
			Jeff Miller	3/21/2016	F
			Beto O'Rourke	3/22/2016	F

Health Care Operations Workgroup

The health care operations workgroup was organized around five main topics: access standards, scheduling, clinical workflow, staffing (HR), and productivity. The workgroup (select Commissioners and support staff) first met face-to-face on October 7, 2015 to: introduce the staff, review guiding principles and business rules, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics was discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research on the four main topics; and cover other issues that may have come up during sessions (i.e., Best Practices) or from questions posed by Commissioners. To supplement the Commission conferences, the workgroup held teleconferences to cover additional research or present information from subject matter experts or emailed informational briefs and write-ups for review before a workgroup teleconference. Feedback from the Commissioners was addressed and the potential recommendations were refined. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

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Table F-3. Health Care Operations Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Access Standards	10/20/2015	M	Stephanie Mardon	10/6/2015	F
	12/3/2015	C	Kristin Cunningham	10/6/2015	F
	2/25/2016	C	Institute of Medicine	10/13/2015	S
	4/27/2016	C	Institute of Medicine	10/20/2015	F
Scheduling	10/7/2015	M	McKinsey Co	9/22/2015	F
			Stephanie Mardon	10/6/2015	F
			Kristin Cunningham	10/6/2015	F
			Dr. Michael Davies	10/14/2015	S
			Gary Monder	10/14/2015	S
			Steve Green	10/14/2015	S
			Michael McGinnis	10/14/2015	S
			Ken Mullins	10/14/2015	S
			Marianne Hamilton Lopez	10/14/2015	S
			Institute of Medicine	10/20/2015	F
			Dr. Michael Davies	10/20/2015	F
			Dr. Michael Davies	11/18/2015	W
Clinical Workflow	10/27/2015	C	McKinsey & Co.	9/22/2015	F
	2/18/2016	C	Nora Socci	12/29/2015	S
	4/6/2016	C	Diane Pulphus	2/3/2016	S
			Hugh Scott	2/26/2016	S
Staffing	11/4/2015	C	McKinsey Co	9/22/2015	F
	12/3/2015	C	Dr. Jonathan Perlin	10/19/2015	F
	1/20/2016	M	Barbara Ward	12/7/2015	S
	2/18/2016	C			
	2/25/2016	C			
	4/6/2016	C			
Productivity	12/15/2015	M	McKinsey Co	9/22/2015	F
			Gene Migliaccio	10/6/2015	F
			Boston VAMC	12/7/2015:	S
			Dr. Michael Charness		
			Melanie Gilhern		
			Meredith Walker		
Best Practices	1/6/2016	C	Dr. Melanie Vielhauer		
			Rosemary Conlon		
	1/6/2016	C	McKinsey Co	9/22/2015	F
	1/20/2016	M	Dr. Theresa Cullen	12/2/2015	W
	2/25/2016	C	Dr. Daniel Bochicchio	12/3/2015	S
	3/14/2016	E	David Atkins	1/5/2016	S
			Linda Lipson	1/5/2016	S
			Amy Kilbourne	1/5/2016	S
			Bob Monte	1/5/2016	S
			Rachel Goffman	1/5/2016	S
			Dr. Daniel Bochicchio	1/20/2016	S
			Barbara Meadows	2/25/2016	W
			Barbara Meadows	3/17/2016	W

Health Care Data, Tools & Infrastructure Workgroup

The Health Care Data, Tools & Infrastructure (DTI) workgroup organized its work around four main topics: Health Information Technology, Business Processes, Supplies and Facilities. DTI first met face to face on October 7, 2015 to: introduce the staff, review the charge of DTI, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics were discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research via white papers on the four main topics; and cover other issues that may have come up during sessions or from questions posed by Commissioners. To supplement the Commission face-to-face meetings, the workgroup held teleconferences to cover additional research or present information from subject matter experts. Feedback from the Commissioners was incorporated into the white papers and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

Table F-4. Data, Tools & Infrastructure Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call		S=met with staff		
	E= email review		W=met with workgroup		
	M= face-to-face meeting		F=full Commission testimony		
	Date	Type	Expert	Date	Type
Health IT	10/7/2015	M	MITRE Co	9/22/2015	F
	11/18/2015	C	Dr. Brett Giroir	10/19/2015	S
	12/2/2015	C	LaVerne Council,	10/27/15	HVAC
	3/7/2016	C	Chris Miller, Brian Burns		Hearing
	3/14/2016	C	Brookings Institution	11/6/2015	S
	3/21/2016	M	LaVerne Council	11/25/2015	S
	4/4/2016	C & E	Dr. Theresa Cullen	12/2/2015	W
			Chris Miller	12/15/2015	F
			Chuck Hume	12/15/2015	F
			Elaine Hunolt	12/15/2015	F
			Jim Wood	12/15/2015	F
			Mariam Yeager	12/15/2015	F
			LaVerne Council	12/15/2015	F
			Jamie Bennett	3/2/2016	S
			Margaret Donahue	3/11/2016	S
			Kai Miller	4/12/2016	S
Business Processes	10/20/2015	M	SecVA Bob McDonald	9/21/2015	F
	10/26/2015	M			
	3/14/2016	C			
	3/21/2016	M			
	4/4/2016	C			

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WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting	Date	Expert	Date	Type
Supplies (Pharmaceutical & Medical Devices)	10/7/2015	M	McKinsey Co	9/21/2015	F
	10/26/2015	M	Jonathan Miller	12/4/2015	S
	2/23/2016	E	Tucker Taylor	12/4/2015	S
	2/24/2016	C			
	3/7/2016	C			
	3/14/2016	C			
	3/21/2016	M			
Facilities	10/7/2015	M	Bob McDonald	9/21/2015	F
	11/18/2015	M	Jim Sullivan	11/11/2015	S
	12/2/2015	C	Mark W. Johnson	12/21/2015	S
	12/22/2015	M	Kyle Reinhardt	12/22/2015	S
	2/16/2016	E	Thom Kurmel	12/22/2015	S
	2/17/2016	C	Rick Bond	12/22/2015	S
	2/24/2016	C & E	John Bulick	12/22/2015	S
	3/7/2016	C	John Kay	12/22/2015	S
	3/14/2016	C	Jim Sullivan	2/16/2016	S
	3/21/2016	M	Ed Bradley	2/16/2016	S
	4/4/2016	C	Jim Sullivan	2/17/2016	W
	4/11/2016	C	Jim Sullivan	3/15/2016	S
	4/27/2016	C			
Other	11/5/2015	E			
	11/6/2015	E			
	3/11/2016	E			

Health Care Leadership Workgroup

The leadership workgroup organized its work around five main topics: organizational health and cultural transformation and four leadership system issues: recruitment, retention, development and advancement; organizational structure and function; performance management and performance measurement; and human capital management. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic received an evidence review and summary which was the basis for a conference call or a face-to-face discussion. On a few topics, Commissioners or staff heard directly from VA staff or outside experts to inform the deliberation. Then, in a second meeting on the topic, the Commissioners debated a strawman proposal and alternative recommendations based on the evidence review and the prior Commission discussion. Feedback from the Commissioners was incorporated into the strawman and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. The papers were finalized and presented to the full Commission for deliberation and feedback on March 22, 2016. A summary of the work completed on each topic is provided in the table below.

APPENDIX F
THE COMMISSION'S PROCESS

Table F-5. Leadership Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Organizational Health and Cultural Transformation	12/2/2015	C	Stephen Kirin	9/23/2015	F
	12/9/2015	C	Jay Schnitzer	9/23/2015	F
	2/9/2016	M	Vivian Riefberg	9/23/2015	F
	2/17/2016	C	Dee Ramsel	11/9/2015	S
	3/11/2016	E	Ashby Sharpe	11/9/2015	S
			Ken Berkowitz	11/9/2015	S
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
Recruitment, Retention, Development, and Advancement	11/17/2015	M	Stephen Kirin	9/23/2015	F
	11/25/2015	C	Jay Schnitzer	9/23/2015	F
	2/17/2016	C	Vivian Riefberg	9/23/2015	F
	2/24/2016	C	Volney Warner	11/9/2015	S
	3/9/2016	C	Lisa Red	11/17/2015	W
	3/11/2016	E	Payton Rica-Lewis	11/17/2015	W
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Georgia Coffey	2/22/2016	S
			David Perry	2/24/2016	S
			Audrey Oatis-Newsome	2/24/2016	S
Organizational Structure and Function	10/27/2015	C	Stephen Kirin	9/23/2015	F
	2/9/2016	M	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Charles Rossotti	12/16/2015	F
			Michael Kussman	1/19/2016	F
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Robin Hemphill	3/4/2016	S
Performance Management and Performance Measurement	11/4/2015	C	Stephen Kirin	9/23/2015	F
	11/12/2015	C	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Peter Almenoff	10/30/2015	S
			Joe Francis	1/8/2016	S
			Carolyn Clancy	1/8/2016	S
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Noel Baril	3/9/2016	S

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WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Human Capital Management	12/15/2015	M	Stephen Kirin	9/23/2015	F
	12/23/2015	C	Jay Schnitzer	9/23/2015	F
	3/11/2016	E	Vivian Riefberg	9/23/2015	F
			Sam Retherford	12/15/2015	W
			Joleen Clark	2/8/2016	F
Leadership Vision	1/6/2016	C			
	1/21/2016	M			
	2/3/2016	C			
	2/4/2016	E			
Leadership Pre-amble	3/14/2016	E			

Site Visits

Background

In the coming decades there will be increased demand for accountability in health care and increased emphasis on health care outcomes and measurements, and VHA will need to rise to meet these expectations to survive and remain competitive in the demanding and turbulent health care environment.⁷⁹⁷ The changing nature of health care organizations, including pressure to reduce costs, improve the quality of care, and meet stringent guidelines, has forced health care professionals to reexamine how they evaluate performance.⁷⁹⁸ Although many health care organizations have long recognized the need to look beyond financial measures when evaluating performance, many still struggle with what measures to select and how to use the results of those measures.⁷⁹⁹

As the nation's largest health care system in 2016, VHA employs more than 305,000 health care professionals and support staff at more than 1,000 sites of care, including hospitals, community-based outpatient clinics (CBOCs), nursing homes, domiciliaries, and 300 Vet Centers.⁸⁰⁰ Given the scope of this health care system, the Commission recognized the importance of direct lines of communication and interaction with VHA leaders, staff, and patients, to include conducting facility site visits. Commissioners conducted facility site visits to their local VA facilities to assist in the evaluation of the findings identified by the *Independent Assessment Report*, to contribute to an environmental scan of the VHA, and to inform the development of recommendations.⁸⁰¹

Scope of Site Visits

In January and February 2016, most of the 15 Commissioners conducted site visits to the VA medical centers (VAMCs) and CBOCs proximal to their respective residences. The Commissioners approached these site visits with a collaborative and information-seeking tone with the purpose of having open discussions with VAMC leadership, staff, and patients.

Individual Commissioners visited 12 VAMC facilities or CBOCs in 7 out of 19 Veteran Integrated Service Networks (VISNs). Additionally, all the Commissioners who attended the February 29, 2016, meeting in Dallas, TX, toured the Dallas VAMC.

⁷⁹⁷ Kenneth W. Kizer, M.D., M.P.H./Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation for the Veterans Healthcare System*, accessed March 1, 2016, <http://www.va.gov/healthpolicyplanning/rxweb.pdf>.

⁷⁹⁸ Kicab Castaneda-Mendez/Quality Digest, *Performance Measurement in Health Care*, accessed, March 1, 2016, <http://www.qualitydigest.com/magazine/1999/may/article/performance-measurement-health-care.html#>.

⁷⁹⁹ Ibid.

⁸⁰⁰ Department of Veterans Affairs, Undersecretary for Health, accessed March 1, 2016, <http://vaww.ussh.va.gov/>.

⁸⁰¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, v, accessed March 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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Table F-6. VA Facility Site Visit Locations

VISN	VISN Name	VA Facility
2	VISN 2	VA Hudson Valley Health Care System (Montrose, NY)
6	VA Mid-Atlantic Health Care Network	Fredericksburg Community-based Outpatient Center, (Fredericksburg, VA)- part of Hunter Holmes McGuire VA Medical Center, Richmond, VA
7	VA Southeast Network	Ralph H. Johnson VA Medical Center (Charleston, NC) Wm. Jennings Bryan Dorn VA Medical Center (Columbia, SC)
10	VA Health Care System	VA Ann Arbor Health care System (Ann Arbor, MI) John D. Dingell VA Medical Center (Detroit, MI)
17	VA Heart of Texas Health Care System	Dallas VA Medical Center (Dallas, TX)
21	Sierra Pacific Network	Southern Nevada Health care System (Las Vegas, NV) VA Northern California Health Care System (Mather, CA) VA Palo Alto Health Care System (Palo Alto, CA)
22	Desert Pacific Health Care Network	Greater Los Angeles Health care System (Los Angeles, CA) VA San Diego Health care System (San Diego, CA)

The Commissioners were provided with a generic basic agenda as guidance, though they had the latitude to determine their own agendas as appropriate for the locations they visited. The model agenda included the following activities: a welcome and overview of the VA health care facility; tour of the facility; veteran discussion session (informal or formal); VHA employee session (e.g., informal or small group discussion); a discussion with the facility leadership, and were provided the recommended questions listed below:

- What does the medical center do well?
- What unique resources can the medical center draw on?
- What do others see as the strengths of the medical center?
- What could the medical center improve?
- Where does the medical center have fewer resources than others?
- What are others likely to see as weaknesses of medical center?
- What opportunities are open to the medical center?
- What trends could the medical center take advantage of?
- How can the medical center turn its strengths into opportunities?
- What threats could harm the medical center?
- What obstacles does the medical center face?
- What threats do the medical center's weaknesses expose it to?

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- What is the impact of MyVA?
- How do employees view working at VA compared to two or three years ago? If there is a change, what is driving it?
- In your view, what is the most important factor affecting patient satisfaction with the care you provide?
- In your view, has there been a change in the perception of the quality of care provided by the medical center? If so, what might be driving this different perception?

Once the Commissioners completed their visits, they provided the data they gathered to Commission staff to be organized in a strengths-weaknesses-opportunities-threats (SWOT) analysis framework. A SWOT analysis is a simple but useful framework for analyzing the four factors as they are faced by an organization. It helps organizations develop strengths, minimize threats, and take the greatest advantage of available opportunities.⁸⁰²

Findings

VHA leadership and staff enthusiastically shared their time, insights, perspective, and data on organizational and operational processes with the Commissioners. The site visits provided insight and reinforced the findings of the *Independent Assessment Report*.

Confirming what the *Independent Assessment Report* stated, the Commissioners found VHA facilities' staff members exhibit a deep commitment to serving veterans, but that VHA's health care facilities deliver strikingly different patient experiences, apply inconsistent business processes, and differ widely on key measures of performance and efficiency.⁸⁰³ Based on Commissioners' observations of weaknesses, challenges, and threats related to daily operations, VAMC staff members appear to be searching for suitable solutions. Anecdotal responses provided to the Commissioners illuminated the following systemic problem areas at the VAMCs:

- Care authorities: health care capabilities (i.e., purchased care)
- Staffing: productivity (i.e., human resources), health care capabilities, access standards, clinical workflow
- Leadership: staffing, productivity (i.e., human resources)
- Facilities: health care authorities (i.e., patient-centered community care)

Data from Commissioners' observation notes were organized into a SWOT analysis chart based on the common themes of the Commissioners' facility site visits. The purpose of this exercise was to gather information to inform the Commission's recommendations and to confirm or

⁸⁰² "SWOT Analysis," Mind Tools, accessed March 15, 2016, https://www.mindtools.com/pages/article/newTMC_05.htm.

⁸⁰³ "Veterans Integrated Service Networks (VISN)," Department of Veterans Affairs, VHA, accessed March 14, 2016 <http://www.va.gov/directory/guide/division.asp?dnum=1>.

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dispute the findings of the *Independent Assessment Report*. The Commissioner site visit inputs are summarized in the table below.

Table F-7. SWOT Analysis of Commissioner Site Visit Observations

Strengths	Weaknesses	Opportunities	Threats
<ul style="list-style-type: none"> ▪ VA medical center workforce customer service and dedication ▪ Research and national databases ▪ Veterans service – connected services and programs ▪ Partnerships with medical schools and training programs 	<ul style="list-style-type: none"> ▪ Inefficient/ineffective HR policies ▪ High levels of staffing vacancies ▪ Lack of clinical space; inefficient configurations of clinical space ▪ Poor access to VA care for rural veterans ▪ Lack of an effective financial system to provide real-time payment process to veterans Choice and Purchased Care Programs ▪ Lack of effective VHA leadership workforce ▪ Lack of capacity/access to appointments in VHA ▪ Insufficient federal government health care appropriation rules 	<ul style="list-style-type: none"> ▪ Modernization of VA IT ▪ Customer service training/standards ▪ Strategic focus on VHA core mission ▪ Local funding flexibility from Congress ▪ New vision and mission for VHA health care ▪ Process/systems reengineering ▪ Recruitment of outside leader candidates and retention of high-performing VHA leaders 	<ul style="list-style-type: none"> ▪ Misalignment between Congress's health care operational plans for veterans and VHA strategic health care plans ▪ Competing stakeholders health care interests ▪ Office of Personnel Management outdated standards/policies ▪ Insufficient VHA leadership development ▪ Insufficient IT funding ▪ The physician shortages around the nation has severely impacted the care of patients

Conclusions

Fundamental transformation of VHA is needed to ensure optimal delivery of veteran-centered, high-quality care. Essential to laying the path to excellence and strategic planning is a comprehensive understanding of the current state as well as the opportunities and threats facing the system. A robust connection between leaders in VHA Central Office and leaders in the field is critical to meet the needs of the veteran population served.

As part of the strategic planning process, VA/VHA leadership should make recurring site visits to VHA facilities, including VAMCs, VISN headquarters, and CBOCs to obtain current insight of the following critical areas: health care trends, health care operations, facility management and renovation/replacement, business processes and contracting, and other trends or issues affecting VAMCs. VA/VHA leaders should use performance management tools and activities to ensure the strategic goals are being met in an effective and efficient manner. It is a constant challenge to continuously and reliably measure the pulse of the organization. Site visits promote a healthy culture of sharing and building an understanding of organizational mission.

APPENDIX G: VETERAN FEEDBACK

In addition to the more than 4,000-page *Independent Assessment Report*, the Commission examined dozens of other reports, studies, and presentations as cited in the hundreds of footnotes dispersed throughout this Final Report. Collectively, these many sources provide a wealth of information on the challenges VHA confronts in realizing a vision for veterans' healthcare that leverages the strengths of VA and capitalizes on the potential non-VA providers offer.

A key source the Commission considered was the views of veterans themselves. Given the Commission's brief tenure, it was not possible to conduct a survey representative of the views of millions of veterans receiving health care from VHA. Instead, the Commission encouraged veterans to offer feedback on their health care experiences and the work of the Commission through its website. Many veterans service organizations (VSOs) also provided views representing their members in open sessions with the Commission and in formal letters and position statements directly to the Commission.

The feedback offered by veterans through the Commission's web site covered a range of health care topics, such as whether and to what extent care should be privatized, how much choice veterans should have in deciding on their care, and their assessment of the quality of care received. Not surprisingly, veterans (including a few who were also VA employees) are quite passionate about their views on health care. For the most part, veterans' feedback from the web site expressed opposition to efforts to *privatize* VHA, although a few did want more access to non-VA providers. The *Choice Program* was frequently criticized for long delays in appointments, convoluted or misapplied eligibility criteria, and issues with how providers should be reimbursed for treatment and how much the veteran should pay. When the quality of care was noted, on balance veterans praised the care received from VHA, with a few disappointed, especially when care was outsourced to non-VA providers. Because the feedback was unstructured, veterans could offer any observations they found pertinent.

The Disabled American Veterans (DAV) shared with the Commission a compendium of more than 4,000 verbatim comments on veterans' health care experiences gathered from their members during April 2016. The DAV reviewed the comments and categorized 82 percent of the comments as "overall positive experiences."⁸⁰⁴ The Commission staff reviewed the comments from DAV, with findings consistent to DAV's.

⁸⁰⁴ Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.

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VA Efforts to Gather Input on Veterans Views on Health Care

Like most institutions that provide products and services to customers, VA/VHA solicits input from veterans on their health care needs and their views on specific services VA/VHA provides. Surveys, focus groups, and in-depth interviews are the more typical means for gathering input from veterans. On occasion, VA, like most agencies, encourages veterans and others to submit comments on a particular aspect of VA services and benefits.⁸⁰⁵

The following sections describe the more typical methods employed by VA/VHA to gather input from veterans.

VHA Survey of Veterans' Health and Use of VHA

Conducted by the assistant deputy undersecretary for policy and planning, the survey of veteran enrollees' health and use of health care (Survey of Enrollees) is an annual survey of more than 40,000 veterans who are enrolled in VA's health care system. The Survey of Enrollees was initially designed to give VHA the information it needed to predict the demand for services in the future. The data are used to develop health care budgets and to assist VA with its annual enrollment decisions. Over the years, the data have also been used to analyze policy decisions, provide insights into specific populations and their perspectives, and inform management decisions affecting delivery of care. In addition to collecting basic demographic information, the survey explores insurance coverage, use of health care inside and outside of VA, pharmaceutical use, attitudes and perceptions about VHA services, perceived health status, and trends in smoking among veterans enrolled in the VHA system.⁸⁰⁶

Survey of Healthcare Experiences of Patients⁸⁰⁷

The Survey of Healthcare Experiences of Patients (SHEP) program was initiated in 2002 in an effort to create standardized survey instruments administered monthly to assess ambulatory and inpatient care. In an effort to standardize its survey instruments with other health care providers, SHEP now employs the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey methodology for VHA's primary care and inpatient medical and surgical services. These surveys are supported in the public domain by the CAHPS Consortium, Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, and National Committee for Quality Assurance. Although SHEP deployed the standardized CAHPS surveys,

⁸⁰⁵ "Quality of Care Feedback Form," Department of Veterans Affairs, accessed June 20, 2016, <http://www.va.gov/QUALITYOFCARE/apps/contact.asp>. As an example, the VA web site provides a Quality of Care feedback page for veterans and others to enter comments on the care a veteran received.

⁸⁰⁶ Westat, 2015 Survey of Veteran Enrollees' Health and Use of Health Care, accessed June 6, 2016, http://www.va.gov/healthpolicyplanning/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁸⁰⁷ For more details on SHEP and VHA's recent initiatives to expand the scope of the program, see "Health Services Research & Development, Commentary: Listening to Veterans about Access to Care," Steven M. Wright, VHA Office of Analytics and Business Intelligence, U.S. Department of Veterans Affairs, accessed June 20, 2016, <http://www.hsrd.research.va.gov/publications/forum/nov15/default.cfm?ForumMenu=nov15-1>.

the access questions were limited and did not evaluate the full scope of services used by veterans.

VHA intends to expand the SHEP program with additional surveys in 2016 and beyond. These surveys will focus on satisfaction with various specialty care services and experience with community care available through the Veterans Access, Choice, and Accountability Act of 2014. VHA has also launched a survey that focuses on new veteran enrollments and their experience with first clinic appointments.

Veteran Insights Panel

VHA also established a Veteran Insights Panel, comprising more than 3,200 veterans that are representative of users of VA health care.⁸⁰⁸ VHA interacts with the panel through email notification and a special access website (mobile device enabled). This approach provides VHA an opportunity to engage panel members in direct discussions, including real time feedback via live chat, about important themes and issues, and survey development and testing. The panel can be engaged collaboratively with operational program offices and researchers to prompt direct discussions with our veterans.

Voices of Veterans: On-going Research

Initiated in the spring of 2014, the VA Center for Innovation (VACI) sponsors an on-going effort to employ human-centered design (HCD)⁸⁰⁹ concepts in a pilot to explore veterans' experience with VA through the eyes of 40 veterans across a range of demographics and locations.⁸¹⁰ The pilot had two goals:

- To test the usefulness and application of an HCD methodology within the context of VA.
- To better understand veterans' experiences interacting with VA, identify pain points in the present day service delivery model, and explore opportunities to transform these interactions into a more veteran-centered experience.

Developing Veteran Personas

As a part of this pilot, VACI set out to identify high-level trends in ways veterans seek out assistance, use technology, take advantage of services, and react to challenging interactions. Based on these patterns, VACI created a set of four profiles, or personas, that represent the

⁸⁰⁸ Ibid.

⁸⁰⁹ Human-centered design (HCD) is a discipline in which the needs, behaviors and experiences of an organization's customers (or users) drive product, service, or technology design processes. It is a practice used heavily across the private sector to build a strong understanding of users, generate ideas for new products and services, test concepts with real people, and ultimately deliver easy-to-use products and positive customer experiences. HCD is a multi-disciplinary methodology which draws from the practices of ethnography, cognitive psychology, interaction and user experience design, service design, and design thinking. It is closely tied to "user-centered design," which applies parallel processes to technology projects, and "service design" which address the service specific experiences.

⁸¹⁰ U.S. Department of Veterans Affairs, Center for Innovation, *Toward a Veteran-Centered VA: Piloting Tools of Human-Centered Design for America's Vets, Findings Report, July 2014*, accessed June 20, 2016, http://www.innovation.va.gov/docs/Toward_A_Veteran_Centered_VA_JULY2014.pdf.

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kinds of users within the set of 40 veterans engaged in the pilot (see Table G-1). Each persona is an archetype based on commonalities observed among veterans who exhibited similar behaviors and approaches to accessing VA services. They are not categorized by positive or negative experiences, but by shared expectations and needs. These personas were designed to help VHA begin to understand that it is serving users who are seeking not just different services, but also varied degrees of contact, support, information, and so forth. For this exercise, VACI assessed veterans' modes of communication, channels, frequency, stated and observed needs, reactions to service experiences, military service, and analyzed observed behavior and service experiences.

*Table G-1. Veteran Profiles Developed by the VA Center for Innovation*⁸¹¹

THE LIFER	THE TRANSACTIONAL
<p>Frequently use VA services and plans to continue doing so. Look to VA to play a supporting, community-building role in life. Grateful for VA benefits, but get frustrated when problems arise which break up the continuity of care—like when doctors change too frequently and when they cannot get transportation to VA facilities. Generally, try to speak highly of VA and wants to contribute to making it work better for fellow veterans.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA cares and takes the time to understand veteran's needs and story ▪ That cost of VA services won't rise ▪ That veteran can reach someone at VA anytime <p>Needs</p> <ul style="list-style-type: none"> ▪ Does not want to tell story over and over, especially after using VA for so long ▪ Wants to know what is going on with services and especially benefits ▪ Likes patient, nurturing health care 	<p>Joined the military largely based on the promise of the opportunities it would provide in life. Plan to use VA services to "get life on track" post-service. Tend to be in the younger generation of veterans (OEF, OIF, OND). Often engaged in the veteran community, see other veterans as allies, and advocates in helping folks understand and use their benefits. Will share frustrations if feels like VA is not helping as promised.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA will deliver on its promises and help veteran access the benefits earned ▪ That VA has benefits available to veterans families ▪ That it will be a headache, and veterans will have to figure it out on their own with the help of network <p>Needs</p> <ul style="list-style-type: none"> ▪ Accurate expectations ▪ Financial support at times, especially for family ▪ To feel a part of a community

⁸¹¹ Ibid.

THE JUST-IN-CASE	THE INFREQUENT
<p>Proud of service, but does not need VA and plans on using it only as a backup. Mature and organized by nature, has all papers in order with VA and have a good idea of services for which they are eligible. Grateful for the benefits available, but see working with VA as a tradeoff for time and will likely only lean on VA as a backup plan.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That will likely never need VA benefits ▪ That VA will be there if needed ▪ That there are benefits available to family ▪ That private benefits are of higher quality and greater ease <p>Needs</p> <ul style="list-style-type: none"> ▪ Peace of mind ▪ To be assured that all documents are in order ▪ To easily get in touch with one person about one question 	<p>Does not think very much about VA. Have used VA benefits in lifetime, yet often years will go by between those interactions. This might be because these veterans live in places where it is difficult to access VA services, because veterans are financially comfortable, or because it seems like too much hassle. Tend to prefer quick interaction—a short phone call or a few clicks on a website.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA is slow—like any bureaucracy ▪ That VA is for “other, injured veterans who need it more” ▪ That someone will tell veterans when and if they are eligible for something <p>Needs</p> <ul style="list-style-type: none"> ▪ To be able to quickly navigate processes ▪ To be reminded every few years of how VA might be able to help

Vantage Point: VA’s Official Blog

In addition to surveys, focus groups, and town-hall sessions, VA instituted a blog on its website and invites veterans and others interested in veterans matters to submit guest posts of potential interest to others in the community. Like most blogs, the content offered is vetted by the VA. Since 2010, Vantage Point includes hundreds of contributors with articles on various health care topics.⁸¹²

Veterans’ Views Gathered by VSOs

Like VHA, the VSOs solicit input from their membership and other stakeholders on a variety of topics and issues relevant to veterans. Occasionally surveys and polls are undertaken, but most VSO efforts to gather input take place at the grassroots level during town halls, chapter meetings and other gatherings. While these venues often suffer from self-selection bias and non- or under-represented participant samples, these are nevertheless an important source of timely information on topics of interest and concern to veterans. What follows is a selection of VSO efforts to gather input on issues important to veterans.

⁸¹² “Vantage Point: Official Blog of the U.S. Department of Veterans Affairs,” Department of Veterans Affairs, accessed June 20, 2016, <http://www.blogs.va.gov/VAntage/>.

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The DAV Veterans Pulse Survey (2015)

In mid-2015 the DAV surveyed a nationally representative sample of veterans to solicit their views on issues important to veterans.⁸¹³ The survey includes questions on various aspects of veterans' healthcare. The survey consists of a national probability sample of 1,701 veterans intended to represent the veteran population in the United States. Oversampling occurred in certain subgroups, such as female veterans and veterans age 18-40 to allow for more precision in the response estimates for these subgroups.

Veterans of Foreign Wars Our Care Veterans Survey (2015)

In the fall of 2015, the Veterans of Foreign Wars of the U.S. (VFW) published a report on its veterans 2015 Health Care Options, Preferences and Expectations Survey.⁸¹⁴ In response to the intensified debate over reform of veterans' healthcare, the VFW launched a survey in the summer of 2015 designed to evaluate veterans' options, expectations, and preferences when seeking health care. The survey did not just focus on VA services, but sought to paint a picture of how the veterans' community at large interacts within the American health care infrastructure, and the choices they make in today's health care marketplace. According to the VFW report, 1,847 veterans responded to the survey, with 92 percent eligible for care and 83 percent of those eligible reporting that they utilize VA health care.⁸¹⁵ Respondents' average age was 65, with about two-thirds Vietnam War veterans.

VFW Survey of Women Veterans (2016)

In an effort to identify barriers women veterans face when accessing their earned veterans' benefits and services, the VFW has commissioned a survey of women veterans that will guide the VFW's policy priority goals for women veterans.⁸¹⁶ Though the survey data collection phase is completed, results have not been published prior to release of the Commission's Final Report.

⁸¹³ Disabled American Veterans (DAV), *The DAV Veterans Pulse Survey: A landmark study of the attitudes and perceptions of America's veterans*, accessed June 20, 2016, <https://www.dav.org/wp-content/uploads/DAV-Pulse-Report-Final.pdf>. The survey was conducted on behalf of DAV by GfK Knowledge Networks, Inc. using their KnowledgePanel® survey participants in November 2015.

⁸¹⁴ Veterans of Foreign Wars, *Our Care: A Report on Veterans' Options, Preferences and Expectations in Health Care*, September 22, 2015, accessed June 20, 2016, http://www.vfw.org/uploadedFiles/VFW.org/VFW_in_DC/VFWOurCareReport2015.pdf.

⁸¹⁵ Ibid., 4.

⁸¹⁶ "VFW Survey of Women Veterans: Help Hold the VA Accountable," Veterans of Foreign Wars, December 22, 2015, accessed June 20, 2016, <http://www.vfw.org/News-and-Events/Articles/2015-Articles/VFW-Survey-of-Women-Veterans/>.

The American Legion Survey of Patient Health Care Experiences (2014)

This survey of 3,116 opt-in, self-reported veterans focuses on satisfaction and levels of perceived benefits with VA's posttraumatic stress disorder/traumatic brain injury (PTSD/TBI) programs, including alternative and complementary treatments.⁸¹⁷

Survey questions include veteran status; gender; era of service; number of times deployed; diagnosis of TBI and/or PTSD; availability of appointments; time and distance to care facilities; treatment type (therapy, medication and complementary and alternative medicine); reported symptoms; efficacy of treatment; and side effects.

The American Legion Women Veterans Survey Report (2011)

This survey of 3,012 women veterans, and the resulting report, was prepared by ProSidian Consulting, LLC on behalf of The American Legion. The survey assessed the perceptions of and satisfaction with women veterans' health care and other benefits delivered to women veterans through the VA system. Additionally, the survey sought to determine the factors driving women veterans' decision to use the VA system as opposed to other private or public health care systems.⁸¹⁸

Iraq and Afghanistan Veterans of America Member Survey (2015)

During the first half of 2015, 1,501 Iraq and Afghanistan Veterans of America members completed a wide-ranging on-line survey covering such issues as employment, education, GI Bill usage, health (including mental health), VA utilization, VA benefits, reintegration and more. The survey was composed of approximately 300 questions, with respondents answering only questions relevant to their experiences. Health care topics included percent enrollment in and reliance on VA care; health insurance coverage by type; and experience rating for VA care. Usage percent and experiencing rating for the VA *Choice Program* was also covered separately.⁸¹⁹

The 2015 Wounded Warrior Project® Alumni Survey

This web-enabled, opt-in survey of 23,200 Wounded Warrior Project (WWP) members measures a series of outcome domains within the following general topics about WWP Alumni: background information (military experiences and demographic data), physical and mental well-being, and economic empowerment.⁸²⁰ This WWP membership survey has been conducted annually since 2010. As it has done in prior years, Westat conducts the survey and population-

⁸¹⁷ "Legion survey to measure effectiveness of PTSD/TBI treatment," The American Legion, July 29, 2015, accessed June 20, 2016, <http://www.legion.org/pressrelease/229354/legion-survey-measure-effectiveness-ptsdtbi-treatment>.

⁸¹⁸ ProSidian Consulting, LLC, *The American Legion Women Veterans Survey Report*, March 9, 2011, accessed June 20, 2016, http://www.legion.org/documents/legion/pdf/womens_veterans_survey_report.pdf.

⁸¹⁹ "Media Advisory: IAVA to Release Groundbreaking Veterans Survey," Iraq and Afghanistan Veterans of America (IAVA), May 23, 2016, accessed June 20, 2016, <http://iava.org/press-release/media-advisory-iava-to-release-groundbreaking-veterans-survey-2/>.

⁸²⁰ Westat, *2015 Wounded Warrior Project Survey, Report of Findings*, August 14, 2015, accessed June 20, 2016, https://www.woundedwarriorproject.org/media/2118/2015_wwp_alumni_survey_full_report.pdf.

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weights the reported results, to include adjustments for potential non-response bias, to be representative of the WWP membership base (approximately 59,000).

Right to Care: Voices of Swords to Plowshares' Veteran Community (2015)

The Swords to Plowshares, Institute for Veteran Policy interviewed in-person or by phone 22 veterans.⁸²¹ Although the topics were established in advance, Swords to Plowshares characterized these interviews as individual “conversations” with a preselected group of veterans. The veterans were chosen to represent a cross-section of combat eras and VHA usage levels. The topics covered included: navigating VA care, reliance on VA and non-VA care, comprehensiveness of care, and rating quality of care. The study includes extensive verbatim comments from veterans on these topics.

Comments from Veterans About Their Experiences as Users of VHA (DAV, 2016)

During April 2016, DAV reached out to veterans around the United States and asked them to share their experiences with the VA health care system. As a result, DAV received (as of April 2016) more than 4,000 responses from veterans sharing their own stories about the care they received from VHA.⁸²² The Commission’s review of the material showed that a majority of the veterans’ comments were positive in nature. DAV’s own analysis concluded that 82 percent of the comments could be categorized as “overall positive experiences.”

Other Surveys on Veterans Issues

In addition to efforts by VA and VSOs to gather feedback from veterans on their health care, other organizations have also addressed veterans’ health care issues.

Concerned Veterans for America Survey of Veterans' Healthcare (November, 2014)

The Concerned Veterans for America commissioned The Tarrance Group to conduct a national survey of 1,000 veterans during November 2014.⁸²³ This survey used a random, demographically representative sample of veterans. Four survey items addressed health care, including: knowledge of any problems at VA; need for reform of veterans’ healthcare; importance of more choice (or options) in health care for veterans; and importance of best possible veterans care, even if outside VA.

⁸²¹ Megan Zottarelli, *RIGHT to CARE: Voices of Swords to Plowshares' Veteran Community*, Swords to Plowshares, Institute for Veterans Policy, April 2016.

⁸²² Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.

⁸²³ Concerned Veterans for America, *Fixing Veterans Health Care*, A Bipartisan Policy Taskforce, accessed June 20, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>.

Vet Voice Foundation Survey of Veterans (October, 2015)

Chesapeake Beach Consulting and Lake Research Partners conducted 800 phone (landline and cell) interviews of veterans during October 2015. The results were population weighted by demographics. Topics included rating the job VA hospitals are doing in their area and the extent they favor/oppose privatizing some of VA's health care.

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APPENDIX H: ADDITIONAL RESOURCES

The VHA health care system is immense and complex. This report provides background for the areas for which the Commission has made recommendations, yet this information is but a glimpse at the intricacies of veterans' health care. The resources below may serve as a starting point for those who would like to develop a deeper understanding of the topic than the Commission could address in this report.

Independent Assessment Report

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow – Scheduling)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow – Clinical)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

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Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

Veteran Health Competency Resources

American Nurses Foundation

The American Nurses Foundation, the philanthropic arm of the American Nurses Association, is launching an innovative web-based PTSD Toolkit for registered nurses. The toolkit provides easy to access information and simulation based on gaming techniques on how to identify, assess and refer veterans suffering from PTSD. www.nurseptsdtoolkit.org

American Osteopathic Association

The American Osteopathic Association (AOA) represents osteopathic physicians, many of whom are in primary care practice, and essentially all of whom treat America's veterans and their families. The AOA is raising awareness in the osteopathic community about the importance of having a comprehensive understanding of the unique physical and mental health care needs of our service members, veterans, and their families. The AOA is committed to ensuring that medical students, physicians, and other health care providers understand that an individual's physical and/or mental health condition may be linked to his or her military experience.

www.osteopathic.org/inside-aoa/public-policy/Pages/federal-initiatives.aspx

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Center for Deployment Psychology

The Center for Deployment Psychology of the Uniformed Services University of the Health Sciences, Department of Medical and Clinical Psychology offer a wide variety of on-line courses and other resources to help uniformed clinical providers, VHA providers, and community clinicians provide care consistent with the needs and experience of military service members, veterans and their families.

<http://deploymentpsych.org/online-courses>

<http://deploymentpsych.org/military-culture-course-modules>

Rural Clergy Training Program

The Rural Clergy Training Program, an initiative of the VHA National Chaplain Center and the Office of Rural Health, offers training and information to clergy providing pastoral services to veterans and their families.

http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December_2015.pdf

Swords to Plowshares Combat to Community Training

Swords to Plowshares is nationally recognized for its expertise in providing comprehensive services and promoting and protecting the rights of veterans. Swords to Plowshares' *Combat to Community*® training is a series of accredited cultural competency curricula developed by its Institute for Veteran Policy team with the purpose of educating the community to address the reintegration challenges veterans face and the unique skill sets they acquire in service. The training was developed for law enforcement, first responder, mental health, and service professionals to teach:

- Commonly shared attitudes, values, goals, and practice that often characterize service in the military
- Recruitment and retention strategies for veteran employment
- How deployment, combat experience, service related injuries, and disability can impact veterans
- How veteran or military family status can inform interactions and services
- Potential resources to refer veterans and families to for supportive services

The training incorporates knowledge developed by experts in the fields of veteran culture and direct services with practical tools and resources to increase understanding and improve interactions with veterans.

<https://www.swords-to-plowshares.org/combat-to-community>

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VA Military Culture Training Courses on TMS

The resources below are available to VA employees and contractors. Versions of these courses should be made available to community providers through an alternative to TMS that allows outside providers to access the training.

- **Military Culture Training for Health Care Professionals – Organization and Roles (VA 19332)**

The first module of this online course provides an overview of the differences between the explicit and implicit features of military culture and describes the characteristics of implicit military culture. The next module identifies four sources of information about implicit military culture and describes six defining characteristics of warrior ethos. The learner is provided information about the influence of military guiding ideals and values on the lives of service members and veterans. The final module offers an overview regarding the connotations of implicit military culture on the health care professional.

- **Military Culture Training for Health Care Professionals: Self-Awareness and Military Ethos (VA 19333)**

This online course, sponsored by the Department of Veterans Affairs and Department of Defense, helps health care professionals understand the role that military culture plays in the lives of those they serve. The course is comprised of four modules: 1) Self-Assessment and Introduction to Military Ethos, 2) Military Organization and Roles, 3) Stressors and Their Impact, and 4) Treatment Resources and Tools.

- **Military Culture Training for Health Care Professionals: Stressors & Resources (VA 19334)**

This online course offers the learner an explanation of how stress can be either helpful or harmful depending on the nature of the provoking stressor and the availability of resources. The four phases of modern operational deployment cycles is presented in great detail in module 3. The next two modules describe the characteristic operational stressors and the spectrum of operational stress states and outcomes experienced by service members and their families during each deployment cycle phase.

- **Military Culture Training for Health Care Professionals: Treatment Resources, Prevention & Treatment (VA 19335)**

This online course in the military culture curriculum outlines the military culture impact on patient care and the health care professional's role and explains the range of DoD and VA psychological health services. The course also provides information on interpreting military culture knowledge into patient assessment and treatment. Finally, the learner is exposed to the military culture implications of VA/DoD clinical practice guidelines relevant to the care of service members and veterans and the strategies for identifying current military culture relevant patient and health care professional resources.

- **Military Cultural Awareness (NFED 1341520)**

This military cultural awareness online course provides a common foundation for all VA employees. This course offers an overview of common military culture and courtesies, roles and ranks within the military, differences between the branches of the armed services, some of the conflicts in which veterans have served, and why this information

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is important in helping VA employees better serve the needs of veterans and their families. After taking this course, participants will understand the perspective of the veterans they serve by having a greater awareness of the military experience, and the customs and courtesies that are common in the military environment.

- **PTSD 101: Understanding Military Culture When Treating PTSD (VA 9494)**
This online web-based course is part of the PTSD 101 education series which is presented by subject-matter experts to increase provider knowledge related to the assessment and treatment issues of PTSD. Each course specifically addresses trauma events, treatments, or special population issues, not normally addressed in general therapy protocols. This course is specifically designed to familiarize clinicians with military culture, terminology, demographics, and stressors. It also provides an overview of programs offered by DoD for managing combat or operational stress, as well as implications for assessment and treatment.
- **Why Military Culture Matters (Mobile Accessible) (VA 16353)**
This independent online study activity is designed to help the learner better connect with veterans and understand how veterans' military experiences influence their health. This course is formatted to be accessible using a VA networked mobile device.

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APPENDIX I: ENABLING DOCUMENTS

Veterans Access, Choice, and Accountability Act of 2014

TITLE II—HEALTH CARE ADMINISTRATIVE MATTERS

SEC. 201. INDEPENDENT ASSESSMENT OF THE HEALTH CARE DELIVERY SYSTEMS AND MANAGEMENT PROCESSES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) INDEPENDENT ASSESSMENT. —

(1) ASSESSMENT. — Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into one or more contracts with a private sector entity or entities described in subsection (b) to conduct an independent assessment of the hospital care, medical services, and other health care furnished in medical facilities of the Department. Such assessment shall address each of the following:

(A) Current and projected demographics and unique health care needs of the patient population served by the Department.

(B) Current and projected health care capabilities and resources of the Department, including hospital care, medical services, and other health care furnished by non-Department facilities under contract with the Department, to provide timely and accessible care to veterans.

(C) The authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Department facilities, including whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care.

(D) The appropriate system-wide access standard applicable to hospital care, medical services, and other health care furnished by and through the Department, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation.

(E) The workflow process at each medical facility of the Department for scheduling appointments for veterans to receive hospital care, medical services, or other health care from the Department.

(F) The organization, workflow processes, and tools used by the Department to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.

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(G) The staffing level at each medical facility of the Department and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics, which may include an assessment of any of the following:

(i) The case load of, and number of patients treated by, each health care provider at such medical facility during an average week.

(ii) The time spent by such health care provider on matters other than the case load of such health care provider, including time spent by such health care provider as follows:

(I) At a medical facility that is affiliated with the Department.

(II) Conducting research.

(III) Training or supervising other health care professionals of the Department.

(H) The information technology strategies of the Department with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by Department, especially those strategies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Department in Department or non-Department facilities.

(I) Business processes of the Veterans Health Administration, including processes relating to furnishing non-Department health care, insurance identification, third- party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows:

(i) To avoid the payment of penalties to vendors.

(ii) To increase the collection of amounts owed to the Department for hospital care, medical services, or other health care provided by the Department for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate.

(iii) To increase the collection of any other amounts owed to the Department with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate.

(iv) To increase the accuracy and timeliness of Department payments to vendors and providers.

(J) The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Department, including the following:

(i) The prices paid for, standardization of, and use by the Department of the following:

(I) Pharmaceuticals.

(II) Medical and surgical supplies.

(III) Medical devices.

(ii) The use by the Department of group purchasing arrangements to purchase pharmaceuticals, medical and surgical supplies, medical devices, and health care related services.

(iii) The strategy and systems used by the Department to distribute pharmaceuticals, medical and surgical supplies, medical devices, and health care related services to Veterans Integrated Service Networks and medical facilities of the Department.

(K) The process of the Department for carrying out construction and maintenance projects at medical facilities of the Department and the medical facility leasing program of the Department.

(L) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.

(2) PARTICULAR ELEMENTS OF CERTAIN ASSESSMENTS. —

(A) SCHEDULING ASSESSMENT. — In carrying out the assessment required by paragraph (1)I, the private sector entity or entities shall do the following:

(i) Review all training materials pertaining to scheduling of appointments at each medical facility of the Department.

(ii) Assess whether all employees of the Department conducting tasks related to scheduling are properly trained for conducting such tasks.

(iii) Assess whether changes in the technology or system used in scheduling appointments are necessary to limit access to the system to only those employees that have been properly trained in conducting such tasks.

(iv) Assess whether health care providers of the Department are making changes to their schedules that hinder the ability of employees conducting such tasks to perform such tasks.

(v) Assess whether the establishment of a centralized call center throughout the Department for scheduling appointments at medical facilities of the Department would improve the process of scheduling such appointments.

(vi) Assess whether booking templates for each medical facility or clinic of the Department would improve the process of scheduling such appointments.

(vii) Assess any interim technology changes or attempts by Department to internally develop a long-term scheduling solutions with respect to the feasibility and cost effectiveness of such internally developed solutions compared to commercially available solutions.

(viii) Recommend actions, if any, to be taken by the Department to improve the process for scheduling such appointments, including the following:

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(1) Changes in training materials provided to employees of the Department with respect to conducting tasks related to scheduling such appointments.

(II) Changes in monitoring and assessment conducted by the Department of wait times of veterans for such appointments.

(III) Changes in the system used to schedule such appointments, including changes to improve how the Department –

(aa) measures wait times of veterans for such appointments;

(bb) monitors the availability of health care providers of the Department; and

(cc) provides veterans the ability to schedule such appointments.

(IV) Such other actions as the private sector entity or entities considers appropriate.

(B) MEDICAL CONSTRUCTION AND MAINTENANCE PROJECT AND LEASING PROGRAM ASSESSMENT. – In carrying out the assessment required by paragraph (1)(K), the private sector entity or entities shall do the following:

(i) Review the process of the Department for identifying and designing proposals for construction and maintenance projects at medical facilities of the Department and leases for medical facilities of the Department.

(ii) Assess the process through which the Department determines the following:

(1) That a construction or maintenance project or lease is necessary with respect to a medical facility or proposed medical facility of the Department.

(II) The proper size of such medical facility or proposed medical facility with respect to treating veterans in the catchment area of such medical facility or proposed medical facility.

(iii) Assess the management processes of the Department with respect to the capital management programs of the department, including processes relating to the methodology for construction and design of medical facilities of the Department, the management of projects relating to the construction and design of such facilities, and the activation of such facilities.

(iv) Assess the medical facility leasing program of the Department.

(3) TIMING. – The private sector entity or entities carrying out the assessment required by paragraph (1) shall complete such assessment not later than 240 days after entering into the contract described in such paragraph.

(b) PRIVATE SECTOR ENTITIES DESCRIBED. – A private entity described in this subsection is a private entity that –

(1) has experience and proven outcomes in optimizing the performance of the health care delivery systems of the Veterans Health Administration and the private sector and in health care management; and

(2) specializes in implementing large-scale organizational and cultural transformations, especially with respect to health care delivery systems.

(c) PROGRAM INTEGRATOR. —

(1) IN GENERAL. — If the Secretary enters into contracts with more than one private sector entity under subsection (a), the Secretary shall designate one such entity that is predominately a health care organization as the program integrator.

(2) RESPONSIBILITIES. — The program integrator designated pursuant to paragraph (1) shall be responsible for coordinating the outcomes of the assessments conducted by the private entities pursuant to such contracts.

(d) REPORT ON ASSESSMENT. —

(1) IN GENERAL. — Not later than 60 days after completing the assessment required by subsection (a), the private sector entity or entities carrying out such assessment shall submit to the Secretary of Veterans Affairs, the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and the Commission on Care established under section 202 a report on the findings and recommendations of the private sector entity or entities with respect to such assessment.

(2) PUBLICATION. — Not later than 30 days after receiving the report under paragraph (1), the Secretary shall publish such report in the Federal Register and on an Internet website of the Department of Veterans Affairs that is accessible to the public.

(e) NON-DEPARTMENT FACILITIES DEFINED. — In this section, the term “non-Department facilities” has the meaning given that term in section 1701 of title 38, United States Code.

SEC. 202. COMMISSION ON CARE.

(a) ESTABLISHMENT OF COMMISSION. —

(1) IN GENERAL. — There is established a commission, to be known as the “Commission on Care” (in this section referred to as the “Commission”), to examine the access of veterans to health care from the Department of Veterans Affairs and strategically examine how best to organize the Veterans Health Administration, locate health care resources, and deliver health care to veterans during the 20-year period beginning on the date of the enactment of this Act.

(2) MEMBERSHIP. —

(A) VOTING MEMBERS. — The Commission shall be composed of 15 voting members who are appointed as follows:

(i) Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a veteran.

COMMISSION ON CARE FINAL REPORT

(ii) Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a veteran.

(iii) Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a veteran.

(iv) Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a veteran.

(v) Three members appointed by the President, at least two of whom shall be veterans.

(B) QUALIFICATIONS. — Of the members appointed under subparagraph (A) —

(i) at least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code;

(ii) at least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000;

(iii) at least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)));

(iv) at least one member shall be familiar with the Veterans Health Administration but shall not be currently employed by the Veterans Health Administration; and

(v) at least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.

I DATE. — The appointments of members of the Commission shall be made not later than 1 year after the date of the enactment of this Act.

(3) PERIOD OF APPOINTMENT. —

(A) IN GENERAL. — Members shall be appointed for the life of the Commission.

(B) VACANCIES. — Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(4) INITIAL MEETING. — Not later than 15 days after the date on which eight voting members of the Commission have been appointed, the Commission shall hold its first meeting.

(5) MEETINGS. — The Commission shall meet at the call of the Chairperson.

(6) QUORUM. — A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(7) CHAIRPERSON AND VICE CHAIRPERSON. — The President shall designate a member of the commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.

(b) DUTIES OF COMMISSION. —

(1) EVALUATION AND ASSESSMENT. — The Commission shall undertake a comprehensive evaluation and assessment of access to health care at the Department of Veterans Affairs.

(2) MATTERS EVALUATED AND ASSESSED. — In undertaking the comprehensive evaluation and assessment required by paragraph (1), the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201, including any findings, data, or recommendations included in such assessment.

(3) REPORTS. — The Commission shall submit to the President, through the Secretary of Veterans Affairs, reports as follows:

(A) Not later than 90 days after the date of the initial meeting of the Commission, an interim report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(B) Not later than 180 days after the date of the initial meeting of the Commission, a final report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(c) POWERS OF THE COMMISSION. —

(1) HEARINGS. — The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

(2) INFORMATION FROM FEDERAL AGENCIES. — The Commission may secure directly from any Federal agency such information as the Commission considers necessary to carry out this section. Upon request of the Chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

(d) COMMISSION PERSONNEL MATTERS. —

(1) COMPENSATION OF MEMBERS. —

(A) IN GENERAL. — Each member of the Commission who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily

COMMISSION ON CARE FINAL REPORT

equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission.

(B) OFFICERS OR EMPLOYEES OF THE UNITED STATES. — All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES. — The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(3) STAFF. —

(A) IN GENERAL. — The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(B) COMPENSATION. — The Chairperson of the Commission may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(4) DETAIL OF GOVERNMENT EMPLOYEES. — Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES. — The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals that do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(e) TERMINATION OF THE COMMISSION. — The Commission shall terminate 30 days after the date on which the Commission submits the report under subsection (b)(3)(B).

(f) FUNDING. — The Secretary of Veterans Affairs shall make available to the Commission from amounts appropriated or otherwise made available to the Secretary such amounts as the Secretary and the Chairperson of the Commission jointly consider appropriate for the Commission to perform its duties under this section.

(g) EXECUTIVE ACTION. —

(1) ACTION ON RECOMMENDATIONS. — The President shall require the Secretary of Veterans Affairs and such other heads of relevant Federal departments and agencies to

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implement each recommendation set forth in a report submitted under subsection (b)(3) that the President —

(A) considers feasible and advisable; and

(B) determines can be implemented without further legislative action.

(2) REPORTS. — Not later than 60 days after the date on which the President receives a report under subsection (b)(3), the President shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives and such other committees of Congress as the President considers appropriate a report setting forth the following:

(A) an assessment of the feasibility and advisability of each recommendation contained in the report received by the President.

(B) For each recommendation assessed as feasible and advisable under subparagraph (A) the following:

(i) Whether such recommendation requires legislative action.

(ii) If such recommendation requires legislative action, a recommendation concerning such legislative action.

(iii) A description of any administrative action already taken to carry out such recommendation.

(iv) A description of any administrative action the President intends to be taken to carry out such recommendation and by whom.

H.R. 4437: Extension of Deadline for Submittal of Final Report by Commission on Care

[114th Congress Public Law 131]

[[Page 130 STAT. 292]]

Public Law 114-131

114th Congress

An Act

To extend the deadline for the submittal of the final report required by the Commission on Care.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. 38 USC 1701; EXTENSION OF DEADLINE FOR SUBMITTAL OF FINAL REPORT BY COMMISSION ON CARE.

COMMISSION ON CARE FINAL REPORT

Section 202(b)(3)(B) of the Veterans Access, Choice, and Accountability Act of 2014, 128 Stat. 1775 (Public Law 113-146; 128 Stat. 1773) is amended by striking “Not later than 180 days after the date of the initial meeting of the Commission” and inserting “Not later than June 30, 2016”.

Approved February 29, 2016.

DEPARTMENT OF VETERANS AFFAIRS
CHARTER OF THE
COMMISSION ON CARE

1. OFFICIAL DESIGNATION: Commission on Care
2. AUTHORITY: The Commission on Care established as required by section 202 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Public Law 113-146, and operates under the provisions of the Federal Advisory Committee Act (FACA), as amended, 5 U.S.C. App. 2.
3. OBJECTIVES AND SCOPE OF ACTIVITIES: The Commission on Care (the "Commission") is established to examine the access of Veterans to health care from the Department of Veterans Affairs (VA) and strategically examine how best to organize the Veterans Health Administration (VHA), locate health care resources, and deliver health care to Veterans during the 20-year period beginning on the date of the enactment of VACAA, August 7, 2014.
4. DUTIES OF THE COMMISSION:
 - A. Evaluation and Assessment: In accordance with section 202(b)(1), the Commission shall undertake a comprehensive evaluation and assessment of access to health care at VA.
 - B. Matters Evaluated and Assessed: In undertaking the comprehensive evaluation and assessment required by section 202(b)(1) of VACAA and paragraph (4)(A) above, the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201 of VACAA, including any findings, data, or recommendations included in such assessment.
 - C. Reports: In accordance with section 202(b)(3) of VACAA, submit an interim report not later than 90 days after the initial meeting of the Commission to the President, through the Secretary of Veterans Affairs, and a final report not later than 180 days after the initial meeting of the Commission. The reports shall include (i) the findings of the Commission with respect to the evaluation and assessment required by section 202(b)(1); and (ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through VHA.
5. OFFICIAL TO WHOM THE COMMISSION REPORTS: The Commission reports to the President, through the Secretary of Veterans Affairs.

VA is responsible for ensuring the reporting requirements of Section 6(b) of the FACA are fulfilled.

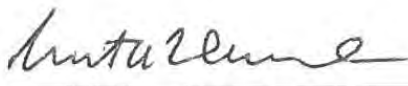
COMMISSION ON CARE FINAL REPORT

6. OFFICE RESPONSIBLE FOR PROVIDING THE NECESSARY SUPPORT FOR THE COMMISSION: VHA is responsible for providing support to the Commission.
7. ESTIMATED ANNUAL OPERATING COSTS AND STAFF-YEARS: Annual operating cost for the Commission is estimated at \$3,600,000 per year, including compensation of members and staff, in accordance with section 202(d) of VACAA. All members will receive travel expenses and a per diem allowance in accordance with the Federal Travel Regulations for any travel made in connection with their duties as members of the Commission. Approximately 15 FTE are anticipated.
8. DESIGNATED FEDERAL OFFICER: The Designated Federal Officer (DFO) or an Alternate DFO, full-time or permanent part-time VA employees, will be present at all meetings, including subcommittee meetings. The DFO will work with the Commission Chair to schedule the meetings and develop meeting agendas. The DFO is authorized to adjourn any meeting when he or she determines it is in the public interest to do so.
9. ESTIMATED NUMBER AND FREQUENCY OF MEETINGS: The Commission will meet at the call of the Chair for the duration of the Commission. The Commission may hold such hearings, sit and act at such times and places, and take such testimony, and receive such evidence as the Commission considers advisable to carry out its duties under section 202 of VACAA. A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.
10. DURATION: The Commission is subject to the termination date as specified below in section 11.
11. TERMINATION: The Commission shall terminate 30 days after the date on which the Commission submits the final report required by section 202(b)(3)(B) of VACAA.
12. MEMBERSHIP: The Commission shall be composed of 15 voting members who are appointed as Special Government Employees and described in paragraph (A) below for the life of the Commission and have the qualifications described in paragraph (B) below:
 - A. APPOINTMENT AUTHORITY:
 - i. Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a Veteran.
 - ii. Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a Veteran.

- iii. Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a Veteran.
 - iv. Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a Veteran.
 - v. Three members appointed by the President, at least two of whom shall be Veterans.
- B. QUALIFICATIONS: Of the members appointed under 12(A) –
- i. At least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of Veterans under 38 U.S.C. 5902;
 - ii. At least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000;
 - iii. At least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined by in section 1905(1)(2)(B) of the Social Security Act (42 U.S.C. 1396d(1)(2)(B));
 - iv. At least one member shall be familiar with VHA but shall not be currently employed by VHA; and
 - v. At least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.
- C. CHAIRPERSON AND VICE CHAIRPERSON: The President shall designate a member of the Commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.
- D. VACANCIES: If a vacancy occurs, it shall be filled in the same manner as the original appointment.
13. SUBCOMMITTEES: The Commission is authorized to establish subcommittees, with DFO approval, to perform specific projects or assignments as necessary and consistent with its mission. The Commission Chair shall notify the Secretary, through the DFO, of the establishment of any subcommittee, including its function, membership, and estimated duration. Subcommittees will report back to the Commission.
14. RECORDKEEPING: Records of the Committee shall be handled in accordance with General Records Schedule 26 or other approved agency records disposition schedules. Those records shall be available for public inspection and copying, subject to the Freedom of Information Act 5, U.S.C. 552.

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15. DATE CHARTER IS FILED:

Approved:  Date 7/14/15
Robert A. McDonald
Secretary of Veterans Affairs



APPENDIX J:

COMPOSITION OF THE COMMISSION

Nancy M. Schlichting, Chairperson

Appointed by President Barack Obama

Nancy M. Schlichting is Chief Executive Officer of Henry Ford Health System (HFHS), a nationally recognized \$5 billion health care organization with 27,000 employees and recipient of the 2011 Malcolm Baldrige National Quality Award, 2011 John M. Eisenberg Patient Safety Quality Award, and 2004 Foster G. McGaw Award. She is credited with leading the health system through a dramatic financial turnaround and for award-winning patient safety, customer service and diversity initiatives.

Schlichting joined HFHS in 1998 as its Senior Vice President and Chief Administrative Officer, served as Executive Vice President and Chief Operating Officer, President and CEO of Henry Ford Hospital and was named President and CEO of the System in 2003. Her career in health care administration spans over 35 years of experience in senior level executive positions.

Schlichting serves on several national and community boards including The Kresge Foundation, Walgreens Boots Alliance, the Federal Reserve Bank of Chicago – Detroit Branch, the Detroit Regional Chamber, the Detroit Economic Club, and the Downtown Detroit Partnership. Nancy is also a Fellow of the American College of Healthcare Executives.

In 2015, Schlichting was honored as one of the 100 Most Influential People in Healthcare by Modern Healthcare magazine, the eighth time she received this recognition. She was also named to the Top 25 Women in Healthcare by Modern Healthcare, the fourth time she received this recognition and the only Michigander named to the list. Her other awards include: NCHL Gail L. Warden Leadership Excellence award, ACHE Senior-Level Healthcare Executive Regent's Award, AHA/HRET 2014 TRUST Award, Becker's Hospital Review "40 of the Smartest People in Healthcare-2014," Crain's Detroit Business "2012 Newsmaker of the Year," HealthLeaders Media "20 People Who Make Healthcare Better-2012," and most recently was named one of "Crain's 100 Most Influential Women in Michigan."

Author of the acclaimed book, *Unconventional Leadership*, Schlichting is a highly regarded expert and accomplished speaker on strategic leadership, quality, patient/family-centered care, and diversity.

Schlichting received her A.B. in Public Policy Studies, Magna Cum Laude from Duke University and her M.B.A. from Cornell University. She has also been the recipient of honorary doctoral degrees from Walsh College, Eastern Michigan University and Central Michigan University.

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Delos M. (Toby) Cosgrove, MD, Vice Chairperson*Appointed by Speaker of the House John Boehner*

Toby Cosgrove, CEO of Cleveland Clinic, presides over a \$6.2 billion health care system comprising Cleveland Clinic, eight community hospitals, 16 family health and ambulatory surgery centers, Cleveland Clinic Florida, the Lou Ruvo Center for Brain Health in Las Vegas, Cleveland Clinic Toronto, and Cleveland Clinic Abu Dhabi. His leadership has emphasized patient care and patient experience, including the reorganization of clinical services into patient-centered, organ- and disease-based institutes. He launched major wellness initiatives for patients, employees, and communities. Under his leadership, Cleveland Clinic has consistently been named among America's top four hospitals by U.S. News & World Report and is one of only two hospitals named among America's 99 Most Ethical Companies by the Ethisphere Institute.

Cosgrove was a surgeon in the U.S. Air Force and served in Da Nang, Republic of Vietnam, as the chief of U.S. Air Force casualty staging flight. He received the Bronze Star and the Republic of Vietnam Commendation Medal.

He has published nearly 450 journal articles, book chapters, one book, and 17 training and continuing medical education films. He performed more than 22,000 operations and earned an international reputation for expertise in all areas of cardiac surgery, especially valve repair. As an innovator, Cosgrove has 30 patents filed for developing medical and clinical products used in surgical environments.

Cosgrove received his medical degree from the University of Virginia School of Medicine in Charlottesville, VA, and completed his clinical training at Massachusetts General Hospital, Boston Children's Hospital, and Brook General Hospital in London. He received a BA in biology from Williams College in Williamstown, MA.

Michael A. Blecker*Appointed by House Minority Leader Nancy Pelosi*

Michael Blecker has been associated with Swords to Plowshares since 1976 and has served as Executive Director since 1982. The agency was started in 1974 by returning Vietnam veterans and VISTA volunteers assigned to the VA regional office in San Francisco.

In the 1980s, when homelessness exploded, Swords to Plowshares started a transitional housing program with funding support from VA and the city and county of San Francisco. Swords to Plowshares continues to provide housing, employment, case management, and benefits advocacy for veterans from offices in San Francisco and Oakland. In 2005, the Iraq Vet Project (IVP) was established to help veterans of those wars and to shape policies affecting them. Recognizing Swords to Plowshares' long and effective history of challenging and shaping public policy with regard to veterans, in 2011, the IVP became known as the Institute for Veterans Policy.

Under Blecker's leadership, Swords to Plowshares' annual budget has grown from \$75,000 to nearly \$16 million. He has a nationwide reputation for dedicated service and as an authority on

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veterans' services and veterans' rights. He served on the Advisory Committee on Homeless Veterans (2002-2007), which advises the Secretary of Veterans Affairs. He is cofounder of both the National Coalition for Homeless Veterans and the California Association of Veterans' Service Agencies. He has served on the Congressional Commission on Service Members and Veterans Transition Assistance, the California Senate Commission on Homeless Veterans, the San Francisco Mayor's Homeless Planning Committee, the National Agent Orange Settlement Advisory Board, The Agent Orange Information Center, and the Veterans Speakers Alliance.

Blecker served in the U.S. Army as a combat infantryman in Vietnam in 1968-69 with the 101st Airborne Division, achieving the rank of E-5. He received an AB degree in criminology from University of California, Berkeley and a JD degree from New College of California Law School.

David P. Blom

Appointed by Speaker of the House John Boehner

David Blom has been instrumental in the development and growth of the OhioHealth system. He has served as president of OhioHealth's central Ohio hospitals – Grant Medical Center, Riverside Methodist Hospital, and Doctors Hospital – while also serving as executive vice president and chief operating officer of OhioHealth. He was named president and CEO of OhioHealth in March 2002. He has a track record of achievement with a solid understanding of complex issues facing health care delivery. He has expertise in leading strategic initiatives, managing and developing human capital, improving profitability, and improving quality of care and customer experience.

Blom maintains many professional and community affiliations, currently serving as a board member of the Voluntary Hospitals of America (VHA), a member and treasurer of Columbus' Downtown Development Corporation (CDDC), member of the Columbus Partnership, and member of the local World President's Organization (WPO). In 2001, he was named a Top 100 Business Leader by Smart Business and in 2012 CEO of the Year by Columbus CEO Magazine.

He received a BA from Ohio State University and an MA in health care administration from The George Washington University.

David W. Gorman

Appointed by President Barack Obama

David Gorman is a retired, combat-disabled veteran of the Vietnam War, who was appointed executive director of the Disabled American Veterans (DAV) National Service and Legislative Headquarters in Washington, DC in 1995. His responsibilities include oversight of the DAV National Service, Legislative, and Voluntary Service Programs. He is the organization's principal spokesperson before Congress, the White House, and the U.S. Department of Veterans Affairs.

Gorman entered the U.S. Army in 1969 and served with the 173rd Airborne Brigade, the famed "Sky Soldiers" of the Vietnam War. During a campaign to secure an area in Central Vietnam

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where U.S. forces suffered extremely high casualties, Mr. Gorman was severely wounded. His wounds required amputation of both legs.

Discharged from the Army in 1970, he immediately joined the DAV and is currently a life member of the DAV's National Amputation Chapter and DAV Chapter 39 in Greer, SC.

Gorman retired from his post executive director at the Washington Headquarters for Disabled American Veterans and now resides in Simpsonville, SC. Gorman attended Cape Cod Community College.

The Honorable Thomas E. Harvey, Esq.

Appointed by Senate Majority Leader Mitch McConnell

Thomas Harvey is a Vietnam combat veteran whose decorations include the Silver Star, the Purple Heart and 12 others for valor and service. In Vietnam, he spent a year as a company commander with the 173rd Airborne brigade and a year and a half as an advisor with the Vietnamese Airborne Division.

A lawyer by training, Harvey has spent much of his professional career working with veterans and issues of concern to them. He has served as Chief Counsel and Staff Director of the Senate Veterans Affairs Committee, Deputy Administrator of the Veterans Administration, and Assistant Secretary for Congressional Affairs of the Department of Veterans Affairs. Following 5 years with a major Wall Street law firm, Harvey came to Washington, DC, in 1977 as a White House fellow, serving as an assistant to ADM Stansfield Turner, then director of the Central Intelligence Agency. He has also served in the Department of Defense and as General Counsel and Congressional Liaison of the United States Information Agency. For 5 years, he was Senior Counselor of the Institute of International Education, which administers the Fulbright Program on behalf of the U.S. Department of State, as well as a number of other international educational exchange programs.

He currently serves on the boards of the Milbank Memorial Fund, the focus of which is public health policy, and of the Art Students League of New York, where he studies watercolor painting. He holds both BA and JD degrees from the University of Notre Dame and a LLM degree from the New York University School of Law.

Maj. Stewart M. Hickey, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Since 2011, Stewart Hickey has served as American Veterans (AMVETS) National Executive Director, operating the nation's fourth largest congressionally chartered veterans service organization and its subordinate organizations, and the daily advocacy of issues affecting veterans, national security, foreign affairs, and the economy.

Previously, Hickey was chief executive officer for the Hyndman (Pennsylvania) Area Health Center, a multisite community health center providing medical and dental services to several counties of Pennsylvania, West Virginia, and Maryland. His health care administration experience includes serving as chief human resources officer and chief operating officer of

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Western Maryland Hospital Center in Hagerstown, Maryland, a 123-bed Joint Commission on Accreditation of Healthcare Organizations accredited, long-term care and sub-acute hospital with rehabilitation, occupational therapy, physical therapy, and respiratory care.

Hickey enlisted in the U.S. Marine Corps Reserve in February 1977, in Cumberland, MD, as an infantryman, and transferred to platoon leaders class in the summer of 1978. He served in Operation Desert Storm and Desert Shield and was awarded a Bronze Star Medal with Combat "V" for his achievements as commanding officer, Company D, Third Tank Battalion, Task Force RIPPER, 1st Marine Division, I Marine Expeditionary Force, Saudi Arabia from September 1990 to February 1991. His military education includes the Basic School, Armor Officer Basic, Amphibious Warfare School, Armor Officer Advanced Course, and Marine Corps Command and Staff College.

Hickey resides on his family farm in Cumberland Valley Township in McConnellsburg, PA. He and his wife, Ellen, have five children: Monroe, Ali, Charles, Andrew, and Bryce. Three of his sons, Andrew, Monroe, and Charles, followed their father's path and currently serve in the U.S. military.

Hickey received a BA in history from Penn State University and an MA in management from Webster University.

Rear Adm. Joyce M. Johnson, DO, US PHS (ret.)

Appointed by President Barack Obama

Joyce Johnson is a physician with senior public health leadership experience in civilian and military sectors.

Johnson served in the U.S. Public Health Service (Rear Admiral, Upper Half). Her last active-duty assignment was with the U.S. Coast Guard as Director, Health and Safety ("surgeon general"). She managed the Coast Guard's health care system, including 150 sickbays and clinics, and coordinated both medical and behavioral health care for the beneficiary population. She also had responsibility for the Coast Guard's safety and work-life programs. She held a Top Secret security clearance.

Other government assignments included senior scientific and management positions with the Food and Drug Administration (pharmaceutical safety and post-market surveillance) and the Substance Abuse and Mental Health Services Administration. She has held clinical positions at the National Institute of Mental Health and the Department of Veterans Affairs. At the Centers for Disease Control and Prevention, she was an Epidemiologic Intelligence Service (EIS) Officer and staff epidemiologist in the Center for Infectious Disease.

In the private sector, Johnson served as vice president, health sciences and chief medical officer for a large research organization, where she managed a portfolio of government contracts, including laboratory and social sciences research, and held a top secret security clearance.

Johnson is an osteopathic physician board certified in psychiatry and public health/preventive medicine. She is also a certified clinical pharmacologist and certified addiction specialist. In

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addition to her medical degree, she earned a master's degree in hospital and health administration. She has been conferred six honorary doctoral degrees. She is a Distinguished Life Fellow of the American Psychiatric Association.

Johnson has extensive international health experience on all seven continents. She has particular interests in global mental health, health systems development, infectious disease, and disaster relief. She has led five Flag Expeditions with the Explorers Club. For more than a decade she has been a consultant to the National Science Foundation on the health care system in Antarctica.

Johnson recently coauthored the book, *Lizard Bites and Street Riots, Travel Emergencies and Your Health, Safety and Security*, and writes a monthly medical column. She is a Clinical Professor and Adjunct Professor at Georgetown University. She has served on expert committees including the Committee on Substance Abuse in the Military, National Academy of Medicine. She is active in numerous professional associations including the American Psychiatric Association, serving on the Committee on Psychiatric Dimensions of Disasters; the American Osteopathic Association, serving on the Bureau of International Osteopathic Medicine; and the Explorers Club, serving on the Medical Committee.

The Honorable Ikram U. Khan, MD

Appointed by Senate Minority Leader Harry Reid

Ikram Khan currently, he is president and 50-percent partner of Quality Care Consultants, LLC, founded in March 1992. The company provides consultant services in health care strategy and policy development for employers and other health care organizations. The company assists clients in development and implementation of wellness and disease-management programs. The company also develops quality improvement initiatives and techniques and assists in development and implementation of programs for cost-effective utilization of medical resources. Major emphasis is on clinical outcomes and data monitoring analysis.

Khan is a member the United States Institute of Peace (USIP) Board of Directors; he was nominated by President George Bush, and confirmed by the U.S. Senate on June 5, 2008. He is also currently a member of the Nevada Homeland Security Commission, having been appointed by the Governor of Nevada.

He was nominated by President Clinton and confirmed by the U.S. Senate to serve as member of The Board of Regents Uniformed Services University of Health Sciences, an advisory board to U.S. Secretary of Defense (1999-2006).

Khan also served as Special Advisor on Healthcare to Former Nevada Governor Gibbons, was a member of the Nevada Academy of Health (appointed by Nevada Governor Gibbons), and is a past member of the Nevada Academy of Health Sciences (appointed by Nevada Governor Kenny Guinn). He is past member of Nevada Governor's Commission for Medical Education, Research and Training and was a member of the Nevada State Board of Medical Examiners for eight years. Dr. Khan received "Special Congressional Recognition" for invaluable community service in 1994 and a Congressional citation—"U.S. Senate - Honoring Dr. Ikram Khan"—on April 25, 1994.

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Khan currently serves as member on the board of trustees at Sunrise Hospital Las Vegas-a 600 bed hospital. He has received recognition as “Most Influential Man in Southern Nevada” in 2000. He is also a recipient of a Las Vegas Chamber of Commerce community achievement award (October 1999), and a “Distinguished Community Service Award” from Anti-defamation League of B’nai B’rith (1994).

November 30, 1999 was declared “Dr. Ikram U. Khan Day” by the Governor of the State of Nevada, Mayor of Las Vegas, and the Board of Commissioners of Clark County.

During the course of his practice as General Surgeon, Khan has served in multiple leadership positions at various hospitals in Las Vegas.

Ikram Khan is president of quality Care Consultants LLC in Las Vegas Nevada. He received a doctor of medicine and surgery (MBBS) degree from University of Karachi, Pakistan.

Khan received a Doctor of Medicine and Surgery (MB, BS) in August 1972 from the University of Karachi, Pakistan. He completed post-graduate surgical residency in General Surgery in New York from 1974 through 1978, and practiced as a General Surgeon in Las Vegas through 2005.

Phillip J. Longman

Appointed by Senate Minority Leader Harry Reid

Phil Longman is a director at New America, a public policy institute. He is also a senior editor at the Washington Monthly and a lecturer at Johns Hopkins University, where he teaches a course in health care policy.

Longman has written extensively on issues related to health care delivery system reform, including in his book *Best Care Anywhere* (currently in its third edition). The book chronicles the quality transformation of the Veterans Health Administration during the 1990s and applies its lessons to the broader U.S. health care system.

Longman received a BA in philosophy from Oberlin College.

Col. Lucretia M. McClenney, USA (ret.)

Appointed by House Minority Leader Nancy Pelosi

Lucretia McClenney is a consultant with the Department of Defense Vietnam War Commemoration Office and Executive Coach with the Brookings Institute Executive Education Program. Previously she served as director of the Department of Veterans Affairs Center for Minority Veterans. As director, she served as the principal advisor to the Secretary of Veterans Affairs on policies and programs affecting minority veterans. Prior to her appointment, she served as special assistant to the assistant secretary for policy, planning, and preparedness, Department of Veterans Affairs (VA). She led the department’s emergency exercise planning, training, and evaluation program, and served as liaison to other government agencies. She has served on numerous working groups to include the congressionally mandated National Commission on VA Nursing, Task Force on Employment of Women at VA, and as the Secretary

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of Veterans Affairs' representative on the American Red Cross Board of Governors and Disaster and Chapter Services Committee.

Serving 30 years in the Army, McClenney retired as a colonel in November 2001. She served in various medical treatment facilities and on staffs worldwide serving as director, population health integration team, TRICARE management activity; chief nurse, European regional medical command and deputy commander for nursing, Landstuhl Regional Medical Command; deputy commander for nursing, Moncrief Army Community Hospital, Fort Jackson, South Carolina; assistant deputy for human resources, Office Of The Assistant Secretary Of The Army for Manpower and Reserve Affairs, the Pentagon; chief ambulatory nursing, Walter Reed Army Medical Center; senior policy analyst, Office of the Secretary of Defense (Health Affairs), The Pentagon; and member of the President's National Health Care Reform Task Force.

McClenney's military and civilian awards/decorations include the Legion of Merit (two oak leaf clusters), Defense Meritorious Service Medal, Meritorious Service Medal (seven oak leaf clusters), Army Commendation Medal (two oak leaf clusters), Navy Commendation Medal, Army Achievement Medal, Army Good Conduct Medal, the Army Staff Identification Badge, Office of the Secretary of Defense Staff Identification Badge, the coveted "9A" designator, in recognition of numerous achievements at the pinnacle of nursing excellence, and The Outstanding Civilian Service Medal for her significant contribution to the mission of the United States Army and Department of Defense in assisting with the production of the book, *For Children of Valor – Arlington National Cemetery*. Her professional affiliations include the Association of Military Surgeons of the United States, Sigma Theta Tau, National Nursing Honor Society, Alpha Kappa Alpha Sorority, Inc., Top Ladies of Distinction, Inc., The ROCKS, Inc., the Order of Military Medical Merit, Past President, Federal Health Care Executives Interagency Institute Alumni Association, and former Board Member of the Bon Secours Health Care System and Chair, Quality Committee.

She is a graduate of the Command and General Staff College and the United States Army War College Fellowship Program at George Washington University, Washington, DC. She is also a graduate of the Johnson & Johnson-Wharton's Fellows Program in Management for Nurse Executives, Wharton School of Business, University of Pennsylvania; Federal Health Care Executives Interagency Institute at George Washington University, Washington, DC; Leadership VA 2004; and Brookings Institute Executive Fellowship Program. She received a BSN from Murray State University and an MS in psychiatric/mental health nursing from Catholic University.

Capt. Darin S. Selnick, USAF (ret.)

Appointed by Speaker of the House John Boehner

Darin Selnick is an independent consultant who provides a variety of services to organizations in the areas of government and community relations, business development, and veterans' issues. He is currently the senior veterans affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He also volunteers his time as Chairman of the West Los Angeles Veterans Home Support Foundation and as the Vice President of Development for the GI Film Festival.

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From 2001–2009, Selnick was an appointee at the Department of Veteran Affairs. From 2004–2009 he served as the director of the center for faith-based and community initiatives. In this role he was responsible for the management and operations of the Center and was the VA liaison to the White House Office of faith-based and community initiatives. From 2001–2004 he served as Special Assistant to the Secretary and Associate Dean, VA Learning University. In this role he was responsible for providing program and operational oversight of VA Learning University.

Selnick is a retired Air Force officer who attained the rank of Captain. He has been very active in veterans' issues and joined the Jewish War Veterans in 1994. Since that time he has taken various leadership positions and is the past department commander of the Department of California. Mr. Selnick is also a member of the American Legion, AMVETS, Air Force Association, and National Association of Uniformed Services.

Darin Selnick currently serves as senior veterans' affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He lives in Oceanside, CA. Selnick is retired from the U.S. Air Force. He received a BS in health science from California State University, Northridge and an MA in political science/public management from Midwestern State University.

Lt. Gen. Martin Steele, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Martin Steele enlisted in the Marine Corps in January 1965 and rose from private to three-star general, culminating his military career in August 1999 as the deputy chief of staff for plans, policies, and operations at Headquarters, U.S. Marine Corps, in Washington, DC. A decorated combat veteran with 34½ years of service, he is a recognized expert in the integration of all elements of national power (diplomatic, economic, informational, and military) with strategic military war plans and has served as an executive strategic planner/policy director in multiple theaters across Asia. His extraordinary career was chronicled as one of three principals in the award winning military biography, *Boys of '67*, by Charles Jones.

Upon his retirement from active duty in 1999, he served as president and CEO of the Intrepid Sea-Air-Space Museum in New York City. Currently, Steele serves as The Associate Vice President for Veterans Partnerships, the Executive Director, Military Partnerships, and Co-chair of the Veterans Reintegration Steering Committee at the University of South Florida in Tampa, Florida. Additionally, Steele is the chairman and CEO of Steele Partners, Inc., a strategic advisory and leadership consulting company. He has led a philanthropic transition program assisting exiting Marines into private-sector jobs throughout the country, at no cost to the Marine participants, the Marine Corps, or the companies that provide employment opportunities.

Steele serves proudly on several boards across the country. He is currently the Chairman of the Board, Marine Corps Scholarship Foundation. He was appointed to the Board of Directors of Florida is for Veterans, Inc., a not for profit, state legislated organization designed to assist both Veterans and businesses throughout Florida in not only hiring Veterans but also developing entrepreneurship programs designed for veterans. He is a member of Fisher House Foundation;

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chairman of the advisory committee, Stability Institute; advisory committee member, Call of Duty Endowment; advisory board member, Stay in Step Foundation; advisory council member, Operation Helping Hand; member, Veterans Advantage; board member, University of Arkansas Veterans Resource and Information Center; and advisory committee member, Jesse Lewis Choose Love Movement.

Steele is a graduate of the University of Arkansas where he obtained a bachelor's degree in history and was recognized as a distinguished graduate of the Fulbright College of Arts and Sciences. He is a recipient of the 2013 Arkansas Alumni Award Citation of Distinguished Alumni, which recognizes exceptional professional and personal achievement and extraordinary distinction in a chosen field. He also holds master's degrees from Central Michigan University, Salve Regina College, and Naval War College.

Charlene M. Taylor

Appointed by House Minority Leader Nancy Pelosi

Charlene Taylor joined Kaiser Permanente in 1997 as the director of specialty services for the Permanente Medical Group at South Sacramento. In 2002 she became the service director for Kaiser Foundation Hospitals, responsible for perioperative and perinatal services at South Sacramento. In 2008, she was promoted to chief nursing officer at the Sacramento Medical Center where she was responsible for a 287-bed tertiary acute care hospital that conducted more than 11,000 operations per year. There, she oversaw 800 full-time employees and a budget of \$150 million. Taylor was promoted to chief operating officer in 2010 and retired from Kaiser Permanente in 2013.

Before working for Kaiser Permanente, Taylor served as assistant hospital administrator for Sutter Health at the Sutter Amador Hospital from 1988 to 1997. She is a member of the Veterans of Foreign Wars, Reserve Officers Association, and the Society of Air Force Nurses.

Taylor's patriotic and adventurous nature led her to join the Air Force as a reserve officer at the age of 40, rising to the rank of Lieutenant Colonel. She was commissioned as a Captain in the United States Air Force (Reserve Command) in October 1993, earning her flight nurse wings in 1994. She subsequently was selected to be a flight nurse instructor followed by a promotion to evaluator status. Her last squadron assignment was that of chief nurse at the 349 AMDS, Travis Air Force Base.

In addition to years of experience conducting aeromedical evacuation missions throughout the world, Taylor was activated in support of Operation Enduring Freedom from March 2003 to March 2004. In January 2005 she was selected to be the chief nurse of the 379th Expeditionary Aeromedical Squadron in support of Operation Iraqi Freedom. While transporting the injured out of Mosul, Iraq in a C-130, the aircraft took enemy fire, landing without casualties. Due to the demands of her civilian position, Taylor transferred to inactive status in the Air Force Reserve Command. Taylor is the recipient of two Meritorious Service medals, Expert Marksmanship (2), and multiple other medals.

Taylor currently serves on the Veterans Board. In 2012 she was appointed to the Board by Gov. Jerry Brown and approved by the Senate. She became chair in 2014 and continues to serve

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in that role. The California Veterans Board serves as an advocate for veterans affairs, identifying needs and working to ensure and enhance the rights and benefits of California veterans and their dependents.

Taylor is a diploma nurse graduate from the Kaiser Foundation School of Nursing. She continued her education receiving a BSN from the State University of New York in Albany, New York. She earned a master's degree in nursing administration from the University of California, San Francisco.

Taylor lives in Elk Grove, CA.

Marshall W. Webster, MD

Appointed by Senate Minority Leader Harry Reid

Marshall Webster is a senior vice president of the University of Pittsburgh Medical Center (UPMC), and a distinguished service professor of surgery at the University of Pittsburgh. A graduate of Penn State University and the Johns Hopkins Medical School, he trained in surgery at the University of Pittsburgh, and subsequently served 2 years as a surgeon on active duty in the U.S. Navy.

Webster returned to the University of Pittsburgh as a faculty vascular surgeon, including initially, a part-time attending staff position at the Pittsburgh VA Medical Center for 3 years. He has held the Mark M. Ravitch Chair in Surgery, and has had a long academic career of clinical practice, research, and service in varied administrative leadership roles. From 2002–2012, he was an executive vice president of UPMC, president of UPMC's physician services division, and president of the University of Pittsburgh Physicians, the clinical practice plan of the university faculty.

His current focus is primarily strategic development: building clinical relationships and care models throughout the region with a large number of community hospitals and providers. Webster has oversight of UPMC's graduate medical education program, which sponsors a substantial number of resident rotations at the Pittsburgh VA Medical Center. He recently served for 2 years as the interim chair of the Department of Anesthesiology at UPMC. He has had a long-standing interest in patient safety and quality initiatives, and recently completed a 6-year term on the board of the Pennsylvania Patient Safety Authority.

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APPENDIX K: COMMISSION STAFF

Susan M. Webman, Esq.
Executive Director

Michael Bargmann	Program Analyst
Robert Burke, PhD	Program Analyst
Donald Cicotte	Program Analyst
Pauline Cilladi-Rehrer	DFO
John Clinton	Staff Assistant
Monica Cummins	Program Analyst, ADFO
Christopher Danns	Program Analyst
Stephen Dillard	Program Analyst, ADFO
Susan Edgerton	Program Analyst
Beth Engiles	Program Analyst
Sharon Gilles	Program Analyst, DFO
Wilmya Goldsberry	Program Analyst
John Goodrich	Executive Officer, DFO
Sherri Hans, PhD	Program Analyst
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Bernadette Philpot	Staff Assistant
Patrick Ryan, Esq.	Program Analyst
Jamie Taber, PhD	Economist
SaKeithia Taylor	Staff Assistant
Linda (Yvonne) Williams	Staff Assistant

DFO – Designated Federal Officer

ADFO – Assistant Designated Federal Officer

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APPENDIX L: ACRONYM LIST

ACRONYM	DEFINITION
ACA	Affordable Care Act
ACHE	American College of Healthcare Executives
APRN	Advanced Practice Registered Nurse
BRAC	Base Realignment and Closure
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARES	Capital Asset Realignment for Enhanced Services
CDS	Community Delivered Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CITC	Care in the Community
CMD	Chief Medical Director
CMIO	Chief Medical Information Officer
CMOP	Consolidated Mail Outpatient Pharmacy
COTS	Commercial Off-The-Shelf
CPRC	Clinical Product Review Committee
CPRS	Computerized Patient Record System
CVA	Concerned Veterans for America
CVCS	Chief of VHA Care System
DAV	Disabled American Veterans
DEPSECVA	Deputy Secretary, Department of Veterans Affairs
DHP	Digital Health Platform
DM&S	Department of Medicine and Surgery
DoD	Department of Defense
DUSH	Deputy Under Secretary for Health
ECF	Executive Career Fields
EES	Employee Education System
EEO	Equal Employment Opportunity

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ACRONYM	DEFINITION
EHCPM	Enrollee Health Care Projection Model
eHMP	Enterprise Health Management Platform
EHR	Electronic Health Record
FFS	Fee-for-Service
FY	Fiscal Year
GAO	Government Accountability Office
GHATP	Graduate Health Administration Training Program
GUI	Graphic User Interface
HCD	Human-Centered Design
HEC	Healthcare Executive Council
HPDM	High Performance Development Model
HR	Human Resources
HRA	Human Resources and Administration
HSC	Health Service Category
HTM	Healthcare Talent Management
IAVA	Iraq and Afghanistan Veterans of America
IDIQ	Indefinite Delivery/Indefinite Quantity
IDN	Integrated Delivery Network
IDP	Individual Development Plan
IT	Information Technology
JC	Joint Commission
JEC	Joint Executive Committee
JLV	Joint Legacy Viewer
MSA	Medical Support Assistant
MTF	Military Treatment Facility
NAS	National Academy of Sciences
NCEHC	National Center for Ethics in Health Care
NCOD	National Center for Organization Development
NLC	National Leadership Council
NVTC	Northern Virginia Technology Council
OAA	Office of Academic Affiliations

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APPENDIX L
ACRONYM LIST

ACRONYM	DEFINITION
OEF	Operation Enduring Freedom
OGC	Office of General Counsel
OI&T	Office of Information and Technology
OIF	Operation Iraqi Freedom
OMB	Office of Management and Budget
ONC	Office of the National Coordinator
OND	Operation New Dawn
OPM	Office of Personnel Management
OTH	Other Than Honorable (Discharge)
PACT	Patient Aligned Care Team
PC3	Patient-Centered Community Care
PG	Priority Group
PHS	U.S. Public Health Service
PO	Program Office
PTSD	Posttraumatic Stress Disorder
QUERI	Quality Enhancement Research Initiative
RCLF	Relevant Civilian Labor Force
RIF	Reduction in Force
SCI	Spinal Cord Injury
SECVA	Secretary, Department of Veterans Affairs
SE	Senior Executive
SES	Senior Executive Service
SHEP	Survey of Healthcare Experiences of Patients
TBI	Traumatic Brain Injury
TMS	Talent Management System
USH	Under Secretary for Health
VA	U.S. Department of Veterans Affairs
VACAA	Veterans Access, Choice, and Accountability Act of 2014
VACI	VA Center for Innovation
VACO	VA Central Office
VAEB	VA Executive Board

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ACRONYM	DEFINITION
VAMC	VA Medical Center
VERC	Veterans Engineering Resource Center
VFW	Veterans of Foreign Wars of the U.S.
VHA	Veterans Health Administration
VHACO	VHA Central Office
VISN	Veterans Integrated Service Network
VSO	Veterans Service Organization
WWP	Wounded Warrior Project



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QUESTIONS ABOUT LICENSED PROFESSIONAL COUNSELORS IN THE VA

1. How many Licensed Professional Counselors have been hired by the VA since the development of the qualification standards in 2010?
2. Of those hired, please provide the total number by GS rank.
3. How many LPMHC hold Supervisory positions in the VA?
4. How many stations have included LPMHC on their Leadership Boards?
5. How many LPMHC currently sit on the Professional Standards Board? How many have been on this board in the past?
6. Why is the LPMHC and LMFT PSB led by a Psychologist, and explain why neither board has ever met standards for PSB as described in VHA Handbook 5005?
7. Why does the LPMHC series have to hold a Supervisory position in order to be promoted to GS-12. Why aren't LPMHC allowed to promote to GS-12 by specialties as is done with Social Workers.
8. How many LPC's were in the VA, doing clinical work under different titles (Readjustment Counseling Therapist, Addictions Therapist) prior to the implementation of the qualification standards? (There was an action item about this...so they know.. I have the action item)
9. How many of these LPC's remain in clinical positions, performing clinical duties as Title 5 employees under the same titles held prior to the implementation of the qualification standards?
10. The VA has admitted to hire of LPC's prior to the development of the qualification standards, simply under other job titles. These hires were made with position vacancies requesting Licensure preferred.
11. How do you explain the VA billing for, verifying licensure of, requiring NPI's and VETPRO for these providers that were hired prior to the development of the qualification standards?
12. How do you justify the continued use of Licensed providers in clinical positions, with Position Descriptions that match the duties of the LPMHC performing these duties under Title 5 (Non-Clinical) positions (Readjustment Counseling Therapist, Addiction Therapist etc)? Title 5 positions are not clinical.
13. How do you justify the decision of the VA to implement an overly restrictive qualification standard (CACREP) and not offer any grandfathering to clinicians who were already employed by the VA (as DoD and Tricare did)? Psychology and Social Work were grandfathered.
14. How do you justify the decision of the VA to implement overly restrictive qualification standard (CACREP), without grandfathering, knowing that this restriction would disqualify a large majority of Professional Counselors, a lot of them Veterans, myself included.
15. How do you justify the decision of the VA to implement an overly restrictive qualification standard (CACREP), without grandfathering, while knowing that the CACREP degree required (60 hour Clinical Mental Health Counseling) was not available in most States, and specifically was not available near military installations for those people who are older. (16 programs nationwide in 1998 that would qualify you for LPC Licensure, some States had a couple CACREP Programs, most States did not have any).
16. How do you justify the continued lack of vacancy position openings in the VA for LPMHCs?
17. How do you justify leadership positions excluding LPMHC and LMFT from position vacancies?
18. Who was on the Board that determined the overly restrictive qualification standard?
19. What empirical data was used to come to the decision to use CACREP as the ONLY qualification without grandfather?
20. Please explain why LPC's who are under other job titles have been denied request to join the list serve for LPMHC's?
21. Please explain why CACREP was provided a \$500,000 contract, under full and open competition after exclusion of sources: Number of offers received ONE. To write standards for the "Counselor

National Emergency Preparedness Language” that was later used to justify the restrictive qualification standard within the VA, DoD and Tricare? (Notice this contract was awarded in September 2006...just before the passage of the bill recognizing LPC’s in December 2006. Also, note...EXTENT COMPETED:

“Full and Open Competition after Exclusion of Sources

This contract was commissioned to write the standards for “Counselor National Emergency Preparedness Language

22. Please explain why the PSB for LPMHC utilized Non-CACREP LPC’s to Board the few LPMHCs that qualified into the VA, then told them that they did not qualify to Board?

23. Please explain why programs for LPMHC internships have not been established or offered at VA’s?

24. Please explain how the VA justifies this negatively impacting Veterans who received their education in and around the military bases at which they were stationed?

25. Please explain why open positions for LPMHC also state that Social Workers and Psychologists are qualified for the position? However, the reverse is not true.

26. How many organic LPMHC’s (not dually licensed) sit on Leadership Boards to include National Representation?

27. Of those, how many are Veterans?

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February 21, 2017

Re: Licensed Professional Mental Health Counselors at Veterans Affairs

Dear Dr. Shulkin:

I recently attended the American Federation of Government Employees (AFGE) legislative conference. I was able to briefly discuss my concerns with you regarding the problems Licensed Professional Mental Health Counselors (LPMHC) experience while working for Veterans Affairs.

Public Law 109-461, which was enacted December 22, 2006, explicitly recognized both "licensed professional mental health counselors" and "marriage and family therapists" as mental health providers within Veterans Affairs. On September 28, 2010, the Department of Veterans Affairs (VA) released a set of qualification standards for licensed professional mental health counselor (LPMHC) positions, as well as for marriage and family therapist positions. Prior to the adoption of the new standards, counselors were typically eligible only for "rehabilitation counseling therapist" positions, at a maximum General Service (GS) level of 11. At this level, counselors were not allowed to work in supervisory positions. Although LPMHC's have qualification standards, there are still limited opportunities for advancement, training, transferability, or promotion. Although hundreds of employees with these credentials have been working in the VA under different position descriptions, they have not been transitioned into an LPMHC position. This may be because the VA has made it a local decision to transition the employee. Or, the National standards still do not recognize these employees because they may not have attended a school that was accredited. The accreditation was not available to many of these employees when they went to school. The accreditation is anecdotal according to the Council for Accreditation of Counseling & Related Educational Programs (CACREP) own website. The Department of Defense and TRICARE have recognized these providers and grandfathered them into a provider status. The VA is the only employer that does not recognize LPMHC's that did not attend a CACREP accredited school. The VA has also grandfathered Social Workers and Psychologists prior to having accreditation in their professions. We are asking for a grandfather clause for any provider that is State licensed or eligible. We are asking that the VA transition any employee that is eligible to work in that position automatically that chooses to do so.

Many of the providers that do not qualify for the LPMHC position are working as Addiction Therapists, Readjustment Counselors, or Psychology Technicians to name a few. These are Title 5 positions and are considered "non-clinical". These are direct line staff that have clinical duties within these professions to provide specialized care to Veterans. We ask that if the VA is unwilling to grandfather LPMHC's, they instead bring these positions to a Hybrid 38 status and GS-11 pay scale to reflect their knowledge, skills, and abilities.

The Commission on Care report recommendation #2 stated that the VA should "enhance clinical operations through more effective use of providers and other health professions, and improved data collection and management". This would be an effective way to utilize the providers already in place and at their disposal, increase Veterans access to care, and decrease workload on higher level providers. The RAND report which is a survey of 522 psychiatrists, psychologists, and licensed clinical social workers found that 13% met the study's criteria for "cultural competency" in the military, only 6% had ever served in the military. According to the RAND report, LPMHC's scored the highest for familiarity of evidenced-based practices for PTSD and combat-related mental health issues. Many of the LPMHC's attended their schooling on military installations where CACREP was not available, therefore excluding them from LPMHC positions.

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I would like to have the opportunity to discuss this matter in more detail. I have attached 25 questions I would like to have answered by the Veterans Affairs. I have tried to get the answers to these questions, but I was met with hostility. This is a brief synopsis of a larger systemic problem that negatively impacts Veteran care and employee morale. Please contact me through my personal information listed below. I appreciate any assistance you can provide.

Regards,

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[REDACTED]

[REDACTED]

(217) 474-(b) (6)

(b) (6)@gmail.com

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Ready to Serve

Community-Based Provider Capacity to Deliver
Culturally Competent, Quality Mental Health Care
to Veterans and Their Families

Terri Tanielian

Coreen Farris

Caroline Epley

Carrie M. Farmer

Eric Robinson

Charles C. Engel

Michael William Robbins

Lisa H. Jaycox



AMERICAN
OVERSIGHT

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OVERVIEW

Addressing the mental health needs of military service members, veterans, and their families is a national priority and the focus of many efforts at the federal, state, and local levels.¹ Over the past decade, several studies have documented the extent of the need for mental health treatment among this population, and billions of dollars have been invested to expand the capacity of the systems designed to support veterans and their families at multiple levels and across sectors.² The White House and Congress have been working directly with the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to ensure that mental health providers are hired and programs are disseminated to address mental health needs within the veteran community,³ but concerns remain about whether the capacity of these systems is sufficient to meet the demand.⁴ Recently, new federal legislation was enacted to increase VA beneficiary access to private, civilian-sector care.⁵ Although the opportunity to receive care in the community existed in the past, the new law will likely greatly expand the rate at which eligible veterans seek care outside of the VA. This raises a new concern about the capacity of the civilian mental health service sector to meet the needs of veterans and their families.

While many veterans already receive care from private providers and community-based organizations,⁶ little is known about the extent to which veterans and their families receiving such care are getting high-quality care, are benefiting from that care, and are satisfied with their providers. There have been multiple efforts at the national, state, and community levels to promote awareness of military and veteran-related issues among community-based mental health providers, including the development of specialized training curricula and certification programs. With the intent of improving providers' understanding of and skills for addressing needs in the population, these training opportunities vary from short webinars to weeklong courses to intense, certificate- or degree-awarding programs.⁷

In addition, nongovernmental organizations have pursued the formation of specialized networks, such as Give An Hour and the Star Behavioral Health Provider network,⁸ and the opening of new community-based clinics dedicated to treating military service members, veterans, and their families.⁹ To date, however, little is known about the capacity and performance of these networks and specialized clinics.

Monitoring access to and quality of mental health care for service members, veterans, and their families is important for ensuring that their needs are met effectively. A recent Institute of Medicine (IOM) study highlighted the challenges that both DoD and the VA face in monitoring such issues within their own systems—including the facilities they own and operate—and noted that their visibility into the “outside” systems where the population also receives care is even more limited.¹⁰

RAND's study was designed to assess the potential performance of the system of care for service members, veterans, and their families, with a particular focus on community-based, civilian providers. This study specifically addresses the potential readiness of mental health providers working in community settings to deliver culturally competent, high-quality care to service members, veterans, and their families. This study builds upon previous studies examining similar issues for providers working within VA and DoD settings, as well as two studies of civilian providers.¹¹ We explore provider capabilities, attitudes, and behaviors as they relate to providing high-quality and culturally appropriate care, and we examine what factors may predict their readiness to deliver such care. Understanding the skills and training of mental health providers from non-DoD and non-VA settings who are potentially delivering care to service members, veterans, and families will help inform expectations about what types of care these beneficiaries may experience within civilian settings and the extent to which that care is of a high quality. Such information can also help direct future training efforts designed to ensure that providers are ready, capable, and willing to address the mental health needs of our nations' veterans and their families. The following sections provide additional information about our approach, findings, and the implications from this research.

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SURVEY OF MENTAL HEALTH PROVIDERS

Improving mental health outcomes for veterans and their families requires both *access to care* and receipt of *high-quality care*.¹² The overall goal of this study was to understand the readiness of community-based providers to deliver high-quality mental health care to veterans and their families once they access such care. The IOM has defined *high-quality care* as care that has been demonstrated as effective (i.e., evidence-based), safe, patient-centered, timely, efficient, and equitable.¹³ Using this definition as a reference point for our study, we conceptualize the readiness of providers to deliver veteran-friendly, high-quality mental health care as having two main components (see Figure 1). The first is *cultural competency*, or the degree to which providers are sensitive to the unique needs and relevant issues of concern within the veteran population. This cultural sensitivity and competency can facilitate providers' ability to deliver patient-centered care and develop an effective therapeutic rapport.¹⁴ The second main component of our provider readiness definition is the degree to which community-based providers have the *capacity and inclination to deliver clinically appropriate, evidence-based care*. In particular, the survey focused on evidence-based care related to major depressive disorder (MDD) and posttraumatic stress disorder (PTSD). These conditions were highlighted because of their prevalence among the recently returned veteran population and their association with experiences common to military deployments. Each concept is defined in further detail in subsequent sections.

To assess provider readiness to deliver high-quality, culturally competent care to service members, veterans, and their families, we employed a web-based survey of mental health providers. The sections below outline the methods used to sample providers and describe the survey measures used to assess the relevant components of readiness. We also gathered data on the characteristics of responding providers, their clinical caseloads, and their practice settings to explore how these factors relate to overall readiness.

Sampling

To identify and survey mental health providers working in community-based settings, we relied upon existing panels of health care providers maintained through GfK Custom Research and two of their vendors. Practicing mental health

professionals in the panels were sent emails inviting them to participate, and participants were provided with tokens of appreciation through the traditional means of providing incentives in their host panels (i.e., awarded points based on the anticipated respondent burden). Specifically, psychiatrists were recruited from an existing GfK provider panel originally drawn from the American Medical Association membership list and later augmented to refresh and expand the panel. Psychologists were recruited from an existing allied health care provider panel maintained by Research Now. Social workers and licensed professional counselors were recruited from existing panels maintained by Research Now and a separate panel maintained by EMI. The demographic and practice characteristics of all mental health providers within these panels were not available and the degree to which their panel membership is representative of each provider population is unknown. GfK emailed potentially eligible participants a standard recruitment email asking for their participation in a 30-minute survey about their mental health practice.

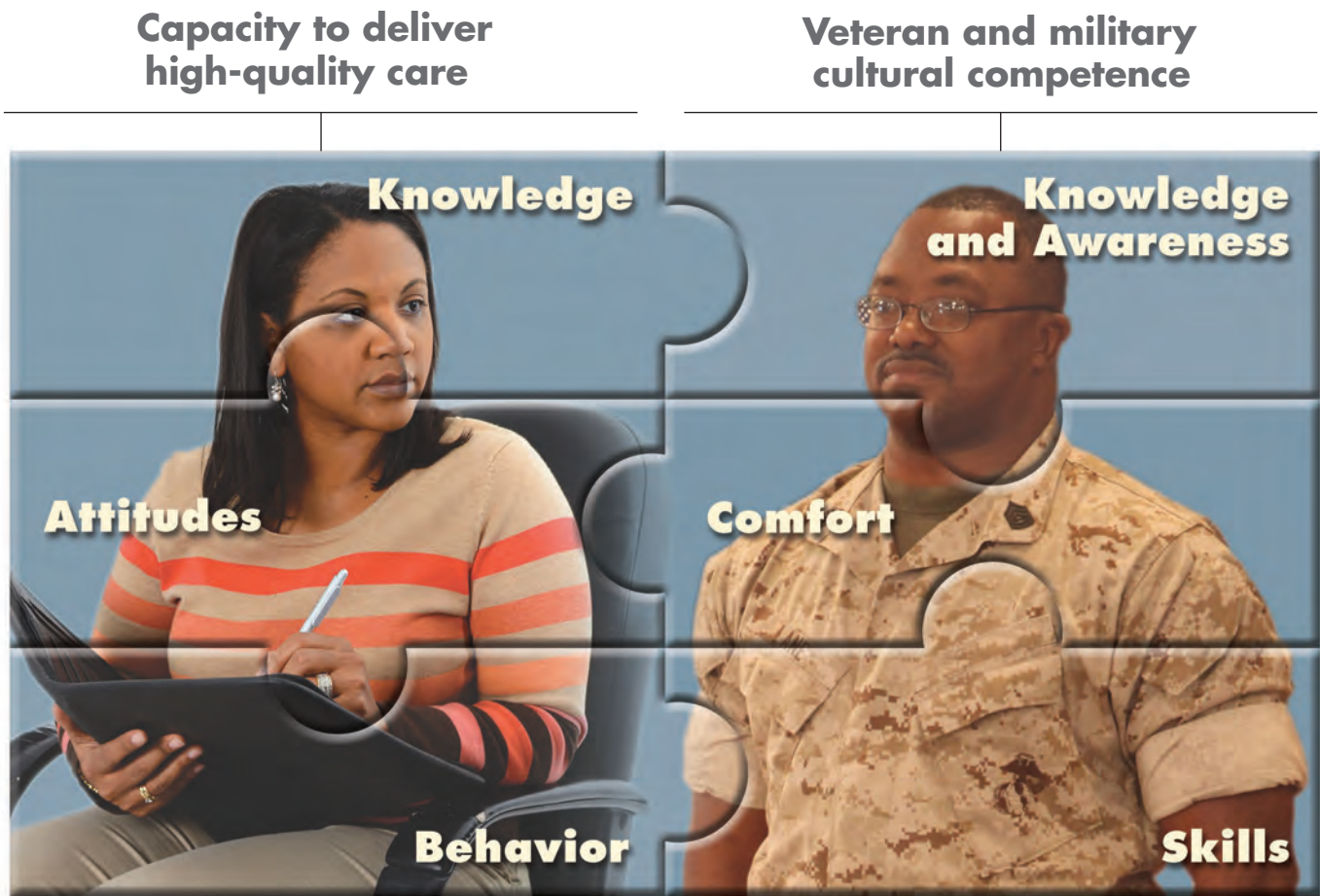
The web-based survey was fielded only for the period of time required to reach the target numbers of each provider

Abbreviations

CBT	Cognitive Behavioral Therapy
CPG	clinical practice guideline
CPT	Cognitive Processing Therapy
DO	doctor of osteopathic medicine
DoD	Department of Defense
EAP	Employee Assistance Program
EBP	evidence-based psychotherapy
EMDR	Eye Movement Desensitization and Reprocessing
IPT	Interpersonal Therapy
IOM	Institute of Medicine
LCSW	licensed clinical social worker
LMHC	licensed mental health counselor
LPC	licensed professional counselor
MD	doctor of medicine
MDD	major depressive disorder
MCSW	master's of clinical social work
ns	not significant
PE	Prolonged Exposure Therapy
PhD	doctor of philosophy
PsyD	doctor of psychology
PTSD	posttraumatic stress disorder
SIT	Stress Inoculation Therapy
VA	Department of Veterans Affairs
WRAIR	Walter Reed Army Institute for Research

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Figure 1: Readiness for Veteran-Friendly, High-Quality Mental Health Care



type (target goal was 125 respondents in each provider group, to ensure sufficient sample size for detecting differences between provider groups). All target numbers were reached within three weeks. Responding providers were screened to ensure that they were

- trained and licensed as a professional provider of mental health services in their state
- working directly with patients/clients as part of their professional responsibilities
- one of the four provider types of interest
 - psychiatrist—doctor of medicine (MD) or doctor of osteopathic medicine (DO)
 - clinical psychologist—doctor of philosophy (PhD) or doctor of psychology (PsyD)
 - licensed clinical social worker (LCSW) or master's in clinical social work (MCSW)
 - master's-level licensed professional counselor (LPC) or licensed mental health counselor (LMHC).

Participants who indicated later in the survey that they were fully retired or not currently in practice were excluded. The study was determined to be exempt from human subjects review by the RAND Human Subjects Protection Committee. The topics of military and veteran mental health care, cultural competency, and evidence-based practice were not specifically identified in the recruitment email sent by GfK or in the introductory page of the survey; thus, the topic was not likely to influence the choice to participate or complete the full survey. As with all surveys conducted among convenience samples, it is difficult to understand the potential bias introduced by those choosing to participate in such panels and surveys compared to the full population of providers.

Measures

RAND researchers designed a web-based survey to collect information from mental health providers across several domains. For each of the two components of our

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readiness concept, providers were asked about their knowledge, attitudes, and behaviors relevant to the concept. Where possible, survey items come from or were adapted from prior surveys of mental health professionals. Where necessary, RAND researchers developed new items for domains without published survey instruments. Table 1 provides an overview of the survey domains, their corresponding items, and information about how the items were used to characterize providers and inform the analysis. The following section briefly describes the measures used across the domains of interest. Readers interested in additional details about specific items, including psychometric properties and scoring criteria, where available, can reference the Appendix at http://www.rand.org/pubs/research_reports/RR806.html.

Provider Characteristics

In addition to asking respondents to indicate their provider type (e.g., social worker, psychologist), we gathered information on provider gender, years since most recent degree, whether they ever served in the armed forces,¹⁵ whether they had any close family members who served in the military, and if they ever worked in a military setting or in the VA (including training or fellowships).¹⁶ We also asked how providers spent their time across a series of activities, including conducting assessments, providing direct patient care (psychotherapy and medication management), receiving supervision or consultation from others, providing supervision to others, and other professional or administrative responsibilities such as research or teaching.¹⁷ In addition, we asked a series of questions about enrollment in provider networks that typically serve military and veteran populations, including TRICARE (the DoD insurance program for active component service members and their families, retirees and their families, as well as some eligible Guard and Reserve Component personnel and their families), Military OneSource (an Employee Assistance Program [EAP]–like program that employs some mental health providers to support DoD beneficiaries), and the new VA Patient Centered Community Care Contract (established for specialty providers).

Practice and Clinical Caseload Characteristics

To understand the context in which respondents practice, we assessed a number of features of their practice settings and their clinical caseloads. All questions in this section were structured

to assess caseloads, hours, and setting characteristics of the most recent typical work week.

We asked providers to report the size of their patient caseload in the most recent typical week, including patients seen in individual or family format as well as those seen in group settings. We gathered information about the proportion of patients by the locus of care, by age group, and by current diagnosis using categories from the Diagnostic and Statistical Manual—Version 5. We also asked respondents to estimate the proportion of their current caseload that: were current members of the military, were former members of the military (veterans), or were family members of current or former members of the military.

To understand the types of settings and facilities our respondents were working within, we assessed the percentage of patient care hours that were spent in different physical locations (e.g., solo office practice, VA facility). Using responses to the setting and insurance items, we classified providers into one of three groups: DoD/VA providers (those providers spending any patient care time in a DoD or VA health care setting), non-DoD/VA providers who accept TRICARE, and all other providers (i.e., those that do not spend any time in a DoD or VA facility or accept TRICARE).

We also gathered the ZIP code of the facility in which the provider saw the greatest number of patients in the most recent typical work week. Using the ZIP code information for the provider's setting, we calculated the distance between their setting and the nearest DoD or VA health care facility to create a proximity to DoD/VA variable. With this continuous variable, we also created a categorical variable for analyses: within ten miles or 11 or more miles away.¹⁸ Similarly, we used the ZIP code of the provider's setting to determine if they worked in an urban or rural setting.¹⁹

Assessment Behaviors

To understand the frequency of routine screening practices employed by respondents, we asked providers to report how often, using a 5-point scale (never, seldom, occasionally, often, and always), they screened patients: (1) to determine if they are current or former members of the Armed Forces or a family member of such a person; (2) for history of any traumatic events, including those experienced during military service, and (3) about stressors related to military life or being a veteran.

Table 1: Overview of Mental Health Provider Survey Domains

Domain	Types of Items	Source and Use
Provider characteristics	<ul style="list-style-type: none"> • Training (MD, DO, PhD, LCSW, MCSW, LMHC, LPC) • Gender • Years in practice/experience • Primary therapeutic orientation • DoD or VA work experience • Relationships with current/former members of Armed Forces 	These items were adapted from prior VA, U.S. Army, and American Psychiatric Association studies. They are used to characterize the respondents and examine predictors of practice behaviors and provider attitudes.
Practice and caseload characteristics	<ul style="list-style-type: none"> • Caseload size • Distribution of caseload by age, diagnosis, insurance type, and military status • Setting (outpatient/inpatient/partial, solo/group, public/private) • Participation in networks that serve military members and veterans 	These items were adapted from prior American Psychiatric Association and U.S. Army surveys of mental health providers. They are included to help describe the practice setting and typical patient caseload served by respondents. The data are used to characterize the respondents and examine predictors of high-quality mental health care.
Assessment behaviors	<ul style="list-style-type: none"> • Employment of routine screening approaches, including taking a military history and assessing suicide risk and comorbid problems such as pain and sleep disturbances • Use of validated screening or interview instruments • Frequency of engaging other clinicians and family members 	These items were adapted from prior surveys used by the Center for Deployment Psychology and the U.S. Army. The data are used to understand provider assessment practices.
Military cultural competency	<ul style="list-style-type: none"> • Knowledge of military and veteran culture • Comfort working with military service members and veterans • Self-reported proficiency in treating military service members and veterans • Participation in military/veteran culture training 	These items were adapted from prior surveys used by the Center for Deployment Psychology and the VA. The data will describe respondents' knowledge of military and veteran culture. The data are also used to define analytic groups of providers with respect to their military cultural competency.
Training to deliver evidence-based care	<ul style="list-style-type: none"> • Training and supervision in evidence-based psychotherapies (EBPs) 	These items were adapted from other surveys used by the U.S. Army and assess receipt of training and supervision in EBPs for PTSD and MDD.
Comfort with treatment approaches and military/veteran populations	<ul style="list-style-type: none"> • Comfort treating depression • Comfort treating PTSD • Comfort treating military members and veterans • Comfort addressing war-related stress • Comfort treating military family members 	These items were developed by RAND researchers for this study. The items provide descriptive information about the level of "comfort" among respondents in these areas. Some items are also used in the derivation of the military cultural competency variable.
Use of guideline-concordant care for PTSD and MDD	<ul style="list-style-type: none"> • Self-reported proportion of caseload treated with EBPs • Use of psychotherapeutic techniques consistent with EBPs 	These items were adapted from other surveys used by the U.S. Army, U.S. Air Force and RAND and assess use of EBPs recommended in civilian and DoD/VA practice guidelines.
Attitudes toward practice guidelines	<ul style="list-style-type: none"> • Attitudes toward clinical practice guidelines (CPGs) and evidence-based medicine 	These items were adapted from an instrument developed for the New York State Psychiatric Association. The items ask providers to rate their attitudes toward using clinical guidelines and may help explain variation observed in use of guideline-concordant care for PTSD and MDD.
Prescribing practices	<ul style="list-style-type: none"> • Most common medications prescribed for PTSD and MDD 	This item was adapted from an Army study titled "Steps Up" and is a measure of guideline-concordant pharmacological treatment for PTSD and MDD. We examine the percentage of providers who prescribe appropriate medications for PTSD and MDD.

SOURCES: We used several instruments as references in developing this survey. All of these prior surveys were developed for other purposes, but provided relevant information and suggestions for items that would help us to assess use of guideline-concordant care, evidenced-based approaches, and routine practice behaviors. We also drew on items in other surveys used to assess the impact of military and veteran cultural awareness training on participants through the Center for Deployment Psychology (for example, the Star Behavioral Health Providers) programs to inform our items on knowledge/attitudes/awareness of military and veteran culture. It should be noted that the overwhelming majority of the items have been modified in some manner from our original references; that is, we changed scales, reference points (all patients versus "this" patient), and response items in an effort to tailor this survey to the specific issues and population for this study. More information about the surveys reviewed can be found in the Appendix.

Military Cultural Competency

To understand the degree to which providers were sensitive to military and veteran culture, we asked a series of questions designed to assess providers' knowledge and awareness of, and attitudes toward, military culture. We also assessed their perceived proficiency in working with military and veteran populations and exposure to prior training in military cultural competency. Figure 2 provides an overview of the concepts we used to define cultural competency for this study.

To assess knowledge and awareness of military and veteran culture, we asked providers to rate their level of familiarity (on a 5-point Likert scale) with U.S. military culture and practices. Similarly, we asked providers to indicate their level of comfort with respect to working with military service members and veterans, working with patients/clients with military or war-related stress, and working with family members of military service members or veterans.

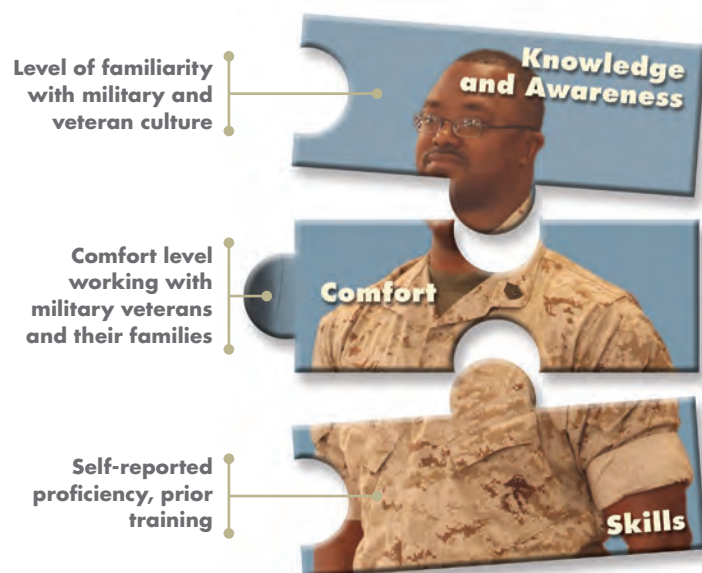
Respondent proficiency in military and veteran culture was assessed via ten items that tapped self-reported perceptions of cultural competency in three different domains, cultural knowledge (three items), cultural sensitivity (one item), and cultural skill (six items). These items, modified from items on the Nurse Cultural Competence Scale,²⁰ asked respondents to read statements and agree or disagree on a 5-point scale. Training in military culture was assessed via one yes/no item that asked about receipt of formal training in military and veteran culture.

Using all of these items described above, we derived a military cultural competency score by scoring each item as described in Table 2. This overall measure of military cultural competency summed the continuous variables for a range of 0–22, and a cut-score of 15 or more points was defined as “high military cultural competency.”

Capacity to Deliver Evidence-Based Care

As highlighted earlier, provider capacity to deliver evidence-based care to patients may depend on several factors. For example, prior training in the delivery of evidence-based approaches may be one indicator that a provider has capacity to deliver high-quality care; however, it is also important to understand the degree to which they have or will use these techniques to address the mental health needs of veterans and their families when they access providers. Other factors, such as their beliefs or attitudes about such approaches, may affect their willingness to use the techniques. Thus, to understand provider capacity to deliver evidence-based care, we assessed several domains:

Figure 2: Concepts Related to Provider Military Cultural Competency



training in evidence-based approaches, use of such treatment in routine practice, attitudes toward practice guidelines, and other routine behaviors. These are described in Figure 3 and in the following sections.

Training in Evidence-Based Psychotherapies for PTSD and MDD

To assess provider capacity to deliver evidence-based psychotherapies (EBPs) for PTSD and MDD, we assessed whether providers: (a) held formal certification or intensive/advanced training and (b) had supervised professional practice in any of five psychotherapies specified as first-line therapies for PTSD and depression in VA/DoD CPGs (2009, 2010).²¹ Providers who had received training and supervision in at least one type of EBP were classified as “capable” of delivering evidence-based treatment for the given condition.

Use of Evidence-Based Treatment Approaches

A dichotomous variable was used to summarize providers' reliance on evidence-based treatment modalities. Each provider estimated the percentage of patients that they treated in the most recent typical work week with 16 different treatment approaches. Treatments ranged from well-validated approaches for treating PTSD (e.g., Prolonged Exposure Therapy [PE]) to general therapeutic techniques without strong efficacy find-

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Table 2: Measures of Military Cultural Competency

Concept	Measure	Response Scale	# of Items	Operationalization
Knowledge and awareness	Level of familiarity with military and veteran culture	1–5 Likert scale (<i>Completely unfamiliar–Extremely familiar</i>)	8	1= <i>Very familiar</i> or <i>Extremely familiar</i> ; 0 otherwise (0–8 range)
Comfort	Comfort level working with military veterans and their families	1–5 Likert scale (<i>Not at all comfortable–Extremely comfortable</i>)	3	1= <i>Mostly comfortable</i> or <i>Extremely comfortable</i> ; 0 otherwise (0–3 range)
Skills	Self-reported proficiency	1–5 Likert scale (<i>Strongly disagree–Strongly agree</i>)	10	1= <i>Agree</i> or <i>Strongly agree</i> ; 0 otherwise (0–10 range)
	Prior training in military culture	Yes/No	1	1=Yes; 0=No (0–1 range)

ings (e.g., supportive psychotherapy). Approaches categorized as evidence-based treatments included those for PTSD (PE, Cognitive Processing Therapy [CPT], Eye Movement Desensitization and Reprocessing [EMDR], and Stress Inoculation Training [SIT]), depression treatments (Cognitive Behavioral Therapy [CBT], Interpersonal Therapy [IPT], and Acceptance and Commitment Therapy), and two additional treatments with support for use with patients who had substance use disorders or borderline personality disorder (i.e., Motivational Interviewing, Dialectical Behavioral Therapy).²² Past-week evidence-based practice was dichotomized between providers who reported treating 75 percent or more of their patients with EBP and those who did not meet this threshold. This threshold creates an easily summarized estimate of the proportion of providers from which patients are reasonably certain to receive an evidence-based treatment.

Practice Behaviors Related to Use of Psychotherapy for PTSD

To assess providers' adherence to therapeutic techniques associated with three validated PTSD psychotherapies (PE, EMDR, CPT), we used a modified version of a session behavior scale used in a Walter Reed Army Institute for Research (WRAIR) study in 2013.²³ Two items assessed treatment techniques representative of PE, two items assessed techniques associated with CPT, and one item assessed a technique unique to EMDR. For this report, we summarize the proportion of providers who reported that they “often” or “always” use therapeutic techniques associated with at least one EBP approach for PTSD. Note that providers who do not see patients with PTSD reported instead on their likelihood of using each technique if they “were to treat patients with PTSD.”

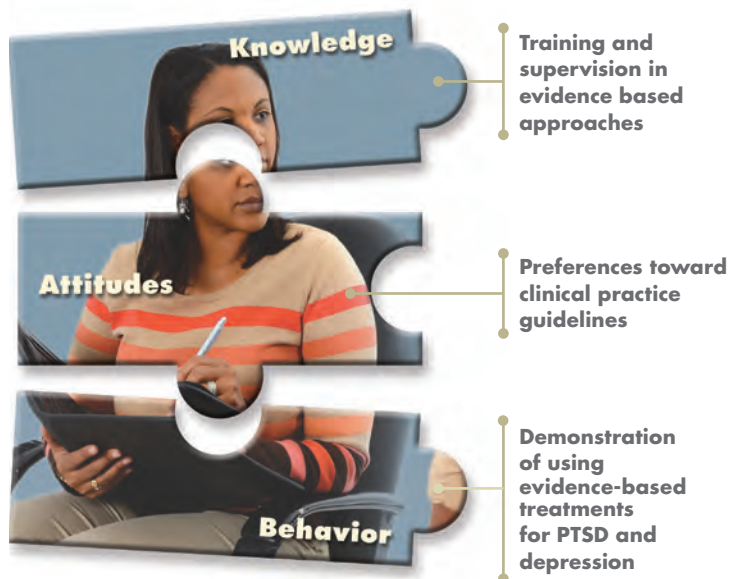
Practice Behaviors Related to Use of Psychotherapy for Depression

We used a modified version of the Psychotherapy Practice Scale to assess providers' adherence to the therapeutic techniques associated with two evidence-based approaches to depression treatment (CBT and IPT). The original scale prompted providers to consider a specific, randomly selected patient from their caseload with MDD. For ease of administration, these instructions were modified to ask providers who treat patients with depression to estimate the frequency with which they use nine distinct therapeutic techniques. Providers who do not see depressed patients were asked to estimate the likelihood that they would use each technique if they were to treat a patient with depression. Three items assessed treatment techniques representative of CBT, three assessed techniques associated with IPT, and three assessed common, but less well-supported, psychodynamic techniques. For this study, the full, 16-item Psychotherapy Practice Scale was reduced to nine items to reduce respondent burden.²⁴ For this report, we summarize the proportion of providers who reported that they “often” or “always” use the therapeutic techniques associated with either CBT or IPT with depressed patients. Note that providers who do not see patients with depression reported instead on their likelihood of using each technique if they “were to treat patients with depression.”

Medication Management for PTSD and Depression

To assess adherence to evidence-based guidelines for psychopharmacologic treatment of PTSD and MDD,²⁵ prescribing providers listed the “two most common first-line psychopharmacologic treatments” they prescribe for patients with each condition. A list of 90 common psychoactive medications—including antidepressants, anxiolytics, sedative-hypnotics, psychostimulants, and opioid analgesics—was provided for

Figure 3: Concepts Related to Provider Capacity to Deliver Evidence-Based Care



respondents to select from. To meet our criteria for “evidence-based prescriptive practice,” respondents had to select at least one antidepressant from the list for depression *and* one selective serotonin reuptake inhibitor or prazosin for PTSD.

Attitudes Toward CPGs

CPGs provide recommendations designed to improve patient care. They are developed after a systematic review of the evidence and consideration of the harm and benefit associated with a given approach.²⁶ Although the intent is to ease provider burden by succinctly recommending best practices for a given condition, some providers see CPGs as overly rigid, oversimplified, and as a threat to their clinical independence. For this study, we included the 11-item CPG Attitudes Scale from a New York State Psychiatric Association study as a proxy for provider attitudes toward evidence-based medicine and validated treatments for PTSD and MDD.²⁷ In the descriptive analyses below, scale scores are dichotomized into those who, on average, “agree” or “strongly agree” with CPG supportive statements (labeled “above threshold”) and those who fall below this threshold. Attitudes toward CPGs are entered as a continuous variable in the regression analysis, that is, the mean of all 11 items.

Analysis

We performed analyses to describe the provider sample that generally fall into three types: (1) basic univariate analyses,

(2) bivariate comparisons across pairs of variables, and (3) logistic or linear regressions to assess the contribution of sets of predictors to key dependent variables. First, univariate statistics were calculated to provide an introductory understanding of the pattern responses. For instance, the mean and standard deviation of the CPG Attitude Scale were calculated.

To assess relationships across pairs of dichotomous and continuous variables, we used independent-sample t-tests. To assess relationships across pairs of categorical variables, we used chi-square analyses. Finally, logistic and linear regressions were used to assess the relationship between a binary outcome and multiple predictor variables simultaneously. These regressions identify which predictors (if any) are most influential with respect to a specific outcome variable after controlling for the effect of all other predictor variables in the model.

RESPONDENT CHARACTERISTICS

We recruited a total of 522 mental health care professionals to participate in the survey (Table 3). Respondents included roughly equal groups (by design) of psychiatrists ($n=128$), psychologists ($n=127$), social workers ($n=132$), and licensed counselors ($n=135$). The majority of participants across professions were female (60 percent) with some variation by profession (the majority of psychiatrists—77 percent—were male).²⁸ Respondents generally worked full time. In addition, participants reported seeing the majority of their patients (77 percent on average) in outpatient settings in the most recent typical work week, and smaller percentages of patients (17 percent on average) were seen in inpatient and other settings (5 percent), such as schools, correctional facilities, or partial day programs. On average, providers reported spending the majority of their professional hours (19 percent) in a solo office setting, followed by a group office setting (15 percent). The percentage of professional hours spent by setting did vary by provider type.

As described earlier, we created an indicator of provider affiliation relative to military and VA settings, as well as the TRICARE provider network. The first group included any provider who indicated seeing patients (any number of patients) currently in a DoD or VA setting ($n=61$). The second group included those providers who did not see any current patients in a DoD or VA setting, but who reported being affiliated with the TRICARE network ($n=135$). The final group reported neither of these military affiliations ($n=520$).

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Prior Experience in the Military or in VA Settings

On average, 6 percent of respondents reported that they had served in the military.²⁹ Participating psychiatrists had the highest rates of military service, at 10 percent. More than one-third of respondents reported having family members in the armed forces. We note that it is not clear from our survey whether time spent in service was as a mental health provider or if individuals pursued their mental health care licensing following their military service.

Military and VA treatment settings each provide professional training opportunities for health care providers in the United States.³⁰ The VA in particular offers several clinical internship and fellowship opportunities for health care providers, including mental health professionals. We found that, overall, about one-third of respondents reported some experience working in some capacity (during training or in other roles) in either a military setting or in the Veterans Health Administration. There was some variation by provider type with regard to experience in military and VA settings, with

more psychiatrists reporting having worked in a military or VA setting (62.5 percent) compared to one-third of psychologists and one-fifth of social workers and licensed counselors. The average time that providers worked in military or VA settings was 4.5 years ($SD=6.06$). It should be noted that we asked about time spent in either a military or VA setting; however, these settings may differ in important ways with respect to the nature of the experience and training offered. In addition, for providers reporting having served or working in military or VA settings, their time spent in service or working in these facilities may have been in a different capacity than as a mental health provider. This is particularly true for licensed counselors who are traditionally not employed with VA health settings as mental health providers. Thus, some of these providers may have worked within military or VA settings as nonmedical counselors or in other capacities either before or after their licensing. Regardless of their professional designation within these settings; however, the providers are reporting having worked in such settings and as such likely had exposure to military and/or veteran patients and families.

Table 3: Respondent Demographic and Practice Characteristics

Respondents	All (n=522)	Psychiatrists (n=128)	Psychologists (n=127)	Social Workers (n=132)	Licensed Counselors (n=135)
Female	59.8%	22.7%	74%	80.3%	61.5%
Works full time	95.7%	98.4%	97.6%	94.7%	92.3%
Setting in which greatest number of patients seen	Solo office practice	Solo office practice	Solo office practice	"Other" setting	Group office practice
Solo office practice	18.4%	31.3%	22.8%	6.8%	13.3%
Group office practice	16.5%	15.6%	13.4%	9.8%	2.7%
Ever served in Armed Forces	6.1%	10.2%	4.7%	1.5%	8.2%
Has family in Armed Forces	38.1%	29.7%	44.9%	42.4%	35.6%
Ever worked in DoD or VA setting	34.9%	62.5%	34.7%	21.1%	22.2%
Primary setting is within ten miles of either VA or DoD	55.5%	53.9%	56.7%	59.4%	51.9%
Registered in TRICARE network	29.5%	37.5%	28.3%	27.2%	25.1%
Part of Military OneSource	5.2%	3.2%	3.2%	5.3%	8.9%
Registered in VA Veterans Patient Centered Community Care network	6.1%	5.5%	3.9%	6.8%	8.1%
Average number of years since completing training	18.0 years	26.2 years	17.0 years	16.6 years	13.9 years

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Practice Settings and Proximity to Military or VA Facilities

Respondents reported working and seeing patients in a number of different settings. Figure 4 displays the percentage of professional hours that respondents reported spending in the most recent typical work week by clinical practice setting; Table 4 summarizes the percentage of patients seen by the locus of care (outpatient versus inpatient). Geographically, respondents reported working in practice locations across the continental United States and in Hawaii, Alaska, and Puerto Rico. A little more than one-half of participating providers practiced within ten miles of either a VA or DoD facility. Figure 5 displays a map of respondents' practice locations, military treatment facility locations, and VA hospital or clinic locations. The map also includes a state-by-state indication of the veteran population as a proportion of the overall population.

Provider Activity

Across all provider types, respondents reported working an average of 48 hours per week ($SD=22.87$). They indicated spending the largest percentage of their time in direct patient care doing either medication management or psychotherapy and assessment (Table 5). Participating social workers, psychologists, and licensed counselors reported spending about half their time on psychotherapy and assessment. Participating psychiatrists reported spending a majority of their time

(59 percent) on medication management and only about 30 percent of their time on psychotherapy and assessment. Amount of participants' time spent on professional and administrative activities—such as committees, Continuing Medical Education, research, writing, training, and forensic activities—varied by provider type. For example, psychiatrists reported that they spend about 8 percent of their time on professional and administrative activities, whereas psychologists reported spending about 31 percent of their time on those activities.

Therapeutic Orientation

The primary therapeutic orientation reported by respondents also varied by provider type (Table 6). The majority of social worker and licensed counselor respondents reported that their primary therapeutic orientation was cognitive and/or behavioral. A large proportion of psychologists also identified cognitive and/or behavioral as their primary therapeutic orientation (41 percent), and others identified with integrative or eclectic approaches (30 percent). Psychiatrists generally identified biological/psychopharmacologic as their primary orientation.

Certification, Training, and Supervision in Therapeutic Techniques

Respondents indicated being certified or trained in an array of EBPs for PTSD and MDD and have been supervised by others

Figure 4: Percentage of Total Professional Hours Reported, by Clinical Setting

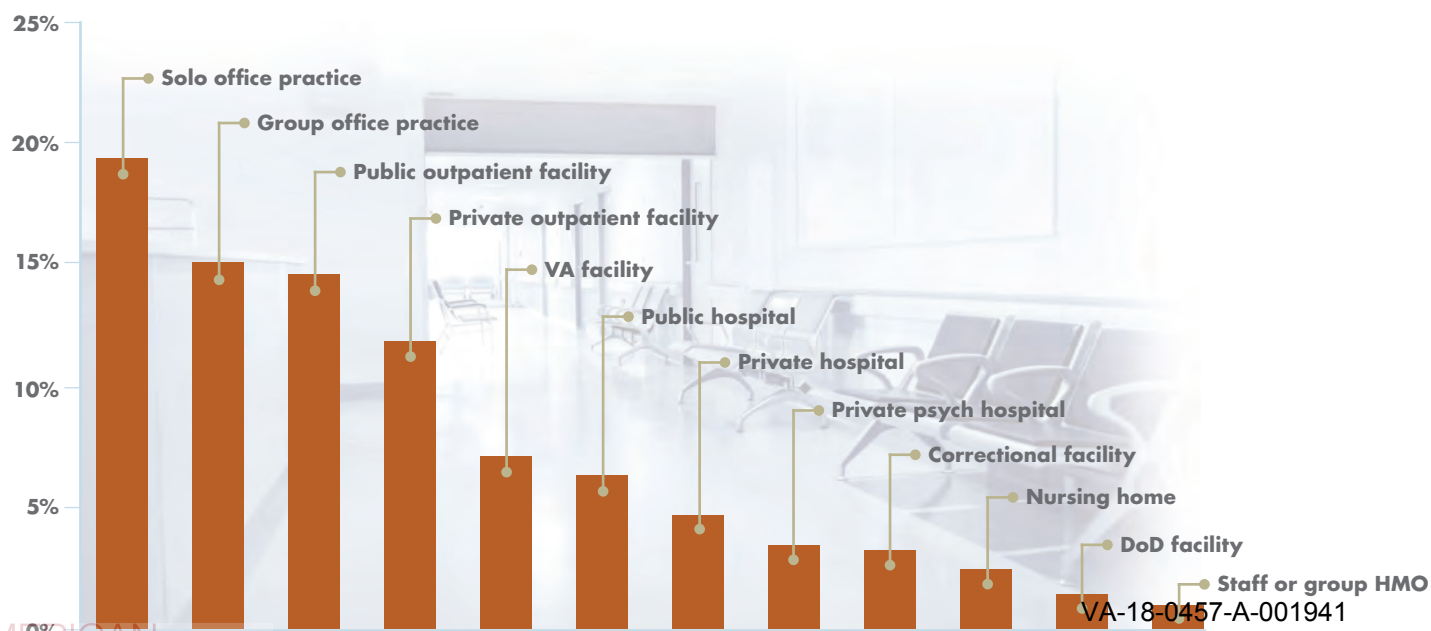


Table 4: Percentage of Patients Seen, by Respondents by Setting

	All (n=522)	Psychiatrists (n=128)	Psychologists (n=127)	Social Workers (n=132)	Licensed Counselors (n=135)
Outpatient setting	77.4	84.2	81.9	69.4	74.4
Inpatient setting	17.0	14.3	9.8	24.0	24.0
Other settings (school, prison, etc.)	5.0	1.5	8.3	6.6	5.6

in these methods. As Table 7 shows, CBT was the most common therapeutic technique respondents reported being trained to deliver, followed by IPT and CPT. Relatively fewer respondents had training and supervision in PE, EMDR, and SIT.

Assessment Behaviors

To understand the usual practice behaviors of participating providers, we asked them how often they implement a series of practices related to screening and assessment. While these screening behaviors are not necessarily linked specifically to quality or cultural competency, they do inform whether providers routinely adopt recommended approaches in their clinical settings. Figure 6 shows that the majority of respondents report often or always screening for a history of trauma, suicide risk, physical health problems, sleep issues, and pain. Only one-half reported screening for military affiliation and less than one-half report assessing stressors associated with military life. Less than one-half of the respondents reported often or always using validated screening tools to assess for such conditions as depression, PTSD, or alcohol and drug use.

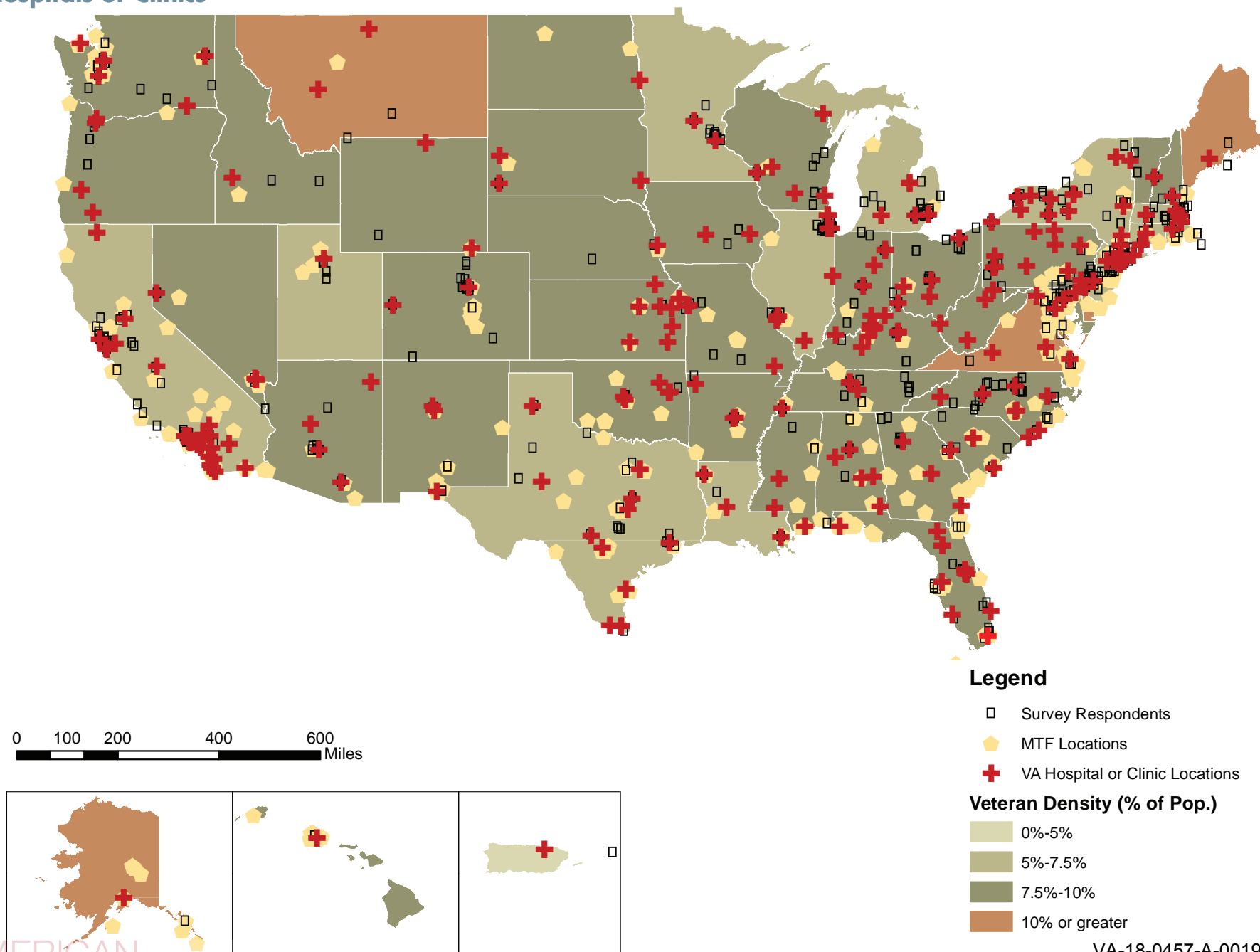
MILITARY CULTURAL COMPETENCY

In this section, we report our findings on the military cultural competency of survey respondents. Cultural competency includes their knowledge and comfort related to military culture, self-reported proficiency working with veteran and military-affiliated patients, and prior training in military culture. We also report how individual and practice characteristics are associated with these aspects of military cultural competency. Understanding which factors are related to being more “veteran friendly” can help direct military cultural competency training to the set of providers most in need. We hypothesized that military cultural competency would be low among those providers who do not already treat veteran or military-affiliated patients.

Respondents reported being either “very familiar” or “extremely familiar” on an average of 1.84 ($SD=2.7$) of the eight military knowledge items presented and reported being “mostly comfortable” or “extremely comfortable” with an average of 1.62 ($SD=1.3$) of the three comfort items. A breakdown of knowledge items can be seen in Table 8, and indicates a wide range of self-reported knowledge on different aspects of military culture, with only 15 percent reporting being very or extremely familiar with military deployment and slang terms, but 38 percent saying they were very or extremely familiar with the way behaviors learned at war can be maladaptive at home. In terms of self-reported proficiency working with veteran or military-affiliated patients, respondents reported “agree” or “strongly agree” on an average of 4.52 ($SD=3.2$) of the ten proficiency items presented. A breakdown of self-reporting proficiency can be seen in Table 9, again with some differences across the items. Of the respondents, 18 percent agreed or strongly agreed that diagnosing and treating military personnel and veterans with mental health problems is no different than diagnosing and treating civilians with mental health problems, whereas 75 percent reported they usually actively strive to understand each military and veteran client’s values and beliefs. Thirty-four percent reported receiving prior training in military culture. When these items were compiled into the overall military cultural competency score, total scores averaged 8.32 ($SD=6.4$) out of a possible 22 points. Overall, 19 percent were categorized as having “high military cultural competency” (with a total score of 15 or greater).

Although 70 percent of those working in a military or VA setting had high military cultural competency, only 24 percent of those participating in the TRICARE network and 8 percent of those without military or TRICARE affiliation met this threshold ($p<0.001$; see Table 7). Nearly one-quarter (23 percent) of those practicing within ten miles of a VA or military treatment facility met the threshold for high military cultural competency, whereas only 15 percent of those practicing more distantly from these facilities met the thresh-

Figure 5: Map of Survey Respondents' Practice Locations, Military Treatment Facility Locations, and VA Hospitals or Clinics



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Table 5: Time Spent in Typical Week, by Activity (percentage)

	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
Psychotherapy or assessment	49.7	29.7	54.6	58.6	54.9
Medication management	21.7	58.5	2.8	4.1	15.8
Professional/administrative activities	20.8	7.6	31.4	23.0	20.1
Receiving supervision/consultation	7.3	4.2	5.9	9.5	9.0
Supervising others	6.6	3.7	8.8	8.7	5.1

Table 6: Provider Primary Therapeutic Orientation (percentage)

	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
Cognitive and/or behavioral	41.2	7.8	44.1	58.3	53.3
Biological/psychopharmacologic	21.8	71.8	0.8	1.5	14.1
Integrative or eclectic	17.8	12.5	29.9	16.7	12.6
Psychodynamic/relational	10.2	5.5	11.8	9.8	13.3
Interpersonal	4.8	0.0	6.3	10.6	2.2
Acceptance and commitment	1.1	0.0	1.6	0.7	2.2
Other	3.1	2.3	5.5	2.3	2.2

Table 7: Provider-Reported Psychotherapy Training and Supervision (percentage)

	All		Psychiatrists		Psychologists		Social Workers		Licensed Counselors	
	Trained	Supervised	Trained	Supervised	Trained	Supervised	Trained	Supervised	Trained	Supervised
CBT	69.4	68.6	57.0	63.3	71.6	68.5	67.4	61.4	80.7	80.7
IPT	37.0	37.4	40.6	50.0	37.0	35.4	25.8	21.2	45.2	42.9
CPT	33.0	27.6	18.0	17.2	35.4	23.6	28.8	25.0	50.4	43.7
EMDR	18.6	17.2	12.0	14.1	20.5	15.8	13.6	12.1	28.2	26.7
PE	18.0	16.9	14.0	15.6	24.4	25.2	11.4	5.3	22.9	21.5
SIT	13.6	10.9	6.3	6.3	15.8	11.0	9.1	6.1	22.9	20.0

old ($p < 0.05$). Neither provider type nor years in practice were related to overall military cultural competency.

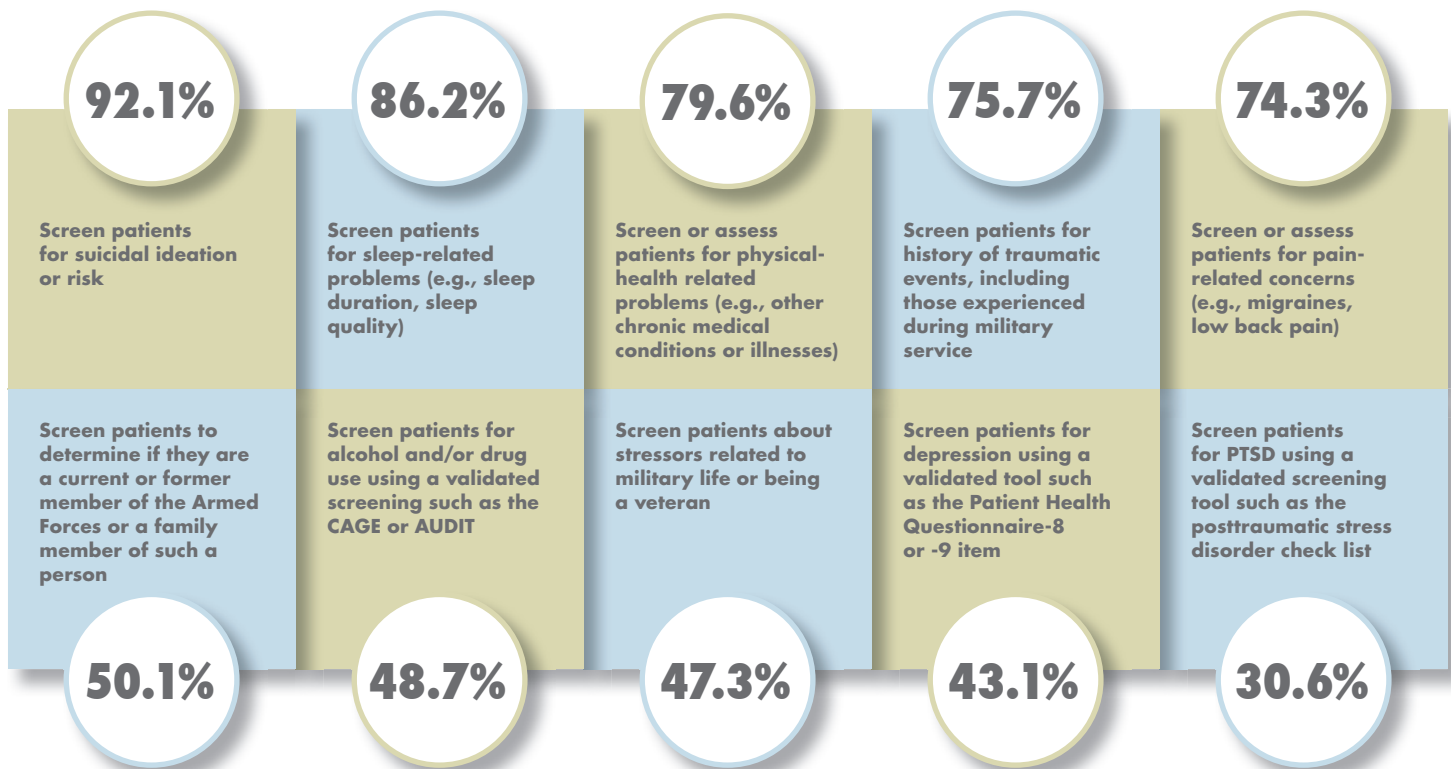
Consistent with the bivariate analyses (shown in Table 10), a logistic regression model confirmed that, relative to those working outside military or VA settings who are part of the TRICARE network, those working in military or VA settings are more likely to meet the threshold for high cultural competency, and those working outside such settings who are not part of TRICARE are less likely to meet the threshold. The remaining independent variables failed to reach significance. A linear regression predicting the continuous variable for military cultural competency showed similar results.³¹

USE OF EVIDENCE-BASED PRACTICES FOR PTSD AND MDD

In this section, we explore respondents' reported capability of delivering evidence-based care for PTSD and MDD. We report on whether participating providers were trained and inclined to implement guideline-concordant care for PTSD and MDD, and whether these providers reported using such care in their usual practice. The success of efforts to outsource mental health care for service members and veterans to civilian providers will depend, in part, on whether providers in the community are able and willing to deliver the high-quality care outlined in the VA/DoD CPGs for MDD and PTSD.³² Based on previous reviews of provider practices,³³ we expected that a substantial proportion of civilian providers would *not* be prepared to deliver high-quality mental health care.

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Figure 6: Percentage of Providers Who Endorse Performing Each Assessment Behavior



We explored the relationships between training in and use of evidence-based care and psychotherapist type (social worker, licensed professional counselor, or clinical psychologist), military affiliation (employed in a military setting, TRICARE affiliated, or non-TRICARE affiliated), number of years since graduate training, and attitudes toward CPGs. Understanding the practice and provider characteristics associated with provision of high-quality mental health care may allow policymakers to better direct care for service members seeking services outside the military and veteran health systems.

The types of services specified as “evidence-based” differ substantially between mental health specialists (hereafter referred to as “psychotherapists”) and psychiatrists. Although psychiatrists are licensed to provide both medication management and “talk” therapies for mental health conditions, most deliver more medication management than psychotherapy (see also Table 3). Psychotherapists are not licensed to provide medications and are more likely than psychiatrists to deliver “talk” therapies, including EBP such as CBT or PE. This divergence in practice motivates our analytic structure. Below, we report first on psychotherapists’ training in and delivery of EBPs for PTSD and MDD. Second, we report findings on

psychiatrists’ delivery of evidence-based medication management for PTSD and MDD.

Evidence-Based Practices Among Psychotherapists

Training in Evidence-Based Psychotherapies for PTSD and MDD

Only one-third (35 percent) of psychotherapists reported that they had been trained and received supervision to deliver at least one EBP for PTSD and at least one for depression (see Figure 6). Licensed counselors (LPC/LMHCS) were most likely to report having training in EBPs ($p < .001$). Nearly one-half (48 percent) reported being trained to deliver an EBP for PTSD and depression. One-third of clinical psychologists reported receiving training (34 percent), and only one-fourth of licensed clinical social workers (LCSW/MCSWs) indicated they were trained (23 percent). Neither attitudes toward CPGs nor years since clinical training were significantly associated with EBP training. A logistic regression model predicting EBP training confirmed the bivariate relationships described above.³⁴

Table 8: Providers Reported Knowledge of Military and Veteran Culture (percentage)

Reported Being Very Familiar or Extremely Familiar With	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
Military rank structure	21.6	25.0	25.2	15.9	20.7
Subculture of military branches	16.5	16.4	17.3	13.6	18.5
Differences and similarities between active and reserve components of the military	23.6	30.5	14.4	18.9	20.7
General and deployment-related military slang and terms	14.6	14.8	15.7	12.9	14.8
General and deployment-related stressors for service members and veterans	25.1	21.9	32.3	23.5	23.0
General and deployment-related stressors for military families	27.2	23.4	32.3	27.3	25.9
Programs and services available to support healthy adjustment for military-affiliated clients	17.8	13.3	19.7	19.7	18.5
How behaviors learned in war can be maladaptive at home	37.5	29.7	48.0	37.9	34.8

Table 9: Self-Reported Proficiency (percentage)

Reported Agree or Strongly Agree	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
I can list methods or ways of collecting a military history and related mental health information (e.g., military and veteran benefits, options or eligibility for care)	40.4	39.1	43.3	42.4	37.0
I can explain how the perceptions of mental health beliefs are influenced by military and veteran culture	54.6	46.9	61.4	56.1	54.1
I usually actively strive to understand each military and veteran client's values and beliefs	74.5	75.8	77.2	77.3	68.1
I can teach and guide colleagues on the important features of military culture	25.1	22.7	26.0	25.0	26.7
I can teach and guide colleagues on planning mental health care for military and veteran clients	28.7	26.6	30.7	27.3	30.4
I can teach and guide colleagues on effective communication skills with military and veteran clients	39.5	31.3	44.1	40.2	42.2
Collecting information on a military or veteran client's mental health is easy for me	47.3	46.9	50.4	45.5	46.7
When implementing care, I can fulfill the mental health needs of military and veteran clients	54.2	56.3	57.5	48.5	54.8
I have the skills to communicate effectively with military and veteran clients	69.3	74.2	71.7	65.2	66.7
Diagnosing and treating military personnel and veterans with mental health problems is no different than diagnosing and treating civilians with mental health problems	18.4	21.9	16.5	12.1	23.0

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Table 10: Relationship Between Cultural Competency and Provider Characteristics

Provider	Military Culturally Competent ≥ 15 (%)
All respondents	19.2
Provider type	
LPC or LMHC	17.8
LCSW or MCSW	18.2
Clinical Psychologist	21.3
Psychiatrist	19.5
	$\chi^2=0.621$, $p=\text{not significant (ns)}$
Affiliation	
Works in military or VA setting	70.5
TRICARE affiliated	23.7
Not TRICARE affiliated	7.7
	$\chi^2=133.38$, $p<.001$
Years since graduate training	
Ten years or less	20.7
More than ten years	18.4
	$\chi^2=0.389$, $p=\text{ns}$
Geographic proximity	
Within ten miles	14.7
More than ten miles	22.8
	$\chi^2=5.555$, $p<.05$

Delivery of Evidence-Based Psychotherapy to at Least Three-Quarters of Patients in the Most Recent Typical Work Week

One-third of psychotherapists (33 percent) self-reported that, in the most recent typical work week, they treated a substantial majority of their patients (≥ 75 percent) with an EBP (see Figure 6). Providers who had been trained to deliver at least one evidence-based PTSD and MDD psychotherapy (41 percent) were more likely than those without training (29 percent) to report delivering EBPs to most of their patients in the most recent typical week ($p<.05$). Providers with positive attitudes toward CPGs (45 percent) were also more likely than those with negative opinions about CPGs (31 percent) to report delivering EBPs to their patients. Among providers who self-reported delivering EBPs to most of their patients in the most recent typical week, fewer years had elapsed since their graduate training relative to providers who did not deliver EBPs to the majority of their patients (13.9 years and 16.7 years, respectively). A logistic regression model predicting self-reported delivery of EBP confirmed the bivariate relationships.³⁵

Consistent Use of Evidence-Based Psychotherapy Techniques in Session

About 30 percent of psychotherapists reported that they “often” or “always” used the psychotherapy techniques associated with at least one EBP for PTSD and MDD (see Table 11). Provider type was not related significantly to use of EBP techniques. Perhaps not surprisingly, positive attitudes toward CPGs and training in EBPs for PTSD and MDD significantly predicted frequent use of EBP techniques. Neither affiliation nor years since graduate training were significant predictors of EBP techniques. A logistic regression, conducted to estimate the independent contributions of the predictor variables, confirmed the bivariate relationships described above.³⁶

Evidence-Based Practices Among Psychiatrists

When asked to report the most common first-line medications that they would prescribe to a patient with PTSD or MDD, 89 percent of psychiatrists specified at least one of the VA/

Table 11: Relationship Between Provider Characteristics, and Training and Delivery of EBPs for PTSD and MDD

	Trained in 1+ EBPs for PTSD and MDD (%)	Reported Treating ≥75% of Patients with an EBP in the Last Typical Work Week (%)	Reported Often/Always Using EBP Techniques for PTSD and MDD (%)
All Respondents	35.0	33.0	29.4
Provider Type			
LPC or LMHC	48.2	36.3	32.6
LCSW or MCSW	22.7	31.1	22.0
Clinical Psychologist	33.9	31.5	33.9
	$\chi^2(2)=19.06, p<.001$	$\chi^2(2)=1.02, p=ns$	$\chi^2(2)=5.39, p=ns$
Affiliation			
Works in a VA or military setting	48.1	26.9	40.4
TRICARE affiliated	37.4	40.7	34.1
Not TRICARE affiliated	31.5	31.5	25.5
	$\chi^2(2)=5.50, p=ns$	$\chi^2(2)=3.56, p=ns$	$\chi^2(2)=5.81, p=ns$
Supportive of CPGs			
Below threshold	34.1	30.8	25.8
Above threshold	40.0	45.0	50.0
	$\chi^2(1)=0.77, p=ns$	$\chi^2(1)=4.61, p<.05$	$\chi^2(1)=14.40, p<.001$
Years since graduate training	$t(392)=0.64, p=ns$	$t(392)=2.36, p<.05$	$t(392)=1.59, p=ns$
Trained in 1+ EBP			
No	—	28.9	22.7
Yes	—	40.6	42.0
	—	$\chi^2(1)=5.53, p<.05$	$\chi^2(1)=16.20, p<.0001$

Providers who meet one threshold, such as culturally sensitive or competent, may not meet the other (trained in or report using evidence-based care).

DoD CPGs include as appropriate, evidence-based psychopharmacological treatments for these conditions. Psychiatrists' practice affiliation was not significantly related to their likelihood of prescribing an evidence-based medication ($\chi^2(2)=1.20$, $p=ns$). Evidence-based prescribing was also unrelated to attitudes toward CPGs ($\chi^2(2) = 2.09$, $p=ns$). However, years since graduate training were related to self-reported practices. Psychiatrists who adhered to practice guidelines for medication management of PTSD and MDD had been practicing for about five fewer years ($M=25.6$, $SD=7.93$) than those who reported not providing guideline-concordant care ($M=31.0$, $SD=9.02$; $t(126)=2.37$, $p<.05$).

Given that very few psychiatrists indicated that they would use a nonevidence-based medication management strategy ($n=14$), there was insufficient power to conduct a logistic regression predicting psychiatrist prescribing patterns with multiple independent variables.

OVERALL PROVIDER READINESS FOR VETERAN-FRIENDLY, QUALITY CARE

In this section, we explore the extent to which providers are “ready” to deliver culturally competent, high-quality care to veterans and their families. As we outlined in earlier sections, cultural competency can facilitate the development of therapeutic rapport and improve treatment receptivity, and the definition of *high-quality care* includes the use of treatments demonstrated to be effective (i.e., evidence-based). Thus, our concept of provider readiness in this study combines the domains of cultural competency and capacity to deliver high-quality care. We are particularly interested in understanding not only the

proportion of providers that meet our definition of readiness, but also in examining the factors that may be associated with such readiness. As we outlined in the previous sections, different factors have been shown to be associated with cultural competency and the use of evidence-based approaches. And, providers who meet one threshold, such as culturally sensitive or competent, may not meet the other (trained in or report using evidence-based care).

We operationalized our concept of readiness by building upon and combining the two outcomes described in the prior sections. We include providers we defined to be culturally competent (having scored 15 or greater out of a total of 22 possible on our cultural competency scale), who indicated they had been trained in an evidenced-based therapy for PTSD and MDD, and who self-reported using evidence-based treatments for PTSD and MDD. For each variable, the criteria for inclusion differed across MD and non-MD provider types due to the low numbers of psychiatrists who deliver nonmedication-based approaches. As we outlined in earlier sections, the focus for psychotherapists (non-MD providers) was on use of specific psychotherapies demonstrated to be effective for PTSD and MDD. For psychiatrists, evidence-based treatment meant selecting appropriate medications for PTSD and MDD. The previous section provides more detail on how providers perform separately on these two outcomes.

As shown in Table 12, only 13 percent of respondents met our readiness criteria. We examined associations between providers' years in practice (years since training in two categories: less than ten years, or ten years or greater), practice affiliation, proximity to military or veteran treatment facilities (within ten miles versus more than ten miles away), region (primary practice setting is in a metropolitan statistical area—defined urban or rural region), and insurance status (greater than 50 percent of patient care is not compensated through insurance). As shown, and as was confirmed in a multivariate model, we find that only providers' practice affiliation is significantly associated with readiness: Providers who work primarily in a military or VA setting were significantly more likely to meet our criteria for being culturally competent and delivering evidenced-based care for PTSD or MDD than providers who do not work in a military or VA facility, but those who indicated they were a registered provider within the TRICARE provider network were more likely to meet criteria than those who were not registered with a TRICARE provider network.

Table 12: Relationship Between Provider Characteristics and Readiness

	Culturally Competent and Reported Being Trained in 1+ EBP and Reported Often/Always Using Evidence-Based Treatment for PTSD and/or MDD (%)
All respondents	13.4
Provider type	
LPC or LMHC	13.3
LCSW or MCSW	9.8
Clinical psychologist	12.6
Psychiatrist	18.0
	$\chi^2=3.806, p=ns$
Affiliation	
Works in military or VA setting	45.9
TRICARE affiliated	17.8
Not TRICARE affiliated	5.5
	$\chi^2=75.149, p<.001$
Supportive of CPGs	
Not CPG friendly	13.2
CPG friendly	14.7
	$\chi^2=0.119, p=ns$
Years since graduate training	
Ten years or less	16.0
More than ten years	12.2
	$\chi^2=1.418, p=ns$
Geographic proximity	
Within ten miles of DoD or VA facility	15.9
More than ten miles	10.3
	$\chi^2=3.436, p=ns$

NOTE: Value and statistical tests are not shown for the associations between readiness and having greater than 50 percent of uncompensated/self-pay care because the number of providers in some cells were fewer than ten, making such tests unreliable.

As veterans and their families seek care to address mental health concerns, they will be turning to providers working across multiple sectors.

IMPLICATIONS FOR THE FUTURE

As veterans and their families seek care to address mental health concerns, they will be turning to providers working across multiple sectors. This study aimed to assess the readiness of those mental health providers working in community settings. While multiple factors may facilitate or inhibit a provider's ability to deliver high-quality care—including the system-level incentives and treatment models employed within their settings—we focused on those related to the characteristics of the providers themselves. To do so, we examined the characteristics of a convenience-based sample of mental health professionals and assessed their knowledge, attitudes, and behaviors with respect to military and veteran culture, as well as evidence-based practices for mental health problems common in veteran populations.

We find that providers vary in whether they report being knowledgeable in and comfortable with treating military- and veteran-affiliated patients. We also observe variation in the extent to which participating providers were trained in and demonstrated use of evidence-based treatments for PTSD and MDD. We found that, across our outcomes of interest, the characteristics of the provider are related to the setting in which they work.

With respect to cultural competency, respondents endorsed a high degree of knowledge on less than one-quarter of knowledge items, a high degree of comfort on about two-thirds of comfort items, and a high degree of proficiency on fewer than one-half of self-reported proficiency items. Fewer than one-fifth of respondents exceeded the threshold for a high degree of cultural competency, and as expected, those respondents were more likely to be working in DoD or VA work settings or to have reported being in the TRICARE network than not.

The majority of psychotherapists (65 percent) reported that they had not received the training and supervision necessary to deliver at least one EBP for PTSD and MDD. In other words, a psychotherapist selected from the community is unlikely to have the skills necessary to deliver high-quality mental health care to service members or veterans with these conditions.

Licensed counselors (LPC/LMHC) were more likely than other psychotherapists to report adequate training in EBPs. Further examination of differences across graduate training models may provide policy recommendations to improve training for the next generation of psychotherapists.

Training in EBPs, in turn, predicts implementation of these practices with the majority of patients. Increasing community-based psychotherapists' incentives to complete training in EBPs may improve patient access to these behavioral treatments for their conditions. At the same time, even among psychotherapists with training, only 41 percent reported delivering evidence-based care to most of their patients. Thus, training alone does not ensure delivery of high-quality care; other barriers to CPG adherence must be explored. Providers who delivered EBPs to most of their patients were comparatively recent graduates, having completed their training about three years after those who were not consistently implementing evidence-based care. This may reflect a trend among graduate programs toward an increasing emphasis on evidence-based strategies for care, or it may be that younger clinicians are more likely to pursue training and supervision in treatments that have been demonstrated through research to reduce clinical symptoms.

Among psychiatrists, the majority of respondents reported prescribing appropriate medication for MDD and PTSD. In general, most reported using specific psychotropic medications that are considered generally acceptable for these conditions. However, we were unable to assess the appropriateness of specific dosages and length of use.

When we combined responses for cultural competency and use of evidence-based approaches to examine the level of overall readiness to deliver culturally competent, evidence-based care, we found very few respondents (13 percent) met our threshold. Similar to our findings on cultural competency, providers who met this threshold were more likely to be affiliated with a DoD or VA facility than not, and more likely to be a part of the TRICARE network than not if working outside DoD or the VA. Although actual knowledge and practice behaviors were not assessed in this study, the data

gathered on respondents' perceptions of their own knowledge, attitudes, and behaviors offer important insights into how ready they are to work with veterans and service members, as well as their families.

These findings suggest that when service members, veterans, or family members seek care from providers not affiliated with DoD or the VA, they may encounter providers who are not as well prepared to deliver culturally sensitive care. However, the degree to which providers deliver evidence-based care for PTSD and MDD appears equivalent across settings, with those providers who have received training in evidence-based approaches more likely to deliver such care routinely to their patients.

Study Limitations

While this study provides important insight into the characteristics of community mental health professionals, several limitations should be noted. First, we relied upon a convenience sample. Thus, the results are not necessarily representative of all mental health professionals. While the topics of military and veteran mental health care, cultural competency, and evidence-based practice were not specifically identified in the recruitment email sent by GfK or in the introductory page of the survey, it is possible that providers more interested in these topics of military and veteran populations completed the survey. As with all surveys conducted among convenience samples, it is difficult to understand the potential bias introduced by those choosing to participate in such panels and surveys as compared to the full population of providers.

Further, while we compare providers across different types of characteristics, care should be taken in making inferences about differences across provider groups because we did not sample systematically. Future work should be designed to implement similar assessments in larger samples, ideally those that are designed to represent provider groups (defined within provider networks, professional categories, settings, etc.). Another limitation is that we rely on self-report methods to assess practice behaviors. As with all self-report surveys, there is the potential for socially desirable responses. We tried to minimize this bias by including anchor/reference periods or referring to specific types of patients (e.g., those with PTSD or MDD); however, the potential for selecting socially desirable responses may still remain.

In addition, we measured some aspects of potential care experiences for veterans and their families within this survey, such as self-reported knowledge about military culture and proficiency with various treatment approaches, but did not

include others, such as actual knowledge on how to apply specific techniques and practice behaviors for these populations. Thus, many important aspects of knowledge, attitudes, and behavior among community-based mental health providers remain to be explored. Further, other techniques—such as gathering patient-level data on symptom levels, functioning, and experiences with care (which could be implemented within rigorous performance monitoring approaches)—would help to inform the extent to which providers' techniques are actually helping patients to improve.

Recommendations and Next Steps

Despite the exploratory nature of this study, there are several implications for informing future efforts to improve the capacity of community-based providers to deliver culturally competent, high-quality care to veterans and their families.

Conduct Better Assessments of Civilian Provider Capacity

With continued emphasis on hiring more providers into the VA,³⁷ workforce development and evaluation efforts are critically needed to understand more about the size and characteristics of the mental health workforce in the United States, and

These findings suggest that when service members, veterans, or family members seek care from providers not affiliated with DoD or VA, they may encounter providers who are not as well prepared to deliver culturally sensitive care.

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While provider cultural competency may be important for engaging the population and thereby increasing access to care, other specific efforts may be needed to increase providers' use of quality therapeutic approaches.

in particular, whether the civilian sector can meet expectations regarding timeliness and quality of care. Unfortunately, at this time, there are no recent representative data on any of the specific professions within the mental health workforce.

Until such population-based data can be generated, organizations that maintain registries or provider networks of mental health professionals should conduct assessments related to their own networks, with a special focus on examining access and quality of care among those providers. Even registries or networks established specifically for military and veteran populations would benefit from an assessment of which providers have availability and appropriate capacity to render timely, culturally appropriate, high-quality care to veterans and their families. For example, while being part of such registries or networks may indicate a provider's willingness to accept military-affiliated patients, providers often place limits on the number of patients they accept under those arrangements. In this study, about 30 percent of providers reported they were part of the TRICARE network; however, TRICARE represented the primary payment source for only a small proportion (2.5 percent) of the patients treated by our participating providers in a typical week.

A related issue has to do with efforts to hire and train more providers working within DoD and the VA over the past several years. These efforts have been hampered by the ability to ensure an adequate pipeline of mental health providers, both in terms of numbers and quality, particularly in remote or rural areas. Several have pointed to the concerns about a national shortage in mental health,³⁸ and efforts to draw more providers into DoD and the VA may further deplete the civilian workforce. Again, careful study of the existing workforce may help to identify strengths and gaps and provide more information about how and where to enhance the pipeline of new professionals entering the workforce.

Assess the Impact of Trainings in Cultural Competency on Provider Capacity

In the President's 2012 Executive Order (and reinforced in new Executive Actions announced in August 2014), he called upon DoD, the VA, and the Department of Health and Human Services to collaborate in an effort to educate community-based providers about the unique needs of service members, veterans, and their families. In response to the most recent Call to Action, DoD and the VA announced an intent to disseminate their cultural competency course to civilian mental health providers. While this new initiative may help increase community-based providers' awareness of the unique issues of veterans and their families, training by itself it will not necessarily increase cultural competency or expand access or quality of care for veterans. While training may be an important underpinning for developing awareness and skills, seeing and interacting with the patient population was a significant predictor of overall competency, with providers' affiliation with DoD and VA settings and TRICARE affiliation significantly related to high military cultural competency scores in our scale.

Further, while provider cultural competency may be important for engaging the population and thereby increasing access to care, other specific efforts may be needed to increase providers' use of quality therapeutic approaches. DoD and the VA have a long history of requiring training for their providers on evidence-based approaches, as well as promulgating CPGs for the care of patients with specific conditions (including PTSD and depression), but there are few such requirements in the civilian setting. Large-scale dissemination and training efforts can be resource-intensive and require significant investment of staff time and leadership to promote participation and adherence to guidelines. Different models have been employed and many engage champions, train-the-trainer, or supportive implementation models to help disseminate information

broadly and encourage uptake. Often, these efforts also involve the development and distribution of provider resource guides, pocket tools, and other decisionmaking aids to facilitate utilization of the skills and practice recommendations. Studies that have evaluated the impact of these efforts have demonstrated success,³⁹ yet few programs that implement trainings of this nature evaluate their efficacy and long-term effectiveness. Many training and dissemination programs may show early success but adherence and use of new skills may wane as the support and infrastructure subsides.

DoD utilizes the Center for Deployment Psychology to train military mental health professionals in the evidence-based modalities. Recently, the Center began collaborating with academic organizations to bring training to civilian providers as well. Their approach includes specific focus on cultural competency, as well as evidence-based therapies, organized across three training tiers reflecting different topics and levels of intensity. Other promising programs have also begun designing and implementing more rigorous curricula on both the topics of cultural competency and specific evidence-based modalities using models shown to facilitate provider practice change.⁴⁰ Understanding the extent to which participating in such training affects providers' capability to serve this population will require well-designed evaluations of the training programs themselves, as well as rigorous studies to explore how providers implement the material in practice settings in the short and long terms.

Expand Access to Effective Trainings in Evidence-Based Approaches for PTSD and MDD

This study clearly points to the need for additional training on evidence-based approaches among the civilian mental health workforce, particularly for practitioners who completed their

formal professional training some time ago. Recent graduates in certain professions appear to be getting training in these models more often; thus, expansion to all professional training programs as well as to more mature professionals is needed. Over the past several years, numerous organizations have sought to implement training programs for practicing providers in evidence-based approaches in mental health, with varying success based upon the particular model adopted.⁴¹ As we outlined earlier, the type of training programs in military cultural competency and evidence-based approaches for PTSD and MDD currently available varies greatly—from short online courses, to lengthier in-person opportunities. Participation in these varying continuing education opportunities may help to expand provider skills and ability to implement these models; however, providers may need some additional motivation for attaining such training and then applying their new skills in routine practice.

While some of these training opportunities are available at little or no cost (such as web downloads), others may impose specific costs related to access and participation (including travel expenses). Beyond these participation fees, the participation time itself may be a cost for providers, as the time spent in training may detract from their time providing compensated patient care (particularly for providers working in independent, fee-for-service settings). Thus, strategies for facilitating low-cost access may be needed to increase provider willingness to participate. While some courses offer continuing education credits, not all provider groups and states have specific requirements for these credits and it may not be enough motivation to facilitate providers becoming trained. It should be noted that while we recommend greater access to training in evidence-based approaches for PTSD and MDD, we acknowledge that not all training may be equivalent in terms of quality and effectiveness in providing the appro-

This study clearly points to the need for additional training on evidence-based approaches among the civilian mental health workforce, particularly for practitioners who completed their formal professional training some time ago.

Improving the mental health of service members, veterans, and their families will require that the providers who treat them adopt and routinely use appropriate and effective approaches for addressing their conditions.

priate instruction and supervision in specific, evidence-based approaches. As such, rigorous evaluations will be needed to assess the extent to which training is effective in improving providers' skills and changing their practice behaviors.

Facilitate Providers' Use of Evidence-Based Approaches

Improving the mental health of service members, veterans, and their families will require that the providers who treat them adopt and routinely use appropriate and effective approaches for addressing their conditions. We found that prior training is associated with the use of evidence-based approaches; however, adoption of such techniques was not universal among those who received such training. Thus, providers may need additional motivation to use appropriate techniques in their usual practices. Supportive implementation models of training have shown success in increasing clinical skill acquisition and spreading evidence-based treatments among community providers, but other barriers to regular use may remain.⁴²

System- or practice-level performance-monitoring approaches and quality improvement techniques have been shown to improve providers' use of specific evidence-based

approaches.⁴³ These monitoring and improvement strategies may be applied more often within closely managed settings that prioritize quality—therefore, providers working in independent office practices may not be part of any such oversight other than what is provided through reimbursement mechanisms (e.g., claims adjudication processes). As such, motivating providers in private, independent settings within the civilian sector may require that health payers begin to monitor the quality of care provided more closely and consider strategies for incentivizing use of evidence-based approaches, either through altering reimbursement rates or providing preferred referral authorizations (particularly for those providers who choose not to accept any health insurance).⁴⁴

Prior research has demonstrated that there is a business case for providing access to high-quality care for all veterans with PTSD and MDD.⁴⁵ Thus, strategies for facilitating providers' use of evidence-based approaches have the potential to reduce the overall costs of such care and the burden on society associated with undertreated mental health conditions. Based on our findings, it is reasonable to expect that increasing training in and incentivizing providers' use of such techniques will begin to facilitate the delivery of high-quality care to veterans and their families.

Notes

¹ On August 31, 2012, President Obama signed Executive Order 13625, “Improving Access to Mental Health Services for Veterans, Service Members, and Military Families.” Government Printing Office. (2012) Retrieved October 8, 2014, from <http://www.gpo.gov/fdsys/pkg/DCPD-201200675/pdf/DCPD-201200675.pdf>.

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³¹ A logistic regression model was used to predict high cultural competency. Compared to the constant-only model, the full logistic regression model improved discrimination between those with high cultural competency and those that did not meet the threshold (Wald $\chi^2(6)=73.58$, $p<.0001$). Consistent with the bivariate analyses above, the Wald criterion confirmed that, relative to those working outside military or VA settings who are part of the TRICARE network, those working in military or VA settings are more likely to meet the threshold for high cultural competency ($OR=9.62$, $p<.0001$), and those working outside those settings who are not part of TRICARE are less likely to meet the threshold ($OR=0.36$, $p<.01$). The remaining independent variables failed to reach significance. A linear regression predicting the continuous variable for military cultural competency showed similar results.

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³⁴ A logistic regression was conducted to estimate the independent contributions of provider type, military affiliation, attitudes toward CPGs, and years since graduate training to the prediction of having received training/supervision in EBP for PTSD and MDD. Compared to the constant-only model, the full model improved discrimination between trained and untrained psychotherapists (Wald $\chi^2(6)=27.00$, $p<.001$). Consistent with the bivariate analyses, the Wald criterion confirmed that relative to LPC/LMHCs, clinical psychologists ($OR=0.52$) and licensed social workers ($OR=0.28$) were less likely to report receiving adequate training in EBPs for PTSD and MDD ($p<0.05$). The remaining predictor variables failed to reach significance.

³⁵ A logistic regression, in which all variables were entered simultaneously, examined the independent contribution of provider type, affiliation, attitudes toward CPGs, years since graduate training, and training in EBPs to the prediction of whether the provider used EBPs with most of their PTSD and MDD patients. The full model improved discrimination relative to the intercept-only model (Wald $\chi^2(7)=28.5$, $p<.001$). Consistent with the bivariate analyses, positive attitudes toward CPGs increased the likelihood that the provider would deliver EBPs to their patients ($OR=1.08$, $p<.0001$). As the length of time since a provider's clinical education increased, the likelihood that they would deliver EBPs to their patients with PTSD and MDD declined ($OR=0.97$, $p<.01$). Finally, providers who were trained in at least one MDD and one PTSD EBP were 1.6 times more likely to deliver EBPs to the majority of their patients ($OR=1.62$, $p<.05$). Provider type and affiliation were not significantly related to self-reported delivery of EBPs in the model.

³⁶ A logistic regression was conducted to estimate the independent contributions of provider type, affiliation, attitudes toward CPGs, years since graduate training, and training in EBPs to a prediction of likelihood of "often" or "always" implementing EBP techniques. Compared to the constant-only model, the full model improved discrimination between therapists who consistently versus inconsistently implement evidence-based techniques (Wald $\chi^2(7)=35.10$, $p<.0001$). Providers with positive attitudes toward CPGs were more likely to consistently implement EBP techniques ($OR=1.08$, $p<.001$). Providers who had been trained to deliver EBP were twice as likely to do so relative to those without training ($OR=2.16$, $p<.01$). The remaining model variables failed to reach significance.

³⁷ The White House, *Fact sheet: President Obama announces new executive actions to fulfill our promises to service members, veterans, and their families*, August 26, 2014. Retrieved October 14, 2014, from <http://www.whitehouse.gov/the-press-office/2014/08/26/fact-sheet-president-obama-announces-new-executive-actions-fulfill-our-p>

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Eric Robinson is a research programmer and analyst at the RAND Corporation. His research focuses on data-driven analyses of military personnel and operations. He was a coauthor and lead data analyst for Hidden Heroes, RAND's nationwide survey and assessment of military caregivers, and has contributed to the RAND Deployment Life Study.

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Lisa H. Jaycox is a senior behavioral scientist who focuses on trauma, interventions, and mental health services for both adults and children. Her research is especially focused on dissemination of evidence-based practices into community settings, and evaluation of existing practices that focus on depression and anxiety.

About This Report

Ensuring that military veterans and their families have access to high-quality mental health care is a national priority. Over the past several years, the Departments of Defense and Veterans Affairs have increased the number of mental health professionals working within their facilities and have rolled out training and quality improvement initiatives designed to promote the use of evidence-based treatments. Despite these important efforts, research continues to demonstrate that many veterans prefer to seek services outside the Department of Defense and/or the Department of Veterans Affairs. Thus, providers working in the civilian sector are an increasingly important part of the overall mental health workforce addressing veterans' mental health needs.

To better understand a key aspect of our nation's ability to provide veterans and their families with access to high-quality mental health care, RAND conducted a survey of civilian mental health providers to gather information about their knowledge, attitudes, and preferences for delivering services to veterans and their families. This report provides the results of that survey. The findings and recommendations from this study should be relevant to individuals, organizations, and policy officials concerned about the capacity of the civilian health care sector to deliver culturally competent, high-quality services to veterans and their families.

The authors wish to thank several individuals who helped make this study a success. First, we thank Shelly Espinosa, Tracy Malone, and Kathy Beasley for their guidance and support with this project. We thank the mental health professionals who took the time to participate in our survey, as well as Carolyn Chu and Michael Lawrence from GfK Custom Research, who facilitated the implementation of the survey.

We thank our quality assurance reviewers, Lisa Meredith and David Riggs, for their constructive reviews. Collectively, their comments and feedback greatly enhanced the report. We also thank our report production team of editors and designers, including Arwen Bicknell, Steve Oshiro, and Tanya Maiboroda.

This research was sponsored by the United Health Foundation in collaboration with the Military Officers Association of America and conducted within RAND Health. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health. This research was co-led by Terri Tanielian and Lisa H. Jaycox. Questions about the report may be directed to Terri_Tanielian@rand.org.

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Good afternoon Dr. Shulkin,

I watched your confirmation and the Town Hall this afternoon. I hope that you will read my letter and help get the answers I would like to have regarding the use of Licensed Professional Mental Health Counselors and Licensed Marriage and Family Therapists in the VA. The letter and the questions documents pertain to my concerns. The RAND report and Commission on Care are supplemental evidence to support my argument. Thank you for your consideration.

Regards,

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Commission on Care

Final Report



COMMISSION ON CARE

June 30, 2016

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COMMISSION ON CARE

Final Report of the Commission on Care

June 30, 2016

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COMMISSION ON CARE

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June 30, 2016

We are honored to submit to the President, through the Secretary of Veterans Affairs, in accordance with the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), the enclosed recommendations for transforming veterans' health care. We believe these recommendations are essential to ensure that our nation's veterans receive the health care they need and deserve, both now and in the future.

We worked with an absolute commitment to putting veterans at the heart of our deliberations, and believe our recommendations will create an integrated, community-based health care system for veterans that will be sustainable for the long term. During the term of the Commission on Care, we evaluated the 4,000-page *Independent Assessment Report*; held public meetings; listened to a broad range of stakeholders, including veterans and leaders of veterans service organizations; made site visits to Veterans Health Administration (VHA) facilities; and exchanged ideas with individual veterans, VA and VHA leaders, VHA employees and health care providers, members of Congress, economists, and health care experts.

Overall, the Commissioners agree with the findings of the *Independent Assessment Report*, which are consistent with the expansive body of other evidence the Commissioners have reviewed. This evidence shows that although care delivered by VA is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes. The Commissioners also agree that America's veterans deserve much better, that many profound deficiencies in VHA operations require urgent reform, and that America's veterans deserve a better organized, high-performing health care system.

The most public and glaring deficiency was access problems. Congress attempted to solve this problem through a provision in VACAA that directed VHA to implement a temporary program allowing for greater choice. The Commission finds, however, that the design and execution of the *Choice Program* are flawed. In its place, we offer specific recommendations for standing up integrated veteran-centric, community-based delivery networks that will optimize the balance of access, quality, and cost-effectiveness.

The Commission also finds that the long-term viability of VHA care is threatened by problems with staffing, facilities, capital needs, information systems, health care disparities and procurement. Fixing these problems requires deliberate, concurrent, and sequential actions. It also requires fundamental changes in governance and leadership of VHA to guide the organization during the next two decades through the rapid changes coming in demographics, technology, and in the structure of the overall U.S. health care system.

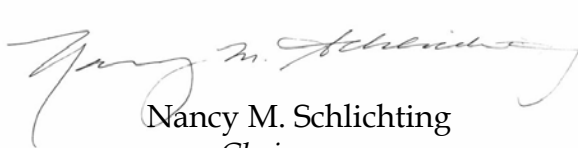
VHA has many excellent clinical programs, as well as research and educational programs, that provide a firm foundation on which to build. As the transformation process takes place, VHA must ensure that the current quality of care is not compromised, and that all care is on a trajectory of improvement. VHA has begun to make some of the most urgently needed changes outlined in the *Independent Assessment Report*, and we support this important work.

Implementing the recommendations in this report will greatly enhance VHA's ongoing reform efforts by providing both a systems-oriented framework and vitally needed changes in organizational structure. Foundational among these changes is forming a governing board to set long-term strategy and oversee the implementation of the transformation process, and building a strong, competency-based leadership system.

The remaining recommendations work in harmony to ensure veterans receive timely access to care, have options for where and how they receive care, are cared for in an environment that embraces diversity and inclusion, and are supported in making informed decisions about their own health and well-being. These recommendations are

not small-scale fixes to finite problems. Instead, they constitute a bold transformation of a complex system that will take years to fully realize, but that our country must undertake to provide our veterans with the high-quality health care they richly deserve.

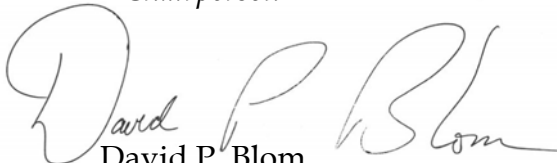
Respectfully Submitted,



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Vice Chairperson



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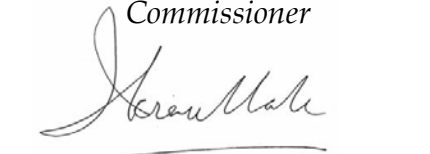
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EXECUTIVE SUMMARY

Two years ago, a scandal over VHA employees' manipulation of data systems to cover up long appointment scheduling delays made headlines and left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. The White House appointed new leadership, including the secretary of veterans affairs (SECVA) and the undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program*, to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The independent assessment included an examination of the hospital care, medical services, and other health care provided in VA medical facilities.¹ The legislation identified 12 specific areas for in-depth evaluation:

- Demographics
- Health Care Capabilities
- Care Authorities
- Access Standards
- Workflow–Scheduling
- Workflow–Clinical
- Staffing/Productivity
- Health Information Technology
- Business Processes
- Supplies
- Facilities
- Leadership

The *Independent Assessment Report* provided a detailed analysis of the assessment and associated findings. The Commission work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

In an effort to focus the Commission's recommendations and set the tone for subsequent change, the Commissioners developed a vision, a mission, and a set of values to drive reform as shown below. The vision provides the conceptual framework for the model of veterans' health care put forth in this report, and the mission and values shape the content of the recommendations.

Vision

Transforming veterans' health care to enhance quality, access, choice, and well-being.

- *Quality: Provide community-based, innovative care that drives improved outcomes.*
- *Access: Ensure timely access to the best providers for meeting veterans' health care needs.*

¹ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113–146, § 201(a)(1).

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- *Choice: Integrate health care within communities to foster convenience and efficiency.*
- *Well-Being: Support veterans in achieving optimal physical and mental health.*

Mission

Provide eligible veterans prompt access to quality health care.

Values

- Provide veteran-centric care.
- Involve all stakeholders, and especially veterans and their families, in designing the evolving future health care for veterans.
- Assimilate veterans into the greater community.
- Create community-based integrated networks to improve health care access and choice for veterans.

The recommendations in this report acknowledge that although VHA provides health care that is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes.

Some of these challenges are not exclusive to VHA, and reflect large-scale problems in the U.S. health system in general, such as acute shortages of primary care doctors and lack of health care capacity in poor and rural areas. Other challenges reflect deficiencies within VHA itself, in areas such as staffing, facilities, capital needs, information systems, healthcare disparities and procurement.

It is important to understand VA's long history as a health care provider, which has included previous cycles of crisis and renewal that offer lessons for the present. It is also important to consider how VHA can implement major reform in a manner that is sustainable. This report addresses both of these issues.

The Commission's focus on access to care clearly highlighted the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The report begins with an *Introduction* that addresses the controversy over veterans' health care and gives a brief description of the Commission's vision for improving it. There are three main recommendation sections: *Redesigning the Veterans' Health Care Delivery System*; *Governance, Leadership, and Workforce*; and *Eligibility*. Each section includes detailed discussions of the high-level areas in which change must occur in the respective areas to facilitate bold reform. The format for each discussion includes identification of the problem, the Commission's recommendations for addressing the problem, background information, analysis, and implementation steps for Congress, VA, and other agencies. This executive summary provides a brief overview of each of the recommendations.

For the ease of our readers, the appendices contain all additional content. Of particular interest are appendices on *Financing the Vision and Model, Leadership Implementation, History as a Context for Systemic Transformation, Veteran Feedback, and Additional Resources*. These and other appendices provide policymakers and those charged with implementing the plan with a clear picture of the rationale for the recommendations and the context that frames them.

Recommendations

The Commission does not intend for these recommendations to be piecemeal fixes to everyday problems. Instead, they are presented as the foundation for far-reaching organizational transformation that adheres to a systems approach. The Commission's recommendations comprise the essential elements for such transformation.

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Due to changing veteran demographics, increasing demand for VHA care in some markets and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Congress tasked VHA with creating the temporary *Choice Program*. It was designed to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

The Commission Recommends That . . .

- VHA Care System governing board (see recommendation on p. 94) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.

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- Integrated community-based health care networks be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.
- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

The recommendations above work together to support the VHA Care System, as outlined in Table 1 below.

Table 1. VHA Care System Operations

Key Component	Expectations
Choice	<ul style="list-style-type: none"> ▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	<ul style="list-style-type: none"> ▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.²

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.³ For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified “not working to top of provider licensure” as a barrier in health care provision.⁴

² RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

³ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁴ Ibid., 95.

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VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

The Commission Recommends That. . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally supported programs.

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.⁵ Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).⁶

As part of the MyVA initiative, the Secretary of Veterans Affairs has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.⁷ The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.⁸

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a revised clinical-appeals process.

⁵ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

⁶ VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷ "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, <http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx>.

⁸ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.⁹

VHA has a program of system engineering — Veterans Engineering Resource Center (VERC) — that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to identify proactively problem areas within the system and offer assistance.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*, Assessment F (Workflow—Clinical), 14 and A-2, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

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A systematic review of VHA in 2007 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.¹⁰ VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues—the Health Equity Action Plan (HEAP)—but it has not been fully implemented.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.¹¹

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

Veterans who turn to VHA to meet health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of those barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks holds the promise of markedly improving veterans' access to care. That promise cannot be realized without transformative changes to VHA's capital structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of building out the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as

¹⁰ Somnath Saha et al., *Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review*, U.S. Department of Veterans Affairs, Health Services Research & Development Service, June 2007, accessed June 22, 2016, <http://www.hsrd.research.va.gov/publications/esp/RacialDisparities-2007.pdf>.

¹¹ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

much control as possible to drive the process to ensure that all facility plans are fully integrated with the strategic vision for the VHA Care System.

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meets its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission (BRAC) process to be implemented as soon as practicable. The Commission recommends the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems; enables scheduling, billing, claims, and payment, and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.¹² VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, VHA lacks an experienced senior health care IT leader focusing on the strategic health care IT needs of veterans.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing

¹² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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and implementing a comprehensive health IT strategy and developing and managing the health IT budget.

- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.¹³

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.

¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

Governance, Leadership, and Workforce

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center, and similar problems at multiple other VA medical centers, had both direct and indirect causes. Weak governance was found to be among those indirect causes.¹⁴ As the authors of a root-cause analysis of the Phoenix scandal highlighted, “a governance gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed to the wait-time problems.¹⁵ The report authors observed, “Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors.”¹⁶ The governance limitations made evident in the Phoenix scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration’s expectations for short-term results,¹⁷ and VHA’s operating in a “dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with competing demands”¹⁸ offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act (FACA) and be structured based on the key elements included in Table 5.

¹⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁵ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

Leadership

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

High-performing organizations have healthy cultures in which diverse staff feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government. For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

The Commission Recommends That . . .

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report on it to the CVCS and the new VHA Care System board of directors (see governance discussion in the previous section).

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and

promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an OMB management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and the functions overlap or are duplicated. The role of the VISN is not clear, and the delegated responsibilities of the medical center director are not defined.

The Commission Recommends That . . .

- VHA redesign VHACO to create high-performing support functions that serve VISNs and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the CVCS with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report.

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Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

To achieve the Commission’s vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set—identical to private-sector standards—will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes to veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders’ performance not just on *what* they achieve but *how* they achieve it.

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Personnel Performance Management System

- VHA create a new performance management system appropriate for health care executives, tied to health care executive competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of

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these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veterans' care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does all of the following:
 - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
 - Promotes veteran preferences and hiring.

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- Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, due process) through simplified, sensible processes that work for managers and employees.
 - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
 - Provides due process and appeals standards to adverse personnel actions.
 - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
 - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
 - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
 - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
 - Grandfathers current employees with respect to pay and benefits.
- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

Recommendation #16: Require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Effective planning for and management of human capital are core enabling requirements for any business: If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

The Commission Recommends That . . .

- VHA hire a chief talent leader who holds responsibility for the operation's entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the chief of VHA Care System.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.

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- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

In some cases, individuals have been dismissed from military services with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury [TBI], posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

The Commission Recommends That . . .

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an OTH discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Although VHA continues to offer the promise of health care to all eligible veterans, its capacity to meet that promise is constrained by appropriated funding.¹⁹

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use

¹⁹ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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underutilized VHA providers and facilities, providing payment through private insurance.

- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

Conclusion

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, though, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient-provider engagement and in where and how care is delivered. VHA must keep pace with, and even be a leader in, these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand access to reflect not only timeliness, but care quality, and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone: Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report* emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The Commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term transformation, the Commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the nation's obligation to those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission fully acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the Commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For

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example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net. Even considering these strengths, some may question how a system beleaguered with the problems VHA faces can achieve lofty transformation goals. This is not the first time VHA has faced challenges; however, and history has demonstrated that with appropriate structure and strategies in place, transformation can be achieved and sustained.

Transformation is a difficult process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. The Commission's recommendations in some areas acknowledge VHA's efforts to begin the transformation process and suggest that where these efforts align with the Commission's recommendations, they should be sustained. Reaping the fruits of transformation will take more than a single Congress or a single 4-year administration. For this reason, the Commission strongly recommends a new governance model and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission's recommendations, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

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INTRODUCTION

Two years ago, a scandal over VHA employees manipulating data systems to cover up long delays in scheduling care left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. In response, the White House appointed new leadership, including the secretary of veterans affairs (SECVA) and undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program*, to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The Commission on Care's work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

The charge given this Commission, with its emphasis on access to care, reflects the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the Commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, however, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient-provider engagement, and in where and how care is delivered. VHA must keep pace with, and even be a leader, in these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand *access* to reflect not only timeliness, but care quality and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone; Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report*

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emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term *transformation*, the commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the obligation owed those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net.

Others may question how a system with the range of problems VHA faces can meaningfully improve, let alone realize a transformation. Mindful of its 20-year charge, the Commission notes that VA health care faced similar challenges 20 years ago and underwent a historic transformation. The long history of the VA health care system has seen highs and lows. Among the lessons in that history is that the mission—to care for those who have borne the battle—is not only powerful, but enduring. History has demonstrated that transformation can be achieved, but also that structures and strategies for sustainability must be built into the framework.

As the commission report emphasizes, transformation is difficult. It is a process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. VHA has begun some of this work; our recommendations in some areas acknowledge VHA's efforts and suggest that where they are aligned with the Commission's recommendations, they should be sustained. The fruits of the transformation, though, will not be realized over the course of a single Congress or a single 4-year administration. For this reason, the Commission, strongly recommends a new form of governance and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission recommends, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

COMMISSION RECOMMENDATIONS

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Problem

Due to changing veteran demographics, increasing demand for VHA care in some markets, and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With the passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACA), Congress tasked VHA with creating the temporary *Choice Program*. It was intended to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

The Commission Recommends That . . .

- VHA Care System governing board (see Recommendation #9) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.
- Integrated, community-based health care networks be developed with *local* VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.

Recommendations continue on next page. =>

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Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

Background

VHA has long had authority to purchase hospital care and medical services based on geographic inaccessibility or VHA's lack of a required service.²⁰ In 2013, VA moved beyond the use of individual purchased-care authorizations to regional contracting under the Patient-Centered Community Care (PC3) Program.²¹ In all cases, purchased care was a secondary means of providing care, to be used "when VA health care facilities are not feasibly available."²² Even before the creation of the *Choice Program* in 2014, some 10 percent of VHA medical spending went for purchased-care services.

When Congress enabled what became known as the *Choice Program*, it tasked VHA with implementing a fundamentally new mechanism for purchasing care. Unlike traditional purchased-care authority (which still exists), the *Choice Program* promises veterans who meet specific geographic or wait-time-related criteria that they can elect to receive treatment from within a network of a community providers.²³

Under the current *Choice Program*, however, most VHA patients are promised little or no actual choice of providers outside VHA. To be eligible for the program, VHA patients must meet the following criteria:²⁴

The Commission Recommends That . . .

<= Recommendations continued from previous page.

- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- The VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

²⁰ Contracts for Hospital Care and Medical Services in Non-Department Facilities, 38 U.S.C. § 1703(a).

²¹ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, 37, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

²² Non-VA Medical Care Program, VHA Directive 1601, (2013).

²³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014).

²⁴ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014), as amended by Construction Authorization and Choice Improvement Act, Pub. L. No. 114-19, 129 Stat. 215, (2015). The Independent Assessment proposed that VA should "Develop and implement more sensitive standards of geographic access to care. VA should compare the 'one-size-fits-all' approach of driving distance to alternative standards that are more sensitive to differences between Veteran subgroups, clinical populations, geographic regions, and individual facilities. This

- Live more than 40 miles from the closest VHA facility with a full-time primary care provider
- Cannot be seen within 30 days of the date veterans' providers indicate they need to be seen.
- Cannot be seen within 30 days of veterans' preferred appointment date if providers have not provided a specific appointment date.

This standard is difficult to reconcile with other statutory priorities for VA care.²⁵ For example, under the *Choice Program*, a veteran with severe service-incurred health conditions may have no access to providers outside VHA, yet a veteran with no service-related disabilities does have such a choice.²⁶ Implementing the *Choice Program* has posed challenges, including difficulties arising from overlapping, but fundamentally different, care-purchasing authorities. Veterans, VHA staff, and community providers²⁷ have been confused because of conflicting requirements and processes in eligibility rules, referrals and authorizations, provider credentialing and network development, care coordination, and claims management.²⁸

Adding to the confusion is the fact that VHA, facing a 90-day deadline for implementing the program, outsourced the creation and management of its provider networks to two private contractors, thus blurring lines of responsibility and leaving both patients and providers confused about who exactly holds responsibility for what. In execution, the program has aggravated wait times and frustrated veterans, private-sector health care providers participating in networks, and VHA alike.²⁹

In October 2015, VA submitted a report to Congress that proposed legislation to harmonize the different purchased-care authorities into a single approach.³⁰ VA's report also set out a plan for establishing high-performing networks. The report acknowledged that "[n]o organization can excel at every capability," and that "[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers."³¹ As further articulated by Dr. David Shulkin, USH:

assessment highlighted the importance of time spent driving, mode of transportation, traffic, and availability of needed services as key considerations in assessing geographic access to care."

²⁵ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705.

²⁶ Ibid.

²⁷ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, 43, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf. Pete Henry, retired VA medical center director, response to questions about the challenges facing field officials, email to Commission on Care staff, January 18, 2016.

²⁸ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

²⁹ "Despite \$10B 'Fix,' Veterans are Waiting Even Longer to See Doctors," Quil Lawrence, Eric Whitney, and Michael Tomsic, accessed May 16, 2016, <http://www.npr.org/sections/health-shots/2016/05/16/477814218/attempted-fix-for-va-health-delays-creates-new-bureaucracy>.

³⁰ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

³¹ Ibid., 18.

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It's become apparent that the VA alone cannot meet all the health care needs of U.S. veterans. The VA's mission and scope are not comparable to those of other U.S. health systems. Few other systems enroll patients in areas where they have no facilities for delivering care. Fewer still provide comprehensive medical, behavioral, and social services to a defined population of patients, establishing lifelong relationships with them. These realities, combined with the wait-time crisis, have led the VA to reexamine its approach to care delivery . . . [A]ddressing veterans' needs requires a new model of care: rather than remaining primarily a direct care provider, the VA should become an integrated payer and provider. This new vision would compel the VA to strengthen its current components that are uniquely positioned to meet veterans' needs, while working with the private sector to address critical access issues.³²

Analysis

VHA needs systemic transformation, and merely clarifying and simplifying the rules for purchased care, as proposed in the *Independent Assessment Report*, is not sufficient to achieve that goal. VHA must replace the arbitrary eligibility requirements and unworkable clinical and administrative restrictions of current purchased programs with the new VHA Care System, available to all enrolled veterans.

The VHA Care System is defined as VHA employed providers and facilities; Department of Defense (DoD) and other federally-funded providers and facilities; and community-based, VHA-credentialed community providers and facilities, forming integrated networks to deliver high-quality and high-access care to enrolled veterans across the United States. VHA may establish the networks with the use of national contractors or with internal resources, but networks should be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.

This new delivery model must preserve critical VHA programs and competencies that are unique to VHA or that are of higher quality or greater scope than is available in the private sector, either locally or nationally³³ They include specialized behavioral health care programs, integrated behavioral health and primary care (in patient-aligned care teams), specialized rehabilitation services, spinal cord injury centers, and services for homeless veterans.³⁴ These and similar programs and services are core competencies and special capabilities that serve the needs of combat veterans, veterans with conditions incurred or aggravated in service, and veterans reliant on safety-net services and supports.³⁵ Because of its unique capabilities and competencies, VHA should play an important role in expanding and enhancing the care of veterans across the United States by collaborating with local network providers to improve the

³² David J. Shulkin, "Beyond the VA Crisis — Becoming a High-Performance Network," *New England Journal of Medicine*, 374, (2016): 1003-1005, accessed June 15, 2016, <http://doi.org/10.1056/NEJMp1600307>.

³³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

³⁴ Special capabilities like spinal cord injury care, which draw from specialty care available in the full-service hospitals in which they are currently provided, merit continued support and investment. Thus, in instances where VHA might no longer operate a full-service hospital that had once housed a spinal cord injury center, it would need to establish community partnerships to assure veterans would continue to receive the same high quality care.

³⁵ David J. Shulkin, "Why VA Health Care Is Different," *Federal Practitioner*, 33, no. 5 (2016): 9-11, <http://www.fedprac.com/home/article/why-va-health-care-is-different/c8da5ba1261bdbc726bdddcbceea81f27.html>.

availability and quality of care in areas especially needed by veterans, such as mental health and rehabilitation.

Management and Oversight

VHA Care System networks will be built out in a well-planned, phased approach overseen by the new governing board, which will determine the criteria and sequencing for the phases, to ensure effective execution of the strategy. The timing and phasing criteria may include veteran service needs, access issues, quality issues, facility issues, and IT capabilities.

The networks within the VHA Care System will require ongoing management and evaluation of their performance. This process will be the responsibility of VHA management and board, with board oversight of network performance.

The governing board will oversee the budget for the VHA Care System. Local leadership will provide input on funding, and the local networks will determine their funding needs and submit their respective requests to the chief of VHA Care System (CVCS), formerly the undersecretary of health for VHA. The governing board will recommend to Congress the budget required to implement the VHA Care System, with multiyear appropriations. The local network leaders will have the flexibility to manage their respective network budgets based upon local needs. A key element of the new system will be combining a national strategy and local flexibility for managing the budget to allow for effective decision making to ensure veterans' needs are met.

Provider Payment

Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS). MACRA is intended to move the health care industry away from a fee-for-service model to value-based payments.³⁶ Such a system is expected to drive improved quality and lower costs.³⁷

Care Administration

From a strategic perspective, service-connected disabled veterans should receive the highest priority access to the VHA Care System. This principle should guide access to all types and points of care. Veterans with limited financial means should also have high priority. If needed, cost sharing (applicable only to those who are non-service-connected disabled and not financially needy) can provide a means for offering broader choice. The current time and distance criteria for community care access (30 days and 40 miles) should be eliminated. VISN geography should also be eliminated as a factor in determining where veterans can access care. Eligible veterans should be permitted to receive care at any facility and by any provider in the VHA Care System, whether in a veteran's home VISN or not.

Choice and Care Coordination

The topic of choice was the most contentious issue considered by the Commission. Some Commissioners advocated complete choice of providers for veterans, with no requirement for

³⁶ "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, <http://www.nationalpartnership.org/issues/health/macra.html>.

³⁷ Ibid.

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care coordination by primary care physicians. Others advocated for a tightly managed model with VHA controlling access to community providers, as is done today. After considering the costs of various design options, the importance of care coordination, and the need for greater veteran access to both primary care and specialty care services, the Commission agreed to the following design principles:

- VHA will establish and credential community networks with a focus on quality of providers, access to comprehensive services, and utilization of VHA resources.
- Veterans will have complete choice of primary care providers within the VHA Care System.
- All primary care providers in the VHA Care System (including VHA providers, DoD and other federally funded providers, and community providers) will coordinate veterans' care.
- Specialty care will require a referral from a primary care provider.
- VHA will assume overall responsibility for care coordination and navigation for all enrolled veterans.

Quality of care must be a core element of network design and consistently monitored with metrics that are routinely used by the private sector. Accordingly, VHA must adopt standards that both ensure networks are composed of high-quality providers and set appropriate expectations of those providers. Critically, all providers in the networks must have fully interoperable IT platforms to allow for complete data exchange. Providers must work together to maximize patients' well-being using evidence-based protocols of care.

Lack of coordination among providers is a major quality and patient-safety issue throughout the U.S. health care system. It is important for VHA to coordinate the care it provides because it serves an especially vulnerable population that has more chronic medical conditions, behavioral health conditions, and individuals of lower socioeconomic status than the general medical population.³⁸ Veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers.³⁹

³⁸ Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, <http://doi.org/10.1001/jama.2012.196>.

³⁹ "The Impact of the Affordable Care Act on VA's Dual Eligible Population," Patricia Vandenberg et al., Department of Veterans Affairs, accessed June 2, 2016, <http://www.hsrd.research.va.gov/publications/forum/apr13/apr13-1.cfm>. Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, <http://doi.org/10.1001/jama.2012.196>. Brigham R. Frandsen et al., "Care Fragmentation, Quality, and Costs Among Chronically Ill Patients," *American Journal of Managed Care*, 21, no. 5, (2015): 355-362, accessed June 20, 2016, <http://www.ajmc.com/journals/issue/2015/2015-vol21-n5/care-fragmentation-quality-costs-among-chronically-ill-patients>. Chuan-Fen Liu et al., "Use of Outpatient Care in Veterans Health Administration and Medicare among Veterans Receiving Primary Care in Community-Based and Hospital Outpatient Clinics," *Health Services Research*, 45, no. 5 part 1, (2010): 1268-1286, accessed June 20, 2016, <http://doi.org/10.1111/j.1475-6773.2010.01123.x>.

VHA Care System will operate as outlined in Table 2 below.

Table 2. VHA Care System Operations

Key Component	Expectations
Choice	<ul style="list-style-type: none"> ▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	<ul style="list-style-type: none"> ▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Scope of Provider Networks

In setting up networks within the VHA Care System, VHA must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans' choice, yet would also consume far more financial resources (i.e., taxpayer dollars) due to increased utilization or cost shifting. Currently, money VHA spends on expanding choice is not available to spend on other programs and services vital to its mission.⁴⁰

Health plans commonly limit the size and scope of networks as a cost-management tool, offering insurance products with narrow networks (managed care plans) or more open networks (preferred provider plans). Well-managed, narrow networks can maximize clinical quality by requiring participating clinicians to adhere to evidence-based protocols of care.⁴¹ Achieving high quality and cost effectiveness may constrain consumer choice. A patient's preferred doctor, clinic, or hospital may not be part of that smaller network or the narrow network may not offer sufficient geographic access for some patients.⁴²

VHA must balance these competing considerations. In doing so, it faces a variety of options. In addition to the scope of networks, for example, is the question of whether and how VHA will play a role in steering patients to different providers within the networks. This is another area involving tradeoffs among competing values and considerations. Private-sector health plans

⁴⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 23 accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴¹ "What Tier Networks Will Mean to You," Ken Terry, accessed June 2, 2016, <http://medicaleconomics.modernmedicine.com/medical-economics/content/what-tiered-networks-will-mean-you>.

⁴² Ibid. U.S. Congress, House of Representatives, Committee on Ways and Means, Subcommittee on Health, *Hearing on "Health Care Consolidation"*, 112th Congress, 1st Session, (2011), (Statement of Paul B. Ginsburg, President, Center for Studying Health System Change, Research Director, National Institute for Health Care Reform), accessed June 2, 2016, http://waysandmeans.house.gov/UploadedFiles/Ginsburg_Testimony_9-9-11_Final.pdf.

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often require all specialty care to be preapproved through a referral from a primary care physician. Managed care plans may also use prospective and concurrent utilization review and care management for hospitalization. For prospective reviews, patients must receive approval from their health plan before being admitted to the hospital to ensure the admission is clinically appropriate. Plans may also use concurrent utilization or case management for inpatient care to ensure the care and tests ordered and the length of stay in the hospital are appropriate.⁴³

The Commission carefully weighed these issues in recommending an approach. The Commission considered the effect of cost using various configurations of VHA services and community delivered services (CDS). Options considered by the commission include the following:

- **Recommended Option:** This option provides an integrated network of VHA, DoD and other federally funded providers, and community providers, credentialed by VHA. It requires veterans to attain a referral from their primary care provider to access specialty care.
- **CDS Alternative 1:** The main difference between this option and the *Recommended Option* is primary care, inpatient medical and surgical care, and some standard specialty care would not be eligible for CDS networks and would be accessed within VHA unless the *Choice Program* distance exception applies.
- **CDS Alternative 2:** The division of care between VHA providers and CDS network providers would be the same as for *CDS Alternative 1*; however, veterans would only need to consult their primary care provider before seeking specialty care, rather than obtaining a referral.
- **CDS Alternative 3:** This option would combine the broad network in the *Recommended Option*, but would have no referral or consultation requirement; thus, it would be an extremely generous benefits package.
- **Premium Support:** Under this scenario, enrollees who are younger than 65 would choose a subsidized insurance premium with cost sharing. Access to VA services, including special services, would be eliminated.
- **Eligibility Expansion:** Under this scenario the VA health care system would expand to allow all veterans, regardless of priority group.
- **Other-Than-Honorable Discharges:** A policy change for which individuals with other-than-honorable (OTH) discharge is outlined in Recommendation #17. This option would allow temporary eligibility for VA health care to those with an OTH discharge until the adjudication process to determine long-term eligibility took place.

⁴³ Paul B. Ginsburg, "Achieving Health Care Cost Containment Through Provider Payment Reform that Engages Patients and Providers," *Health Affairs*, 32, no. 5, (2013): 929-934, accessed June 20, 2016, <http://doi.org/10.1377/hlthaff.2012.1007>. While these approaches can help keep costs down, patients, doctors and hospitals can experience the process as bureaucratic interference in clinical care. To implement utilization management, health plans usually include a strong clinical appeals process that both doctors and patients can access to question the decisions made by administrators.

Below is a more detailed summary of the Commission's *Recommended Option*. Additional information, including cost projections for all of the options above, can be found in Appendix A.

Cost Model for Commission Recommended Option

This option would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VHA. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in a substantially different way than by VHA).⁴⁴ In 2014, 68 percent of care would have been eligible for CDS networks at current VHA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network (i.e., from any provider in the VHA Care System). In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

Both CDS networks and traditional Care in the Community (CITC) are priced at Medicare allowable rates by matching Medicare fee schedule data to VA Health Service Categories.⁴⁵ A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities. For care shifting into the CDS networks, we assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance; those costs are not modeled.

We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a provider in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and

⁴⁴ Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health, and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

⁴⁵ Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

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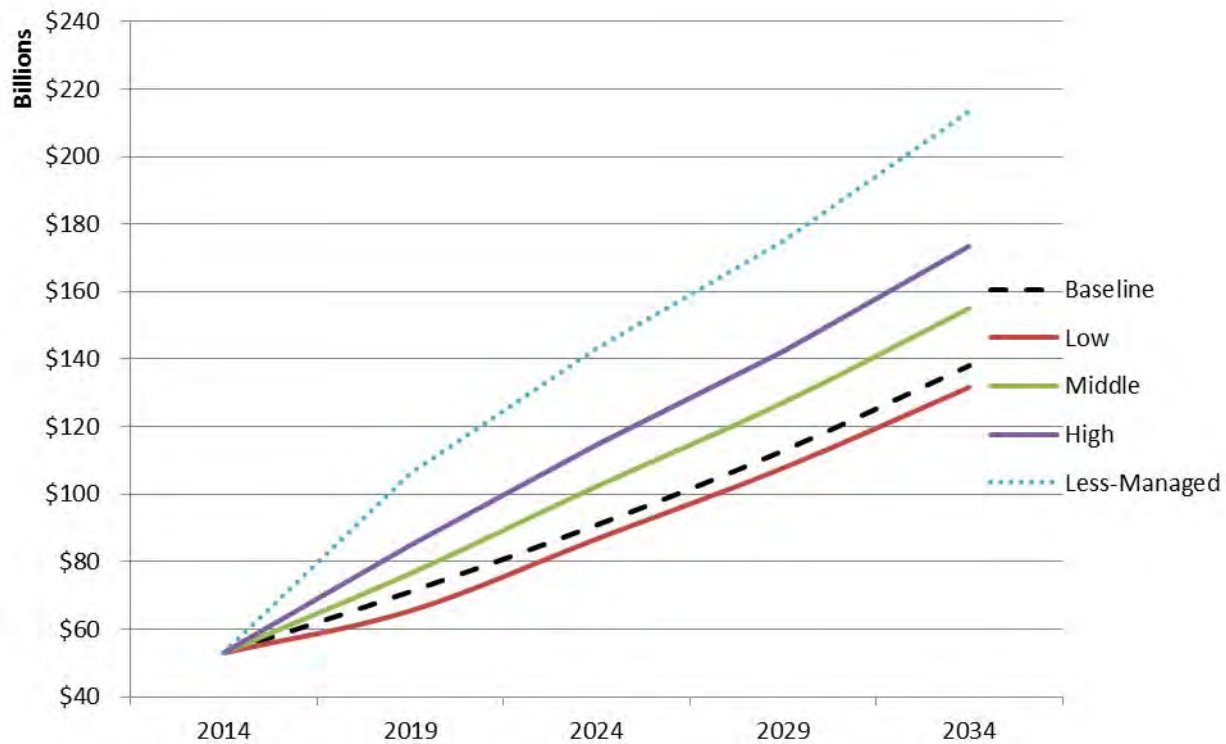
20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was formerly subject to sizable cost sharing with private insurance or Medicare and now would be subject to little, if any, cost sharing associated with VA-financed care.

There are a number of caveats associated with our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects on quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. Finally, estimates do not include administrative costs associated with CDS networks; these costs could be substantial.

Figure 1 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from \$65 billion to \$85 billion in 2019, with a middle estimate of \$76 billion. The middle estimate is moderately above the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is \$106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

This model is described more fully in Appendix A, along with models for a range of other options, some of which are previously described in this section. Consult Appendix A for more details on the technical assumptions necessary to understand the results presented here. The assumptions and caveats detailed in Appendix A play a critical role in our estimates, and any deviation from these assumptions could substantially affect the estimates.

Figure 1. Projected Costs of Recommended Option



Mitigating Risks

Choice involves tradeoffs. Reducing drive times to see a doctor may lead to longer wait times, for example, if it induces substantially more veterans to seek more care.⁴⁶ VHA reliance on contracting could also have unintended consequences for already underserved communities. Providers in such communities who join the local VHA network may decide to limit the number of Medicare and Medicaid patients they accept into their practices. In other, highly concentrated health care markets, which are increasingly common throughout the United States, VHA may not be able to contract for care in the community except at higher prices.⁴⁷ Such circumstances underscore the importance of VHA retaining the option of building its own capacity.

Policymakers must also carefully weigh concerns that leaders of seven major veterans organizations expressed in a recent joint letter in which they warned “choice should never be the ultimate goal of a health care system designed to meet the unique needs of veterans.”⁴⁸ These organizations do not support providing unfettered choice, and the VSO leaders stated that “any health care reform proposal that elevates the principle of ‘choice’ above all other clinical considerations would have severe consequences for veterans who rely on VA, resulting

⁴⁶ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 284, accessed May 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁴⁷ David M. Cutler and Fiona Scott Morton, “Hospitals, Market Share, and Consolidation,” *Journal of the American Medical Association*, 310, no. 18, (2013): 1964-1970, accessed June 20, 2016, <http://doi.org/10.1001/jama.2013.281675>.

⁴⁸ Garry J. Augustine, Disabled American Veterans et al., letter sent to Commission on Care, April 29, 2016.

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in less ‘choice’ rather than the intended desire for more health care options for many disabled veterans.”⁴⁹

The Commission has addressed this concern in several ways, including the following:

- recommendations to substantially improve VHA operations, thereby enhancing the attractiveness of using VHA providers and facilities by enrolled veterans
- VHA control of network design
- VHA Care System governing board oversight of network execution and phasing
- high standards for community provider participation, including credentialing, military competence, and quality and utilization performance
- VHA oversight of care coordination and navigation
- requirement of primary care referral for specialty care

The Commission recognizes that greater choice of provider can result in higher utilization of health care services, which increases costs. This risk can be mitigated by recommendations in this report that will produce cost savings. To incentivize cost mitigation, all cost savings associated with improved efficiency and operations should be reinvested into the VHA Care System. Examples of cost mitigation strategies include the following:

- recovering third-party payments owed to VHA more effectively
- maintaining VHA as a secondary payer when veterans have other health insurance and treatment is for non-service-connected care
- increasing cost-sharing or changes in eligibility and/or benefit design could also substantially contain the projected costs of increasing provider-choice
- reducing fixed costs of underutilized facilities and services
- managing the supply chain to produce cost savings
- improving facilities to increase provider productivity (e.g., increase in outpatient exam rooms)
- adopting information technology that improves the quality and efficiency of care

Effectively implementing and managing integrated networks will require extensive changes in the governance and leadership of VHA, as well as flexible and smart procurement policies and

⁴⁹ Ibid.

contracting authorities, as discussed elsewhere in this report. The highest priority for standing up networks should be locations where VHA quality of care is deficient or capacity is strained.⁵⁰

Where capacity constraints exist within networks, first priority for care should go to those veterans with greatest medical need, followed by service-connected disabled veterans and indigent veterans.⁵¹ VHA should develop processes and procedures for insuring that veterans have the knowledge and assistance they need to make informed health care decision and to navigate effectively through the expanding health care networks. By employing strategies proven by other managed care plans, VHA will find administrative means to guard against inappropriate treatment, wasteful spending, and fraud.

As many surgical and medical procedures that previously required inpatient hospital stays have routinely become outpatient procedures, there continues to be a substantial shift from inpatient to outpatient care.⁵² Consequently, to ensure improved access to care for veterans, the VHA Care System and long-term plans for facilities should focus on creating a robust ambulatory network and reshaping inpatient resources to match expected demand. Additionally, to inform veterans' and providers' decisions and create increased accountability for performance, all VHA and community network providers and facilities must provide transparent information on inpatient and outpatient quality, service, and access using the same performance metrics, including those used by Medicare.

Implementation

Legislative Changes

- Enact legislation amending 38 U.S. Code, Chapter 17 to consolidate existing purchased-care authorities and authorize the SECVA to furnish enrolled veterans needed hospital care and medical services through agreements with providers the SECVA deems meet quality standards the SECVA will establish. Veterans would be eligible for community care on the same basis as for VHA-furnished care, and current wait time and geographic distance criteria should no longer be applicable.

VA Administrative Changes

- Develop national policy to govern local establishment of networks, and in doing so, focus its design and long-term planning on creating a robust ambulatory capability and reshaping inpatient resources to match expected demand.
- Establish standards that community providers must meet to qualify for participation in community networks, to include becoming fully credentialed, meeting patient-access criteria, demonstrating high-quality clinical outcomes and appropriate use decisions, demonstrating military cultural competency, and having capability for interoperable data exchange.

⁵⁰ Information on what medical centers are deficient in their care is available, for example, from the VHA's own Strategic Analytics for Improvement and Learning (SAIL) data.

⁵¹ It would seem prudent to begin such phased development by piloting that effort, and limiting the scope of unfettered choice to service-connected veterans.

⁵² Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/21183845>.

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- Establish systems to ensure that all primary care providers in the VHA Care System can effectively coordinate veterans' care.
- Provide veterans navigation services for complex care needs, including information needed by patients and their families for informed decision making about treatments and providers. Navigation services should assist veterans and their families with eligibility, cost-sharing, and other administrative issues.
- Establish policies and procedures to ensure that VHA provider as well as community providers within each network, provide transparent information (using the same metrics) on care-quality, service, and access.
- Eliminate the practice of cross-country referrals if quality care is available locally.
- Employ the most current payment approaches that incentivize quality and appropriate use of health care services.

Other Department and Agency Administrative Changes

- None required.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

Problem

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.⁵³

The Commission Recommends That . . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.⁵⁴ For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified “not working to top of provider licensure” as a barrier in health care provision.⁵⁵

VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

Background

A large part of the VHA’s problem with inadequate clinical support staff derives from its difficulties in hiring, retaining, and training medical support assistants (MSAs). These individuals answer phones, schedule care, and verify health care eligibility, among other duties.

⁵³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁵⁴ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵⁵ *Ibid.*, 95.

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Congress has recently given VHA the flexibility to offer MSAs market-based pay rates.⁵⁶ VHA is changing cumbersome rules that have made hiring new MSAs exceptionally time-consuming.⁵⁷

VHA is working to resolve its problems with resource allocation in clinics. For example, the agency has committed to increasing use of clinical managers to help medical centers better match resources to patient demand. Widely used by other health care systems, clinic managers enhance operations by ensuring that telephone protocols, scheduling, and clinic workflow are operating at peak efficiency. They also ensure that staff members are assigned appropriate caseloads and are meeting productivity standards and wait time targets and that administrative staff has appropriate training in scheduling, coding, and/or documentation.

Many states have already taken the steps to ensure APRNs have full practice authority. VHA is working to do the same, which will allow a vast increase in the number of VHA clinicians available to treat patients independently.⁵⁸

To effectively manage clinician supply for the inpatient setting, administrators require accurate bed count data. Currently in VHA, data integrity of bed counts is compromised as a consequence of disclosure requirements of Congress. VHA is required by statute to complete a complicated reporting, approval, and notification process when it closes hospital beds.⁵⁹ To avoid the reporting requirements some VA medical centers count beds as unavailable indefinitely. This action can skew occupancy rates and thwart planning activities. VHA developed its guidance in part to satisfy the Millennium Act⁶⁰ and other requirements that essentially froze beds at FY 1998 levels.⁶¹

Analysis

VHA has taken a number of measures to address data integrity issues. VHA has started hiring clinical managers to assist in managing resources for effective performance. VHA has made efforts to address problems affecting supply and training of MSAs. Additionally, VHA has recently proposed a rule that would authorize full practice for APRNs working within the agency.⁶²

These measures by themselves, however, will not be sufficient to solve the current problems. VHA must ensure all facilities have enough support positions—both clerical and clinical—to

⁵⁶ Sloan D. Gibson, Deputy Secretary, Department of Veterans Affairs, presentation to Commission on Care, April 18, 2016.

⁵⁷ 38 U.S.C. § 7401(3)(A)(iii).

⁵⁸ Establishing Medication Prescribing Authority for Advanced Practice Nurses, VHA Directive 2008-049, (2008).

⁵⁹ Inpatient Bed Change Program and Procedures, VHA Handbook 1000.01, (2010).

⁶⁰ The Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545, Sec. 301. Title III of the Millennium Act prohibits the secretary from closing in any fiscal year more than 50 percent of the beds within a department medical center unless the secretary first submits to the veterans' committees a justification for such closure and waits to take action on a closure until 21 days after the submission of the report. It also requires the secretary to report annually to the veterans committees on bed closures during the preceding fiscal year.

⁶¹ Extended Care Services, 38 U.S.C. § 1710B(b) requires staffing for extended care to remain at FY 1998 levels.

⁶² "VA Proposes to Grant Full Practice Authority to Advanced Practice Registered Nurses," Department of Veterans Affairs, accessed June 3, 2016, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2793>.

enable all clinicians to work at the top of their licenses and to avoid problems with turnover, unexpected staff absences, and surges in patient demand.⁶³

VHA must have authority to pay competitive rates for the personnel it needs. This goal would be accomplished in part by adopting Recommendation #15 of this report for creating a new personnel system under Title 38 for all VHA employees. Currently, for example, clinical managers and practitioners earn far more in the private sector.⁶⁴

As VHA develops improved clinic management tools such as the Health Operations Dashboard, these tools draw from clinical data, patient data, and other sources to allow managers to make decisions using real-time data.⁶⁵ To be effective tools, the data fed into them must be accurate. Relieving VHA from some of the reporting requirements of the Millennium Act will help accomplish effective use of the dashboard for inpatient management.

Implementation

Legislative Changes

- Create a new alternative personnel system under Title 38 authority as mentioned in Recommendation #15.
- Eliminate bed reporting requirements under the Millennium Bill, and require VHA to report new beds as closed, authorized, operating, staffed, or temporarily inactive within 90 days of enactment.

VA Administrative Changes

- Develop policy to allow full practice authority for APRNs.
- Develop leadership tracks, including clinical and group practice managers, for ambulatory settings.
- Develop training programs for medical support assistants (MSAs).
- Modify policy in VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, as appropriate.

Other Department and Agency Administrative Changes

- None required.

⁶³ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 17-18, accessed June 3 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

⁶⁴ For example, Salaries.com listed a median salary for Clinic Manager III (a manager of a clinic with more than 50 physicians) in Dallas, TX, as \$94,000.⁶⁴ The pay grade assigned for this position is GS-13, which pays about \$73,800 in the first step and increases up to \$96,000. Office of Personnel Management, *Schedule 1 General Schedule*, accessed March 31, 2016, <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/pay-executive-order-2016-adjustments-of-certain-rates-of-pay.pdf>.

⁶⁵ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, presentation to Commission on Care, April 18, 2016.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-supported programs.

Problem

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.⁶⁶ Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).⁶⁷

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a national revised clinical-appeals process.

As part of the MyVA initiative, the SECVA has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.⁶⁸ The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.⁶⁹

Background

VHA policy has long required medical centers to operate a patient advocate program to address patient complaints.⁷⁰ In 1996, Congress enacted an eligibility reform statute that, for the first time, gave enrolled veterans access to a uniform benefits package.⁷¹ In implementing that law, VHA conducted a systemwide review of how clinical disputes were handled and consequently instituted an external appeal system in FY 2000. The policy, as outlined in a subsequent directive, allowed VISNs to request external professional boards to conduct impartial reviews of clinical determinations.⁷² That directive also addressed a process for internal clinical appeals. It stated as policy that patients or their representatives who have disputes regarding clinical determinations or services pertaining to provision or denial of care that are not resolved at the facility level must have access to a fair and impartial review of those disputes that could result in a different and/or improved clinical outcome. That policy requires VISN directors to have written policy and procedures in place for how internal appeals are to be handled. Under this policy, VISNs still have authority to request an external review at any time during the clinical

⁶⁶ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

⁶⁷ VHA Clinical Appeals, VHA Directive 2006-057, (2006).

⁶⁸ "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, <http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx>.

⁶⁹ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷⁰ VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁷² VHA Clinical Appeals, VHA Directive 2006-057 (2006).

appeals process.⁷³ Although the directive itself expired in 2011, it continues to serve as guidance because it has not been renewed or replaced.

VHA policy directs that all facilities have a patient advocate office to manage and attempt to resolve complaints. That office, which can serve as the liaison between patients and clinicians, is generally the first stop for veterans who are dissatisfied with a clinical decision.⁷⁴ If a clinical issue is not resolved at the point of the service, it generally goes to the facility director, who is to provide veterans written notification of the facility's decision and inform veterans about the VISN's appeals process. Under the same policy directive, veterans may appeal the facility decision to the VISN director. That official, or a clinical review panel that he or she establishes, is to render a decision within 30 days (or 45 days if the director requests an external clinical review).⁷⁵ Should the VISN director agree with the facility, he or she must notify the veteran that the decision is final or may refer the matter to a VACO office to arrange for an external review.⁷⁶

The VHA process does not appear fully comparable to procedures required under other federal and federally-supported health care programs. For example, under the Affordable Care Act, health care plans are required to provide external reviews to beneficiaries whose internal appeals have been denied.⁷⁷ Unlike those and other appeals processes, veterans have no right to external review; such review is at the discretion of the VISN director. Medicare has an extensive review process for clinical disputes between its managed care organizations and beneficiaries. Beneficiaries have the right to an internal appeal with an option for an expedited review, an internal reconsideration of the initial review, an independent review, a hearing with an administrative law judge, a review by the Medicare Appeals Council and, finally, a federal district court review.⁷⁸ Medicaid has requirements for localities to review appeals from its beneficiaries and for states to offer timely access to fair hearings to determine whether managed care organizations have denied or terminated medically necessary care.⁷⁹ Although VHA's timeframe for decision making seems reasonable, the national policy makes no provision for an expedited review, unlike Medicare managed care organizations and plans providing health benefits to federal employees. VHA's policy is also silent on meeting with veterans to hear their cases much less hold hearings during any point of the appeal. Unlike Medicaid, VHA also lacks any provision for service-continuity while the matter is being appealed. The Commission recommends that VHA develop a revised clinical-appeals process that provides veterans protections at least comparable to those afforded patients under other federal and federally-supported programs, including, at a minimum, a right to an external review at the veteran's discretion.

⁷³ Ibid.

⁷⁴ VHA Patient Advocacy Program, VHA Handbook 1003.4, (2005).

⁷⁵ VHA Clinical Appeals, VHA Directive 2006-057, (2006).

⁷⁶ Ibid.

⁷⁷ "Appealing Health Plan Decisions," Department of Health & Human Services, accessed June 1, 2016, <http://www.hhs.gov/healthcare/about-the-law/cancellations-and-appeals/appealing-health-plan-decisions/index.html>.

⁷⁸ Centers for Medicare & Medicaid Services, *Managed Care Appeals Flowchart CY2016*, accessed May 26, 2016, <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Managed-Care-Appeals-Flow-Chart.pdf>.

⁷⁹ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

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Implementation***Legislative Changes***

- None required.

VA Administrative Changes

- Convene an interdisciplinary panel to assist in developing a revised clinical-appeals process and policy that includes all care provided within the VHA Care System, to include representation from Patient Care Services, MyVA's Patient Advocates and Veterans Experience Program, the Office of Equity, the National Center for Ethics in Health Care, and the Office of Access and Clinical Administration. VHA should have that panel examine and offer recommendations regarding the following:
 - Each level of review in the clinical-appeals process – from the facility's initial reconsideration to a final decision by the VISN director to assess the fairness and impartiality in those processes compared to Medicare Managed Care and Medicaid appeals processes and private-sector managed care providers' best practices.
 - Whether VHA should establish a uniform national clinical appeals process.
 - The advisability of requiring review panels consisting of individuals such as attorneys, clinicians, case managers, patient advocates, and administrators to review clinical appeals.
 - Whether hearings or judicial reviews are appropriate at any level of the appeals process.
 - Whether resolutions of clinical appeals are equitable for all types of veterans (service-connected or non-service-connected, by racial or ethnic group, by age, or gender).
 - Options for increasing veterans' awareness of the clinical-appeals process.
- Publish the new clinical appeals policy and process for comment and input by veterans, VHA business partners, and other stakeholders.
- Once the new policy is finalized, VHA must train staff on the new process.

Other Department and Agency Administrative Changes

- None required.

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

Problem

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.⁸⁰

VHA has a program of systems engineering — the Veterans Engineering Resource Center (VERC) — that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to proactively identify problem areas within the system and offer assistance.

Background

To become a truly veteran-centric care provider, VHA is working to become a learning organization.⁸¹ Learning organizations focus on worker competency rather than on rules compliance. Instead of using results to identify high- and low-performers, VHA will use this information to identify opportunities to intervene with training or other resources to improve employees' performance universally. Employees and patients should benefit from this approach because it values listening and encourages risk taking and innovation.

VA and VHA have adopted the tenets of LEAN Six Sigma as a systemic change approach to move the system forward. This methodology employs a rigorous define, measure, analyze, improve, and control approach to systemic change. LEAN, initially used by manufacturers, has been used successfully by many health care organizations.⁸² The goal of implementing LEAN practices is to eliminate waste, ensuring that any work done adds value. The MyVA plan calls for MyVA districts and the Office of Policy and Planning to ensure the transmission of best practices and the adopting of LEAN throughout the enterprise to provide a more comprehensive view of quality that balances a results-oriented approach with more process-

⁸⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow—Clinical)*, 14 and A-2 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁸¹ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.

⁸² MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 12, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

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oriented practice.⁸³ So far these efforts have been guided by trial and error, rather than directives and adopting a LEAN, process-driven model.⁸⁴ VHA must sustain its commitment to LEAN Six Sigma as a continuous improvement methodology.

VHA will have to use VERC staff and other trained staff members to ensure that principles of LEAN Six Sigma are applied at every level of the system. VERC has the mission to propose, develop, and facilitate innovative solutions to challenges within VHA health care delivery through the integration of systems engineering principles.

With VERC's reach already extending into access to care, health policy, population health, LEAN management, business systems, clinical systems, safety systems, and innovation, all other programs and initiatives become redundant or ancillary. VHA must assess its new system for best practice diffusion to ensure that selected practices are being appropriately scaled. This goal can best be achieved by collapsing all related efforts into VERC.

There are a number of emerging best practices within the health care sector that apply to all aspects of VHA – health care capabilities, staffing, access, supplies, and facilities – and involve the testing, dissemination, and application of procedures or systems that have been shown to improve approaches, processes, or systems.⁸⁵ VHA needs to have the opportunity to fully leverage and build on institutional strengths by implementing best practices.

VHA has recently developed the Diffusion of Excellence Initiative, which is designed to serve as the mechanism for improving practice through a combination of targeted national guidance and nationally-supported local best practice sharing and innovation.⁸⁶ Its organizational structure includes a governance board chaired by the USH, a Diffusion Council, and action teams responsible for implementing promising practices.

VHA also has many business lines charged with disseminating best practices information, including VERC, Systems Redesign SharePoint – Center for Improvement Education, VA Center for Innovation, MyVA – Best Practices in LEAN, MyVA Blog, MyVA Performance Improvement Hub, Knowledge Management System–Improvement in Action (I-ACT), VA Idea House, VA Pulse: Promising Practices Consortium, Evidence-based Synthesis Program (ESP), Quality Enhancement Research Initiative (QUERI), the Annual Conference on the Science of Dissemination and Implementation, and the Diffusion of Excellence Initiative.

Analysis

LEAN Six Sigma offers VHA a methodology to effect change and VERC offers VHA the agents to lead its implementation. VHA must consolidate its transformational tools, including its best

⁸³ MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 21, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

⁸⁴ The MITRE Corporation, Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow—Clinical), viii accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁸⁵ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 41, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁸⁶ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.

practice repositories within VERC. The VERC uses a systemic change process to streamline workflow and procedures by eliminating waste and redundancy to ensure that every step in the process adds value. The VERC offers services to VHA health care facilities upon request, but VHA would substantially benefit if the service was authorized to perform outreach to ensure awareness across the VHA Care System.⁸⁷

Until developing the Diffusion of Excellence Initiative, VHA lacked a uniform way to scale and optimize best practices throughout the enterprise. Although the Diffusion Initiative is initially targeting best practices from within VHA, to be successful, a long-term plan should also allow for the adoption of best practices from the private sector and other government sectors (e.g., the Medicare program related to pricing, contracting, privatization, value-based purchasing, management, and oversight). Plans should also allow for adaptation at the local and regional levels to reflect respective differences in provider supply, veteran needs, and marketplace characteristics.⁸⁸

VHA has multiple offices and sites invested in system reengineering, continuous process improvement, and best practices implementation. Repositories of best practices do not get information to the intended person or group that could benefit from the information and are dependent upon VHA employees knowing they exist.⁸⁹

VHA's National Leadership Council has proposed consolidating these best practice repositories under the VERC, which now serves within the Office of Organizational Excellence. Until recently, VERC has been underutilized because it is not known throughout the enterprise.⁹⁰

QUERI is a system that identifies evidence-based care practices that may be scaled for systemwide implementation. QUERI was integrally involved in the transformation of VHA from a largely hospital-based system to one centered on primary care⁹¹ and is now integral to the collaborative endeavor to transform VHA into a learning organization. QUERI recently released a policy brief that indicated veterans' reliance on VHA was strongly correlated to economic factors such as unemployment rates and availability of other health care coverage.⁹²

VA should use a systematic, continuous performance improvement process to improve access to care. Although many VA facilities achieve very high-performance ratings on key access and quality measures, a systematic effort is needed to improve performance. These efforts need to

⁸⁷ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

⁸⁸ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, 28, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf

⁸⁹ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

⁹⁰ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 27, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁹¹ "HSR&D Perspectives Blog, QUERI Corner: Surviving and Thriving," Amy Kilbourne, QUERI Program Director, January 20, 2015, accessed from VA Intranet, April 4, 2016, <http://vaww.blog.va.gov/hsrd/category/queri-corner/>.

⁹² Christine Yee, Austin Frakt, and Steven Pizer, U.S. Department of Veterans Affairs, "Economic and Policy Effects on Demand for VA Care," Partnered Evidence-based Policy Resource Center, Policy Brief, March 2016, accessed June 21, 2016, http://www.queri.research.va.gov/partnered_evaluation/YeeFraktPizer.pdf.

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be embedded into routine use across the VA system. The best solutions should be adjusted to reflect local needs and designed to respond to veterans' preferences, needs, and values.⁹³

A systems approach to health care is “one that applies scientific insights to understand the elements that influence health outcomes, models the relationships between those elements, and alters design, processes, or policies based on the resultant knowledge in order to produce better health at lower cost”⁹⁴ and would benefit VA greatly, especially with resources like VERC to serve as a guide.

Emerging best practices have improved health care access and scheduling in various locations and serve as promising bases for research, validation, and implementation.⁹⁵ A variety of quality improvement organizations are involved in establishing and maintaining standards in health care as well as developing measures for the monitoring and assessment of these standards, including The Centers for Medicare & Medicaid Services, the Joint Commission, the National Committee for Quality Assurance, and the National Quality Forum.⁹⁶

The tools of operations management, industrial engineering, and systems approaches are successful in increasing process gains and efficiencies. In particular, a wide range of industries have employed systems-based engineering approaches to address scheduling issues, among other logistical challenges.⁹⁷

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Consolidate all best practices and continuous improvement portals under VERC to provide a more accessible and comprehensive approach to best practice sharing and adoption.

Other Department and Agency Administrative Changes

- None required.

⁹³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 110 and 297 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁹⁴ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 27 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁹⁵ Ibid., 15.

⁹⁶ Ibid., 60.

⁹⁷ Ibid., 27-28.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

Problem

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.⁹⁸

A systematic review of VHA in 2015 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.⁹⁹ VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues—the Health Equity Action Plan (HEAP)—but it has not been fully implemented.

Background

It is time to refocus, reinforce, and repeat the message that health disparities exist and that health equity benefits everyone.¹⁰⁰

Across the nation, health care systems are raising awareness about health care equity, inequality, and disparities.¹⁰¹ The growing incidence of health care disparities and inequities is said to be ascribed to individual and collective cultural indifference on the part of health care

⁹⁸ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

⁹⁹ Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, accessed May 19, 2016, <http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf>.

¹⁰⁰ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

¹⁰¹ Centers for Disease Control and Prevention, *CDC Health Disparities and Inequalities Report – United States, 2013*, accessed April 5, 2016, <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>.

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providers and the health care system as a whole.¹⁰² A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on racial or ethnic group, gender, age, sexual orientation, military era, geographic location, religion, socioeconomic status, mental health, cognitive/sensory/physical disability, and other characteristics historically linked to discrimination or exclusion.¹⁰³

The United States is becoming increasingly diverse, with racial and ethnic minorities making up more than 36 percent of the population.¹⁰⁴ Indicators of overall health, such as life expectancy and infant mortality, have improved for most Americans; however, some minorities still face comparatively greater likelihood of preventable disease, death, and disability.¹⁰⁵

Although the country's veteran population is projected to decline from 22 million to 14.5 million by 2040, the percentage of minority veterans will increase from 20 percent to 34 percent during the same period.¹⁰⁶ Currently, African Americans make up 11 percent of the veteran population, and Hispanics, 6 percent.¹⁰⁷

Survey data show that minority veterans use VA health care more than White veterans, as shown below:¹⁰⁸

- African American: 38 percent
- Hispanic: 34 percent
- American Indian/Alaska Native: 38 percent
- White: 32 percent

¹⁰² G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," *JHSA* (2011), 146.

¹⁰³ "Office of Health Equity," U.S. Department of Veterans Affairs, accessed June 12, 2016, <http://www.va.gov/HEALTHY/index.asp>.

¹⁰⁴ "Minority Health and Health Equity – CDC," Centers for Disease Control and Prevention (CDC), accessed March 28, 2016, <http://www.cdc.gov/minorityhealth/index.html>.

¹⁰⁵ *Ibid.*

¹⁰⁶ National Center of Veterans Analysis and Statistics, *Minority Veterans 2011 Report*, May 2013, accessed April 6, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf.

¹⁰⁷ U.S. Census Bureau, *American Community Survey, Public Use Microdata Sample (PUMS)*, 2011. Department of Defense, *Population Representation in the Military Services Fiscal Year 2011 Report*, accessed April 5, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf

¹⁰⁸ Reliance projections here are based on ambulatory care utilization. Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 82, accessed May 19, 2016,

http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

Survey data on racial and ethnic minority veterans' use of VHA health care offer revealing insights on current equity issues:¹⁰⁹

- Fifty-seven percent of African Americans indicated they are more likely to use VA as their primary source of health care as compared to 45 percent of Whites.¹¹⁰
- The percentage of African Americans who reported they use VA for all or most of their care needs is 18 percent higher than the percentage of Whites who do so.¹¹¹
- A higher percentage of Whites assessed their health to be good or excellent than did African Americans.¹¹²

Analysis

VHA Office of Health Equity

VA created the OHE in 2012 to identify health care inequities, understand the cause of them, and bring to clinical practice interventions intended to reduce disparity drivers within VA. OHE partners with other VA offices, federal government offices, and nongovernment institutions with missions aimed at promoting health equity.¹¹³ OHE has substantial stakeholder involvement from minority veterans groups, including the Advisory Committee on Minority Veterans (ACMV), rural veterans groups, women veterans, and the Office of Diversity and Inclusion (ODI).¹¹⁴ A staunch internal partner and stakeholder of OHE, ODI's mission is to foster a diverse workforce and an inclusive work environment. The OHE and ODI missions intersect with ODI's special emphasis programs, intended to engage affinity groups and agencies to raise the awareness of the importance of diversity and demonstrate VA's commitment to a diversity model.¹¹⁵

OHE's foundational work included updated systematic reviews and data analyses that not only revalidated VA's previous findings on health care inequities, but also identified more areas of health care disparity among veterans. For instance, hepatitis C virus (HCV) was noted to have disparate effect on racial/ethnic minority veterans and Vietnam-era veterans. Additionally, OHE convened stakeholders and worked with the Health Equity Coalition to develop the VHA Health Equity Action Plan (HEAP), which aligns with the VHA Strategic Plan Objective 1e: Quality & Equity, which states, "Veterans will receive timely, high quality, personalized, safe effective and equitable health care irrespective of geography, gender, race, age, culture or sexual

¹⁰⁹ Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.

¹¹⁰ Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, 85, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.

¹¹¹ Ibid.

¹¹² Ibid.

¹¹³ Department of Veterans Affairs, Office of Health Equity, *US Department of Veterans Affairs Office of Health Equity Mission and Accomplishments*, accessed March 30, 2016, http://www.va.gov/HEALTHEQUITY/docs/OHE_Mission_and_Accomplishments_November_2015.pdf.

¹¹⁴ "Office of Diversity and Inclusion (ODI)," Department of Veterans Affairs, accessed May 13, 2016, <http://www.diversity.va.gov/>.

¹¹⁵ "Office of Diversity and Inclusion (ODI), Special Emphasis Programs," Department of Veterans Affairs, accessed May 17, 2016, <http://www.diversity.va.gov/programs/default.aspx>.

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orientation.”¹¹⁶ HEAP aims to address five strategic areas: awareness, leadership, health system and life experience, cultural and linguistic competency, and data that are vital for effectively implementing its mission. HEAP implementation strategies are conceptually modeled after the goals and strategies of the National Partnership for Action to End Health Disparities’ National Stakeholder Strategy for Achieving Health Equity sponsored by the U.S. Department of Health and Human Services.¹¹⁷

Despite OHE’s best efforts, HEAP was not fully implemented because VHA leadership failed to establish it as a strategic priority with adequate staffing, resources, and support, and the departure of the then USH, a champion for health equity. These factors led to the reduction of OHE staffing from 8 to 2 FTEs in FY 2013 and a realignment of OHE to several layers down in the organization. As a result of an FY 2015 budget reduction, OHE continues to operate with a two-person staff.¹¹⁸ The reduced staffing level is inadequate to meet the requirements and mission of the office.

OHE has a broad and challenging mission, particularly given the number of minority veterans who rely on VA health care, the health risks in those populations, and the health care disparities those populations experience.¹¹⁹ OHE faces serious challenges in its efforts to carry out its action plan and to realize its broad and critical mission, challenges intensified by its limited staffing and the downgrade of this office within VHA’s organization structure. These include the following:¹²⁰

- lack of quality data on vulnerable populations and disparate health outcomes
- health equity projects that have been delayed or halted due to staff and resource limitations
- lack of data on the overall impact of existing health equity initiatives at facilities
- lack of common definitions on vulnerable populations and health equity concepts

Notwithstanding its limited staffing, OHE has compiled a substantial record of accomplishments. Among its initiatives, OHE embarked in 2015 on a strategy of working collaboratively with the Quality Enhancement Research Initiative (QUERI) to advance health equity. The two collaborative efforts focus on using a population health approach to examine the distribution of diagnosed health conditions, mortality, and health care quality across the VA health care system. A fully staffed OHE would have the capability of creating additional

¹¹⁶ Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018*, accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.

¹¹⁷ “National Partnership For Action (NPA), National Stakeholder Strategy for Achieving Health Equity,” U.S. Department of Health & Human Services, accessed May 16, 2016, <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286>

¹¹⁸ Uche S. Uchendu, Executive Director, OHE, briefing to Commission on Care, December 14, 2015.

¹¹⁹ “Management Brief no. 99,” Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=eBrief-no99. Somnath Saha et al., “Racial and Ethnic Disparities in the VA Health Care System: A Systematic Review,” *Journal of General Internal Medicine*, 23, no. 5, (2008): 654-671.

¹²⁰ Uche S. Uchendu, Executive Director, Office of Health Equity, briefing to Commission on Care, December 14, 2015.

analytical tools to manage the daily health care equity program and provide needed services to advance health equity.¹²¹

Health Care Disparities Among Minority Veterans

Minority groups are at increased risk of major, life-threatening health conditions, as documented in a substantial body of research¹²² and illustrated in the table below:¹²³

Table 3. Major Health Conditions in Racial/Ethnic Minority Groups

Major Health Conditions Identified and Examined in Racial/Ethnic Minority Groups		
African Americans	Hispanics	American Indian or Alaska Natives
<ul style="list-style-type: none"> ▪ Colon Cancer ▪ HIV ▪ Chronic Kidney Disease ▪ Diabetes ▪ Stroke ▪ Venous Thromboembolism (VTE) ▪ Cancer ▪ Heart Disease 	<ul style="list-style-type: none"> ▪ Hepatitis C ▪ Cancer ▪ Heart disease 	<ul style="list-style-type: none"> ▪ Major Non-cardiac Surgery ▪ Pregnant Women with PTSD

HCV is more prominent among some racial and ethnic minority veterans and they are less likely to receive treatment for HCV. In VHA, some racial and ethnic minorities diagnosed with HCV are disproportionately more at risk for having associated liver disease (ALD). Disparities among veterans in the incidence of HCV, illustrated in the graphs below, show the important policy and resource implications for VA.¹²⁴

¹²¹ Ibid.

¹²² Andy I. Choi et al., “White/Black Racial Differences in Risk of End-Stage Renal Disease and Death,” *The American Journal of Medicine*, 122, no. 7, (2009): 672-678. Andy I. Choi et al., “Racial Differences in End-Stage Renal Disease Rates in HIV Infection with Diabetes,” *Journal of the American Society of Nephrology*, 18, no. 11 (2007): 2968-2974. Hashem B. El-Serag et al., “Racial Differences in the Progression to Cirrhosis and Hepatocellular Carcinoma in HCV-Infected Veterans,” *The American Journal of Gastroenterology*, 109, no. 9, (2014): 1427-1435. Cleo A. Samuel et al., “Racial Disparities in Cancer Care in the Veterans Affairs Health Care System and the Role of Site of Care,” *American Journal of Public Health*, 104, Supplement 4, (2014): S562-571.

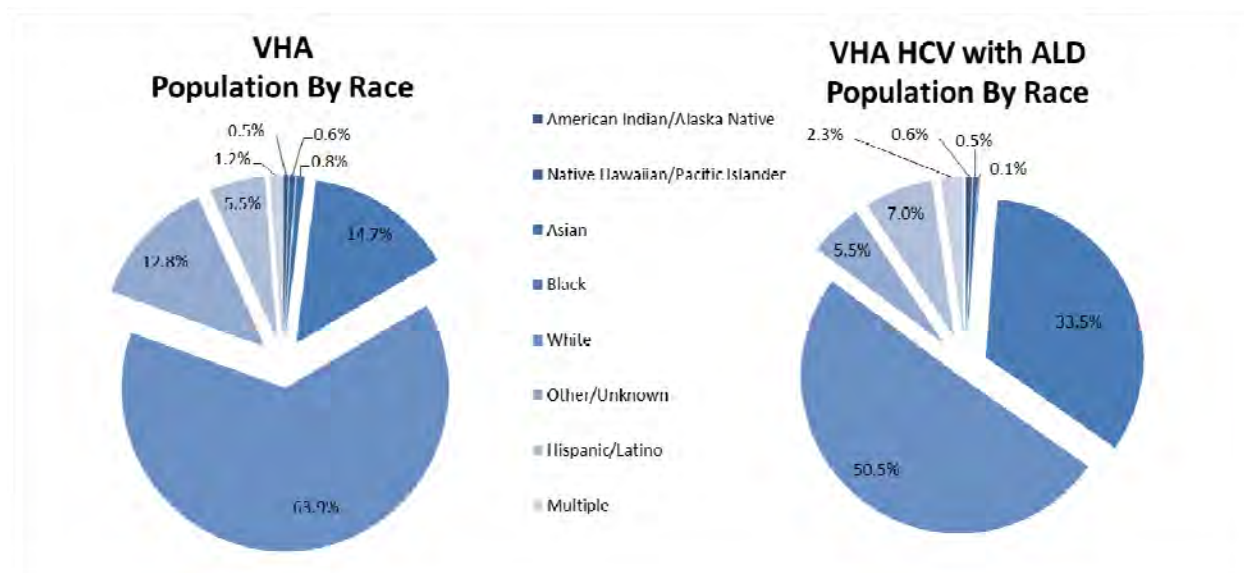
¹²³ Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, accessed May 19, 2016,

<http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf>.

¹²⁴ Department of Veterans Affairs, Office of Health Equity, *Hepatitis C Factsheet, Hepatitis C, Advanced Liver Disease & Health Care Disparities*, accessed May 25, 2016, <https://github.com/departement-of-veterans-affairs/VHA-Asset/raw/master/Hep%20C%20FACT%20SHEET%20FINAL%2010162015.pdf>.

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Figure 2. Disparities Among Veterans in the Incidence of Hepatitis C Virus



A recent review of evidence related to racial and ethnic differences in outcomes for VA patients showed moderate- and low-strength evidence suggestive of gaps in morbidity and mortality outcomes among vulnerable veteran populations with major health conditions. These data, presented in the table below, highlight targets for further research.¹²⁵

Table 4. Comparison of Health Outcomes by Race

Comparison		Worse Health Outcomes For Racial Minority Group Relative to Reference Population (usually White)
Moderate-Strength Evidence		
(based on VA data from the early 2000s)		
African American v. White	Increased end-stage renal disease among chronic kidney disease patients	
	Increased end-stage renal disease among HIV patients (with or without diabetes)	
	Decreased colon cancer survival 3 years after diagnosis	
Hispanic v. White	Increased cirrhosis and hepatocellular carcinoma among hepatitis C patients	
Low-Strength Evidence		
(each finding supported by only a single retrospective study with important methodological limitations)		
African American v. White	Increased mortality among diabetes patients	
	Increased risk of preterm birth among PTSD patients	
	Increased mortality at 2 years post-hospitalization among stroke patients	
	Decreased survival 3 years after diagnosis of rectal cancer	
American Indian or Alaskan Native v. White	Increased risk of 30-day post-op mortality after major noncardiac surgery	
	Increased risk of preterm birth among PTSD patients	
Combined other racial/ethnic minority groups v. African American	Increased injury-related death among alcohol use disorder patients	

¹²⁵ "Management Brief no. 99," Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=eBrief-no99, VA-18-0457-A-002031

OHE's focus, health equity, is intended to combat health care disparities, namely, the differences in the preventive, diagnostic, or treatment services offered to veterans with similar health conditions. Health care disparities stem from a combination of complex factors occurring at the level of the health system, provider, and patient.¹²⁶ Health care disparities can result from biological differences among various racial/ethnic groups as well as from social disparities,¹²⁷ also termed social determinants, which stem from such factors as socioeconomic status, discrimination, education levels, housing, transportation, and crime and violence, and are causally linked to subsequent adult disease.¹²⁸ For example, poor-quality housing poses a risk of exposure to many conditions that can contribute to poor health, such as indoor allergens that can lead to and exacerbate asthma, injuries, and exposure to lead and other toxic substances.¹²⁹ Social determinants that drive health disparities among African Americans, Hispanics, American Indians, and Alaska Natives include race/ethnicity; gender; age; geographic location; religion; socio-economic status; sexual orientation; military era; disabilities, including cognitive, sensory, or physical; and other characteristics historically linked to discrimination or exclusion. Positioned in a department that also provides benefits that fall within the social determinants of health, OHE is in a unique position to improve veterans' health.

The Henry Ford Health System (HFHS) is an example of a health system that is committed to health equity and one VHA can emulate as it works to improve health equity. HFHS is a nonprofit, vertically integrated health care organization that serves the primary and specialty health care needs of residents in southeastern Michigan, including Detroit and its surrounding metropolitan area.¹³⁰ HFHS's comprehensive health equity staff has a health care equity campaign with a goal of increasing knowledge, awareness, and opportunities to ensure health care equity is understood and practiced by HFHS providers and other staff, the research community, and the community-at-large.¹³¹ The campaign is also intended to make health care equity a key, measurable aspect of clinical quality.¹³² A similar effort by VHA would create a system for tracking improvement of health equity over time and holding the organization accountable for ongoing efforts in this regard.

The VHA strategic plan for FY 2013–2018 states that veterans will receive timely, high quality, personalized, safe, effective, and *equitable* health care, irrespective of geography, gender, race, age, culture, or sexual orientation.¹³³ Although that statement signals a sensitivity to health equity, the level of funding support for the VHA office with the lead role in promoting health equity and reducing disparity calls into serious question the leadership priority and commitment to that strategic goal. VHA leadership must make health care equity a strategic

¹²⁶ Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, <http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf>.

¹²⁷ James H. Price, Molly A. McKinney, and Robert E. Braun, *Social Determinants of Racial/Ethnic Health Disparities in Children and Adolescents*, accessed April 1, 2016, <http://www.sophe.org/Sophe/PDF/Webinars/20120416151902.pdf>.

¹²⁸ Ibid.

¹²⁹ "What Drives Health," Robert Wood Johnson Foundation, Commission to Build a Healthier America, accessed April 1, 2016, <http://www.commissiononhealth.org/WhatDrivesHealth.aspx>.

¹³⁰ Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, <http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf>.

¹³¹ Ibid.

¹³² Ibid.

¹³³ Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018*, accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.

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priority by directing and funding the implementation of VHA HEAP nationwide and designating a leader and clinical champions within each VISN and VAMC, as a designated full-time equivalent (FTE), providing OHE budgetary support in FY 2017 and beyond to fully staff the office so that it can successfully achieve its mission and goals, to include providing additional needed funding to support implementation of the VHA HEAP; and ensuring OHE reports to the chief of VHA Care System (CVCS).

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Make health equity a strategic priority by directing the implementation of the VHA HEAP nationwide and designating a leader and health equity clinical champion within each VISN and VAMC for whom part of their respective FTE position descriptions includes focusing on health equity issues.
- Reestablish OHE staffing based on the 2011 VHA Health Care Equality Workgroup recommendations to enable OHE to fulfill VHA's vision to provide appropriate individualized health care to each veteran in a method that eliminates disparate health outcomes and assures health equity. Action required includes, but is not limited to, funding FTE staffing levels commensurate with the scope and size of other federal offices of health equity.
- Reinstate OHE within the office of the CVCS to underscore health equity as a priority and to position the office to champion successfully the advancement of health equity for all veterans.¹³⁴
- Monitor and evaluate the department's success in implementing HEAP.

Other Department and Agency Administrative Changes

- None required.

¹³⁴ Department of Veteran Affairs, Health Equity Coalition Request for VHA Commitment, February 2016. Principal Deputy Under Secretary of Health Memorandum, Health Equity Coalition, March 21, 2013.

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

Problem

Veterans who turn to VHA to meet their health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern ambulatory health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of these barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks, as proposed in

Recommendation #1 holds the promise of markedly improving veterans' access to care.

That promise cannot be realized without transformative changes to VHA's capital

structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of the build out of the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as much control as possible to drive the process so that all facility plans are fully integrated with the strategic vision for the VHA Care System.

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meet its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission process to be implemented as soon as practicable. The Commission recommends that the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

Background

Most VHA health care centers were designed when care was focused on inpatient hospital treatment. VA acquired some of these facilities nearly a century ago from the Public Health Service; many others were transferred from the War Department shortly after World War II.¹³⁵ The average VHA building is 50 years old – five times older than the average building age of not-for-profit hospital systems in the United States.¹³⁶ Most of its facilities were designed to meet markedly different needs than today's health care facilities. Some were tuberculosis

¹³⁵ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

¹³⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, vi, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

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sanatoriums, others for years primarily housed patients with mental health conditions.¹³⁷ Although many have been extensively renovated, the renovations themselves are now outdated, and the condition of buildings shows this strain. Independent assessments of infrastructure and facilities showed that VHA facilities average a *C minus* score,¹³⁸ meaning much of the total facilities portfolio is nearing the end of its useful life, and 70 percent of facility correction repairs are being made on Grade D facilities.¹³⁹

During the past 8 years, veteran inpatient bed days of care have declined nearly 10 percent as outpatient clinic workload has increased more than 40 percent.¹⁴⁰ Current facilities, whether they have been maintained adequately or not, often do not support contemporary ambulatory care needs, with outpatient care often housed in converted inpatient spaces.

Through its capital planning methodology, VA has identified more than \$51 billion in total capital needs during the next 10 years.¹⁴¹ Capital funding during the past 4 years has averaged just \$2 billion annually.¹⁴² If funding levels remain consistent during the next 10 years, anticipated funding would be \$25 billion to \$35 billion less than the \$51 billion capital requirement.¹⁴³ VA planning must also take account of demographic changes and population migration that have led to underutilized medical centers in some areas of the country, and a need for new capacity in others.¹⁴⁴

Analysis

New Planning Paradigm

As the department acknowledged, “VA’s health care delivery model must . . . change.”¹⁴⁵ Importantly, it recognizes that “No organization can excel at every capability,” and stated “[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers.”¹⁴⁶ The acknowledgement that VHA can best serve veterans by focusing on its core competencies and unique capabilities, while relying more heavily on purchased care holds important implications for VHA’s capital needs and capital asset management. Rather than assessing VHA’s capital needs by reference to an expectation that each VA medical center, or constellation of medical centers, must provide virtually all needed hospital and medical services, capital needs must be redefined within the framework of the VHA Care System’s high-performing integrated community health care networks. VHA must determine what services it will continue to provide directly in a given community before it can determine its respective infrastructure needs. In identifying its core competencies, unique

¹³⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

¹³⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 27, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹³⁹ *Ibid.*

¹⁴⁰ *Ibid.*, 46.

¹⁴¹ *Ibid.*, 17.

¹⁴² *Ibid.*, 18.

¹⁴³ *Ibid.*, 18.

¹⁴⁴ *Ibid.*, 59-61.

¹⁴⁵ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 18, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

¹⁴⁶ *Ibid.*

capabilities, and needed ancillary services, VHA would be setting at least a general framework through which network and local planners could assess where and how needed services would be delivered, including which would be provided directly by VHA and which through purchased care. Such a mapping exercise would be a first step in developing the integrated community health care networks.

The shape of an integrated delivery network will take different forms in each service-area, and planning and developing those local networks will necessarily require assessing VHA's physical plant and capacity in a new light. That reassessment process would inform capital planning, and must take account of at least three distinct needs: capital needs associated with buildings VA would retain; meeting new or replacement space needs; and the disposal of unused, unneeded property.

Property Divestiture

VHA's principal mission is to provide health care to veterans, yet over time it has acquired an ancillary mission: caretaker of an extensive portfolio of vacant buildings. As recently as October 2015, VA reported that its inventory includes 336 buildings that are vacant or less than 50 percent occupied, requiring it to expend patient-care funds to maintain more than 10,500,000 square feet of unneeded space.¹⁴⁷ The SECVA recently testified that it costs VA an estimated \$26 million annually to maintain and operate vacant and underutilized buildings.¹⁴⁸

VA's authority to carry out property-management is circumscribed in law,¹⁴⁹ and the department at times faces insurmountable challenges in either attempting to repurpose or divest itself of underutilized or vacant property.¹⁵⁰ In contrast to more rigid property-divestiture provisions, VA has had success in using a flexible authority to enter into long-term leases of VA property for *enhanced use*.¹⁵¹ This authority allows VA to lease underutilized capital

¹⁴⁷ Ibid., 92.

¹⁴⁸ "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, <https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2>.

¹⁴⁹ Authority for Transfer of Real Property; Department of Veterans Affairs Capital Asset Fund, 38 U.S.C. § 8118 Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122. For example, under section 8118, VA must receive at least full market value in transferring property, unless the property is transferred to an entity that provides services to homeless veterans, and any proposed transfer is subject to the requirement in section 8122 that VA first hold hearings, notify Congress in advance, and not proceed for a specified period. VA property can be determined to be "excess," though under 38 U.S.C. § 8122(d)(1), VA may not make such a declaration unless the property is not suitable for use for provision of services to homeless veterans and reviewed for possible disposal under the Property Act Disposal, administered by the General Services Administration (GSA) (40 U.S.C., subchapter III). GSA employs a rigorous, multistep process to assure that the asset is not needed by any other Federal agency. Under the Act, the agency disposing of the asset is responsible for funding disposal costs, including environmental remediation. GAO has testified that properties remain in an agency's possession for years and continue to accumulate maintenance and operations costs because of the legal requirements agencies must meet and the length of the process. (U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain*, GAO-11-520T (Washington, DC, 2011), 5, <http://www.gao.gov/products/GAO-11-520T>).

¹⁵⁰ With many properties under the protection of the National Historic Preservation Act (16 U.S.C. § 470h-3), VA faces obstacles and delays in efforts to divest itself of these properties; VACO staff report that stakeholder concerns have been obstacles.

¹⁵¹ Enhanced-Use Leases of Real Property, 38 U.S.C. §§ 8161-8169, as amended by Veterans Millennium Health Care and Benefits Act, Section 208, Pub. L. No. 106-117, 113 Stat. 1545 (1999), as in effect when GAO testified on this successful program (U.S. Government Accountability Office, *VA Real Property: VA Emphasizes Enhanced-Use Leases to* VA-18-0457-A-002036

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assets to private-sector entities for up to 75 years to develop housing for homeless and at-risk veterans and their families. Most recently, however, Congress imposed severe limits on that leasing authority.¹⁵²

Ongoing Capital Needs

Establishing a transformative new health care delivery model that relies more on purchased care will not eliminate the need for new clinics, facility renovations, and remedying VHA space deficiencies. The scope of those needs must still be determined in light of a proposed new delivery system, but they cannot be ignored. The *Independent Assessment Report* catalogued the challenges of managing and operating VA's capital program and the need to deploy best practices to improve total performance, and clearly address the importance of more modern facilities for delivering high quality care.¹⁵³

Of particular concern is an apparent breakdown in the process of bringing new clinics online and renewing the leases of existing clinics. With current law requiring congressional approval of any lease with an average annual rental of more than \$1 million,¹⁵⁴ a Congressional Budget Office (CBO) ruling¹⁵⁵ has upended the approval process and halted the leasing program.¹⁵⁶ Indicative of the scope of the problem, VHA's then USH testified in 2013 that VA, since 2008, had opened 180 leased medical facilities, 50 of which required authorization as major leases.¹⁵⁷ Currently, 24 major VA leases are in limbo.¹⁵⁸

Manage its Real Property Portfolio, GAO-09-776T (Washington, DC, 2009), <http://www.gao.gov/assets/130/122697.pdf>. For example, VA has authority to outlease its facilities for up to 3 years, but may not retain the proceeds of any such leasing (Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122(a)(1)). U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain*, GAO-11-520T (Washington, DC, 2011), 5, <http://www.gao.gov/products/GAO-11-520T>.

¹⁵² Before the sunset of that authority in 2011, VA could enter into such a long-term lease if (1) at least part of the property's use would contribute to VA's mission, (2) the lease would not be inconsistent with that mission; and (3) the lease would enhance the use of the property (Enhanced-Use Leases, 38 U.S.C. § 8162(a)(2)). Congress reauthorized enhanced-use leasing, but limited it to a single use: the development of supportive-housing for veterans who are homeless or at risk of homelessness (Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Sec. 211, Pub. L. No. 112-154, 126 Stat. 1165 (2012).)

¹⁵³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁵⁴ Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104.

¹⁵⁵ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., 42 (June 27, 2013) (Statement of Robert A. Sunshine, Deputy Director, Congressional Budget Office), accessed June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

¹⁵⁶ *Ibid.* CBO maintains that the structure of VHA's lease transactions—the lease of a facility, designed by and built for VHA, and for which payments retire most or all of the debt over the life of the lease—is in the nature of a governmental purchase, and, as such, the full cost of acquiring the facility should be budgeted up front, rather than spread over the duration of the lease. As budget rules generally require that Congress offset that aggregate cost, CBO's position has had the effect of blocking what had previously been a manageable funding process.

¹⁵⁷ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., 44 (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

¹⁵⁸ "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, <https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2>.

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One of the primary benefits of leasing is that it can provide flexibility and speed.¹⁵⁹ But the time VHA has required to execute a lease, from planning through to activation, has taken almost 9 years in the case of a major lease,¹⁶⁰ in contrast with private-sector expectations of build-to-suit leases that often take fewer than 3 years.¹⁶¹

In acknowledging the magnitude of the challenges associated with VA's capital program and the budget constraints within which VA is operating, the *Independent Assessment Report* includes a suggestion that transformative options be considered, to include alternative vehicles for capital delivery such as public-private partnerships.¹⁶²

Capital Asset Management

Capital asset management itself requires reengineering. Facilities-related functions are dispersed through VA, resulting in a lack of accountability for outcomes, a mismatch between planning efforts and funding decisions, and separation of project execution and facilities management,¹⁶³ suggesting a need for transformative changes in operations.¹⁶⁴

In its work to foster transformation, department officials have recognized many organizational and process challenges that require priority attention, including the need to realign its infrastructure, identify new (private) sources of financing, streamline investment decision making and contracting, and improve the management of capital projects.¹⁶⁵ Organizational change aimed at streamlining and better aligning core processes is vital to effective operation of VA's facilities programs.

Capital-Asset Imperatives

The planning and development of a new delivery model centered on establishing integrated networks of care has major implications for identifying, planning for, and realizing VHA's capital needs. Greater reliance on community care, inherent in that model, establishes a new set of imperatives, specifically, a need for

- facility realignment
- more effective means of repurposing or other divestiture of unneeded buildings and land
- new, more effective tools to meet VHA's need for new clinic capacity and major construction
- more effective management of VHA's capital needs

¹⁵⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 159, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁶⁰ Ibid., 159-160.

¹⁶¹ Ibid., 160.

¹⁶² Ibid., vii-ix, 34.

¹⁶³ Ibid., vi, 20.

¹⁶⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, K-5, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁶⁵ Interviews of VA staff by Commission on Care staff, April 2016.

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Facility Realignment

VA planning must closely examine the role of, and future for, individual facilities, in light of a transformative new delivery model. For more than a quarter century, VHA leaders have cited the need for medical center mission changes, realignments, disposal of unneeded buildings, and where indicated, hospital closures.¹⁶⁶ The critical importance of transforming VA health care delivery gives new urgency to providing tools to realign VHA's care-delivery infrastructure. The Commission recognizes that the SECVA does have authority to "consolidate, eliminate, abolish, or redistribute the functions of . . . [VA] facilities, and to carry out an administrative reorganization" of a field facility.¹⁶⁷ But that authority may generally not be unilaterally exercised.¹⁶⁸ In addition, despite VA's having established two previous commissions to address the need for facility realignment, leaders have had only limited success in achieving that objective. The exercise of SECVA's broad authority to reorganize is tempered by the prerogatives and fiscal authority held by Congress. Congress has rejected legislation that proposed a process to reassess the future of individual VA facilities,¹⁶⁹ reflecting concerns over veterans losing access to care and the potential of constituents losing employment. Such concerns can be addressed. To be successful, a capital asset realignment process must be conducted on a systemwide basis within a framework that provides for sound planning; the exercise of objective, independent expertise; and a reliable mechanism for implementation. Congress can look to and adapt a proven model¹⁷⁰ — the military base realignment and closure (BRAC) process — to meet those objectives and achieve marked improvements in access to care.

Congress should enact legislation, based on DoD's BRAC model, to establish a VHA capital asset realignment process to more effectively align VHA facilities and improve veteran's access to care. Creating a robust capital asset realignment process is vital because previous capital divestiture efforts have failed.¹⁷¹ This process should offer a level of rigor far beyond what currently exists for repurposing and selling capital assets. It should require VHA to employ criteria set by the VHA Care System governing board (see Recommendation #9) to conduct locally-based analyses of capital assets, based on national process criteria. Information generated would be used to assist an independent commission, established under the

¹⁶⁶ "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com*, accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578>.

¹⁶⁷ Authority to Reorganize Offices, 38 U.S.C. § 510.

¹⁶⁸ Authority to Reorganize Offices, 38 U.S.C. § 510(c). In instances where a reorganization would reduce employment by 15 percent or more at a facility, VA must provide Congress a detailed plan and justification, and must defer implementation for at least 45 days.

¹⁶⁹ Veterans Millennium Health Care and Benefits Act, H.R. 2116, 106th Cong. (1999). Section 107 of House-passed H.R. 2116 would have established a mechanism for VA to cease providing hospital care at medical centers which were no longer providing high quality, efficient hospital care because of factors such as aging physical plant, functional obsolescence, and low utilization, and to redirect funds instead toward establishment of enhanced-service programs. In taking up H.R. 2116, the Senate did not adopt that provision, and it was not included in the Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545 (1999), accessed January 12, 2016, <https://www.gpo.gov/fdsys/pkg/PLAW-106publ117/html/PLAW-106publ117.htm>

¹⁷⁰ Defense Base Closure and Realignment Commission, *Defense Base Closure and Realignment Act of 1990 (as amended through FY 05 Authorization Act)*, accessed June 23, 2016, <http://www.brac.gov/docs/BRAC05Legislation.pdf>.

¹⁷¹ "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com*, accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578>.

legislation, in making recommendations regarding realignment and capital asset needs.¹⁷² The independent commission would conduct a thorough, one-time process, to include making site visits and holding hearings to inform recommendations that would constitute a proposed national realignment plan. The VHA Care System governing board would review, and adopt or make recommendations to revise, the independent commission's recommended realignment plan. The commission would then empower the VHA Care System governing board to implement the recommendations unless, within a specified timeframe, Congress disapproves the entire plan on an up or down vote. The Commission on Care envisions that after the completion of a realignment carried out under such proposed legislation and in the course of ongoing VHA transformation, the VHA Care System governing board would make all additional facility alignment decisions, to meet veterans' needs and to fully integrate with the strategic vision for the VHA Care System.

Repurposing and Divestiture of Unneeded Buildings and Land

Maintaining health care facilities to provide state-of-the-art care requires ongoing financial support. Bearing the additional cost of maintaining outdated, vacant, and unused buildings diminishes operating funds needed for patient care, and yields no benefit. Even taking unused buildings offline and placing them in *mothball status*, requires tens of millions of dollars in basic building maintenance.¹⁷³ If VA could sell, repurpose, or otherwise divest itself of unused or underutilized buildings in a timely, cost-effective manner, it would free funds for the purposes for which they are appropriated.¹⁷⁴

Enhanced-use leasing authority has in the past provided VHA a viable tool that prevents the need for such unnecessary spending, while permitting development of vacant property for uses compatible with VHA's mission, and effective use of the proceeds, whether in cash or in kind.¹⁷⁵ This leasing mechanism has been put to particularly effective use in leveraging an asset that VHA can no longer use, but which has development potential, as consideration for an asset it may need, such as clinic space. But limiting enhanced-use leasing to a single use that may not be feasible in many locations precludes effective use of a valuable capital-alignment tool.

In many instances, however, the condition or remote location of VHA buildings does not lend itself to enhanced-use leasing. Given the need to dispose of a large inventory of vacant

¹⁷² The process should take into account the community health needs assessments (CHNA) that not-for-profit hospitals are required to carry out under current law, (Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119, sec. 9007(a) (2010)) and opportunities to engage community providers in collaborative partnerships. This provision requires tax-exempt hospitals to create a hospital community health needs assessment every three years. This hospital CHNA is developed alongside community stakeholders. The community health needs assessment requirements include: demographic assessment identifying the community the hospital serves; a community health needs assessment survey of perceived healthcare issues; quantitative analysis of actual health care issues; appraisal of current efforts to address the healthcare issues; and formulation of a 3-year plan under which the community comes together to address those remaining issues collectively.

¹⁷³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 49, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁷⁴ *Ibid.*, B-13.

¹⁷⁵ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), accessed June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

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buildings for which there is no realistic prospect of their being repurposed, a streamlined divestiture process is needed.

Meeting Clinic Capacity and Other Infrastructure Needs

Developing a new delivery model and establishing a thorough realignment process may shrink VHA's future capital needs but will not eliminate them. As congressional budget rules have frustrated VHA efforts to lease needed clinic space, it is critical that VHA and Congress find models or remedies to establish new ambulatory care space and renew leases of existing clinics. Congress and VHA should work together to find the means to meet VHA's need for new clinic capacity. Given an impasse in congressional authorization of VA clinic leasing based on build-to-lease contracts, VA should explore the feasibility of restructuring those arrangements. VA should explore an arrangement that remedies the concern that it is entering into capital leases. Such an approach, for which VA provides the builder with space needs rather than a complete design, would have the additional benefit of bringing projects on line much sooner. Absent an effective solution to meeting VA's ongoing need for clinic space, Congress must be willing, as it was in passing VACAA, to take extraordinary steps¹⁷⁶ to overcome a funding challenge, and, in this instance to waive, or suspend for at least 5 years, the operation of current congressional authorization and scorekeeping requirements governing major medical leases.

In addition to severe leasing challenges, current statutory spending limits make it difficult for VHA to modernize and renovate its aging facilities.¹⁷⁷ Notably, minor construction funds, available for "constructing, altering, extending, and improving"¹⁷⁸ any VA facility, are limited to \$10 million,¹⁷⁹ yet such projects may require substantially more given the age and condition of many VA buildings. Congress last lifted the threshold of what constitutes a major medical facility project – the amount above which a project requires specific authorization – more than a decade ago.¹⁸⁰ The Commission believes that with the tight controls a governing board would exercise, that threshold should be lifted substantially, providing needed flexibility to carry out minor construction projects.

As VHA works more closely with community providers and participates in discussions regarding community health needs, it should be open to opportunities to discuss and potentially work toward joint efforts at meeting infrastructure needs.¹⁸¹

¹⁷⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 stat. 1754, sec. 803 (2014).

¹⁷⁷ VA Office of Inspector General, *Veterans Health Administration: Review of Minor Construction Program*, 8, accessed June 3, 2016, <http://www.va.gov/oig/pubs/VAOIG-12-03346-69.pdf>.

¹⁷⁸ Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242 Div. J., Title II, Department of Veterans Affairs (2015).

¹⁷⁹ A major medical facility project is one involving a total expenditure of more than \$10 million. Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(a)(3)(A).

¹⁸⁰ Sec. 812 of the Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. No. 109-461, 120 Stat. 3403 (2006), raised the threshold as to what constitutes a major medical facility project from more than \$7 million to more than \$10 million.

¹⁸¹ One such public-private model, such as under discussion in Omaha, NE, where talks have centered on private donors' partially funding construction of a replacement medical center, necessarily poses challenges, but merits exploration and support. ("VA Exploring Public-Private Plan for New Facility," Lincoln Journal Star, accessed June 3, 2016, http://journalstar.com/news/state-and-regional/nebraska/va-exploring-public-private-plan-for-new-facility/article_6a90778e-6962-545f-a86a-3f27930bd84e.html.) Although Congress must ultimately provide apt facilities for VA care-delivery, the law has long authorized the SECVA to accept gifts or donations, for purposes of facility

Capital Asset Management

The Commission fully recognizes that VHA has much to do on its own to more effectively meet its capital asset needs. At the core, leaders must strengthen and streamline the capital asset programs' management and operation, to include better aligning the component elements; streamlining the leasing program, contracting, and investment decisions; managing and streamlining project delivery for construction and renovation; and adopting a facility (or building) life-cycle-model planning tool. These are all important elements of needed system transformation.

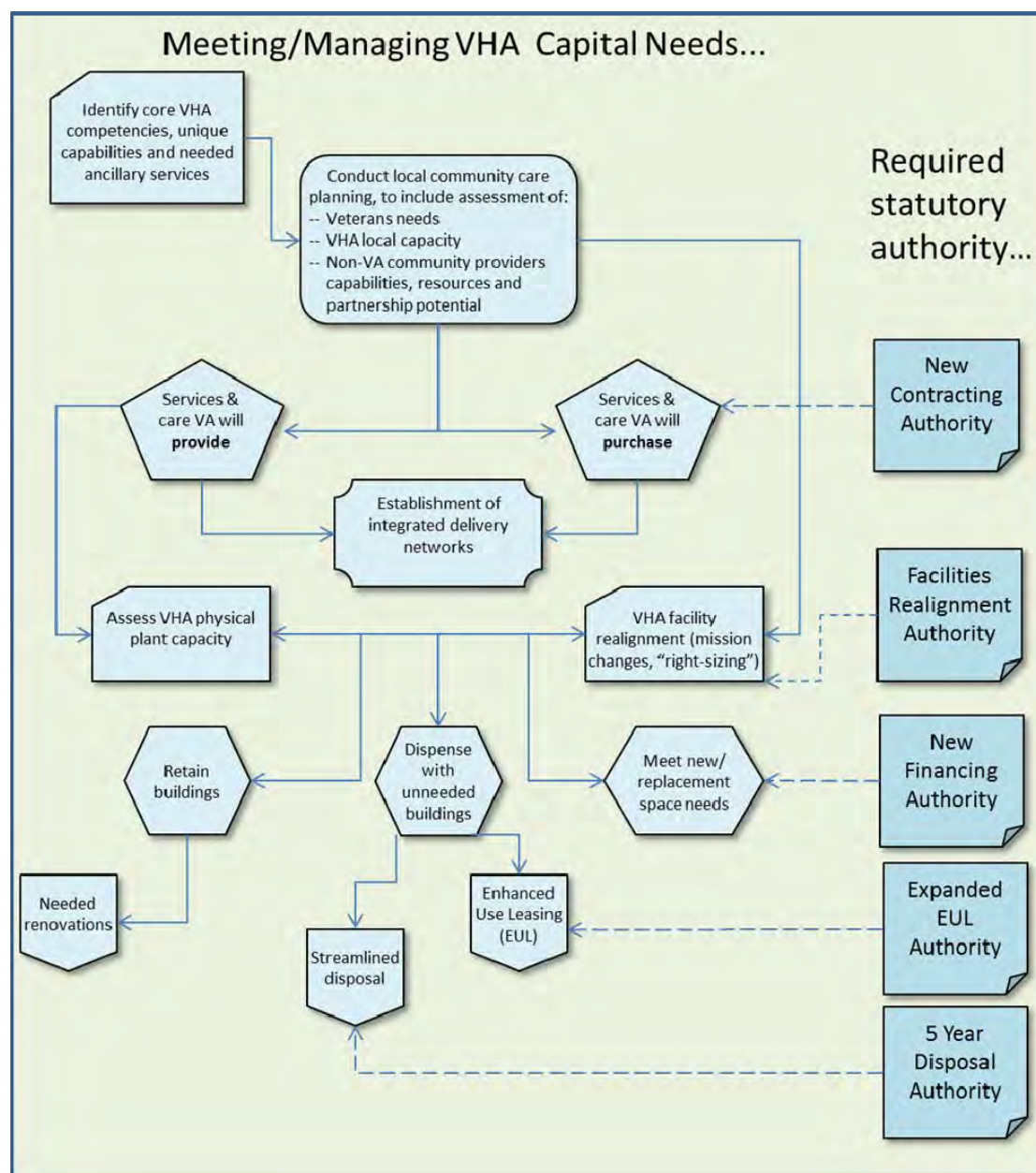
As depicted in Figure 3, meeting and managing VHA's capital-asset needs require an integrated approach that requires congressional support to tackle the multiple capital-asset challenges facing VHA. The Commission's recommendations for meeting and managing those interrelated capital-asset needs are set forth in the *Implementation* section following Figure 3.

construction. (Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(e)) Nevertheless, new legislative authority would almost assuredly be needed to permit development of public-private partnerships that provide new platforms for the construction of new or replacement medical facilities. For example, H.R. 5099 would establish a pilot program permitting VA to enter into public-private partnership agreements to plan, design, and construct new VA facilities using private donations. To Establish a Pilot Program on Partnership Agreements to Construct New Facilities for the Department of Veterans Affairs, H.R. 5099, 114th Cong. (2016), <https://www.congress.gov/bill/114th-congress/house-bill/5099>.

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Figure 3. The Complicated Process of Meeting and Managing VHA's Capital-Needs

**Implementation****Legislative Changes**

- Provide VA new, more flexible authorities to realign facilities, meet capital-asset needs, and divest itself of unneeded buildings.
- Establishing a VHA capital asset realignment process that provides (notwithstanding any other law) for more effectively aligning VHA facilities with the objective of improving the access, quality, and cost-effectiveness of VA care, and provides for:

- Establishing an independent commission (empowered to hold public hearings, make site visits, and have full access to VHA analyses and data) charged with developing a national capital asset realignment plan that would include recommendations to the VHA Care System governing board (see Recommendation #9) for systemwide facility realignment (to include changes in facility mission, facility downsizing, integration of facilities, and closures), with the rationale for each recommended change.
- The proposed plan would identify (a) the criteria used in developing realignment recommendations, (b) proposals for reinvestment and savings/cost avoidance resulting from the realignment, (c) the projected care improvements that would result, and (d) mechanisms to minimize the adverse effects on displaced employees, to include assuring that, to the extent feasible, VA retrain and reemploys displaced employees.
- The VHA Care System governing board would be empowered to adopt or alter the proposed realignment plan, and to implement the final plan unless, within a specified timeframe, Congress disapproves the plan as a whole on an up-or-down vote.
- Waive or suspend for at least 5 years current authorization and scorekeeping requirements governing major medical facility leases under 38 U.S.C. § 8104.
- Amend 38 U.S.C. § 8104 to lift the threshold of what constitutes a major medical facility project from \$10 million to \$50 million.
- Amend pertinent provisions of 38 U.S.C. § 8161, and what follows, to reinstate and extend for 10 years the authority in prior law (as in effect on December 30, 2011) for VHA to enter into enhanced-use leases for any use that is not incompatible with VA's mission.
- Provide the VHA Care System governing board authority to promulgate regulations that for a period of not more than 5 years, and notwithstanding any other law, would ease the divestiture of unneeded vacant VHA buildings, to include (a) shifting to a third party the cost of meeting environmental requirements, (b) allowing VHA to retain the proceeds of any property sale, and (c) creating a streamlined process to address historic preservation considerations.

VA Administrative Changes

- None required.

Other Department and Agency Administrative Changes

- None required.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

Problem

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems and other health care providers; enables scheduling, billing, claims, and payment; and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.¹⁸²

VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, currently within VHA, there is no experienced senior health care IT leader focusing on the strategic health care IT needs of veterans and VHA staff.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing and implementing a comprehensive health IT strategy and developing and managing the health IT budget.
- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Background

A fully functional electronic health record (EHR) can improve the quality of patient care, help avert medical errors, and improve communication among providers and with patients.¹⁸³ Starting in the 1970s, VHA became a leader in the development of EHR technology with VistA and a computerized patient record system (CPRS).¹⁸⁴ Full implementation of the EHR, together with other reforms, helped improve the quality of care at VHA.¹⁸⁵ During the last decade, VHA has not been able to maintain an IT advantage.¹⁸⁶ Although in the past most VHA clinicians

¹⁸² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁸³ "Does health information technology improve quality of care?" Robert Wood Johnson Foundation, accessed May 20, 2016, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71333.

¹⁸⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 29-30, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

¹⁸⁵ Phillip Longman, *Best Care Anywhere: Why VA Care Is Better Than Yours* (3rd ed., Berrett-Koehler Publishers, Inc., 2012). Jonathan B. Perlin, Robert M. Kolodner, and Robert H. Roswell, "The Veterans Health Administration: Quality, Value, Accountability, and Information as Transforming Strategies for Patient-Centered Care," *The American Journal of Managed Care* (November 2004), 828-836, accessed June 3, 2016, <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.476.450&rep=rep1&type=pdf>.

¹⁸⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, vi, accessed April 5, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

have had a high opinion of the clinical applications and databases enabled by VistA and CPRS, a lack of upgrades has put VHA's EHR at risk of becoming obsolete.¹⁸⁷ Many large U.S. health care systems that were early adopters of homegrown EHR systems found themselves in similar circumstances and have since purchased and migrated to commercial off-the-shelf (COTS) products.¹⁸⁸ DoD recently made the same choice.¹⁸⁹

To achieve the Commission's vision of a health care system that delivers quality, access, choice, and veteran well-being, VHA requires effective, robust, and modern information technology systems. A robust EHR system would allow veterans and clinical providers to send, receive, find, and use electronic health information in a manner that is appropriate, secure, timely, and reliable. It would be seamlessly interoperable with other systems including DoD, private-sector providers, and with other VA enterprise systems such as those in the Veterans Benefits Administration (VBA). It would support VHA clinical workflow, evidence-based practice, and patient safety. It would provide clinicians, patients, and administrators the data, analytic power, and user interfaces required to monitor the effectiveness of care and improve it over time. A robust IT system for VHA should include more than just the EHR, however, extending to all the systems and tools required to facilitate and automate business processes that support access and veterans' care. These capabilities include an effective scheduling system, telephone systems, mobile applications, telehealth, financial management systems, human resources systems, and other systems that enable community care.

To realize such a transformation of IT in a system as complex as VHA requires exceptional leadership and staff, sufficient budget, a robust change management plan, effective systems for accountability and quality control, and efficient and agile contracting.¹⁹⁰ Presently, VHA appears to lack a majority of these factors required for success.¹⁹¹

Analysis

Leadership and Staff

Prior to 2006, VHA had a chief health informatics officer responsible for the VHA electronic record system and for coordinating with VA on IT systems. The programmers in VHA worked closely with the clinicians who used the tool to create a system that met their needs.¹⁹² VHA was able to prioritize clinical needs and patient safety requirements within its overall budget and plan for IT spending; however, there was no specific budget line item for the electronic health

¹⁸⁷ Ibid., 29-30.

¹⁸⁸ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

¹⁸⁹ "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

¹⁹⁰ LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

¹⁹¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 41, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁹² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

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record system or related technology, and there was limited central oversight or accountability for information technology infrastructure.

VA's IT budget was centralized in 2006, and the Office of Information and Technology (OIT) was assigned to deliver, operate, and manage IT and its budget, across the department. With this change, VHA's needs became only one of the priorities that OIT has had to accommodate and VHA's priorities have not always prevailed.¹⁹³

To ensure that clinical needs and patient safety are a priority, many large health care systems, such as DoD, Cleveland Clinic, Geisinger, and Kaiser Permanente, have a medical CIO (i.e., CMIO) who manages and advocates for the clinical IT needs of the organization. A CMIO ensures that clinicians are involved in the selection of any IT systems they use to perform their job functions and provide patient care, including EHRs. Clinicians involved in the selection and deployment of an IT system are more likely to feel ownership of it and fully adopt its use. The CMIO usually reports to the health system's CEO or CMO, and working in concert with these individuals and the organization's CIO, makes sure that health information needs are prioritized and funded.¹⁹⁴

VA does not have staff with the necessary expertise to execute large-scale IT projects. Previous system implementations have failed because VA did not have individuals with adequate experience to effectively plan and manage system development and deployment. If VA had an adequate system and skilled staff to monitor and identify program and contracting problems affecting the progress of prior IT implementations, effective and timely decisions could have been made to either redirect or terminate VA IT projects that ultimately failed. To avoid repeating these previous IT implementation failures, VA needs to develop effective oversight systems and develop in-house staff with the expertise to oversee, fully support, manage, and execute complex integrated IT programs.¹⁹⁵

Given all of these critical needs, the Commission believes that it is essential for VHA to have a CIO with health care expertise and substantial experience, reporting to the chief of VHA Care System. The VHA CIO will be responsible for managing the complex implementation of a state-of-the-art comprehensive information system platform to support the new integrated VHA Care System, with the functionality, interoperability, and data management capabilities to support the delivery and coordination of high-quality health care for veterans. The CIO will need to work closely with clinical and operational leaders on the effective execution of the new system, and will also need to collaborate with the VA CIO to ensure the integration and coordination of the health care information system and the Veterans Benefit Administration system.

¹⁹³ Ibid., 10.

¹⁹⁴ "CMIOs Help Hospitals Make Tech Transitions," Naseem S. Miller, accessed May 13, 2016, <https://www.acep.org/content.aspx?id=79744>.

¹⁹⁵ Department of Veterans Affairs Office of the Inspector General, *Review of the Awards and Administration of Task Orders Issues by the Department of Veterans Affairs for the Replacement Scheduling Application Development Program*, accessed May 25, 2016, <http://www.va.gov/oig/52/reports/2009/VAOIG-09-01926-207.pdf>.

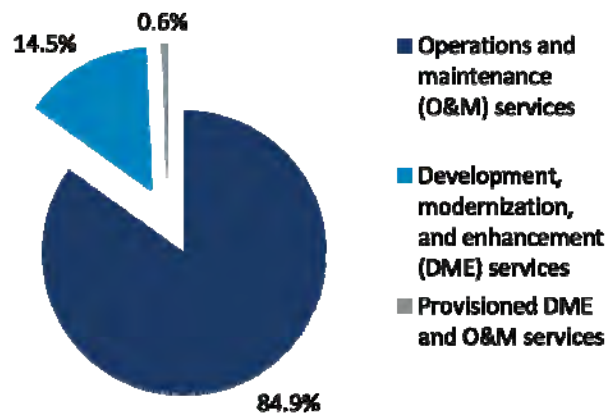
Budget

The 1-year budget appropriations cycle makes it difficult to secure multiyear funding for long-term development and important IT projects.¹⁹⁶ The budget process is disconnected from total lifecycle IT costs.¹⁹⁷ That disconnect has grown wider with a change in law¹⁹⁸ under which Congress provides VHA advanced medical care appropriations—in effect a 2-year budget—while health IT funding remains 1-year money.¹⁹⁹ As the Congressional Research Service (CRS) testified,

*providing an advance appropriation for some VHA accounts and funding IT accounts under a regular appropriation act could create a situation whereby, for example, VHA could not purchase computer software although it has procured medical equipment that needs software. Another example would be the difficulty of procuring IT infrastructure to support opening of a new community-based outpatient clinic (CBOC).*²⁰⁰

Spending on new systems and upgrades to existing systems now represents only 15 percent of VA's total IT budget (see Figure 4),²⁰¹ meaning that essential upgrades like a new scheduling package and EHR modernization have not had the funding or focus required to succeed. Clinical users have become increasingly frustrated by the lack of any clear advances with VistA during the past decade. Numerous VHA clinicians have experience with commercial EHR systems and want the same level of features, modern clinical capabilities, integration, and mobility they see emerging in the commercial marketplace.²⁰²

Figure 4. VA IT Spending



In July 2015, DoD awarded a \$4.3 billion, 10-year contract to overhaul the Pentagon's electronic health records for millions of active-duty military members and retirees. Officials estimate that

¹⁹⁶ "Coming in 2016: Cloud Legislation," Aisha Chowdhry and Adam Mazmanian, accessed January 12, 2016, <https://fcw.com/articles/2015/12/22/cloud-bill-2016.aspx>.

¹⁹⁷ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.

¹⁹⁸ Veterans Health Care Budget Reform and Transparency Act of 2009, Pub. L. No. 111-81, 123 Stat. 2137 (2009).

¹⁹⁹ With the Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235 (December 16, 2014), Congress expanded advanced appropriations to additional VA program accounts.

²⁰⁰ U.S. Congress, House of Representatives, Committee on Veterans Affairs, *Funding the U.S. Department of Veterans Affairs of the Future: Hearing before the Committee on Veterans Affairs U.S. House of Representatives*, 111th Congress, 1st Sess., April 29, 2009, 60, accessed June 3, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-111hhrg49914/pdf/CHRG-111hhrg49914.pdf>.

²⁰¹ Department of Veterans Affairs, *Information Technology Agency Summary*, accessed May 25, 2016, <https://itdashboard.gov/drupal/summary/029>.

²⁰² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

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during its potential 18-year life, the contract could be worth just less than \$9 billion.²⁰³ The recent Senate appropriations bill for VA OIT allots \$63 million toward development and modernization of VA's existing EHR (i.e., VistA Evolution).²⁰⁴ Assuming that VA's implementation of a new COTS EHR would be similar in size and scope to DoD's EHR implementation, VA would be short \$3.67 billion in funding for a new COTS EHR, given the current funding amount of \$63 million per year. VA will require a substantial increase in IT funding to support the successful implementation of a new comprehensive COTS EHR.

Robust Change Plan

Because VistA has been customized at each medical center, there are few standard data elements. The varied algorithms lead to a complex, heterogeneous mix of hardware and software that impedes system changes and new capabilities and raises operations and maintenance costs.²⁰⁵ Due to excessive project management overhead, a complex legacy IT infrastructure that is difficult to modernize, and more than 130 variations of the primary software system deployed across VHA medical facilities, the implementation of improved IT capabilities in the last 10 years has been extremely limited.²⁰⁶ VA is currently weighing whether to continue to modernize VistA or purchase a COTS health information technology platform. The Commission recommends moving to a COTS program.

Whether VHA moves forward with the purchase of a COTS product, as recommended by the Commission, or continues attempting to modernize VistA, VHA must effectively manage the change process. At present, a lack of standard clinical documentation has made it harder to develop effective clinical decision-support systems and hinders EHR information exchange among VA Medical Centers (VAMC), between VA and non-VA facilities (including those of DoD), and between VA and individual veterans. Shared data must be well labeled in a way that the receiving system can identify and properly ingest such data. An electronic medical record can contain as many as 100,000 different data fields. The lack of data standards presents challenges to using comparable data for analysis and disparities among the 130 tailored local instances of VistA, complicating information sharing, data aggregation, and analytics.²⁰⁷ VHA has not established comprehensive semantic definitions for data elements through the use of standard nomenclatures, terminologies, and code sets. Doing so is required to ensure consistency and integration across multiple systems, leverage follow-on IT products, and facilitate analytics for clinical decision making.²⁰⁸

The Office of the National Coordinator (ONC) for Health IT, under HHS, is responsible for advancing national connectivity and interoperability of health information technology. The

²⁰³ "Cerner wins \$4.3 billion DoD contract to overhaul electronic health records," Amy Brittain, *The Washington Post*, accessed May 25, 2016, https://www.washingtonpost.com/national/health-science/cerner-wins-dod-contract-to-overhaul-electronic-health-records/2015/07/29/7fbfccfa-35f5-11e5-b673-1df005a0fb28_story.html.

²⁰⁴ S. Rept. 114-237 – Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, 2017, accessed May 25, 2016, <https://www.congress.gov/congressional-report/114th-congress/senate-report/237/1>.

²⁰⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²⁰⁶ *Ibid.*, 41.

²⁰⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, vi, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁰⁸ *Ibid.*, viii.

ONC developed the National Interoperability Roadmap with the goal of being able to use electronic health information exchange, so information can follow a patient where and when it is needed, across organizational, health IT developer, and geographic boundaries. The roadmap lays out a clear path to catalyze the collaboration of stakeholders who are going to build and use the health IT infrastructure.²⁰⁹ VA's intent to expand veteran care to more community providers through the creation of locally-integrated health care networks will mean that it is important for VHA to follow the ONC roadmap and standards. Following this roadmap includes using the continuity of care document to exchange data, which was established by ONC and is followed by community health care providers. VA OIT is currently collaborating with the ONC on VA's plans for interoperability and has committed VA to following the roadmap.²¹⁰

VHA does not yet have a robust, detailed strategy and roadmap for IT initiatives across VHA that integrates veteran access to scheduling via phone, telehealth, and mobile apps.²¹¹ National deployment of the VistA Scheduling Enhancement and the veteran mobile scheduling Veteran Appointment Request app, are initial steps to prepare for the implementation of new COTS electronic medical system with a scheduling package.

To resolve the underlying systemic issues with VistA scheduling, VA awarded a contract for the implementation of VA's new COTS medical appointment scheduling system in August 2015.²¹² This system is a COTS scheduling solution that, when implemented, is expected to move VHA from primarily a face-to-face appointment model to a coherent, resource-based system with broad opportunities for improved services for VA stakeholders.²¹³ Deployment is awaiting the final decision on whether VHA will continue with VistA or purchase a full COTS product.

COTS Solution

The current VistA/computerized patient records systems are based on a tightly integrated, monolithic architecture and design with numerous and diverse functional components and associated interdependencies. These characteristics impose barriers to modernizing the respective systems. In addition, the high cost of infrastructure operation and maintenance (85 percent of the total IT budget) reduces funding available for new development efforts.²¹⁴ Maintenance and data sharing are further complicated because most VAMCs have customized their local versions of VistA, leading to approximately 130 different versions of VistA across the country.²¹⁵

²⁰⁹ "A Shared Nationwide Interoperability Roadmap Version 1.0," HealthIT.gov, accessed March 29, 2016, <https://www.healthit.gov/policy-researchers-implementers/interoperability>.

²¹⁰ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²¹¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 44, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²¹² "\$623M Medical Appointment Scheduling System (MASS) Contract," G2Xchange, accessed May 3, 2016, <https://www.g2xchange.com/statics/623m-medical-appointment-scheduling-system-mass-contract>.

²¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 40, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²¹⁴ *Ibid.*, vi.

²¹⁵ *Ibid.*, vi.

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VHA relies on a VistA scheduling package to provide veterans with access to health care. The system is antiquated, highly inefficient, does not optimally support processes or allow for efficient scheduling of appointments. A report on scheduling published by the Northern Virginia Technology Council (NVTC) in October 2014, showed that VA's exam-scheduling processes are not enabled by state-of-the-art technologies or consistently applied standard operating procedures.²¹⁶ To improve this situation, VHA has developed, and is in the process of a national roll out of, VistA scheduling enhancements, which provides an improved user interface (i.e., graphic user interface or GUI). Although the new GUI will help veterans gain access to care by implementing better scheduling procedures, it does not address the need that managers, planners, and administrators have for accurate and timely data on clinic use.²¹⁷ For instance, VHA's new health care operations dashboard shows that more than 55 percent of clinic slots in VHA go unused each day.²¹⁸ However when questioned about this data, VHA notes that it is not correct.²¹⁹ The underlying VistA scheduling software does not allow accurate representation of clinician time toward each clinic stop. As a result, whether data is presented in a dashboard or a new GUI tool, as long as the underlying data cannot be captured accurately, then VHA will not have the information it needs to effectively manage the supply of clinic slots.²²⁰

VA's financial management information technology system is woefully outdated and VA has previously wasted approximately \$500 million in two failed attempts to replace it. Given VA's lack of an integrated finance and logistics IT system, VA has no method to perform commitment accounting.²²¹ VA's current financial management system does not support streamlining and automation of VA's revenue cycle.²²²

Community care processes currently include eligibility determinations, referrals and authorizations, care coordination, network management, claims, and customer service.²²³ VA's information technology systems limitations often demand manual processes to support community care that can reduce the timeliness and accuracy of data and obscure the true state of VHA's activities. Relying on manual processes slows collections and payment activities and introduces errors and waste into the process.²²⁴ Barriers to automation are multifactorial,

²¹⁶ Ibid., 39-40.

²¹⁷ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

²¹⁸ Crystal Wilson, Office of Analytics and Business Intelligence, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.

²¹⁹ Joe Francis, Director of Clinical Analytics and Reporting, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.

²²⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

²²¹ Jan R. Frye, *Letter to Secretary McDonald, March 19, 2015*, accessed May 17, 2016, http://extras.mnginteractive.com/live/media/site36/2015/0522/20150522_025126_WhistleblowerMemo.pdf.

²²² Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, 24, accessed May 24, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf.

²²³ Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.

²²⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 42, accessed March 28, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

including confusing eligibility rules governing which veterans may receive care outside VHA and for what conditions, in what circumstances, and which services may be billed to third-party insurers.²²⁵ In addition, there are multiple authorities for purchasing community care—all with different business rules²²⁶ and reimbursement rates, as well as antiquated financial management information systems that are not standardized to private-sector processes. All of these impediments are exacerbated by workers throughout the revenue cycle who are poorly compensated and marginally trained, experience high turnover, and work in environments with a continuous 20 percent vacancy rate;²²⁷ thus, they cannot effectively manage certain business practices such as insurance verification and ensuring clinicians complete necessary coding documentation.²²⁸

Many large U.S. health care systems that originally developed in-house EHRs have since purchased and migrated to COTS EHRs.²²⁹ DoD recently made the same choice, deciding to replace its homegrown EHR with a COTS product to take advantage of private-sector innovation and have an EHR that communicates with private-sector systems. For a system in which 60 to 70 percent of military health care takes place outside the DoD,²³⁰ this was an important business consideration that is also consistent with VHA's long term direction. Very large IT programs with purpose-built systems and labor-driven business models are shifting rapidly toward more open source, COTS systems. Large proprietary IT solutions are increasingly being replaced by less risky, agile, and open-source solutions or IT as-a-service models, and getting away from client-server models.²³¹

Interoperability

VHA's EHR issues stymie interoperability among VHA facilities as well as between VHA and DoD and other non-VHA providers. Multiple assessments noted the lack of interoperability resulted in incomplete patient records with potentially substantial implications for veterans and VHA. Incomplete records introduce unnecessary clinical risk, complicate the transition from

²²⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I (Business Processes)*, 19-20, accessed April 26, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²²⁶ Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.

²²⁷ Healthcare Talent Management, Veterans Health Administration, email to Commission on Care, April 11, 2016. Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America's Veterans*, accessed April 25, 2016, <http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf>.

²²⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I, Business Processes*, I3-I4, accessed November 24, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²²⁹ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

²³⁰ "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

²³¹ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

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DoD to VHA care, and inhibit VHA's ability to bill and collect revenue in an accurate and timely manner.²³²

As GAO reported in August 2015, VA and DoD have taken initial steps to increase interoperability between their existing electronic health record systems.²³³ They have deployed the Joint Legacy Viewer (JLV), which provides a patient-centric, integrated view of a patient's health data from VA, DoD, and community health partners on one screen. It has been available at all VA medical centers since October 2014 and currently has more than 70,000 users.²³⁴ The JLV is a positive step in supporting coordination of care among VA, DoD, and community partners, but it only allows for providers to view veterans'/service members' medical records and does not yet allow for the other agencies' medical records to be updated by providers.²³⁵

VA's next evolution in interoperability with DoD and community partners is the deployment of their Enterprise Health Management Platform (eHMP). eHMP is intended to provide VA streamlined access to complete patient history from VA, DoD, and community health partners in a single, reliable, customizable, and secure interface that is easy to use. It is reported to deliver a modern, web-based user interface and supporting infrastructure and is intended to replace the Computerized Patient Record System (CPRS) as VA's primary point-of-care application. The national rollout of eHMP is expected to be completed by December 2017.²³⁶

VHA does not have everything that is needed in an IT system to manage the business and clinical aspects of care in the community and support the overall veteran experience in an expanded community network. To address these gaps and provide health care well into the future, VA intends to develop in house a comprehensive and interoperable digital health platform (DHP). The DHP is intended to seamlessly integrate all of VHA's core processes, including scheduling, supply chain management, billing, and claims. Through consolidation of more than 40 contact center systems and more than 130 versions of the VistA EHR and clinical procurement/inventory systems, the DHP is designed to enable VHA's operation as a holistic, platform business and greatly reduce the cost of system maintenance across the IT enterprise.²³⁷

Because there is no unique patient identifier, problems exist with "1) accessing and integrating information from different providers and provider computer systems, 2) aggregating and providing a lifelong view of a patient's information, and 3) supporting population-based research and development."²³⁸ To accurately match veteran patient data that is exchanged between VA and non-VA providers, both organizations need to use the same unique patient

²³² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 44, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²³³ "Electronic Health Records: VA and DOD Need to Establish Goals and Metrics for Their Interoperability Efforts," U.S. Government Accountability Office, accessed April 1, 2016, <http://www.gao.gov/products/GAO-16-184T>.

²³⁴ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²³⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, A-35, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²³⁶ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²³⁷ LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²³⁸ "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPVU-508.pdf>.

identifier. This practice is currently not used.²³⁹ Each health care system uses a unique patient identifier number, but it is specific to that system.²⁴⁰ VA uses patients' social security numbers as unique identifiers; whereas, due to stricter security standards required by HIPPA privacy laws that community providers must adhere to, many non-VA providers use other personally identifiable information (e.g., first name, last name, date of birth, and phone number) to match patient identities between record systems. Studies have shown that patient identification error rates range from 7-20 percent.²⁴¹ For VA to accurately identify patients and their records, a unique national patient identifier is essential.

The security of electronic records is an ongoing concern. One in three Americans had health care records breached in 2015.²⁴² Recent hacks of U.S. hospital health care systems through the use of ransomware, viruses that hold systems hostage until victims pay for a key to regain access, further highlight the need for enhanced VA cybersecurity.²⁴³ VA's OIG has repeatedly identified the same weaknesses and deficiencies in VA's information security program in its annual FISMA audit reports.²⁴⁴ Although VA has recently made some progress in developing policies and procedures to address current security gaps, OIG's FY 2015 audit concluded that information security is still a *material weakness* for VA and that VA must take comprehensive measures to mitigate security vulnerabilities affecting VA's mission-critical systems.²⁴⁵ For sharing of veteran data to be secure, only the designated correct parties can have access to patients' data.²⁴⁶ Interoperability increases the risk to veterans' health records.²⁴⁷ Cybersecurity guidelines and best practices are being developed by HHS in response to the requirements in the recently enacted Cybersecurity Information Sharing Act;²⁴⁸ however, security protocols also cannot impede health information exchange with VA community providers and health systems. VA OIT needs to be involved in the health information exchange planning discussions, which

²³⁹ "Interoperability 2015: Current State and Next Steps", Kent Gale, KLAS Research, accessed March 9, 2016, <http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0>.

²⁴⁰ "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPAVU-508.pdf>.

²⁴¹ "The Right Fit: How We Solve the Puzzle of Interoperability," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, <http://www.futureofhealthcarenews.com/telemedicine/the-right-fit-how-we-solve-the-puzzle-of-interoperability>.

²⁴² "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, <http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records>.

²⁴³ "Virus Infects Medstar Health System's Computers, Forcing an Online Shutdown," John Woodrow Cox, Karen Turner and Matt Zapotosky, accessed March 28, 2016, https://www.washingtonpost.com/local/virus-infects-medstar-health-systems-computers-hospital-officials-say/2016/03/28/480f7d66-f515-11e5-a3ce-f06b5ba21f33_story.html?hpid=hp_local-news_medstar-health-virus-345pm_percent3Ahomepage_percent2Fstory.

²⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, A-24, accessed May 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁴⁵ Department of Veterans Affairs, Office of the Inspector General, *Federal Information Security Modernization Act Audit for Fiscal Year 2015*, accessed May 25, 2016, <http://www.va.gov/oig/pubs/VAOIG-15-01957-100.pdf>.

²⁴⁶ "Interoperability 2015: Current State and Next Steps; Market Immaturity Highlights Opportunity," Kent Gale, KLAS Research, accessed March 9, 2016, <http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0>.

²⁴⁷ Jon White, M.D., The Office of the National Coordinator for Health Information Technology, briefing to Commission on Care, December 15, 2015.

²⁴⁸ "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 17, 2016, <http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records>.

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are currently handled solely within VHA, so that VA OIT can assist in removing impediments to health information exchange.²⁴⁹

Veterans currently have to opt in (i.e., provide consent) to allow VA to share their health information with non-VHA/community care providers. Although the technology is in place for VA to exchange patient health information with more than 100 health information exchange partners, only a fraction of data can be exchanged in these networks because, due to lack of awareness, only 3 percent of veterans have opted in to allow VA to share their health information.²⁵⁰ The standard industry policy is to have patients opt out of having their health data shared with their other health care providers. VA is prohibited from taking this approach because statutory language in 38 U.S.C. § 7332 prohibits VA from disclosing information relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia, except when required in emergencies, without written authorized consent from the patient.²⁵¹

In response to this limitation, VA approved and submitted Legislative Proposal VHA-10 (10P-07), Authority for the Department of Veterans Affairs (VA) to Release Patient Information under 38 U.S.C. § 7332 to Health Care Providers for Treatment of Shared Patients in 2013. The proposal allows veterans to opt out of sharing their data with VA community providers instead of having to opt in. The proposal was approved by OMB and was included in the president's 2015 Budget. VHA provided a briefing to a Senate Veterans Affairs Committee staff in April 2015 on this legislative proposal. A House Bill was introduced, but it limited the opt-out option to the *Choice Program*. VA's Office of Congressional and Legislative Affairs responded back to Congress that the bill should be expanded to include all external purchased care options (i.e., community providers) thus directly supporting more veterans.²⁵²

Collaboration between VA OIT and VHA is paramount to transforming VHA's health IT infrastructure. Such collaboration would be most effectively achieved by establishing an IT leader for VHA who is focused on ensuring that the strategic and operational IT needs of VHA clinicians, staff, and veterans are met. Current OIT leadership is in the process of modernizing VA's IT management processes, to include putting in place IT account managers (ITAMs) for each of the agency's departments, including VHA.²⁵³ An account manager is neither senior enough, nor has the level of expertise and experience, to manage the complexity of the VHA IT system. VHA's extensive IT needs require a VHA CIO with authority over the health IT budget and the execution of the health IT strategy. VA needs a robust process for IT investment decisions, especially those relating to VHA's health strategy. The VHA CIO would work with the CVCS and the VA CIO to define the health IT strategy and key IT acquisitions/projects and ensure that health IT funding is aligned and committed to the execution of VHA's health IT

²⁴⁹ Jamie Bennett, VLER Health Program Manager, phone call with Commission on Care Staff, March 2, 2016.

²⁵⁰ Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015

²⁵¹ 38 U.S.C. § 7332 Subchapter III - Protection of Patient Rights Sec. 7332 - Confidentiality of certain medical records.

²⁵² Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015.

²⁵³ "OI&T Enterprise Strategy: Putting Veterans First," LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.

strategy. Rolling out a new system takes multiple years, and VA must commit to funding system deployments to completion.

The modernization of VHA's IT infrastructure requires a substantial increase in and reallocation of VA's IT budget to implement it. The budget process for VA health care IT funding should be the same as the process for VHA medical care funding. That shift can be accomplished by establishing a separate line item for *health* IT within VA's IT appropriation, and providing for advanced appropriations for that account. In addition, there is also a potential supplementary role for government-wide IT legislation. For example, H.R. 4897, the Information Technology Modernization Act of April 2016, would create a \$3.1 billion revolving fund for upgrading outdated federal IT systems.²⁵⁴

The Commission strongly recommends that VA purchase a comprehensive COTS health IT platform, and implement all information systems with minimal customization. VHA leadership is in the process of assessing whether VistA is the best solution to support veterans' future health care needs or whether a new EHR, such as a COTS product or open-source EHR, should be used.²⁵⁵ The decision to choose a COTS product would be consistent the approach adopted by DoD and by other large health systems that have moved away from homegrown solutions to commercial and open-source products. It would allow VHA to focus energy on excellent patient care as a core competency and shift the IT development and maintenance risk of software products to external vendors with more expertise in this area.²⁵⁶ It is also likely to accelerate interoperability as vendors continue to offer IT solutions that meet meaningful use standards and the roadmap published by ONC.

A COTS product must be able to execute key functionalities required by VHA. These requirements include one standard version of an EHR across all VHA sites of care; interoperability within VA, such as with Veterans Benefit Administration (VBA), and between VHA and DoD, and community providers; robust security; and the ability to accommodate a national unique patient identifier. This system must also be a robust clinical management tool that supports VHA clinical workflow and has a customizable interface for clinical users, allows for evidence-based clinical order sets and patient safety features like automated medication reconciliation, has robust analytic capability for both clinical and administrative functions, and enables automated abstraction and reporting of performance measures.

The system must also seamlessly support administrative functions like scheduling, patient intake, eligibility determination, referrals, and patient out-of-pocket expense determination. The system must enable effective business operations in billing coding, automated claims processing, and all aspects of supply chain management. This COTS purchase should include a scheduling package. Improvements in scheduling should dramatically increase access and satisfaction, as well as data quality, productivity, and operational reporting capabilities.

²⁵⁴ "Two IT Modernization Bills Could See Movement in Congress," Aisha Chowdhry, accessed April 28, 2016, <https://washingtontechnology.com/articles/2016/04/22/it-bills-congress.aspx>.

⁷³ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²⁵⁶ "DoD awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

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Broadening and improving scheduling capabilities will provide more opportunities for veterans to become active partners in their own care.²⁵⁷

For VHA to transition to a COTS product, the new VHA CIO must develop and implement a strategy that will allow the current nonstandard data to effectively roll into a new system, engage clinical-end users and internal experts in the procurement and transition process, ensure effective cybersecurity, and limit spending on the current systems to fund only critical changes required for continued operations. Finally, this plan should be coordinated with ONC and DoD.

Implementation

Legislative Changes

- Provide a specific appropriation to fully fund the complete development and deployment of the comprehensive COTS electronic health platform, recognizing this will require significant resources above the current annual appropriation and funding to support VHA's IT transformation; including funds that ensure appropriate training of all staff, recognize loss of staff productivity during implementation, and provide proper maintenance and upgrades of VA IT infrastructure in preparation for new and successor technologies.
- Establish within the Department's IT appropriation a line item for health IT, and provide for advanced appropriations for that account, consistent with the overall VHA IT strategy.
- Amend section 38 U.S.C. §7332, to authorize VA to share protected health information under the same rules as all other HIPAA protected information.

VA Administrative Changes

- Hire a CIO for the VHA IT transformation. The CIO should report to the CVCS, with secondary reporting responsibility to VA CIO.
- Establish a transformation strategy that addresses all of the following needs (as directed by the VHA CIO):
 - standardizes data elements in the current IT systems through the use of standard nomenclatures, terminologies and code sets in order to promote the transition to a COTS EHR and to support interoperability²⁵⁸
 - develops a robust cybersecurity plan for VHA IT infrastructure, in coordination with VA CIO and Chief Information Security Office, which addresses both current systems and defines
 - the requirements for new systems

²⁵⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 46, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁵⁸ *Ibid.*, 55.

- collaborates with the Office of the National Coordinator for Health IT on national interoperability standards and implementation
- limits any continued VistA development and associated spending to only those upgrades required to keep VistA functioning until a new system is in place
- Plan and implement procurement of a comprehensive COTS electronic health platform that executes all of the following requirements:
 - establishes one logical version of an electronic health record platform in VHA²⁵⁹
 - standardizes evidenced-based, best practice clinical order sets across VHA
 - incorporates effective analytic capabilities to drive health and business outcomes and offers the ability to interface with other tools for data management and presentation²⁶⁰
 - modernizes appointment scheduling so that it accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veterans²⁶¹
 - accomplishes a coordinated IT infrastructure for appointment scheduling, coding, billing, claims payment, third party collections, and other core VHA business processes, including the following specific capabilities: integration across patient intake, medical records, coding, and billing systems; single sign-on capability; automated first-party claims matching; real-time estimate of out-of-pocket patient expenses; and automation to support algorithmic edits and claims correction²⁶²
 - supports the business processes required to implement integrated community care networks, including eligibility determinations, referrals and authorizations, care coordination, network management, claims and customer service
 - promotes full interoperability with IT systems across VA (including VBA and National Cemetery Administration) and between VA and DoD
 - supports the development of full interoperability with integrated community care network facilities and providers

²⁵⁹ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²⁶⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, viii, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁶¹ The Independent Budget, *The Independent Budget—Veterans Agenda for the 114th Congress: Policy Recommendations for Congress and the Administration*, accessed May 17, 2016, http://www.independentbudget.org/2016/IB_FY16.pdf.

²⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 49, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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- enables automated abstraction and reporting of quality performance measures including process and outcome measures of clinical quality, access measures, and cost effectiveness that are the same as the private sector
- includes functionality to use a national unique patient identifier
- integrates supply chain and financial systems with the electronic health records to provide accurate operational data²⁶³
- Streamline its current IT procurement processes so that IT procurement is expeditious, including lengthier contract vehicles with more options, the use of indefinite delivery indefinite quantity vehicles, blanket purchase agreements, time and material contracts, and flexible contract structures to allow for the onboarding of emerging technologies in a competitive fashion.
- Increase health IT expertise within VHA.

Other Department and Agency Administrative Changes

- CMS and federal health care providers should collaborate to develop a national unique patient identifier standard. CMS should require health care providers to use these identifiers as a condition of participation in Medicare and HHS should require federally qualified health centers to use them as a condition of participation. The President should require all federal health care providers to adopt the standard.

²⁶³ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Problem

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.²⁶⁴

Background

Health systems nationwide, under pressure from reforms driven by the Affordable Care Act, are looking at every aspect of their business to maximize cost savings, while maintaining quality services.²⁶⁵ This effort includes examining the supply chain for ways to save money.²⁶⁶

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.
- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

²⁶⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁶⁵ Bob Kehoe, "Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness," *Health Facility Management Magazine*, 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.

²⁶⁶ "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, <http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends>. "5 Ways Supply Chain Can Reduce Rising Health Care Costs," Jasmine Pennie, accessed April 28, 2016, <http://hitconsultant.net/2013/05/13/5-ways-supply-chain-can-reduce-rising-health-care-costs/>.

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Price competition achieved through technology and aggressive management of supply chain efficiencies by retailers such as Walmart and Amazon are held up as just the kind of disruption that health care requires.²⁶⁷ Health care organizations as diverse as Kaiser Permanente, Cleveland Clinic, Stanford Medicine, and Johns Hopkins Health System have taken on the challenge of transforming their supply chains, realizing savings of as much as hundreds of millions of dollars.²⁶⁸ VHA, which in FY 2014 spent approximately \$3.4 billion on clinical supplies, medical devices, and prosthetic appliances, has an opportunity to realize similar savings.²⁶⁹

Opportunities for efficiency in the supply chain include reducing pricing for purchases and lowering operating costs of procurement processes. To achieve price savings, organizations must have detailed information on what products they use, understand and reduce variability in the products purchased, and aggressively negotiate pricing, usually by consolidating purchases to a small number of preferred vendors who are willing to offer volume discounts and improve service delivery. On the operations side, cost savings are achieved by managing inventory lifecycle and restocking processes; order management; and the logistics of shipping, receiving, and transportation to drive down costs and lower waste and breakage. In health care, it also pays to ensure that clinical staff, both nurses and doctors, are treating patients rather than conducting inventory checks or ordering and collecting supplies.²⁷⁰ To be successful in managing the supply chain in health care, a partnership with clinical staff is key. Variability in device and supply purchases can be driven by clinician preferences and thus, to reduce variability, clinicians must be engaged in analyzing product options and examining data on product effectiveness to determine what products to use with patients.²⁷¹

VHA has a successful internal model of aggressive supply chain management that can serve as a model for improving the management of medical, surgical and other supplies: the VHA Pharmacy Benefits Management Service (PBM). PBM has taken a systems approach to

²⁶⁷ John Agwunobi and Paul London, "Removing Costs from the Health Care Supply Chain: Lessons from Mass Retail," *Health Affairs*, 28, no 5, (2009): 1336-1342, accessed April 26, 2016, <http://content.healthaffairs.org/content/28/5/1336>.

²⁶⁸ "In Age of Mergers, Hospitals Get Strategic with Medical Supply Purchasing," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/age-mergers-hospitals-get-strategic-medical-supply-purchasing>. "Supply Chain Management," Cleveland Clinic, accessed April 27, 2016, <http://my.clevelandclinic.org/services/supply-chain-management>. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering>.

²⁶⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 47, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁰ "EY Provider Post: Choosing Your Innovation Pathway," EY, accessed April 26, 2016, <http://www.ey.com/US/en/Industries/United-States-sectors/Health-Care/Provider-Post--Choosing-your-innovation-pathway>.

²⁷¹ "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, <http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends>. "Strategic Supply Chain Management," Lee Ann Jarrow, accessed April 28, 2016, <http://www.hhnmag.com/articles/4522-strategic-supply-chain-management>. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering>.

managing pharmaceutical supplies, logistics, and prescribing.²⁷² PBM has largely solved the internal contracting deficiencies in VA by consolidating its activities under just two contracting organizations that oversee all national-level contracts for pharmaceuticals. PBM also applies effective mechanisms to drive standardization of supplies through a national formulary, clinical guidelines for prescribers and utilization review, and feedback to help clinicians identify outlier prescribing practices.²⁷³ Vital to the success of this program is the involvement of clinicians and pharmacists in a vertically integrated model of engagement and decision making through facility-level, Veterans Integrated Service Network (VISN)-level, and national-level PBM committees that contribute to formulary and clinical guideline decisions and manage utilization review with local clinicians.²⁷⁴ PBM also has a sophisticated web of communications, education, and engagement efforts to ensure clinical leaders across the system are helping drive PBM policy and practices.²⁷⁵ As a result, 90 percent of purchases are acquired through pharmaceutical prime vendor contracts.²⁷⁶

PBM, taking advantage of standardized industry nomenclature and bar codes for pharmaceuticals, has implemented automated dispensing, distribution, and ordering processes, including VA's Consolidated Mail Outpatient Pharmacy (CMOP).²⁷⁷ The use of CMOP, a system of seven highly automated pharmacies that process more than 460,000 prescriptions every work day, results in exceptional accuracy and lower processing costs than would result if filling prescriptions at each VAMC.²⁷⁸ Eighty percent of prescriptions in VHA are filled through CMOP,²⁷⁹ which has been recognized for the last 6 years as the best or one of the best mail order pharmacies in the country meeting or exceeding customer satisfaction scores of health care systems like Kaiser Permanente and on-line pharmacies like Express Scripts and Walgreens Online Pharmacy.²⁸⁰ Customer service, veteran satisfaction, and patient safety delivered through team-based care are a hallmark of the mission of PBM,²⁸¹ and are a useful reminder of the principles that must drive any successful transformation of supply chain management in VHA.

²⁷² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 19, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷³ *Ibid.*, 20.

²⁷⁴ VHA Formulary Management Process, VHA Handbook 1108.08 (2009).

²⁷⁵ Clinical Pharmacy Services, VHA Handbook 1108.11, 28-30 (2015). The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 32-34, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁷ *Ibid.*

²⁷⁸ "VA Mail Order Pharmacy," U.S. Department of Veterans Affairs, accessed April 29, 2016, http://www.pbm.va.gov/PBM/CMOP/VA_Mail_Order_Pharmacy.asp.

²⁷⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁸⁰ "U.S. Pharmacy Study – Mail Order (2015)," J.D. Power, accessed April 29, 2016, <http://www.jdpower.com/ratings/study/U.S.-Pharmacy-Study-Mail-Order/631ENG2>.

²⁸¹ "Pharmacy Benefits Management Services," U.S. Department of Veterans Affairs, accessed April 29, 2016, <http://www.pbm.va.gov/PBM/index.asp>.

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Analysis

VHA's supply chain for clinical supplies, medical devices, and related services is inadequate compared to the agency's pharmacy organization or to best practices in leading hospital systems.

*Its contracting processes are bureaucratic and slow, which can delay veterans access to care. Purchasing processes are cumbersome which has driven VHA staff to work arounds and exacerbates the variation in prices VA pays for products. Utilization is difficult to measure or manage given a lack of data which likely leads to significant avoidable expense for VA.*²⁸²

Leadership and Organizational Structure and Function

Best-in-class supply chain organizations typically have a single group responsible for the strategy, sourcing, procurement, and logistics of clinical supplies and medical devices. The organization is typically led by an executive-level leader, such as a chief supply chain officer (CSCO), and personnel are aligned along product categories to develop and use deep expertise in the products and suppliers they manage.²⁸³ In contrast, the organizational structure for contracting, logistics, and supply management in VA and VHA is complex and duplicative.²⁸⁴ Four contracting entities are located within VA central office but report to two different management offices within VA's office of acquisition, logistics, and construction (OALC).²⁸⁵ Procurement personnel within VHA's regional contracting and VISN offices report to VHA's national office of procurement. In contrast, facility-based and VISN logistics personnel report to their local VAMC or VISN director and not to the national VHA logistics office.²⁸⁶ To further complicate the management picture, clinical supplies are managed by the logistics organization, yet medical devices are managed by the Prosthetics and Sensory Aid Service (PSAS)²⁸⁷ (see Figure 5). In most health care organizations, the supply chain chief operating officer and their integrated supply chain group manages the procurement and distribution of all clinical supplies and medical devices.²⁸⁸ This is not the case in VA. Senior leaders in VA's and VHA's supply chain organizations and field-based supply chain personnel indicate current organizational structure is too complex and should be simplified.

*National supply chain leaders expressed lack of clarity regarding the scope of responsibilities of the entities for which they are responsible, which has led to some tension and what one leader described as a 'turf war.' Others described a vacuum of ownership and accountability, and lack of clarity on roles and responsibilities.*²⁸⁹

²⁸² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, v, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁸³ Ibid., 57-58.

²⁸⁴ Ibid., ix.

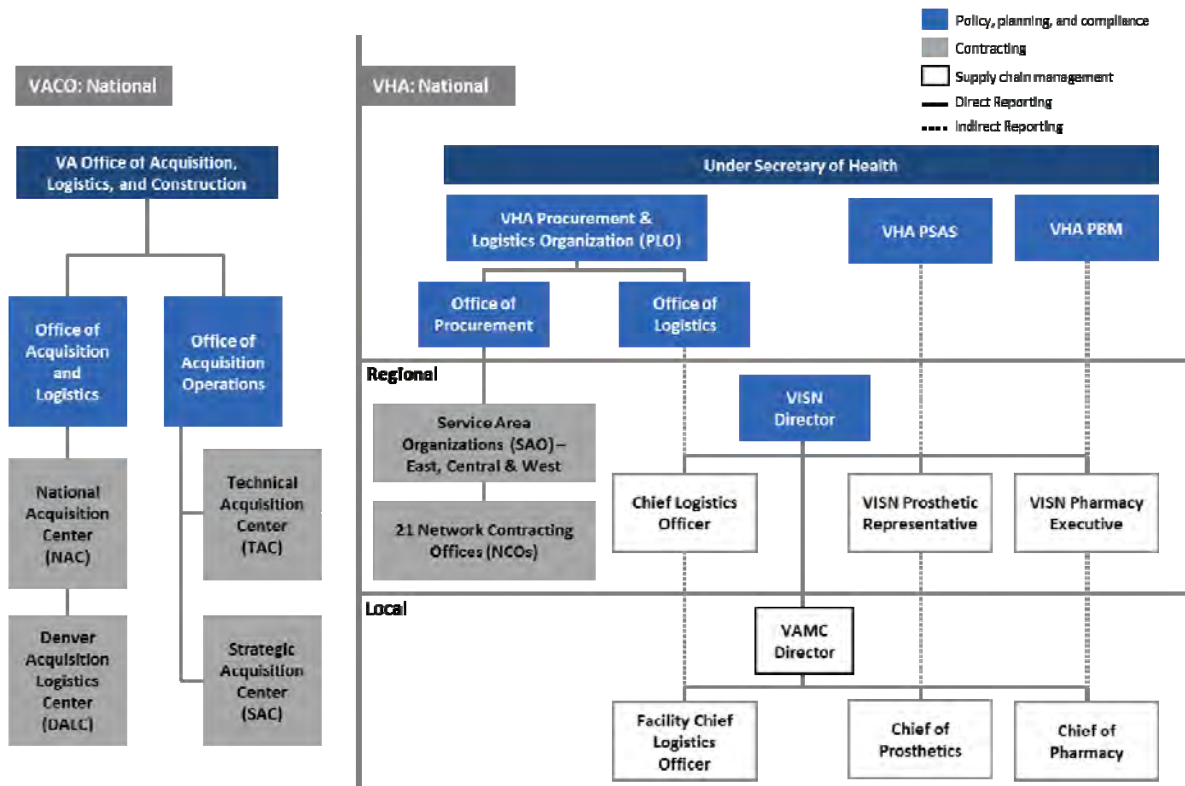
²⁸⁵ Ibid., 96-97.

²⁸⁶ Ibid., 47-50.

²⁸⁷ Ibid., 58.

²⁸⁸ Ibid.

²⁸⁹ Ibid., 55.

Figure 5. Organizations Comprising VA's Supply Chain²⁹⁰

Notes: Some VISNs may have different reporting relationships with facility prosthetics staff.

The separation of clinical supplies and prosthetics/medical devices causes issues in coordinating products needed for procedures. Frontline staff members indicate the time it takes to procure simple items through contracting (1 to 3 months) is problematic. For example, heart valve surgery may be delayed because some heart valves cost more than the micro-purchase threshold (\$3,000), thus the purchase must be made through the contracting process.²⁹¹ Medical center staff consistently expressed concern that VHA procurement offices are not responsive to the needs of a health care organization and do not communicate effectively with them,²⁹² findings borne out by low customer satisfaction scores given to these organizations.²⁹³

There is great overlap and redundancy in procurement and logistics functions in VA and VHA and the reporting structures are not aligned to ensure that the needs of veteran patients and their clinical providers are met. In an environment with limited sharing of best practices and a lack of transparent, open communications, the current complicated reporting structures impede customer-service quality and effectiveness. The original intent behind the current structure was to consolidate and strengthen purchasing power through the establishment of national contracts; however implementation of the vision has been poor and the result has been a

²⁹⁰ Ibid., 49.

²⁹¹ Ibid., 67.

²⁹² Ibid., 68.

²⁹³ Ibid., 69.

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complicated, bureaucratic system filled with redundancies.²⁹⁴ These broken processes serve as a precursor for catastrophic systems failures.²⁹⁵

There is an immediate need to consolidate and streamline procurement and logistics for medical and surgical supplies under one leader in VHA, the VHA chief supply chain officer (CSCO), who would be accountable for transforming VHA supply chain management. As identified under MyVA, medical and surgical supply chain management is the first priority but the rest of the supply chain needs to be addressed by the CSCO in a staged approach. The VERC or other experts in business process engineering must be engaged to create a vertically aligned organizational structure with clear delegated responsibilities at each level of the organization to create an efficient and responsive procurements and logistics process which the VHA CSCO would lead.

Clinical Engagement and Value Analysis

In contrast to pharmaceuticals, usage of clinical supplies and medical devices is not strictly monitored or managed in VA. In general, physicians and nurses can choose whichever products they believe are best for patients and the supply chain organization's role is to make those items available.²⁹⁶

VHA does not have a means to determine what supplies should be standardized or a feedback loop administrators and staff use to assess whether standards were being used when they did exist.²⁹⁷ As a result, limited product standardization has been achieved across VHA, despite VHA establishment of national standardization user groups in 2001 responsible for identifying items for standardization based on national procurement data.²⁹⁸ To date, national product standardization has been achieved in only a limited number of categories.²⁹⁹ Since 2011,

VHA required that medical centers establish Clinical Product Review Committees (CPRCs) to: (i) review and approve the use of new clinical items and reusable medical equipment (RME) at each medical center; (ii) maintain a list of approved expendable clinical supplies and RME by establishing and maintaining a Medical/Surgical Supply Formulary; and (iii) ensure compliance with nationally standardized contracts and blanket purchase agreements. In all sites visited, CPRCs exist and meet regularly but reviews were generally formalities.³⁰⁰

²⁹⁴ Ibid., 47-50.

²⁹⁵ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

²⁹⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 54, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁹⁷ Ibid., xii.

²⁹⁸ VHA Handbook 1761.1, Standardization of Supplies and Equipment Procedures, July 2003.

²⁹⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 81, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁰ Ibid., 82.

Under this 2011 policy, the establishment of VISN oversight committees was also required to provide accountability and feedback to the local committees, but these committees were apparently never established.³⁰¹

VHA, with the engagement of the Veterans Engineering Resource Center (VERC), is making progress on clinician alignment to accomplish value-based purchasing decisions for medical and surgical supplies. VERC has recently rolled out a national clinical product review committee (CPRC-E) e-portal to better organize this function. This portal provides a central system and standard processes for all new product requests and approvals to inform the procurement processes.³⁰²

In the area of medical and surgical supplies, clinician preference can drive variability in procurement and utilization. As has been done in VHA for pharmaceutical prescribing, a similar system to engage and align clinicians must be undertaken for medical devices and surgical supplies. VERC has started this process, but requires further funding and leadership support to fully implement a clinician-driven sourcing process. Current and future leaders of VA and VHA must ensure that VERC continues to receive the funding support and leadership engagement it needs to fully accomplish this transformation with support and direction from a VHA CSCO.

Information Technology, Data Standards, and Analytics

Information technology systems, data systems, and analytical capability for finance, inventory management, and purchasing impede VHA's ability to effectively manage its supply chain.³⁰³ VHA needs greater "end-to-end visibility into the operational and financial performance of their supply chain" and more effective means to accomplish supply chain budgeting, forecasting, inventory management and automation of at least some key supply chain functions.³⁰⁴

*VA lacks visibility into supplies and devices spending at the level of granularity usually seen in the private sector. For example, in the private sector, it is typically possible to measure clinical supply spend and utilization at the service, patient, or physician level. However, this is not possible in VHA because it does not capture such data. Therefore, supplies spend per case can only be calculated in aggregate, which is relatively meaningless and does not allow for fair comparison across hospitals, services, or physicians. This inhibits VA's ability to manage utilization and to understand fully the impact of product standardization efforts.*³⁰⁵

VERC is working to reduce the more than 130 versions of VistA in place across the country so that the same data sets can be tracked and reported.³⁰⁶ Funding was approved by OIT for the Future Transformation Tool (FTT) graphical user interface that will standardize product names

³⁰¹ Ibid., 54.

³⁰² Heather Woodward-Hagg, PhD, email to Commission on Care, March 17, 2016.

³⁰³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁴ Ibid.

³⁰⁵ Ibid., 60.

³⁰⁶ Ibid.

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and provide data integration across all of VHA. Point of Use Solution, a commercial off the shelf supply management software product, has been purchased to achieve better inventory and demand management control and has been deployed to 32 percent of facilities, as of April 2016.³⁰⁷

True sustainment of a clinician driven process cannot be achieved with fragmented information systems that do not communicate. Leaders at all levels of the organization are not able to effectively identify and manage procurement requirements or provide effective feedback to clinicians on utilization. Similarly, automated inventory control, ordering, billing, and payment cannot occur without a seamless information technology infrastructure. With a current IT system in which fiscal, supply chain, and clinical informatics systems do not interface, the hopes of moving to automated processes for supply ordering, equipment life cycle management, and vendor communications cannot be realized. A plan for the transformation of supply chain management, developed by a VHA CSCO with support from VERC, must be fully integrated with planning and procurement within OI&T and fully financed to accomplish these important goals.

Policy and Procedures

Ninety-eight percent of all clinical supplies are acquired using purchase cards³⁰⁸ and 75 percent of what VHA spends on clinical supplies is made through this purchase mechanism.³⁰⁹ This is not a surprise given that the standard contracting process can take anywhere from 150 to 180 days to complete,³¹⁰ yet use of purchase cards is inefficient as this mechanism does not take advantage of economies of scale and potential cost savings an organization the size of VHA can achieve through price negotiations and strategic sourcing.³¹¹ It can also be contrary to law, as use of purchase cards often necessitates orders be split to remain under the \$3,000 purchase card limit.³¹² An analysis of purchase records showed that 38 percent of supply orders were made through standing vendor contracts which is in stark contrast to the private sector benchmark of aiming to complete 80-90 percent of supply purchases from master contracts with negotiated price discounts.³¹³ Indeed, the private sector trend in health care has been for hospitals and health care systems to form alliances in “group purchasing organizations” to achieve the scale that VHA naturally enjoys.³¹⁴ Weaknesses in logistic management have been recognized in VHA for some time and still remain.³¹⁵ For instance, a review of logistics business

³⁰⁷ Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.

³⁰⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁹ Ibid., xii.

³¹⁰ Ibid., x.

³¹¹ U.S. Government Accountability Office, *Strategic Sourcing: Improved and Expanded Use Could Save Billions in Annual Procurement Costs*, accessed April 28, 2016, <http://www.gao.gov/assets/650/648644.pdf>.

³¹² U.S. Department of Veterans Affairs, Office of Inspector General, *Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System*, accessed April 28, 2016, <http://www.va.gov/oig/pubs/VAOIG-11-00826-261.pdf>.

³¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xii, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³¹⁴ Bob Kehoe, “Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness,” *Health Facility Management Magazine*, 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.

³¹⁵ U.S. Government Accountability Office, *Veteran’s Health Care: VHA Has Taken Steps to Address Deficiencies in Its Logistics Program, but Significant Concerns Remain*, accessed April 28, 2016, <http://www.gao.gov/assets/660/653886.pdf>.

practices at 17 VHA medical facilities in 2014 showed that none of the facilities achieved 100 percent compliance on the factors assessed, and the rate of noncompliance ranged from 53 to 88 percent, depending on the business metrics examined.³¹⁶

VA is inhibited by a failure to update its acquisition regulations to take advantage of modernization made in 2014 to the governmentwide regulations to promote simplified purchasing procedures.³¹⁷

VERC initiatives to improve VHA supply chain are intended to standardize business processes and address the great price variations for the purchasing of medical and surgical supplies. A national medical surgical prime vendor (MSPV) contract has been established. This development has several advantages to include (a) increased ability to leverage pricing negotiations; (b) standardized pricing; (c) elimination of redundant contract development, bidding, and selection; and (d) future ability to integrate with CPRC E-Portal.³¹⁸ VA has established a goal for 85 percent of all orders in FY 2016 be made under the prime vendor contract and has made 1,100 contracting officers available to meet demand against the contract.³¹⁹ As of April 2016, an estimated \$24.4 million in supply chain costs had already been avoided since January.³²⁰

The establishment of a new MSVP contract in April 2016, the assignment of 1,100 staff to support its use, and the expectation communicated to the field that 85 percent of all purchases be made from the contract are important steps in the right direction. For efficient ordering processes to take hold and be sustained across VHA, all of the policies and procedures from the bedside (or surgical suite) to the head contracting office must be reworked to align with the desired business outcomes. Reworking policies and procedures must occur together with appropriate training and communication at all levels of the organization. Each staff member involved in the procurement process must be held accountable for meeting the new requirements and expectations assigned to them. Updating the VA Acquisition Regulation (VAAR) is just one small piece of such a transformational change. The VERC or others with appropriate experience in aligning business processes within government should be assigned responsibility to finish developing and implementing plans for such a transformation under the direction of a VHA CSCO.

Contracting

Analysis of the *Independent Assessment Report* confirmed issues with the responsiveness of contracting. For example, at one facility, if a request was submitted to contracting that was incomplete or inaccurate, it took on average 21 to 39 days from the date of initial submission to

³¹⁶ U.S. Department of Veterans Affairs, *VA Supply Chain News*, Issue 13, Jan/Feb 2015.

³¹⁷ Jonathan Miller, Director of Logistics Operations, VHA Procurement & Logistics Office, phone call with Commission on Care, December 9, 2015.

³¹⁸ Heather Woodward-Hagg, PhD, Acting Director, Veterans Engineering Resource Center, phone call with Commission on Care, March 18, 2016.

³¹⁹ Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.

³²⁰ Ibid.

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receive the first response from contracting requesting, for example, additional information or paperwork.³²¹ This problem appears to be a widespread.

In another instance, interviews conducted as part of the independent assessment showed that VA vendor contracting processes to order equipment valued at less than \$3,000, for example, scalars for dentistry, can be confusing and lengthy, leading to shortages in equipment and delays in clinic as equipment is located. Delays in sterile processing were also indicated by providers as an issue pertaining to equipment availability.³²²

Communication with contracting is another substantial challenge within VHA. In surveys that assessed the effectiveness of VA's contracting organization, VHA employees' customers rated the communications received from contracting officials the lowest of all contracting dimensions that were evaluated.³²³ Several interviewees recommended that VA provide more clarity on the status of contracting requests to help them plan and schedule care.³²⁴

Individuals in contracting believed that VAMC staff members were responsible for some of the delays in the contracting process. They reported that requests submitted to them from VAMCs were often incomplete or unclear and that facilities were poor at forecasting demand for items, leading to unpredictable peaks in demand for contracting services that exceeded their capacity. The VHA Procurement and Logistics Organization (PLO) and facilities are seeking to address these challenges by placing contract liaisons in facilities to better support contracting officer representatives throughout the process.³²⁵

Contracting compliance analysis showed substantial opportunity for improvement. Analysis of purchase order data showed that 38 percent of purchases were made on a government contract, 27 percent were made at open-market prices, and 34 percent did not have a source type specified.³²⁶ Private-sector organizations typically aim to buy 80 to 90 percent of their clinical supplies and medical devices on some type of negotiated contract.³²⁷

Interviews and observations undertaken as part of the independent assessment revealed that there are two primary reasons for VHA's relatively high share of open-market purchasing. First, in contrast to pharmaceutical purchasing, VHA's supply purchasing systems are not integrated

³²¹ The consulting team based this on an IFCAP/eCMS transmission log received during a VAMC site visit (2015). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²² Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 91, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

³²³ The consulting team derived this from a VHA procurement metrics book. McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 69, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²⁴ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²⁵ Ibid.

³²⁶ Ibid., xii.

³²⁷ Ibid.

with contract or pricing catalogs. Therefore, the purchasing process relies on buyers (often clinical staff) to research whether an item is on contract and through which contract a purchase should be made. Because of that complexity, several buyers reported that they bypass this step and buy products through the channel that is most familiar and convenient, for example, by replicating previous orders to their usual supplier, despite changes that may have occurred (new contracts and pricing arrangements, for example). Second, VHA has limited ability to monitor and drive compliance with the contract hierarchy because the required data are not captured electronically. In fact, more than 60 percent of all clinical supply items do not have a contract number listed.³²⁸

VHA's fragmented inventory management systems and processes also create challenges. VHA's current inventory management does not have a feedback loop to link inventory to product use, contracting, ordering, and vice versa. This lacking information prevents optimal use of the MSPV contract program and creates missed opportunities to establish more effective volume-based national or regional contracts. It also leads to peaks and troughs in demand for contracting services, which can overwhelm contracting's capacity.³²⁹

There are pockets of good performance and innovation in VHA that could be replicated across its supply chain. The *Independent Assessment Report* notes that the Denver Acquisition and Logistics Center (DALC) is a bright spot within VHA's supply chain organization in its acquisition and distribution of select devices such as hearing aids to veterans. It has developed an integrated operating model that brings together clinicians, contracting, finance, logistics, and program management. That integrated team makes decisions around product and supplier selection based on a holistic view of what is best for veterans and for VHA.³³⁰

Talent Management

VHA is unable to hire good talent to manage its supply chain. In 2014, 20 to 30 percent of logistics positions were unfilled, and 20 percent of medical supply aide jobs were vacant.³³¹ The causes were identified as lengthy time-to-hire, nonexistent internal career progression ladders for these individuals, and inability to provide competitive pay due to position downgrades made by OPM under Title 5.³³² Examples of recent downgrades include supply technician, mail manager, administrative officer, and materials handler.³³³

*It is well known in the health care industry that there is a shortage of supply chain talent currently. The private sector organizations interviewed during this assessment stated that they are recruiting more highly trained individuals than they did in the past and, because of competition for talent, are paying them more than they used to. This may be contributing to VHA's recruitment and retention challenges.*³³⁴

In Recommendation #15, the application of the more than 60-year old standards and processes used in the Title 5 personnel system does not serve the needs of a modern health care delivery

³²⁸ Ibid.

³²⁹ Ibid.

³³⁰ Ibid., xiii.

³³¹ Ibid.

³³² Ibid.

³³³ Ibid., 87.

³³⁴ Ibid., 88.

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organization. Health care supply chain management is a recognized field of study and a valued component of leadership teams at the highest performing health care organizations. For VHA to compete for top leadership talent in this field and frontline staff, logistics and procurement personnel must be included in a new excepted personnel system for VHA under Title 38 (see Recommendation #15).

To address talent management issues, VERC has established a new VA Acquisition Academy (VAAA) Supply Chain Management School.

The mission of the Supply Chain Management School is to provide best-in-class education, training, professional development, and certification of the VA supply chain workforce. VAAA's competency-based curriculum addresses general and technical skills, VA-specific functional areas, and core activities for VA logistics professionals. Emphasis is on translating theory, fundamentals, and concepts to practical application with realistic VA-based scenarios utilizing hands-on application of problem-solving skills.³³⁵

The supply chain management school is organized under VAAA which has been recognized by external organizations to offer high quality training.³³⁶

Implementation

Legislative Changes

- Establish a new excepted personnel system under Title 38 to permit VHA to compete effectively with the private sector for personnel required to run a complex health care system, including staff to manage and operate a modern supply chain system.

VA Administrative Changes

- Establish an executive position for supply chain management, a VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- Transform policy and procedures for supply chain management in parallel with identification and procurement of new management software: new software should support the new processes and not the existing, poorly organized business processes and requirements.
- Establish a staged process for the transformation of all supply chain operations in VHA under the direction of a VHA CSCO, with support from VERC.
- Reconcile the VAAR with the Federal Acquisition Regulation (FAR) to ensure the VAAR aligns with recent updates to the FAR to permit streamlined acquisition processes.
- Provide consistent and standardized training to ensure those developing and administering contracts have updated information regarding FAR and VAAR

³³⁵ "Message from the Vice Chancellor," Veterans Affairs Acquisition Academy, accessed April 28, 2016, <http://www.acquisitionacademy.va.gov/schools/scm/message.asp>.

³³⁶ "VA Acquisition Academy Recognized as a 2016 Learning Elite Organization," U.S. Department of Veterans Affairs, accessed May 13, 2016, <http://www.acquisitionacademy.va.gov/rss/index.xml#20160413b>.

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regulations as well as a thorough understanding of their responsibilities under the new approach to supply chain management and how to carry out these duties.

Other Department and Agency Administrative Changes

- None required.

Governance, Leadership, and Workforce

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

Problem

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center (VAMC), and similar problems at multiple other VAMCs, had both direct and indirect causes. Weak governance was found to be among those indirect causes.³³⁷ As the authors of a root-cause analysis of the Phoenix scandal highlighted, “a governance gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed to the wait-time problems.³³⁸ The report authors observed, “Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors.”³³⁹ The governance limitations made evident in the Phoenix scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration’s expectations for short-term results,³⁴⁰ and VHA’s operating in a “dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act and be structured based on the key elements included in Table 5.
- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term to allow for continuity and to protect the CVCS from political transition. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

³³⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³³⁸ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.

³³⁹ Ibid.

³⁴⁰ Ibid.

competing demands”³⁴¹ offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

Background

VHA, as an agency within a cabinet department, is accountable to the secretary of Veterans Affairs (SECVA) and to the President. This framework, when it works well, can provide VHA access to, and support from, the President and White House staff. Like other executive branch agencies, VA and VHA undergo Office of Management and Budget (OMB) oversight; must win OMB approval of proposed rulemaking, budgets, IT development, and performance plans; and are also subject to governmentwide regulation of such areas as procurement, personnel, and property management. VHA health care and operations are subject to close congressional scrutiny.³⁴² VHA undergoes oversight from several independent bodies, including the internal Office of the Inspector General audits and external Government Accountability Office audits.

Within VA, VHA participates in the VA Executive Board (VAEB) and Senior Review Group, which are designated as the principal governance bodies of the department.³⁴³ VAEB serves as the department’s risk-governance board and determines VA’s strategic direction. VAEB oversees the department’s planning, programming, budgeting, and execution. Notwithstanding certain strengths inherent in this framework, VHA governance can be paralyzed by bureaucratic decision-making processes and competing stakeholder concerns.³⁴⁴

Among its principal recommendations, the *Independent Assessment Report* calls for “establishing a governance board to develop fundamental policy, define the strategic direction, insulate VHA leadership from direct political intervention, and ensure accountability for the achievement of established performance measures.”³⁴⁵

Analysis

In recent years, VHA leadership priorities and strategic direction have been unclear. Leaders have been consumed by crisis and by responding to congressional demands, creating a reactive, rather than proactive environment.³⁴⁶ Additionally, the leadership vision has lacked continuity.³⁴⁷ The SECVA and deputy secretary of Veterans Affairs may exercise oversight of

³⁴¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³⁴² “Legislation,” U.S. House of Representatives, House Committee on Veterans’ Affairs, accessed June 15, 2016, http://veterans.house.gov/legislation?type=hearing&tid=All&tid_1=All&page=3. Over the course of calendar year 2015, the House Veterans Affairs Committee and its subcommittees alone held 18 oversight hearings relating to the Veterans Health Administration, with VHA and/or VA officials testifying as often as three times in a month.

³⁴³ Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014).

³⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 26, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³⁴⁵ *Ibid.*, 23.

³⁴⁶ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 52-54.

³⁴⁷ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, vi-viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Linda Belton, former VHA VISN Director and Director of National Center for Organizational Development, written submission to the Commission on Care Staff, January 19, 2016.

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VHA and try to impose accountability, but incumbents do not necessarily have experience in federal health care administration or delivery.³⁴⁸ The SECVA has often lacked independent information and metrics on VHA performance, and the oversight, risk management, and compliance functions of VHA report to the undersecretary for health (USH) or to lower officials in VHA.³⁴⁹

Previous studies, dating back 20 years,³⁵⁰ have proposed fundamental change in VHA's governance and government structure, to include a proposal that it be restructured as a government corporation.³⁵¹ The earliest rationale for making VHA a government corporation was based on the view that the system needed a new service-delivery strategy,³⁵² and envisioned specific legislation to permit the corporation to operate more expansively under a wide range of reforms.³⁵³ Although the authors of the 1996 report presented a VHA government

³⁴⁸ Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Under Secretary of Health, 38 U.S.C. § 305. While statute requires the USH of VHA to be appointed “solely on the basis of demonstrated ability in the medical profession, in health-care administration and policy formulation, or in health-care fiscal management; and on the basis of substantial experience in connection with the programs of the Veterans Health Administration or programs of similar content and scope” there is no such selection criteria for the VA Secretary or VA Deputy Secretary. Of the eight men to hold the position of Secretary of Veterans Affairs, only one, James Peake would qualify to be USH (“United States Secretary of Veterans Affairs,” Wikipedia, accessed June 15, 2016, https://en.wikipedia.org/wiki/United_States_Secretary_of_Veterans_Affairs#List_of_Secretaries_of_Veterans_Affairs) and of the six men to hold the position of DEPSECVA, none would qualify to be USH.

³⁴⁹ Department of Veterans Affairs, *2014 Functional Organizational Manual v2.0: Description of Organization Structure, Missions, Functions, Tasks, and Authorities*, 57-58, accessed June 15, 2016, http://www.va.gov/ofcadmin/docs/va_functional_organization_manual_version_2.0a.pdf.

³⁵⁰ Veterans Benefits Improvement Act of 1994, Pub. L. No. 103-446, 108 Stat. 4645 (1994). In 1994, Congress in sec. 1104 of Public Law 103-446 called for an independent examination of the justifiability of establishing an alternative government structure to provide health care services for veterans, culminating in the 1996 report.

³⁵¹ Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. A government corporation has been described as “a government agency that is established by Congress to provide a market-oriented public service and to produce revenues that meet or approximate its expenditures.” Kevin R. Kosar, Congressional Research Service, *Federal Government Corporations: An Overview*, 2, accessed June 15, 2016, <https://fas.org/sgp/crs/misc/RL30365.pdf>. Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report* September 22, 2015. Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce*, accessed June 15, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>. Commission on the Future for America's Veterans, *Preparing for the Next Generation*, 3, accessed June 15, 2016, http://s3.amazonaws.com/siteninja/site-ninja1-com/1438121489/original/2014-05_Commission-Report-on-America-Veterans.pdf. That task force study, for example, called for an independent governance model and stated that “the operational structure of VHA does not lend itself to progress. Due to its size, governmental structure and geographic extension it does not readily foster innovation and faces challenges in addressing the politics of changing demographics and ancient facilities.” The study report states, “VHA provides excellence in care in spite of its operations/governance structure, not because of it.”

³⁵² Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. The strategy was premised in part on the view that VHA would be operating in a resource-constrained environment and lacked the resources it would need to invest in making significant changes.

³⁵³ Ibid. The 1996 report proposed such measures as providing VHA authority to seek additional revenue streams, to include billing and keeping funds from Medicare, Medicaid, and other government sources; authorizing it to invest nonappropriated funds; developing a trust fund for deposit of Medicare taxes by active-duty personnel; incorporating VHA as a Federal Employee Health Benefits Plan selection; allowing it to become part of health maintenance organization (HMO) networks and open HMO enrollment to veterans; changing appropriation law to create

corporation as a means of achieving specific objectives, those objectives were largely met (though ultimately not fully sustained) by reforms within existing government structures and processes set in place by former USH Kenneth W. Kizer.³⁵⁴

Nearly 20 years later, the report analyzing the root causes of delayed care at the Phoenix and other VA centers proposed creation of “governance mechanisms to bridge ‘Secretary suite’ leadership transitions and provide more stable strategy, oversight, and stewardship.”³⁵⁵ Explaining that “the study team feels that the complexity of this organization requires a more stable and professionalized governance model that more closely resembles the governance of large health care systems in the private sector,”³⁵⁶ the study authors proposed the creation of a board-of-directors-type oversight board to set the strategy for the organization, define priorities, provide operational oversight, and review budget requests. “The board would . . . create a body that would be the steward of the organizational vision, providing institutional memory and continuity as senior political appointees transition.”³⁵⁷

Frequent turnover of the USH is a critical problem. Recently, each USH has served for only a relatively short period, leaving office with a change in administration or sooner. This pattern has deprived VHA of vitally needed sustained leadership and has likely contributed to short-term decision making. VHA history shows a connection between longer tenure and transformative accomplishment.³⁵⁸ As testimony to the Commission from three former USHs would indicate, brevity of tenure tends to limit leaders’ strategic horizon and create a pattern of leadership discontinuity. Because transformative change can only be realized through many years of focused leadership, VHA and those who depend on it cannot afford the senior leadership turnover routinely associated with a change in administration.

The complex, sustainable transformation VHA needs will take years to implement. To succeed, VHA needs strong, consistent leadership and a governance framework that can assure effective development and execution of transformation plans over time. The current governance structure emphasizes operational, rather than strategic priorities; experience has shown it to be incapable of sustaining transformational change. Establishing a well-designed, overarching-governance model would provide an opportunity to achieve objectives shared by both the executive and legislative branches.

To be effective, a VHA Care System governance model should be empowered with a governing board that exercises fiduciary-like responsibilities (not subject to the Federal Advisory Committee Act) to carry out the following key functions:

multiyear/no-year appropriations; reforming human resources management practices for increased flexibility in hiring and firing, compensation, leave, and other functions; and reforming; and reforming procurement and contracting.

³⁵⁴ Ibid., 46, 48. The Klemm report saw a VHA corporation as having greater capacity to focus on strategic as well as short term goals; greater results orientation; greater flexibility; greater capacity to replicate and develop best practices; upgraded staff competence and expertise at senior levels; and greater political independence.

³⁵⁵ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 59.

³⁵⁶ Ibid.

³⁵⁷ Ibid.

³⁵⁸ See Dr. William S. Middleton, Chief Medical Director (1955-1963) and Dr. Kenneth W. Kizer, Under Secretary for Health (1994-1999).

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- select the chief of VHA Care System (CVCS) and recommend the appointment of the CVCS to the President
- provide long-term, strategic direction for VHA Care System and establish priorities, milestones, and timelines
- oversee, direct, and make critical decisions regarding the transformation process
- review and approve major operational, business, and organizational plans
- set VHA Care System performance objectives and provide annual reports to Congress and the President on VHA Care System performance
- review and make decisions regarding VHA's budget request, and independently assess and report to Congress on the adequacy of VHA budgets

New governance and changes to assure continuity of leadership are critical to meeting the needs of VHA and veterans who depend on it. At the core of this foundational recommendation, the Commission calls for establishing a VHA board of directors,³⁵⁹ referred to as the VHA Care System governing board, which is independent of department leadership to provide governance, strategic direction, decision making, and oversight of VHA Care System's operations and transformation. Table 5 provides details regarding the governing board.

Table 5. Overview of VHA Care System Governing Board

Detailed Outline for VHA Care System Governing Board	
Voting Members	The President, the majority leader of the Senate, speaker of the House, the minority leaders of the Senate and House would each appoint two members. In addition, the SECVA would serve on the Board as a voting member.
Qualifications	Members would be selected to achieve collectively broad experience, expertise, and leadership, such as experience in senior management of large, private, integrated health care systems; clinical expertise; extensive experience with federal government health care systems; extensive experience with (though not current employment in) VHA; expertise in federal medical facility construction and leasing, and commercial property transactions; expertise in government contracting; expertise in federal health care budgeting and finance; expertise in health equity and disparities; and veterans' representation. Because of the importance of veterans' representation, at least one of each congressional leader's two appointees would be a veteran; at least one of the appointees of the President would be a veteran who receives VHA care.

³⁵⁹ Michael A. Froomkin, "Reinventing the Government Corporation," *University of Illinois Law Review*, (1995): 543, accessed June 15, 2016, <http://osaka.law.miami.edu/~froomkin/articles/reinvent.htm>. Congress need not create a government corporation to meet VHA's governance needs. The Commission notes that Congress has created entities it has called government corporations that are not predominantly commercial enterprises, rely on appropriations, and do not have the potential to become self-sustaining. A principal intention behind assigning this status and title has been to provide insulation from central management oversight agencies and the application of general management laws. When the corporation relies in whole or in part on appropriations, Congress retains the power of the purse, and the means of exercising it on matters large and small, and through formal and informal means.

Detailed Outline for VHA Care System Governing Board	
Terms	Governing board members would serve staggered terms of up to 7 years, with the governing board members electing a chair and vice chair from among the membership (other than the SECVA, who would not be eligible to serve as the chair) for 3-year terms.
Personnel Matters	Compensation would be at a rate equal to the daily equivalent of annual pay prescribed for level IV of the executive level. ³⁶⁰
Funding	Congress would provide a specific budget for the operation of the governing board as a separate account within VA's appropriations.
Relationship to the CVCS	Relationship to the CVCS: The governing board would provide the President its recommendation for a chief of VHA Care System (CVCS); the President would appoint that executive to a 5-year term; the governing board would annually review the CVCS's performance and be empowered to reappoint that official to a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. The CVCS can be removed by mutual agreement of the President and the governing board.
Staff	The chairperson would determine the size and compensation of the permanent staff of the board, including an executive director responsible for governing board operations and a chief of staff. The director of the proposed transformation office within VHA would report to the chairperson through the CVCS.
Powers	<p>The board would have the power to do the following:</p> <ul style="list-style-type: none"> ▪ Select the CVCS and recommend the candidate to the President. ▪ Review the performance of the CVCS on an annual basis. ▪ Reappoint the CVCS to a second 5-year term. ▪ Remove the CVCS with the mutual agreement of the President. ▪ Direct and exercise decision-making authority regarding the transformation process and operations related to the transformation process. ▪ Establish priorities, milestones, and timelines for the transition process. ▪ Review and approve major new initiatives; major operational and organizational plans (including plans regarding capital asset and facility management); strategic and business plans; and goals and metrics for operational performance and established priorities. ▪ Oversee and manage facility and capital asset strategies and operations. ▪ Review, approve, and/or amend VHA's budget requests, and independently assess and comment on pertinent elements of the President's budget, as deemed appropriate.
Reporting	The board would report annually to the President and Congress on VHA's progress toward transformation.

Navigating transformation of one of the largest agencies in the federal government requires not only extraordinary leadership, but steady, sustained, long-range-focused governance. A governing board structured to provide continuity of membership—as the Commission proposes through staggered terms among members—is vital. A second critical step toward assuring such continuity would be to address the tenure of the CVCS and the process for selecting candidates for that position.³⁶¹ VHA, Congress, and the President would be better served by a VHA leader who holds a 5-year term of office, with the governing board empowered to reappoint that leader to a second 5-year term.

³⁶⁰ The rate of compensation provided for members of the Commission on Care.

³⁶¹ Under Secretary of Health, 38 U.S.C. § 305. Current law provides that the Under Secretary is appointed by the President with the advice and consent of the Senate. When a vacancy in that position occurs or is anticipated, the Secretary is to convene a commission (the composition of which is set forth in the statute) which is to recommend at least three individuals to the Secretary, who is to forward those names, with any comments the Secretary considers appropriate, to the President.

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It is important that that the CVCS report to the board and function as a chief executive officer of VHA. Although the Commission envisions that the President would appoint this official, it is critical that the governing board be empowered to recommend to the President an individual for appointment when the office becomes vacant. This would replace the framework in current law that requires the establishment of a new commission convened solely to carry out the task of recommending candidates to the President.³⁶²

A governing board must be tailored to the unique needs of VHA.³⁶³ It should include members of appropriate expertise and experience to provide strategic guidance and continuity of leadership and it should possess authority to exercise the powers needed to realize and sustain a VHA transformation.³⁶⁴

Although some might consider Congress to be VA or VHA's board of directors and might question the appropriateness of establishing a VHA board of directors, this governance model does not diminish Congress's role. Instead, a board that would report periodically to congressional committees would provide a level of close oversight and health care expertise that would complement, and in many ways enhance, Congress's work.

A change in governance alone will not bring about successful transformation. This recommendation must be instituted in concert with many other Commission recommendations. For example, a board will require data, and data systems, to carry out its responsibilities, and establishing these and other appropriate systems, as addressed throughout this report, is key to empowering a board to drive and sustain transformation.

Implementation

Legislative Changes

- Amend 38 U.S.C., Chapter 3 to establish a VHA Care System governing board.
 - Amend 38 U.S.C. § 305 – which currently provides in subsection (a) for the President to appoint the USH by and with the advice and consent of the Senate, and subsection (c) for the establishment of a commission to provide recommendations for appointees for USH when a vacancy is expected or has occurred – as follows:
 - Amend subsection (a) to provide for the President to appoint the CVCS to a 5-year term of office.
 - Repeal subsection (c) of that section.
 - Provide instead for the governing board to recommend a CVSC candidate.
 - Authorize the governing board to reappoint the CVSC to a second 5-year term.

VA Administrative Changes

- None required.

³⁶² Under Secretary of Health, 38 U.S.C. § 305.

³⁶³ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 60.

³⁶⁴ The Board is not an advisory body, and as such would not be subject to the Federal Advisory Committee Act.

Other Departments and Agency Administrative Changes

- None required.

Leadership**Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.****Problem**

High-performing organizations have healthy cultures in which diverse staff members feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government.³⁶⁵ For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

The Commission Recommends That . . .

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report to the chief of the VHA Care System and the new VHA Care System governing board (also included in Recommendation #12).

Background

Healthy organizations successfully align, execute, and renew themselves through learning and innovation.³⁶⁶ They are characterized by a high level of trust, accountability, and ownership among staff; high functioning, empowered teams; and an environment that provides psychological safety and open communication, focuses on the needs of customers, and instills pride in performance.³⁶⁷ An inclusive workplace where diversity is valued, staff feel empowered and supported, are treated with fairness, and cooperation and open communication helps engage employees and drive organizational performance.³⁶⁸ Engaged

³⁶⁵ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 56, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

³⁶⁶ "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, <http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage>.

³⁶⁷ [http://organizationalhealth.vssc.med.va.gov/Resource percent20Library/Forms/AllItems.aspx](http://organizationalhealth.vssc.med.va.gov/Resource%20Library/Forms/AllItems.aspx)

³⁶⁸ "Diversity & Inclusion; Federal Workforce At-A-Glance," U.S. Office of Personnel Management, accessed May 13, 2016, <https://www.opm.gov/policy-data-oversight/diversity-and-inclusion/federal-workforce-at-a-glance/>.

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employees who are dedicated to their work and attached to the organization and its mission support a healthy organization.³⁶⁹

Companies that have a healthy organizational culture or engaged staff outperform those that do not. Companies that score in the top 25 percent of organizational health metrics outperform comparable companies in the bottom 25 percent by more than two-fold.³⁷⁰ Similarly, high employee engagement is correlated with better staff and customer experiences that include higher patient satisfaction, higher staff retention, better safety and quality, higher productivity and lower absenteeism.³⁷¹ Companies with engaged employees outperform those without by more than 200 percent.³⁷² Leaders and supervisors play a key role in establishing and sustaining employee engagement and in establishing a positive environment and culture that supports a healthy organization.³⁷³

Analysis

VHA staff and leaders are highly dedicated to the mission of VA and to serving veterans.³⁷⁴ This dedication is arguably VHA's greatest strength, and it can be leveraged to create and sustain positive change.³⁷⁵ There are substantial impediments to moving VHA forward, however, as noted in the *Independent Assessment Report*. There is a pervasive lack of trust throughout the organization.³⁷⁶ Staff perceives VHA to be bureaucratic and political and to lack a systems orientation.³⁷⁷ Employees want to work for an organization that is accountable and efficient, but instead they operate in a bureaucratic, siloed, and political organization.³⁷⁸ The culture creates risk aversion in staff, and when cultural factors are measured in VHA, none of the metrics align with the definition of a healthy organization.³⁷⁹ Staff find the work environment at VA challenging, with no connection to leadership, and feel they receive little positive

³⁶⁹ U.S. Office of Personnel Management, *Strategic Plan FY2014-2018: Recruit, Retain, and Honor*, 22, accessed January 25, 2016, <https://www.opm.gov/about-us/budget-performance/strategic-plans/2014-2018-strategic-plan.pdf>. Office of Management and Budget, *Memorandum for Heads of Executive Departments and Agencies: Strengthening Employee Engagement and Organizational Performance*, M-15-04, December 23, 2014, accessed May 16, 2016, <https://www.whitehouse.gov/sites/default/files/omb/memoranda/2015/m-15-04.pdf>.

³⁷⁰ "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, <http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage>.

³⁷¹ U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015, 4. Melissa Bottrell, *Ethics Quality Helps Build Healthy Organizations*, VHA Organizational Health, Volume 19, Summer 2013, 4-5, accessed January 25, 2016, http://www.ethics.va.gov/docs/integratedethics/art_bottrell_orghealth_v19_2013.pdf.

³⁷² U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015, 4. Dee Ramsel, Improving VHA's Culture: A Presentation Before the National Leadership Council, Veterans Health Administration, December 2015, 7-9. U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change*, 6, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.

³⁷³ Dee Ramsel, "Improving VHA's Culture. A Presentation Before the National Leadership Council, Veterans Health Administration," December 2015, 7-9.

³⁷⁴ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 43, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

³⁷⁵ *Ibid.*, 44.

³⁷⁶ *Ibid.*, 47.

³⁷⁷ *Ibid.*, 46.

³⁷⁸ *Ibid.*, 46.

³⁷⁹ *Ibid.*, 49-51.

reinforcement or clear feedback on performance.³⁸⁰ As demonstrated in the Federal Employee Viewpoint Survey for 2015, VHA staff does not believe top leaders lead (only 47 percent positive³⁸¹) and only 65 percent have a positive view of their immediate supervisor compared to 70 percent in other large federal agencies.³⁸²

Through the review of available documents and briefings from key staff, the Commission found VA and VHA have a number of activities intended to support a positive environment and culture in VHA (see Table 6), but the efforts are not systematic, integrated, or broadly deployed.³⁸³ The efforts are under-resourced to achieve success. Specifically, the effort lacks mandatory positions at the facilities to lead these efforts and has no requirements on the VHA Central Office (VHACO) program offices to participate in the efforts.³⁸⁴ At the same time, the efforts are duplicative in that multiple offices communicate similar, but distinct messages to field staff and leaders. VHA appears to lack systematic mechanisms to ensure leaders at all levels of the organization have the knowledge, skills, and ability to create an effective culture; metrics are not comprehensive or aligned with a single-change model; and leaders in VHACO and the field are not consistently held accountable for their actions in support of a positive organizational culture.³⁸⁵

*Table 6. Cultural Transformation Efforts in VA and VHA*³⁸⁶

Program/Initiative	Responsible Office
Servant Leadership	VHA National Center for Organizational Development
Leaders Developing Leaders	MyVA
Just Culture	VHA National Center for Patient Safety
Civility, Respect, and Engagement in the Workplace (CREW)	VHA National Center for Organizational Development
Organizational Transformation Pilot	MyVA
Employee Engagement Playbooks	MyVA
VHA Voices	VHA Office of Patient Centered Care and Cultural Transformation

³⁸⁰ Ibid., 53 and 60.

³⁸¹ U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change*, 47, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.

³⁸² Ibid.

³⁸³ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 29-31. Dee Ramsel, Virginia Ashby Sharpe, Veterans Health Administration, conference call with staff of the Commission on Care, November 9, 2015.

³⁸⁴ See “Ethical Leadership, Fostering an Ethical Environment and Culture,” National Center for Ethics in Health Care, U.S. Department of Veterans Affairs, accessed June 22, 2016, <http://www.ethics.va.gov/integratedethics/elc.asp>. “Stop the Line for Patient Safety Initiative,” U.S. Department of Veterans Affairs, accessed June 22, 2016, <http://www.qualityandsafety.va.gov/StoptheLine/StoptheLine.asp>. “VHA Center for Organizational Development,” U.S. Department of Veterans Affairs, accessed from VA Intranet, May 16, 2016, http://vaww.va.gov/NCOD/Organizational_Health.asp. U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015.

³⁸⁵ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 13-14. Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan, Network Director and Medical Center Director*, November 20, 2015.

³⁸⁶ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 29-31.

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VHA must rebuild a high-performing, healthy culture by cultivating greater employee collaboration, ownership, and accountability to accomplish its mission.³⁸⁷ This cultural transformation needs to occur at all levels of the organization (VA, VHACO, veterans integrated service network [VISN], VA medical center, and community-based outpatient clinic). To achieve transformation in VHA, create a healthy environment and culture, and sustain staff engagement, the solution must start with leaders. Leaders must understand and believe in the powerful effect they have on the climate and culture in their organization. Change occurs one employee at a time. Leaders at all levels must commit to this change process. They must be inspired by top executives and embrace the values and mission of VHA and then, in turn, inspire their teams, engaging with individual employees to make change. Leaders must be given the roadmap and tools to make such change and then be supported with training, coaching, and feedback to achieve success. They must also be held accountable for their personal behavior and for the actions they take to positively influence the environment and culture of their unit or facility. Leaders should not be on their own in this transformation. Fellow leaders, outside experts, national program offices, and VA and VHA top executives must provide them with incentives, support, feedback, coaching, and, when needed, admonishment to support this cultural transformation.

To align leaders at all levels with expectations for the cultural transformation, all leaders must understand the role they play in the process. VHA must create standards for the behavior and actions leaders adopt to accomplish the transformation and widely publicize the standards among leaders and staff to establish uniform expectations across the organization and a single vision of cultural transformation. The CVCS and other senior leaders must model and reinforce these behaviors to further embed expectations. These behaviors and actions should be integrated into leadership assessment tools such as a 360 evaluation, performance management frameworks, and coaching guides to ensure expected behaviors and actions are reinforced across the leadership development and advancement system. The strategy must include the development of tools, training, guidelines, and operating procedures that create a living curriculum to support leaders in developing and deploying these new skills and behaviors. Finally, to ensure leaders at all levels implement the behaviors and actions, the strategy must establish both explicit rewards and sanctions. The rewards and recognition (nonmonetary) should liberally acknowledge and publicize leaders and staff who embody the very best standards of behaviors and actions that support a positive organizational culture. At the same time, leaders and staff at all levels must clearly understand what behavior and actions are not acceptable and be held accountable through disciplinary action if they cross these boundaries. Expectations and repercussions should be clearly articulated.

VA and VHA have a number of competing models of organizational health and staff engagement. The models are not integrated with one another or with an overall leadership competency model. Some models are robust, coupling abundant resources and training, while others are not. To create a clear focus for engagement and organizational health and guide

³⁸⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 55 accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

transformation effectively, one model must be selected for use in VHA. To do so, VHA must establish a cross functional executive team to make this decision. The team should include all of the stakeholder offices involved in current efforts, but none of them should lead the effort, to avoid parochial interests driving decisions. Once a single model is selected, the executive team must then outline a clear strategy, involving and engaging the offices in VHA with relevant expertise and resources to support the execution, and put forward a single strategic plan. Consequently, each of those offices must also be required to stand down its own efforts that are not part of this new model going forward and align its work and budget behind a single focused model and strategy. Tools, training, and communication to support broad deployment must be part of the strategy, and the CVCS and the executive team must present a compelling, transparent rationale for what the model is, why it was selected, and how it is to be deployed. All leaders and staff members in the organization must understand their roles in cultural transformation and what is expected of them.

The strategy must establish and articulate a clear set of behaviors and actions expected of staff to ensure their alignment around the transformation. The standards should be incorporated into the hiring process to ensure that VHA is hiring into the new culture and avoids a poor fit from the start. These behavioral expectations must be articulated clearly in the on-boarding process and reinforced on an ongoing basis in performance evaluations, reviews, and individual development plans. Leaders at all levels of the organization must also reinforce these behavioral expectations with staff and be provided with tools, messages, and communication support to accomplish this. Leaders must also recognize and reward the positive examples of the desired behaviors and sanction the worst examples, up to and including discipline and removal.

The change strategy should also recognize that cultural transformation and staff engagement go beyond individual leader and staff behaviors. Systems and processes at both the local and national level can impede the realization of the positive organizational culture desired. As such, the transformation strategy must also anticipate changing systems and processes as an explicit component of transformation. Leaders at all levels must establish mechanisms to elicit staff concerns and have quality improvement tools in place to address them, such as LEAN Six Sigma. Line staff must be engaged as part of the solution to these system issues. Leaders should be transparent about these issues and publicly track and report on progress.

To ensure the effective execution of this strategy, specific responsibilities must be assigned to program offices. The program offices must also support the VISN and facilities in their transformation effort by developing the standards and guidance for them to use and making program office expertise available to support coordination, coaching, and sharing of best practices across the institution. The program offices must be held accountable for supporting the application of these same standards and process within VHACO.

Standards for facility implementation must include a funded, full-time equivalent employee to support each major facility director³⁸⁸ and be the point person to coordinate efforts with VHACO and other facilities. Facilities may take the opportunity to consolidate related functions that currently exist in the facility. Each facility must have a local mechanism, such as an organizational health council, to integrate and drive transformation locally. But this does not

³⁸⁸ This equates to one person at each of the approximately 141 VHA health care systems led by a facility director.

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mean the facility should create yet another committee or oversight group to accomplish the transformation. Instead, facilities must look to existing leadership structures and activities, consolidating similar efforts to create an efficient process.

Finally, the executive team must oversee the development of a consolidated and meaningful set of metrics, using community standards where available, to track cultural transformation, organizational health and staff engagement. The metrics should not only measure the desired outcomes but also provide insights to leaders on how to fix problems by providing sufficient detail and specificity to offer this insight. Once deployed, the metrics should be used by the executive team and responsible program offices to identify under-performing facilities and to provide additional expertise, resources, and support to help those facilities improve. If, after much support, the continuing behavior and actions of the leaders at the under-performing facility are identified as the cause of the long-term culture problem, these individuals must be removed from leadership positions in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Develop and implement a strategy for cultural transformation.
- Establish a cross-functional senior executive team reporting directly to the CVCS with long-term responsibility for creating, executing, and tracking the cultural transformation.
- Align frontline staff in support of the cultural transformation strategy.
- Require standards and a strategy for execution of the cultural transformation from every program office and facility and these efforts must be fully funded.
- Develop consolidated, meaningful metrics for organizational health and staff engagements with input from experts and field users.

Other Department and Agency Administrative Changes

- None required.

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

Problem

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an Office of Management and Budget management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Background

*Our Corps does two things for America: We make Marines and we win our nation's battles. Our ability to successfully accomplish the latter depends upon how well we do the former.*³⁸⁹

Effective leaders are required for organizational success. Thus, attracting, growing, and advancing leaders is a key business imperative across all sectors.³⁹⁰ The most urgent human capital management need worldwide, according to one survey, is the development of leadership talent.³⁹¹ This need is driven by a changing workforce that is motivated more by passion than by monetary incentives, a rapid advance in knowledge that quickly creates obsolescence, and technology drivers that change business practices over months instead of years.³⁹² Investing in new supervisors and emerging leaders is critically important because

³⁸⁹ U.S. Marine Corps, *Sustaining the Transformation*, Foreword, accessed June 9, 2016, [http://www.marines.mil/Portals/59/Publications/MCRP percent206-11D percent20Sustaining percent20the percent20Transformation.pdf](http://www.marines.mil/Portals/59/Publications/MCRP%20206-11D%20Sustaining%20the%20Transformation.pdf).

³⁹⁰ Jim Collins, *Good to Great: Why Some Companies Make the Leap . . . And Others Don't* (New York, NY: HarperCollins Publishers, Inc., 2001), 17-40. Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015).

³⁹¹ Deloitte Consulting LLP and Bersin by Deloitte, *Global Human Capital Trends 2014: Engaging the 21st Century Workforce*, 25, accessed June 10, 2016, http://dupress.com/wp-content/uploads/2014/04/GlobalHumanCapitalTrends_2014.pdf.

³⁹² *Ibid.*, 3.

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employees report that when they quit a job they leave their supervisors and not their organization.³⁹³ In an organization like VHA, with more than 300,000 employees but only a bit more than 200 executives, VHA's 28,000 supervisors are responsible for leading the staff.³⁹⁴

Going back to at least 1998, the federal civilian sector has had difficulty identifying and promoting individuals with leadership skills.³⁹⁵ Staff members who can produce results and meet organizational objectives are promoted into supervisory and leadership positions.³⁹⁶ Yet, the skills needed to be a successful leader are different than those needed to be a successful technical expert. Today, soft skills such as empathy, effective listening, and team coaching are valued in leaders.³⁹⁷ The most effective leaders are those who consistently display integrity, high moral character, and the ability to inspire others.³⁹⁸ An effective leadership system develops leaders at all levels, from frontline supervisor to executives, and does so in all dimensions of leadership: "knowing, doing, and being."³⁹⁹

Analysis

In a review of VHA's approach to leadership development, the *Independent Assessment Report* noted the current system was not sufficient to meet VHA's need for high-quality, prepared leaders.⁴⁰⁰ VHA lacks a comprehensive approach to leadership development that would include formal structured programs such as networking, reflection, goal setting, learning, mentoring, experiential learning, and a clear career ladder. As a result, leaders are unable to fully prepare

³⁹³ "People Leave Managers, Not Companies," Victor Lipman, accessed June 10, 2016, <http://www.forbes.com/sites/#/sites/victorlipman/2015/08/04/people-leave-managers-not-companies/#78b15df216f3>.

³⁹⁴ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 21-23, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

³⁹⁵ U.S. Merit Systems Protection Board, Office of Policy and Evaluation Perspectives, *Federal Supervisors and Strategic Human Resources Management*, accessed June 10, 2016, <http://www.mspb.gov/netsearch/viewdocs.aspx?docnumber=280538&version=280868&application=ACROBAT>.

³⁹⁶ Ibid. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

³⁹⁷ Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. "Creating and Retaining Great Leaders," Dominique Jones, accessed June 10, 2016, <http://www.hrreview.co.uk/analysis/analysis-hr-news/dominique-jones-creating-and-retaining-great-leaders/60419>. "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, <http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success>.

³⁹⁸ Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015). "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, <http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success>. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

³⁹⁹ Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. U.S. Marine Corps, *Sustaining the Transformation*, accessed June 9, 2016, [http://www.marines.mil/Portals/59/Publications/MCRP percent206-11D percent20Sustaining percent20the percent20Transformation.pdf](http://www.marines.mil/Portals/59/Publications/MCRP%20percent206-11D%20Sustaining%20the%20Transformation.pdf).

⁴⁰⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

for future roles.⁴⁰¹ Although VHA does have some components of a development program, the activities are not connected to a career path and not well coordinated. Comprehensive development efforts are impeded by the use of multiple competing competency models in VA that make it impossible to align assessment and development with a cohesive standard. Emerging leaders are left to navigate career progression largely on their own and may be stymied because development opportunities are cancelled due to budget restrictions. Even when promising young leaders complete the current activities, gaps remain in their experience and training because the training programs are not coordinated.⁴⁰² As a result, VHA does not have a robust pipeline of young leaders ready to take on higher-level responsibilities.⁴⁰³

Included in the *Independent Assessment Report* is a recommendation that VA stabilize, grow, and empower leaders. This recommendation includes suggestions to fill current vacancies with high-quality leaders, improve the attractiveness of the roles, ensure leaders are prepared to assume their roles, and create a comprehensive strategy that connects top performers to leadership opportunities and development plans.

There is little concrete information in the assessment to suggest how VA and VHA should accomplish these objectives. The commission examined VA's and VHA's current work to assess whether they have created plans to operationalize the leadership development recommendations articulated in the *Independent Assessment Report*.

Neither VA nor VHA has rationalized the multiple competency models within the department. A competency model is the core driver informing recruitment, development, assessment, and advancement in any comprehensive approach to leadership development and management.⁴⁰⁴ Having a cogent competency model is a prerequisite to a coherent strategy.⁴⁰⁵ Leading a health care organization requires specialized knowledge and skills not required of leaders in other fields.⁴⁰⁶ Thus, any competency model applied in VHA must include health care specific components. Health care executive competencies embrace such topics as an understanding of ethics in health care, management of self-governing professionals (e.g., physicians, nurses), the technical knowledge of health care regulation and operational management, and leading change, in addition to other leadership skills and knowledge.⁴⁰⁷

The current models used in VHA do not reference external benchmarks, and they are not health care specific. VHA plans to continue to use the High Performance Development Model (HPDM) as its competency model.⁴⁰⁸ HPDM was developed by VHA and is not benchmarked to private-sector competency models for health care executives. VHA plans to use the model to drive

⁴⁰¹ Ibid.

⁴⁰² Ibid., 38.

⁴⁰³ Ibid., 37.

⁴⁰⁴ The American College of Healthcare Executives, *ACHE Healthcare Executive: 2016 Competencies Assessment Tool*, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf.

⁴⁰⁵ Ibid.

⁴⁰⁶ Ibid.

⁴⁰⁷ Ibid. "Joint Medical Executive Skills," Joint Medical Executive Skills Program, U.S. Department of Defense, accessed May 16, 2016, http://www.au.af.mil/au/awc/awcgate/leadership/med_exec_skills.htm. "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁰⁸ "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

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position requirements, performance management, and training content.⁴⁰⁹ The plan mentions coordination with VA Learning University but provides no detail.⁴¹⁰ The plan also does not provide specific information about how the use of HPDM will link to formal recruitment, performance assessment, and advancement of leaders.⁴¹¹

VHA is working to understand the current career progression of candidates who move into field-based executive positions. VHA field leaders are cultivated from within VHA with about 98 percent advancing from lower-level field positions such as associate director, service chief, or chief of staff.⁴¹² As a result, field senior executives often lack outside experience and first-hand knowledge of alternative management methods.⁴¹³ Most companies look for a mix of internal and external hires, and the circumstances of the organization often drive the mix.⁴¹⁴ For instance, Henry Ford Health System, a successful growing company with a robust internal leadership development program has set a target of 70 percent internal promotions and 30 percent external hires.⁴¹⁵

The VHA pool of internal candidates is also deficient in racial and ethnic diversity with striking under-representation of women of color in all of the positions that constitute the pipeline for medical center director positions (see Figures 6 and 7).⁴¹⁶ VHA leadership development programs have failed to effectively recruit and advance under-represented minorities with a striking over-representation of White men in the leadership class that feeds the senior executive service (see Table 7).⁴¹⁷ Minority women shoulder the biggest burden of formal mentoring within the organization.⁴¹⁸ VHA also has the lowest representation of veterans among its staff (31 percent) compared to Veterans Benefit Administration (52 percent) and National Cemetery Administration (74 percent). The number of veterans among doctors and dentists in VHA is only about 14 percent of the employees.⁴¹⁹ Among leaders, 22 percent of senior executives are veterans and a similar number (23.8 percent) populate the leadership pipeline.⁴²⁰

⁴⁰⁹ Ibid.

⁴¹⁰ Ibid.

⁴¹¹ Ibid.

⁴¹² Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A*, November 23, 2015.

⁴¹³ Ibid.

⁴¹⁴ Eric Krell, "Staffing Management: Look Outside or Seek Within?" *HR Magazine*, January/February 2015.

⁴¹⁵ "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

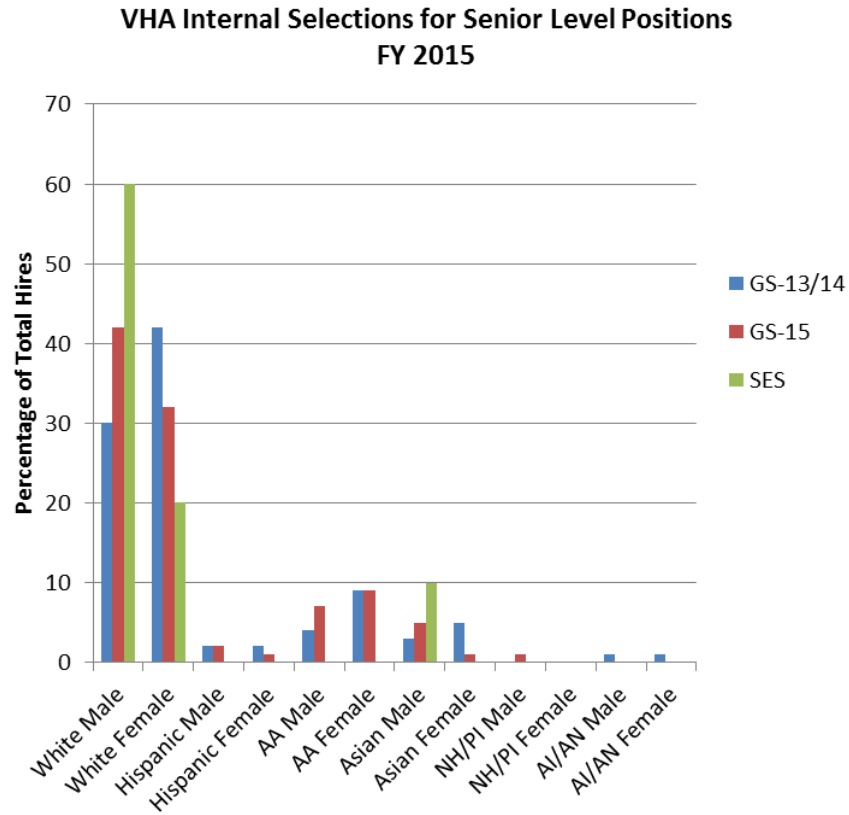
⁴¹⁶ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

⁴¹⁷ Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A*, November 23, 2015.

⁴¹⁸ Ibid.

⁴¹⁹ Health Care Talent Management Office from PAID and NOA, September 17, 2015: Path to Medical Center Director, Healthcare Leadership Talent Institute.

⁴²⁰ VHA Health Care Talent Management Office, provided to Commission on Care for employees in VHA as of September 30, 2015 by request, March 8, 2016.

Figure 6. Diversity of Senior-Level Hires in VHA

AA = African American

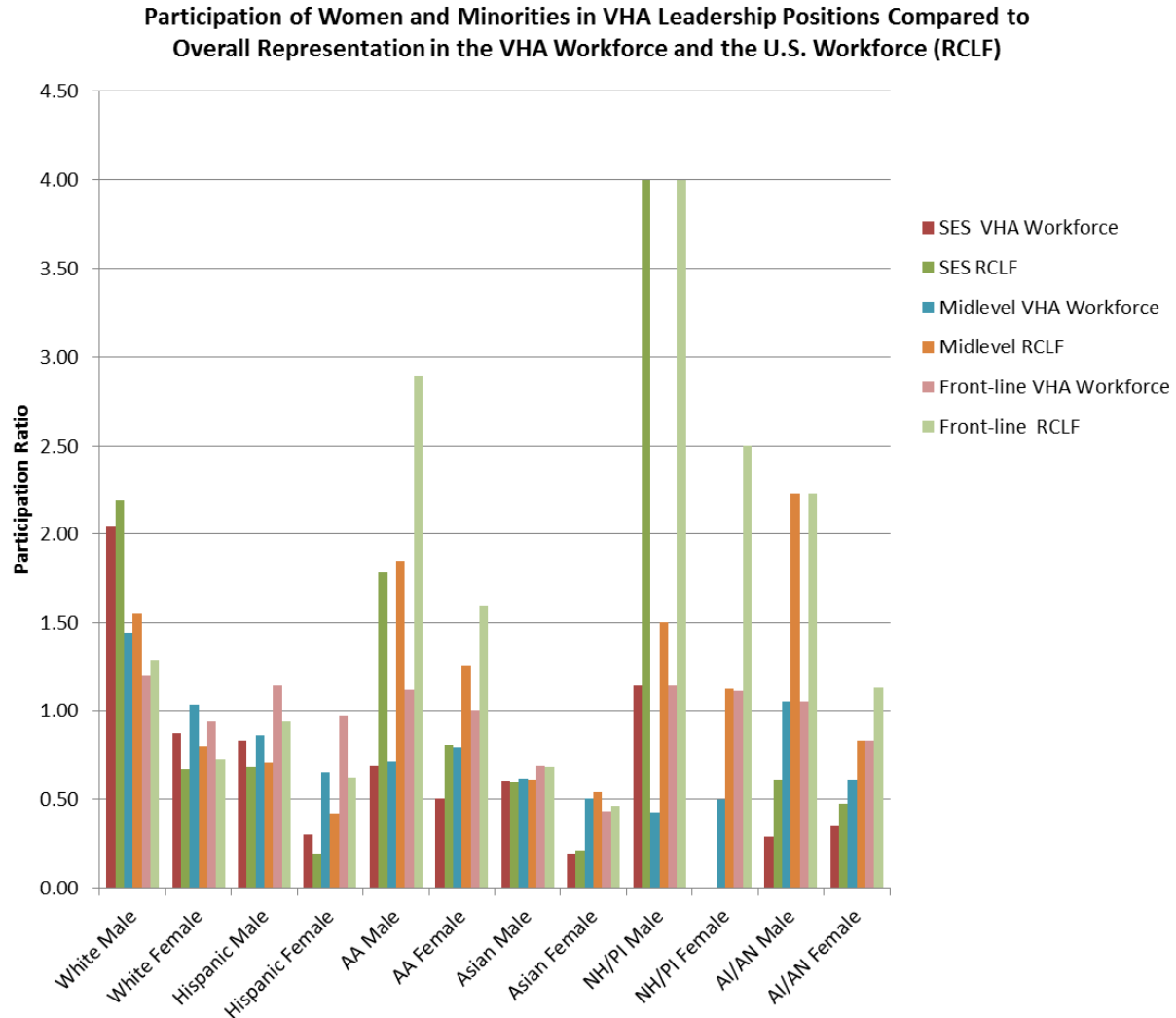
NH/PI = Native Hawaiian/Pacific Islander

AI/AN = American Indian/Alaska Native

Note: In FY 2015, VHA failed to select many candidates from diverse racial and ethnic backgrounds for senior executive positions. These data were drawn from the VHA annual equal employment opportunity (EEO) report.

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Figure 7. Minority Women are Under Represented in Higher-Level Positions in VHA



AA = African American

NH/PI = Native Hawaiian/Pacific Islander

AI/AN = American Indian/Alaska Native

Note: Women and particularly minority women are under-represented in comparison to their participation in the U.S. workforce (relevant civilian labor force [RCLF]) and their participation in the VHA workforce at higher levels in the organization. Some minority men are also under-represented in high-level positions. These data were derived from the VHA annual EEO report.

Table 7. White Males are Over Represented in VHA SES Development Program, HCLDP

	TCF 2015 (N)	GHATP 2014 (N)	Facility LEAD 2015 (N)	VISN/CO LEAD 2015 (N)	HCLDP 2015 (N)	VHA Workforce
White Male	35% (78)	30% (14)	19% (160)	22% (69)	41% (151)	23%
White Female	16% (35)	28% (13)	41% (342)	41% (127)	39% (144)	36%
African American Male	15% (33)	9% (4)	8% (66)	8% (24)	4% (14)	9%
African American Female	19% (42)	15% (7)	22% (180)	16% (50)	6% (23)	15%
Hispanic/Latino Male	4% (10)	4% (2)	3% (23)	4% (11)	1% (5)	3%
Hispanic/Latina Female	3% (7)	2% (1)	3% (29)	3% (10)	1% (4)	4%
Asian Male	4% (9)	2% (1)	1% (9)	>1% (2)	2% (7)	3%
Asian Female	2% (5)	9% (4)	2% (16)	4% (13)	3% (12)	5%
Native Hawaiian/Pacific Islander Male	0% (0)	0% (0)	>1% (3)	0% (0)	0% (0)	>1%
Native Hawaiian/Pacific Islander Female	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	>1%
American Indian/Alaska Native Male	2% (4)	0% (0)	>1% (1)	>1% (2)	1% (3)	1%
American Indian/Alaska Native Female	0% (0)	0% (0)	1% (7)	1% (4)	1% (3)	1%

Note: VHA offers career development opportunities from entry-level programs (TCF and GHATP) to an SES preparatory curriculum (HCLDP). Overall, White men make up about 23% of VHA employees but are over-represented in the HCLDP program at 41%. African American and Hispanic men and women are under-represented in the same program.

TCF= Technical Career Field; GHATP=Graduate Healthcare Administration Training Program; LEAD=Leadership, Effectiveness, Accountability, and Development; HCLDP=Health Care Leadership Development Program.

No evidence was presented to indicate that career progression mapping is occurring for positions within VHA central office, where high-quality leaders are also required.⁴²¹

⁴²¹ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

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VHA has much work to do to produce an effective leadership management system. Recruitment, retention, development and advancement are key processes that require immediate and sustained attention from VHA leaders. Without substantial changes, high-potential staff will continue to struggle to understand their career trajectory. Without a driving competency model and coordinated training to guide advancement, hiring decisions will continue to be made without uniform standards against which to measure applicants and new executive hires will continue to struggle to understand VHA and their role in leading it. Without the committed engagement and support of the chief of VHA Care System (CVCS) and the other top VHA executives for the leadership management system and their direct communications about and modeling of the leadership competencies, VHA will continue to flounder. As a result, veterans will be denied the high-performing health system they deserve.

Executive Commitment

The long-term success of any enterprise rests on having excellent leaders in key positions and sustaining them over time. To accomplish this goal, leadership management, development, and recruitment must be a core responsibility and a priority for VHA senior executives. To start, VA must include the goal of achieving an effective leadership management system in VHA as a component of the department's management agenda in the annual budget. The goal is a robust, high-quality, diverse leadership team in VHA. VA needs to establish a credible operational plan and accountability mechanisms for meeting this goal. Executive leaders are then held accountable for attaining the leadership management goals, including personally investing time in meeting diversity targets, recruitment plans, and succession planning objectives. These targets are to be reviewed in the individual performance of top leaders as well as in the Office of Management and Budget's ongoing review of the department's management objectives. Executive leaders need to also set and communicate clear expectations for the behavior of leaders and staff and to invest their own time in mentoring, coaching, and developing subordinate leaders and promising staff, including under-represented populations. They must be visible and role-model leadership competencies in meetings, training, and new-hire orientations. They must take an interest in developing leaders and help create opportunities for them to gain leadership experience and competencies. The CVCS and senior executives must keep in mind that their sole role is not to manage crises or to oversee a process or to manage up. Rather, their primary role is to lead their people. Their time and attention must reflect that priority.

Leadership Model

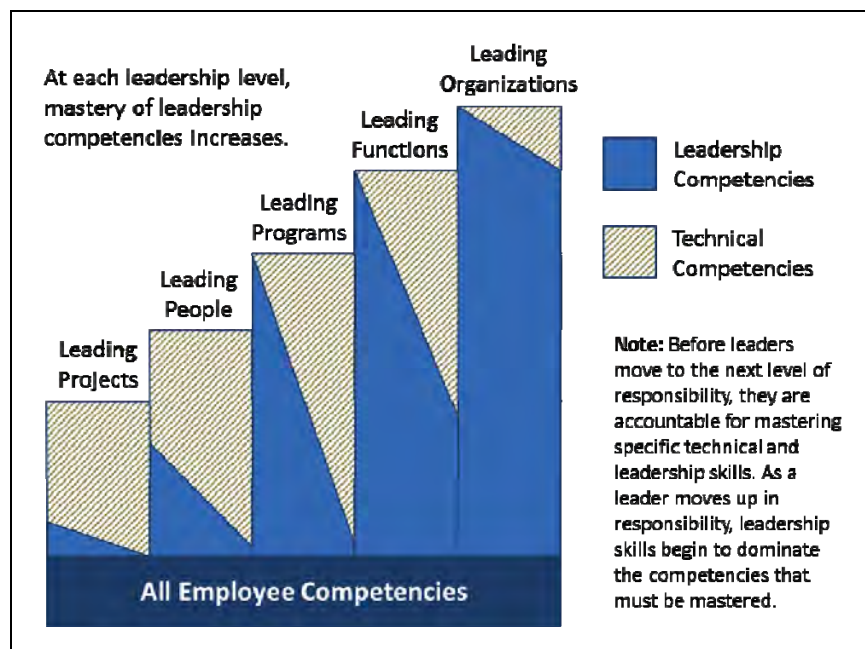
To establish clear leadership standards to guide hiring, development, and the advancement of leaders, VHA needs to adopt one benchmarked health care competency model. Currently, VHA is subject to the Office of Personnel Management executive core qualifications, HPDM, and standards for servant leadership. Although all of the models have value, none provide a clear trajectory for high-potential staff to follow, and they do not provide opportunities for VHA to intersect with leaders in the private sector. VHA must stop using these varied competency models and instead adopt a single model that is benchmarked to private-sector standards. The Commission is not making a recommendation about which model VHA should choose. Rather VHA should apply the criteria below to select a model around which to base its leadership development program:

- The standard must embrace leading through ethics and values, demonstrating character and concern for others, and creating a strong organizational culture.
- The standard must be health care based and describe the knowledge, skills, ability, and leadership bearing and behaviors that health care leaders must master to be effective.
- The standard must be a robust competency model including aligned training and tools to permit quick implementation.
- The model must describe different career tracks and the mastery requirements for key points in each career track. Key career tracks such as VISN director, facility director, and VHA Central Office (VHACO) program executive should fit into the competency model.
- A career path must specify the competencies that require mastery before moving to a higher position.
- VHA may need to enhance the model with competencies in care and services to Veterans and knowledge of military occupational health.

Training and Assessment

VHA needs to develop assessment tools based on the competency model, including 360, 180, self-assessment, and supervisory review processes. Leaders and developing leaders should be required to use at least one of the assessments each year and to apply the results to identifying their training and development needs. Findings from the assessments should be rolled into an individual development plan (IDP) for each leader or developing leader and enrollment in a leadership course should require a documented need from one of these assessments.

Figure 8. At Each Leadership Level, Mastery of Leadership Competencies Increases



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Training must be mapped against the competency model career track. All current leadership training should be mapped against the model. Gaps should be identified and filled with commercially available, or where needed, internally developed training. This training should include leadership competencies for the care of veterans, including an understanding of military occupational health, combat injuries and exposure, combat readjustments, and military sexual trauma. (See Appendix H for descriptions of such training material.) VHA should look for opportunities to partner with Department of Defense and the private sector to provide joint training and development opportunities to fill some of the identified gaps. VHA must develop one or more face-to-face training series that allow high-potential candidates to complete all the competencies required to move to the next career stage. As VHA strengthens its partnership with community providers and health systems, executive and high-potential training resources from VHA should be made available to community health care leaders and VHA should join training offered by these private-sector partners.

Based on the benchmarked competency model, VHA should collaborate with Academic Affiliates to establish two new programs. The first is to create opportunities for VHA physicians to gain masters-level training in health care management to prepare them to lead a medical facility. Second, VHA should work to create rotations in VHA for external physicians who are completing graduate health care management programs. Like academic affiliate residency training programs, VHA should collaborate with academic medicine to establish, fund, and run these programs with the goal that all participants rotate in management positions in VHA or VHA-partnered private-sector systems for six or more months during their training. Graduates of such programs would be candidates for recruitment into the VHA leadership pipeline and would encumber a pay-back commitment to VHA for any direct funding provided.

All training should include formal assessment to assure that learners have mastered the material and this mastery should be noted in their IDPs and training record.

As part of the leadership development model, experiential learning opportunities and formal coaching are critical to executive learning. Individual and group coaching standards and programs must be established for all developing and new leaders. A program for senior leaders to pair them with private-sector health care leaders must also be supported. VHA must establish rotation opportunities for developing leaders to rotate for substantial periods (e.g., 3 to 18 months) in not-for-profit hospital systems. This program could be structured as a certificate program that the employee and VHA jointly fund and include a payback commitment on the part of the trainee. Similar rotations from the private sector into VHA should be developed with health care system partners to help develop private-sector competencies in care for veterans and inject private-sector approaches into VHA.

Apply the Leadership Model

VHA is required to apply the competency model in all hiring decisions for executive career field positions. Thus all functional statements must be based on the model, all interview protocols must incorporate the competencies, and all candidates who are not internally certified to the standard of the job must undergo an assessment by a board to ensure they meet the position requirements. Conversely, internal candidates must be required to demonstrate mastery of the competencies before qualifying to apply for a position. VHA must adopt the strategies of executive recruiters to identify and recruit needed experts outside of government with the

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competencies VHA seeks. Recruiters can look to the pipelines the Commission has recommended building to bring military treatment facility commanders and other senior leaders and private sector experts into VHA as a network for identifying additional recruits. Executive recruiters can particularly help ensure diverse candidates are identified for open positions.

VHA will require competency assessments and IDPs for all existing executives, potential executives, and new hires. Current leaders and new hires who have an identified gap in any competency must have it included in their IDP and be required to fill these deficiencies by a specific deadline or face demotion or dismissal. Completion of IDP development opportunities is required for advancement in grade or promotion to higher position within the leadership pipeline.

VHA will aggressively manage its leadership candidate pool by identifying and tracking all high-potential individuals. Diversity statistics should be tracked and diversity in this pool actively managed. This pool of candidates derives from annual ratings as well as leadership development program graduates. Supervisors and executive leaders must provide ongoing coaching for higher positions to this pool of developing leaders. VHA must identify anticipated succession needs and offer development opportunities that would help prepare candidates for these anticipated openings. Once the positions are open, individuals in the high-potential pool must receive notices of new job postings and detail opportunities that provide experience into higher positions. Candidates who agree to be in this pool should be required to enter into formal mentoring relationships with leaders outside their chain of command to further advance their career development. For highest-level positions (VISN director, facility director, VHACO chief officer) a formal pool of approved or precertified candidates should be established.

To expand the perspectives and management experience in its leadership pipeline, VHA must develop explicit strategies to on-ramp diverse candidates at critical midcareer transition points. This process includes creating pathways for retiring commanders and other senior officers of military treatment facilities to compete effectively for leadership positions in VHA. To increase VHA understanding of private-sector health care, VHA must develop midcareer entry points for private-sector candidates. This could be accomplished through the use of temporary hiring authority and the ability to convert these positions to permanent staff positions if leadership competencies standards have been met by the candidates. Such opportunities can be modeled on efforts recently announced by DoD and, wherever practicable, should be developed collaboratively with DoD to establish the legal and policy requirements for implementing these programs. Finally, the current graduate health administration training program (GHATP) program should be expanded to include more schools and programs with diverse trainees. This expansion must allow high-performing residents to continue to convert to full time positions.

On-boarding

A formal on-boarding process should be instituted for all new executive hires. In addition to the transactional knowledge the individual will need, on boarding should establish the expectations for what it means for that executive to be successful in VHA. The values of the organization and the expectations for ethical practice must be conveyed by the CVCS and the top leadership team. A formal assessment of knowledge and skills should be made during on-boarding and an IDP established to cover the probationary period of new hires if any deficiencies are identified.

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Completion of the IDP is required for continued employment. All new leadership hires should be assigned a coach based on their individual needs. Within their first 6 months of employment, the undersecretary for health and Secretary should meet with these new executives to build a relationship with them and hear their fresh perspectives on the performance of VHA.

Stabilize Leadership

VHA should immediately stabilize its leadership ranks by authorizing VA medical center and veterans integrated services network (VISN) director details to last up to a year with no restrictions on an acting leader competing for the permanent position. VHA should also create flexible capacity by creating more assistant-level positions (e.g., assistant director, assistant VISN chief medical officer, assistant nurse executive, deputy chief officer). These individuals would comprise the pool of potential leaders and also allow for cross filling positions that are empty due to development assignments, training, or other leadership development opportunities.

Implementation

Legislative Changes

- Establish direct-hire authority from the graduate health care administration training program, military treatment facility, and private-sector fellow pools, clarifying application of merit-system principles, including approaches to managing veterans' preference in these programs.
- Establish Intergovernmental Personnel Act authority for VHA to include the for-profit private sector; this could be done as a pilot program with a report to Congress before considering whether to make the authority permanent.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.
- Aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: All hires and promotions are required to demonstrate these competencies.
- Require a formal on-boarding process for HPDM 3 and 4 leaders at all levels that reinforces the leadership competency model.
- Take immediate steps to stabilize the continuity of leadership by extending the length of authorized details to extend the continuity of leadership at medical centers and allow leaders detailed to a position to compete for a permanent appointment to the position by removing the non-compete requirements.

COMMISSION RECOMMENDATIONS

- Establish the competency model in regulation and include requirements for its use in hiring, promotion and dismissal and clarify the application of veterans' preference in executive development.

Other Department and Agency Administrative Changes

- None required.

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Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Problem

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and their functions overlap or are duplicative. The role of the Veterans Integrated Service Network (VISN) is not clear, and the delegated responsibilities of the medical center director are not defined.

Background

A prerequisite of a successful, high-performing system is having strong leaders and a strong leadership system.⁴²² An organization's leadership system is "the way leadership is exercised, formally and informally, throughout the organization; the basis for key decisions and the way they are made, communicated, and carried out."⁴²³ It includes "structures and mechanisms for making decisions; ensuring two-way communication; selecting and developing leaders and managers; and reinforcing values, ethical behavior, directions, and performance expectations."⁴²⁴ In an organization the size of VHA, with a budget of \$69 billion,⁴²⁵ more than 300,000 employees, and more than 1,000 sites of care,⁴²⁶ strong leadership systems are essential.

The Commission Recommends That . . .

- VHA redesign VHA Central Office (VHACO) to create high-performing support functions that serve Veterans Integrated Service Networks (VISNs) and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the chief of VHA Care System with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report (also included in Recommendation #10).

⁴²² Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 50.

James Collins, *Good to Great: Why Some Companies Make the Leap and Others Don't*, (New York, NY: HarperCollins, 2001), 17-64.

⁴²³ Ibid.

⁴²⁴ Ibid.

⁴²⁵ Department of Veterans Affairs, *VA 2017 Budget Request: Fast Facts*, accessed March 10, 2016, <http://www.va.gov/budget/docs/summary/FY2017-FastFactsVAsBudgetHighlights.pdf>.

⁴²⁶ "About VHA," Department of Veterans Affairs, accessed February 5, 2016, <http://www.va.gov/health/aboutVHA.asp>.

In the last successful reorganization of VHA in 1995,⁴²⁷ the organizational design and functional roles of the leadership system were organized into clear structures with clear functions. The VISNs were responsible for operations⁴²⁸ and VHACO program offices were responsible for policy, guidelines, and outcomes.⁴²⁹ The National Leadership Board (made up of VISN directors and all program office leaders) was responsible for collective, fact-based decision making and the Friday Hotline call was used to communicate leadership priorities and decisions directly to VA medical center (VAMC) leadership. A negotiated performance measurement system based on consistent, benchmarked, outcome-focused metrics⁴³⁰ was also established that was supported by centralized functions that benefit from economies of scale.⁴³¹ As part of the reorganization, VHA experienced a reduction in staff and consolidation of VHACO offices to create a flat, agile leadership system.⁴³² Because this functional matrix was not sustained, VHA now faces the challenge of reinstituting an effective leadership system.

Analysis

Twenty years after the Kizer reorganization, VHA has a very different leadership system, under which it “is intensely, unnecessarily complex due to a lack of clear operating model, limited role clarity, fragmentation of authority, and overlapping responsibilities.”⁴³³ The *Independent Assessment Report* included the following findings about the VHA operating model:⁴³⁴

- VHACO has grown rapidly since 2009 from 753 in FY 2009 to 1,990 in FY 2014.
- The VISNs’ ability to manage and support their regions is heavily hampered by resourcing restrictions and direct VHACO control over VAMC operations.
- The VAMCs’ operating model suffers from powerful silos, which prevent an effective end-to-end mission focus.
- VA’s increasingly top-down management style, coupled with poor prioritization and the external political environment, result in a lack of clarity around strategic direction, reactivity to external headwinds, and flawed efforts to standardize.

VHACO has grown rapidly in the past few years.⁴³⁵ The growth in central office was driven in part by new ideas, new priorities, and new crises being addressed through the creation of new

⁴²⁷ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco, CA: Berrett-Koehler Publishers, Inc., 2012), 54.

⁴²⁸ Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 35. Kizer, Kenneth W and Ashish Jha, “Restoring Trust in VA Health Care,” *New England Journal of Medicine*, 371, (2014): 295-297.

⁴²⁹ Ibid.

⁴³⁰ Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 61-72.

⁴³¹ Ibid., 33.

⁴³² Ibid., 60. Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation of the Veterans Healthcare System*, Objective 3 and 17, 1996.

⁴³³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 95, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁴³⁴ Ibid.

⁴³⁵ Ibid., 98.

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offices and new staff infrastructure to support it.⁴³⁶ A portion of the growth came from the centralization of functions that were previously managed in the field such as business office functions. The final component has come from the duplication in VHA of offices in which decision-making authority rests with VA, such as communications and regulatory management. VHA has also duplicated functions and responsibilities between two or more offices in VHA, such as primary care, surgery, mental health, and geriatrics and extended care. This increased growth in staff and offices has resulted in more complex and lengthy decision processes, often with little clarity as to whom ultimate responsibility for decisions or follow up falls.⁴³⁷

One symptom of the top-down management is VHACO control of budgeting and resource management. “Support funding is outside local control” and the “increasing share of Specific Purpose funding hinders” local leaders in their ability to use resources effectively.⁴³⁸ In FY 2015, specific-purpose funds were spread across more than 450 line items,⁴³⁹ taking money away from general purpose funding and restricting how this money can be used. Both VHACO and Congress have been complicit in taking control away from medical center directors through these budget controls.⁴⁴⁰ For instance, the congressional appropriation to fund VHA for 1998 included only five appropriation line items; medical care, medical administration, construction major, construction minor, and medical and prosthetic research.⁴⁴¹ In contrast, the budget request to Congress for FY 2016 included 12 budget categories relevant to VHA with some of those accounts having four or five subcategories.⁴⁴² In his testimony before the Commission and Congress, Secretary McDonald made the point that such fragmentation of the VHA budget and the prohibition to reallocate across budget categories without first receiving Congressional approval was an impediment to effective and agile management of the department.⁴⁴³ Greater Congressional control of VHA spending is understandable in light of VA’s lack of adequate management systems and data analytic capabilities to track expenditures in real time⁴⁴⁴ and report them to Congress and central office. The only means available to hold the medical centers

⁴³⁶ Ibid., 96-99.

⁴³⁷ Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health*, (Washington, DC, Veterans Health Administration, February 2015), 7-9.

⁴³⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership)*, 102, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴³⁹ Ibid., 107.

⁴⁴⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership)*, 102-108, accessed June 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴⁴¹ PL 105-65, October 27, 1997.

⁴⁴² Department of Veterans Affairs Fiscal Year 2016 Budget Submission, Volume II Medical Programs and Information Technology, Accessed June 10, 2016, <http://www.va.gov/budget/products.asp>.

⁴⁴³ On January 21, 2016, Secretary of Veterans Affairs, Robert A. McDonald, provided the following testimony before the U.S. Senate Committee on Veteran’s Affairs “Flexible Budget Authority: We need flexible budget authority to avoid artificial restrictions that impede our delivery of care and benefits to Veterans. Currently, there are over 70 line items in VA’s budget that dedicate funds to a specific purpose without adequate flexibility to provide the best service to Veterans. These include limitations within the same general areas, such as health care funds that cannot be spent on health care needs and funding that can be used for only one type of Care in the Community program, but not others. These restrictions limit the ability of VA to deliver Veterans with care and benefits based on demand, rather than specific funding lines.” accessed June 10, 2016,

<http://www.veterans.senate.gov/imo/media/doc/VA%20Sec%20Testimony%2001.21.2016.pdf>

⁴⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 105, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

accountable was to fund the priority initiatives as separate budget lines or indicate allocations to be made under the specific-purpose process.

To fix the overly complex and bureaucratic structure of VHA, the *Independent Assessment Report* suggests that VHA “redesign (its) operating model to create clarity for decision-making authority, prioritization, and long-term support.”⁴⁴⁵ VHA must take a systems approach to reorient its leadership operations, restructuring and re-orienting VHACO program offices to ensure all of the following:⁴⁴⁶

- fact based, innovative decision making that is responsive to the field, other offices, and external stakeholder requirements
- feedback mechanisms to incorporate system learning into policy development and operational guidance
- communication mechanisms to effectively share information across offices and reach VISN and facilities to explain expectations and tie decisions to organizational values and goals
- effective execution of policy decisions through expert coaching, deployment of resources, and guidance based on external benchmarks and sharing of internal best practices
- analytic capability and infrastructure to effectively monitor progress and outcomes of all organizational priorities

Such a reorientation will involve a different skill set and expertise than currently required in VHACO. Transformation will call for recruiting new expertise, making advancement decisions based on these new competencies, reinforcing them through recognition and performance assessment, and developing new skills in current staff through training and coaching. This skill set includes a high level of technical expertise relevant to the program office; the ability to build relationships with external stakeholders; demonstrated skills in coaching, staff development, and training; certification in quality improvement methodologies; analytic capabilities to develop and track metrics; and the ability to lead transformational change. VHA must fully fund the retraining and the hiring of skilled staff in VHACO to accomplish this transformation.

For the VHACO program offices to work effectively with one another and with the field, the specific authority of each office must also be defined. Where overlap and confusion exists between offices, programs must be combined and streamlined or eliminated with a corresponding reduction in force. In changing the structure and orientation of VHACO program offices, VHA leadership can take the opportunity to align functions to achieve its stated priority of patient-centered care. In a fully aligned operating structure, business processes from the VAMC front line to central office must be organized to deliver important

⁴⁴⁵ Ibid., ix.

⁴⁴⁶ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 7, 34, and 50.

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patient outcomes rather than aligned in professional silos. For instance, instead of having an office of nursing, one for social work, and a lead for physician assistants, business offices should be aligned around the work they do together, like patient aligned care teams, to deliver positive outcomes for veterans.

The administrative operations of VHACO should also be flattened. Senior staff should be speaking directly to other senior staff to discuss and make decisions rather than relying on bureaucratic, paper-based processes as a means of negotiation: It is neither a healthy culture nor an efficient process. At the same time, VHACO needs to take full advantage of being a large-scale enterprise by centralizing functions such as acquisition package development, recruitment package development, and account reconciliation so that staff is not required in each program office to take on these occasional but complex activities. The net savings resulting from this reorganization and delayering of the bureaucracy must be reinvested in the transformation process.

VISNs must also examine the skills needed to take on an expanded role as facilitators, coaches, and guides in improving services and sharing best practices across facilities. VISNs are critical players in the feedback loop between service delivery and VHACO to identify ineffective processes, problems, and emerging issues that need to be raised to VHACO for help in clearing away barriers to effective operations. Similar to VHACO, VISNs must define the new skill set required by their staffs and establish these requirements in hiring, promotion, and performance evaluation as well as training and coaching staff to develop these competencies. Finally, the chief of VHA Care System (CVCS) should establish a required staffing ratio for the VISN office and reduce the staffing in VISNs that exceed this standard.

A new operating model also means that medical center directors must control the budget, staff, supplies, and infrastructure required to deliver needed health care. This model includes consolidation of budget lines and new authority and expanded authority to reallocate funds across the remaining budget categories. To manage the new VHA Care System and ensure that facility and network directors have the local control needed to make decisions about how to deliver services, fewer restrictions should be placed on the VHA budget. To start, specific-purpose funds must no longer be used to direct obligations at facilities. Congress should also work with the administration to reduce the number of budget lines and specific spending authorities back to a simpler system like that used in 1998. To support these changes and create transparency, medical centers should be accountable for their expenditure of funds by ensuring accurate, complete, and timely cost accounting. This last requirement, however, can only be met if it is supported by effective financial management data systems and fully trained staff and leadership who understand how to use such systems.

To support the leaders, program offices, and the field in this transformation, the CVCS must establish a transformation office that has appropriate expertise in business process reengineering and is fully funded to conduct this work. Existing offices with the requisite expertise, including the Office of Strategic Integration and the Veterans Engineering Resource Center (VERC), should be rolled into the transformation office. This office would oversee transformation and incubate new initiatives with the goal of incorporating them into regular work of other program offices once the new initiative is established. This mechanism, if used consistently, would prevent VHA from growing new offices as new priorities arise.

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Finally, as part of cultural change within the leadership system, the CVCS, VISN directors, and program office leaders must promote open and productive dialogue among themselves about problems and solutions. To accomplish this goal, leaders must address both the culture within the leadership ranks, as well as establish systems and processes that support identification and discussion of problems. The CVCS must model this behavior by inviting input on problems and rewarding leaders when they bring issues forward, including rewarding them with access to expertise, staff, and money; removing barriers; and aligning other leaders in support of solutions.

In its work to oversee change in VHA, the transformation office will create an implementation plan for transformation, identifying key strategies and milestones. This plan will drive data collection, development of strategic goals and supporting objectives to encourage effective planning, accountability, and the ability to unearth critical gaps that need to be addressed. The transformation office will require each new initiative to establish a project plan and provide periodic reports that include all of the following components: tactic/action, initiative owner, cost (i.e., operational, equipment, contracts), number of FTEs, start and completion dates, outcome measures, strategic drivers, and milestone.⁴⁴⁷ The President's Management Agenda Scorecard will serve as the evaluation model. The Office of Management and Budget created this tool to evaluate new initiatives and track progress on outcomes over time with regular spotlight reports (red, yellow, green) to leadership.⁴⁴⁸

Implementation

Legislative Changes

- Simplify the VHA budget to include fewer accounts while at the same time requiring more transparent and detailed accounting of VHA expenditures.

VA Administrative Changes

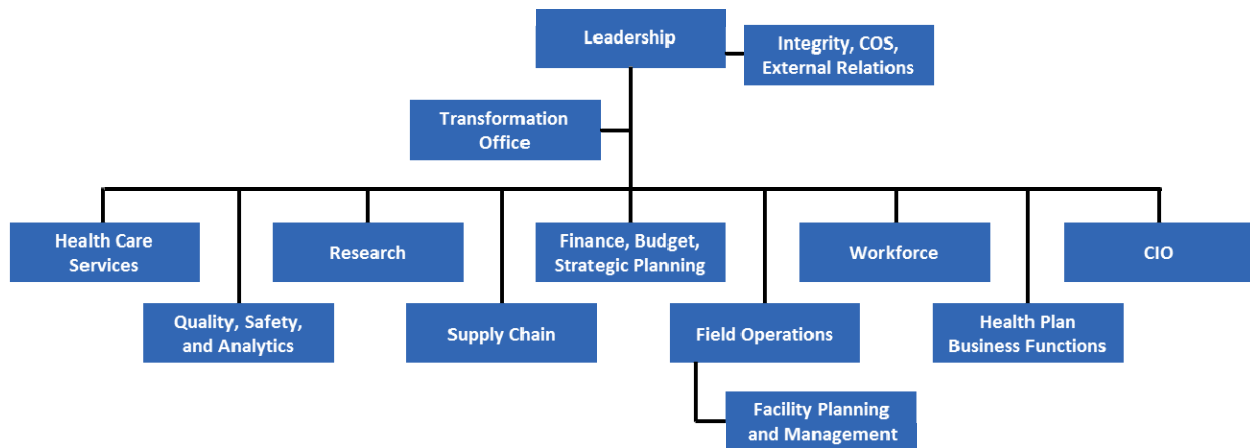
The following administrative changes are a priority during the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B. Responsibility for establishing a transformation plan with milestones, timelines, and evaluation of outcomes is assigned to the transformation office that the Commission recommends be established in VHA.

- Eliminate duplication within VHA and consolidate program offices to create a flat structure. Figure 9 is one model of an organizational chart for accomplishing this goal. This organizational chart shows how VHA can be streamlined to mirror the structure of large private-sector hospital systems. Figure 10 is the current VHA organizational chart, provided as a point of comparison and to emphasize the cumbersome nature of the current structure.

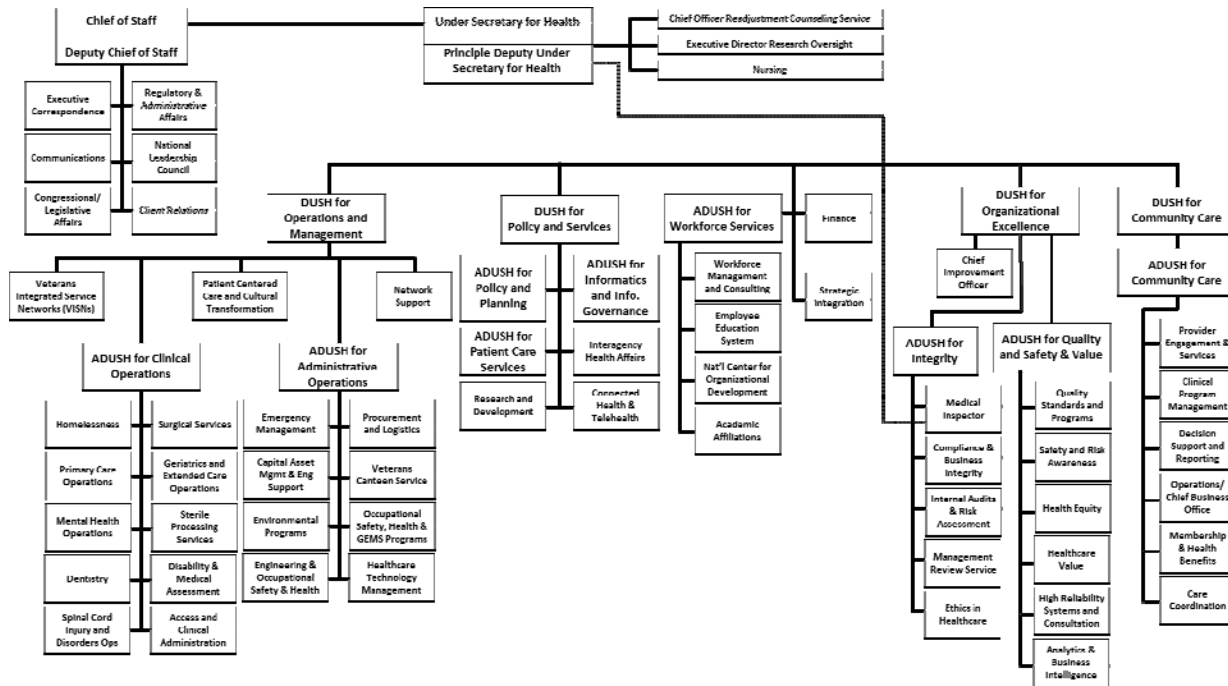
⁴⁴⁷ For example, see "VA Faith-based and Community Initiative President Management Agenda Scorecard," September 30, 2008,

⁴⁴⁸ "Office of Federal Financial Management President's Management Agenda," Office of Management and Budget, accessed June 15, 2016, https://www.whitehouse.gov/omb/financial_fia_pma/.

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Figure 9. Proposed VHA Organizational Chart⁴⁴⁹

Note: This organizational chart is an example of how to align VHA functions to create a flatter organization, remove duplication, and streamline decision making as discussed throughout this section of the report. Of note, the placement of the Transformation Office, CIO, and supply chain in this diagram is consistent with recommendations made by the Commission elsewhere in this report. In this chart, COS is chief of staff.

Figure 10. Current VHA Organizational Chart⁴⁵⁰

⁴⁴⁹ Modified from Appendix C, Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health*, (Washington, DC, Veterans Health Administration, February 2015), 41.

⁴⁵⁰ Ibid.

COMMISSION RECOMMENDATIONS

- Eliminate the duplication of functions between VHA and VA by closing VHA offices as needed.
- Create innovative organizational structures that are aligned to patient's needs rather than professional silos, to support clinical care.
- Undertake a reduction-in-force in VHACO that facilitates delayering and efficiency in communication and decision making.
- Establish a transformation office implementation plan to ensure effective and comprehensive implementation of the transformation across VHA. The transformation plan is to capture all of the transformation activities recommended in the Commission report, establish specific timelines and milestones for accomplishing each objective, and report on both progress and outcomes at least quarterly to VHA leadership and the governing board. Periodic evaluation of the effect of these change initiatives on internal and external stakeholders would also be appropriate.
- Clarify the roles and responsibilities of VISNs and facilities and implement a change strategy to orient staff and leaders to these new expectations. Establish effective leadership communication mechanisms to promote transparency, dialogue, and collaboration among VHACO offices and with the field.

Other Department and Agency Administrative Changes

- None required.

Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

Problem

To achieve the Commission's vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set, identical to private-sector standards, will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes for veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders' performance not just on *what* they achieve but *how* they achieve it.

Background

One of the criteria for performance excellence in health care is the measurement, analysis, and improvement of organizational performance.⁴⁵¹ Performance measurement is used to track daily operations, overall organizational performance, and progress in achieving organizational objectives and action plans. Performance measurement is also used to benchmark organizational performance against internal and external standards.

Organizational performance measurement is not the same as workforce performance management.⁴⁵² Workforce performance management is intended to reinforce intelligent risk taking, help focus the workforce on the needs of patients and other customers, and support

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Workforce and Leadership Performance Management System

- VHA create a new performance management system appropriate for health care leaders, tied to health care leadership competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

⁴⁵¹ Baldrige Performance Excellence Program, 2015-2016 *Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.

⁴⁵² Ibid., 20.

health care delivery and the achievement of action plans.⁴⁵³ Although there is a relationship between organizational performance measurement and workforce performance management, they are not synonymous processes.

Workforce performance management is made up of much more than just clinical outcome measures. As noted by the American College of Healthcare Executives (ACHE), performance evaluations of hospital CEOs must also evaluate leadership traits such as judgment, communication, and diplomacy.⁴⁵⁴ Furthermore, ACHE emphasizes the inclusion of individual professional objectives in performance plans, such as promoting ethical behavior, supporting diversity and inclusion within the organization, or fostering effective medical staff relationships.⁴⁵⁵ ACHE and other leading practitioners⁴⁵⁶ emphasize that performance management is not a plan or an event, but rather a continuous, ongoing process and conversation among the leaders and their reviewers. A workforce performance management system must also make meaningful distinctions among individuals⁴⁵⁷ and promote high performance through rewards, recognition, and incentive practices.⁴⁵⁸ Ideally, when coupled with a leadership competency model and development program, workforce performance management should also help to identify high-performing potential leaders and provide guidance to the workforce on how to move up in the leadership ranks.⁴⁵⁹ As deployed in FY 2015 and evaluated by the *Independent Assessment Report*, VHA's performance management system failed to effectively achieve any of these objectives.⁴⁶⁰

Analysis

One of the findings in the *Independent Assessment Report* was that “hundreds of operational performance measures overwhelm leaders and this, combined with limited transparency and inconsistent data availability, makes it difficult to focus on what is most important.” More than 300 measures spanned everything from critical clinical metrics to political priorities introduced to address the most recent crisis. VHA reports that it was tracking approximately 500 measures,

⁴⁵³ Ibid.

⁴⁵⁴ “Policy Statement: Evaluating the Performance of Hospital or Health System CEO,” November 2013 (revised), American College of Healthcare Executives, accessed February 18, 2016, <https://www.ache.org/policy/ceo-perf.cfm>.

⁴⁵⁵ Ibid.

⁴⁵⁶ Ibid. NeuroLeadership Institute’s “Reengineering Performance Management: How Companies are Evolving Beyond Ratings” webinar, scheduled on January 14, 12-1.

⁴⁵⁷ “Implementing FCAT-M Performance Management Competencies: Differentiating Performance,” Office of Personnel Management, Performance Management: Performance Management Cycle, accessed June 10, 2016, <https://www.opm.gov/policy-data-oversight/performance-management/performance-management-cycle/developing/differentiating-performance/>.

⁴⁵⁸ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization’s Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.

⁴⁵⁹ Office of Personnel Management. Proficiency Levels for Leadership Competencies. <https://www.opm.gov/policy-data-oversight/proficiencylevelsforleadershipcompetencies/>. “Joint Medical Executive Skills Institute,” Health.mil: The official website of the Military Health System and the Defense Health Agency, accessed June 13, 2016, <https://www.jmes.army.mil/documents.asp>, National Center for Healthcare Leadership. NCHL Healthcare Leadership Competency Model. <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁶⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 78-79, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

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including 156 related to access, 29 measuring employee engagement, 18 on high-performing networks, 250 best practice measures, and seven related to trust.⁴⁶¹

Distinct from performance measurement, the performance management process⁴⁶² is a cycle that begins with clear input from top leadership on the priorities of the organization, followed by clear targets, performance tracking, reviews, and rewards. The *Independent Assessment Report* noted that, “Individual performance management processes are hindered by targets inconsistent with the VHA mission, delayed implementation, lack of meaningful performance dialogue, and limited rewards.”⁴⁶³ Many of the same system flaws that impede effective organizational performance also impede individual success. Performance plans are released late in the performance cycle,⁴⁶⁴ metrics are hard to track in real time and lack the detail required for individual performance assessment,⁴⁶⁵ and few plans are written to support shared accountability and team-based solutions. In addition, participants observed that the current senior executive performance agreements and rating process (a) do not result in meaningful distinctions in performance between individuals, (b) do not drive meaningful conversations about individual performance, (c) and do not consistently focus on key health care metrics of quality, safety, patient experience, operational efficiency, finance, and human resources.⁴⁶⁶ The *Independent Assessment Report* notes that the rewards currently offered to employees do not motivate them to work toward exceptional performance.⁴⁶⁷

Information provided to the Commission indicates that VHA has taken action to address some of these findings. First, the USH has reestablished a performance accountability workgroup (absent for a number of years) comprising leaders from the field and VHACO to provide oversight and direction to the performance measurement process.⁴⁶⁸ The workgroup has been charged with aligning metrics to each level of VHA, dramatically simplifying metrics, and increasing the capacity of the organization to focus on measures that truly matter.⁴⁶⁹ The group has created an aspirational vision of a performance measurement system that describes cascading accountability from the top of the organization with health system outcomes (reported annually) through strategic measures (reported quarterly), to tactical measures (reported monthly) to transactional measures (reported in real time).⁴⁷⁰ It is critical that these aspirations become policy.

⁴⁶¹ Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.

⁴⁶² McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 78, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁴⁶³ Ibid., 82.

⁴⁶⁴ Ibid., 82.

⁴⁶⁵ Ibid., 84.

⁴⁶⁶ Ibid., 84.

⁴⁶⁷ Ibid., 87.

⁴⁶⁸ David Shulkin, *Charter of the Performance Accountability Workgroup*, (Washington, DC, Veterans Health Administration, September 22, 2015).

⁴⁶⁹ Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.

⁴⁷⁰ Ibid.

Starting in the 1990s, VHA has used performance measurement, benchmarking, and reporting internally to motivate higher clinical quality performance by individuals and teams.⁴⁷¹ As a large, national health care system, internal benchmarking can be a valid method to drive change, yet both internal and external audiences may ask how well VHA performance compares to that of private-sector providers. VHA currently posts some patient quality, safety, and outcome measures on both its website and on the Department of Health and Human Services (HHS) Hospital Compare website.⁴⁷² These measures allow patients to evaluate the quality of care they receive from VA and make informed health care decisions. They include measures of timely and effective health care; measures of readmissions; complications of death, surgical complication measures and health-care related infection measures; survey data of patient experiences; and other measures required of hospitals participating in Medicare.⁴⁷³ Former USH Kizer believes this reporting is insufficient, noting

*the VA health care system has become increasingly insular and inward-looking. It now has little engagement with private-sector health care, and too often it has declined to make its performance data public. For example, it contributes only a small proportion of its data to Hospital Compare and has declined to participate in other public performance reporting forums such as the Leapfrog Group's efforts to assess patient safety.*⁴⁷⁴

The Commission has reviewed VHA's principal measurement approach, Strategic Analytics for Improvement and Learning Value Model (SAIL) and has determined that although it is modelled on private-sector approaches to measurement and rating, measures are not exactly the same as those reported in the private sector and consequently impede direct benchmark comparisons of VHA to the private sector. Updating these measures so they are consistent with the private sector will be especially important as integrated delivery networks are established and more care is received in the community, as they will allow for making objective comparisons.

Measurement, analysis, and improvement of organizational performance work together as a key system.⁴⁷⁵ The USH has signed a new organizational chart for VHA that acknowledges the interconnection of these elements by establishing an office for organizational excellence that encompasses all of these functions.⁴⁷⁶ To be effective, not only must all of the various units within this office work together but also they must work with personnel in the field to coach and develop their ability to effectively apply performance measurement and improve organizational performance.

⁴⁷¹ "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation?" Ashish K. Jha, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, September 2006, accessed April 21, 2016, <https://psnet.ahrq.gov/perspectives/perspective/31/what-can-the-rest-of-the-health-care-system-learn-from-the-vas-quality-and-safety-transformation>.

⁴⁷² "Quality of Care: How Does Your Medical Center Perform?" Medical Center Performance Search (MCPS), U.S. Department of Veterans Affairs, accessed May 16, 2016, <http://www.va.gov/qualityofcare/apps/mcps-app.asp>.

⁴⁷³ Title XVIII of the Social Security Act 42 U.S.C. § 1395 et seq.

⁴⁷⁴ Kenneth Kizer and Ashish Jha, *Restoring Trust in VA Health Care*, N Engl J Med 2014; 371:295-297, July 24, 2014

⁴⁷⁵ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.

⁴⁷⁶ See the proposed organizational chart at end of Recommendation #12.

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These improvements in performance measurement do not appear to be mirrored on the performance management side of the equation. The draft FY 2016 performance plan template for network directors and medical center directors,⁴⁷⁷ although more streamlined than in previous years, continues to reflect confusion of performance measurement and performance management. It also continues to distribute all of the organization's key (and not so key) priorities under OPM executive core qualifications of leading change, leading people, business acumen, building coalitions, and results driven. The new, streamlined performance measures described above could be considered results-driven; however, the rest of the plan continues to be a confusing presentation of instructions to field leaders, restatements of policy, and performance objectives for action plans. Only the last category is appropriate for workforce performance management.⁴⁷⁸ The Corporate Senior Executive Management Office has implemented a new online performance management data tool that allows for tracking and assessment of the performance management process for senior executive service and equivalent leaders in VA.⁴⁷⁹

To improve performance measurement and organizational performance, the *Independent Assessment Report* recommends that VHA focus and simplify organizational performance measurement to clarify accountability, actively support the mission, and promote continuous improvement. Specifically, VHA must create a simplified, focused, balanced scorecard that reduces the total number of metrics to about 20; establish metrics that support cross-functional collaboration; cascade metrics down the organizational hierarchy; and make data tracking transparent, timely, broadly available, credible, reliable, and meaningful down to the lowest level of the organization. Furthermore, leaders should support continuous improvement, problem-solving, and the exchange of best practices across the organization rather than focusing on only correcting poor performance.⁴⁸⁰ The Commission broadly agrees with this approach to performance measurement. In addition, the Commission emphasizes that VHA customers and stakeholders require public reporting of clinical quality measures that are the same as, and therefore directly comparable to, measures used by the private sector. Although VHA may require an enhanced set of measures that reflects services not broadly deployed in the private sector, or for which measures do not yet exist, a minimum set that are the same as private-sector measures must be used by VHA. As VHA expands integration of care with the community, the use of the same measures as the private sector will be important so that direct comparisons can be made of care delivered inside VHA and that delivered under contract or partnership agreement by the VHA community care network.

VHA also requires a cohesive, integrated personnel performance management system that is specific to the knowledge, skills, and abilities required of health care leaders; includes

⁴⁷⁷ Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan Template*, Network Directors and Medical Center Director, November 20, 2015.

⁴⁷⁸ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.

⁴⁷⁹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁴⁸⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 81, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

accountability to key organizational outcomes; but also assesses organizational and professional objectives. A new personnel performance management system must be free of OPM requirements for executive core qualification and certification process and instead be benchmarked to the private sector⁴⁸¹ and consistent with the new leadership competency model. Congress required DoD to establish independent competency standards for the Commanders of Military Treatment Facilities (MTFs) and should consider doing the same for VHA.⁴⁸² This new performance management model must be based on both evaluation of leadership competencies and demonstrated success in delivering on strategic priorities. To break with current perceptions of the rating scales, it would be helpful to establish a new rating scale for the performance management system. Once the new system is developed, VHA must conduct training to describe the system, rating process, and expectations for both participants and raters.

A performance management system must also address the responsibilities of the rater. This includes clearly establishing written performance requirements for subordinates that are both timely (i.e., prior to the start of the rating period) and meaningful. Raters must be required to provide continuous feedback and assessment throughout the year to recognize and reward progress and outstanding achievements as well as to coach and trouble shoot when needed. The CVCS must establish this expectation by clearly communicating what is required of raters, and most importantly, by modeling the behavior. Finally, raters must provide meaningful ratings that distinguish achievement based on objective performance and demonstrated leadership skills. For instance, the Cleveland Clinic has moved to a system of forced rankings for which the top 10 percent of performers are celebrated and the bottom 10 percent are given intensive coaching or, if justified, sanctioned.⁴⁸³ To accomplish the last point, raters themselves must be given feedback and oversight to understand how their approach to rating compares to other leaders in the organization. If raters' assessments are not consistent with rating standards, their supervisor must bring this issue to their attention and include it in the performance assessment they receive.

The newly established performance management data tool can be used to support the performance management process. The submission of written performance plans (or failure to do so) can be tracked and reported; and the quality of those plans can be audited to provide feedback to raters. Final ratings and a comparison of raters can be conducted and provided to all of the executive raters in the organization. Finally, such a tool can also be used to identify and track high performers who deserve further investment and development as leaders from VHA.

⁴⁸¹ The American College of Healthcare Executives, *2016 Competencies Assessment Tool*, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf. "NCHL Health Leadership Competency Model™," National Center for Healthcare Leadership, accessed May 16, 2016 <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁸² Department of Defense Appropriations Act of 1999, Pub. L. No 105-262, Section 8052 (1998): "None of the funds appropriated in this Act may be used to fill the commander's position at any military medical facility with a health care professional unless the prospective candidate can demonstrate professional administrative skills."

⁴⁸³ Delos M. (Toby) Cosgrove, MD, CEO, Cleveland Clinic, statement during Commission on Care public meeting, March 22, 2016.

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Implementation***Legislative Change***

- Obtain legislative relief from the requirement to use the OPM executive core qualifications system of competencies and ratings and tied to new Title 38 pay authority for health care leaders (see Recommendation #15).

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Establish a workgroup and engage outside experts to create a new performance management system for VHA leaders that is appropriate for health care executives.
- Establish standards and processes to hold raters accountable for creating meaningful distinctions in performance between subordinate leaders.
- The new Office for Organizational Excellence should work with experts to reorganize their internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Other Department and Agency Administrative Changes

- None required.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

Problem

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans, and must become a strategic priority throughout the organization, because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veteran's care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Background

Cultural competence is the ability of health care organizations and their providers to understand and respond effectively to the cultural, language, and in VA's case, military service experience brought by the patient to the health care encounter. It has been endorsed as a viable skill set to reduce, if not eliminate, the rate at which health care disparities occur. VHA has recognized the problem of health disparities among its patient population and has taken steps to address it by tasking certain internal offices with building cultural and military competence throughout the organization. For example, VHA established the Office of Health Equity (OHE) and charged it with championing the efforts to identify, understand, and address health care disparities among veterans.

Analysis

There are seven essential strategies for promoting and sustaining organizational and systemic cultural competence. These strategies include the following:⁴⁸⁴

- Provide executive-level support and accountability.
- Foster patient, community, and stakeholder participation and partnerships.
- Conduct organizational cultural competence assessments.
- Develop incremental and realistic cultural competence action plans.

⁴⁸⁴ Miriam E. Delphin-Rittmon et al., "Seven Essential Strategies for Promoting and Sustaining Systemic Cultural Competence," *Psychiatric Quarterly*, 84, (2013), 53-64.

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- Ensure linguistic competence.
- Diversify, develop, and retain a culturally competent workforce.
- Develop an agency strategy for managing staff and patient grievances.

VA has taken some steps to address cultural and military competence strategies, but these programs are not sufficient to address the breadth and depth of the problem. These strategies will not take hold and become fully ingrained in VHA's culture unless VHA leadership makes them a key priority and commits the resources and on-going, comprehensive training required to build cultural competencies across the entire VHA workforce.

Military Competency

In addition to addressing the needs of minority veterans and vulnerable veterans populations, VA must address military-specific needs and ensure that all providers in the VHA Care System have sufficient military competency (i.e., knowledge of specific issues and health care needs of those who served in the military). VHA's Office of Academic Affiliations developed a *Clinician Pocket Card* for providers that includes questions for clinicians to ask veterans about their military health history.⁴⁸⁵ The *Pocket Card* and similar resources should be given to all VHA and community providers to leverage during veteran patient medical assessments and appointments. In addition, VA's Office of Public Health (OPH) provides information on VA health care programs for veterans who were exposed to environmental and occupational hazards during military service, such as Agent Orange, chemicals leading to Gulf War veterans' illnesses, and Camp Lejeune water contamination.⁴⁸⁶ This military exposure information should be leveraged in VA's cultural competency strategy.

Health care disparities often result from patients' lack of trust in their health care provider; therefore, enhancing the patient-provider relationship is paramount in overcoming these disparities. Stereotypical thinking on the part of providers about certain patient groups, including veterans, may unwittingly influence their prognosis.⁴⁸⁷ Specific reasons for the increase of health care disparities in the military population include the following:

- the cultural norms of the military are such that to admit or display any signs of perceived weakness, especially related to mental health issues, discourages military personnel and veterans from seeking medical care and treatment
- changes in the demographical makeup of the civilian population result in similar changes to the military population
- a small but gradual increase in the number of foreign born personnel who have joined the ranks of the military

⁴⁸⁵ Department of Veterans Affairs, Office of Academic Affiliations, *Military Health History: Pocket Card for Health Professions Trainees and Clinicians*, accessed June 12, 2016, <http://www.va.gov/oaa/archive/Military-Health-History-Card-for-print.pdf>.

⁴⁸⁶ "Public Health: Military Exposures," U.S. Department of Veterans Affairs Intranet, accessed June 12, 2016, <http://vaww.publichealth.va.gov/exposures/index.asp>

⁴⁸⁷ G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," JHHSA (2011), 148.

- a disengaged provider culture that may have become more immersed in the medical culture than the military culture

VA must make cultural and military competence a strategic priority, provide the resources needed to execute the strategy, and hold leadership and providers, both within VHA and community partners, accountable for strategy implementation and integration into VA's culture.

Women

Women are the fastest growing group within the veteran population.⁴⁸⁸ As of 2011, approximately 1.8 million (8 percent) of the 22.2 million veterans were women. Data indicate that by 2020 women veterans will comprise nearly 11 percent of the total veteran population. As the number of women veterans increases, VHA continues to prepare for an increasing demand for women veterans' health care needs.⁴⁸⁹ To address the health disparities affecting women veterans, VHA must provide high-quality, equitable care on par with that of men, deliver that care in a safe and healing environment, provide seamless coordination of services, and actively recognize women as veterans.⁴⁹⁰

In the past, VHA found gaps in its ability to provide comprehensive primary care for women veterans because many primary care providers had little or no exposure to women patients and women were often referred outside of primary care for gender-specific care. To close these gaps, VHA has implemented women's health comprehensive primary care clinic models with the goal of providing complete primary care from one designated women's health provider (DWHP) at one site. An analysis of FY 2012 data revealed that women assigned to DWHPs had more positive overall experiences with care and were more satisfied on six composite scores including access, communication, shared decision making, self-management support, comprehensiveness, and office staff.⁴⁹¹ VA has substantially reduced gender gaps in care,⁴⁹² but women veterans still encounter challenges when accessing care. VHA leadership must support the future planning of women's services and programming so that women veterans receive the highest quality health.⁴⁹³

LGBT Equity

In its systemwide implementation of cultural competency, VHA should leverage best practices from an area in which the agency is already an equity leader: treatment of LGBT patients. Every year since 2007, the Human Rights Campaign has published a Health Equality Index (HEI) report that aims to measure the quality of health care for LGBT patients based on core criteria

⁴⁸⁸ "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, <http://www.womenshealth.va.gov/>.

⁴⁸⁹ U.S. Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care*, April 2015, accessed June 12, 2016, http://www.womenshealth.va.gov/WOMENSHEALTH/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf.

⁴⁹⁰ Patricia M. Hayes, Chief Consultant Women's Health Services, VHA Office of Patient Services, briefing to the Commission on Care, October 19, 2015.

⁴⁹¹ Ibid.

⁴⁹² Ibid.

⁴⁹³ "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, <http://www.womenshealth.va.gov/>.

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that require health care systems to couple strong policies with appropriate training.⁴⁹⁴ In 2016, VAMCs made up 20 percent of all HEI participants. Among participating VAMCs, 84 percent were designated with *Leader* status.⁴⁹⁵ VHA hospitals publicize that discrimination against LGBT patients and employees is prohibited. Senior managers are registered for HEI training. And equal visitation rights are granted to families and friends of LGBT patients. VHA hospitals play a critical role in promoting patient care equality in states where VHA is the only Equality Leader.⁴⁹⁶ VHA should create strong policies and mandatory training, like that used to promote health equity for LGBT patients, to address equity issues for racial and ethnic minorities and women.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- VHA Care System providers should be required to ask patients about their military health history and incorporate veterans' responses into patients' treatment plans.
- VHA leadership should support the future planning of women's services and programming so that women veterans receive the highest quality health care.
- VHA should leverage the best practices developed in support of LGBT equity and implement them across VHA.
- VHA Care System providers should be required to attend comprehensive, on-going cultural and military competency training.

Other Department and Agency Administrative Changes

- None required.

⁴⁹⁴ "How the VA is leading the way on LGBT patient care," Andrew Park, The Week, February 25, 2014, accessed June 12, 2016, <http://theweek.com/articles/450361/how-v-a-leading-way-lgbt-patient-care>.

⁴⁹⁵ "Office of Health Equity: Healthcare Equality Index," U.S. Department of Veterans Affairs, accessed June 15, 2016, http://www.va.gov/HEALTHYEQUITY/Healthcare_Equality_Index.asp

⁴⁹⁶ "How the VA is leading the way on LGBT patient care," Andrew Park, The Week, February 25, 2014, accessed June 12, 2016, <http://theweek.com/articles/450361/how-v-a-leading-way-lgbt-patient-care>.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

Problem

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

Background

During the 1990s, Congress passed the Government Performance and Results Act⁴⁹⁷ to correct shortcomings in the way government was managed and assessed in an effort to bring modern business management practices into the federal government. The law was updated in 2011,⁴⁹⁸ yet one essential

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does all of the following:
 - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
 - Promotes veteran preferences and hiring.
 - Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, due process) through simplified, sensible processes that work for managers and employees.
 - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
 - Provides due process and appeals standards to adverse personnel actions.
 - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
 - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
 - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
 - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
 - Grandfathers current employees with respect to pay and benefits.
- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

⁴⁹⁷ Government Performance and Results Act of 1993, Pub. L. No. 103-62, 107 Stat. 285 (1993).

⁴⁹⁸ GPRA Modernization Act of 2010, Pub. L. No. 111-352, 124 Stat. 3866 (2011).

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component of modernizing the management of federal programs is still missing: reform of human capital management.⁴⁹⁹

The Civil Service Act was initially passed in 1883 and revised in 1978.⁵⁰⁰ The *general schedule*, which governs the pay and job classification process, was codified by regulation in 1949. The U.S. workforce, including the federal workforce, has changed dramatically since these laws and regulations were implemented. As noted in a recent report from the Partnership for Public Service, “the personnel system, designed more than 60 years ago, now governs more than 2 million workers and is a relic of a bygone era, reflecting a time when most federal jobs were clerical and required few specialized skills.”⁵⁰¹ As of 2013, nearly two-thirds of federal employees work in professional or administrative positions focused on knowledge-based work, with the Department of Veterans Affairs accounting for the largest percentage of such workers.⁵⁰²

The Partnership for Public Service calls for broad reform of the civil service system, noting that the

*the federal workforce has become an island disconnected from the larger talent market for knowledge-based professional and administrative occupations that are mission critical. . . . Federal employee pay . . . is not tied to the broader labor market, making it harder to compete with the private sector for talent. That disconnect is exacerbated by a job classification system that describes a workplace from the last century.*⁵⁰³

This system lacks mechanisms for rewarding top performers, demoting or firing poor performers, and holding managers accountable.⁵⁰⁴ The unnecessarily complex hiring system is difficult for applicants to navigate and makes it challenging for hiring managers to identify the most qualified candidates, hindering the ability to bring in experienced candidates from the private sector.⁵⁰⁵

*The civil service system has become a maze of rules and procedures that are not perceived as rational by the people who serve in government or by the general public. . . . Rigid policies . . . are now a burden on a government that needs to encourage flexibility and innovation to meet rapidly changing and difficult challenges.*⁵⁰⁶

⁴⁹⁹ U.S. General Accountability Office, Office of the Comptroller General, *Human Capital – A Self-Assessment Checklist for Agency Leaders*, accessed April 11, 2016, <http://www.gao.gov/assets/80/76520.pdf>. U.S. General Accountability Office, *Transforming the Civil Service: Building the Workforce of the Future – Results of a GAO Sponsored Symposium*, accessed April 11, 2016, <http://www.gao.gov/assets/200/197256.pdf>.

⁵⁰⁰ The Pendleton Civil Service Reform Act of 1883, Pub. L. No. 16, 22 Stat. 403 (1883).

⁵⁰¹ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵⁰² Ibid. The Department of Defense in total has more knowledge workers but the numbers for each service are reported independently and are below the total for the VA workforce.

⁵⁰³ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵⁰⁴ Ibid.

⁵⁰⁵ Ibid.

⁵⁰⁶ Ibid.

The General Accounting Office (GAO) also continues to point to human capital management as a high-risk area across government.⁵⁰⁷ DoD has proposed walking away from the Title 5 civil service system to support modernization of human capital management,⁵⁰⁸ President Barack Obama has repeatedly called for a commission to overhaul and modernize the civil service,⁵⁰⁹ and Congress is considering whether the time is right for civil service reform.⁵¹⁰

VHA currently uses three different personnel systems: Title 5 (the civil service/general schedule system) for senior executive service (SES) and other, mostly nonclinical, employees; Title 38 for physicians, dentists, and other specified health care professionals;⁵⁰⁹ and Title 38 Hybrid for allied health professionals such as pharmacists and licensed physical therapists.⁵¹⁰ Each system has its own set of requirements, procedures, and rules for the employees under its respective authority.⁵¹³ Currently, about two-thirds of VHA employees serve in the Title 38 Hybrid occupations.⁵¹⁴

VHA is not alone in having an excepted service system. More than a dozen agencies have special legislative authority to create a personnel system to fit their particular needs, including the Federal Bureau of Investigation, National Institutes of Health, National Security Agency, U.S. Public Health Service, Defense Intelligence Agency, U.S. Nuclear Regulatory Commission, and National Aeronautics and Space Administration.⁵¹¹ In an acknowledgement of the failure of the general schedule process to meet the needs of certain professions, OPM has also instituted governmentwide direct hiring authority for difficult-to-recruit positions, including medical officer, nurse, pharmacist, radiologic technician, and information technologist – all positions critically important to VHA’s mission success.

Modernizing human capital management is a global imperative for the private sector as well, with 92 percent of participants in one assessment of 7,000 businesses noting that a new approach to human resources is a critical organizational priority in 2016.⁵¹² According to a report from Deloitte, which examined broad human resource (HR) trends, “HR is redesigning almost everything it does – from recruiting to performance management to onboarding to reward systems” to learning and development.⁵¹³ Younger workers are driving many of these

⁵⁰⁷ U.S. GAO, *Federal Workforce—Human Capital Management Challenges and the Path to Reform, Testimony Before the Subcommittee on Federal Workforce U.S. Postal Service and the Census, Committee on Oversight and Government Reform, House of Representatives, Statement of Robert Goldenkoff*, GAO-14-723T, July 15, 2014, Washington, DC, 2014, accessed June 12, 2016, <http://www.gao.gov/assets/670/664772.pdf>.

⁵⁰⁸ “Draft Proposal Calls for Major Revamp of DoD Civilian Personnel System,” Jared Serbu, Federal News Radio, accessed April 8, 2016, <http://federalnewsradio.com/defense/2015/09/draft-proposal-calls-major-revamp-dod-civilian-personnel-system/>.

⁵⁰⁹ “Obama’s Budget Touts Progress Within Federal Workforce, but Offers It Nothing New,” Eric Katz, Government Executive, accessed April 8, 2016, <http://www.govexec.com/management/2016/02/obamas-budget-touts-progress-within-federal-workforce-offers-it-nothing-new/125815/>. The Office of Management and Budget, *Fiscal Year 2016 Budget of the U.S. Government*, accessed May 13, 2016, <https://www.whitehouse.gov/sites/default/files/omb/budget/fy2016/assets/budget.pdf>.

⁵⁰⁹ “Brace Yourselves: Congress Preps Civil Service Reform,” Andy Medici, Federal Times, accessed April 8, 2016, <http://www.federaltimes.com/story/government/management/oversight/2015/01/19/congress-civil-service-reform/21458717/>.

⁵¹⁰ Ibid.

⁵¹¹ See, e.g., 38 U.S.C. § 7401(1).

⁵¹² See, e.g., 38 U.S.C. § 7401(3).

⁵¹³ Joleen Clark, Jack Hetrick, and Donna Schroeder, “Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers,” Alternative Personnel System (2014).

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changes with expectations for meaningful work, learning opportunities, and career progression.⁵¹⁴ These workers have been choosing the federal government in diminishing numbers, with only 6 percent of federal employees currently younger than 30 years of age (compared to 23 percent of the civilian workforce).⁵¹⁵ In VHA, millennials (those 34 and younger) make up only 15 percent of the workforce, but are disproportionately over-represented among staff that quit VHA, at 20 percent.⁵¹⁶

As of January 2016, VHA had a vacancy rate of 16 percent for all positions, despite filling more than 40,000 positions in FY 2015.⁵¹⁷ VHA faces the additional challenge that 40 percent of its overall workforce is eligible for retirement in the next few years.⁵¹⁸ This problem occurs in the face of acknowledged national shortages of physicians⁵¹⁹ and geographic misalignment of the current health care workforce that leaves many localities short of needed providers.⁵²⁰ Taken together, this information makes clear that excellence in human capital management continues to be a business imperative for VHA.

Analysis

The human resource function within VHA needs a fundamental overhaul to increase responsiveness, efficiency, and customer service, as well as to align its orientation to the business needs of VHA.⁵²¹ Medical center directors do not receive the support they need from HR to accomplish hiring, disciplining, and planning for succession of employees.⁵²² During exit interviews, staff members who leave VHA cite barriers to career growth, insufficient professional development, a lack of promotions, and poor on-boarding and training as reasons for departing.⁵²³ In a recent national survey of VA employees, improving end-to-end hiring, recognizing stellar job performance, and providing professional development and career

⁵¹⁴ U.S. GAO, *The Excepted Service: A Research Profile*, GAO/GGD-97-92, accessed April 12, 2016, <http://www.gao.gov/assets/80/79968.pdf>.

⁵¹⁵ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 12, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵¹⁶ Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.

⁵¹⁷ “VA Struggles to Fill Medical Center Positions in Arizona, Across Nation,” Danika Worthington, Arizona Daily Sun, accessed April 5, 2016, http://azdailysun.com/news/local/va-struggles-to-fill-medical-center-positions-in-arizona-across/article_a14e6937-ecc1-5415-9391-7a6d759e5025.html.

⁵¹⁸ Joleen Clark, Jack Hetrick, and Donna Schroeder, *Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers*, *Alternative Personnel System* (2014).

⁵¹⁹ IHS Inc., *The Complexities of Physician Supply and Demand: Projections from 2013-2025*, accessed April 12, 2016, <https://www.aamc.org/download/426242/data/ihsreportdownload.pdf>.

⁵²⁰ “Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations,” U.S. Department of Health and Human Services, Health Resources and Services Administration, accessed April 12, 2016, <http://www.hrsa.gov/shortage/>.

⁵²¹ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, x, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵²² Ibid., vii.

⁵²³ Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.

planning ranked, numbers one, six, and nine respectively as top priorities for improving the employee experience at VA.⁵²⁴

The Civil Service System Does Not Support a High-Performing Health System.

Recruitment in VHA operates in an incredibly complex environment. Federal rules and regulations make HR more challenging than it is in the private sector.⁵²⁵ For example, interviews in 2014 with more than 500 VHA hiring managers and HR staff members pointed to the top problems with Title 5 recruitments as OPM classification standards, grading of position descriptions, position characterization, and the ranking and rating process.⁵²⁶ The group specifically noted that there are many staff positions required in a health care delivery system that do not translate into a general schedule occupational series; therefore, when the positions are graded, the grade and salary is too low to compete with the private sector. Examples of such positions are custodial workers (hospital employees need to apply antiseptic cleaning techniques, but general custodians do not) and general facilities and equipment maintenance (hospital employees need to understand the maintenance of such items as specialized medical equipment, positive pressure rooms, and sterile plumbing systems that are not requirements for general plant maintenance at an office building).⁵²⁷ In another example, VHA managers noted that the OPM classification standard for supply chain positions rendered VHA unable to compete for local talent because the assigned grade was too low.⁵²⁸

The general schedule system also has been identified as a barrier to career advancement.⁵²⁹ Clerical staff members in particular often cannot advance in pay and responsibility without leaving their positions and moving into a different job series.⁵³⁰ Similarly, frontline customer service staff under the general schedule cannot receive advanced steps within the grade for better performance or completing job-related certifications or degrees, unlike nurses and allied health professionals who can receive advances in pay for these accomplishments.⁵³¹

The hiring process in VHA is acknowledged to take too long.⁵³² “HR is expected to fill a position within 60 calendar days . . . but process requirements, even if perfectly executed, take about 49

⁵²⁴ “MyVA, Putting Veterans First,” MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.

⁵²⁵ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵²⁶ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People. Powerpoint of findings, July 29, 2014.

⁵²⁷ Veterans Health Administration, “Leading Access Scheduling Initiative – People, Assessment of Hiring Barriers,” VHA Classification Workgroup, 2014.

⁵²⁸ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xiii, accessed December 28, 2015, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

⁵²⁹ Ibid.

⁵³⁰ “Classification and Qualification: Classifying General Schedule Positions,” U.S. Office of Personnel Management, accessed November 24, 2015, <https://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/>.

⁵³¹ Pay Administration, VA Directive 5007 (2002). Staffing, VA Directive 5005 (2002).

⁵³² McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 109, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

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to 62 days.” Hiring timelines can span 4-8 months compared to private-sector hiring that takes between 0.5 and 2 months.⁵³³

This finding was echoed in a Northern Virginia Technology Council report on information technology challenges in VA that indicated across the board hiring of needed staff proceeds too slowly. “The causes are complex, but much of the delay can be traced to redundant, inconsistent, and inefficient hiring processes.”⁵³⁴ One driver of extended VHA hiring times is the government background checks and the licensing and credential review for clinical staff that is managed through VetPro, an internet-enabled data bank for credentialing VHA personnel.⁵³⁵

Although addressing recruiting and hiring problems will not be easy, doing so is essential to maintaining VHA’s workforce.⁵³⁶ An internal VHA workgroup that examined HR concluded that a complete break with Title 5 and a reworking of current Title 38 hiring authority is required, stating:

*The existing Personnel system does not meet today’s market or demand. With VHA’s tremendous volume of occupations to hire and significant turn-over rate in critical positions, it is necessary to promote an efficient organizational system to be able to hire qualified candidates as quickly as possible. The current classification system led to disparity across the systems and only looks at the duties of the position versus the qualifications of the person. The VHA hiring system must be agile and attractive to recruit those that just graduated or are entering the workforce... An agency specific excepted employment system would allow VHA to meet the unique staffing demands that are required of a complex health care organization.*⁵³⁷

VHA is Not Competitive in Pay for Many Positions

Many VHA staff have substantially lower earning potential than their private-sector counterparts. Despite a generous benefits package and the possible opportunities for greater work-life balance, and for research and teaching in a system that serves the important role of caring for the nation’s veterans, lower salaries reduce VHA’s competitive edge in the marketplace when trying to attract top talent.⁵³⁸ For example, although VHA is often able to provide physicians an entry salary that is comparable or better than industry standards, physicians’ long-term earning potential is dramatically less in VHA than that of their private-sector peers. “At the top of the salary ranges, VHA providers made less than their counter parts

⁵³³ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow-Clinical)*, 45-49, accessed May 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁵³⁴ Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America’s Veterans*, 12, accessed April 25, 2016, <http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf>.

⁵³⁵ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 37, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵³⁶ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵³⁷ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report*, August 2014.

⁵³⁸ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 39, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

by up to \$310,000 and on average, \$74,631. The only specialties for which VHA physicians made equal to or more than industry averages were anesthesiology, nephrology, ophthalmology, and psychiatry.”⁵³⁹ In another example of barriers to competitive pay, current provisions in law limit VA to a 60 percent level of market pay compensation for allied health professionals, even when recruitment failures demonstrate the need to offer higher salaries.⁵⁴⁰ As noted above in the discussion on classification, failure to appropriately classify positions also leads to a salary that is not competitive with private-sector health care organizations for positions such as customer service personnel.

In the area of educational debt repayment relief, VHA lags behind other federal and state agencies that use such programs to fill critical physician shortages in medically under-served areas.⁵⁴¹ VHA can offer up to a maximum of \$60,000 for 2 years (\$30,000 per year). HRSA National Health Service Corps (NHSC) runs three programs: the NHSC loan repayment program that provides up to \$50,000 in loan payments, the Student-to-Student Loan Repayment Program for up to \$120,000, and the State Loan Repayment Program with each state establishing loan amounts that are administered by HRSA.⁵⁴² These amounts range broadly from \$80,000 in Arizona and Arkansas, \$90,000 in Colorado, \$100,000 in Georgia and Alabama, and \$190,000 in California.⁵⁴³

Clinic Staffing Is Impaired by Current Law, Regulation, and Policy

Successfully reallocating staff to meet veterans’ needs in a rapidly evolving health care environment is difficult in VHA. The *Independent Assessment* recommended that VHA use extended clinic hours and weekend clinics to better optimize space and increase access to care for veterans.⁵⁴⁴ VA policy currently prohibits full-time VA physicians from receiving fee-basis compensation from the same VA facility in which they are salaried, although they can, under certain circumstances, receive fee-basis appointments at other VA facilities.⁵⁴⁵

These restrictions can make it hard to meet policy requirements for night and weekend schedules⁵⁴⁶ without reducing staffing on inpatient units or under-resourced primary care clinics. Use of alternative work schedules and overtime pay for physicians to meet local patient demands should be under control of local medical center directors.

⁵³⁹ Ibid., 40.

⁵⁴⁰ Increases in Rates of Basic Pay, 38 U.S.C. § 7455.

⁵⁴¹ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report*, August 2014.

⁵⁴² “Loan Repayment Program,” U.S. Department of Health and Human Services, National Health Service Corps, accessed June 9, 2016, <http://nhsc.hrsa.gov/loanrepayment/>.

⁵⁴³ “Physician Loan Repayment Guide,” Jimmy Karnezis, accessed April 13, 2016, <https://www.credible.com/blog/physician-loan-repayment-guide/>.

⁵⁴⁴ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 136, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵⁴⁵ VA Handbook 5005, pt. II, ch. 3, § A, para. 3b.

⁵⁴⁶ Extended Hours Access for Veterans Requiring Primary Care Including Women’s Health and Mental Health Services at Department of Veterans Affairs Medical Centers and Selected Community Based Outpatient Clinics, VHA Directive 2013-001 (2013).

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VHA Staff Receive Inadequate Training Including at Initial Hire

Leading practices include providing mandatory onboarding training that introduces policies, procedures, and necessary skills. Onboarding programs include various activities that expose new hires to the culture of the organization and expectations based on roles and responsibilities. A report released by the Society for Human Resources Management suggests, “Formal orientation programs help new employees understand many important aspects of their jobs and organizations, including the company’s culture and values, its goals and history and its power structure.”⁵⁴⁷ To make up for inadequate on-boarding and to fill current staff’s understanding of VA, VHA is providing VA 101 training for current employees, with 60 facilities having completed the training in FY 2015.⁵⁴⁸ Employees in VA continue to desire a wide array of training, including customer service training, professional development, peer-to-peer training, hands-on training, and role-specific training.⁵⁴⁹

HR Professionals Must Focus on People and Business Priorities Not Compliance

VHA job candidates indicate they have unsatisfactory recruiting experiences, noting failures in timely follow-up and communication.⁵⁵⁰ VA human resources management and administration indicate that VA HR professionals do not exhibit a uniform level of competency, frequently do not understand the employee recruitment process end-to-end, and fail to provide high quality consultative support to managers with respect to all HR functions, but particularly in the area of progressive discipline and firing of employees.⁵⁵¹ Currently HR professionals in VA are largely focused on compliance with a complex set of rules,⁵⁵² rather than adding true value to the organization and being able to be full partners in accomplishing VHA business objectives. Resolving these staffing issues would render the overall HR function more effective.

VHA must become the employer of choice to attract and retain the very best health care workforce. To help it accomplish this goal, VHA requires competitive pay and flexible hiring and talent management processes. VHA cannot achieve that goal within its current personnel systems. A uniform alternative personnel system under Title 38 for all VHA human capital management would accomplish all of the following:

- Meet the unique staffing demands of a health care delivery organization.
- Allow market-based compensation and pay-setting latitude using broad pay bands to support staff growth and progression within their job. VHA must consider total compensation (with benefits), as compared to market rates because the government provides many more benefits than private-sector organizations. Consequently, VA may

⁵⁴⁷Talya Bauer, Society for Human Resource Management, *Onboarding New Employees: Maximizing Success*, 2010, 9-10, accessed May 13, 2016, <https://www.shrm.org/about/foundation/products/documents/onboarding-percent20epg-percent20final.pdf>.

⁵⁴⁸ Veterans Health Administration, *Blueprint for Excellence: Fiscal Year 2015 Results: Communicating Accomplishments*, presented to the National Leadership Committee, March 22, 2016.

⁵⁴⁹ “MyVA, Putting Veterans First,” MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.

⁵⁵⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁵¹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁵² Ibid.

pay less than private-sector employers for a position, but the total compensation (with benefits) may end up being equivalent to private-sector total compensation.

- Allow flexibility in the processes used to hire staff including direct hiring when needed.
- Support career planning and professional development through the application of competency models and training specific for health care as part of position management.
- Simplify the management tasks for supervisors and hiring managers who will only need to know one set of rules and processes instead of four.
- Simplify the job of HR professionals who will only need to know one set of rules and processes instead of four.
- Allow development and training of the HR workforce in VHA to focus on only one personnel system to create true end-to-end hiring expertise.
- Reduce competition within government where shortages of HR professionals create competition for Title 5 trained HR professionals.
- Create streamlined and uniform standards and approach to discipline and dismissal.
- Create fairness among staff in sick leave, vacation pay, salary, awards and bonuses, and compensatory time off.
- Support flow of staff between the field and VHA Central Office (VHACO) under a single personnel system.

Establishing a new human capital management system in VHA will neither be easy nor quick, nor will it be a panacea that alone will fix all that is wrong with recruitment, retention, development, and advancement. In designing and implementing a new system, VHA must take full advantage of private-sector resources and expertise in human resource management and ensure that the new system is built to be compatible with the private-sector. As VHA moves toward greater integration of care delivery, with networks of community providers, compatibility in personnel systems and a resulting greater flow of employees between VHA and community sites can help create closer linkages between the two parts of the care delivery system.

Implementation

Legislative Changes

- Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.
- Update student loan reimbursement limits to be competitive with other federally administered programs and market conditions.

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- Establish an appeals process that provides staff appropriate due process that is based on the regulatory standards for the new alternative personnel system.

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- Eliminate barriers to creating hiring pools for positions with frequent turnover (e.g., extend the length of time over which candidates can continue to be hired from a completed certification until all of the qualified candidates are hired or have declined offers).
- Eliminate barriers to initiating a recruitment process when vacancies are anticipated; positions need not be empty before recruitment ensues. In some cases, hires should also be made before the departure of key personnel to allow for on-the-job training and mentoring of the replacement.
- Benchmark credentialing to private-sector processes and consider outsourcing the process as much as practicable through centralized mechanisms.
- Release market pay and total compensation information to the field for all job categories using commercially available data and information, at least every 2 years.

Other Department and Agency Administrative Changes

- OPM should continue to oversee and administer benefits for VHA but not impose any of the other existing conditions or requirements on the management of the new alternative personnel system. The new personnel system should be governed by the new legislative requirements and those established during the anticipated rulemaking process in VA. These requirements include market-based pay, performance awards, or performance and disciplinary processes other than those imposed under Title 38.

Recommendation #16: Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Problem

Effective planning for and management of human capital are core enabling requirements for any organization. If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

Background

As recognized by GAO, “to attain the highest level of performance and accountability, federal agencies depend on three enablers: people, process, and technology. The most important of these is people, because an agency’s people define its character and its capacity to perform.”⁵⁵³ Human capital management, although often viewed as a cost, must be viewed as an investment in business success.⁵⁵⁴ For too long, VA human capital management has been undervalued and under resourced. A 1993 report from GAO outlined many of the same deficiencies found in 2016: a focus on compliance instead of outcomes, a lack of proactive human capital planning and management, and a weak system of rewards and incentives to attract and retain qualified personnel.⁵⁵⁵

Today, VA Human Resources and Administration (HRA) shares responsibility for human capital management with VHA. Neither organization has been able to establish a high-performing, effective, human capital management system. For VHA to transform to a high-performing organization, human capital management must do the same.

Analysis

VA “needs a fundamental overhaul of the core support functions (including human resources) . . . to increase responsiveness and efficiency and improve customer service. These functions should be aligned with the needs of the VHA organizations delivering care to

The Commission Recommends That . . .

- VHA hire a chief talent leader who holds responsibility for the operation’s entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the CVCS.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.
- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

⁵⁵³ U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders*, GAO/OCG-00-14G, version 1, September 2000, 3, accessed June 10, 2016, <http://www.gao.gov/assets/80/76520.pdf>.

⁵⁵⁴ Ibid.

⁵⁵⁵ U.S. General Accountability Office, *Management of VA: Improved Human Resource Planning Needed to Achieve Strategic Goals*, GAO/HRD-93-10, March 1993, accessed June 10, 2016, <http://www.gao.gov/assets/220/217512.pdf>.

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Veterans.”⁵⁵⁶ Governance and responsibility for human capital management is fragmented and complicated.⁵⁵⁷ Medical center directors appear to be largely on their own in addressing human capital management needs, without competent and timely assistance to support hiring employees, planning for succession, and taking disciplinary actions.⁵⁵⁸ Recruiting takes too long and is cumbersome because information is not shared freely among the various organizational components.⁵⁵⁹ Candidates are not treated with respect, experience lengthy intervals between contacts from VA, fail to receive timely follow-up once candidates are selected, and experience a lengthy on-boarding process.⁵⁶⁰ Human capital management also fails to effectively support the disciplinary process, which is perceived as too long and too difficult.⁵⁶¹ Insufficient resources are devoted to training,⁵⁶² leaving VHA vulnerable to failure.

VA requires a comprehensive redesign of the human resources function to be more responsive, more efficient, and more focused on customer service.⁵⁶³ Transforming HR will require “redesigning key processes, shifting the mindset of [human resources] staff from compliance to effectiveness, training [human resources] and its customers on key roles and responsibilities, and rationalizing its technology systems.”⁵⁶⁴

Some progress has been made in updating human capital management functions. VA is in the process of implementing new talent management software to provide better process management and analytics.⁵⁶⁵ HRA has also started a new HR Academy.⁵⁶⁶ The academy is intended to demonstrate alignment between training resources and competency requirements⁵⁶⁷ and to describe the experience needed to advance to the next position level in human resources.⁵⁶⁸ VA instituted a new online senior executive service performance management system that permits real-time tracking of the performance management process and analysis of

⁵⁵⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁵⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁵⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, L3, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁵⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 109, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁶⁰ *Ibid.*, 110.

⁵⁶¹ *Ibid.*, 61.

⁵⁶² *Ibid.*, 67.

⁵⁶³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, L5, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁶⁴ *Ibid.*

⁵⁶⁵ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁶⁶ *Ibid.*

⁵⁶⁷ Department of Veterans Affairs, HR Academy, *TMS User eIDP Checklist*, accessed January 25, 2016, www.vahracademy.va.gov/docs/TMSUserIDPChecklist.pdf.

⁵⁶⁸ “VA HR Academy: Resources,” Department of Veterans Affairs, accessed January 25, 2016, www.vahracademy.va.gov/resources.asp. Department of Veterans Affairs, *VA HR Competency Model Reference Guide*, accessed January 25, 2016, www.vahracademy.va.gov/docs/VAHRCompetencyModelReferenceGuide.pdf.

performance outcomes;⁵⁶⁹ however, HR specialists must still use as many as 30 different IT systems that do not communicate with each other to do their work.⁵⁷⁰ Although some new systems have been purchased, life cycle funding for them is not guaranteed by the Office of Information and Technology and no concrete plan has been approved to replace and consolidate the many current systems that are not interoperable. In addition, funding support for HRA initiatives overall are not planned, allocated, and maintained at consistent levels year-to-year in the departmental budget, impeding long term transformation.⁵⁷¹

A VHA workgroup was formed with HR subject matter experts and leadership to identify hiring barriers and develop recommendations for improvements. The workgroup fielded a survey in July 2014 to gather broad input from VHA on the deficiencies in the management of human capital in VHA. These experts concluded that VHA should move to a new alternative personnel system under Title 38.⁵⁷² (See Recommendation #15.)

Substantial deficiencies in human capital management still remain in VA. The funding mechanism to support the departments' human capital management does not support long-range planning and effective program implementation. The lines of authority and management for human capital management professionals do not permit consistency in the quality and skill of the human capital management professionals hired and promoted, nor does the reporting structure allow HRA to hold human capital management staff accountable for effective service delivery. The investment in human capital management information technology systems has been inadequate for decades.⁵⁷³

Top leadership, including the SECVA, DEPSECVA, and CVCS, must make the transformation of human resources a top priority as demonstrated by investing their personal time in human capital management transformation; reviewing and endorsing a transformation plan including the funding required to accomplish it; receiving regular progress updates; and engaging in problem-solving sessions with human capital management leaders to refine and advance transformation efforts. Top leadership must demonstrate to other leaders that human capital management transformation is an organizational priority by disseminating clear goals for transformation in planning documents, communicating expectations for change that are clear to all key employees, and sharing successes with subordinate leaders and employees. The CVCS must ensure that the executive who leads the human capital management function has the demonstrated knowledge, skills, and experience in human capital management to competently lead the function and make this individual part of the executive leadership team on par with other key functions like finance and clinical operations. (See suggested organization chart in Recommendation #12.)

⁵⁶⁹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁷⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 24, 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁷¹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁷² Ibid.

⁵⁷³ Ibid.

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The SECVA, DEPSECVA, and CVCS must engage subordinate leaders in the transformation process by ensuring the needs of these leaders have informed the transformation solutions; that subordinate leaders are assigned specific responsibilities under the transformation plan; and they are held accountable by the CVCS for outcomes. They must also ensure that the HR transformation and ongoing HR function is adequately resourced to be successful.

The VA HRA and VHA Workforce Management Office must engage change management experts to undertake a review of human resource business processes, management structures, funding, and technology needs to create a transformation agenda and human capital management plan. As VHA is shifting to a new alternative personnel system under Title 38, the human capital management plan should consolidate in VHA the HR functions, responsibility, and authority required to hire, manage, develop, reward, and discipline staff and consider whether functions such as benefit management remain with HRA or move to VHA. Furthermore, the plan should address all of the following issues:

- need for a chief of talent management
- consistency with benchmark standards of private-sector health care systems
- key organizational structures and roles and responsibilities of VA and VHA in human capital management that are clearly defined and consistent with benchmark organizations
- the full life cycle of human capital management (i.e., planning, recruitment, hiring, retention, development, performance management, and discipline), which should be supported effectively by human capital management and fully meet the needs of managers and staff
- federal sharing authority and the ability to outsource human capital management functions to the private sector are addressed
- IT investments and analytical capability to provide meaningful, timely data to managing staffing, performance tracking, and accountability
- meaningful performance metrics and risk management indicators that are established for human capital management⁵⁷⁴
- funding and full-time equivalent employee staffing for human capital functions that meet private-sector benchmark standards for health care
- knowledge, skills, and ability required of human capital management professionals at each grade and within each series, which should be clearly defined, and a requirement to assess current staff, new hires, and promotions against this standard, which should include procedures for dismissal

⁵⁷⁴ U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders*, GAO/OCG-00-14G, version 1, September 2000, 34, accessed June 10, 2016, <http://www.gao.gov/assets/80/76520.pdf>.

Once completed, this analysis and draft plan must be shared widely within the department to gain feedback and input, and it must be shared with OPM, OMB, and Congress. After incorporating feedback and finalizing the plan, HRA should engage change management experts to fully implement the transformation agenda and new human capital management plan. Implementation will require funding contributions from VA and VHA that the SECVA must mandate.

HRA must develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 Hybrid, Title 38 7306, and SES). This process must include clear standards, guidelines, and training for supervisors and managers on how to implement the new progressive discipline process. All managers and supervisors and human capital management professionals must complete the training, and VA must establish a process for ensuring that new supervisors and managers complete the training on an ongoing basis. HRA must develop HR staff to be effective coaches so they can provide the coaching and support that managers need as they embark on disciplinary procedures to ensure timely and effective interventions.

VHA supervisors and managers must be held accountable for applying these procedures when poor performance or conduct occurs. To enable accountability, VHA must have a technology infrastructure to actively track and manage poor performance (annual ratings and disciplinary actions) that both human capital managers and supervisors can use to keep track of issues.

The Commission notes GAO is launching a comprehensive audit of human capital management functions in VA to be delivered to Congress in September 2016.⁵⁷⁵ The review and resulting recommendations will provide further insights to promote meaningful transformation of human capital management in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Employ HR and change management experts to undertake a review of its business processes, management structures, funding, technology, and the legal authority needed in HR to create a transformation agenda and human capital management plan.
- Require VHA to allocate budget to fully support the change plan and ongoing HR operations.

⁵⁷⁵ Ms. Frieda Stenzel, lead investigator, U.S. Government Accountability Office, during an initial meeting with VACO HR&A about a new study being undertaken by GAO, December 18, 2015. The study is intended to 1) assess VHAs capacity to perform its workforce planning and talent management, and 2) evaluate the effectiveness of VHAs human capital functions.

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- Develop and implement an effective progressive discipline process for all staffing authorities.

Other Department and Agency Administrative Changes

- None required.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

Problem

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

The Commission Recommends That . . .

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an other-than-honorable discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

In some cases, individuals have been dismissed from military service with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury, posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

Background

Veteran status is the basis for eligibility for all VA benefits,⁵⁷⁶ and under law a veteran is a person who has met three criteria: active-duty military service (subject to specified exceptions), 2 years of continuous service, and discharge or separation from the military under conditions other than dishonorable.⁵⁷⁷ The military characterizes discharges into one of five categories: honorable, general (under honorable conditions), OTH, bad conduct (adjudicated by a general court or special court-martial), and dishonorable.⁵⁷⁸

Congress has established specific bars to VA benefits. Those barred by statute include deserters, individuals sentenced by a general court-martial, and conscientious objectors who refused to perform military duty.⁵⁷⁹ VA regulations interpret the phrase "discharged or released . . . under conditions other than dishonorable" to mean that a discharge or release because of one of the following offenses is considered to have been issued under dishonorable conditions:

(1) acceptance of an OTH discharge to escape trial by general court-martial, (2) mutiny or

⁵⁷⁶ Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁷⁷ Veterans Benefits, 38 U.S.C. § 101(2).

⁵⁷⁸ Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁷⁹ Certain Bars to Benefits, 38 U.S.C. § 5303(a).

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spying, (3) an offense involving moral turpitude, (4) willful and persistent misconduct, and (5) certain homosexual acts involving aggravating circumstances.⁵⁸⁰

Limited exceptions to those statutory and regulatory bars permit VA to award of benefits. A claimant may be granted benefits if VA determines that the claimant was insane at the time of the offense leading up to discharge.⁵⁸¹ Benefits may be granted based on a prior period of other-than-dishonorable service for individuals with two or more periods of service.⁵⁸²

Former service members with an OTH discharge as a result of a regulatory (rather than a statutory) bar are eligible for VA care for service-incurred conditions.⁵⁸³ Former service members with OTH discharges are not recognized as veterans, so they will be routinely denied treatment unless they initiate, and prevail in, an adjudication conducted by the Veterans Benefits Administration as to the character of their discharge. No routine mechanism exists to trigger adjudication to determine if such a discharge is not dishonorable. In many instances, the character of an individual's discharge is predicated on behaviors that resulted from, or are linked to, behavioral health conditions that had their origin in service, yet VA regulation bars the individual from receiving benefits.⁵⁸⁴

Analysis

Veterans' benefits are understood to be earned. The principle has been described as follows: In harsh environments in which lives may be on the line, serious breaches of conduct that interfere with the military mission should rightfully brand the offender for life and should likewise prohibit them from being eligible for the special military benefits and entitlements reserved for honorable and meritorious service.⁵⁸⁵

Some argue the offender's mental state at the time of the misconduct must be taken into account when considering veteran status.⁵⁸⁶ For example, many service members have experienced combat and sustained psychological wounds of war that manifest behaviors that lead to military discipline.⁵⁸⁷ VA regulations not only fail to account for the role of those psychic wounds, but are themselves overbroad, weak discriminators as to what is truly dishonorable service. To illustrate, commentators have identified two regulatory bars as particularly problematic: those based on moral turpitude,⁵⁸⁸ and willful and persistent misconduct.⁵⁸⁹ Neither of those two regulatory terms, which originated in 1944,⁵⁹⁰ are defined; neither provides

⁵⁸⁰ Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸¹ Certain Bars to Benefits, 38 U.S.C. § 5303(b).

⁵⁸² Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁸³ Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).

⁵⁸⁴ Certain Bars to Benefits, 38 U.S.C. § 5303(a). Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸⁵ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 12-13, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁸⁶ *Ibid.*, 13.

⁵⁸⁷ *Ibid.*

⁵⁸⁸ Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸⁹ *Ibid.*

⁵⁹⁰ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the

criteria or examples of what is or is not covered. Both are ambiguous and susceptible to subjective judgment,⁵⁹¹ with great potential for different VA regional offices reaching different outcomes on the same facts.⁵⁹² VA officials have acknowledged that these terms are broad and imprecise,⁵⁹³ and advocates have documented the resultant disparities in VA adjudicative decisions.⁵⁹⁴

The only specific mental-health exception to the bar-to-benefits rules — that the person was insane at the time of the commission of offense⁵⁹⁵ — is very limited. VA regulations define the term *insane*, as follows:

*An insane person is one who, while not mentally defective or constitutionally psychopathic, except when a psychosis has been engrafted upon such basis condition, exhibits, due to disease, a more or less prolonged deviation from his normal method of behavior; or who interferes with the peace of society; or who has so departed (become antisocial) from the accepted standards of the community to which by birth and education he belongs as to lack the adaptability to make further adjustments to the social customs of the community in which he resides.*⁵⁹⁶

VA's Office of General Counsel (OGC), in a now almost 20-year old precedential opinion, has construed that regulation narrowly. Responding to a request for an opinion regarding the parameters for behavior that would constitute insanity under the regulation, the General Counsel advised, as follows:

*The question of insanity arises in numerous legal proceedings, and its meaning may vary according to the jurisdiction and the object or purpose of the proceeding. However, in all contexts, the term indicates a condition involving conduct which deviates severely from the social norm. Black's Law Dictionary, at 794, states that '[t]he term is more or less synonymous with . . . psychosis, which itself has been defined as "a mental disorder characterized by gross impairment in reality testing' or, in a more general sense, as a mental disorder in which 'mental functioning is sufficiently impaired as to interfere grossly with the . . . capacity to meet the ordinary demands of life.'"*⁵⁹⁷

Armed Forces," *Military Law Review*, 214, Winter, (2012): 160-192, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁹¹ Ibid., 164, 186.

⁵⁹² Ibid., 10, 172. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable*, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁵⁹³ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 67, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁹⁴ Ibid., 68-70.

⁵⁹⁵ Characters of Discharge, 38 C.F.R. 3.12(b).

⁵⁹⁶ Determinations of Insanity, 38 C.F.R. 3.354(a).

⁵⁹⁷ "Office of General Counsel: Opinions Year 1997," U.S. Department of Veterans Affairs, accessed June 15, 2016, <http://www.va.gov/ogc/opinions/1997precedentopinions.asp>. Vet. Aff. Op. Gen Couns. Prec. 20-97, VAOPGCPREC 20-97, 1997, accessed June 15, 2016, <http://www.va.gov/ogc/docs/1997/Prc20-97.doc>.

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As understood by VA OGC at the time, *insanity*, with its emphasis on gross impairment, and as reflected in practice,⁵⁹⁸ is a highly restrictive standard. That narrow standard is also limiting with respect to the range of symptoms that could be considered under the *insanity* exception: gross cognitive impairment or gross impairment in capacity to function in daily life. That limited range effectively excludes behaviors associated with a widely prevalent service-related condition, PTSD. Those behaviors, which often lead to disciplinary actions, include aggressive behavior, substance-abuse,⁵⁹⁹ impulsivity, and risk-taking (including sensation seeking, aggressive driving, interpersonal violence, and self-injurious or suicide-related behavior).⁶⁰⁰ Research has shown that combat veterans with PTSD and other psychiatric diagnoses have a heightened risk of misconduct outcomes.⁶⁰¹ Other than its *insanity* rule, the regulations provide no specific opportunity to consider mental health as a likely cause of, or mitigating factor in, disciplinary issues leading to an individual's discharge.

The following are illustrative examples of how these regulations have worked in practice:

- John, a service member with multiple deployments to Iraq and Afghanistan and 7 years of service, received an OTH discharge after self-medicating with marijuana. He was denied VA treatment for PTSD.⁶⁰²
- Tim, a rifleman with two purple hearts and four campaign ribbons for service in Vietnam, was sent to combat while still 17 years old, and had a nervous breakdown and suicide attempt before his 18th birthday. He was sent back to Vietnam involuntarily for a second tour, and had a third nervous breakdown that led to an AWOL and OTH discharge. He was denied service connection for PTSD because the nature of his discharge.
- Tom, a combat infantryman in the first Gulf War, on his return, started experiencing symptoms of PTSD and attempted suicide. He was denied leave to be with his family,

⁵⁹⁸ Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable,"* accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁵⁹⁹ Deirdre MacManus et al., "Aggressive and Violent Behavior Among Military Personnel Deployed to Iraq and Afghanistan: Prevalence and Link with Deployment and Combat Exposure," *Epidemiologic Reviews*, 37, no. 1, (2015): 196-212, <http://doi.org/10.1093/epirev/mxu006>.

Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, <http://dx.doi.org/10.1186%2F1471-244X-10-88>.

⁶⁰⁰ Lisa M. James, Thad Q. Strom, and Jennie Leskela, "Risk-Taking Behaviors and Impulsivity Among Veterans With and Without PTSD and Mild TBI," *Military Medicine*, 179, no. 4, (2014): 357 – 363, <http://publications.amsus.org/doi/pdf/10.7205/MILMED-D-13-00241>.

⁶⁰¹ Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, <http://dx.doi.org/10.1186%2F1471-244X-10-88>.

⁶⁰² Swords to Plowshares, presentation to Commission on Care, January 21, 2016, accessed June 25, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former service members.

but left anyway. After a 60-day absence, he returned and was given an OTH discharge. He was denied services for 20 years.⁶⁰³

In short, the VA regulation used to determine whether the character of a veteran's OTH discharge is disqualifying does not take into account behavioral health problems associated with military service. As a result, former service members who were discharged for disciplinary problems that cannot be disassociated from PTSD or other behavioral health disorders are routinely barred from VA treatment for those disorders.

Individuals with PTSD and traumatic exposure are at heightened risk of substance abuse,⁶⁰⁴ depression,⁶⁰⁵ homelessness,⁶⁰⁶ premature mortality,⁶⁰⁷ and suicide.⁶⁰⁸ Access to VA health care is vital to successful reintegration of combat-traumatized veterans into society because it provides "the only reservoir of combat PTSD expertise."⁶⁰⁹

The importance of early access to needed treatment for behavioral health conditions like PTSD cannot be overstated,⁶¹⁰ yet many former service members are reluctant to seek treatment for behavioral health problems.⁶¹¹ Those with unfavorable discharge records who finally come forward to seek medical care must not only initiate a request for a character of discharge adjudication, but be prepared to confront a lengthy process if they elect to do so.⁶¹²

⁶⁰³ Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁶⁰⁴ Kipling M. Bohnert et al., "The Association Between Substance Use Disorders and Mortality among a Cohort of Veterans with Posttraumatic Stress Disorder: Variation by Age, Cohort, and Mortality Type," *Drug and Alcohol Dependence*, 128, no. 1-2, (2013): 98-103, <http://www.sciencedirect.com/science/article/pii/S0376871612003328>.

⁶⁰⁵ Leo Sher, Maria Dolores Braquehais, and Miquel Casas, "Posttraumatic Stress Disorder, Depression, and Suicide in Veterans" *Cleveland Clinic Journal of Medicine*, 79, no. 2 (2012): 92-97, <http://doi.org/10.3949/ccjm.79a.11069>.

⁶⁰⁶ Eve B. Carlson et al., "Traumatic Stressor Exposure and Post-Traumatic Symptoms in Homeless Veterans," *Military Medicine*, 178, no. 9, (2013): 970-973, <http://doi.org/10.7205/MILMED-D-13-00080>.

⁶⁰⁷ Joseph A. Boscarino, "Posttraumatic Stress Disorder and Mortality Among U.S. Army Veterans 30 Years After Military Service," *Annals of Epidemiology*, 16, no. 4 (2005): 248-256, <http://www.sciencedirect.com/science/article/pii/S1047279705001109>.

⁶⁰⁸ Holly J. Ramsawh et al., "Risk for Suicidal Behaviors Associated with PTSD, Depression, and their Comorbidity in the U.S. Army," *Journal of Affective Disorders*, 161, no. 1, (2014): 116-122, <http://www.sciencedirect.com/science/article/pii/S0165032714001189>.

⁶⁰⁹ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 14, accessed June 20, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁶¹⁰ Ronald C. Kessler, "Posttraumatic Stress Disorder: The Burden to the Individual and to Society," *Journal of Clinical Psychology*, 5, Suppl. 5, (2000): 4-12, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/10761674>.

⁶¹¹ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶¹² Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 74-78, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

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Several generations of former service members were exposed to combat trauma and continue to live with the psychological wounds of war. Lack of access to treatment for those who sustained psychological wounds that went untreated and were manifest in undesirable behavior in service is concerning. Although Congress could address this concern, VA has the means to remedy the problem without congressional action by amending its own regulations. VA could afford former service members needed treatment for their conditions when they are able to establish that their health problems were incurred in service.⁶¹³ In other circumstances, when it is likely an individual could establish eligibility for VA care, current regulation permits the individual to receive the care on the basis of a tentative eligibility determination.⁶¹⁴ This regulation permits VA to provide treatment without prior adjudication of the character of discharge.

VA should revise its regulations to lift the immediate bar to health care for former service members who have an OTH discharge. VA should award tentative eligibility for health care to at least some former service members who have an OTH discharge. The criteria for awarding tentative eligibility for care could include service in a combat theater, more than a single enlistment, duration of service, or some combination thereof. This approach would allow VA to provide meaningful access to treatment without delay for those likely to be granted eligibility. For health care purposes, VA should also revise its regulations by recognizing that the severe punishment of characterizing a person's service as OTH is not justified when extenuating circumstances (to include behavioral health issues at the time) explain or mitigate that misconduct that resulted in the OTH discharge.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Amend 38 C.F.R. 17.34 to provide for tentative eligibility determinations applicable to individuals with OTH discharges who have had substantial honorable service, including service in a combat theater.
- Amend of 38 C.F.R. 3.12(d) to provide for recognition of extenuating circumstances that show, for purposes of health care eligibility, that service was not OTH.

Other Departments and Agency Administrative Changes

- None required.

⁶¹³ Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).

⁶¹⁴ Tentative Eligibility Determinations, 38 C.F.R. 17.34.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Problem

Although VHA continues to offer the promise of health care to all veterans, its capacity to meet that promise is constrained by appropriated funding.⁶¹⁵ Congress and VA leadership must work to identify who VHA will serve, and what services it will provide, yet eligibility criteria have not been examined in 20 years.⁶¹⁶

Background

VHA's core mission is to care for veterans who has borne the battle. But its secondary mission of caring for veterans' non-service-connected health care needs is longstanding, dating back to Civil War origins. Congress has included veterans without service-connected needs among those eligible as highlighted below:

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use underutilized VHA providers and facilities, providing payment through private insurance.
- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

- In March 1865, Congress incorporated the National Home for Disabled Volunteer Soldiers and Sailors, originally intended for Union veterans who suffered economic distress from disabilities incurred during the Civil War. The National Home constructed the first hospitals for Civil War veterans in 1866, and after a series of acts of Congress, those hospitals were opened in 1887 to veterans suffering economic distress from disabilities not incurred in military service.⁶¹⁷
- The World War Veterans Act of 1924, which established the Veterans Bureau⁶¹⁸ (the predecessor to the Department of Veterans Affairs), authorized its director to provide hospitalization and related travel expenses to veterans whose services dated back as far as 1897, regardless of the type or cause of their disabilities, as long as those veterans who were unable to pay received preferential admission.⁶¹⁹
- Public Law 85-56 (1957), which codified prior VA laws and regulations, effectively expanded eligibility to veterans of future wars, providing needed hospital care for veterans with service-connected disability incurred or aggravated during war, or for any other disability if the veteran is unable to pay for hospital care.⁶²⁰

⁶¹⁵ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶¹⁶ *Ibid.*, 25.

⁶¹⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

⁶¹⁸ The Veterans Bureau consolidated the National Home and other veterans-related functions housed in different government bureaucracies.

⁶¹⁹ World War Veterans Act, 1924, Pub. L. No. 68-242, (1924).

⁶²⁰ Veterans Benefits Act of 1957, Pub. L. No. 85-56, 71 Stat. 83 (1957). That law provided separate authority in section 512 for outpatient medical treatment, which was limited to treatment for a service-connected disability.

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- In 1966, Congress expanded eligibility for hospital care to *peacetime* veterans (of service after January 1955).⁶²¹
- In 1970, Congress extended eligibility for hospital care to veterans 65 and older for a non-service-connected disability,⁶²² exempting that group of veterans from taking the then-required oath affirming their inability to defray the expense of care for non-service-connect ailments.⁶²³
- With the Veterans Health Care Expansion Act of 1973, Congress eliminated the distinction between wartime and peacetime veterans for purposes of eligibility for outpatient care, and further expanded eligibility to outpatient care. It granted veterans who are 80 percent or more service-connected disabled eligibility for treatment of any condition, and authorized others eligible for hospital care to receive outpatient care to prepare for or preclude a need for hospitalization or to complete treatment initiated during hospitalization.⁶²⁴
- Congress expanded eligibility again in 1976, authorizing hospital care for treating a non-service-connected condition of any veteran 65 or older (without regard to ability to pay), authorizing outpatient care for any disability to any veteran 50 percent or more service-connected disabled, and directing VA to ensure, by regulation, special treatment priority to service-connected veterans and others receiving benefits because of a need for aid and attendance, or being permanently housebound.⁶²⁵

Eligibility laws for veterans' health care have changed substantially during the past century, yet the commitment to serving service-connected veterans and veterans in financial need has remained constant.

Prior to enactment of the Veterans' Health Care Eligibility Reform Act of 1996,⁶²⁶ VHA was a hospital-based model with entirely different eligibility rules for hospital care than for outpatient care. The eligibility reform law was aimed at transforming access to VA care from a 1950s hospital-based model to one that erased distinctions between eligibility for hospital and outpatient care.⁶²⁷ It essentially provided that all veterans are eligible for VA hospital care and *medical services*.⁶²⁸

⁶²¹ Veterans Readjustment Benefits Act of 1966, Pub. L. No. 89-358, 80 Stat. 12 (1966).

⁶²² Pub. L. No. 91-500.

⁶²³ S. Rep. No. 91-481.

⁶²⁴ Veterans Health Care Expansion Act of 1973, Pub. L. No. 93-82, 87 Stat. (1973).

⁶²⁵ Veterans Omnibus Health Care Act of 1976, Pub. L. No. 94-581, 90 Stat. 2842 (1976). The patchwork of eligibility provisions resulting from a succession of incremental changes set the stage for development and enactment of the Veterans' Health Care Eligibility Reform Act of 1996, Pub. Law 104-262.

⁶²⁶ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁶²⁷ *Ibid.*

⁶²⁸ The term "medical services" was broadly defined to include in addition to medical examination and treatment, preventive health services; surgical services; wheelchairs, artificial limbs, and similar appliances; optometric and podiatric services; noninstitutional extended care services; and rehabilitative services (including services to restore physical, mental, and psychological functioning. Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C.

§ 1701(6),(8). VA regulations more fully set out the "medical benefits package" that VA is to provide patients, as needed; VA regulations detail that the benefits package includes services ranging from emergency care and prescription drugs to

Recognizing there could be circumstances in which VHA might lack capacity to provide timely care, Congress noted in the reform act that the requirement to provide care would be in effect only to the degree to which there were appropriated funds to pay for such care.⁶²⁹ This qualified availability of care clearly indicated veterans' health care is not an entitlement. Congress went further, though, and established a statutory patient enrollment mechanism for VA to manage access.⁶³⁰ The law specifically requires VA to establish and operate a patient enrollment system managed in accordance with statutory priorities and within any additional priority classifications established by VA. The eligibility reform act gave VA tools both to limit demand consistent with available funding and to discourage veterans from seeking VA care simply to fill an occasional need not met by a private health plan.⁶³¹ The act also requires the SECVA to manage the enrollment system such that care is timely and of acceptable quality.⁶³²

The enrollment system the department established is not being used today to calibrate supply and demand as envisioned.⁶³³ Although law and VA regulation require a system of annual patient enrollment,⁶³⁴ VHA last curtailed enrollment in 2003, and then only for veterans who were deemed eligible based on the category 8 criteria (see Table 8) that include those with higher-level incomes who lack any higher priority. In 2009, the Obama administration eased access for higher income veterans. Under that policy, veterans whose gross household income exceeds VA's current geographic income limit by 10 percent or less may enroll for VA care, subject to cost-sharing requirements.⁶³⁵ In 2014, Congress established the *Choice Program* to expand availability of care through contracts with community providers. Veterans' choice was limited by reference to distance and wait-time issues, but was otherwise broadly open to any enrolled veterans.⁶³⁶

comprehensive rehabilitative services, home health services, noninstitutional extended care services, hospice care, and pregnancy and delivery services and newborn care. Medical Benefits Package, 38 C.F.R. 17.38.

⁶²⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General 38 U.S.C. § 1710(a)(4).

⁶³⁰ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705. As explained in the report of the House Committee on Veterans Affairs which developed the legislation, "[T]he Act would...provide the VA with an important tool, the authority to design and manage access to care through a system of patient enrollment...Enrollment...would help the VA plan more effectively, so that facilities can better calculate and dedicate the resources needed to provide the care its enrollees require. The Act would direct the Secretary...to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment (or registration) system would operate. For example, the VA would be able to establish a system which simply registers patients throughout all or part of a fiscal year, or could employ a time-limited registration period. Significantly, the Act would permit the Secretary to set priorities within the specified priority classifications established in the Act. The Secretary could, for example, establish a policy which, within any priority classification, gives veterans who have previously been "enrolled" as VA patients priority over new applicants. However, the Committee expects any enrollment system to be designed and administered to assure that any veteran with a service-connected condition would receive priority treatment for that condition whether or not that veteran had enrolled for VA care." H. Rep. No.104-690, 6-7.

⁶³¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262; 110 Stat. 3177 (1996).

⁶³² Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705(b).

⁶³³ H. Rep. No. 104-690, 16.

⁶³⁴ Enrollment, 38 C.F.R. sec. 17.36(c). VA regulations state that "[i]t is anticipated that that each year the Secretary will consider whether to change the categories and subcategories of veterans eligible to be enrolled."

⁶³⁵ Enrollment, 38 C.F.R. 17.36(b)(8)(ii),(iv).

⁶³⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014). Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, Pub. L. No. 114-41 (2015).

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Table 8. Priority Groups

Priority Group	Definition
1	<ul style="list-style-type: none"> Veterans with VA-rated service-connected disabilities 50% or more disabling Veterans determined by VA to be unemployable due to service-connected conditions
2	<ul style="list-style-type: none"> Veterans with VA-rated service-connected disabilities 30% or 40% disabling
3	<ul style="list-style-type: none"> Veterans who are former prisoners of war Veterans awarded a Purple Heart medal Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty Veterans with VA-rated service-connected disabilities 10% or 20% disabling Veterans awarded special eligibility classification under Title 38, U.S.C. § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation" Veterans awarded the Medal of Honor
4	<ul style="list-style-type: none"> Veterans who are receiving aid and attendance or housebound benefits from VA Veterans who have been determined by VA to be catastrophically disabled
5	<ul style="list-style-type: none"> Non-service-connected veterans and noncompensable service-connected veterans rated 0% disabled by VA with annual income below VA's and geographically (based on resident zip code) adjusted income limits Veterans receiving VA pension benefits Veterans eligible for Medicaid programs
6	<ul style="list-style-type: none"> Compensable 0% service-connected veterans Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki Project 112/SHAD (shipboard hazard and defense) participants Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975 Veterans of the Persian Gulf War who served between August 2, 1990 and November 11, 1998 *Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987 Veterans who served in a theater of combat operations after November 11, 1998 as follows: <ul style="list-style-type: none"> Currently enrolled veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge. **Combat veterans who were discharged between January 2009 and January 2011, and did not enroll in the VA health care during their five-year period of eligibility have an additional one year to enroll and receive care. The additional one-year eligibility period began February 12, 2015 with the signing of the Clay Hunt Suicide Prevention for America Veterans Act. <p>Note: At the end of this enhanced enrollment priority group placement time period veterans will be assigned to the highest Priority Group (PG) their unique eligibility status at that time qualifies for.</p> <p>*Note: While eligible for PG 6; until system changes are implemented you would be assigned to PG 7 or 8 depending on your income.</p> <p>*Note: While eligible for PG 6; due to system limitations, veterans will be manually assigned to PG 8c, yet eligible for the enhanced benefits</p>
7	<ul style="list-style-type: none"> Veterans with gross household income below the geographically-adjusted income limits for their resident location and who agree to pay copays

Priority Group	Definition
8	<ul style="list-style-type: none"> ▪ Veterans with gross household income above VA and the geographically-adjusted income limits for their resident location and who agrees to pay copays <p>Veterans eligible for enrollment:</p> <p>Noncompensable 0% service-connected:</p> <ul style="list-style-type: none"> – Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA or geographic income limits by 10% or less <p>Non-service-connected and:</p> <ul style="list-style-type: none"> – Subpriority c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority d: Enrolled on or after June 15, 2009, whose income exceeds the current VA or geographic income limits by 10% or less <p>Veterans not eligible for enrollment:</p> <p>Veterans not meeting the criteria above:</p> <ul style="list-style-type: none"> – Subpriority e: Noncompensable 0% service-connected (eligible for care of their service-connected condition only) – Subpriority g: Non service-connected

Analysis

Two decades have passed since Congress last reexamined VHA eligibility and benefits, and many far-reaching changes that affect veterans' health care have occurred in that time. In more than a decade of war, 2.75 million troops have deployed to Iraq and Afghanistan⁶³⁷ where many have faced long and repeated deployments; constant risk of injury and death; and high levels of psychological disorders, substance abuse issues, and physical health problems.⁶³⁸ Post-9/11-era veterans are enrolling for VA care at historically high levels.⁶³⁹

Under current law and VA policy, enrollment is open to a relatively broad spectrum of veterans, though some veterans with higher incomes are not eligible to enroll.⁶⁴⁰ As discussed above, the law draws distinctions between those whose health problems have been adjudicated as service-connected and those whose problems are deemed non-service-connected. If Congress substantially reduced funding for VA medical care, the distinction would be important because those with service-connected issues have higher priority for enrollment. Under VA's current enrollment policy, which bars only veterans with higher incomes from receiving care, the

⁶³⁷ Defense Manpower Data Center, *Contingency Tracking System (CTS) Deployment File*, (Dec. 31, 2015).

⁶³⁸ Institute of Medicine of the National Academies, *Returning Home from Iraq and Afghanistan: Readjustment Needs of Veterans, Service Members, and Their Families*, (Washington, DC: The National Academies Press, 2013), accessed June 25, 2016, <http://www.nationalacademies.org/hmd/Reports/2013/Returning-Home-from-Iraq-and-Afghanistan.aspx>.

⁶³⁹ Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *Profile of Post-9/11 Veterans: 2014*, accessed May 27, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Post_911_Veterans_Profile_2014.pdf.

⁶⁴⁰ Veterans Health Administration, *Enrollment Determinations*, VHA Handbook 1601A.03, 9-10 (2015). Veterans with gross household income that do not exceed VA's means test threshold and a geographic means test by more than 10 percent may enroll for care, while those with higher income and no other special eligibility may not.

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statutory service-connected enrollment priority has little practical significance.⁶⁴¹ Future budget constraints could result in more restrictive enrollment criteria⁶⁴² or recurrence of lengthy wait times that hinder service-connected, disabled veterans' ability to receive timely care.

Current eligibility law does afford special status to veterans who deployed to a combat theater. It grants a 5-year window of eligibility for care to those veterans who are not otherwise eligible.⁶⁴³ All combat veterans are also eligible for readjustment counseling services at VHA Vet Centers without needing to enroll in VHA care and without time limitation.⁶⁴⁴ It is questionable, however, if the 5-year time limit takes sufficient account of continued reluctance of some veterans to seek care for behavioral health problems⁶⁴⁵ or of the difficulties of establishing service-connection years later for conditions that may be linked to wartime exposures to toxic substances.⁶⁴⁶ It is challenging for veterans to establish service-connection for health conditions that may have been caused by or associated with a long-distant exposure for which there may be no documentation. Given emerging evidence that combat exposure should be considered a risk factor for coronary heart disease,⁶⁴⁷ it has been suggested that combat exposure may not only take a toll on psychological health, but may exert a physiologic toll as well.⁶⁴⁸

Congress has attempted to remedy the challenge of documenting toxic exposures and establishing that particular illnesses are linked to wartime or other service exposure. It has, for example, enacted statutes that provide certain veterans eligibility for health care on the presumption that they were exposed to particular toxic substances.⁶⁴⁹ Congress went a step further in the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 which provided eligibility for care for several types of cancer and other specified conditions for family members of veterans who had been exposed to drinking water contaminated with industrial solvents and other toxic chemicals at the Marine Corp base.⁶⁵⁰

Congress has made only limited provision for VA to cover care for family members of certain veterans,⁶⁵¹ but with research suggesting that long combat deployments can take a

⁶⁴¹ Prior to 1996, provisions of law required VA to ensure special priority to service-connected veterans in furnishing outpatient care. 38 U.S.C. § 1712(i), repealed by § 101(c), Pub. L. No. 104-262.

⁶⁴² Enrollment, 38 C.F.R. 17.36(c)(1).

⁶⁴³ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(3), as amended by Sec. 7, Pub. L. No. 114-2 (2015), accessed June 20, 2016, <https://www.govtrack.us/congress/bills/114/hr203/text>.

⁶⁴⁴ Readjustment Counseling Service, 38 U.S.C. § 7309.

⁶⁴⁵ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶⁴⁶ Matthew S. King et al., "Constrictive Bronchiolitis in Soldiers Returning from Iraq and Afghanistan," *New England Journal of Medicine*, 365, no. 10 (2011): 222-230, accessed June 20, 2016, <http://doi.org/10.1056/NEJMoa1101388>.

⁶⁴⁷ Nancy F. Crum-Cianflone et. al., "Impact of Combat Deployment and Posttraumatic Stress Disorder on Newly Reported Coronary Heart Disease Among US Active Duty and Reserve Forces," *Circulation*, 129, (2014), accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.113.005407>.

⁶⁴⁸ Rachel Lampert, "Veterans of Combat: Still at Risk When the Battle is Over," *Circulation*, 129, (2014): 1797-1798, accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.114.009286>.

⁶⁴⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(10).

⁶⁵⁰ Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Pub. L. No. 112-154, 126 Stat. 1165 (2012).

⁶⁵¹ Health Care of Persons Other Than Veterans, 38 U.S.C. §§ 1781-1787.

psychological toll on family members,⁶⁵² there may be circumstances under which it might be argued that VA should afford such family members behavioral health services. Studies indicate that longer deployments, deployment extensions, and posttraumatic stress disorder in military personnel are associated with psychological problems for the spouse.⁶⁵³ Long-term effects are unknown, yet studies suggest children may have heightened risk for psychosocial issues during a parent's deployment.⁶⁵⁴

The experience of the nation's longest war and increased options available under the Affordable Care Act (ACA), particularly to previously uninsured non-service-connected veterans, may raise new questions for policymakers.⁶⁵⁵ VHA's most recent survey of enrollees showed that 20 percent of enrollees reported that they were uninsured, down from 22 percent in 2014.⁶⁵⁶ Enrollment in VHA-provided care meets the ACA requirement for health care coverage, creating pressure to continue to provide care to those enrolled.⁶⁵⁷ Given that VHA serves large numbers who are poor or near poor and have chronic medical conditions and behavioral health problems,⁶⁵⁸ it is important to note that receiving care under an ACA plan would not necessarily be a substitute for the rich benefits afforded through VHA. In addition, adults in this population are only eligible for coverage under ACA through state expansion of Medicaid that 19 states have elected not to accept, making this option unavailable to poor or near poor veterans in many parts of the country.⁶⁵⁹

Over time Congress has expanded VA health care eligibility to increasingly more cohorts of non-service-connected veterans. There is wide variability among different cohorts in the extent to which veterans rely on VA care. Those at the higher-income levels (priority categories 7 and 8) who were generally not eligible for ambulatory care prior to 1996, for example, rely on VA for

⁶⁵² Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, accessed June 20, 2016, <http://dx.doi.org/10.1186%2F1471-244X-10-88>. Swords to Plowshares, presentation to Commission on Care, January 21, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former servicemembers. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁶⁵³ H. Thomas De Burgh et al., "The Impact of Deployment to Iraq or Afghanistan on Partners and Wives of Military Personnel," *International Review of Psychiatry*, 23, no. 2 (2011): 192-200, <http://www.ncbi.nlm.nih.gov/pubmed/21521089>.

⁶⁵⁴ Gregory H. Gorman, Matilde Eide, and Elizabeth Hisle-Gorman, accessed June 20, 2016, "Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints," *Pediatrics*, 126, no. 6 (2010): 1058-1066, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-2856>. Anita Chandra et al., "Children on the Homefront: The Experience of Children from Military Families," *Pediatrics*, 125, no. 1 (2010): 16-25, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-1180>.

⁶⁵⁵ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁶ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁵⁷ "Affordable Care Act & Veterans," Department of Veterans Affairs, accessed May 27, 2016, <http://explore.va.gov/health-care-affordable-care-act?show=all>.

⁶⁵⁸ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁹ "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update," Rachel Garfield and Anthony Damico, Kaiser Family Foundation, accessed March 29, 2016, <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/>.

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less than 22 percent of their outpatient care-needs, based on VA's most recent survey of veteran enrollees' health and use of care.⁶⁶⁰

One consideration, as suggested by a few Commissioners, is the feasibility of allowing veterans' family members and currently ineligible veterans to purchase VHA care through their health plans in areas where VHA hospitals and other facilities might otherwise need to close. In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. A related challenge is maintaining safe volume of care when patient loads decline. As an extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁶¹ Similarly, VHA may be unable to continue offer specialty care in certain areas if it forced to close facilities. Patients in a polytrauma unit for example, require a full spectrum of routine and nonroutine health care.

Closing a low-volume hospital may be the answer in some instances. But closing VHA facilities reduces the choices available to veterans. Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. See Appendix C for a further discussion of the challenge of future VHA hospital closures and an outline of suggested pilot programs.

Substantial changes have occurred since Congress last comprehensively examined eligibility for VHA care. These changes merit a reexamination of VA health care eligibility.⁶⁶² The Commission did not, however, view its charge of examining veterans' access and how best to organize VHA, locate health care resources, and deliver care in the years ahead⁶⁶³ as calling for it to make recommendations on this fundamental policy issue, and recommends that the President or Congress consider tasking another body to develop recommendations for VA care eligibility and benefit design. The Commission's work, however, has illuminated the fact that nothing in law or regulation assures a service-connected, disabled veteran of priority for care. VA can and should amend its regulations to provide for such priority, subject to a necessarily higher priority for urgent and emergent care.

Implementation

Legislative Changes

- Task another body to examine the need for changing eligibility for VA care and benefits design, which would include simplifying eligibility criteria, and may include exploring

⁶⁶⁰ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 75, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁶¹ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

⁶⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 25, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶⁶³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

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pilots for expanding eligibility for nonveterans to use underutilized providers and facilities when paid for through private insurance.

VA Administrative Changes

- SECVA should amend 38 C.F.R., chapter 17 to establish that veterans with service-connected disabilities shall be afforded priority for access to care, subject to the priority dictated by clinical care needs.

Other Departments and Agency Administrative Changes

- None required.

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APPENDIX A: FINANCING THE VISION AND MODEL

Estimating the Cost of Alternative Policy Proposals

This chapter presents estimates of the costs of allowing veterans access to expanded community care through integrated networks, as well as a range of other options. In the *Recommended Option*, the one chosen by the Commission and described in Recommendation #1, veterans would be eligible to receive community care for primary and standard specialty care with a referral from any primary care doctor in the VHA Care System. Special emphasis care, care provided in a distinctive fashion by VHA, is not included in community networks.

In addition to the *Recommended Option*, we considered three alternatives that are based on a similar concept of integrated networks, but which have potential costs that could vary dramatically due to differences in the openness of access to community care and the breadth of services eligible. We also estimated the costs of three options that differ in focus from the integrated network options, including options that move selected services entirely to the community, set up a premium support model, and expand access to all Priority 8 veterans. Finally, we estimated costs for two additional policies: expanding nurse navigator/care coordinator staff to help guide and coordinate veterans' care in the integrated networks of expanded community care and granting temporary eligibility for VA health care to those with other-than-honorable discharges.

Baseline Projections

We used projections from the Enrollee Health Care Projection Model (EHCPM) produced by VHA and Milliman as the baseline upon which to build our estimates. However, with the exception of the options involving premium support and an expansion of Priority 8 enrollment, we use separate analyses and not the EHCPM to derive the estimates. Costs of VA care are modeled as the product of utilization and cost per unit of care (unit cost). Utilization is dependent on both enrollment in, and reliance on, the VA health care system, total demand for health care, and other factors. Enrollment measures how many people enroll to receive VA health care, and reliance is the percentage of their medical care that enrollees receive through VA or VA-financed community care. Unit costs measure the cost of each health care service. Unit costs can be calculated for care in VA facilities, for care outside of VA facilities, or for both, depending on the scenario being estimated.

Utilization

Utilization depends on enrollment, reliance, total demand for health care, and characteristics of the health care system, such as medical technology and practice patterns. We discuss enrollment and reliance in further detail below, but overall demand for health care is similarly important. Enrollment, reliance, and overall demand each have a multiplicative effect on

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utilization and total costs. For example, if enrollment increases by 10 percent, costs will increase by 10 percent (assuming new enrollees have the same characteristics as existing enrollees). Thus, it is important to consider carefully the effect of any policy change on enrollment, reliance, and overall demand for health care. Each of these factors is subject to effects by policies that make care more convenient, less expensive, or less restricted.

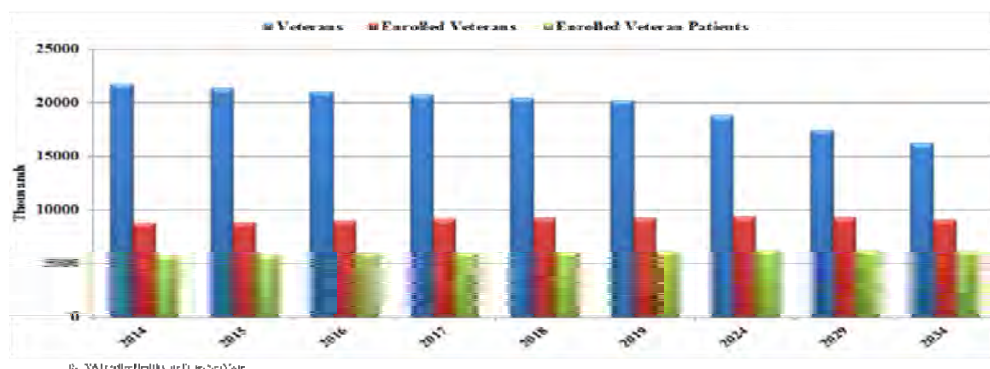
Enrollment

Currently there are 22 million veterans, 9 million of whom have enrolled and 7 million of whom are eligible to enroll but have not done so. Even though the number of veterans is decreasing, projected numbers of enrollees and patients should remain relatively stable during the next 20 years. Younger veterans enroll at particularly high rates, and once enrolled, they remain continuously enrolled until death.

This enrollment trend is subject to change based on various inputs. Enrollment rates are projected based on current policy, and if policy changes, the number of enrollees and patients will change. For example, an increase in cost sharing would likely decrease enrollment and the number of patients, yet easing access to care would likely increase enrollment and the number of patients. Changes to other health insurance policies outside of VA can also affect enrollment and the number of patients (for example, changes to the Affordable Care Act).

Figure A-1. Changes in Number of Veterans, Enrollees over a 20-year Period

Veterans, Enrollees, and Patients FY 2014-2034



Reliance

On average, enrolled veterans receive 34 percent of their health care through VHA, and approximately 80 percent of enrollees have other health insurance in addition to VA health care. Many factors affect reliance rates including, age, income, service-connected disabilities, distance from VA facilities, cost-sharing levels, and characteristics of other insurance options. Any policy that affects the cost of receiving VA care, the convenience of receiving VA care, the cost or convenience of other health insurance held by enrollees, or demographic or health characteristics of enrollees, is likely to change reliance. Any increase in reliance will increase

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costs to VHA, and the effect can be very large. In the absence of a policy change, VHA predicts that reliance will decline slightly from 34 percent to 32 percent during the next 20 years.

Unit Cost

Unit cost measures how much a particular service, procedure, or drug costs to provide. Unit costs can measure the cost of the unit of care in the VHA system or in the community, depending on where veterans receive care. We used unit cost projections from the EHCPM for 78 Health Care Service Categories (HSCs). The unit of measurement depends on the service. Examples include office visits, pathology procedures, vision exams, and inpatient surgical days. Unit cost projections reflect anticipated changes in price inflation and health care practice patterns, as well as historical trends. EHCPM projects separate unit costs, depending on whether veterans receive a service in a VA facility, in the community at historic Care in the Community (CITC) rates, or in the community at Medicare allowable rates. Any policy that affects the quantity of care provided in VA facilities, as opposed to the community, will have an effect on the total cost of care. If veterans receive care in the community, the rate of provider reimbursement will also affect costs.

Baseline Cost Projections

The baseline cost projections, produced by the EHCPM, show how cost will change in the future. They incorporate projected changes in enrollment, reliance, unit costs, and other factors. The projections reflect current policy with regard to enrollment eligibility and VA health care benefits, with the exception of the *Choice Program*, which is assumed to continue for veterans living more than 40 miles away from a VA medical care facility.⁶⁶⁴

We based the projections on assumptions about inflation and anticipated effects of changes in health care practice on the cost of VA health care in the next 20 years. New military conflicts, policies, legislation, regulations, and external factors, such as economic recession, can occur and change projected demand for VA health care during this period. The projections do not include requirements for several activities/programs not projected by the VA EHCPM, including nonrecurring maintenance; readjustment counseling; state-based, long-term services and support programs; and some components of the CHAMPVA program.

In the absence of any policy changes, costs increase from \$53 billion in 2014 to \$125 billion in 2032. This growth is largely due to inflation and how health care practices are expected to change over time, which reflects factors that affect the cost of both VA and non-VA health care. These trends increase the cost of VA health care regardless of changes in enrollment growth and demographics. Within enrollment, the increasing number of enrollees adjudicated for service-connected disabilities by the Veterans Benefit Administration (VBA) is the most significant driver of cost increases. Enrollees will likely increase their reliance to reflect the substantially higher reliance of enrollees in the service-connected Priorities 1-3.

These baseline estimates, along with our scenario estimates presented below, carry some key limitations. First, the EHCPM does not track capacity at VA facilities. We assume health care

⁶⁶⁴ Veterans qualifying based on wait times or excessive travel burdens are not included.

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utilization will increase or decrease at the average unit cost, when in fact it is the marginal cost that would be relevant for cost estimates. This marginal cost could be smaller or larger than the average cost, depending on existing capacity. Although we did make some assumptions about fixed and variable unit costs when care leaves VA facilities in our policy estimates below, precise estimates are not possible given data availability. Second, the EHCPM does not consider health care capacity in local communities. For these and other reasons, the EHCPM is best for the near future and for policy scenarios that do not stray dramatically from current policy. A 2008 RAND review of the EHCPM highlighted these limitations, which are particularly important for analyzing policy changes such as expanded community care.⁶⁶⁵ In light of the types of policy choices VHA is likely to consider in the future, it would be particularly beneficial for VHA to collect and incorporate the data necessary to mitigate these limitations. Due both to these limitations and to the general uncertainty regarding any long-term changes in the health care system, we suggest focusing attention on the 2019 estimates of the scenarios below, as 2019 is the first year to incorporate the fully phased-in effects of the scenarios.

Policy Estimates

In this section, we present results for the *Recommended Option* and three alternative options for expanding access to providers outside of VA through integrated networks. These options expand community care for different categories of care and vary by whether referrals are required to receive specialty care. We present estimates for several other scenarios we examined, each with a design or focus that differs from the integrated network options. Finally, we estimate costs for two other policies discussed in this report: (1) expanding the use of nurse navigators to help patients coordinate their care in VA and in the community, and (2) expanding eligibility to all veterans with an other-than-honorable (OTH) discharge until the adjudication process is complete to determine whether they will remain eligible.

Community-Delivered Services Networks

This section describes the *Recommended Option* and the first three alternative options. At least initially, all care currently provided by VA would continue to be provided by VA. In addition, expanded community care, also called Community-Delivered Services (CDS), will be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA. CDS will focus on tertiary and quaternary care, and may include primary care and all standard specialty care, depending on the scenario considered. CDS will not include special-emphasis care and some types of specialty care provided in a distinctive fashion by VHA. The network of CDS providers that VA will coordinate varies by community. To make the flow of service both appropriate and smooth in operation, there will be navigators who will help guide veterans to the best and most appropriate providers inside and outside VA.

The Commission's recommendation to create the VHA Care System (see Recommendation 1) considers the ways in which health plans can vary the size and scope of networks as a means of managing costs. It highlights that broad, open networks offer greater choice, but narrow, well-

⁶⁶⁵ Katherine M. Harris, James P. Galasso, and Christine Eibner, "Review and Evaluation of the Enrollee Health Care Projection Model," RAND Corporation, Santa Monica, CA, 2008.

managed networks potentially result in lower costs. It discusses ways in which, after networks are designed, VHA could exercise additional cost controls by steering patients to different providers within the networks. Finally, the recommendation regarding the VHA Care System emphasizes that access and local needs are important considerations in setting up the integrated networks, and that governance of the networks should be a process of ongoing management and evaluation.

In the estimates that follow, we assume that networks are designed and governed in a way that gives major consideration to cost, choice, and access. We assume that management of the integrated networks would be an iterative process that involves continual evaluation of resulting outcomes, including cost outcomes, and that networks would be adjusted in light of those outcomes. We also assume that local communities and services with poor access would require more community providers and/or expanded capacity within VHA than those that already have adequate access. Finally, we assume that the networks will be integrated, relatively narrow, and well-managed with the aim of controlling costs effectively. One exception is that for the *Recommended Option*, we added an estimate that assumes less-managed, broader networks to illustrate that costs are sensitive to network size and management.

Technical Assumptions for Community-Delivered Services Options

We based our estimates on utilization and unit cost data and projections for 78 HSCs that we obtained from the VHA Office of Policy and Planning. Starting from a base year of 2014, we projected utilization and unit costs through 2034. For HSCs that are eligible for CDS networks, we assume a certain fraction of care, depending on the option, shifts from VA facilities to the networks. We assume traditional CITC will be offered and used at baseline levels.⁶⁶⁶ We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks. All effects are phased in during the first 5 years.

Both CDS networks and CITC are priced at Medicare allowable rates by matching Medicare fee schedule data to VA HSCs.⁶⁶⁷ A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities.

For care shifting into the CDS networks, we use data on the components of HSC unit costs that we obtained from the VA Allocation Resource Center. We assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. These portions, which together averaged approximately 10 percent of care in 2014, form our proxy for the portion of unit costs that VA will not be able to shed in scenarios for which, on net, care leaves VA facilities for CDS networks. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance. These costs are not part of the EHCPM, and costs and/or savings associated with changes to facilities and nonrecurring maintenance are not included in our estimates.

⁶⁶⁶ CITC accounted for approximately 11 percent of modeled expenditures in the base year 2014.

⁶⁶⁷ Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

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Improving access, choice, and/or quality of services is likely to induce greater reliance and enrollment in the VA system. Although reliance and enrollment increases result in greater budgetary costs for VA, it is important to note that these increases do not represent societal costs or costs to the government. The VA budgetary cost increases may be associated with reductions in out-of-pocket expenses and improved health care benefits for patients, as well as savings to Medicare, Medicaid, and other government programs. Our cost estimates are confined solely to the VA budget.

Approximately 52 percent of eligible veterans have enrolled in VA health care, and enrolled veterans receive 34 percent of health care through VA. There is little data from which to anticipate how reliance and enrollment might change under the scenarios, and our estimates use wide ranges of assumptions for these parameters. In forming our assumptions, we consider a variety of factors, such as insurance coverage and other characteristics of eligible veterans (both enrolled and unenrolled), survey responses of veterans (both enrolled and unenrolled) on use and reasons for lack of use of VA health care, and research on take-up of health insurance coverage.⁶⁶⁸ We are confident that enrollment and reliance would increase more with greater patient choice and access. For all options, we present low, middle, and high estimates.

In addition to increases in reliance and enrollment, reduced cost sharing, increased convenience of receiving community care, and the removal of a requirement to get a referral for specialty care can increase the total amount of medical care that a patient receives. Depending on the option considered, some health care is subject to reduced cost sharing from levels typical of private insurance coverage and Medicare to the very small levels of cost sharing found in the VA system. We assume utilization increases for health care subject to lower cost sharing and/or removal of a requirement to get a referral, with our estimates based in part on the literature examining how cost sharing affects health care demand.⁶⁶⁹

Caveats

There are a number of caveats associated with all of our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. New enrollees are assumed to cost slightly less than existing enrollees for *CDS Alternative 3* and the

⁶⁶⁸ Examples of sources include: the 2014 American Community Survey; the 2010 National Survey of Veterans; the 2015 Survey of Veteran Enrollees' Health and Use of Health Care; Katherine Baicker, William J. Congdon and Sendhil Mullainathan, "Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics," *The Milbank Quarterly*, 90(1) (2012), 107-134.

⁶⁶⁹ Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," Washington, DC, 2008. Willard G. Manning, Joseph P. Newhouse, Naihua Duan, Emmett B. Keeler, Arleen Leibowitz, and M. Susan Marquis, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review* 77(3) (1987), 251-77.

same as existing enrollees in the *Recommended Option* and *CDS Alternatives 1 and 2*.⁶⁷⁰ Finally, we do not estimate any administrative costs associated with CDS networks other than the additional RN care managers hired to handle the increased clinical and administrative burden of expanded community care. These additional, nonmodeled administrative costs could be substantial.

Commission Recommended Option

The *Recommended Option* would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA or a third-party administrator. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in VA in a distinct fashion).⁶⁷¹ In 2014, 68 percent of care would have been eligible for CDS networks at current VA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network. In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a doctor in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and 20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was

⁶⁷⁰ Assumptions based on previous analysis by VHA and Milliman.

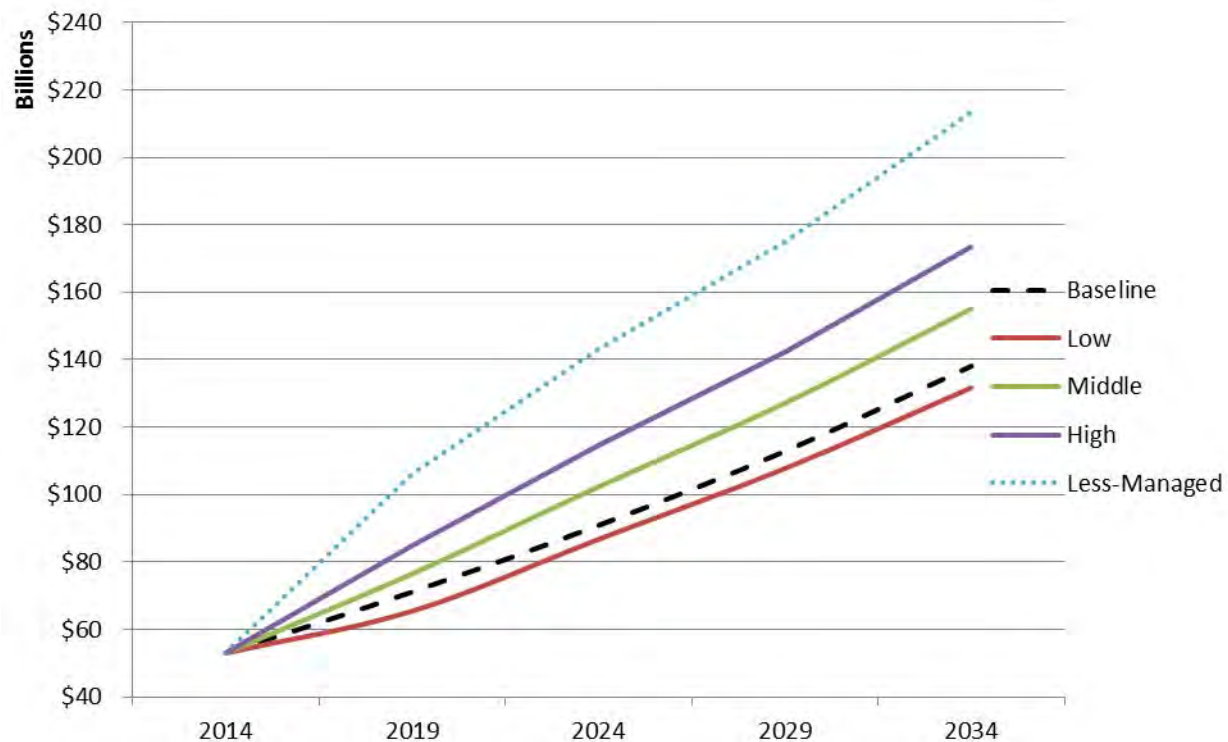
⁶⁷¹ Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

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formerly subject to sizable cost sharing with private insurance or Medicare, and now it would be subject to little if any cost sharing associated with VA-financed care.

Figure A-2 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from \$65 billion to \$85 billion in 2019, with a middle estimate of \$76 billion. The middle estimate is moderately above the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is \$106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

Figure A-2. Projected Costs of Recommended Option



APPENDIX A

FINANCING THE VISION AND MODEL

COST ESTIMATES Commission on Care Scenarios							
	Brief Description	Utilization Increase	Enrollment Increase (low, middle, high)	Reliance (low, middle, high)	Cost FY 2014 Actual (billions)	Cost FY 2019 Projected (billions)	Cost FY 2034 Projected (billions)
Baseline	2014 Actual		9,078,615	34%	\$53	\$ 71	\$ 138
Recommended (low)	Referral Based Care in VHCS (68% of current VHA care eligible as CDS)	+20% of new demand in CDS Care	5%	40%	\$	65	\$ 132
Recommended (middle)	same	same	15%	50%	\$	76	\$ 155
Recommended (high)	same	same	20%	60%	\$	85	\$ 173
Recommended (less-managed)	same	same	50%	60%	\$	106	\$ 213
Alternative 1 (low)	Similar to Recommended but primary care, inpatient med and surg and some standard specialty care not eligible for CDS remain in VHA (47% of care eligible for CDS)	+20% of new demand in CDS Care	0%	10%	\$	66	\$ 128
Alternative 1 (middle)	same	same	5%	35%	\$	73	\$ 140
Alternative 1 (high)	same	same	10%	50%	\$	78	\$ 151
Alternative 2 (low)	Similar to Alternative 1 but primary care coordinator must only be consulted; no referral required (47% of care eligible for CDS)	+20% CDS eligible Care	5%	60%	\$	97	\$ 191
Alternative 2 (middle)	same	same	10%	80%	\$	123	\$ 243
Alternative 2 (high)	same	same	20%	100%	\$	154	\$ 307
Alternative 3 (low)	Similar to Alternative 2 but primary care, inpatient med/surg and specialty care eligible for CDS and no consult required	+20% CDS eligible Care	75% (level)	80%	\$	167	\$ 320
Alternative 3 (middle)	same	same	85% (level)	90%	\$	206	\$ 395
Alternative 3 (high)	same	same	95% (level)	100%	\$	250	\$ 479
Keep Selected Services (low)	Move most standard ambulatory specialty care to community	+20% of new demand in CDS Care	0%	10%	\$	64	\$ 128
Keep Selected Services (middle)	same	same	4%	25%	\$	70	\$ 136
Keep Selected Services (high)	same	same	8%	40%	\$	75	\$ 145
Premium Support	Enrollees under age 65 can choose a subsidized insurance premium with cost sharing in lieu of VHA care	42% of enrollees <65 choose premium support	6%		\$	82	\$ 158
Eligibility Expansion	Allow all eligible veterans to enroll	increase to 30% market share among priority 8	5%		\$	72	\$ 140
Initiatives	Nurse navigators for CDS care				\$	71	\$ 138
	Make veterans with Other than Honorable Discharges Temporarily Eligible for VA Health Care While Claims are Adjudicated				\$	72	\$ 139

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Additional Sample Cost Models

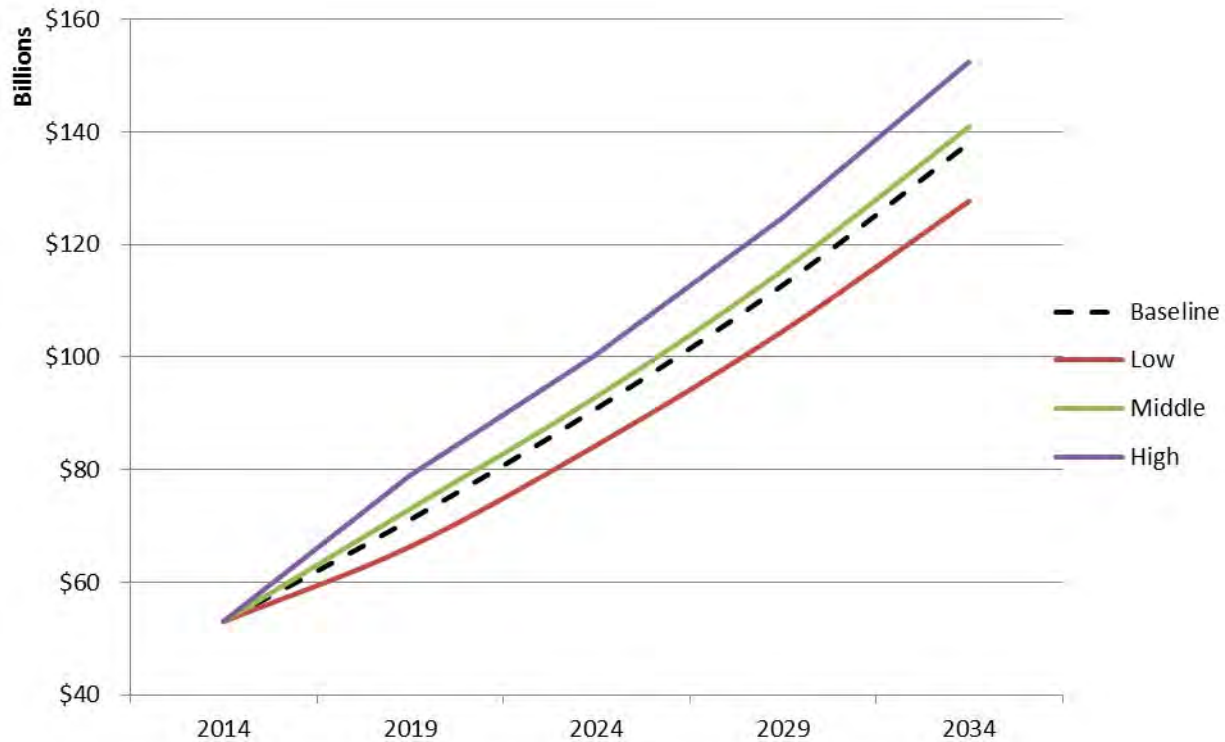
CDS Alternative 1

CDS Alternative 1 is similar to the Commission's *Recommended Option* above. The main difference is that a narrower subset of services is available in the CDS networks. Primary care, inpatient medical and surgical care, and some standard specialty care are not eligible for CDS networks and must be accessed within VA. The CDS network for *CDS Alternative 1* would focus on tertiary and quaternary care; it would not include primary care, some specialty care, inpatient medical and surgical care, and special-emphasis care (care that is provided in VA in a distinct fashion). In 2014, 47 percent of care would have been eligible for CDS networks.

Because less care is eligible for CDS networks than in the *Recommended Option*, less care will shift to CDS networks, reliance increases will be smaller, and enrollment increases will be smaller. We assumed that 50 percent of eligible care shifts from VA facilities to CDS networks. We modeled increases in reliance of 10, 35, and 50 percent, which correspond to reliance rates of approximately 37, 46, and 51 percent. These reliance increases pertain only to CDS care, not CDS-eligible care provided in VA facilities. We modeled enrollment increases of 0, 5, and 10 percent. As in the *Recommended Option*, we assume newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks.

Figure A-3 displays estimates for CDS Alternative 1. Estimates range from \$66 billion to \$78 billion in 2019, with a middle estimate of \$73 billion. As in the *Recommended Option*, the middle estimate is close to the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to Medicare allowable rates for CDS networks and CITC offsets these effects.

Figure A-3. Projected Costs of CDS Alternative 1



CDS Alternative 2

Like *CDS Alternative 1*, CDS care in *Alternative 2* would focus on tertiary and quaternary care. CDS networks would not include primary care, special-emphasis care, inpatient medical and surgical care, and some types of specialty care.

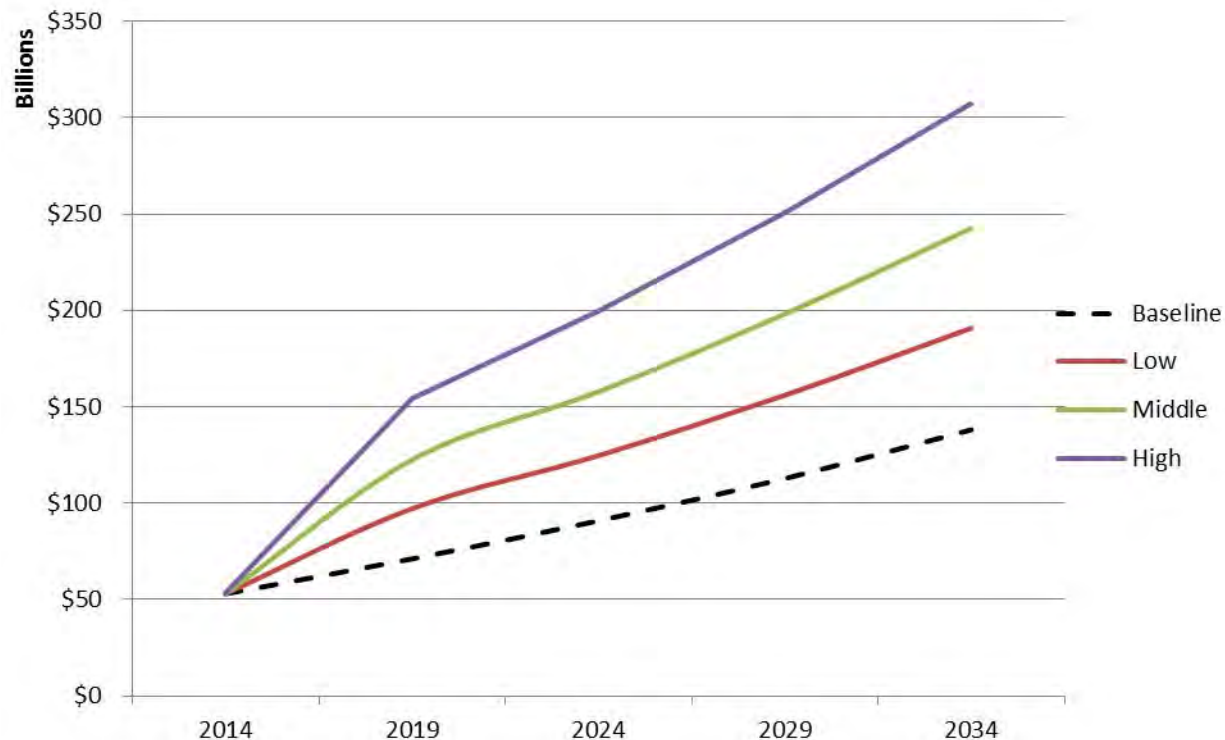
This option differs from the *Recommended Option* and *CDS Alternative 1* in that veterans must consult their VHA primary care provider in some way before seeking specialty care, but they *do not* need a referral to receive CDS eligible care whether they receive it in or out of VA. Some specialty care, all primary care, and all special-emphasis care are only provided in VA unless the veteran is eligible for traditional CITC. However, after the primary care consultation, the choice of whether to seek eligible care in CDS networks is entirely up to the veteran. As in *CDS Alternative 2*, the care eligible for CDS networks comprised 47 percent of total modeled expenditures in 2014.

We expect reliance increases to be relatively high, and we apply these reliance increases to CDS eligible care regardless of where veterans receive it because referrals are not required for any CDS eligible care. Further, we expect enrollment increases to be higher than the *Recommended Option* and *CDS Alternative 1* because the absence of a referral requirement makes this a more attractive policy for potential enrollees. We model reliance rates of 60, 80, and 100 percent for care eligible for CDS networks; enrollment increases of 5, 10, and 20 percent; 70 percent of VA facility care shifting into CDS networks; and a 20 percent utilization increase for CDS eligible care.

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Estimates are displayed in Figure A-4. In 2019, the baseline projection is \$71 billion. *CDS Alternative 2* estimates range from \$97 billion to \$154 billion, with a middle estimate of \$123 billion. The potential for considerable reliance and enrollment increases could push costs substantially higher than the baseline.

Figure A-4. Projected Costs of CDS Alternative 2



CDS Alternative 3

CDS Alternative 3 differs from *Alternative 2* in two main ways. First, a broader array of care is eligible for CDS networks. CDS would include primary and standard specialty care, including inpatient medical and surgical care. It would not include special-emphasis care (care that is provided in VA in a distinct fashion). This array of eligible care is the same as that for the *Recommended Option*, and comprised 68 percent of total modeled expenditures in 2014. Second, enrollees do not need to consult with a primary care doctor in order to access CDS eligible care.

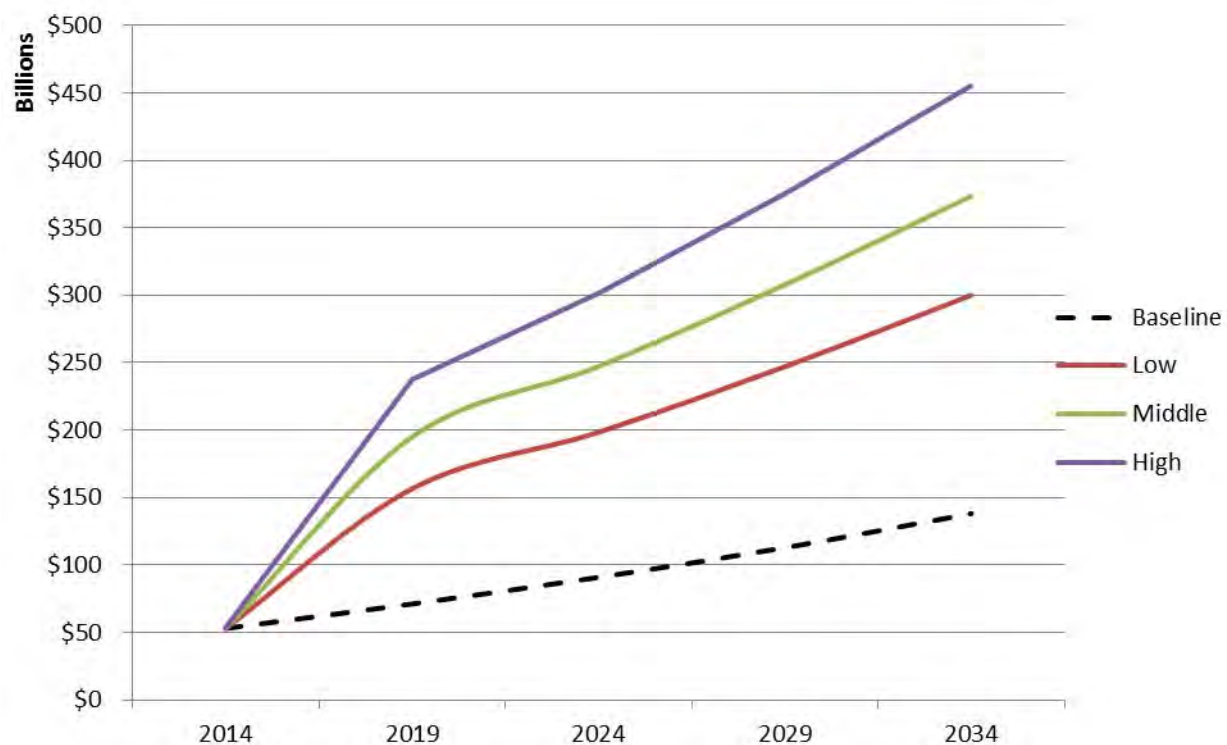
CDS Alternative 3 would offer an extremely generous benefits package for patients. With no referral or consultation, no premiums, and little if any copayments, patients would have access to a robust network of high-quality providers in their area. Although care within VA facilities would be available, no clinical contact would be necessary for those seeking care in CDS networks. Even within VA facilities, care is more attractive because patients would no longer need to consult their primary care doctors to receive specialty care. The benefits of this option contrast with the 10 to 30 percent cost sharing typical in Medicare and private coverage, the low

provider reimbursements, stigma and access barriers often associated with Medicaid,⁶⁷² and the requirements for referrals and/or prior authorizations that are widespread among health insurance plans. Few veterans would have reason to turn down such an attractive option.

Consequently, we model high ranges for reliance, enrollment, and care shifting into CDS networks. We model reliance rates of 80, 90, and 100 percent for all CDS eligible care; enrollment shares of 75, 85, and 95 percent; and a 70-percent rate of eligible care shifting from VA facilities to CDS networks. We apply the reliance increases to all care eligible for CDS networks, even if the care is provided in VA facilities or traditional CITC, because this option eliminates the need for consultations with primary care doctors for all CDS eligible care. Additionally, we assume that the total amount of CDS eligible care received by veterans from any provider and payer increases by 20 percent due to the lack of a referral requirement and/or reduced cost sharing.

Estimates are displayed in Figure A-5. In 2019, when effects are fully phased-in, estimated costs range from \$156 billion to \$237 billion, with a middle estimate of \$195 billion. This compares to a baseline projection of \$71 billion. Although estimates are highly uncertain, a key takeaway is that this option could result in very large cost increases relative to the baseline scenario, *Recommended Option*, and CDS Alternatives 1 and 2.

Figure A-5. Projected Costs of CDS Alternative 3



⁶⁷² Yu-Chu Shen and Stephen Zuckerman, "The Effect of Medicaid Payment Generosity on Access and Use among Beneficiaries," *Health Services Research* 40, no. 3 (2005), 723-44. Jennifer Stuber and Karl Kronebusch, "Stigma and Other Determinants of Participation in TANF and Medicaid," *Journal of Policy Analysis and Management* 23, no. 3 (2004), 509-530.

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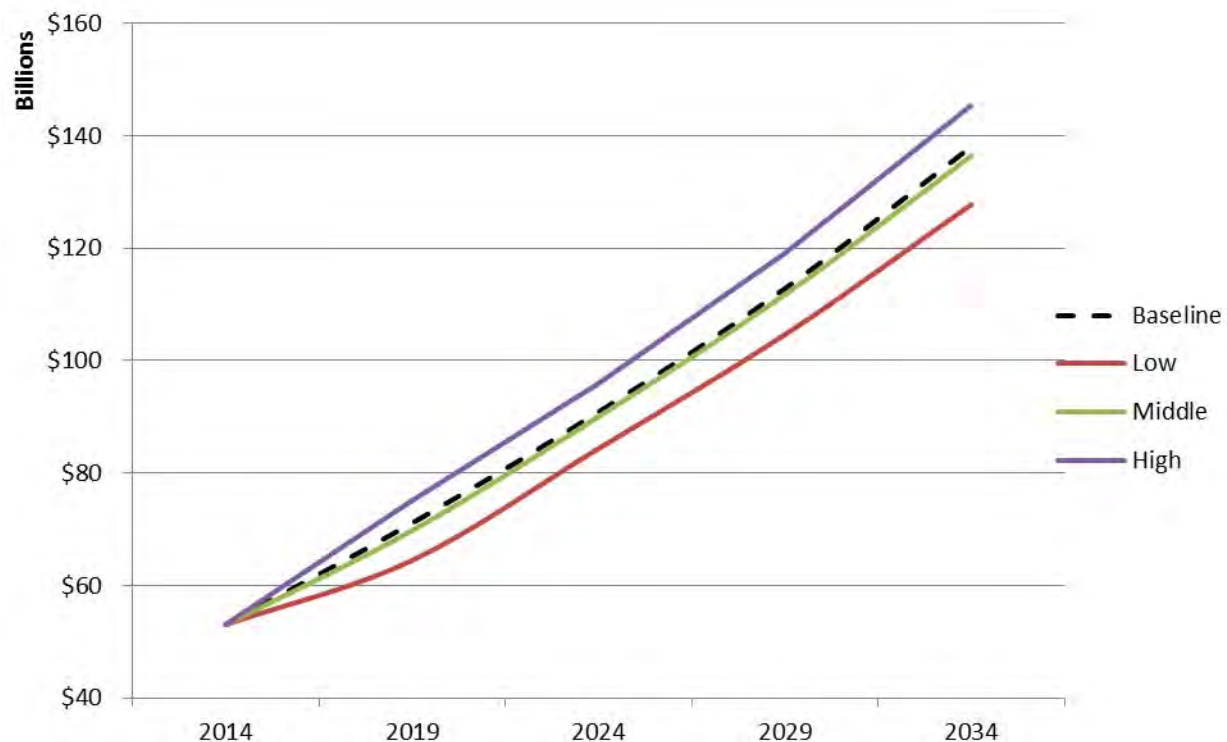
Keep Selected Services

The *Keep Selected Services (KSS)* scenario would move most standard ambulatory specialty care entirely into the community, yet keep the remainder of care entirely within VA facilities or traditional CITC. Although VA would no longer provide most standard ambulatory specialty care in VA facilities, it would continue to provide primary care, inpatient care, and special-emphasis care in VA facilities, including long term services and supports, prosthetics and orthotics services, inpatient and outpatient mental health and substance abuse, inpatient medical and surgical care, prescription drugs, medication management, recreational therapy, and immunizations. Under this scenario, approximately 35 percent of the cost of care currently provided in VA would be provided solely in the community. Providers in the community would receive Medicare rates.

We modeled increases in reliance of 10, 25, and 40 percent, which correspond to reliance rates of approximately 37, 43, and 48 percent. These reliance increases pertain only to care that moves into the community. We modeled enrollment increases of 0, 4, and 8 percent.

Estimates are displayed in Figure A-6. In 2019, when effects are fully phased-in, estimated costs range from \$64 billion to \$75 billion, with a middle estimate of \$70 billion. This estimate compares to a baseline projection of \$71 billion. Although estimates are highly uncertain, a key takeaway is that even with expanded community care, cost increases are constrained when veterans cannot choose whether they receive care in VA facilities or in the community.

Figure A-6. Projected Costs of Keep Selected Services Scenario



Premium Support⁶⁷³

Under the *Premium Support* (PS) scenario, all current and future enrollees younger than age 65 can choose a subsidized insurance premium with cost sharing (for some priorities) in lieu of their current VHA benefit. Enrollees electing the premium and cost sharing subsidy no longer have access to any VA services, including the special services VA offers. Under this scenario, there is an annual election period, and VA actively engages with enrollees to make a decision. Enrollees ages 65 and older receive no additional benefit options.

For those enrollees choosing the subsidized insurance program, the cost sharing varies by priority level: 10 percent for priorities 1 and 2; 20 percent for priorities 3 and 4; 30 percent for priorities 5 and 6; and 40 percent for priorities 7 and 8. Veterans would buy *Silver* policies on the state individual insurance exchanges, and VA would provide additional cost sharing assistance to meet the target subsidy. If enrollees purchased plans offered with lower cost sharing, such as *Gold* (20 percent cost sharing) or *Platinum* plans (10 percent cost sharing), the additional premium costs would likely exceed the cost of purchasing a Silver plan and subsidizing the cost sharing. The cost estimates did not consider the potential effect of adding a large number of veterans on exchange plans. Were VA to do this, considerations for veteran morbidity as well as the proposed cost sharing subsidies would need to be accounted for within the purchase of state exchange plans from commercial insurers.

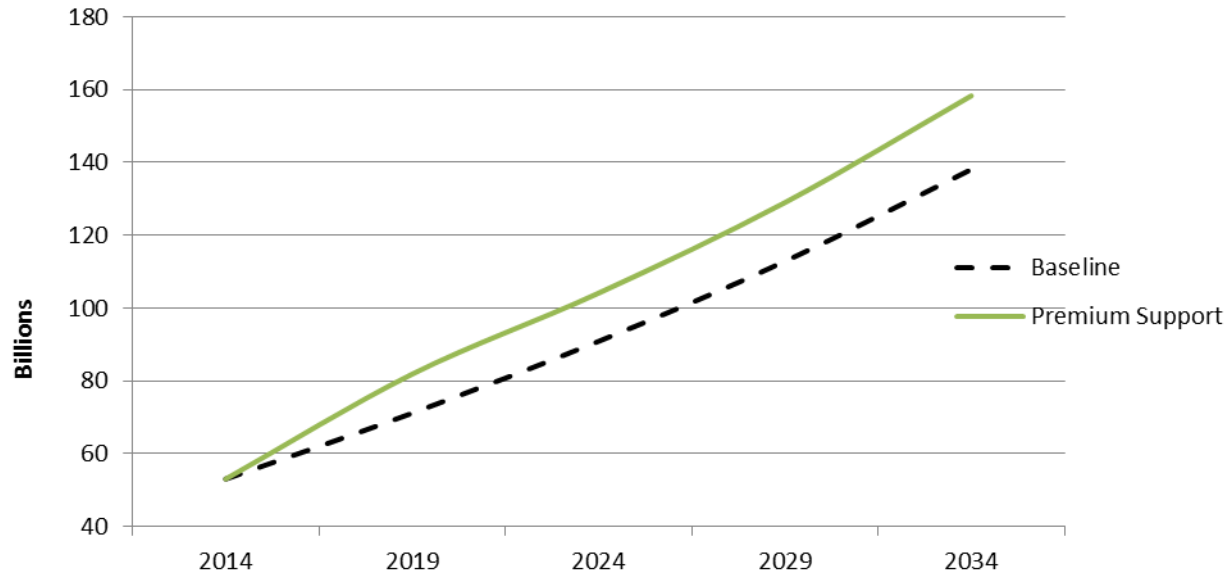
To determine participation rates in the subsidized premium program, we summarized enrollees' FY 2014 baseline data into cost brackets by attaching 2015 EHCPM unit costs to workload and then summarizing the total cost of workload provided to each enrollee. Overall, 42 percent of enrollees younger than age 65 were assumed to select the subsidized premium option, but the model assigned different rates of participation depending on enrollees' priority level and historical VA utilization. Enrollees with little to no costs were assumed to participate in the program at a higher rate as compared to those who had larger levels of VA costs. Participation rates for priority 5 veterans were assumed to be half the rates set for other priority levels. This assumption was made because many of these lower-income enrollees already have the option of participating in a highly subsidized state exchange plan with low cost sharing. It is also assumed that offering this option will motivate additional nonenrolled veterans to enroll to receive the subsidized premium plan. To estimate this effect, we analyzed the proportion of veterans by priority level with either no insurance or individual insurance plans, as reported in recent years of data captured by the American Community Survey (ACS). We estimated that this potential subsidy would lead to an additional 577,000 enrollees over the projection period.

Finally, it is assumed that the subsidized premium plan serves as a primary payer and does not supplement other coverage available to the enrollee, such as Medicare or employer sponsored insurance.

⁶⁷³ Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.

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Figure A-7. Projected Costs of Premium Support Scenario



Eligibility Expansion⁶⁷⁴

Under the *Eligibility Expansion* (EE) scenario, the VA health care system expands to allow all veterans to enroll in VA health care. In 2014, half of veterans eligible under priorities 1-7, 8b,⁶⁷⁵ and 8d were enrolled, representing a 50 percent *market share*,⁶⁷⁶ with the highest market share among those with service-connected priorities. The market share among Priorities 8a and 8c was an estimated 21 percent, reflecting enrollment from before suspension began in January 2003 and from enrollees who initially enrolled in another priority and later transitioned to Priorities 8a and 8c. If the suspension of new priority 8 enrollment had never occurred, we estimate that the market share would be 28 percent in 2014 and 30 percent in 2021 under natural growth and priority transition rates.

Under a scenario of lifting priority 8 enrollment suspension beginning in FY 2017, we estimate that the market share would climb steadily during a 5-year phase-in period to reach 30 percent in 2021, which equates to 464,000 new priority 8 enrollees. The market share is not expected to reach the level observed among other priorities because Priority 8 veterans have higher incomes, are not service-connected disabled, are more likely to have employer-sponsored coverage and individually purchased health plans, and are less likely to be uninsured relative to other priorities. Further, regression analysis of market shares among veterans in census data demonstrated that higher income veterans, nondisabled veterans and veterans with employer-sponsored health insurance are all less likely to enroll. To develop the cost estimates, newly

⁶⁷⁴ Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.

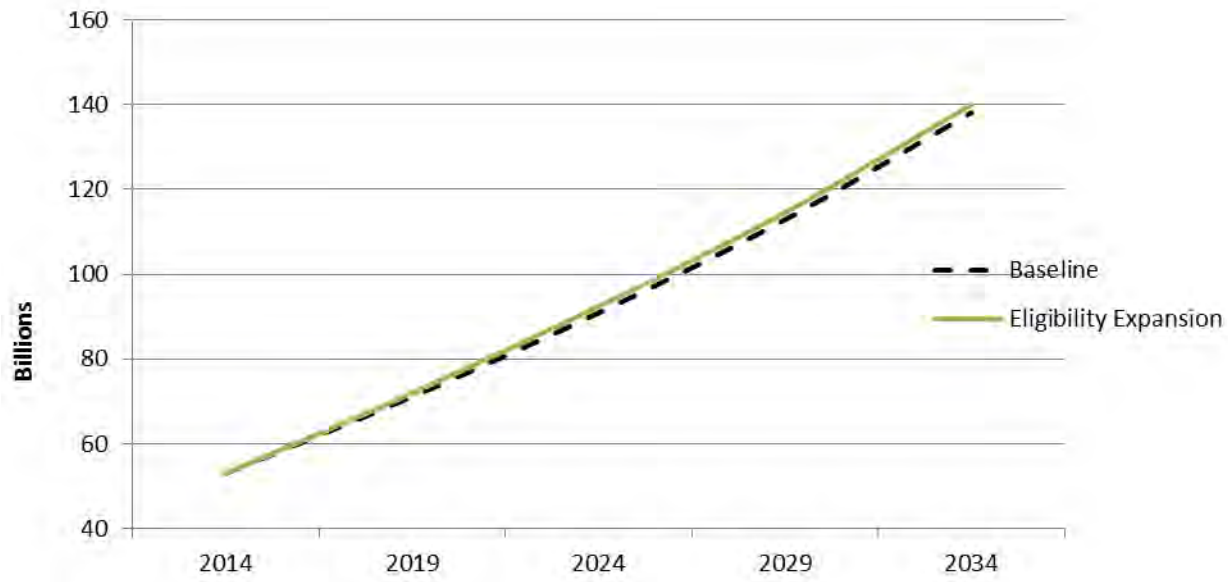
⁶⁷⁵ Priority 8b and 8d were enrolled on or after June 15, 2009 and have incomes that exceed the current VA or geographic income limits by 10 percent or less.

⁶⁷⁶ Market share is the percentage of veterans who are enrolled in VHA out of all veterans. This differs from the enrollment share, which is the percentage of eligible enrollees who are enrolled.

eligible priority 8 veterans are assumed to have the same morbidity and reliance as current priority 8 enrollees.

By 2032, based on the estimated market share, we project an additional 368,000 priority 8 enrollees with an additional \$1.8 billion in costs.

Figure A-8. Projected Costs of Eligibility Expansion Scenario



Additional Cost Factors

Nurse Navigators

VHA already has a robust care manager program that largely overlaps with the proposed nurse navigators in the CDS scenarios. VHA patient aligned care teams (PACTs) were created to coordinate care and maintain long-term relationships with patients. Most PACTs exist in a primary care setting, but there are also special-emphasis PACTs, such as those for spinal cord injury and disorders, geriatrics, and HIV care. All patients may choose to be assigned to a primary care PACT, and the vast majority do so: There are approximately 5.3 million unique patients in primary care PACTs out of a total of 5.8 million.

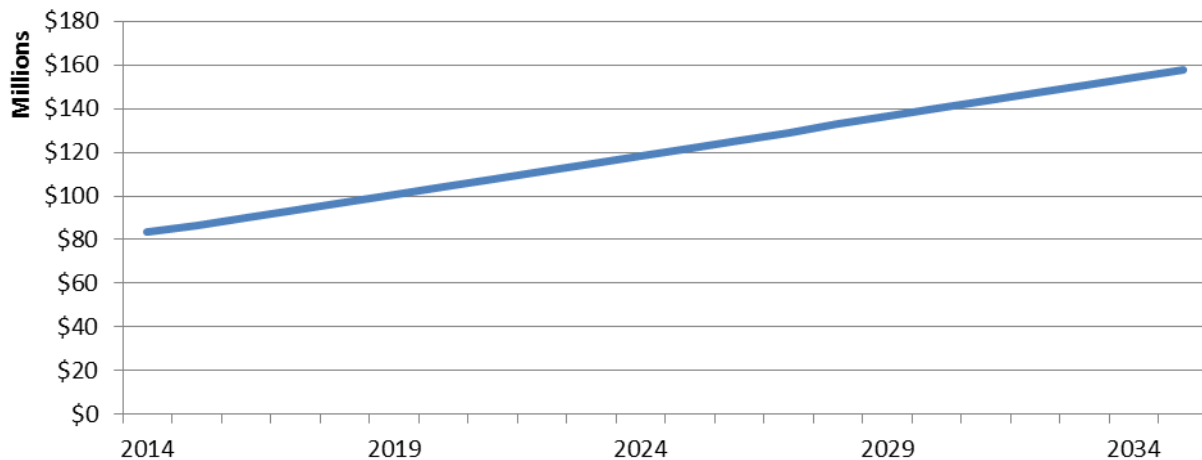
The primary care PACT typically consists of a provider, an RN care manager, a clinical associate, and a clerk. This team is assigned to a panel of approximately 1,200 patients. There are also expanded team members who are assigned to multiple panels, such as clinical pharmacy specialists, nutritionists, and behavioral health professionals. The RN care manager is the lynchpin of the primary care PACT.

One of the tasks of the care manager is to coordinate care received in VHA facilities with care received in the community. Because this coordination role would increase with the CDS scenarios, we provide a notional estimate for expanding the number of care managers to account for the additional administrative and clinical burden of an increase in community care.

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Based on discussions with VHA primary care operations and policy staff, we assume that one additional RN care manager per five panels would be necessary to handle a substantial increase in community care such as that associated with the CDS scenarios.⁶⁷⁷ Based on 2014 data on the number of patients in PACTs and the recommended panel size, we estimate that 882 RN care managers would need to be hired if the CDS scenarios were fully phased in. Incorporating the average total compensation of RN care managers (\$94.4 thousand in FY 2014) and inflating costs using the projected patient population and personnel inflation trend from the EHCPM, we generate the following cost estimates. These estimates are assumed to be fully phased in. The cost of this policy is \$100 million in 2019 and rises to \$158 million in 2034.

Figure A-9. Cost of Hiring Additional RN Care Managers



Other-than-Honorable Discharges

We also consider a policy for which those with an OTH discharge are made temporarily eligible for VA health care while their claims are adjudicated. The adjudication process would determine whether these individuals would remain eligible for care or would lose eligibility. Adjudication would be based on the reason for the discharge. For example, if the discharge were due to behavior associated with a mental health condition caused by serving in the military, that person would likely be positively adjudicated. However, the specific criteria for adjudicating cases still needs to be determined.

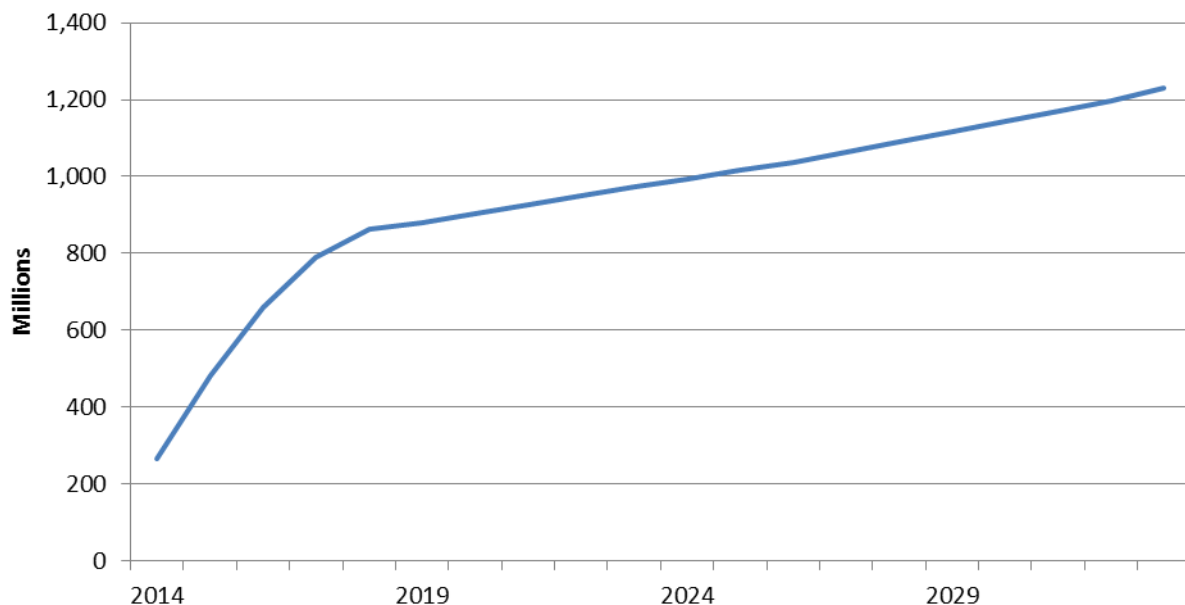
To model the cost of this proposal, we assume all people with an OTH discharge who would otherwise be eligible for VHA care are initially eligible. We assume that, consistent with the rest of the population, 73 percent of veterans with an OTH discharge are eligible for VA health care based on income and disability criteria. During a period of 5 years, their cases are examined, and 50 percent are positively adjudicated. Whether this number is actually higher or lower than 50 percent will depend on the exact details of the policy as well as the specific circumstances of veterans with an OTH discharge. In our model, the number of eligible veterans with an OTH discharge who enroll increases during the first 5 years as they become aware of the new rules. It

⁶⁷⁷ These estimates would differ depending on the CDS option pursued, but we provide a single notional estimate to give a sense of the magnitude of costs involved.

increases to 52 percent, which is the enrollment share of veterans who are currently eligible. In reality, this rate could be higher or lower for those with an OTH discharge if they are different from those who are already eligible. We assume costs per patient are similar to other veterans of the same age.

The cost of this policy increases from \$264 million in 2014 to \$1.23 billion in 2033. Fully phased-in, the cost is \$864 million in 2019. The shape of the cost curve reflects increasing enrollment during the first 5 years as veterans learn about the new rule and sign up. It also reflects adjudications as all enrolled veterans are initially eligible and then their eligibility is adjudicated during the 5 years. These calculations reflect estimates that the number of veterans with an OTH discharge for active duty military has fallen from a high of 8.8 percent in 2002 to 2.1 percent in 2015. We assume that the rate continues at 2.1 percent of discharges throughout the projection window.

Figure A-10. Projected Costs of Temporarily Covering Veterans with OTH Discharges



Conclusion

The estimated cost of allowing veterans to receive expanded community care through integrated networks varies dramatically depending on the specifics of the policy, including which categories of care are eligible for the community and whether referrals are required to access specialty care. We estimate that the *Recommended Option*, which provides increased community care that is reimbursed at Medicare allowable rates but maintains referrals for specialty care, increases costs modestly, assuming that networks are narrow and well-managed with cost as a major consideration. *CDS Alternative 1*, which offers a more restricted array of services eligible for CDS care, yet maintains a referral requirement, does not substantially increase costs. However, *CDS Alternative 3* and to a lesser degree *Alternative 2*, which eliminate the need for referrals for standard specialty care, potentially lead to very high costs. The estimated costs of the other scenarios range from small to substantial, though these costs would

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ultimately depend on the details of the proposals (e.g., the premium support schedule). Finally, we find that the costs of introducing expanded nurse navigators/care coordinators and making those with OTH discharge temporarily eligible are comparatively modest.

APPENDIX B: LEADERSHIP IMPLEMENTATION

Table B-1. Organizational Health and Cultural Transformation

Action	Responsible	Timeline
That VHA create a comprehensive, coordinated, sustainable cultural transformation effort by aligning programs and activities around a single, benchmarked concept.		
Establish the charter for the cross-functional SE team responsible for cultural transformation.	SECVA/DEPSECVA or CVCS depending on level	Now (0-6 mos)
Assess cultural transformation models and decide on a single model.	Chartered SE team	Now (0-6 mos)
Create an execution strategy for cultural transformation.	Chartered SE team	Now (0-6 mos)
Develop communication strategy and materials and release.	Chartered SE team	Near (18 mos)
That VHA aligns leaders at all levels in support of the cultural transformation strategy.		
Establish a subcommittee under the SE team to drive leadership transformation.	Chartered SE team	Near (6 mos)
Establish leadership standards for behaviors and actions.	Chartered SE team Subcommittee	Near (6-9 mos)
Publicize the standard.	Chartered SE team Subcommittee/CVCS/HTM	Near (12 mos)
Develop assessment tools.	SE Subcommittee/NCOD, NCEHC, HTM	Near (12-24 mos)
Establish expectations (in policy) for use of leadership standards in IDPs, performance review, hiring, promotions.	HTM/CVCS	Near (12-36 mos)
Provide coaching to the standard.	(Current HCM office responsible)	Near (24 mos)
Collect standards, training, support materials into a living curriculum for leaders.	EES/HTM	Near (24 mos)
Modify VA Directive 5021 (Employee/Management Relations) to include unacceptable behavior and unacceptable performance standards related to organizational transformation responsibilities of leaders and update table of penalties to correspond.	HRA/HTM	Future (36 mos)
That VHA align frontline staff in support of the cultural transformation strategy.		
Establish subcommittee to support staff transformation.	Chartered SE team	Near (9 mos)
Establish behavioral expectations/requirements for staff.	Subcommittee	Near (9-18 mos)
Develop hiring tools against the staff standard.	Subcommittee	Near (18-36 mos)
Establish requirements (in policy) for use of the standard for IDP, performance reviews, advancement in grade/promotions.	HTM/HRA/nursing and similar/unions	Near (18-36 mos)

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Action	Responsible	Timeline
Support leaders and supervisors at all levels of the organization to communicate and reinforce these standards with staff (see align leaders, above).	(Policy owner)	Near (18 mos)
Establish program office and VAMC standards and strategy for execution.		
Establish subcommittee to develop VAMC and PO execution standards.	Chartered SE team	Near (18 mos)
Establish execution strategy and policy requirements.	Chartered SE team Subcommittee/NCEHC/ NCOD	Near (18-36 mos)
Develop consolidated, meaningful metrics with input from experts and field users.		
Assign responsibility for metric development.	Chartered SE team/CVCS	Near (6 mos)
Develop and test metrics.	Organizational Excellence	Near (6-18 mos)
Deploy metrics.	Chartered SE team/CVCS/ (policy owner)	Near (18 mos)
Identify outliers and intervene.	SE team/CVCS/(policy owner)	Near (24 mos)

Table B-2. Recruitment, Retention, Development, and Advancement

Action	Responsible	Timeline
VHA executives are required to make the leadership system a top priority for funding, strategic planning, and investment of their own time and attention.		
Establish a VHA leadership management goal for inclusion in the 2018 budget with specific targets, including diversity targets.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (3 mos)
Submit the leadership management goal to VA for inclusion in the budget submission for 2018.	VHA OPP and CVCS	Now (3 mos)
Adopt VHA leadership management goal and submit to OMB/White House.	VA OPP and SECVA	Now (3 mos)
Establish an operational plan and accountability mechanisms for meeting these goals.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (4 mos)
Include yearly targets in the performance plan of the CVCS and SES members.	VHA NLC subcommittee on performance planning	Now (4 mos)
Schedule regular communication (at least quarterly) to the field that speaks to mission, vision, values, and expectations for ethical behavior.	CVCS	Now – ongoing
Schedule regular meetings with VHACO and field senior staff that allows for a discussion of mission, vision, values and expectations for ethical behavior.	CVCS	Now – ongoing
Develop opportunities for developing leaders to participate in the leadership and management decisions and processes of VHA.	CVCS /ask NLC executive committee to develop and implement a plan	Now (6 mos)
Adopt and implement a comprehensive system for leadership development and management.		
Convene a group to review ACHE and the National Center for Health Care Executives and devise a benchmarked model that meets the needs of health care executives in VHA as well as the private sector.	NCEHC with NCOD, & Human Capital Management; report to the NLC subcommittee for leadership development	Now (6 mos)
Create career tracks for key positions based on this new competency model.	HTM	Near (within 12 mos)
Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.		
Develop assessment tools (360, 180, self-assessment, supervisory) to support the competency model.	HTM with support as required from other offices, e.g., NCOD, EES	Near (within 18 mos)
Assess existing training against the model and identify gaps.	EES	Near (18 mos)
Develop and implement a plan to fill these gaps.	EES/reporting to NLC to ensure funding	Near (plan 20 mos – fill gaps 36 mos depending on \$)

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Action	Responsible	Timeline
Assess opportunities to share additional leadership training with DoD and create a plan to implement it.	HEC/JEC	Near (9 mos)
Develop and fund a face-to-face training to fulfill competencies for critical career positions.	EES	Near (24 mos)
Develop a masters level training program for clinical leaders in partnership with academic medicine.	EES/Academic Affiliations	Near (36 mos)
Establish sharing agreements with non-profit institutions to permit the exchange of executives for extended rotations.	EES/Academic Affiliations	Near (18 mos)
Create an experiential learning program to parallel the competency model.	EES, HTM reporting to the leadership development subcommittee of the NLC	Near (24 mos)
Establish a coaching program.	HTM/EES	Near (18 mos)
Incorporate tracking of competency assessment, training, coaching, and IDP completion into an appropriate IT platform (e.g., TMS).	HRA/EES/Workforce Management and Consulting	Near (18 mos)
VHA is required to aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: all hires and promotions are required to demonstrate these competencies.		
Create functional statements for all key positions based on the competency model.	HTM	Near (18 mos)
Create interview questions incorporating competencies for all key positions.	HTM	Near (12 mos)
Establish a process for certifying internal candidates for advancement to the next position.	Human Capital Management	Near (18 mos)
Incorporate the tracking of competency achievement with performance ratings and create a tracking mechanisms and pool of high potential candidates.	Human Capital Management	Near (18 mos)
Create regulatory requirements for the use of the competency model in hiring, promotion, development opportunities, and discipline; and incorporate procedures for veterans preferences.	Human Capital Management in VHA	Near (36 mos)
Establish an IDIQ, PBA or similar contract for executive recruitment.	Human Capital Management	Now (6 mos)
Establish requirement in policy for all ECF, SES / SES equivalent to complete IDP.	Human Capital Management	Future (following regulatory change)
Create on-ramp for retiring MTF.	Human Capital Management / DoD Coordination	Now (6 mos)
Expand (GHATP) program.	EES	Now (6 mos)
Establish a plan for developing and managing the candidate pool.	NLC subcommittee for leadership	Now (6 mos)
Require a formal on boarding process for leaders at all levels that re-enforces the leadership competency model.		
Establish an onboarding curriculum and process.	Human Capital Management, EES, HTM	Now and Near (18 mos)

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APPENDIX B
LEADERSHIP IMPLEMENTATION

Action	Responsible	Timeline
VHA is required to take immediate steps to stabilize the continuity of leadership.		
Extend authority for length of details and ability to compete for the detail position.	Human Capital Management	Now (6 mos)
Establish and fund assistant level positions in all key career development tracks.	CVCS	Now (18 mos)

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Table B-3. Organizational Structure and Function

Action	Responsible	Timeline
Eliminate duplication within VHA and consolidate program offices to create a flat structure.		
Eliminate the duplication of functions between VHA and VA by closing VHA offices.		
Create innovative organizational structures to support clinical delivery that are aligned to patient's needs rather than professional silos.		
Undertake a reduction-in-force (RIF) in VHACO that promotes delayering and efficiency in communication and decision making.		
Publish a new organizational chart consistent with Figure 9.	CVCS	Now (1 mos)
Prepare an initial RIF for offices eliminated.	VHA Human Capital Management	Now (3 mos)
Engage VERC (or other resources with expertise in business process reengineering) to re-design the processes and structures with remaining offices to ensure end-to-end support for field function and to further reduce duplication; including clinical function re-organization.	Transformation Office/ VERC	Near (3-12 mos)
Each program office in collaboration with VERC or other transformation resources identifies areas of "stop work" with staffing and budget savings.	Transformation Office/ PO/ CVCS	Near (3-12 mos)
Publish clear roles, responsibilities and expectations that apply to all VHACO offices.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VHACO staff to the new expectations for the role of VHACO.	Transformation Office/ EES	Now (1 mos)
Develop training curriculum to support VHACO staff in developing the skills and competencies required.	Transformation Office/ EES	Near (18 mos)
Develop an engagement strategy to inspire VHACO staff to embrace their new role and tie to in-service training roll out.	Transformation Office/ CVCS	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VHACO employees.	Transformation Office/ EES	Now (6 mos)
Adopt customer service training in VHACO and roll it out; include as part of new employee on-boarding in VHACO.	Transformation Office/ EES	Near (12 mos)
Draft basic competencies for VHACO program staff (e.g., customer service, quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ Each PO	Near (18 mos)
Acquire, configure, and train PO staff on data analytics infrastructure to support program office and field tracking of key performance metrics.	Office of Organizational Excellence/OIT	Near (18 mos)

APPENDIX B
LEADERSHIP IMPLEMENTATION

Action	Responsible	Timeline
Clarify and specifically define the roles and responsibilities of the VISNs and facilities, pushing decision making down to the lowest level.		
Publish clear roles, responsibilities and expectations that apply to the VISNs.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VISN staff to the new expectations for the role of VISN.	Transformation Office/ EES	Now (1 mos)
Develop an engagement strategy to inspire VISN staff to embrace their new role and tie to in-service training roll out.	VISN directors	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VISN employees.	Transformation Office/ EES	Now (6 mos)
Draft basic competencies for VISN staff (e.g., quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ each PO	Near (18 mos)
Gain agreement from Congress to institute three appropriation lines only: medical, major construction, research.	CVCS/SECVA/OMB	Near (12 mos)
Eliminate segregation of specific-purpose funds to the VISNs and facilities.	CVCS/Office of Finance	Now (6 mos)
Modernize financial management system (FMS) to permit effective cost accounting and tracking of priority spending.	OIT/Office of Finance	Future (36 mos)
Develop training to support effective use of FMS to permit effective account tracking and reporting and roll it out.	Finance/EES	TBD post procurement
Establish quarterly spend reports covering all priority areas (e.g., NRM, IT, facility minor, purchased care, mental health, women's health, administration) by facility and release to Congress and the public.	Finance Office	TBD post procurement
Delegate decisions in recruitment, retention and advancement (e.g., hiring bonus, retention bonus, market pay) for staffing to the facility.	CVCS/HCM	Now (1 mos)
Delegate training and travel decisions.	CVCS/EES/OAA	Now (1 mos)
The USH establishes leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue and collaboration.		
Improve communication with field leadership and frontline employees through the liberal use of social media, town halls and other direct engagement channels with a dedicated champion to help the USH and senior staff in this endeavor.	CVCS	Now (3 mos)
Reestablish in-person leadership conferences, at least semi-annually, to foster communication and relationship building between VHACO, VISN and facility leadership.	CVCS/EES/NLC	Now (6 mos)
Add behavioral competencies to performance plans that promote effective communication amongst leaders.	CVCS	Near (12 mos)

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Action	Responsible	Timeline
Establish expectations and requirements for program office leaders to communicate the USH leadership messages, coordinate PO communications with the USH and with one another.	CVCS	Now (3 mos)
Establish a transformation office with broad authority and a supporting budget to accomplish the change.		
Establish the new transformation office in the organizational chart, populate with expertise in business process re-engineering, and fund initially using savings from closure and consolidation of offices in VHACO and a budget reduction to all other VHACO offices.	CVCS	Now (6 mos)
Create a Transformation Office strategic plan to educate and provide guidance to the new initiatives and support the goals of VA and VHA.	Transformation Office	Near (3-6 mos)
Create a new initiative implementation plan to include follow-on priorities, tasks and milestones. The Transformation Office will support the operation and the plan moving forward.	Transformation Office	Near (3-6mos)
The Transformation Office will be responsible for evaluating all new initiatives and programs using the President's Management Agenda Scorecard or a model that emulates its rating standards of Green represents success; yellow for mixed results; and red for unsatisfactory. These ratings are indicative of standards of success or failure.	Transformation Office	Near (3-6mos)

Table B-4. Performance Metrics and Management

Action	Responsible	Timeline
Create a new performance management system for VHA leaders appropriate for health care executives.		
Establish a workgroup and engage outside experts to create the new performance management system that is benchmarked to private-sector models, is consistent with the new leadership competency model, and recognizes both leadership competencies and success in delivering strategic priorities. The model should include a new rating scale.	Transformation Office/Human Capital Management	Now (6 mos)
Develop and conduct training on the new performance management system for all participants to describe the system, rating process, and expectations.	Human Capital Management	Near (6-12 mos)
Establish a mechanism to capture performance assessment outcomes and track and manage high-potential staff.	Human Capital Management/HRA	Now (3 mos)
Establish a project plan to deliver annual guidance on performance plans at least a month in advance of the new fiscal year (i.e., at the start of the new rating period).	Human Capital Management/CVCS/Sec/OMB	Now (3 mos)
Hold raters accountable for creating meaningful distinctions between leaders.		
Provide training to raters on the application of the new performance management system and expectations for ratings.	Human Capital Management	Future (12 mos)
Require raters to establish plans for subordinates that are timely and meaningful; track and provide feedback on meeting this goal.	Human Capital Management/HRA	Now (3 mos)
By modeling the behavior and communicating the requirement, establish expectations that raters, and secondary-level raters, engage in continuous dialogue and coaching with subordinates about performance throughout the year, not just at mid-year and at the end of the rating period.	CVCS	Now (3 mos)
Establish oversight and feedback process for raters and incorporate this into the raters performance evaluation.	Human Capital Management/CVCS	Now (12 mos)
Provide coaching to raters and focused reviews if their rating profile doesn't provide meaningful distinctions in performance.	Supervisors	Near (12 mos)

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Table B-5. Leadership Implementation: Human Capital Management

Action	Responsible	Timeline
VA re-align HR functions and processes to be consistent with best practice standards of high-performing health care systems.		
Charge HRA to undertake an HR transformation study and ensure budget and solicitation of customer requirements.	SECVA/DEPSECVA	Now (0-6 mos)
Engage HR and change management experts to develop a benchmark human capital management plan for VA.	HRA	Now (0-6 mos)
Circulate new human capital plan for feedback and finalize.	HRA with input from VHA, Congress, OPM, OMB, SECVA/DEPSECVA, CVCS	Now (6 mos)
That VA and VHA leaders make transformation of Human Capital management a priority, with adequate attention, funding and continuity of vision.		
Endorse human capital management plan and ensure alignment of budget, IT system funding, training resources, and accountability mechanisms to support it.	SECVA/DEPSECVA and CVCS, as applicable	Near (9 mos)
Employ HR and change management experts to fully implement the transformation agenda and the new human capital management plan.	HRA	Near (12-30 mos)
Create an HR IT technology plan.	HRA & OIT	Near (9 mos)
Establish meaningful measures and risk indicators for VA human capital management.	HRA	Future (24 mos)
Incorporate HR measures into systematic reporting to leadership; and as appropriate into performance plans for key subordinate leaders.	HRA, DEPSECVA, CVCS as appropriate	Near (18 mos)
VA develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 Hybrid, Title 38 7306, and SES).		
Develop clear standards, guidelines, and training on progressive discipline.	HRA (with support from OPM)	Now (6 mos)
Managers, supervisors and HR professionals complete training.	SECVA/ DEPSECVA and CVCS (HTM office)	Near (12 mos)
Train HR staff to be coaches in progressive discipline.	HRA	Now (6-12 mos)
Establish performance metrics for HR professionals and client feedback mechanisms to ensure effective coaching and support for progressive discipline process.	HRA	Near (12 mos)
Establish performance expectations for VA supervisors and managers to apply the progress discipline process.	SECVA/ DEPSECVA, CVCS	Near (12 mos)

APPENDIX C: PILOT PROJECTS FOR EVALUATING EXPANDED CARE

As discussed in Recommendation #18, some Commissioners support the idea of developing pilot programs to test the feasibility of avoiding VA hospital closures by allowing veterans' spouses and currently ineligible veterans to purchase VA care in selected areas.

Problem

In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. This trend is driven by four main factors: (a) the overall decline in the size of veterans population, (b) the migration of veterans away from some parts of the country, such as New England and the Upper-Midwest, (c) the general trend in health care toward less intensive use of acute-care hospital beds, and (d) increased use of purchased care, which now accounts for 27 percent of all appointments.

A related challenge is maintaining safe volume of care when patient loads decline. As extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁷⁸

Simply closing a low-volume hospital is sometimes the answer. But closing a local VA hospital may mean that area veterans will have reduced access not only to routine, but also to specialty care related to their military service, such as for spinal cord or traumatic brain injuries. In many areas, such care is not available or is in short supply outside VHA.

At the same time, it may not be clinically feasible for VHA to engage in highly specialized care if it lacks the ability to offer other forms of care in the same setting. Patients in a polytrauma unit for example, require a full-spectrum of routine and nonroutine health care.

Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. Toward that end, VHA could develop pilot programs to test the feasibility of enabling veterans' spouses and currently ineligible veterans in these areas to purchase VHA care through their health plans. These pilots could be tested in conjunction with the growth of the high-performance, integrated VHA networks recommended elsewhere in this report. These networks will allow VHA far more flexibility than in the past to expand or contract its local capacity in different markets as appropriate.

⁶⁷⁸ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

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Background***Current Nonveteran Access to VHA Care***

VHA already treats many nonveterans. VHA estimates it treated 694,120 unique nonveteran patients at a total cost of \$1.9 billion in 2015,⁶⁷⁹ or 3.6 percent of total VHA obligations.⁶⁸⁰

By far the largest subgroup within the nonveteran patient population are participants in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA beneficiaries are the dependents of permanently and totally disabled veterans, survivors of veterans who died from service-connected conditions or while on active duty, or spouses of veterans who at the time of death were rated permanently and totally disabled from a service-connected condition.

Congress authorized CHAMPVA in 1973. The authorization specifies that VHA is the secondary payer for those with Medicare Part A and B coverage. In cases for which VA medical facilities are equipped to provide the care, VA may use facilities not being used for the care of veterans to provide services to the dependent or survivor.

Congress has also directed VHA to offer specific health care services to many other classes of nonveterans. These include mental health and counseling services for family caregivers of seriously injured veterans of post-9/11 service. Several provisions of law also authorize VA care for certain family members of veterans who were exposed to toxic substances. In the case of veterans with 50 percent or more service-connected disability, VHA must provide by law “consultation, professional counseling, marriage and family counseling, training and mental health services as are necessary in connection with” the veteran’s treatment.⁶⁸¹

Analysis

Others who have developed strategic plans for the long-term future of VA health care have recommended expanding upon these precedents, specifically by allowing currently ineligible veterans and the spouses of veterans to purchase VHA care.⁶⁸² In effect, providing such care would allow VHA to operate as an accountable care organization, capable of receiving reimbursement from patients covered by Medicare, Medicaid, as well as by private insurance plans. Among the potential benefits envisioned are the following:

- optimizing patient safety, productivity, and cost-effectiveness by ensuring sufficient patient volumes in currently under-utilized facilities
- preserving mission critical veterans’ programs that would otherwise need to be terminated in many parts of the country
- optimizing the integration of VHA and non-VHA care within communities

⁶⁷⁹ Allocation Resource Center, information provided to Commission on Care, December 8, 2015.

⁶⁸⁰ Department of Veterans Affairs, “Volume II: Medical Programs and Information Technology Programs, Congressional Submission, FY 2016 Funding and FY 2017 Advance Appropriations,” accessed May 27, 2016, <http://www.va.gov/budget/products.asp>.

⁶⁸¹ Counseling, Training, and Mental Health Services for Immediate Family Members and Caregivers, 38 U.S.C. § 1782.

⁶⁸² Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce*, accessed May 27, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>.

APPENDIX C
PILOT PROJECTS FOR EVALUATING EXPANDED CARE

- providing a *public option* for health care to a wider range of veterans as well as nonveterans in communities where health care choices are currently limited
- bringing in new sources of revenue to contribute to the funding for veterans' healthcare

The pilot projects described below would specifically evaluate whether such a strategy will allow VHA to optimize the quality and cost-effectiveness of its health care system by avoiding low volumes of routine and specialty care in certain sections of the country. These pilot projects would also allow VHA to evaluate whether such a strategy could provide new revenues for sustaining the VA health system while providing other benefits to veterans and the public at large.

The chart below sketches six possible pilot projects designed to test different specific policy configurations. The configurations include projects in which VA care is marketed to health care plans on fee-for-service (FFS) basis, and plans in which VA facilities are markets to health care plans as Accountable Care Organizations that provide integrated health services to a fixed population of insured patients for a fixed cost.

*Demonstration Projects to Assess VHA's Capability to Treat
Nonveteran Spouses and Ineligible Priority 8 Veterans*

	Eligibility	Capitation/Fee For Service	Timing
Demonstration 1: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) With Private Insurance	FFS	Years 2-7
Demonstration 2: FFS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance	FFS	Years 2-7
Demonstration 3: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) with private insurance	FFS	Years 3-8
Demonstration 4: FSS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance and/or Medicare	FFS	Years 3-8
Demonstrations 5 and 6: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses	Enrollment: May choose higher cost plan with more coverage and less copayment; lower cost option with less coverage and higher copayments.	Years 4-9

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	Eligibility	Capitation/Fee For Service	Timing
Demonstrations 7 and 8: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses with private insurance and/or Medicare	Enrollment: May choose higher cost plan with more coverage and less copayment; or lower cost option with less coverage and higher copayments. Pilot sites would be deemed Accountable Health Care Organizations for Medicare Advantage plans.	Years 5-10

Certification of Access: Any participating VHA facility must certify that its waiting times for primary care, specialty care and behavioral health are less than 30 days.

Site selection: Sites should include facilities in different regions with various population densities (urban, suburban, rural) and levels of service complexity. VHA may also consider such factors as stability of medical center leadership, and whether local markets are underserved or subject to high degrees of market concentration among either providers or payers.

Assumptions

- Many provisions are subject to Congressional authorization.
- Participating VHA facilities will be able to retain any “profit” associated with treatment of new users without offset;
- Congress will (preferably) waive the current prohibition on Medicare funding federal health care programs,
- VHA will not be subject to proving “level of effort” in order to receive Medicare funds

Assessment

After the first year of operations, VHA will assess these projects according the following criteria:

- Was access to care or patient satisfaction among veterans already enrolled in the system affected by the demonstration?
- What was the level of patient satisfaction among new users purchasing VA care?
- Did VHA cover the costs of delivering care to its patients purchasing care? If so, what were its net revenues and how were they used?
- If VHA collected Medicare funds, did funding cover costs of delivering care?

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- Were there administrative challenges in opening the VHA to new users? If so, what lessons were learned?
- How did VHA promote the demonstration project to those eligible?
- What are the recommended strategies for further implementation?
- Were there non-financial benefits to treatment of new users, such as diversifying case mix, providing sufficient volume to allow certain VHA services to remain available, or keeping scarce health professionals employed in an area that is medically underserved?
- How did the demonstrations affect the overall quality of care, market structure, pricing, and range of health care options available to both veterans and nonveterans in the surrounding community?

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APPENDIX D:

HISTORY AS A CONTEXT FOR SYSTEMIC TRANSFORMATION

History provides opportunities to see the problems and challenges facing VHA today through the lens of recurring themes from the past. Veterans' health care has, over the course of its history, been marked by periods of both progress and problems. Understanding the challenges of the past and the solutions used to address them provides context for building a plan for reforming veterans' health care in a manner that is flexible and sustainable.

Challenges and Growth

The federal government's role as a care provider for veterans has evolved, paralleling, to some extent, medicine's evolution. Prior to World War I, the only benefits afforded then-eligible veterans were pensions and domiciliary care (which involved only incidental medical treatment), provided under the National Home for Disabled Volunteer Soldiers and Sailors established after the Civil War.⁶⁸³

World War I brought real change. At the time, no single agency was responsible for the anticipated deluge of sick and wounded soldiers. The more than 200,000 wounded who returned home from battle quickly exceeded capacity of the U.S. Public Health Service (PHS), the National Home, and other agencies. According to one account of the period, "[c]haos and confusion reigned for more than two years . . . [n]ew hospital construction languished," and "[b]y 1921, veterans' care had become a national embarrassment."⁶⁸⁴ At the recommendation of a presidential committee, Congress passed legislation in 1921 to consolidate the several veterans-related bureaucracies into a single Veterans Bureau, to which the President Warren Harding transferred 57 PHS hospitals. A new administrator, Frank T. Hines, proposed care and treatment of veterans' non-service-connected ailments when facilities and bed space were available. Congress adopted the proposal in the World War Veterans Act of 1924.⁶⁸⁵

Under Hines' tenure, VA grew from 64 to 91 hospitals, nearly doubling bed capacity. Civil Service Commission personnel rules and low pay led to generally poor quality VA physicians, yet Congress rebuffed VA proposals to set up a VA Medical Corps.⁶⁸⁶ With many physicians having left VA to serve in World War II or for more lucrative practice, the VA health care system was left critically understaffed.⁶⁸⁷

⁶⁸³ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 4.

⁶⁸⁴ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 13-14.

⁶⁸⁵ *Ibid.*, 19.

⁶⁸⁶ *Ibid.*, 21.

⁶⁸⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 149.

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World War II and the need to care for millions of service members, including 671,000 wounded, highlighted the problems facing VA. Scathing reports of shoddy veterans' care, including an exposé characterizing veterans' hospitals as backwaters of medicine, magnified the problems.⁶⁸⁸

Congressional hearings led to a shakeup in leadership and General Omar Bradley was appointed to head the agency, with its network of 97 hospitals, and a need for more.⁶⁸⁹ Dr. Paul Magnuson, who served as VA's chief medical director (CMD) from 1948 to 1951, later described the conditions at the time:

The majority of Veterans Administration hospitals were stuck in far off places, some of them on Indian reservations, others as much as fifty miles from the nearest through-line railway stop. The doctors were all full-time Civil Service employees, hemmed in by regulations and practically forbidden to do any research, attend any medical meetings or otherwise keep in touch with scientific progress. Operating rooms closed at noon so everybody could spend the afternoon happily doing required paperwork, while patients waited days and weeks for surgery.⁶⁹⁰

With President Harry Truman's statement that "the Veterans Administration will be modernized," new VA leadership worked with Congress to pass far-reaching legislation, Public Law 293, which created a VA Department of Medicine and Surgery (DM&S), and freed VA physicians, dentists, and nurses from the Civil Service Commission and its rules.⁶⁹¹ Within weeks, the chief medical director of the new DM&S issued a policy memorandum that outlined a cooperative affiliation agreement between VA and medical schools under which deans' committees would recommend consultants and attending physicians for appointment to VA, and residency-training programs would be established at VA hospitals. The law, and Policy Memorandum #2, broke a recruitment logjam and enabled the short-staffed department to hire medical professionals needed for the dozens of new VA hospitals being built. Soon after, medical students and residents began working in 32 VA hospitals. The reforms instituted under Bradley and his team were palpable,⁶⁹² with the physician staff at VA hospitals increasing from 2,300 (1,700 of whom were detailed by the military) in June 1945 to 4,000 full-time staff a year later.⁶⁹³ By 1948, VA had 125 hospitals in operation with 60 medical school affiliations and 2,000 residents.⁶⁹⁴

After this turn-around, Bradley left to become Army Chief of Staff, and under his successor, "who did not enjoy the same level of prestige and support that Bradley did . . . VA quickly

⁶⁸⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 22.

⁶⁸⁹ Ibid., 23-25.

⁶⁹⁰ Ibid., 22.

⁶⁹¹ "31: The President's News Conference," Harry S. Truman Library & Museum, accessed June 3, 2016, <http://trumanlibrary.org/publicpapers/viewpapers.php?pid=38>.

⁶⁹² James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 27.

⁶⁹³ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 214.

⁶⁹⁴ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 28.

reverted to its pre-Bradley ways and remained that way for the next forty years,”⁶⁹⁵ according to one account.

By the early 1950s, the veteran population had grown to more than 20 million.⁶⁹⁶ VA was operating 162 hospitals, with an average census of more than 104,000 patients.⁶⁹⁷ A VA historian observed that “waiting lists contained 22,613 applicants awaiting admission, none of whom were service-connected, although some of the latter were hospitalized in other than VA hospitals.”⁶⁹⁸ At the time, non-service-connected veterans seeking care had to state under oath that they could not afford to pay for hospitalization, and admission was granted only when beds were available in VA or other federal hospitals.⁶⁹⁹ Critics called for reducing free medical care of non-service-connected veterans, and questioned whether some were getting care that they could afford. This issue led VA to institute a policy of formal counseling under which hospitals would supply the veterans with an estimated cost of care to assist them in determining their ability to pay.⁷⁰⁰

In contrast to the generous Bradley-era funding, the 1950s funding cuts necessitated layoffs, bed-closures, and moth-balling of newly constructed hospital wards.⁷⁰¹ During this period, annual debates over the DM&S budget centered on the number of beds VA should operate. VA leaders contended that the number should be 125,000, yet the director of the Bureau of the Budget (the predecessor to the Office of Management and Budget [OMB]) asserted 87,000 was sufficient.⁷⁰²

The expiration of the incumbent CMD’s term led to the appointment in 1955 of medical educator Dr. William Middleton, dean of the Wisconsin Medical School, and a long-time member of a VA special medical advisory group. One of his first acts as CMD was to champion medical research in VA and broaden its scope to include geriatric research. Soon after, Congress began earmarking funds for VA research, and expanded DM&S’ statutory role to include medical research.⁷⁰³ During Middleton’s tenure, from 1955 to 1963, VA research funding grew from some \$6 million to more than \$30 million.⁷⁰⁴ Middleton’s work laid the foundation for a research program long recognized for pioneering important medical technologies, including medical use of radioisotopes, dialysis, cardiac pacemakers, liver transplantation, as well as seminal studies that documented the benefits of coronary artery bypass surgery and drug treatment of hypertension.⁷⁰⁵ The program also stood out for its capacity to design and rapidly implement large-scale cooperative trials, first mounted in the 1950s with successful evaluation

⁶⁹⁵ Ibid., 29.

⁶⁹⁶ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 254.

⁶⁹⁷ Ibid.

⁶⁹⁸ Ibid.

⁶⁹⁹ Ibid., 253.

⁷⁰⁰ Ibid., 253-254.

⁷⁰¹ Ibid., 256.

⁷⁰² Ibid., 258.

⁷⁰³ Ibid., 262-263.

⁷⁰⁴ Ibid., 263-264.

⁷⁰⁵ Stanley Zucker et al., “Veterans Administration Support for Medical Research: Opinions of the Endangered Species of Physician-Scientists,” *The FASEB Journal*, 18, no. 13, (2004): 1481-1486, <http://doi.org/10.1096/fj.04-1573lfe>.

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of chemotherapy for tuberculosis.⁷⁰⁶ Working on issues relevant to veterans, VA researchers developed functional electrical stimulation systems to allow patients to move paralyzed limbs, helped develop the first ankle-foot prosthesis, and launched the largest-ever trial of psychotherapy to treat posttraumatic stress disorder.⁷⁰⁷

Middleton expanded the VA educational program. In addition to growing the number of medical residents it helped train, VA provided training to a large share of clinical psychologists, graduate dentists, student nurses, occupational and physical therapists, social work students, and dietetic interns. Middleton instituted numerous advances in VA care such as introducing outpatient care for preadmission workups and post-hospital treatment that allowed earlier release from inpatient stays. He moved VA away from operating hospitals for specific diseases (as had been done for tuberculosis and mental illness).⁷⁰⁸

The enactment of Medicare in 1965 raised questions about the effect that program would have on the VA health care system. The House Veterans Affairs Committee sent a questionnaire to a group of 10,000 veterans explaining the new program and asking the veteran to if they preferred VA care or treatment in a community hospital under Medicare.⁷⁰⁹ Some 59 percent responded, and nearly two-thirds of respondents preferred VA.⁷¹⁰ At the time, the policy governing those eligible for VA care based on financial need was that Medicare benefits were to be considered in determining an individual's ability to pay for needed care.⁷¹¹

The enactment of Medicare and other changes in health care in 1977, led to a commission being established by the National Academy of Sciences (NAS) which issued a report pursuant to a congressional directive to evaluate the VA health care system. Among its findings, the commission reported that VA had a surplus of acute beds and recommended that new facilities be constructed only after examining bed availability in the community. It also recommended that underutilized VA hospitals be closed or converted to long-term care facilities, and resources redistributed to permit a shift from inpatient to outpatient care. The NAS commission also recommended that VA experiment with models for community-based integrated care.⁷¹² The commission's recommendation for integrating the VA system into the nation's civilian health care program⁷¹³ provoked objection, particularly in Congress.⁷¹⁴ Hearings produced sharp rejections of the NAS commission findings and its call to end VA's role in providing health care to veterans.

⁷⁰⁶ Ibid.

⁷⁰⁷ Veterans Health Administration, *History of VA Research Accomplishments*, accessed June 3, 2016, http://www.research.va.gov/researchweek/press_packet/Accomplishments.pdf.

⁷⁰⁸ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 265-267.

⁷⁰⁹ Ibid., 390.

⁷¹⁰ Ibid.

⁷¹¹ Ibid.

⁷¹² *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs*, 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.

⁷¹³ J. William Hollingsworth and Philip K. Bondy, "The Role of Veterans Affairs Hospitals in the Health Care System," *New England Journal of Medicine*, 322, no. 10, (1990): 1851-1857, <http://doi.org/10.1056/NEJM199006283222605>.

⁷¹⁴ *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs*, 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.

The VA of the 1970s and 1980s is remembered as bureaucratic, reliant on paper health care records, and driven by patient admissions (on which budgets were based).⁷¹⁵ The quality of VA care was also an issue. Complaints from Vietnam veterans and critical media accounts fueled outrage, and led to the view that the system was broken. The question, how to fix it, reopened an earlier dialogue around making VA a cabinet-level department, a view strongly supported by veterans service organizations (VSOs) and veterans' leaders in the House of Representatives. In 1988, after years of debate, and opposition from administration offices and advisors, President Reagan signed legislation creating a Department of Veterans Affairs.⁷¹⁶ The new department, with DM&S now renamed the Veterans Health Services and Research Administration (to emphasize its research legacy in such fields as infectious disease, pacemaker technology, and prosthetics), employed some 194,000 people with a \$12 billion budget.⁷¹⁷

Facing an aging veteran population⁷¹⁸ expected to overwhelm the system by 2010, the new secretary, Edward Derwinski, in 1989 requested Congress establish an independent commission to review the alignment and mission structure of VA's hospitals. Congress rebuffed the request after VSOs, suspecting a plan to close hospitals, lobbied against it.⁷¹⁹ Derwinski created his own "Commission on the Future Structure of Veterans Health Care" that was to review all VA hospitals and recommend needed mission changes. Instead, the so-called Mission Commission called for expanding eligibility law to enable veterans to obtain the full continuum of VA health care services. Although the commission identified the need for fundamental restructuring of the VA health care system, the subject was soon overtaken by national health reform proposals, and what role VA might have under a universal coverage system.⁷²⁰

Dr. James Holsinger, a new under secretary for health (USH), made care quality a top goal and issued a Blueprint for Quality tool in 1992, setting the stage for more far-reaching changes instituted by his successor, Dr. Kenneth Kizer. Care quality, a perennial topic, had led to the previous under secretary's resignation following reports of multiple veterans' deaths under questionable circumstances at VA's North Chicago medical center.⁷²¹ Two years later, Derwinski lost his job after creating ire among veterans' organizations in response to his proposed pilot program to open two VA hospitals to poor, rural nonveterans.⁷²²

⁷¹⁵ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 30-31.

⁷¹⁶ Ibid., 33-40.

⁷¹⁷ Ibid., 50.

⁷¹⁸ As the General Accounting Office reported in 1990, "The Department of Veterans Affairs (VA) faces a major challenge: planning how to meet the long-term care needs of a rapidly aging veteran population. The number of veterans 65 years old and over is projected to grow to 9 million by 2000—a 50percent increase over the 1988 level.

U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), accessed June 20, 2016, <http://www.gao.gov/assets/150/149139.pdf>.

⁷¹⁹ U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), 51, accessed June 20, 2016, <http://www.gao.gov/assets/150/149139.pdf>.

⁷²⁰ U.S. Government Accountability Office, *Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Care Reform*, GAO/HEHS-95-14 (Washington, DC, 1994), accessed June 20, 2016, <http://archive.gao.gov/f0902a/153054.pdf>.

⁷²¹ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 53.

⁷²² "Angry Veterans Groups Say They Made Bush Oust Agency's Head," Eric Schmitt, accessed June 3, 2016, <http://www.nytimes.com/1992/09/29/us/angry-veterans-groups-say-they-made-bush-oust-agency-s-head.html>.

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Transformational Leadership

VA's second secretary, Jesse Brown, brought his passion as a veterans advocate to the department's leadership.⁷²³ Among Brown's most important early acts was selecting Dr. Kenneth Kizer, a prominent California physician-administrator and educator, from among 90 candidates identified by a search committee for the USH post.⁷²⁴ With experience heading the California department of public health, Kizer saw health care as a system, and data as a tool to improve it.⁷²⁵

Kizer, in essence, launched a major reengineering of the VA health care system through better use of information technology, measurement and reporting of performance, integration of services, and realigned payment policies.⁷²⁶ His vision was large and bold, underscored by his belief that "we have to be able to demonstrate that we have an equal or better value than the private sector, or frankly we should not exist."⁷²⁷ At VA, Kizer found a workforce trapped in a micro-managerial, command-and-control system in which there was little accountability.⁷²⁸ He set the tone for what was to come at a meeting with senior managers at which he stated,

*The old culture must give way to a new culture . . . that is based on innovation and creativity; a culture based on personal initiative and individual and collective accountability; a culture that is based on outcomes and heightened productivity; and a culture that is committed to change.*⁷²⁹

Among his first steps was the development of what was to become a Vision for Change, a new organizational model to restructure both field operations and central office management. At its core was the creation of 22 veterans integrated service networks, or VISNs, (replacing four regions which had been responsible for overseeing 40 to 45 hospitals each), with decision making shifted away from VA Central Office (VACO) to the new VISN directors. VISNs were to be the basic budgetary and planning unit, and to have staffs of no more than 7 to 10 employees.⁷³⁰ Each VISN was in charge of all the care provided to veterans in that network, and each was funded on a capitated basis rather than based on historical costs.⁷³¹ The VACO structure would be marked by its *flatness*, foregoing a tiered hierarchy.⁷³²

⁷²³ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 89.

⁷²⁴ *Ibid.*, 92.

⁷²⁵ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 50-51.

⁷²⁶ Ashish K. Jha et al., "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care," *New England Journal of Medicine*, 348, no. 22, (2003): 2218-2227, accessed June 20, 2016, <http://doi.org/10.1056/NEJMsa021899>.

⁷²⁷ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 51.

⁷²⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 97-8.

⁷²⁹ *Ibid.*, 105.

⁷³⁰ *Ibid.*, 110.

⁷³¹ "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation," Ashish K. Jha, accessed June 3, 2016, <https://psnet.ahrq.gov/perspectives/perspective/31>.

⁷³² James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 111.

The system Kizer and his team inherited was characterized by a multitude of problems.⁷³³ Kizer and his team literally reengineered the veterans' health care system based on a set of transformation strategies: to create management accountability, integrate and coordinate services, improve the quality of care, align system finances with desired outcomes, and modernize information management.⁷³⁴

Kizer also launched a technological revolution in VHA with deployment of a powerful electronic medical record,⁷³⁵ and development of systems such as medication bar-coding to tackle medical errors and ensure patient safety.⁷³⁶

Some of Kizer's successes involved winning support within the administration and from Congress for bold initiatives. He won a critical concession from OMB that VA savings could be reinvested into VA, permitting his transformation efforts to be funded through internal cost-savings rather than new funding,⁷³⁷ and garnered support from Congress for a dramatic reduction of acute care beds and for closing massive regional offices.⁷³⁸ These steps and congressional passage of legislation to reform health care eligibility laws paved the way for establishing universal primary care in VA and developing community-based clinics across the country.⁷³⁹

Sweeping Reform

During a 5-year period, Kizer dramatically changed almost every major VHA management system and improved operational performance through the use of performance measures and contracts. He closed nearly 29,000 acute care beds, merged 52 medical centers into 25 multi-campus facilities, reduced staffing by almost 26,000, opened more than 300 community-based outpatient clinics, and treated 24 percent more patients. In addition to bringing measurable quality into VA health care, Kizer achieved marked reductions in waiting times and medical errors.⁷⁴⁰

Kizer's tenure brought dramatically improved quality, service, and operational efficiency to VHA yet threatened powerful interests. As he noted, "...places like Florida, Arizona, and the

⁷³³ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 316, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷³⁴ Ibid., 318-323.

⁷³⁵ VA in 2006 won the Harvard Innovations in Government Award for its VistA system. James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 211.

⁷³⁶ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 157-165.

⁷³⁷ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 323, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷³⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 128-129.

⁷³⁹ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 319-320, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷⁴⁰ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 170.

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Sun Belt States were not getting their fair share [of funds] and their elected officials were unhappy about it. People from Pennsylvania and Illinois and New York were not about to give their money away, so there was this big disconnect.”⁷⁴¹ Kizer’s team developed a capitation system to more equitably allocate funds across the system. Aware of the political ramifications, he implemented incremental changes during a 2- to 3-year period to make them as painless as possible. But the congressional goodwill he had enjoyed unraveled when Kizer and his VISN directors began cutting and consolidating facilities to accommodate VISN funding cuts. The threat of hospital mergers and consolidations ultimately led several senators to block his confirmation to a second term.⁷⁴²

Under new eligibility reform law, all veterans became *eligible* for VA health care, though its authors did not envision that the system could or would serve all eligible individuals, or even all who might someday seek VA care. The law’s priority-based enrollment system was intended to give VA a tool to align demand for care with its funding level.⁷⁴³ The law instead unleashed political pressure to expand enrollment, opening the door to an influx of veterans who historically had not been VA health care users and many of whom were already covered under military retirement benefits, private insurance, or Medicare.⁷⁴⁴ That expansion led to a tremendous demand for prescription drug benefits by new enrollees and in 2003, Secretary Tony Principi ended enrollment for higher income (category 8) veterans “to keep the system solvent.”⁷⁴⁵ At about the same time, other related pressures led Principi to establish an advisory body, the Capital Asset Realignment for Enhanced Services (CARES) Commission, to develop a comprehensive capital asset plan. Principi cited the age of VA facilities and the changes in medical practice, but also reminded a congressional oversight committee of a 1999 Government Accountability Office finding that “maintaining obsolete or duplicative structures diverts \$1 million a day, every day, every year, away from the care of veterans.” Principi did not want to repeat Kizer’s experience and hoped to avoid political backlash.⁷⁴⁶

The CARES Commission released a final report in February 2004 that recommended relatively few actual facility closures, though it proposed substantial facility mission changes at a number of facilities.⁷⁴⁷ As the then USH later recounted, “CARES, like so many things in Washington, was well-intended, but it was derailed politically once it began moving toward actual targeted action within specific congressional districts.”⁷⁴⁸

Despite such defeats, Principi and VA under secretaries following Kizer met formidable challenges, left legacies, and saw the veterans’ health care system continue to be heralded for several years.⁷⁴⁹ A cascade of other events muddled, and even blackened, VHA’s reputation:

⁷⁴¹ Ibid., 133-134.

⁷⁴² Ibid., 168-169.

⁷⁴³ Veterans Affairs Comm., Veterans’ Health Care Eligibility Reform Act of 1996, H. R. Rep. No. 104-690 (1996), accessed June 3, 2016, <https://www.congress.gov/congressional-report/104th-congress/house-report/690/1>.

⁷⁴⁴ James Rife, *Not Your Father’s VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 193.

⁷⁴⁵ Ibid., 194.

⁷⁴⁶ Ibid., 195.

⁷⁴⁷ Ibid., 196.

⁷⁴⁸ Ibid.

⁷⁴⁹ “The Best Care Anywhere,” Phillip Longman, *Washington Monthly*, accessed June 3, 2016,

accounts of veterans' suicides (and an alleged cover-up); incompetent surgeries and patient deaths at a high-visibility VA medical center (VAMC); failed software acquisitions;⁷⁵⁰ hard-hitting inspector general audit reports on issues such as system flaws, quality of care issues, and lack of timely care that fueled congressional oversight and other constraints. The 2014 scandal that erupted at the Phoenix VAMC represented a decisive turning point and set the stage once again for transforming veterans' health care.

Among initial steps on that long road to transforming the system, the Senate in July 2014 unanimously confirmed Robert A. McDonald, former chief executive officer of Proctor & Gamble, as secretary of veterans affairs. With a business career of delivering better results, McDonald, along with DEPSECVA Sloan Gibson and USH Dr. David Shulkin, has been working to improve VA's health care system and service delivery, and to set a framework for long-term reform. Days after McDonald's confirmation, Congress passed the Veterans Access, Choice, and Accountability Act of 2014, omnibus legislation to improve veterans' access to care. This legislation established the *Choice Program*, mandated an independent assessment of VHA, and established the Commission on Care.

<http://www.washingtonmonthly.com/features/2005/0501.longman.html>. "Revamped Veterans Health Care Now a Model," Gilbert Gaul, accessed June 3, 2016, <http://www.washingtonpost.com/wp-dyn/content/article/2005/08/21/AR2005082101073.html>. "The Best Medical Care in the U.S.: How Veterans Affairs Transformed Itself—and What it Means for the Rest of Us," Catherine Arnst, accessed June 3, 2016, <http://www.bloomberg.com/bw/stories/2006-07-16/the-best-medical-care-in-the-u-dot-s-dot>.

⁷⁵⁰ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 216-217.

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APPENDIX E: THE EVOLVING HEALTH CARE INDUSTRY

Health care has evolved in major ways since the federal government began providing care to veterans after the Civil War, and it will continue to evolve substantially in the future. There are a number of factors that drive evolution in health care, such as population and lifestyle changes, changes within the various health care professions, medical and information systems technology, and systems changes in management and operations.⁷⁵¹ IBM Center for Applied Insight reports that there are 18 trends to watch in health care.⁷⁵² These trends closely encompass those highlighted below. The categories in which the trends fall mirror key topic addressed in the Commission's report to include data system interoperability (10 trends), consumer technology (two trends), health care providers (two trends), government regulations (two trends), and human resources and leadership (two trends). With health care changing so rapidly, and in so many different ways, it is imperative that veterans' health care continually evolve to remain aligned with current and future trends. This section highlights key trends that, based on past experience and current practice, will likely shape health care in the future, were considerations in formulating the Commission's recommendations, and will likely affect transformation of veterans' health care.

Emergence of Large Health Care Systems

The health care industry is moving away from stand-alone community hospitals that serve the needs of a local constituency to large, multiple-campus health care systems.⁷⁵³ The industry will see more high profile mergers and acquisitions in the second half of 2016.⁷⁵⁴ The December 2015 Health Research Institute's report indicates that well-known health care systems may have a market advantage as Americans are willing to travel further for care from a well-known system. This may explain the development and affiliation for Mayo Clinic in Arizona and Florida, and Cleveland Clinic opening in Florida. The report also states that although people are willing to drive for care they are not willing to pay prices higher than the local market. Because of increasing use of outpatient services and same-day surgery, facilities within these health care systems require fewer inpatient beds.⁷⁵⁵ With the advancement of psychotropic drugs, the perceived need for large mental hospitals has declined.⁷⁵⁶ Because of shorter recovery stays, increased outpatient services, telemetry and other monitoring programs, and new medical inventions, hospitals are now built as smaller facilities with parts or sections that can be quickly

⁷⁵¹ Lynn Etheredge, Stanley B. Jones, and Lawrence Lewin, "What is Driving Health System Change?" *Health Affairs*, 15, 4, (1996): 93-104.

⁷⁵² "Healthcare Internet of Things 18 Trends to watch in 2016," Bill Chamberlain, IMB Center for Applied Insights, March 1, 2016, accessed June 20, 2016, <https://ibmcai.com/2016/03/01/healthcare-internet-of-things-18-trends-to-watch-in-2016>.

⁷⁵³ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed April 29, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

⁷⁵⁴ Ibid.

⁷⁵⁵ Ibid.

⁷⁵⁶ "How Release of Mental Patients Began," Richard Lyons, accessed May 1, 2016, <http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all>.

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modified for future changes and medical advances.⁷⁵⁷ VHA will need to consider this trend in evaluating its current physical plant and planning for future facility needs.

Management Changes

As health care systems become increasingly complex, there is a need to manage these institutions using current management theories and models.⁷⁵⁸ During the past few decades, hospital and health care management changed from being managed by a traditional top-down model to continuous quality improvement models that respond to issues such as staff satisfaction, medication errors, safety matters, and wasteful use of supplies. To address errors, hospitals have implemented Six Sigma principles. To address waste, hospitals have implemented LEAN principles. Embracing these changes in management approach and implementing Six Sigma and LEAN principles will support VHA's transformational process.

Health Care Payment

The health care industry is in the midst of transforming its payment model away from a fee-for-service model to value-based payments, a system that drives improved health outcomes.⁷⁵⁹ This transformation is tied to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which health care experts expect to shape care delivery and payment reform across the U.S. health care system over the coming decades. Congress created MACRA as a transformative law to fast track the health care system's transition from a traditional fee-for-service payment model to new risk-bearing, coordinated care models.⁷⁶⁰ Because this legislation is still in rulemaking, it is premature for the Commission to weigh in on its potential effect on VA. The MACRA legislation expands the trend toward creation of accountable care organizations (ACOs) and bundled payments for care. ACO models have been reported to drive reduced hospitalization and generate cost savings.⁷⁶¹

Specialty Care Facilities

With changes in the federal payment for hospitals, some high-cost and longer-stay care treatments have been moving out of community hospitals to specialty hospitals. For example, long-term acute care hospitals primarily treat patients on ventilators; rehabilitation facilities treat short-term, post-acute patients who need primarily physical and occupational therapy services for orthopedic or stroke incidences; and cancer hospitals provide innovative treatments for Stage 4 cancer. As a result, community hospitals may no longer need beds to take care of these special patients. VHA will need to consider this trend in planning integrated care networks and evaluating its facility needs in conjunction with these networks.

⁷⁵⁷ "The Small Hospital of the Future," Shati Matambanadzo, accessed May 3, 2016, <http://www.healthcaredesignmagazine.com/article/small-hospital-future>.

⁷⁵⁸ "How to Solve the Cost Crisis in Health Care," Robert S. Kaplan and Michael E. Porter, accessed May 2, 2016, <https://hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care>.

⁷⁵⁹ "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, <http://www.nationalpartnership.org/issues/health/macra.html>.

⁷⁶⁰ "MACRA: Disrupting the health care system at every level," Deloitte, accessed June 23, 2016, <http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/macra.html>.

⁷⁶¹ "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, Inquisitr: Medicine, accessed May 2, 2016, <http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/>.

Outpatient Care and Lifestyle-oriented Venues for Care

With improvements in surgical procedures, many surgeries that required post-surgery hospital stays are now routinely performed in outpatient settings.⁷⁶² Many nonsurgical procedures are being performed in outpatient clinics as well, such as medical imaging, cardiac catheterization, substance abuse treatment, gastrointestinal screening and cancer treatment.⁷⁶³ As care that was once provided only in hospitals is now provided in specialized medical clinics, care that was once provided only in physicians' offices is now being provided in alternative settings. As reported in Health Affairs, "another health care trend consumers are using to save both time and money is that rather than making appointments with their doctors, they are choosing to use walk-in clinics."⁷⁶⁴ Many of these clinics are located in pharmacies, retail chains, or supermarkets, allowing consumers quick, convenient, less-costly care.⁷⁶⁵ Do-it-yourself health care is also a trend, with increasingly more people taking responsibility for their health care. Consumers are using smart phone apps to monitor vital signs, medication adherence, and even urinalysis.⁷⁶⁶ As part of a commitment to continuous improvement, VHA will need to consider alternative venues as it creates integrated health care networks.

Medical Technology

Medical technology companies create life-changing innovation, and "advanced medical devices and diagnostics allow people to live longer, healthier and more productive lives."⁷⁶⁷ In fact, during the past 30 years, medical advancements helped add five years to U.S. life expectancy and reduce fatalities from heart disease, stroke, and breast cancer by more than half.⁷⁶⁸ These advancements also yield savings across the health care system by replacing more expensive procedures, reducing hospital stays, and allowing people to return to work more quickly.⁷⁶⁹ Ensuring veterans receive care that employs cutting-edge technology will be an important part of establishing integrated care networks.

Telemedicine

According to the American Telemedicine Association, "telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status."⁷⁷⁰ Telemedicine includes a growing variety of applications and

⁷⁶² Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/21183845>.

⁷⁶³ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

⁷⁶⁴ "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, accessed May 2, 2016, <http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/>.

⁷⁶⁵ Ibid.

⁷⁶⁶ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

⁷⁶⁷ "Value of Medical Technology," Advanced Medical Technology Association, accessed May 2, 2016, <http://advamed.org/page/74/value-in-medical-technology>.

⁷⁶⁸ "Value of Medical Innovation," HealthCare Institute of New Jersey, accessed May 2, 2016, <http://hinj.org/value-of-medical-innovation/>.

⁷⁶⁹ Ibid.

⁷⁷⁰ "What is Telemedicine," American Telemedicine Association, accessed May 2, 2016, <http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VwFrqfkrJaQ>.

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services using two-way video, email, smart phones, wireless tools, and other forms of telecommunications technology. The use of telemedicine has spread rapidly and is now becoming integrated into hospitals, specialty departments, home health agencies, private physician offices, as well as consumers' homes and workplaces. The following are examples of how telehealth is being used:

- A specialist assisting the primary care physician in rendering a diagnosis might use interactive video or store-and-forward transmission of diagnostic images or information.
- Home-use devices might be used to remotely collect information such as vital signs, blood glucose, or heart electrocardiogram data and transfer it in real time to a home health agency or a remote diagnostic testing facility for interpretation.
- Consumers' internet and wireless devices might be used to obtain specialized health information or participate in online peer-to-peer support groups.

VHA already excels in the use of telehealth and should expand upon its work in this area.

Midlevel Practitioners

During the past few decades, new categories of health care professionals have become increasingly commonplace in hospital settings. For example, hospitalists, physicians who specialize in the practice of hospital medicine, take over when the community-based physician admits his/her patient to the hospital.⁷⁷¹ The hospitalist does not perform the surgery but rather takes on the monitoring of the hospital services needed by the patient. Another example is medical technicians, who monitor the specialized medical equipment and devices that previously were under the purview of nurses in specialty units such as intensive care units. The growing physician shortage has led to reliance on mid-level health care providers. According to the Centers for Medicare and Medicaid Services' National Provider Identifier dataset, there were approximately 106,000 practicing nurse practitioners and 70,000 practicing physician assistants in 2010.⁷⁷² Provider trends may play into ways VHA can address its current staffing shortage.

Electronic Patient Health Information

Health records have undergone transformation from free-form physician notes of the 17th century to electronic health records (EHRs) of the 21st century. Today, providers are using clinical applications such as computerized physician order entry systems; EHRs; and radiology, pharmacy, and laboratory systems to track patient care and progress. Health plans are providing access to claims and care management, as well as member self-service applications.⁷⁷³ These advances allow the medical workforce to be more mobile and efficient (i.e., physicians can check patient records and test results from wherever they are). Though their use comes with

⁷⁷¹ "Definition of a Hospitalist and Hospital Medicine," Society of Hospital Medicine, accessed May 2, 2016, http://www.hospitalmedicine.org/Web/About_SHM/Hospitalist_Definition/Web/About_SHM/Industry/Hospital_Medicine_Hospital_Definition.aspx.

⁷⁷² "The Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the United States," Agency for Healthcare Research and Quality, accessed May 2, 2016, <http://www.ahrq.gov/research/findings/factsheets/primary/pcwork2/index.html>.

⁷⁷³ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

inherent potential security and privacy risks, they will surely play a substantial role in shaping future health care.⁷⁷⁴ Interoperability of these sources of patient information will be a continuing key issue in private-sector, military, and veterans' healthcare organizations.

Population Health

Population health refers to considering incidence and prevalence of diseases in a given area to determine if the area or the environment is contributing to the illness. Physicians and other health care providers may look at a region's demographics to determine what types of care are needed within the population. For example, if 65 percent of the region is older than age 65, then a series of wellness programs that address the chronic care concerns of this population may be needed. From a population health perspective, communities and their respective populations are as important as the individual patients who comprise them when it comes to keeping residents healthy. For VHA, population health issues may revolve around populations of veterans who served in particular wars and operations and the respective injuries and illnesses associated with them.

Geriatric Care

In the United States and Western Europe the birth rate has slowed⁷⁷⁵ and people are living longer.⁷⁷⁶ Demographic researchers report that if an American makes it to age 65, he/she should have about 17 to 20 additional years of life.⁷⁷⁷ Nursing homes and assisted living facilities are now seeing increasingly more of residents' first-time admissions occurring at age 80 or older. Some congregate care retirement facilities report that even with admission in the 80s, the average life expectancy is another 12 or 13 years.⁷⁷⁸ The aging population accounts for increasingly more hospital admissions, and as a result, hospitals rely on more revenue from Medicare.⁷⁷⁹ The VHA beneficiary population mirrors the general U.S. population, and older veterans receiving care through VHA may be sicker than their private-sector counterparts.

Chronic Disease Care

Chronic conditions now account for more than 50 percent of the death rate. Acute problems had previously been the primary causes of death.⁷⁸⁰ Even HIV/AIDS has moved away from being considered an immediate death sentence, and now, with proper treatment, is considered by

⁷⁷⁴ "Summary of the HIPAA Privacy Rule," U.S. Department of Health and Human Services, accessed May 2, 2016, <http://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/>.

⁷⁷⁵ "Fact Sheet: The Decline in U.S. Fertility," Mark Mather, accessed May 2, 2016, <http://www.prb.org/publications/datasheets/2012/world-population-data-sheet/fact-sheet-us-population.aspx>.

⁷⁷⁶ National Center for Health Statistics, *Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities*, accessed May 2, 2016, <http://www.cdc.gov/nchs/data/abus/abus15.pdf>.

⁷⁷⁷ National Center for Health Statistics, *Life Expectancy at Birth, at Age 65, and at Age 75, by Sex, Race, and Hispanic Origin: United States, Selected Years 1900-2010*, accessed May 2, 2016, <http://www.cdc.gov/nchs/data/abus/2011/022.pdf>.

⁷⁷⁸ Kathleen Harris, *CCRC Resident Demographics and Health Care Utilization: An Analysis*, accessed May 3, 2016, <http://www.avpowell.com/docs/Fall1997.pdf>.

⁷⁷⁹ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

⁷⁸⁰ "Chronic Disease Overview," Centers for Disease Control and Prevention, accessed May 2, 2016, <http://www.cdc.gov/chronicdisease/overview/>.

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most to be a chronic disease.⁷⁸¹ The Centers for Disease Control reports that since 2014, more Americans are dying as a result of chronic conditions and diseases than from acute diseases. Most chronic diseases result from lifestyle choices. Lifestyle diseases result from choices that individuals make.⁷⁸² Health care systems invest resources in addressing lifestyle-related issues caused by behaviors such as smoking, using opiates, and overeating.⁷⁸³ Lifestyle diseases such as cancer caused by smoking, addiction caused by drug use, and diabetes caused by obesity, are costly to treat.⁷⁸⁴ Because lifestyle diseases change over time, they are important to consider in thinking about the future of veterans' healthcare. Treating chronic diseases can be costly because care is ongoing, and assuming this trend continues to become more prominent, it will affect the cost of care and how it is provided.⁷⁸⁵

Needs-based Health Care

The Affordable Care Act requires all not-for-profit hospitals to complete a survey of the community (community health needs assessment, or CHNA) to show what entities in the community will address identified needs (asset mapping) and then report on how the hospital will address these needs in a community health care implementation program (CHIP).⁷⁸⁶ Starting in 2016, hospitals must post these reports on their websites and conduct these evaluations every 3 years thereafter. Monitoring community health needs can lead to preventing or stopping the spread of disease. For example, scarcity of quality food has been documented to result in poor school attendance and increased illness.⁷⁸⁷ Some Americans simply have not been exposed to how to prepare vegetables and fruits because they live in areas that are called *food deserts*, where healthy foods are not readily available. Identifying such needs and how they will be addressed can help improve health for specific populations.⁷⁸⁸ In Washington, DC, such a health assessment led to new treatments and protocols for addressing the appearance of a rare strain of tuberculosis brought in by a group of legal immigrants.⁷⁸⁹ Using CHNA and CHIP could be part of VHA's ongoing planning process.

⁷⁸¹ Steven G. Deeks, Sharon R. Lewin, and Diane V. Havlir, "The End of AIDS: HIV Infection as a Chronic Disease," *Lancet*, 382, 9903, (2013): 1525-1533.

⁷⁸² "Lifestyle Choices: Root Causes of Chronic Diseases," Cleveland Clinic, accessed May 2, 2016, https://my.clevelandclinic.org/health/transcripts/1444_lifestyle-choices-root-causes-of-chronic-diseases.

⁷⁸³ D. B. Resnik, "Responsibility for Health: Personal, Social, and Environmental," *Journal of Medical Ethics*, 33, 8, (2007): 444-445.

⁷⁸⁴ "How to Save a Trillion Dollars," Mark Bittman, accessed May 2, 2016, <http://opinionator.blogs.nytimes.com/2011/04/12/how-to-save-a-trillion-dollars/>.

⁷⁸⁵ "Why We Need Public Health to Improve Healthcare," National Association of Chronic Disease Directors, accessed May 2, 2016, <http://www.chronicdisease.org/?page=WhyWeNeedPH2impHC>.

⁷⁸⁶ "New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act," Internal Revenue Service, accessed May 2, 2016, <https://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501%28c%29%283%29-Hospitals-Under-the-Affordable-Care-Act>.

⁷⁸⁷ "Hunger In Our Schools: Breakfast Is A Crucial 'School Supply' For Kids In Need," Tom Nelson, accessed May 2, 2016, <http://blogs.usda.gov/2015/03/03/hunger-in-our-schools-breakfast-is-a-crucial-school-supply-for-kids-in-need/>.

⁷⁸⁸ "The Capital's Food Deserts," Jeremy Moorhead, accessed May 3, 2016, <http://eatocracy.cnn.com/2012/03/14/the-capitals-food-deserts/>.

⁷⁸⁹ District of Columbia Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration, *District of Columbia HIV/AIDS, Hepatitis, STD, and TB (HAHSTA) Annual Report: 2010*, accessed May 3, 2016, http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2010_Annual_Report_FINAL_0_0.pdf.

Behavioral Health

Treatment for mental health, now more commonly referred to as behavioral health, has changed dramatically since a 1968 federal law required individuals be cared for in the least restrictive environment.⁷⁹⁰ This law led to an expectation that most patients would receive care in out-patient facilities. Recently legislation was passed that requires insurance companies to increase the amount of payment for behavioral health, which could add more patients to the health care system.⁷⁹¹ VHA is a leader in mental health treatment and should continue to be a trendsetter in this regard.

Preventive Medicine

Traditionally, physicians were trained to cure illness and to restore the sick to health. The trend, however, is changing, and physicians are now trained in prevention and are more active participants in the prevention of illness.⁷⁹² Additionally, insurance and Medicare now cover preventive care and annual physicals, further supporting prevention.⁷⁹³ Preventive medicine is a key component of integrated health care and will need to be considered as VHA works to transform veterans' healthcare.

Pharmacy Changes

Health Affairs reports that "in 2015 . . . an alarming trend of new high-cost specialty pharmaceuticals entered the market. . . . Overall drug spending increased 12.2 percent last year, the highest rate of increase in more than a decade."⁷⁹⁴ Escalating drug prices account for some of this increase, including more than 3,500 generic drugs that at least doubled in price from 2008–2015 and about 400 drugs that increased in cost 1000 percent.⁷⁹⁵ Newly emerging and very expensive developments in the area of genomic medication also contribute to the increase. "One way to combat skyrocketing prices will be biosimilar drugs. These drugs are near substitutes for original brand drugs and could bring significant price discounts."⁷⁹⁶ Because many of VHA's beneficiaries seek only prescription benefits, prescription drug trends will be important to consider in the transformation process.

⁷⁹⁰ "How Release of Mental Patients Began," Richard Lyons, accessed May 2, 2016,

<http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all>.

⁷⁹¹ "Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)," Substance Abuse and Mental Health Services Administration, accessed May 2, 2016, <http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>.

⁷⁹² "Opinion 8.075 – Health Promotion and Preventive Care," American Medical Association, accessed May 2, 2016, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8075.page>.

⁷⁹³ "Preventive Services Covered Under the Affordable Care Act," U.S. Department of Health and Human Services, accessed May 2, 2016, <http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/>.

⁷⁹⁴ Anne Martin et al., "National Health Spending In 2014: Faster Growth Driven By Coverage Expansion And Prescription Drug Spending," *Health Affairs*, 35, 1, (2016): 150-160.

⁷⁹⁵ "Generic Drug Prices Quickly on the Rise," Anthony L. Komaroff, accessed May 2, 2016, <http://www.spokesman.com/stories/2016/feb/18/generic-drug-prices-quickly-on-the-rise/>.

⁷⁹⁶ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

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APPENDIX F: THE COMMISSION'S PROCESS

Commission Meetings

From September 2015 to June 2016, the Commission held convened 12 sessions of public meetings (26 days). The content addressed at each meeting is listed in the following table.

September 21-22, 2015

Assessment A: Demographics	RAND Corporation <ul style="list-style-type: none"> Christine Eibner
Assessment B: Health Care Capabilities	RAND Corporation <ul style="list-style-type: none"> Peter Hussey, PhD
VA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> Bob McDonald, Secretary Sloan Gibson, Deputy Secretary David Shulkin, MD, Under Secretary for Health
Assessment C: Care Authorities	RAND Corporation <ul style="list-style-type: none"> Michael D. Greenberg
Assessment I: Business Processes	Grant Thornton LLP <ul style="list-style-type: none"> Lane Jackson Aamir Syed Sharif Ambrose
Assessment E: Scheduling Workflow	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Alex Harris Pooja Kumar
Assessment F: Clinical Workflow	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Gretchen Berlin
Assessment G: Staffing/Productivity/Time Allocation	Grant Thornton LLP <ul style="list-style-type: none"> Peter Erwin, PhD Hillary Peabody Erik Shannon
Assessment J: Supplies	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Robin Roark, MD
Assessment K: Facilities	McKinsey & Company <ul style="list-style-type: none"> Vivian Riefberg John Means

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September 21-22, 2015 (continued)

VHA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning
Assessment Leadership	CMS Alliance to Modernize Health care <ul style="list-style-type: none"> Stephen Kirin Jay Schnitzer, PhD, MD McKinsey & Company <ul style="list-style-type: none"> Vivian Riefberg
Assessment H: Health IT	MITRE Corporation <ul style="list-style-type: none"> Aparna Durvasula Glenn Himes McKinsey & Company <ul style="list-style-type: none"> Celia Huber Vivian Riefberg

October 6, 2015

Eligibility	Veterans Health Administration <ul style="list-style-type: none"> Stephanie Mardon, Chief Business Officer Kristin Cunningham, Director, Business Policy Affairs
2014 Choice Act/2015 Enhancement to Choice/Care in the Community, Current State	Veterans Health Administration <ul style="list-style-type: none"> Stephanie Mardon, Chief Business Officer Kristin Cunningham, Director, Business Policy Affairs
Future State of VA Community Care/ Care in the Community	Veterans Health Administration <ul style="list-style-type: none"> Joe Dalpiaz, Director, VISN 17 Baligh Yehia, MD, Senior Health Advisor to the Secretary of Veterans Affairs Gene Migliaccio, Deputy Chief Business Officer, Managed Care
Academic Affiliations	Veterans Health Administration <ul style="list-style-type: none"> Robert Jesse, MD, Chief, Office of Academic Affiliations Karen Sanders, MD, Deputy Chief, Office of Academic Affiliation Long-Term Care Richard Allman, MD, Chief Consultant, Geriatrics and Extended Care Services

October 19–20, 2015

Independent Assessment, Perspective on VA Health Care, and Q&A/Panel Discussion	<ul style="list-style-type: none"> ▪ Brett Giroir, MD, Senior Fellow, Health Policy Institute, Texas Medical Center ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE ▪ Jonathan Perlin, MD, Chief Medical Officer and President, Clinical Services at Hospital Corporation of America
Women's Health	Veterans Health Administration <ul style="list-style-type: none"> ▪ Patricia Hayes, PhD, Chief Consultant, VA Women's Health Services
Mental Health	Veterans Health Administration <ul style="list-style-type: none"> ▪ David Carroll, Executive Director, Mental Health Operations ▪ Harold Kudler, MD, Chief Mental Health Consultant
Homelessness	Veterans Health Administration <ul style="list-style-type: none"> ▪ Anne Dunn, Deputy Director, VHA Homeless Program Office
Assessment D: Access	Institute of Medicine <ul style="list-style-type: none"> ▪ Michael McGinnis, MD ▪ Marianne Hamilton Lopez
VACAA Section 203	Northern Virginia Technology Council <ul style="list-style-type: none"> ▪ Ken Mullins
Scheduling	Veterans Health Administration <ul style="list-style-type: none"> ▪ Michael Davies, MD, Executive Director of Access and Clinic Administration Program
MyVA Support Services Excellence Overview	Department of Veterans Affairs <ul style="list-style-type: none"> ▪ Bob Snyder, Executive Director, MyVA Task Force ▪ Tom Muir, Director, Support Services

November 16–17, 2015

Health Care Economics/Finance	<ul style="list-style-type: none"> ▪ Mark Yow, Acting Chief Financial Officer, VHA ▪ Paul Mango, McKinsey & Company ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE
Academic Affiliations	Association of American Medical Colleges <ul style="list-style-type: none"> ▪ Atul Grover, PhD, MD, Chief Public Policy Officer ▪ John E. Prescott, MD, Chief Affiliations Officer ▪ Matthew Schick, JD, Director, Government Regulations & Regulatory Counsel
VHA Clinical Matters	Veterans Health Administration <ul style="list-style-type: none"> ▪ Lucille Beck, PhD, Deputy Chief Patient Care Services Officer, Rehab and Prosthetic Services ▪ Donna Gage, PhD, RN, Chief Nursing Officer

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December 14-16, 2015

Minority Affairs and Health Equity	<p>Department of Veterans Affairs</p> <ul style="list-style-type: none"> Barbara Ward, Director, Center for Minority Affairs <p>Veterans Health Administration</p> <ul style="list-style-type: none"> Uchenna S. Uchendu, MD, Executive Director, Office of Health Equity
Framework for the Future of Veterans Health	<ul style="list-style-type: none"> Garry Augustine, Disabled American Veterans Carl Blake, Paralyzed Veterans of America Carlos Fuentes, Veterans of Foreign Wars Ray Kelley, Veterans of Foreign Wars
Veteran Service Organizations	<ul style="list-style-type: none"> Louis Celli, The American Legion Renee Campos, Military Officers Association of America
National Health Information Operability	<ul style="list-style-type: none"> Dr. Jon White, Deputy National Coordinator, Department of Health and Human Services
DoD I Procurement: Lesson Learned/Interagency Program Office	<ul style="list-style-type: none"> Chris Miller, Program Executive Officer, Defense Health Care Management Systems, Department of Defense
Health Information Exchange	<ul style="list-style-type: none"> Elaine Hunolt, Do-Director Interoperability Office, Veterans Health Administration Dr. Harry Leider, Chief Medical Officer, Walgreens James Wood, VP-Federal, Walgreens Mariann Yeager, Chief Executive Officer, The Sequoia Project
Vision for OI&T/Collaboration with VHA	<ul style="list-style-type: none"> LaVerne Council, Chief Information Officer, Department of Veterans Affairs
Leadership and Transformation	<ul style="list-style-type: none"> Charles Rossotti, Former Commissioner, Internal Revenue Service

January 19 and 21, 2016

VHA Leadership	<ul style="list-style-type: none"> Dr. Michael Kussman, former Undersecretary for Health, Veterans Health Administration Dr. Kenneth Kizer, former Undersecretary for Health, Veterans Health Administration
Labor Perspectives	<p>American Federal of Government Employees</p> <ul style="list-style-type: none"> Marilyn Park <p>National Association of Veterans Affairs Physicians and Dentists</p> <ul style="list-style-type: none"> Samuel Spagnolo <p>Nurses Organization of Veterans Affairs</p> <ul style="list-style-type: none"> Joan Clifford Sharon Johnson

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January 19 and 21, 2016 (continued)

Behavioral Health	<ul style="list-style-type: none"> Association of Veterans Affairs Psychologist Leaders <ul style="list-style-type: none"> Thomas Kirchberg Russell Lemle Edgardo Padin-Rivera Antonette Zeiss American Psychiatric Association <ul style="list-style-type: none"> Jenny L. Boyer Association of Veterans Affairs Social Workers <ul style="list-style-type: none"> LeAnn Bruce Jerry Satterwhite
Homeless Veterans	<ul style="list-style-type: none"> Keith Armstrong, San Francisco Veterans Affairs Health care System
Other-Than-Honorable Discharges	<ul style="list-style-type: none"> Branford Adams

February 8-9, 2016

Construction Management	<ul style="list-style-type: none"> Lisa Freeman, Medical Center Director, Palo Alto Health care System
VISN and Field Leadership Perspectives	<ul style="list-style-type: none"> Joleen Clark, Former Network Director, VISN 8 Jon Gardner, Former Medical Center Director, Tucson VA Medical Center Lisa Freeman, Medical Center Director, Palo Alto Health care System
Implementation of the <i>Choice Program</i>	<ul style="list-style-type: none"> Billy Maynard, President HealthNet Federal Service David J. McIntyre, Jr., President and Chief Executive Officer, TriWest Healthcare Alliance
Update on VHA	<ul style="list-style-type: none"> Dr. David Shulkin, Undersecretary for Health, Veterans Health Administration
Determining Feasibility	<ul style="list-style-type: none"> Patrick Ryan, Former Staff Director and Chief Counsel, House Veterans Affairs Committee

February 29 – March 1, 2016

Economist Briefing	<ul style="list-style-type: none"> Gideon Lukens, PhD, Staff Economist Jamie Taber, PhD, Staff Economist
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March 21-23, 2016

Conversation with HVAC Chairman	<ul style="list-style-type: none"> Rep. Jeff Miller (R-FL)
Conversation with HVAC Member	<ul style="list-style-type: none"> Rep. Beto O'Rourke (D-TX)
Veterans Health Administration	<ul style="list-style-type: none"> Dr. David Shulkin, Undersecretary for Health Barbara Manning, Office of Policy and Planning Lyn Stoesen, Office of Policy and Planning

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March 21-23, 2016 (continued)

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Merideth Randles, FSA, MAAA, Milliman, Inc.
- Jamie Taber, PhD, Staff Economist

April 18-19, 2016

Veterans Service Organizations

- Garry Augustine, Disabled American Veterans
- Peter Dickinson, Disabled American Veterans
- Verna Jones, American Legion
- Rick Weidman, Vietnam Veterans of America
- Bill Rausch, Got Your 6
- Ray Kelley, Veterans of Foreign Wars
- Rene Campos, Military Officers Association of America

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Jamie Taber, PhD, Staff Economist

VA Leadership

Department of Veterans Affairs

- Bob McDonald, Secretary
- Sloan Gibson, Deputy Secretary

Community Care

- Baligh Yehia, MD, Assistant Deputy Under Secretary for Community Care, VHA

May 9-11, 2016

VA Office of General Counsel

- Leigh Bradley, General Counsel
- Jessica Tanner, Staff Attorney

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Jamie Taber, PhD, Staff Economist

June 7-8, 2016

No speakers

Commission Workgroups

The Commission on Care organized itself into workgroups in order to complete an analysis of relevant issues, consider options, and suggest recommendations to the full Commission for debate. The Commission formed five workgroups with each responsible for sections of the Independent Assessment or other topics taken on by the group. In establishing each workgroup an effort was made to balance perspectives and expertise, although Commissioners expressed interests were also taken into account in forming the membership of each group. The membership of each workgroup and the topics taken on by each is summarized in Table F-1.

Table F-1. Workgroup Structure and Topics

WORKGROUP NAME	TOPICS	MEMBERSHIP	
Health Care Alignment	<ul style="list-style-type: none"> ▪ Demographics ▪ Health care Capabilities ▪ Care Authorities ▪ Access Standards ▪ Governance 	<ul style="list-style-type: none"> ▪ Blecker ▪ Johnson ▪ Longman ▪ Selnick 	<ul style="list-style-type: none"> ▪ Gorman ▪ Khan ▪ McClenney
Health Care Operations	<ul style="list-style-type: none"> ▪ Access Standards ▪ Workflow Scheduling ▪ Workflow Clinical ▪ Staffing Productivity 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Harvey ▪ Longman ▪ Webster 	<ul style="list-style-type: none"> ▪ Gorman ▪ Hickey ▪ Taylor
Health Care Data, Tools & Infrastructure	<ul style="list-style-type: none"> ▪ Health IT ▪ Business Processes ▪ Supplies ▪ Facilities 	<ul style="list-style-type: none"> ▪ Blom ▪ Harvey ▪ Steele 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Johnson ▪ Taylor
Health Care Leadership	<ul style="list-style-type: none"> ▪ Organizational Health ▪ Leadership Systems 	<ul style="list-style-type: none"> ▪ Blecker ▪ Hickey ▪ Selnick ▪ Steele 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ McClenney ▪ Schlichting
Health Care Trends	<ul style="list-style-type: none"> ▪ Market Trends ▪ Technology ▪ Financing ▪ Vision 	<ul style="list-style-type: none"> ▪ Blom ▪ Johnson ▪ Schlichting 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Khan ▪ Webster

Each workgroup, together with any staff assigned to it, reviewed the findings and recommendations of the Independent Assessment and the Integrated Report; investigated external benchmarks and best practice models; heard testimony in public meetings (with the full Commission); met in workgroup session with VA employees, leaders, former staff and external experts to gather additional insights and explore relevant questions. Commissioners reviewed white papers and strawman proposals prepared by staff and by one another. Based on the assessments and group deliberations, each workgroup developed recommendations for consideration by the full Commission. Details of the process and outputs from each workgroup are described in the following sections.

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Health Care Alignment Workgroup

The alignment workgroup organized its work around six main topics: governance, realignment of facilities and services, medical sharing, eligibility, other than honorable discharges, and the organization of provider networks. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic was introduced through a summary paper or summary points which then were used as the basis for a conference call or a face-to-face discussion. For most topics, subsequent calls were held to discuss more detailed papers or to re-visit outstanding issues not yet resolved.

Commissioners also reviewed draft papers and provided additional feedback, revisions, and comments through written comments. The papers were finalized for inclusion in the draft Commission report for discussion on April 19. A summary of the work completed on each topic is provided in the table below.

Table F-2. Alignment Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E=email review M=face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Governance	11/17/2015	M	Vivian Riefberg	9/22/2015	F
	1/7/2016	C	Stephen Kirin	9/22/2015	F
	1/28/2016	C	Jay Schnitzer	9/22/2015	F
	2/18/2016	C	Paul Light	10/30/2015	S
	3/3/2016	C	Charles Rossotti	12/16/2015	F
	3/10/2016	C	Michael Kussman	1/19/2016	F
	3/17/2016	C	Ken Kizer	1/19/2016	F
	4/7/2016	C	Jeff Miller	3/21/2016	F
Realignment of Facilities and Services	1/7/2016	C	Vivian Riefberg	9/22/2015	F
	1/28/2016	C	John Means	9/22/2015	F
	3/10/2016	C			
	3/17/2016	C			
	4/7/2016	C			
Medical Sharing	1/28/2016	C	Atul Gover	11/16/2015	F
	3/3/2016	C	John Prescott	11/16/2015	F
	3/10/2016	C	Mathew Schick	11/16/2015	F
	3/17/2016	C			
	4/7/2016	C			
Eligibility	11/17/2015	M	Christine Eibner	9/21/2015	F
	12/10/2015	C	Michael Greenberg	9/21/2015	F
	1/28/2016	C	Pat Vandenberg	9/21/2015	F
	2/25/2016	C	Stephenie Mardon	10/6/2015	F
	3/10/2016	C	Kristin Cunningham	10/6/2015	F
	3/17/2016	C	Gail Wilensky	10/19/2015	F
	4/7/2016	C	Michael McGinnis	10/20/2015	F
			Marianne Hamilton Lopez	10/20/2015	F
			Michael Kussman	1/19/2016	F
			Jeff Miller	3/21/2106	F

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E=email review M=face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Other-Than-Honorable Discharge	1/28/2016	C	Bradford Adams	1/20/2016	F
	2/18/2016	C			
	3/10/2016	C			
	3/17/2016	C			
	4/7/2016	C			
Organization of Provider Networks	1/28/2016	C	Peter Hussey	9/21/2015	F
	2/25/2016	C	Joe Dalpiaz	10/6/2015	F
	3/10/2016	C	Baligh Yehia	10/6/2015	F
	3/17/2016	C	Gene Migliaccio	10/6/2015	F
	4/7/2016	C	Michael Kussman	1/19/2016	F
			Jon Gardner	2/8/2016	F
			Billy Maynard	2/8/2016	F
			David McIntrye	2/8/2016	F
			Jeff Miller	3/21/2016	F
			Beto O'Rourke	3/22/2016	F

Health Care Operations Workgroup

The health care operations workgroup was organized around five main topics: access standards, scheduling, clinical workflow, staffing (HR), and productivity. The workgroup (select Commissioners and support staff) first met face-to-face on October 7, 2015 to: introduce the staff, review guiding principles and business rules, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics was discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research on the four main topics; and cover other issues that may have come up during sessions (i.e., Best Practices) or from questions posed by Commissioners. To supplement the Commission conferences, the workgroup held teleconferences to cover additional research or present information from subject matter experts or emailed informational briefs and write-ups for review before a workgroup teleconference. Feedback from the Commissioners was addressed and the potential recommendations were refined. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

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Table F-3. Health Care Operations Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Access Standards	10/20/2015	M	Stephanie Mardon	10/6/2015	F
	12/3/2015	C	Kristin Cunningham	10/6/2015	F
	2/25/2016	C	Institute of Medicine	10/13/2015	S
	4/27/2016	C	Institute of Medicine	10/20/2015	F
Scheduling	10/7/2015	M	McKinsey Co	9/22/2015	F
			Stephanie Mardon	10/6/2015	F
			Kristin Cunningham	10/6/2015	F
			Dr. Michael Davies	10/14/2015	S
			Gary Monder	10/14/2015	S
			Steve Green	10/14/2015	S
			Michael McGinnis	10/14/2015	S
			Ken Mullins	10/14/2015	S
			Marianne Hamilton Lopez	10/14/2015	S
			Institute of Medicine	10/20/2015	F
			Dr. Michael Davies	10/20/2015	F
			Dr. Michael Davies	11/18/2015	W
Clinical Workflow	10/27/2015	C	McKinsey & Co.	9/22/2015	F
	2/18/2016	C	Nora Socci	12/29/2015	S
	4/6/2016	C	Diane Pulphus	2/3/2016	S
			Hugh Scott	2/26/2016	S
Staffing	11/4/2015	C	McKinsey Co	9/22/2015	F
	12/3/2015	C	Dr. Jonathan Perlin	10/19/2015	F
	1/20/2016	M	Barbara Ward	12/7/2015	S
	2/18/2016	C			
	2/25/2016	C			
	4/6/2016	C			
Productivity	12/15/2015	M	McKinsey Co	9/22/2015	F
			Gene Migliaccio	10/6/2015	F
			Boston VAMC	12/7/2015:	S
			Dr. Michael Charness		
			Melanie Gilhern		
			Meredith Walker		
Best Practices	1/6/2016	C	Dr. Melanie Vielhauer		
			Rosemary Conlon		
	1/20/2016	M	McKinsey Co	9/22/2015	F
	2/25/2016	C	Dr. Theresa Cullen	12/2/2015	W
	3/14/2016	E	Dr. Daniel Bochicchio	12/3/2015	S
			David Atkins	1/5/2016	S
			Linda Lipson	1/5/2016	S
			Amy Kilbourne	1/5/2016	S
			Bob Monte	1/5/2016	S
			Rachel Goffman	1/5/2016	S
			Dr. Daniel Bochicchio	1/20/2016	S
			Barbara Meadows	2/25/2016	W
			Barbara Meadows	3/17/2016	W

Health Care Data, Tools & Infrastructure Workgroup

The Health Care Data, Tools & Infrastructure (DTI) workgroup organized its work around four main topics: Health Information Technology, Business Processes, Supplies and Facilities. DTI first met face to face on October 7, 2015 to: introduce the staff, review the charge of DTI, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics were discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research via white papers on the four main topics; and cover other issues that may have come up during sessions or from questions posed by Commissioners. To supplement the Commission face-to-face meetings, the workgroup held teleconferences to cover additional research or present information from subject matter experts. Feedback from the Commissioners was incorporated into the white papers and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

Table F-4. Data, Tools & Infrastructure Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call		S=met with staff		
	E= email review		W=met with workgroup		
	M= face-to-face meeting		F=full Commission testimony		
	Date	Type	Expert	Date	Type
Health IT	10/7/2015	M	MITRE Co	9/22/2015	F
	11/18/2015	C	Dr. Brett Giroir	10/19/2015	S
	12/2/2015	C	LaVerne Council,	10/27/15	HVAC
	3/7/2016	C	Chris Miller, Brian Burns		Hearing
	3/14/2016	C	Brookings Institution	11/6/2015	S
	3/21/2016	M	LaVerne Council	11/25/2015	S
	4/4/2016	C & E	Dr. Theresa Cullen	12/2/2015	W
			Chris Miller	12/15/2015	F
			Chuck Hume	12/15/2015	F
			Elaine Hunolt	12/15/2015	F
			Jim Wood	12/15/2015	F
			Mariam Yeager	12/15/2015	F
			LaVerne Council	12/15/2015	F
			Jamie Bennett	3/2/2016	S
			Margaret Donahue	3/11/2016	S
			Kai Miller	4/12/2016	S
Business Processes	10/20/2015	M	SecVA Bob McDonald	9/21/2015	F
	10/26/2015	M			
	3/14/2016	C			
	3/21/2016	M			
	4/4/2016	C			

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WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting	Date	Expert	Date	Type
Supplies (Pharmaceutical & Medical Devices)	10/7/2015	M	McKinsey Co	9/21/2015	F
	10/26/2015	M	Jonathan Miller	12/4/2015	S
	2/23/2016	E	Tucker Taylor	12/4/2015	S
	2/24/2016	C			
	3/7/2016	C			
	3/14/2016	C			
	3/21/2016	M			
Facilities	10/7/2015	M	Bob McDonald	9/21/2015	F
	11/18/2015	M	Jim Sullivan	11/11/2015	S
	12/2/2015	C	Mark W. Johnson	12/21/2015	S
	12/22/2015	M	Kyle Reinhardt	12/22/2015	S
	2/16/2016	E	Thom Kurmel	12/22/2015	S
	2/17/2016	C	Rick Bond	12/22/2015	S
	2/24/2016	C & E	John Bulick	12/22/2015	S
	3/7/2016	C	John Kay	12/22/2015	S
	3/14/2016	C	Jim Sullivan	2/16/2016	S
	3/21/2016	M	Ed Bradley	2/16/2016	S
	4/4/2016	C	Jim Sullivan	2/17/2016	W
	4/11/2016	C	Jim Sullivan	3/15/2016	S
	4/27/2016	C			
Other	11/5/2015	E			
	11/6/2015	E			
	3/11/2016	E			

Health Care Leadership Workgroup

The leadership workgroup organized its work around five main topics: organizational health and cultural transformation and four leadership system issues: recruitment, retention, development and advancement; organizational structure and function; performance management and performance measurement; and human capital management. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic received an evidence review and summary which was the basis for a conference call or a face-to-face discussion. On a few topics, Commissioners or staff heard directly from VA staff or outside experts to inform the deliberation. Then, in a second meeting on the topic, the Commissioners debated a strawman proposal and alternative recommendations based on the evidence review and the prior Commission discussion. Feedback from the Commissioners was incorporated into the strawman and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. The papers were finalized and presented to the full Commission for deliberation and feedback on March 22, 2016. A summary of the work completed on each topic is provided in the table below.

APPENDIX F
THE COMMISSION'S PROCESS

Table F-5. Leadership Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Organizational Health and Cultural Transformation	12/2/2015	C	Stephen Kirin	9/23/2015	F
	12/9/2015	C	Jay Schnitzer	9/23/2015	F
	2/9/2016	M	Vivian Riefberg	9/23/2015	F
	2/17/2016	C	Dee Ramsel	11/9/2015	S
	3/11/2016	E	Ashby Sharpe	11/9/2015	S
			Ken Berkowitz	11/9/2015	S
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
Recruitment, Retention, Development, and Advancement	11/17/2015	M	Stephen Kirin	9/23/2015	F
	11/25/2015	C	Jay Schnitzer	9/23/2015	F
	2/17/2016	C	Vivian Riefberg	9/23/2015	F
	2/24/2016	C	Volney Warner	11/9/2015	S
	3/9/2016	C	Lisa Red	11/17/2015	W
	3/11/2016	E	Payton Rica-Lewis	11/17/2015	W
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Georgia Coffey	2/22/2016	S
			David Perry	2/24/2016	S
			Audrey Oatis-Newsome	2/24/2016	S
Organizational Structure and Function	10/27/2015	C	Stephen Kirin	9/23/2015	F
	2/9/2016	M	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Charles Rossotti	12/16/2015	F
			Michael Kussman	1/19/2016	F
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Robin Hemphill	3/4/2016	S
Performance Management and Performance Measurement	11/4/2015	C	Stephen Kirin	9/23/2015	F
	11/12/2015	C	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Peter Almenoff	10/30/2015	S
			Joe Francis	1/8/2016	S
			Carolyn Clancy	1/8/2016	S
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Noel Baril	3/9/2016	S

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WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Human Capital Management	12/15/2015	M	Stephen Kirin	9/23/2015	F
	12/23/2015	C	Jay Schnitzer	9/23/2015	F
	3/11/2016	E	Vivian Riefberg	9/23/2015	F
			Sam Retherford	12/15/2015	W
			Joleen Clark	2/8/2016	F
Leadership Vision	1/6/2016	C			
	1/21/2016	M			
	2/3/2016	C			
	2/4/2016	E			
Leadership Pre-amble	3/14/2016	E			

Site Visits

Background

In the coming decades there will be increased demand for accountability in health care and increased emphasis on health care outcomes and measurements, and VHA will need to rise to meet these expectations to survive and remain competitive in the demanding and turbulent health care environment.⁷⁹⁷ The changing nature of health care organizations, including pressure to reduce costs, improve the quality of care, and meet stringent guidelines, has forced health care professionals to reexamine how they evaluate performance.⁷⁹⁸ Although many health care organizations have long recognized the need to look beyond financial measures when evaluating performance, many still struggle with what measures to select and how to use the results of those measures.⁷⁹⁹

As the nation's largest health care system in 2016, VHA employs more than 305,000 health care professionals and support staff at more than 1,000 sites of care, including hospitals, community-based outpatient clinics (CBOCs), nursing homes, domiciliaries, and 300 Vet Centers.⁸⁰⁰ Given the scope of this health care system, the Commission recognized the importance of direct lines of communication and interaction with VHA leaders, staff, and patients, to include conducting facility site visits. Commissioners conducted facility site visits to their local VA facilities to assist in the evaluation of the findings identified by the *Independent Assessment Report*, to contribute to an environmental scan of the VHA, and to inform the development of recommendations.⁸⁰¹

Scope of Site Visits

In January and February 2016, most of the 15 Commissioners conducted site visits to the VA medical centers (VAMCs) and CBOCs proximal to their respective residences. The Commissioners approached these site visits with a collaborative and information-seeking tone with the purpose of having open discussions with VAMC leadership, staff, and patients.

Individual Commissioners visited 12 VAMC facilities or CBOCs in 7 out of 19 Veteran Integrated Service Networks (VISNs). Additionally, all the Commissioners who attended the February 29, 2016, meeting in Dallas, TX, toured the Dallas VAMC.

⁷⁹⁷ Kenneth W. Kizer, M.D., M.P.H./Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation for the Veterans Healthcare System*, accessed March 1, 2016, <http://www.va.gov/healthpolicyplanning/rxweb.pdf>.

⁷⁹⁸ Kicab Castaneda-Mendez/Quality Digest, Performance Measurement in Health Care, accessed, March 1, 2016, <http://www.qualitydigest.com/magazine/1999/may/article/performance-measurement-health-care.html#>.

⁷⁹⁹ Ibid.

⁸⁰⁰ Department of Veterans Affairs, Undersecretary for Health, accessed March 1, 2016, <http://vaww.ush.va.gov/>.

⁸⁰¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, v, accessed March 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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Table F-6. VA Facility Site Visit Locations

VISN	VISN Name	VA Facility
2	VISN 2	VA Hudson Valley Health Care System (Montrose, NY)
6	VA Mid-Atlantic Health Care Network	Fredericksburg Community-based Outpatient Center, (Fredericksburg, VA)- part of Hunter Holmes McGuire VA Medical Center, Richmond, VA
7	VA Southeast Network	Ralph H. Johnson VA Medical Center (Charleston, NC) Wm. Jennings Bryan Dorn VA Medical Center (Columbia, SC)
10	VA Health Care System	VA Ann Arbor Health care System (Ann Arbor, MI) John D. Dingell VA Medical Center (Detroit, MI)
17	VA Heart of Texas Health Care System	Dallas VA Medical Center (Dallas, TX)
21	Sierra Pacific Network	Southern Nevada Health care System (Las Vegas, NV) VA Northern California Health Care System (Mather, CA) VA Palo Alto Health Care System (Palo Alto, CA)
22	Desert Pacific Health Care Network	Greater Los Angeles Health care System (Los Angeles, CA) VA San Diego Health care System (San Diego, CA)

The Commissioners were provided with a generic basic agenda as guidance, though they had the latitude to determine their own agendas as appropriate for the locations they visited. The model agenda included the following activities: a welcome and overview of the VA health care facility; tour of the facility; veteran discussion session (informal or formal); VHA employee session (e.g., informal or small group discussion); a discussion with the facility leadership, and were provided the recommended questions listed below:

- What does the medical center do well?
- What unique resources can the medical center draw on?
- What do others see as the strengths of the medical center?
- What could the medical center improve?
- Where does the medical center have fewer resources than others?
- What are others likely to see as weaknesses of medical center?
- What opportunities are open to the medical center?
- What trends could the medical center take advantage of?
- How can the medical center turn its strengths into opportunities?
- What threats could harm the medical center?
- What obstacles does the medical center face?
- What threats do the medical center's weaknesses expose it to?

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- What is the impact of MyVA?
- How do employees view working at VA compared to two or three years ago? If there is a change, what is driving it?
- In your view, what is the most important factor affecting patient satisfaction with the care you provide?
- In your view, has there been a change in the perception of the quality of care provided by the medical center? If so, what might be driving this different perception?

Once the Commissioners completed their visits, they provided the data they gathered to Commission staff to be organized in a strengths-weaknesses-opportunities-threats (SWOT) analysis framework. A SWOT analysis is a simple but useful framework for analyzing the four factors as they are faced by an organization. It helps organizations develop strengths, minimize threats, and take the greatest advantage of available opportunities.⁸⁰²

Findings

VHA leadership and staff enthusiastically shared their time, insights, perspective, and data on organizational and operational processes with the Commissioners. The site visits provided insight and reinforced the findings of the *Independent Assessment Report*.

Confirming what the *Independent Assessment Report* stated, the Commissioners found VHA facilities' staff members exhibit a deep commitment to serving veterans, but that VHA's health care facilities deliver strikingly different patient experiences, apply inconsistent business processes, and differ widely on key measures of performance and efficiency.⁸⁰³ Based on Commissioners' observations of weaknesses, challenges, and threats related to daily operations, VAMC staff members appear to be searching for suitable solutions. Anecdotal responses provided to the Commissioners illuminated the following systemic problem areas at the VAMCs:

- Care authorities: health care capabilities (i.e., purchased care)
- Staffing: productivity (i.e., human resources), health care capabilities, access standards, clinical workflow
- Leadership: staffing, productivity (i.e., human resources)
- Facilities: health care authorities (i.e., patient-centered community care)

Data from Commissioners' observation notes were organized into a SWOT analysis chart based on the common themes of the Commissioners' facility site visits. The purpose of this exercise was to gather information to inform the Commission's recommendations and to confirm or

⁸⁰² "SWOT Analysis," Mind Tools, accessed March 15, 2016, https://www.mindtools.com/pages/article/newTMC_05.htm.

⁸⁰³ "Veterans Integrated Service Networks (VISN)," Department of Veterans Affairs, VHA, accessed March 14, 2016 <http://www.va.gov/directory/guide/division.asp?dnum=1>.

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dispute the findings of the *Independent Assessment Report*. The Commissioner site visit inputs are summarized in the table below.

Table F-7. SWOT Analysis of Commissioner Site Visit Observations

Strengths	Weaknesses	Opportunities	Threats
<ul style="list-style-type: none"> ▪ VA medical center workforce customer service and dedication ▪ Research and national databases ▪ Veterans service – connected services and programs ▪ Partnerships with medical schools and training programs 	<ul style="list-style-type: none"> ▪ Inefficient/ineffective HR policies ▪ High levels of staffing vacancies ▪ Lack of clinical space; inefficient configurations of clinical space ▪ Poor access to VA care for rural veterans ▪ Lack of an effective financial system to provide real-time payment process to veterans Choice and Purchased Care Programs ▪ Lack of effective VHA leadership workforce ▪ Lack of capacity/access to appointments in VHA ▪ Insufficient federal government health care appropriation rules 	<ul style="list-style-type: none"> ▪ Modernization of VA IT ▪ Customer service training/standards ▪ Strategic focus on VHA core mission ▪ Local funding flexibility from Congress ▪ New vision and mission for VHA health care ▪ Process/systems reengineering ▪ Recruitment of outside leader candidates and retention of high-performing VHA leaders 	<ul style="list-style-type: none"> ▪ Misalignment between Congress's health care operational plans for veterans and VHA strategic health care plans ▪ Competing stakeholders health care interests ▪ Office of Personnel Management outdated standards/policies ▪ Insufficient VHA leadership development ▪ Insufficient IT funding ▪ The physician shortages around the nation has severely impacted the care of patients

Conclusions

Fundamental transformation of VHA is needed to ensure optimal delivery of veteran-centered, high-quality care. Essential to laying the path to excellence and strategic planning is a comprehensive understanding of the current state as well as the opportunities and threats facing the system. A robust connection between leaders in VHA Central Office and leaders in the field is critical to meet the needs of the veteran population served.

As part of the strategic planning process, VA/VHA leadership should make recurring site visits to VHA facilities, including VAMCs, VISN headquarters, and CBOCs to obtain current insight of the following critical areas: health care trends, health care operations, facility management and renovation/replacement, business processes and contracting, and other trends or issues affecting VAMCs. VA/VHA leaders should use performance management tools and activities to ensure the strategic goals are being met in an effective and efficient manner. It is a constant challenge to continuously and reliably measure the pulse of the organization. Site visits promote a healthy culture of sharing and building an understanding of organizational mission.

APPENDIX G: VETERAN FEEDBACK

In addition to the more than 4,000-page *Independent Assessment Report*, the Commission examined dozens of other reports, studies, and presentations as cited in the hundreds of footnotes dispersed throughout this Final Report. Collectively, these many sources provide a wealth of information on the challenges VHA confronts in realizing a vision for veterans' healthcare that leverages the strengths of VA and capitalizes on the potential non-VA providers offer.

A key source the Commission considered was the views of veterans themselves. Given the Commission's brief tenure, it was not possible to conduct a survey representative of the views of millions of veterans receiving health care from VHA. Instead, the Commission encouraged veterans to offer feedback on their health care experiences and the work of the Commission through its website. Many veterans service organizations (VSOs) also provided views representing their members in open sessions with the Commission and in formal letters and position statements directly to the Commission.

The feedback offered by veterans through the Commission's web site covered a range of health care topics, such as whether and to what extent care should be privatized, how much choice veterans should have in deciding on their care, and their assessment of the quality of care received. Not surprisingly, veterans (including a few who were also VA employees) are quite passionate about their views on health care. For the most part, veterans' feedback from the web site expressed opposition to efforts to *privatize* VHA, although a few did want more access to non-VA providers. The *Choice Program* was frequently criticized for long delays in appointments, convoluted or misapplied eligibility criteria, and issues with how providers should be reimbursed for treatment and how much the veteran should pay. When the quality of care was noted, on balance veterans praised the care received from VHA, with a few disappointed, especially when care was outsourced to non-VA providers. Because the feedback was unstructured, veterans could offer any observations they found pertinent.

The Disabled American Veterans (DAV) shared with the Commission a compendium of more than 4,000 verbatim comments on veterans' health care experiences gathered from their members during April 2016. The DAV reviewed the comments and categorized 82 percent of the comments as "overall positive experiences."⁸⁰⁴ The Commission staff reviewed the comments from DAV, with findings consistent to DAV's.

⁸⁰⁴ Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.

VA Efforts to Gather Input on Veterans Views on Health Care

Like most institutions that provide products and services to customers, VA/VHA solicits input from veterans on their health care needs and their views on specific services VA/VHA provides. Surveys, focus groups, and in-depth interviews are the more typical means for gathering input from veterans. On occasion, VA, like most agencies, encourages veterans and others to submit comments on a particular aspect of VA services and benefits.⁸⁰⁵

The following sections describe the more typical methods employed by VA/VHA to gather input from veterans.

VHA Survey of Veterans' Health and Use of VHA

Conducted by the assistant deputy undersecretary for policy and planning, the survey of veteran enrollees' health and use of health care (Survey of Enrollees) is an annual survey of more than 40,000 veterans who are enrolled in VA's health care system. The Survey of Enrollees was initially designed to give VHA the information it needed to predict the demand for services in the future. The data are used to develop health care budgets and to assist VA with its annual enrollment decisions. Over the years, the data have also been used to analyze policy decisions, provide insights into specific populations and their perspectives, and inform management decisions affecting delivery of care. In addition to collecting basic demographic information, the survey explores insurance coverage, use of health care inside and outside of VA, pharmaceutical use, attitudes and perceptions about VHA services, perceived health status, and trends in smoking among veterans enrolled in the VHA system.⁸⁰⁶

Survey of Healthcare Experiences of Patients⁸⁰⁷

The Survey of Healthcare Experiences of Patients (SHEP) program was initiated in 2002 in an effort to create standardized survey instruments administered monthly to assess ambulatory and inpatient care. In an effort to standardize its survey instruments with other health care providers, SHEP now employs the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey methodology for VHA's primary care and inpatient medical and surgical services. These surveys are supported in the public domain by the CAHPS Consortium, Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, and National Committee for Quality Assurance. Although SHEP deployed the standardized CAHPS surveys,

⁸⁰⁵ "Quality of Care Feedback Form," Department of Veterans Affairs, accessed June 20, 2016, <http://www.va.gov/QUALITYOFCARE/apps/contact.asp>. As an example, the VA web site provides a Quality of Care feedback page for veterans and others to enter comments on the care a veteran received.

⁸⁰⁶ Westat, 2015 Survey of Veteran Enrollees' Health and Use of Health Care, accessed June 6, 2016, http://www.va.gov/healthpolicyplanning/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁸⁰⁷ For more details on SHEP and VHA's recent initiatives to expand the scope of the program, see "Health Services Research & Development, Commentary: Listening to Veterans about Access to Care," Steven M. Wright, VHA Office of Analytics and Business Intelligence, U.S. Department of Veterans Affairs, accessed June 20, 2016, <http://www.hsrd.research.va.gov/publications/forum/nov15/default.cfm?ForumMenu=nov15-1>.

the access questions were limited and did not evaluate the full scope of services used by veterans.

VHA intends to expand the SHEP program with additional surveys in 2016 and beyond. These surveys will focus on satisfaction with various specialty care services and experience with community care available through the Veterans Access, Choice, and Accountability Act of 2014. VHA has also launched a survey that focuses on new veteran enrollments and their experience with first clinic appointments.

Veteran Insights Panel

VHA also established a Veteran Insights Panel, comprising more than 3,200 veterans that are representative of users of VA health care.⁸⁰⁸ VHA interacts with the panel through email notification and a special access website (mobile device enabled). This approach provides VHA an opportunity to engage panel members in direct discussions, including real time feedback via live chat, about important themes and issues, and survey development and testing. The panel can be engaged collaboratively with operational program offices and researchers to prompt direct discussions with our veterans.

Voices of Veterans: On-going Research

Initiated in the spring of 2014, the VA Center for Innovation (VACI) sponsors an on-going effort to employ human-centered design (HCD)⁸⁰⁹ concepts in a pilot to explore veterans' experience with VA through the eyes of 40 veterans across a range of demographics and locations.⁸¹⁰ The pilot had two goals:

- To test the usefulness and application of an HCD methodology within the context of VA.
- To better understand veterans' experiences interacting with VA, identify pain points in the present day service delivery model, and explore opportunities to transform these interactions into a more veteran-centered experience.

Developing Veteran Personas

As a part of this pilot, VACI set out to identify high-level trends in ways veterans seek out assistance, use technology, take advantage of services, and react to challenging interactions. Based on these patterns, VACI created a set of four profiles, or personas, that represent the

⁸⁰⁸ Ibid.

⁸⁰⁹ Human-centered design (HCD) is a discipline in which the needs, behaviors and experiences of an organization's customers (or users) drive product, service, or technology design processes. It is a practice used heavily across the private sector to build a strong understanding of users, generate ideas for new products and services, test concepts with real people, and ultimately deliver easy-to-use products and positive customer experiences. HCD is a multi-disciplinary methodology which draws from the practices of ethnography, cognitive psychology, interaction and user experience design, service design, and design thinking. It is closely tied to "user-centered design," which applies parallel processes to technology projects, and "service design" which address the service specific experiences.

⁸¹⁰ U.S. Department of Veterans Affairs, Center for Innovation, *Toward a Veteran-Centered VA: Piloting Tools of Human-Centered Design for America's Vets, Findings Report, July 2014*, accessed June 20, 2016, http://www.innovation.va.gov/docs/Toward_A_Veteran_Centered_VA_JULY2014.pdf.

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kinds of users within the set of 40 veterans engaged in the pilot (see Table G-1). Each persona is an archetype based on commonalities observed among veterans who exhibited similar behaviors and approaches to accessing VA services. They are not categorized by positive or negative experiences, but by shared expectations and needs. These personas were designed to help VHA begin to understand that it is serving users who are seeking not just different services, but also varied degrees of contact, support, information, and so forth. For this exercise, VACI assessed veterans' modes of communication, channels, frequency, stated and observed needs, reactions to service experiences, military service, and analyzed observed behavior and service experiences.

*Table G-1. Veteran Profiles Developed by the VA Center for Innovation*⁸¹¹

THE LIFER	THE TRANSACTIONAL
<p>Frequently use VA services and plans to continue doing so. Look to VA to play a supporting, community-building role in life. Grateful for VA benefits, but get frustrated when problems arise which break up the continuity of care—like when doctors change too frequently and when they cannot get transportation to VA facilities. Generally, try to speak highly of VA and wants to contribute to making it work better for fellow veterans.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA cares and takes the time to understand veteran's needs and story ▪ That cost of VA services won't rise ▪ That veteran can reach someone at VA anytime <p>Needs</p> <ul style="list-style-type: none"> ▪ Does not want to tell story over and over, especially after using VA for so long ▪ Wants to know what is going on with services and especially benefits ▪ Likes patient, nurturing health care 	<p>Joined the military largely based on the promise of the opportunities it would provide in life. Plan to use VA services to "get life on track" post-service. Tend to be in the younger generation of veterans (OEF, OIF, OND). Often engaged in the veteran community, see other veterans as allies, and advocates in helping folks understand and use their benefits. Will share frustrations if feels like VA is not helping as promised.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA will deliver on its promises and help veteran access the benefits earned ▪ That VA has benefits available to veterans families ▪ That it will be a headache, and veterans will have to figure it out on their own with the help of network <p>Needs</p> <ul style="list-style-type: none"> ▪ Accurate expectations ▪ Financial support at times, especially for family ▪ To feel a part of a community

⁸¹¹ Ibid.

THE JUST-IN-CASE	THE INFREQUENT
<p>Proud of service, but does not need VA and plans on using it only as a backup. Mature and organized by nature, has all papers in order with VA and have a good idea of services for which they are eligible. Grateful for the benefits available, but see working with VA as a tradeoff for time and will likely only lean on VA as a backup plan.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That will likely never need VA benefits ▪ That VA will be there if needed ▪ That there are benefits available to family ▪ That private benefits are of higher quality and greater ease <p>Needs</p> <ul style="list-style-type: none"> ▪ Peace of mind ▪ To be assured that all documents are in order ▪ To easily get in touch with one person about one question 	<p>Does not think very much about VA. Have used VA benefits in lifetime, yet often years will go by between those interactions. This might be because these veterans live in places where it is difficult to access VA services, because veterans are financially comfortable, or because it seems like too much hassle. Tend to prefer quick interaction—a short phone call or a few clicks on a website.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA is slow—like any bureaucracy ▪ That VA is for “other, injured veterans who need it more” ▪ That someone will tell veterans when and if they are eligible for something <p>Needs</p> <ul style="list-style-type: none"> ▪ To be able to quickly navigate processes ▪ To be reminded every few years of how VA might be able to help

Vantage Point: VA’s Official Blog

In addition to surveys, focus groups, and town-hall sessions, VA instituted a blog on its website and invites veterans and others interested in veterans matters to submit guest posts of potential interest to others in the community. Like most blogs, the content offered is vetted by the VA. Since 2010, Vantage Point includes hundreds of contributors with articles on various health care topics.⁸¹²

Veterans’ Views Gathered by VSOs

Like VHA, the VSOs solicit input from their membership and other stakeholders on a variety of topics and issues relevant to veterans. Occasionally surveys and polls are undertaken, but most VSO efforts to gather input take place at the grassroots level during town halls, chapter meetings and other gatherings. While these venues often suffer from self-selection bias and non- or under-represented participant samples, these are nevertheless an important source of timely information on topics of interest and concern to veterans. What follows is a selection of VSO efforts to gather input on issues important to veterans.

⁸¹² “Vantage Point: Official Blog of the U.S. Department of Veterans Affairs,” Department of Veterans Affairs, accessed June 20, 2016, <http://www.blogs.va.gov/VAntage/>.

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The DAV Veterans Pulse Survey (2015)

In mid-2015 the DAV surveyed a nationally representative sample of veterans to solicit their views on issues important to veterans.⁸¹³ The survey includes questions on various aspects of veterans' healthcare. The survey consists of a national probability sample of 1,701 veterans intended to represent the veteran population in the United States. Oversampling occurred in certain subgroups, such as female veterans and veterans age 18-40 to allow for more precision in the response estimates for these subgroups.

Veterans of Foreign Wars Our Care Veterans Survey (2015)

In the fall of 2015, the Veterans of Foreign Wars of the U.S. (VFW) published a report on its veterans 2015 Health Care Options, Preferences and Expectations Survey.⁸¹⁴ In response to the intensified debate over reform of veterans' healthcare, the VFW launched a survey in the summer of 2015 designed to evaluate veterans' options, expectations, and preferences when seeking health care. The survey did not just focus on VA services, but sought to paint a picture of how the veterans' community at large interacts within the American health care infrastructure, and the choices they make in today's health care marketplace. According to the VFW report, 1,847 veterans responded to the survey, with 92 percent eligible for care and 83 percent of those eligible reporting that they utilize VA health care.⁸¹⁵ Respondents' average age was 65, with about two-thirds Vietnam War veterans.

VFW Survey of Women Veterans (2016)

In an effort to identify barriers women veterans face when accessing their earned veterans' benefits and services, the VFW has commissioned a survey of women veterans that will guide the VFW's policy priority goals for women veterans.⁸¹⁶ Though the survey data collection phase is completed, results have not been published prior to release of the Commission's Final Report.

⁸¹³ Disabled American Veterans (DAV), *The DAV Veterans Pulse Survey: A landmark study of the attitudes and perceptions of America's veterans*, accessed June 20, 2016, <https://www.dav.org/wp-content/uploads/DAV-Pulse-Report-Final.pdf>. The survey was conducted on behalf of DAV by GfK Knowledge Networks, Inc. using their KnowledgePanel® survey participants in November 2015.

⁸¹⁴ Veterans of Foreign Wars, *Our Care: A Report on Veterans' Options, Preferences and Expectations in Health Care*, September 22, 2015, accessed June 20, 2016, http://www.vfw.org/uploadedFiles/VFW.org/VFW_in_DC/VFWOurCareReport2015.pdf.

⁸¹⁵ Ibid., 4.

⁸¹⁶ "VFW Survey of Women Veterans: Help Hold the VA Accountable," Veterans of Foreign Wars, December 22, 2015, accessed June 20, 2016, <http://www.vfw.org/News-and-Events/Articles/2015-Articles/VFW-Survey-of-Women-Veterans/>.

The American Legion Survey of Patient Health Care Experiences (2014)

This survey of 3,116 opt-in, self-reported veterans focuses on satisfaction and levels of perceived benefits with VA's posttraumatic stress disorder/traumatic brain injury (PTSD/TBI) programs, including alternative and complementary treatments.⁸¹⁷

Survey questions include veteran status; gender; era of service; number of times deployed; diagnosis of TBI and/or PTSD; availability of appointments; time and distance to care facilities; treatment type (therapy, medication and complementary and alternative medicine); reported symptoms; efficacy of treatment; and side effects.

The American Legion Women Veterans Survey Report (2011)

This survey of 3,012 women veterans, and the resulting report, was prepared by ProSidian Consulting, LLC on behalf of The American Legion. The survey assessed the perceptions of and satisfaction with women veterans' health care and other benefits delivered to women veterans through the VA system. Additionally, the survey sought to determine the factors driving women veterans' decision to use the VA system as opposed to other private or public health care systems.⁸¹⁸

Iraq and Afghanistan Veterans of America Member Survey (2015)

During the first half of 2015, 1,501 Iraq and Afghanistan Veterans of America members completed a wide-ranging on-line survey covering such issues as employment, education, GI Bill usage, health (including mental health), VA utilization, VA benefits, reintegration and more. The survey was composed of approximately 300 questions, with respondents answering only questions relevant to their experiences. Health care topics included percent enrollment in and reliance on VA care; health insurance coverage by type; and experience rating for VA care. Usage percent and experiencing rating for the VA *Choice Program* was also covered separately.⁸¹⁹

The 2015 Wounded Warrior Project® Alumni Survey

This web-enabled, opt-in survey of 23,200 Wounded Warrior Project (WWP) members measures a series of outcome domains within the following general topics about WWP Alumni: background information (military experiences and demographic data), physical and mental well-being, and economic empowerment.⁸²⁰ This WWP membership survey has been conducted annually since 2010. As it has done in prior years, Westat conducts the survey and population-

⁸¹⁷ "Legion survey to measure effectiveness of PTSD/TBI treatment," The American Legion, July 29, 2015, accessed June 20, 2016, <http://www.legion.org/pressrelease/229354/legion-survey-measure-effectiveness-ptsdtbi-treatment>.

⁸¹⁸ ProSidian Consulting, LLC, *The American Legion Women Veterans Survey Report*, March 9, 2011, accessed June 20, 2016, http://www.legion.org/documents/legion/pdf/womens_veterans_survey_report.pdf.

⁸¹⁹ "Media Advisory: IAVA to Release Groundbreaking Veterans Survey," Iraq and Afghanistan Veterans of America (IAVA), May 23, 2016, accessed June 20, 2016, <http://iava.org/press-release/media-advisory-iava-to-release-groundbreaking-veterans-survey-2/>.

⁸²⁰ Westat, *2015 Wounded Warrior Project Survey, Report of Findings*, August 14, 2015, accessed June 20, 2016, https://www.woundedwarriorproject.org/media/2118/2015_wwp_alumni_survey_full_report.pdf.

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weights the reported results, to include adjustments for potential non-response bias, to be representative of the WWP membership base (approximately 59,000).

Right to Care: Voices of Swords to Plowshares' Veteran Community (2015)

The Swords to Plowshares, Institute for Veteran Policy interviewed in-person or by phone 22 veterans.⁸²¹ Although the topics were established in advance, Swords to Plowshares characterized these interviews as individual “conversations” with a preselected group of veterans. The veterans were chosen to represent a cross-section of combat eras and VHA usage levels. The topics covered included: navigating VA care, reliance on VA and non-VA care, comprehensiveness of care, and rating quality of care. The study includes extensive verbatim comments from veterans on these topics.

Comments from Veterans About Their Experiences as Users of VHA (DAV, 2016)

During April 2016, DAV reached out to veterans around the United States and asked them to share their experiences with the VA health care system. As a result, DAV received (as of April 2016) more than 4,000 responses from veterans sharing their own stories about the care they received from VHA.⁸²² The Commission’s review of the material showed that a majority of the veterans’ comments were positive in nature. DAV’s own analysis concluded that 82 percent of the comments could be categorized as “overall positive experiences.”

Other Surveys on Veterans Issues

In addition to efforts by VA and VSOs to gather feedback from veterans on their health care, other organizations have also addressed veterans’ health care issues.

Concerned Veterans for America Survey of Veterans' Healthcare (November, 2014)

The Concerned Veterans for America commissioned The Tarrance Group to conduct a national survey of 1,000 veterans during November 2014.⁸²³ This survey used a random, demographically representative sample of veterans. Four survey items addressed health care, including: knowledge of any problems at VA; need for reform of veterans’ healthcare; importance of more choice (or options) in health care for veterans; and importance of best possible veterans care, even if outside VA.

⁸²¹ Megan Zottarelli, *RIGHT to CARE: Voices of Swords to Plowshares' Veteran Community*, Swords to Plowshares, Institute for Veterans Policy, April 2016.

⁸²² Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.

⁸²³ Concerned Veterans for America, *Fixing Veterans Health Care*, A Bipartisan Policy Taskforce, accessed June 20, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>.

Vet Voice Foundation Survey of Veterans (October, 2015)

Chesapeake Beach Consulting and Lake Research Partners conducted 800 phone (landline and cell) interviews of veterans during October 2015. The results were population weighted by demographics. Topics included rating the job VA hospitals are doing in their area and the extent they favor/oppose privatizing some of VA's health care.

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APPENDIX H: ADDITIONAL RESOURCES

The VHA health care system is immense and complex. This report provides background for the areas for which the Commission has made recommendations, yet this information is but a glimpse at the intricacies of veterans' health care. The resources below may serve as a starting point for those who would like to develop a deeper understanding of the topic than the Commission could address in this report.

Independent Assessment Report

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow – Scheduling)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow – Clinical)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

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Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

Veteran Health Competency Resources

American Nurses Foundation

The American Nurses Foundation, the philanthropic arm of the American Nurses Association, is launching an innovative web-based PTSD Toolkit for registered nurses. The toolkit provides easy to access information and simulation based on gaming techniques on how to identify, assess and refer veterans suffering from PTSD. www.nurseptsdtoolkit.org

American Osteopathic Association

The American Osteopathic Association (AOA) represents osteopathic physicians, many of whom are in primary care practice, and essentially all of whom treat America's veterans and their families. The AOA is raising awareness in the osteopathic community about the importance of having a comprehensive understanding of the unique physical and mental health care needs of our service members, veterans, and their families. The AOA is committed to ensuring that medical students, physicians, and other health care providers understand that an individual's physical and/or mental health condition may be linked to his or her military experience.

www.osteopathic.org/inside-aoa/public-policy/Pages/federal-initiatives.aspx

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Center for Deployment Psychology

The Center for Deployment Psychology of the Uniformed Services University of the Health Sciences, Department of Medical and Clinical Psychology offer a wide variety of on-line courses and other resources to help uniformed clinical providers, VHA providers, and community clinicians provide care consistent with the needs and experience of military service members, veterans and their families.

<http://deploymentpsych.org/online-courses>

<http://deploymentpsych.org/military-culture-course-modules>

Rural Clergy Training Program

The Rural Clergy Training Program, an initiative of the VHA National Chaplain Center and the Office of Rural Health, offers training and information to clergy providing pastoral services to veterans and their families.

http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December_2015.pdf

Swords to Plowshares Combat to Community Training

Swords to Plowshares is nationally recognized for its expertise in providing comprehensive services and promoting and protecting the rights of veterans. Swords to Plowshares' *Combat to Community*® training is a series of accredited cultural competency curricula developed by its Institute for Veteran Policy team with the purpose of educating the community to address the reintegration challenges veterans face and the unique skill sets they acquire in service. The training was developed for law enforcement, first responder, mental health, and service professionals to teach:

- Commonly shared attitudes, values, goals, and practice that often characterize service in the military
- Recruitment and retention strategies for veteran employment
- How deployment, combat experience, service related injuries, and disability can impact veterans
- How veteran or military family status can inform interactions and services
- Potential resources to refer veterans and families to for supportive services

The training incorporates knowledge developed by experts in the fields of veteran culture and direct services with practical tools and resources to increase understanding and improve interactions with veterans.

<https://www.swords-to-plowshares.org/combat-to-community>

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VA Military Culture Training Courses on TMS

The resources below are available to VA employees and contractors. Versions of these courses should be made available to community providers through an alternative to TMS that allows outside providers to access the training.

- **Military Culture Training for Health Care Professionals – Organization and Roles (VA 19332)**

The first module of this online course provides an overview of the differences between the explicit and implicit features of military culture and describes the characteristics of implicit military culture. The next module identifies four sources of information about implicit military culture and describes six defining characteristics of warrior ethos. The learner is provided information about the influence of military guiding ideals and values on the lives of service members and veterans. The final module offers an overview regarding the connotations of implicit military culture on the health care professional.

- **Military Culture Training for Health Care Professionals: Self-Awareness and Military Ethos (VA 19333)**

This online course, sponsored by the Department of Veterans Affairs and Department of Defense, helps health care professionals understand the role that military culture plays in the lives of those they serve. The course is comprised of four modules: 1) Self-Assessment and Introduction to Military Ethos, 2) Military Organization and Roles, 3) Stressors and Their Impact, and 4) Treatment Resources and Tools.

- **Military Culture Training for Health Care Professionals: Stressors & Resources (VA 19334)**

This online course offers the learner an explanation of how stress can be either helpful or harmful depending on the nature of the provoking stressor and the availability of resources. The four phases of modern operational deployment cycles is presented in great detail in module 3. The next two modules describe the characteristic operational stressors and the spectrum of operational stress states and outcomes experienced by service members and their families during each deployment cycle phase.

- **Military Culture Training for Health Care Professionals: Treatment Resources, Prevention & Treatment (VA 19335)**

This online course in the military culture curriculum outlines the military culture impact on patient care and the health care professional's role and explains the range of DoD and VA psychological health services. The course also provides information on interpreting military culture knowledge into patient assessment and treatment. Finally, the learner is exposed to the military culture implications of VA/DoD clinical practice guidelines relevant to the care of service members and veterans and the strategies for identifying current military culture relevant patient and health care professional resources.

- **Military Cultural Awareness (NFED 1341520)**

This military cultural awareness online course provides a common foundation for all VA employees. This course offers an overview of common military culture and courtesies, roles and ranks within the military, differences between the branches of the armed services, some of the conflicts in which veterans have served, and why this information

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is important in helping VA employees better serve the needs of veterans and their families. After taking this course, participants will understand the perspective of the veterans they serve by having a greater awareness of the military experience, and the customs and courtesies that are common in the military environment.

- **PTSD 101: Understanding Military Culture When Treating PTSD (VA 9494)**
This online web-based course is part of the PTSD 101 education series which is presented by subject-matter experts to increase provider knowledge related to the assessment and treatment issues of PTSD. Each course specifically addresses trauma events, treatments, or special population issues, not normally addressed in general therapy protocols. This course is specifically designed to familiarize clinicians with military culture, terminology, demographics, and stressors. It also provides an overview of programs offered by DoD for managing combat or operational stress, as well as implications for assessment and treatment.
- **Why Military Culture Matters (Mobile Accessible) (VA 16353)**
This independent online study activity is designed to help the learner better connect with veterans and understand how veterans' military experiences influence their health. This course is formatted to be accessible using a VA networked mobile device.

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APPENDIX I: ENABLING DOCUMENTS

Veterans Access, Choice, and Accountability Act of 2014

TITLE II—HEALTH CARE ADMINISTRATIVE MATTERS

SEC. 201. INDEPENDENT ASSESSMENT OF THE HEALTH CARE DELIVERY SYSTEMS AND MANAGEMENT PROCESSES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) INDEPENDENT ASSESSMENT. —

(1) ASSESSMENT. — Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into one or more contracts with a private sector entity or entities described in subsection (b) to conduct an independent assessment of the hospital care, medical services, and other health care furnished in medical facilities of the Department. Such assessment shall address each of the following:

(A) Current and projected demographics and unique health care needs of the patient population served by the Department.

(B) Current and projected health care capabilities and resources of the Department, including hospital care, medical services, and other health care furnished by non-Department facilities under contract with the Department, to provide timely and accessible care to veterans.

(C) The authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Department facilities, including whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care.

(D) The appropriate system-wide access standard applicable to hospital care, medical services, and other health care furnished by and through the Department, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation.

(E) The workflow process at each medical facility of the Department for scheduling appointments for veterans to receive hospital care, medical services, or other health care from the Department.

(F) The organization, workflow processes, and tools used by the Department to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.

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(G) The staffing level at each medical facility of the Department and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics, which may include an assessment of any of the following:

(i) The case load of, and number of patients treated by, each health care provider at such medical facility during an average week.

(ii) The time spent by such health care provider on matters other than the case load of such health care provider, including time spent by such health care provider as follows:

(1) At a medical facility that is affiliated with the Department.

(II) Conducting research.

(III) Training or supervising other health care professionals of the Department.

(H) The information technology strategies of the Department with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by Department, especially those strategies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Department in Department or non-Department facilities.

(I) Business processes of the Veterans Health Administration, including processes relating to furnishing non-Department health care, insurance identification, third- party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows:

(i) To avoid the payment of penalties to vendors.

(ii) To increase the collection of amounts owed to the Department for hospital care, medical services, or other health care provided by the Department for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate.

(iii) To increase the collection of any other amounts owed to the Department with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate.

(iv) To increase the accuracy and timeliness of Department payments to vendors and providers.

(J) The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Department, including the following:

(i) The prices paid for, standardization of, and use by the Department of the following:

(I) Pharmaceuticals.

(II) Medical and surgical supplies.

(III) Medical devices.

(ii) The use by the Department of group purchasing arrangements to purchase pharmaceuticals, medical and surgical supplies, medical devices, and health care related services.

(iii) The strategy and systems used by the Department to distribute pharmaceuticals, medical and surgical supplies, medical devices, and health care related services to Veterans Integrated Service Networks and medical facilities of the Department.

(K) The process of the Department for carrying out construction and maintenance projects at medical facilities of the Department and the medical facility leasing program of the Department.

(L) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.

(2) PARTICULAR ELEMENTS OF CERTAIN ASSESSMENTS. —

(A) SCHEDULING ASSESSMENT. — In carrying out the assessment required by paragraph (1)I, the private sector entity or entities shall do the following:

(i) Review all training materials pertaining to scheduling of appointments at each medical facility of the Department.

(ii) Assess whether all employees of the Department conducting tasks related to scheduling are properly trained for conducting such tasks.

(iii) Assess whether changes in the technology or system used in scheduling appointments are necessary to limit access to the system to only those employees that have been properly trained in conducting such tasks.

(iv) Assess whether health care providers of the Department are making changes to their schedules that hinder the ability of employees conducting such tasks to perform such tasks.

(v) Assess whether the establishment of a centralized call center throughout the Department for scheduling appointments at medical facilities of the Department would improve the process of scheduling such appointments.

(vi) Assess whether booking templates for each medical facility or clinic of the Department would improve the process of scheduling such appointments.

(vii) Assess any interim technology changes or attempts by Department to internally develop a long-term scheduling solutions with respect to the feasibility and cost effectiveness of such internally developed solutions compared to commercially available solutions.

(viii) Recommend actions, if any, to be taken by the Department to improve the process for scheduling such appointments, including the following:

COMMISSION ON CARE FINAL REPORT

(1) Changes in training materials provided to employees of the Department with respect to conducting tasks related to scheduling such appointments.

(II) Changes in monitoring and assessment conducted by the Department of wait times of veterans for such appointments.

(III) Changes in the system used to schedule such appointments, including changes to improve how the Department –

(aa) measures wait times of veterans for such appointments;

(bb) monitors the availability of health care providers of the Department; and

(cc) provides veterans the ability to schedule such appointments.

(IV) Such other actions as the private sector entity or entities considers appropriate.

(B) MEDICAL CONSTRUCTION AND MAINTENANCE PROJECT AND LEASING PROGRAM ASSESSMENT. – In carrying out the assessment required by paragraph (1)(K), the private sector entity or entities shall do the following:

(i) Review the process of the Department for identifying and designing proposals for construction and maintenance projects at medical facilities of the Department and leases for medical facilities of the Department.

(ii) Assess the process through which the Department determines the following:

(1) That a construction or maintenance project or lease is necessary with respect to a medical facility or proposed medical facility of the Department.

(II) The proper size of such medical facility or proposed medical facility with respect to treating veterans in the catchment area of such medical facility or proposed medical facility.

(iii) Assess the management processes of the Department with respect to the capital management programs of the department, including processes relating to the methodology for construction and design of medical facilities of the Department, the management of projects relating to the construction and design of such facilities, and the activation of such facilities.

(iv) Assess the medical facility leasing program of the Department.

(3) TIMING. – The private sector entity or entities carrying out the assessment required by paragraph (1) shall complete such assessment not later than 240 days after entering into the contract described in such paragraph.

(b) PRIVATE SECTOR ENTITIES DESCRIBED. – A private entity described in this subsection is a private entity that –

(1) has experience and proven outcomes in optimizing the performance of the health care delivery systems of the Veterans Health Administration and the private sector and in health care management; and

(2) specializes in implementing large-scale organizational and cultural transformations, especially with respect to health care delivery systems.

(c) PROGRAM INTEGRATOR. —

(1) IN GENERAL. — If the Secretary enters into contracts with more than one private sector entity under subsection (a), the Secretary shall designate one such entity that is predominately a health care organization as the program integrator.

(2) RESPONSIBILITIES. — The program integrator designated pursuant to paragraph (1) shall be responsible for coordinating the outcomes of the assessments conducted by the private entities pursuant to such contracts.

(d) REPORT ON ASSESSMENT. —

(1) IN GENERAL. — Not later than 60 days after completing the assessment required by subsection (a), the private sector entity or entities carrying out such assessment shall submit to the Secretary of Veterans Affairs, the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and the Commission on Care established under section 202 a report on the findings and recommendations of the private sector entity or entities with respect to such assessment.

(2) PUBLICATION. — Not later than 30 days after receiving the report under paragraph (1), the Secretary shall publish such report in the Federal Register and on an Internet website of the Department of Veterans Affairs that is accessible to the public.

(e) NON-DEPARTMENT FACILITIES DEFINED. — In this section, the term “non-Department facilities” has the meaning given that term in section 1701 of title 38, United States Code.

SEC. 202. COMMISSION ON CARE.

(a) ESTABLISHMENT OF COMMISSION. —

(1) IN GENERAL. — There is established a commission, to be known as the “Commission on Care” (in this section referred to as the “Commission”), to examine the access of veterans to health care from the Department of Veterans Affairs and strategically examine how best to organize the Veterans Health Administration, locate health care resources, and deliver health care to veterans during the 20-year period beginning on the date of the enactment of this Act.

(2) MEMBERSHIP. —

(A) VOTING MEMBERS. — The Commission shall be composed of 15 voting members who are appointed as follows:

(i) Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a veteran.

COMMISSION ON CARE FINAL REPORT

(ii) Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a veteran.

(iii) Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a veteran.

(iv) Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a veteran.

(v) Three members appointed by the President, at least two of whom shall be veterans.

(B) QUALIFICATIONS. — Of the members appointed under subparagraph (A) —

(i) at least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code;

(ii) at least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000;

(iii) at least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)));

(iv) at least one member shall be familiar with the Veterans Health Administration but shall not be currently employed by the Veterans Health Administration; and

(v) at least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.

I DATE. — The appointments of members of the Commission shall be made not later than 1 year after the date of the enactment of this Act.

(3) PERIOD OF APPOINTMENT. —

(A) IN GENERAL. — Members shall be appointed for the life of the Commission.

(B) VACANCIES. — Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(4) INITIAL MEETING. — Not later than 15 days after the date on which eight voting members of the Commission have been appointed, the Commission shall hold its first meeting.

(5) MEETINGS. — The Commission shall meet at the call of the Chairperson.

(6) QUORUM. — A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(7) CHAIRPERSON AND VICE CHAIRPERSON. — The President shall designate a member of the commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.

(b) DUTIES OF COMMISSION. —

(1) EVALUATION AND ASSESSMENT. — The Commission shall undertake a comprehensive evaluation and assessment of access to health care at the Department of Veterans Affairs.

(2) MATTERS EVALUATED AND ASSESSED. — In undertaking the comprehensive evaluation and assessment required by paragraph (1), the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201, including any findings, data, or recommendations included in such assessment.

(3) REPORTS. — The Commission shall submit to the President, through the Secretary of Veterans Affairs, reports as follows:

(A) Not later than 90 days after the date of the initial meeting of the Commission, an interim report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(B) Not later than 180 days after the date of the initial meeting of the Commission, a final report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(c) POWERS OF THE COMMISSION. —

(1) HEARINGS. — The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

(2) INFORMATION FROM FEDERAL AGENCIES. — The Commission may secure directly from any Federal agency such information as the Commission considers necessary to carry out this section. Upon request of the Chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

(d) COMMISSION PERSONNEL MATTERS. —

(1) COMPENSATION OF MEMBERS. —

(A) IN GENERAL. — Each member of the Commission who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily

COMMISSION ON CARE FINAL REPORT

equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission.

(B) OFFICERS OR EMPLOYEES OF THE UNITED STATES. — All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES. — The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(3) STAFF. —

(A) IN GENERAL. — The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(B) COMPENSATION. — The Chairperson of the Commission may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(4) DETAIL OF GOVERNMENT EMPLOYEES. — Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES. — The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals that do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(e) TERMINATION OF THE COMMISSION. — The Commission shall terminate 30 days after the date on which the Commission submits the report under subsection (b)(3)(B).

(f) FUNDING. — The Secretary of Veterans Affairs shall make available to the Commission from amounts appropriated or otherwise made available to the Secretary such amounts as the Secretary and the Chairperson of the Commission jointly consider appropriate for the Commission to perform its duties under this section.

(g) EXECUTIVE ACTION. —

(1) ACTION ON RECOMMENDATIONS. — The President shall require the Secretary of Veterans Affairs and such other heads of relevant Federal departments and agencies to

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implement each recommendation set forth in a report submitted under subsection (b)(3) that the President —

(A) considers feasible and advisable; and

(B) determines can be implemented without further legislative action.

(2) REPORTS. — Not later than 60 days after the date on which the President receives a report under subsection (b)(3), the President shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives and such other committees of Congress as the President considers appropriate a report setting forth the following:

(A) an assessment of the feasibility and advisability of each recommendation contained in the report received by the President.

(B) For each recommendation assessed as feasible and advisable under subparagraph (A) the following:

(i) Whether such recommendation requires legislative action.

(ii) If such recommendation requires legislative action, a recommendation concerning such legislative action.

(iii) A description of any administrative action already taken to carry out such recommendation.

(iv) A description of any administrative action the President intends to be taken to carry out such recommendation and by whom.

H.R. 4437: Extension of Deadline for Submittal of Final Report by Commission on Care

[114th Congress Public Law 131]

[[Page 130 STAT. 292]]

Public Law 114-131

114th Congress

An Act

To extend the deadline for the submittal of the final report required by the Commission on Care.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. 38 USC 1701; EXTENSION OF DEADLINE FOR SUBMITTAL OF FINAL REPORT BY COMMISSION ON CARE.

COMMISSION ON CARE FINAL REPORT

Section 202(b)(3)(B) of the Veterans Access, Choice, and Accountability Act of 2014, 128 Stat. 1775 (Public Law 113-146; 128 Stat. 1773) is amended by striking “Not later than 180 days after the date of the initial meeting of the Commission” and inserting “Not later than June 30, 2016”.

Approved February 29, 2016.

DEPARTMENT OF VETERANS AFFAIRS
CHARTER OF THE
COMMISSION ON CARE

1. OFFICIAL DESIGNATION: Commission on Care
2. AUTHORITY: The Commission on Care established as required by section 202 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Public Law 113-146, and operates under the provisions of the Federal Advisory Committee Act (FACA), as amended, 5 U.S.C. App. 2.
3. OBJECTIVES AND SCOPE OF ACTIVITIES: The Commission on Care (the "Commission") is established to examine the access of Veterans to health care from the Department of Veterans Affairs (VA) and strategically examine how best to organize the Veterans Health Administration (VHA), locate health care resources, and deliver health care to Veterans during the 20-year period beginning on the date of the enactment of VACAA, August 7, 2014.
4. DUTIES OF THE COMMISSION:
 - A. Evaluation and Assessment: In accordance with section 202(b)(1), the Commission shall undertake a comprehensive evaluation and assessment of access to health care at VA.
 - B. Matters Evaluated and Assessed: In undertaking the comprehensive evaluation and assessment required by section 202(b)(1) of VACAA and paragraph (4)(A) above, the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201 of VACAA, including any findings, data, or recommendations included in such assessment.
 - C. Reports: In accordance with section 202(b)(3) of VACAA, submit an interim report not later than 90 days after the initial meeting of the Commission to the President, through the Secretary of Veterans Affairs, and a final report not later than 180 days after the initial meeting of the Commission. The reports shall include (i) the findings of the Commission with respect to the evaluation and assessment required by section 202(b)(1); and (ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through VHA.
5. OFFICIAL TO WHOM THE COMMISSION REPORTS: The Commission reports to the President, through the Secretary of Veterans Affairs.

VA is responsible for ensuring the reporting requirements of Section 6(b) of the FACA are fulfilled.

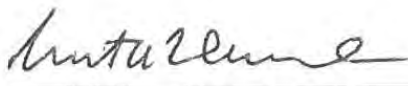
COMMISSION ON CARE FINAL REPORT

6. OFFICE RESPONSIBLE FOR PROVIDING THE NECESSARY SUPPORT FOR THE COMMISSION: VHA is responsible for providing support to the Commission.
7. ESTIMATED ANNUAL OPERATING COSTS AND STAFF-YEARS: Annual operating cost for the Commission is estimated at \$3,600,000 per year, including compensation of members and staff, in accordance with section 202(d) of VACAA. All members will receive travel expenses and a per diem allowance in accordance with the Federal Travel Regulations for any travel made in connection with their duties as members of the Commission. Approximately 15 FTE are anticipated.
8. DESIGNATED FEDERAL OFFICER: The Designated Federal Officer (DFO) or an Alternate DFO, full-time or permanent part-time VA employees, will be present at all meetings, including subcommittee meetings. The DFO will work with the Commission Chair to schedule the meetings and develop meeting agendas. The DFO is authorized to adjourn any meeting when he or she determines it is in the public interest to do so.
9. ESTIMATED NUMBER AND FREQUENCY OF MEETINGS: The Commission will meet at the call of the Chair for the duration of the Commission. The Commission may hold such hearings, sit and act at such times and places, and take such testimony, and receive such evidence as the Commission considers advisable to carry out its duties under section 202 of VACAA. A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.
10. DURATION: The Commission is subject to the termination date as specified below in section 11.
11. TERMINATION: The Commission shall terminate 30 days after the date on which the Commission submits the final report required by section 202(b)(3)(B) of VACAA.
12. MEMBERSHIP: The Commission shall be composed of 15 voting members who are appointed as Special Government Employees and described in paragraph (A) below for the life of the Commission and have the qualifications described in paragraph (B) below:
 - A. APPOINTMENT AUTHORITY:
 - i. Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a Veteran.
 - ii. Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a Veteran.

- iii. Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a Veteran.
 - iv. Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a Veteran.
 - v. Three members appointed by the President, at least two of whom shall be Veterans.
- B. QUALIFICATIONS: Of the members appointed under 12(A) –
- i. At least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of Veterans under 38 U.S.C. 5902;
 - ii. At least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000;
 - iii. At least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined by in section 1905(1)(2)(B) of the Social Security Act (42 U.S.C. 1396d(1)(2)(B));
 - iv. At least one member shall be familiar with VHA but shall not be currently employed by VHA; and
 - v. At least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.
- C. CHAIRPERSON AND VICE CHAIRPERSON: The President shall designate a member of the Commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.
- D. VACANCIES: If a vacancy occurs, it shall be filled in the same manner as the original appointment.
13. SUBCOMMITTEES: The Commission is authorized to establish subcommittees, with DFO approval, to perform specific projects or assignments as necessary and consistent with its mission. The Commission Chair shall notify the Secretary, through the DFO, of the establishment of any subcommittee, including its function, membership, and estimated duration. Subcommittees will report back to the Commission.
14. RECORDKEEPING: Records of the Committee shall be handled in accordance with General Records Schedule 26 or other approved agency records disposition schedules. Those records shall be available for public inspection and copying, subject to the Freedom of Information Act 5, U.S.C. 552.

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15. DATE CHARTER IS FILED:

Approved:  Date 7/14/15
Robert A. McDonald
Secretary of Veterans Affairs



APPENDIX J: COMPOSITION OF THE COMMISSION

Nancy M. Schlichting, Chairperson

Appointed by President Barack Obama

Nancy M. Schlichting is Chief Executive Officer of Henry Ford Health System (HFHS), a nationally recognized \$5 billion health care organization with 27,000 employees and recipient of the 2011 Malcolm Baldrige National Quality Award, 2011 John M. Eisenberg Patient Safety Quality Award, and 2004 Foster G. McGaw Award. She is credited with leading the health system through a dramatic financial turnaround and for award-winning patient safety, customer service and diversity initiatives.

Schlichting joined HFHS in 1998 as its Senior Vice President and Chief Administrative Officer, served as Executive Vice President and Chief Operating Officer, President and CEO of Henry Ford Hospital and was named President and CEO of the System in 2003. Her career in health care administration spans over 35 years of experience in senior level executive positions.

Schlichting serves on several national and community boards including The Kresge Foundation, Walgreens Boots Alliance, the Federal Reserve Bank of Chicago – Detroit Branch, the Detroit Regional Chamber, the Detroit Economic Club, and the Downtown Detroit Partnership. Nancy is also a Fellow of the American College of Healthcare Executives.

In 2015, Schlichting was honored as one of the 100 Most Influential People in Healthcare by Modern Healthcare magazine, the eighth time she received this recognition. She was also named to the Top 25 Women in Healthcare by Modern Healthcare, the fourth time she received this recognition and the only Michigander named to the list. Her other awards include: NCHL Gail L. Warden Leadership Excellence award, ACHE Senior-Level Healthcare Executive Regent's Award, AHA/HRET 2014 TRUST Award, Becker's Hospital Review "40 of the Smartest People in Healthcare-2014," Crain's Detroit Business "2012 Newsmaker of the Year," HealthLeaders Media "20 People Who Make Healthcare Better-2012," and most recently was named one of "Crain's 100 Most Influential Women in Michigan."

Author of the acclaimed book, *Unconventional Leadership*, Schlichting is a highly regarded expert and accomplished speaker on strategic leadership, quality, patient/family-centered care, and diversity.

Schlichting received her A.B. in Public Policy Studies, Magna Cum Laude from Duke University and her M.B.A. from Cornell University. She has also been the recipient of honorary doctoral degrees from Walsh College, Eastern Michigan University and Central Michigan University.

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Delos M. (Toby) Cosgrove, MD, Vice Chairperson*Appointed by Speaker of the House John Boehner*

Toby Cosgrove, CEO of Cleveland Clinic, presides over a \$6.2 billion health care system comprising Cleveland Clinic, eight community hospitals, 16 family health and ambulatory surgery centers, Cleveland Clinic Florida, the Lou Ruvo Center for Brain Health in Las Vegas, Cleveland Clinic Toronto, and Cleveland Clinic Abu Dhabi. His leadership has emphasized patient care and patient experience, including the reorganization of clinical services into patient-centered, organ- and disease-based institutes. He launched major wellness initiatives for patients, employees, and communities. Under his leadership, Cleveland Clinic has consistently been named among America's top four hospitals by U.S. News & World Report and is one of only two hospitals named among America's 99 Most Ethical Companies by the Ethisphere Institute.

Cosgrove was a surgeon in the U.S. Air Force and served in Da Nang, Republic of Vietnam, as the chief of U.S. Air Force casualty staging flight. He received the Bronze Star and the Republic of Vietnam Commendation Medal.

He has published nearly 450 journal articles, book chapters, one book, and 17 training and continuing medical education films. He performed more than 22,000 operations and earned an international reputation for expertise in all areas of cardiac surgery, especially valve repair. As an innovator, Cosgrove has 30 patents filed for developing medical and clinical products used in surgical environments.

Cosgrove received his medical degree from the University of Virginia School of Medicine in Charlottesville, VA, and completed his clinical training at Massachusetts General Hospital, Boston Children's Hospital, and Brook General Hospital in London. He received a BA in biology from Williams College in Williamstown, MA.

Michael A. Blecker*Appointed by House Minority Leader Nancy Pelosi*

Michael Blecker has been associated with Swords to Plowshares since 1976 and has served as Executive Director since 1982. The agency was started in 1974 by returning Vietnam veterans and VISTA volunteers assigned to the VA regional office in San Francisco.

In the 1980s, when homelessness exploded, Swords to Plowshares started a transitional housing program with funding support from VA and the city and county of San Francisco. Swords to Plowshares continues to provide housing, employment, case management, and benefits advocacy for veterans from offices in San Francisco and Oakland. In 2005, the Iraq Vet Project (IVP) was established to help veterans of those wars and to shape policies affecting them. Recognizing Swords to Plowshares' long and effective history of challenging and shaping public policy with regard to veterans, in 2011, the IVP became known as the Institute for Veterans Policy.

Under Blecker's leadership, Swords to Plowshares' annual budget has grown from \$75,000 to nearly \$16 million. He has a nationwide reputation for dedicated service and as an authority on

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veterans' services and veterans' rights. He served on the Advisory Committee on Homeless Veterans (2002-2007), which advises the Secretary of Veterans Affairs. He is cofounder of both the National Coalition for Homeless Veterans and the California Association of Veterans' Service Agencies. He has served on the Congressional Commission on Service Members and Veterans Transition Assistance, the California Senate Commission on Homeless Veterans, the San Francisco Mayor's Homeless Planning Committee, the National Agent Orange Settlement Advisory Board, The Agent Orange Information Center, and the Veterans Speakers Alliance.

Blecker served in the U.S. Army as a combat infantryman in Vietnam in 1968-69 with the 101st Airborne Division, achieving the rank of E-5. He received an AB degree in criminology from University of California, Berkeley and a JD degree from New College of California Law School.

David P. Blom

Appointed by Speaker of the House John Boehner

David Blom has been instrumental in the development and growth of the OhioHealth system. He has served as president of OhioHealth's central Ohio hospitals – Grant Medical Center, Riverside Methodist Hospital, and Doctors Hospital – while also serving as executive vice president and chief operating officer of OhioHealth. He was named president and CEO of OhioHealth in March 2002. He has a track record of achievement with a solid understanding of complex issues facing health care delivery. He has expertise in leading strategic initiatives, managing and developing human capital, improving profitability, and improving quality of care and customer experience.

Blom maintains many professional and community affiliations, currently serving as a board member of the Voluntary Hospitals of America (VHA), a member and treasurer of Columbus' Downtown Development Corporation (CDDC), member of the Columbus Partnership, and member of the local World President's Organization (WPO). In 2001, he was named a Top 100 Business Leader by Smart Business and in 2012 CEO of the Year by Columbus CEO Magazine.

He received a BA from Ohio State University and an MA in health care administration from The George Washington University.

David W. Gorman

Appointed by President Barack Obama

David Gorman is a retired, combat-disabled veteran of the Vietnam War, who was appointed executive director of the Disabled American Veterans (DAV) National Service and Legislative Headquarters in Washington, DC in 1995. His responsibilities include oversight of the DAV National Service, Legislative, and Voluntary Service Programs. He is the organization's principal spokesperson before Congress, the White House, and the U.S. Department of Veterans Affairs.

Gorman entered the U.S. Army in 1969 and served with the 173rd Airborne Brigade, the famed "Sky Soldiers" of the Vietnam War. During a campaign to secure an area in Central Vietnam

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where U.S. forces suffered extremely high casualties, Mr. Gorman was severely wounded. His wounds required amputation of both legs.

Discharged from the Army in 1970, he immediately joined the DAV and is currently a life member of the DAV's National Amputation Chapter and DAV Chapter 39 in Greer, SC.

Gorman retired from his post executive director at the Washington Headquarters for Disabled American Veterans and now resides in Simpsonville, SC. Gorman attended Cape Cod Community College.

The Honorable Thomas E. Harvey, Esq.

Appointed by Senate Majority Leader Mitch McConnell

Thomas Harvey is a Vietnam combat veteran whose decorations include the Silver Star, the Purple Heart and 12 others for valor and service. In Vietnam, he spent a year as a company commander with the 173rd Airborne brigade and a year and a half as an advisor with the Vietnamese Airborne Division.

A lawyer by training, Harvey has spent much of his professional career working with veterans and issues of concern to them. He has served as Chief Counsel and Staff Director of the Senate Veterans Affairs Committee, Deputy Administrator of the Veterans Administration, and Assistant Secretary for Congressional Affairs of the Department of Veterans Affairs. Following 5 years with a major Wall Street law firm, Harvey came to Washington, DC, in 1977 as a White House fellow, serving as an assistant to ADM Stansfield Turner, then director of the Central Intelligence Agency. He has also served in the Department of Defense and as General Counsel and Congressional Liaison of the United States Information Agency. For 5 years, he was Senior Counselor of the Institute of International Education, which administers the Fulbright Program on behalf of the U.S. Department of State, as well as a number of other international educational exchange programs.

He currently serves on the boards of the Milbank Memorial Fund, the focus of which is public health policy, and of the Art Students League of New York, where he studies watercolor painting. He holds both BA and JD degrees from the University of Notre Dame and a LLM degree from the New York University School of Law.

Maj. Stewart M. Hickey, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Since 2011, Stewart Hickey has served as American Veterans (AMVETS) National Executive Director, operating the nation's fourth largest congressionally chartered veterans service organization and its subordinate organizations, and the daily advocacy of issues affecting veterans, national security, foreign affairs, and the economy.

Previously, Hickey was chief executive officer for the Hyndman (Pennsylvania) Area Health Center, a multisite community health center providing medical and dental services to several counties of Pennsylvania, West Virginia, and Maryland. His health care administration experience includes serving as chief human resources officer and chief operating officer of

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Western Maryland Hospital Center in Hagerstown, Maryland, a 123-bed Joint Commission on Accreditation of Healthcare Organizations accredited, long-term care and sub-acute hospital with rehabilitation, occupational therapy, physical therapy, and respiratory care.

Hickey enlisted in the U.S. Marine Corps Reserve in February 1977, in Cumberland, MD, as an infantryman, and transferred to platoon leaders class in the summer of 1978. He served in Operation Desert Storm and Desert Shield and was awarded a Bronze Star Medal with Combat "V" for his achievements as commanding officer, Company D, Third Tank Battalion, Task Force RIPPER, 1st Marine Division, I Marine Expeditionary Force, Saudi Arabia from September 1990 to February 1991. His military education includes the Basic School, Armor Officer Basic, Amphibious Warfare School, Armor Officer Advanced Course, and Marine Corps Command and Staff College.

Hickey resides on his family farm in Cumberland Valley Township in McConnellsburg, PA. He and his wife, Ellen, have five children: Monroe, Ali, Charles, Andrew, and Bryce. Three of his sons, Andrew, Monroe, and Charles, followed their father's path and currently serve in the U.S. military.

Hickey received a BA in history from Penn State University and an MA in management from Webster University.

Rear Adm. Joyce M. Johnson, DO, US PHS (ret.)

Appointed by President Barack Obama

Joyce Johnson is a physician with senior public health leadership experience in civilian and military sectors.

Johnson served in the U.S. Public Health Service (Rear Admiral, Upper Half). Her last active-duty assignment was with the U.S. Coast Guard as Director, Health and Safety ("surgeon general"). She managed the Coast Guard's health care system, including 150 sickbays and clinics, and coordinated both medical and behavioral health care for the beneficiary population. She also had responsibility for the Coast Guard's safety and work-life programs. She held a Top Secret security clearance.

Other government assignments included senior scientific and management positions with the Food and Drug Administration (pharmaceutical safety and post-market surveillance) and the Substance Abuse and Mental Health Services Administration. She has held clinical positions at the National Institute of Mental Health and the Department of Veterans Affairs. At the Centers for Disease Control and Prevention, she was an Epidemiologic Intelligence Service (EIS) Officer and staff epidemiologist in the Center for Infectious Disease.

In the private sector, Johnson served as vice president, health sciences and chief medical officer for a large research organization, where she managed a portfolio of government contracts, including laboratory and social sciences research, and held a top secret security clearance.

Johnson is an osteopathic physician board certified in psychiatry and public health/preventive medicine. She is also a certified clinical pharmacologist and certified addiction specialist. In

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addition to her medical degree, she earned a master's degree in hospital and health administration. She has been conferred six honorary doctoral degrees. She is a Distinguished Life Fellow of the American Psychiatric Association.

Johnson has extensive international health experience on all seven continents. She has particular interests in global mental health, health systems development, infectious disease, and disaster relief. She has led five Flag Expeditions with the Explorers Club. For more than a decade she has been a consultant to the National Science Foundation on the health care system in Antarctica.

Johnson recently coauthored the book, *Lizard Bites and Street Riots, Travel Emergencies and Your Health, Safety and Security*, and writes a monthly medical column. She is a Clinical Professor and Adjunct Professor at Georgetown University. She has served on expert committees including the Committee on Substance Abuse in the Military, National Academy of Medicine. She is active in numerous professional associations including the American Psychiatric Association, serving on the Committee on Psychiatric Dimensions of Disasters; the American Osteopathic Association, serving on the Bureau of International Osteopathic Medicine; and the Explorers Club, serving on the Medical Committee.

The Honorable Ikram U. Khan, MD

Appointed by Senate Minority Leader Harry Reid

Ikram Khan currently, he is president and 50-percent partner of Quality Care Consultants, LLC, founded in March 1992. The company provides consultant services in health care strategy and policy development for employers and other health care organizations. The company assists clients in development and implementation of wellness and disease-management programs. The company also develops quality improvement initiatives and techniques and assists in development and implementation of programs for cost-effective utilization of medical resources. Major emphasis is on clinical outcomes and data monitoring analysis.

Khan is a member the United States Institute of Peace (USIP) Board of Directors; he was nominated by President George Bush, and confirmed by the U.S. Senate on June 5, 2008. He is also currently a member of the Nevada Homeland Security Commission, having been appointed by the Governor of Nevada.

He was nominated by President Clinton and confirmed by the U.S. Senate to serve as member of The Board of Regents Uniformed Services University of Health Sciences, an advisory board to U.S. Secretary of Defense (1999-2006).

Khan also served as Special Advisor on Healthcare to Former Nevada Governor Gibbons, was a member of the Nevada Academy of Health (appointed by Nevada Governor Gibbons), and is a past member of the Nevada Academy of Health Sciences (appointed by Nevada Governor Kenny Guinn). He is past member of Nevada Governor's Commission for Medical Education, Research and Training and was a member of the Nevada State Board of Medical Examiners for eight years. Dr. Khan received "Special Congressional Recognition" for invaluable community service in 1994 and a Congressional citation—"U.S. Senate - Honoring Dr. Ikram Khan"—on April 25, 1994.

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Khan currently serves as member on the board of trustees at Sunrise Hospital Las Vegas-a 600 bed hospital. He has received recognition as “Most Influential Man in Southern Nevada” in 2000. He is also a recipient of a Las Vegas Chamber of Commerce community achievement award (October 1999), and a “Distinguished Community Service Award” from Anti-defamation League of B’nai B’rith (1994).

November 30, 1999 was declared “Dr. Ikram U. Khan Day” by the Governor of the State of Nevada, Mayor of Las Vegas, and the Board of Commissioners of Clark County.

During the course of his practice as General Surgeon, Khan has served in multiple leadership positions at various hospitals in Las Vegas.

Ikram Khan is president of quality Care Consultants LLC in Las Vegas Nevada. He received a doctor of medicine and surgery (MBBS) degree from University of Karachi, Pakistan.

Khan received a Doctor of Medicine and Surgery (MB, BS) in August 1972 from the University of Karachi, Pakistan. He completed post-graduate surgical residency in General Surgery in New York from 1974 through 1978, and practiced as a General Surgeon in Las Vegas through 2005.

Phillip J. Longman

Appointed by Senate Minority Leader Harry Reid

Phil Longman is a director at New America, a public policy institute. He is also a senior editor at the Washington Monthly and a lecturer at Johns Hopkins University, where he teaches a course in health care policy.

Longman has written extensively on issues related to health care delivery system reform, including in his book *Best Care Anywhere* (currently in its third edition). The book chronicles the quality transformation of the Veterans Health Administration during the 1990s and applies its lessons to the broader U.S. health care system.

Longman received a BA in philosophy from Oberlin College.

Col. Lucretia M. McClenney, USA (ret.)

Appointed by House Minority Leader Nancy Pelosi

Lucretia McClenney is a consultant with the Department of Defense Vietnam War Commemoration Office and Executive Coach with the Brookings Institute Executive Education Program. Previously she served as director of the Department of Veterans Affairs Center for Minority Veterans. As director, she served as the principal advisor to the Secretary of Veterans Affairs on policies and programs affecting minority veterans. Prior to her appointment, she served as special assistant to the assistant secretary for policy, planning, and preparedness, Department of Veterans Affairs (VA). She led the department’s emergency exercise planning, training, and evaluation program, and served as liaison to other government agencies. She has served on numerous working groups to include the congressionally mandated National Commission on VA Nursing, Task Force on Employment of Women at VA, and as the Secretary

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of Veterans Affairs' representative on the American Red Cross Board of Governors and Disaster and Chapter Services Committee.

Serving 30 years in the Army, McClenney retired as a colonel in November 2001. She served in various medical treatment facilities and on staffs worldwide serving as director, population health integration team, TRICARE management activity; chief nurse, European regional medical command and deputy commander for nursing, Landstuhl Regional Medical Command; deputy commander for nursing, Moncrief Army Community Hospital, Fort Jackson, South Carolina; assistant deputy for human resources, Office Of The Assistant Secretary Of The Army for Manpower and Reserve Affairs, the Pentagon; chief ambulatory nursing, Walter Reed Army Medical Center; senior policy analyst, Office of the Secretary of Defense (Health Affairs), The Pentagon; and member of the President's National Health Care Reform Task Force.

McClenney's military and civilian awards/decorations include the Legion of Merit (two oak leaf clusters), Defense Meritorious Service Medal, Meritorious Service Medal (seven oak leaf clusters), Army Commendation Medal (two oak leaf clusters), Navy Commendation Medal, Army Achievement Medal, Army Good Conduct Medal, the Army Staff Identification Badge, Office of the Secretary of Defense Staff Identification Badge, the coveted "9A" designator, in recognition of numerous achievements at the pinnacle of nursing excellence, and The Outstanding Civilian Service Medal for her significant contribution to the mission of the United States Army and Department of Defense in assisting with the production of the book, *For Children of Valor – Arlington National Cemetery*. Her professional affiliations include the Association of Military Surgeons of the United States, Sigma Theta Tau, National Nursing Honor Society, Alpha Kappa Alpha Sorority, Inc., Top Ladies of Distinction, Inc., The ROCKS, Inc., the Order of Military Medical Merit, Past President, Federal Health Care Executives Interagency Institute Alumni Association, and former Board Member of the Bon Secours Health Care System and Chair, Quality Committee.

She is a graduate of the Command and General Staff College and the United States Army War College Fellowship Program at George Washington University, Washington, DC. She is also a graduate of the Johnson & Johnson-Wharton's Fellows Program in Management for Nurse Executives, Wharton School of Business, University of Pennsylvania; Federal Health Care Executives Interagency Institute at George Washington University, Washington, DC; Leadership VA 2004; and Brookings Institute Executive Fellowship Program. She received a BSN from Murray State University and an MS in psychiatric/mental health nursing from Catholic University.

Capt. Darin S. Selnick, USAF (ret.)

Appointed by Speaker of the House John Boehner

Darin Selnick is an independent consultant who provides a variety of services to organizations in the areas of government and community relations, business development, and veterans' issues. He is currently the senior veterans affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He also volunteers his time as Chairman of the West Los Angeles Veterans Home Support Foundation and as the Vice President of Development for the GI Film Festival.

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From 2001–2009, Selnick was an appointee at the Department of Veteran Affairs. From 2004–2009 he served as the director of the center for faith-based and community initiatives. In this role he was responsible for the management and operations of the Center and was the VA liaison to the White House Office of faith-based and community initiatives. From 2001–2004 he served as Special Assistant to the Secretary and Associate Dean, VA Learning University. In this role he was responsible for providing program and operational oversight of VA Learning University.

Selnick is a retired Air Force officer who attained the rank of Captain. He has been very active in veterans' issues and joined the Jewish War Veterans in 1994. Since that time he has taken various leadership positions and is the past department commander of the Department of California. Mr. Selnick is also a member of the American Legion, AMVETS, Air Force Association, and National Association of Uniformed Services.

Darin Selnick currently serves as senior veterans' affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He lives in Oceanside, CA. Selnick is retired from the U.S. Air Force. He received a BS in health science from California State University, Northridge and an MA in political science/public management from Midwestern State University.

Lt. Gen. Martin Steele, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Martin Steele enlisted in the Marine Corps in January 1965 and rose from private to three-star general, culminating his military career in August 1999 as the deputy chief of staff for plans, policies, and operations at Headquarters, U.S. Marine Corps, in Washington, DC. A decorated combat veteran with 34½ years of service, he is a recognized expert in the integration of all elements of national power (diplomatic, economic, informational, and military) with strategic military war plans and has served as an executive strategic planner/policy director in multiple theaters across Asia. His extraordinary career was chronicled as one of three principals in the award winning military biography, *Boys of '67*, by Charles Jones.

Upon his retirement from active duty in 1999, he served as president and CEO of the Intrepid Sea-Air-Space Museum in New York City. Currently, Steele serves as The Associate Vice President for Veterans Partnerships, the Executive Director, Military Partnerships, and Co-chair of the Veterans Reintegration Steering Committee at the University of South Florida in Tampa, Florida. Additionally, Steele is the chairman and CEO of Steele Partners, Inc., a strategic advisory and leadership consulting company. He has led a philanthropic transition program assisting exiting Marines into private-sector jobs throughout the country, at no cost to the Marine participants, the Marine Corps, or the companies that provide employment opportunities.

Steele serves proudly on several boards across the country. He is currently the Chairman of the Board, Marine Corps Scholarship Foundation. He was appointed to the Board of Directors of Florida is for Veterans, Inc., a not for profit, state legislated organization designed to assist both Veterans and businesses throughout Florida in not only hiring Veterans but also developing entrepreneurship programs designed for veterans. He is a member of Fisher House Foundation;

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chairman of the advisory committee, Stability Institute; advisory committee member, Call of Duty Endowment; advisory board member, Stay in Step Foundation; advisory council member, Operation Helping Hand; member, Veterans Advantage; board member, University of Arkansas Veterans Resource and Information Center; and advisory committee member, Jesse Lewis Choose Love Movement.

Steele is a graduate of the University of Arkansas where he obtained a bachelor's degree in history and was recognized as a distinguished graduate of the Fulbright College of Arts and Sciences. He is a recipient of the 2013 Arkansas Alumni Award Citation of Distinguished Alumni, which recognizes exceptional professional and personal achievement and extraordinary distinction in a chosen field. He also holds master's degrees from Central Michigan University, Salve Regina College, and Naval War College.

Charlene M. Taylor

Appointed by House Minority Leader Nancy Pelosi

Charlene Taylor joined Kaiser Permanente in 1997 as the director of specialty services for the Permanente Medical Group at South Sacramento. In 2002 she became the service director for Kaiser Foundation Hospitals, responsible for perioperative and perinatal services at South Sacramento. In 2008, she was promoted to chief nursing officer at the Sacramento Medical Center where she was responsible for a 287-bed tertiary acute care hospital that conducted more than 11,000 operations per year. There, she oversaw 800 full-time employees and a budget of \$150 million. Taylor was promoted to chief operating officer in 2010 and retired from Kaiser Permanente in 2013.

Before working for Kaiser Permanente, Taylor served as assistant hospital administrator for Sutter Health at the Sutter Amador Hospital from 1988 to 1997. She is a member of the Veterans of Foreign Wars, Reserve Officers Association, and the Society of Air Force Nurses.

Taylor's patriotic and adventurous nature led her to join the Air Force as a reserve officer at the age of 40, rising to the rank of Lieutenant Colonel. She was commissioned as a Captain in the United States Air Force (Reserve Command) in October 1993, earning her flight nurse wings in 1994. She subsequently was selected to be a flight nurse instructor followed by a promotion to evaluator status. Her last squadron assignment was that of chief nurse at the 349 AMDS, Travis Air Force Base.

In addition to years of experience conducting aeromedical evacuation missions throughout the world, Taylor was activated in support of Operation Enduring Freedom from March 2003 to March 2004. In January 2005 she was selected to be the chief nurse of the 379th Expeditionary Aeromedical Squadron in support of Operation Iraqi Freedom. While transporting the injured out of Mosul, Iraq in a C-130, the aircraft took enemy fire, landing without casualties. Due to the demands of her civilian position, Taylor transferred to inactive status in the Air Force Reserve Command. Taylor is the recipient of two Meritorious Service medals, Expert Marksmanship (2), and multiple other medals.

Taylor currently serves on the Veterans Board. In 2012 she was appointed to the Board by Gov. Jerry Brown and approved by the Senate. She became chair in 2014 and continues to serve

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in that role. The California Veterans Board serves as an advocate for veterans affairs, identifying needs and working to ensure and enhance the rights and benefits of California veterans and their dependents.

Taylor is a diploma nurse graduate from the Kaiser Foundation School of Nursing. She continued her education receiving a BSN from the State University of New York in Albany, New York. She earned a master's degree in nursing administration from the University of California, San Francisco.

Taylor lives in Elk Grove, CA.

Marshall W. Webster, MD

Appointed by Senate Minority Leader Harry Reid

Marshall Webster is a senior vice president of the University of Pittsburgh Medical Center (UPMC), and a distinguished service professor of surgery at the University of Pittsburgh. A graduate of Penn State University and the Johns Hopkins Medical School, he trained in surgery at the University of Pittsburgh, and subsequently served 2 years as a surgeon on active duty in the U.S. Navy.

Webster returned to the University of Pittsburgh as a faculty vascular surgeon, including initially, a part-time attending staff position at the Pittsburgh VA Medical Center for 3 years. He has held the Mark M. Ravitch Chair in Surgery, and has had a long academic career of clinical practice, research, and service in varied administrative leadership roles. From 2002–2012, he was an executive vice president of UPMC, president of UPMC's physician services division, and president of the University of Pittsburgh Physicians, the clinical practice plan of the university faculty.

His current focus is primarily strategic development: building clinical relationships and care models throughout the region with a large number of community hospitals and providers. Webster has oversight of UPMC's graduate medical education program, which sponsors a substantial number of resident rotations at the Pittsburgh VA Medical Center. He recently served for 2 years as the interim chair of the Department of Anesthesiology at UPMC. He has had a long-standing interest in patient safety and quality initiatives, and recently completed a 6-year term on the board of the Pennsylvania Patient Safety Authority.

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APPENDIX K: COMMISSION STAFF

Susan M. Webman, Esq.
Executive Director

Michael Bargmann..... Program Analyst
Robert Burke, PhD Program Analyst
Donald Cicotte..... Program Analyst
Pauline Cilladi-Rehrer DFO
John Clinton Staff Assistant
Monica Cummins Program Analyst, ADFO
Christopher Danns Program Analyst
Stephen Dillard..... Program Analyst, ADFO
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SaKeithia Taylor Staff Assistant
Linda (Yvonne) Williams..... Staff Assistant

DFO – Designated Federal Officer

ADFO – Assistant Designated Federal Officer

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APPENDIX L: ACRONYM LIST

ACRONYM	DEFINITION
ACA	Affordable Care Act
ACHE	American College of Healthcare Executives
APRN	Advanced Practice Registered Nurse
BRAC	Base Realignment and Closure
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARES	Capital Asset Realignment for Enhanced Services
CDS	Community Delivered Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CITC	Care in the Community
CMD	Chief Medical Director
CMIO	Chief Medical Information Officer
CMOP	Consolidated Mail Outpatient Pharmacy
COTS	Commercial Off-The-Shelf
CPRC	Clinical Product Review Committee
CPRS	Computerized Patient Record System
CVA	Concerned Veterans for America
CVCS	Chief of VHA Care System
DAV	Disabled American Veterans
DEPSECVA	Deputy Secretary, Department of Veterans Affairs
DHP	Digital Health Platform
DM&S	Department of Medicine and Surgery
DoD	Department of Defense
DUSH	Deputy Under Secretary for Health
ECF	Executive Career Fields
EES	Employee Education System
EEO	Equal Employment Opportunity

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ACRONYM	DEFINITION
EHCPM	Enrollee Health Care Projection Model
eHMP	Enterprise Health Management Platform
EHR	Electronic Health Record
FFS	Fee-for-Service
FY	Fiscal Year
GAO	Government Accountability Office
GHATP	Graduate Health Administration Training Program
GUI	Graphic User Interface
HCD	Human-Centered Design
HEC	Healthcare Executive Council
HPDM	High Performance Development Model
HR	Human Resources
HRA	Human Resources and Administration
HSC	Health Service Category
HTM	Healthcare Talent Management
IAVA	Iraq and Afghanistan Veterans of America
IDIQ	Indefinite Delivery/Indefinite Quantity
IDN	Integrated Delivery Network
IDP	Individual Development Plan
IT	Information Technology
JC	Joint Commission
JEC	Joint Executive Committee
JLV	Joint Legacy Viewer
MSA	Medical Support Assistant
MTF	Military Treatment Facility
NAS	National Academy of Sciences
NCEHC	National Center for Ethics in Health Care
NCOD	National Center for Organization Development
NLC	National Leadership Council
NVTC	Northern Virginia Technology Council
OAA	Office of Academic Affiliations

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APPENDIX L
ACRONYM LIST

ACRONYM	DEFINITION
OEF	Operation Enduring Freedom
OGC	Office of General Counsel
OI&T	Office of Information and Technology
OIF	Operation Iraqi Freedom
OMB	Office of Management and Budget
ONC	Office of the National Coordinator
OND	Operation New Dawn
OPM	Office of Personnel Management
OTH	Other Than Honorable (Discharge)
PACT	Patient Aligned Care Team
PC3	Patient-Centered Community Care
PG	Priority Group
PHS	U.S. Public Health Service
PO	Program Office
PTSD	Posttraumatic Stress Disorder
QUERI	Quality Enhancement Research Initiative
RCLF	Relevant Civilian Labor Force
RIF	Reduction in Force
SCI	Spinal Cord Injury
SECVA	Secretary, Department of Veterans Affairs
SE	Senior Executive
SES	Senior Executive Service
SHEP	Survey of Healthcare Experiences of Patients
TBI	Traumatic Brain Injury
TMS	Talent Management System
USH	Under Secretary for Health
VA	U.S. Department of Veterans Affairs
VACAA	Veterans Access, Choice, and Accountability Act of 2014
VACI	VA Center for Innovation
VACO	VA Central Office
VAEB	VA Executive Board

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ACRONYM	DEFINITION
VAMC	VA Medical Center
VERC	Veterans Engineering Resource Center
VFW	Veterans of Foreign Wars of the U.S.
VHA	Veterans Health Administration
VHACO	VHA Central Office
VISN	Veterans Integrated Service Network
VSO	Veterans Service Organization
WWP	Wounded Warrior Project



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QUESTIONS ABOUT LICENSED PROFESSIONAL COUNSELORS IN THE VA

1. How many Licensed Professional Counselors have been hired by the VA since the development of the qualification standards in 2010?
2. Of those hired, please provide the total number by GS rank.
3. How many LPMHC hold Supervisory positions in the VA?
4. How many stations have included LPMHC on their Leadership Boards?
5. How many LPMHC currently sit on the Professional Standards Board? How many have been on this board in the past?
6. Why is the LPMHC and LMFT PSB led by a Psychologist, and explain why neither board has ever met standards for PSB as described in VHA Handbook 5005?
7. Why does the LPMHC series have to hold a Supervisory position in order to be promoted to GS-12. Why aren't LPMHC allowed to promote to GS-12 by specialties as is done with Social Workers.
8. How many LPC's were in the VA, doing clinical work under different titles (Readjustment Counseling Therapist, Addictions Therapist) prior to the implementation of the qualification standards? (There was an action item about this...so they know.. I have the action item)
9. How many of these LPC's remain in clinical positions, performing clinical duties as Title 5 employees under the same titles held prior to the implementation of the qualification standards?
10. The VA has admitted to hire of LPC's prior to the development of the qualification standards, simply under other job titles. These hires were made with position vacancies requesting Licensure preferred.
11. How do you explain the VA billing for, verifying licensure of, requiring NPI's and VETPRO for these providers that were hired prior to the development of the qualification standards?
12. How do you justify the continued use of Licensed providers in clinical positions, with Position Descriptions that match the duties of the LPMHC performing these duties under Title 5 (Non-Clinical) positions (Readjustment Counseling Therapist, Addiction Therapist etc)? Title 5 positions are not clinical.
13. How do you justify the decision of the VA to implement an overly restrictive qualification standard (CACREP) and not offer any grandfathering to clinicians who were already employed by the VA (as DoD and Tricare did)? Psychology and Social Work were grandfathered.
14. How do you justify the decision of the VA to implement overly restrictive qualification standard (CACREP), without grandfathering, knowing that this restriction would disqualify a large majority of Professional Counselors, a lot of them Veterans, myself included.
15. How do you justify the decision of the VA to implement an overly restrictive qualification standard (CACREP), without grandfathering, while knowing that the CACREP degree required (60 hour Clinical Mental Health Counseling) was not available in most States, and specifically was not available near military installations for those people who are older. (16 programs nationwide in 1998 that would qualify you for LPC Licensure, some States had a couple CACREP Programs, most States did not have any).
16. How do you justify the continued lack of vacancy position openings in the VA for LPMHCs?
17. How do you justify leadership positions excluding LPMHC and LMFT from position vacancies?
18. Who was on the Board that determined the overly restrictive qualification standard?
19. What empirical data was used to come to the decision to use CACREP as the ONLY qualification without grandfather?
20. Please explain why LPC's who are under other job titles have been denied request to join the list serve for LPMHC's?
21. Please explain why CACREP was provided a \$500,000 contract, under full and open competition after exclusion of sources: Number of offers received ONE. To write standards for the "Counselor

National Emergency Preparedness Language” that was later used to justify the restrictive qualification standard within the VA, DoD and Tricare? (Notice this contract was awarded in September 2006...just before the passage of the bill recognizing LPC’s in December 2006. Also, note...EXTENT COMPETED:

“Full and Open Competition after Exclusion of Sources

This contract was commissioned to write the standards for “Counselor National Emergency Preparedness Language

22. Please explain why the PSB for LPMHC utilized Non-CACREP LPC’s to Board the few LPMHCs that qualified into the VA, then told them that they did not qualify to Board?

23. Please explain why programs for LPMHC internships have not been established or offered at VA’s?

24. Please explain how the VA justifies this negatively impacting Veterans who received their education in and around the military bases at which they were stationed?

25. Please explain why open positions for LPMHC also state that Social Workers and Psychologists are qualified for the position? However, the reverse is not true.

26. How many organic LPMHC’s (not dually licensed) sit on Leadership Boards to include National Representation?

27. Of those, how many are Veterans?

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February 21, 2017

Re: Licensed Professional Mental Health Counselors at Veterans Affairs

Dear Dr. Shulkin:

I recently attended the American Federation of Government Employees (AFGE) legislative conference. I was able to briefly discuss my concerns with you regarding the problems Licensed Professional Mental Health Counselors (LPMHC) experience while working for Veterans Affairs.

Public Law 109-461, which was enacted December 22, 2006, explicitly recognized both "licensed professional mental health counselors" and "marriage and family therapists" as mental health providers within Veterans Affairs. On September 28, 2010, the Department of Veterans Affairs (VA) released a set of qualification standards for licensed professional mental health counselor (LPMHC) positions, as well as for marriage and family therapist positions. Prior to the adoption of the new standards, counselors were typically eligible only for "rehabilitation counseling therapist" positions, at a maximum General Service (GS) level of 11. At this level, counselors were not allowed to work in supervisory positions. Although LPMHC's have qualification standards, there are still limited opportunities for advancement, training, transferability, or promotion. Although hundreds of employees with these credentials have been working in the VA under different position descriptions, they have not been transitioned into an LPMHC position. This may be because the VA has made it a local decision to transition the employee. Or, the National standards still do not recognize these employees because they may not have attended a school that was accredited. The accreditation was not available to many of these employees when they went to school. The accreditation is anecdotal according to the Council for Accreditation of Counseling & Related Educational Programs (CACREP) own website. The Department of Defense and TRICARE have recognized these providers and grandfathered them into a provider status. The VA is the only employer that does not recognize LPMHC's that did not attend a CACREP accredited school. The VA has also grandfathered Social Workers and Psychologists prior to having accreditation in their professions. We are asking for a grandfather clause for any provider that is State licensed or eligible. We are asking that the VA transition any employee that is eligible to work in that position automatically that chooses to do so.

Many of the providers that do not qualify for the LPMHC position are working as Addiction Therapists, Readjustment Counselors, or Psychology Technicians to name a few. These are Title 5 positions and are considered "non-clinical". These are direct line staff that have clinical duties within these professions to provide specialized care to Veterans. We ask that if the VA is unwilling to grandfather LPMHC's, they instead bring these positions to a Hybrid 38 status and GS-11 pay scale to reflect their knowledge, skills, and abilities.

The Commission on Care report recommendation #2 stated that the VA should "enhance clinical operations through more effective use of providers and other health professions, and improved data collection and management". This would be an effective way to utilize the providers already in place and at their disposal, increase Veterans access to care, and decrease workload on higher level providers. The RAND report which is a survey of 522 psychiatrists, psychologists, and licensed clinical social workers found that 13% met the study's criteria for "cultural competency" in the military, only 6% had ever served in the military. According to the RAND report, LPMHC's scored the highest for familiarity of evidenced-based practices for PTSD and combat-related mental health issues. Many of the LPMHC's attended their schooling on military installations where CACREP was not available, therefore excluding them from LPMHC positions.

VA-18-0457-A-002278

I would like to have the opportunity to discuss this matter in more detail. I have attached 25 questions I would like to have answered by the Veterans Affairs. I have tried to get the answers to these questions, but I was met with hostility. This is a brief synopsis of a larger systemic problem that negatively impacts Veteran care and employee morale. Please contact me through my personal information listed below. I appreciate any assistance you can provide.

Regards,

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[REDACTED]

[REDACTED]

(217) 474-(b) (6)

(b) (6)@gmail.com

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Ready to Serve

Community-Based Provider Capacity to Deliver
Culturally Competent, Quality Mental Health Care
to Veterans and Their Families

Terri Tanielian

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OVERVIEW

Addressing the mental health needs of military service members, veterans, and their families is a national priority and the focus of many efforts at the federal, state, and local levels.¹ Over the past decade, several studies have documented the extent of the need for mental health treatment among this population, and billions of dollars have been invested to expand the capacity of the systems designed to support veterans and their families at multiple levels and across sectors.² The White House and Congress have been working directly with the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to ensure that mental health providers are hired and programs are disseminated to address mental health needs within the veteran community,³ but concerns remain about whether the capacity of these systems is sufficient to meet the demand.⁴ Recently, new federal legislation was enacted to increase VA beneficiary access to private, civilian-sector care.⁵ Although the opportunity to receive care in the community existed in the past, the new law will likely greatly expand the rate at which eligible veterans seek care outside of the VA. This raises a new concern about the capacity of the civilian mental health service sector to meet the needs of veterans and their families.

While many veterans already receive care from private providers and community-based organizations,⁶ little is known about the extent to which veterans and their families receiving such care are getting high-quality care, are benefiting from that care, and are satisfied with their providers. There have been multiple efforts at the national, state, and community levels to promote awareness of military and veteran-related issues among community-based mental health providers, including the development of specialized training curricula and certification programs. With the intent of improving providers' understanding of and skills for addressing needs in the population, these training opportunities vary from short webinars to weeklong courses to intense, certificate- or degree-awarding programs.⁷

In addition, nongovernmental organizations have pursued the formation of specialized networks, such as Give An Hour and the Star Behavioral Health Provider network,⁸ and the opening of new community-based clinics dedicated to treating military service members, veterans, and their families.⁹ To date, however, little is known about the capacity and performance of these networks and specialized clinics.

Monitoring access to and quality of mental health care for service members, veterans, and their families is important for ensuring that their needs are met effectively. A recent Institute of Medicine (IOM) study highlighted the challenges that both DoD and the VA face in monitoring such issues within their own systems—including the facilities they own and operate—and noted that their visibility into the “outside” systems where the population also receives care is even more limited.¹⁰

RAND's study was designed to assess the potential performance of the system of care for service members, veterans, and their families, with a particular focus on community-based, civilian providers. This study specifically addresses the potential readiness of mental health providers working in community settings to deliver culturally competent, high-quality care to service members, veterans, and their families. This study builds upon previous studies examining similar issues for providers working within VA and DoD settings, as well as two studies of civilian providers.¹¹ We explore provider capabilities, attitudes, and behaviors as they relate to providing high-quality and culturally appropriate care, and we examine what factors may predict their readiness to deliver such care. Understanding the skills and training of mental health providers from non-DoD and non-VA settings who are potentially delivering care to service members, veterans, and families will help inform expectations about what types of care these beneficiaries may experience within civilian settings and the extent to which that care is of a high quality. Such information can also help direct future training efforts designed to ensure that providers are ready, capable, and willing to address the mental health needs of our nations' veterans and their families. The following sections provide additional information about our approach, findings, and the implications from this research.

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SURVEY OF MENTAL HEALTH PROVIDERS

Improving mental health outcomes for veterans and their families requires both *access to care* and receipt of *high-quality care*.¹² The overall goal of this study was to understand the readiness of community-based providers to deliver high-quality mental health care to veterans and their families once they access such care. The IOM has defined *high-quality care* as care that has been demonstrated as effective (i.e., evidence-based), safe, patient-centered, timely, efficient, and equitable.¹³ Using this definition as a reference point for our study, we conceptualize the readiness of providers to deliver veteran-friendly, high-quality mental health care as having two main components (see Figure 1). The first is *cultural competency*, or the degree to which providers are sensitive to the unique needs and relevant issues of concern within the veteran population. This cultural sensitivity and competency can facilitate providers' ability to deliver patient-centered care and develop an effective therapeutic rapport.¹⁴ The second main component of our provider readiness definition is the degree to which community-based providers have the *capacity and inclination to deliver clinically appropriate, evidence-based care*. In particular, the survey focused on evidence-based care related to major depressive disorder (MDD) and posttraumatic stress disorder (PTSD). These conditions were highlighted because of their prevalence among the recently returned veteran population and their association with experiences common to military deployments. Each concept is defined in further detail in subsequent sections.

To assess provider readiness to deliver high-quality, culturally competent care to service members, veterans, and their families, we employed a web-based survey of mental health providers. The sections below outline the methods used to sample providers and describe the survey measures used to assess the relevant components of readiness. We also gathered data on the characteristics of responding providers, their clinical caseloads, and their practice settings to explore how these factors relate to overall readiness.

Sampling

To identify and survey mental health providers working in community-based settings, we relied upon existing panels of health care providers maintained through GfK Custom Research and two of their vendors. Practicing mental health

professionals in the panels were sent emails inviting them to participate, and participants were provided with tokens of appreciation through the traditional means of providing incentives in their host panels (i.e., awarded points based on the anticipated respondent burden). Specifically, psychiatrists were recruited from an existing GfK provider panel originally drawn from the American Medical Association membership list and later augmented to refresh and expand the panel. Psychologists were recruited from an existing allied health care provider panel maintained by Research Now. Social workers and licensed professional counselors were recruited from existing panels maintained by Research Now and a separate panel maintained by EMI. The demographic and practice characteristics of all mental health providers within these panels were not available and the degree to which their panel membership is representative of each provider population is unknown. GfK emailed potentially eligible participants a standard recruitment email asking for their participation in a 30-minute survey about their mental health practice.

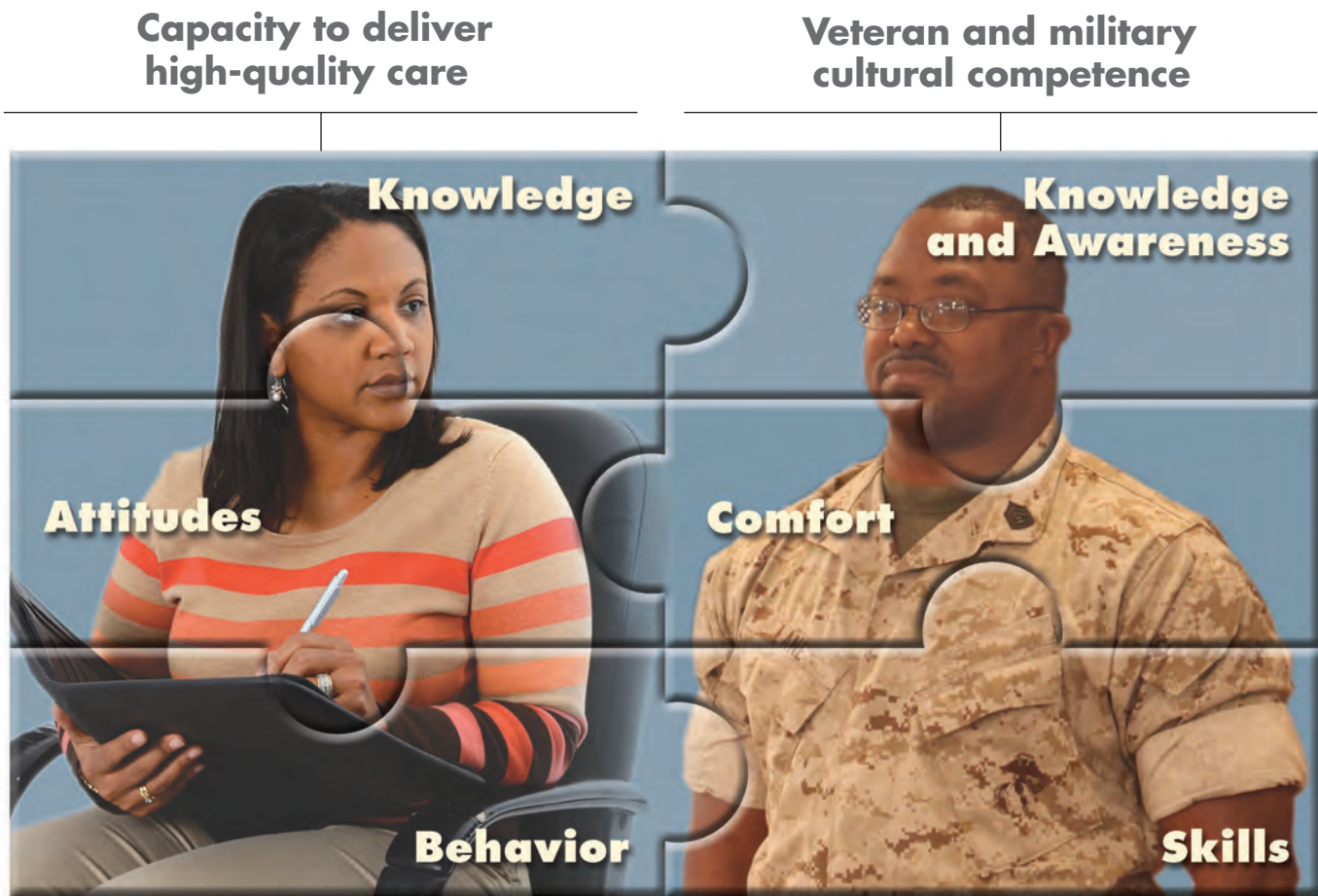
The web-based survey was fielded only for the period of time required to reach the target numbers of each provider

Abbreviations

CBT	Cognitive Behavioral Therapy
CPG	clinical practice guideline
CPT	Cognitive Processing Therapy
DO	doctor of osteopathic medicine
DoD	Department of Defense
EAP	Employee Assistance Program
EBP	evidence-based psychotherapy
EMDR	Eye Movement Desensitization and Reprocessing
IPT	Interpersonal Therapy
IOM	Institute of Medicine
LCSW	licensed clinical social worker
LMHC	licensed mental health counselor
LPC	licensed professional counselor
MD	doctor of medicine
MDD	major depressive disorder
MCSW	master's of clinical social work
ns	not significant
PE	Prolonged Exposure Therapy
PhD	doctor of philosophy
PsyD	doctor of psychology
PTSD	posttraumatic stress disorder
SIT	Stress Inoculation Therapy
VA	Department of Veterans Affairs
WRAIR	Walter Reed Army Institute for Research

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Figure 1: Readiness for Veteran-Friendly, High-Quality Mental Health Care



type (target goal was 125 respondents in each provider group, to ensure sufficient sample size for detecting differences between provider groups). All target numbers were reached within three weeks. Responding providers were screened to ensure that they were

- trained and licensed as a professional provider of mental health services in their state
- working directly with patients/clients as part of their professional responsibilities
- one of the four provider types of interest
 - psychiatrist—doctor of medicine (MD) or doctor of osteopathic medicine (DO)
 - clinical psychologist—doctor of philosophy (PhD) or doctor of psychology (PsyD)
 - licensed clinical social worker (LCSW) or master's in clinical social work (MCSW)
 - master's-level licensed professional counselor (LPC) or licensed mental health counselor (LMHC).

Participants who indicated later in the survey that they were fully retired or not currently in practice were excluded. The study was determined to be exempt from human subjects review by the RAND Human Subjects Protection Committee. The topics of military and veteran mental health care, cultural competency, and evidence-based practice were not specifically identified in the recruitment email sent by GfK or in the introductory page of the survey; thus, the topic was not likely to influence the choice to participate or complete the full survey. As with all surveys conducted among convenience samples, it is difficult to understand the potential bias introduced by those choosing to participate in such panels and surveys compared to the full population of providers.

Measures

RAND researchers designed a web-based survey to collect information from mental health providers across several domains. For each of the two components of our

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readiness concept, providers were asked about their knowledge, attitudes, and behaviors relevant to the concept. Where possible, survey items come from or were adapted from prior surveys of mental health professionals. Where necessary, RAND researchers developed new items for domains without published survey instruments. Table 1 provides an overview of the survey domains, their corresponding items, and information about how the items were used to characterize providers and inform the analysis. The following section briefly describes the measures used across the domains of interest. Readers interested in additional details about specific items, including psychometric properties and scoring criteria, where available, can reference the Appendix at http://www.rand.org/pubs/research_reports/RR806.html.

Provider Characteristics

In addition to asking respondents to indicate their provider type (e.g., social worker, psychologist), we gathered information on provider gender, years since most recent degree, whether they ever served in the armed forces,¹⁵ whether they had any close family members who served in the military, and if they ever worked in a military setting or in the VA (including training or fellowships).¹⁶ We also asked how providers spent their time across a series of activities, including conducting assessments, providing direct patient care (psychotherapy and medication management), receiving supervision or consultation from others, providing supervision to others, and other professional or administrative responsibilities such as research or teaching.¹⁷ In addition, we asked a series of questions about enrollment in provider networks that typically serve military and veteran populations, including TRICARE (the DoD insurance program for active component service members and their families, retirees and their families, as well as some eligible Guard and Reserve Component personnel and their families), Military OneSource (an Employee Assistance Program [EAP]–like program that employs some mental health providers to support DoD beneficiaries), and the new VA Patient Centered Community Care Contract (established for specialty providers).

Practice and Clinical Caseload Characteristics

To understand the context in which respondents practice, we assessed a number of features of their practice settings and their clinical caseloads. All questions in this section were structured

to assess caseloads, hours, and setting characteristics of the most recent typical work week.

We asked providers to report the size of their patient caseload in the most recent typical week, including patients seen in individual or family format as well as those seen in group settings. We gathered information about the proportion of patients by the locus of care, by age group, and by current diagnosis using categories from the Diagnostic and Statistical Manual—Version 5. We also asked respondents to estimate the proportion of their current caseload that: were current members of the military, were former members of the military (veterans), or were family members of current or former members of the military.

To understand the types of settings and facilities our respondents were working within, we assessed the percentage of patient care hours that were spent in different physical locations (e.g., solo office practice, VA facility). Using responses to the setting and insurance items, we classified providers into one of three groups: DoD/VA providers (those providers spending any patient care time in a DoD or VA health care setting), non-DoD/VA providers who accept TRICARE, and all other providers (i.e., those that do not spend any time in a DoD or VA facility or accept TRICARE).

We also gathered the ZIP code of the facility in which the provider saw the greatest number of patients in the most recent typical work week. Using the ZIP code information for the provider's setting, we calculated the distance between their setting and the nearest DoD or VA health care facility to create a proximity to DoD/VA variable. With this continuous variable, we also created a categorical variable for analyses: within ten miles or 11 or more miles away.¹⁸ Similarly, we used the ZIP code of the provider's setting to determine if they worked in an urban or rural setting.¹⁹

Assessment Behaviors

To understand the frequency of routine screening practices employed by respondents, we asked providers to report how often, using a 5-point scale (never, seldom, occasionally, often, and always), they screened patients: (1) to determine if they are current or former members of the Armed Forces or a family member of such a person; (2) for history of any traumatic events, including those experienced during military service, and (3) about stressors related to military life or being a veteran.

Table 1: Overview of Mental Health Provider Survey Domains

Domain	Types of Items	Source and Use
Provider characteristics	<ul style="list-style-type: none"> • Training (MD, DO, PhD, LCSW, MCSW, LMHC, LPC) • Gender • Years in practice/experience • Primary therapeutic orientation • DoD or VA work experience • Relationships with current/former members of Armed Forces 	These items were adapted from prior VA, U.S. Army, and American Psychiatric Association studies. They are used to characterize the respondents and examine predictors of practice behaviors and provider attitudes.
Practice and caseload characteristics	<ul style="list-style-type: none"> • Caseload size • Distribution of caseload by age, diagnosis, insurance type, and military status • Setting (outpatient/inpatient/partial, solo/group, public/private) • Participation in networks that serve military members and veterans 	These items were adapted from prior American Psychiatric Association and U.S. Army surveys of mental health providers. They are included to help describe the practice setting and typical patient caseload served by respondents. The data are used to characterize the respondents and examine predictors of high-quality mental health care.
Assessment behaviors	<ul style="list-style-type: none"> • Employment of routine screening approaches, including taking a military history and assessing suicide risk and comorbid problems such as pain and sleep disturbances • Use of validated screening or interview instruments • Frequency of engaging other clinicians and family members 	These items were adapted from prior surveys used by the Center for Deployment Psychology and the U.S. Army. The data are used to understand provider assessment practices.
Military cultural competency	<ul style="list-style-type: none"> • Knowledge of military and veteran culture • Comfort working with military service members and veterans • Self-reported proficiency in treating military service members and veterans • Participation in military/veteran culture training 	These items were adapted from prior surveys used by the Center for Deployment Psychology and the VA. The data will describe respondents' knowledge of military and veteran culture. The data are also used to define analytic groups of providers with respect to their military cultural competency.
Training to deliver evidence-based care	<ul style="list-style-type: none"> • Training and supervision in evidence-based psychotherapies (EBPs) 	These items were adapted from other surveys used by the U.S. Army and assess receipt of training and supervision in EBPs for PTSD and MDD.
Comfort with treatment approaches and military/veteran populations	<ul style="list-style-type: none"> • Comfort treating depression • Comfort treating PTSD • Comfort treating military members and veterans • Comfort addressing war-related stress • Comfort treating military family members 	These items were developed by RAND researchers for this study. The items provide descriptive information about the level of "comfort" among respondents in these areas. Some items are also used in the derivation of the military cultural competency variable.
Use of guideline-concordant care for PTSD and MDD	<ul style="list-style-type: none"> • Self-reported proportion of caseload treated with EBPs • Use of psychotherapeutic techniques consistent with EBPs 	These items were adapted from other surveys used by the U.S. Army, U.S. Air Force and RAND and assess use of EBPs recommended in civilian and DoD/VA practice guidelines.
Attitudes toward practice guidelines	<ul style="list-style-type: none"> • Attitudes toward clinical practice guidelines (CPGs) and evidence-based medicine 	These items were adapted from an instrument developed for the New York State Psychiatric Association. The items ask providers to rate their attitudes toward using clinical guidelines and may help explain variation observed in use of guideline-concordant care for PTSD and MDD.
Prescribing practices	<ul style="list-style-type: none"> • Most common medications prescribed for PTSD and MDD 	This item was adapted from an Army study titled "Steps Up" and is a measure of guideline-concordant pharmacological treatment for PTSD and MDD. We examine the percentage of providers who prescribe appropriate medications for PTSD and MDD.

SOURCES: We used several instruments as references in developing this survey. All of these prior surveys were developed for other purposes, but provided relevant information and suggestions for items that would help us to assess use of guideline-concordant care, evidenced-based approaches, and routine practice behaviors. We also drew on items in other surveys used to assess the impact of military and veteran cultural awareness training on participants through the Center for Deployment Psychology (for example, the Star Behavioral Health Providers) programs to inform our items on knowledge/attitudes/awareness of military and veteran culture. It should be noted that the overwhelming majority of the items have been modified in some manner from our original references; that is, we changed scales, reference points (all patients versus "this" patient), and response items in an effort to tailor this survey to the specific issues and population for this study. More information about the surveys reviewed can be found in the Appendix.

Military Cultural Competency

To understand the degree to which providers were sensitive to military and veteran culture, we asked a series of questions designed to assess providers' knowledge and awareness of, and attitudes toward, military culture. We also assessed their perceived proficiency in working with military and veteran populations and exposure to prior training in military cultural competency. Figure 2 provides an overview of the concepts we used to define cultural competency for this study.

To assess knowledge and awareness of military and veteran culture, we asked providers to rate their level of familiarity (on a 5-point Likert scale) with U.S. military culture and practices. Similarly, we asked providers to indicate their level of comfort with respect to working with military service members and veterans, working with patients/clients with military or war-related stress, and working with family members of military service members or veterans.

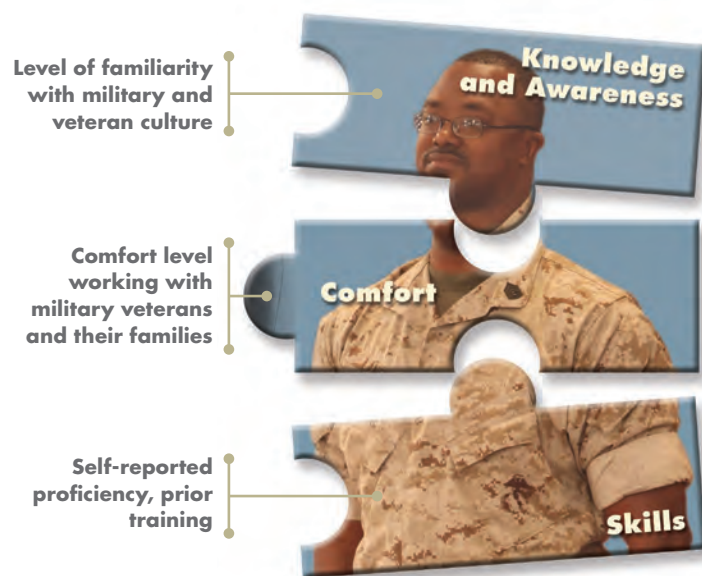
Respondent proficiency in military and veteran culture was assessed via ten items that tapped self-reported perceptions of cultural competency in three different domains, cultural knowledge (three items), cultural sensitivity (one item), and cultural skill (six items). These items, modified from items on the Nurse Cultural Competence Scale,²⁰ asked respondents to read statements and agree or disagree on a 5-point scale. Training in military culture was assessed via one yes/no item that asked about receipt of formal training in military and veteran culture.

Using all of these items described above, we derived a military cultural competency score by scoring each item as described in Table 2. This overall measure of military cultural competency summed the continuous variables for a range of 0–22, and a cut-score of 15 or more points was defined as “high military cultural competency.”

Capacity to Deliver Evidence-Based Care

As highlighted earlier, provider capacity to deliver evidence-based care to patients may depend on several factors. For example, prior training in the delivery of evidence-based approaches may be one indicator that a provider has capacity to deliver high-quality care; however, it is also important to understand the degree to which they have or will use these techniques to address the mental health needs of veterans and their families when they access providers. Other factors, such as their beliefs or attitudes about such approaches, may affect their willingness to use the techniques. Thus, to understand provider capacity to deliver evidence-based care, we assessed several domains:

Figure 2: Concepts Related to Provider Military Cultural Competency



training in evidence-based approaches, use of such treatment in routine practice, attitudes toward practice guidelines, and other routine behaviors. These are described in Figure 3 and in the following sections.

Training in Evidence-Based Psychotherapies for PTSD and MDD

To assess provider capacity to deliver evidence-based psychotherapies (EBPs) for PTSD and MDD, we assessed whether providers: (a) held formal certification or intensive/advanced training and (b) had supervised professional practice in any of five psychotherapies specified as first-line therapies for PTSD and depression in VA/DoD CPGs (2009, 2010).²¹ Providers who had received training and supervision in at least one type of EBP were classified as “capable” of delivering evidence-based treatment for the given condition.

Use of Evidence-Based Treatment Approaches

A dichotomous variable was used to summarize providers' reliance on evidence-based treatment modalities. Each provider estimated the percentage of patients that they treated in the most recent typical work week with 16 different treatment approaches. Treatments ranged from well-validated approaches for treating PTSD (e.g., Prolonged Exposure Therapy [PE]) to general therapeutic techniques without strong efficacy find-

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Table 2: Measures of Military Cultural Competency

Concept	Measure	Response Scale	# of Items	Operationalization
Knowledge and awareness	Level of familiarity with military and veteran culture	1–5 Likert scale (<i>Completely unfamiliar– Extremely familiar</i>)	8	1= <i>Very familiar</i> or <i>Extremely familiar</i> ; 0 otherwise (0–8 range)
Comfort	Comfort level working with military veterans and their families	1–5 Likert scale (<i>Not at all comfortable– Extremely comfortable</i>)	3	1= <i>Mostly comfortable</i> or <i>Extremely comfortable</i> ; 0 otherwise (0–3 range)
Skills	Self-reported proficiency	1–5 Likert scale (<i>Strongly disagree–Strongly agree</i>)	10	1= <i>Agree</i> or <i>Strongly agree</i> ; 0 otherwise (0–10 range)
	Prior training in military culture	Yes/No	1	1=Yes; 0=No (0–1 range)

ings (e.g., supportive psychotherapy). Approaches categorized as evidence-based treatments included those for PTSD (PE, Cognitive Processing Therapy [CPT], Eye Movement Desensitization and Reprocessing [EMDR], and Stress Inoculation Training [SIT]), depression treatments (Cognitive Behavioral Therapy [CBT], Interpersonal Therapy [IPT], and Acceptance and Commitment Therapy), and two additional treatments with support for use with patients who had substance use disorders or borderline personality disorder (i.e., Motivational Interviewing, Dialectical Behavioral Therapy).²² Past-week evidence-based practice was dichotomized between providers who reported treating 75 percent or more of their patients with EBPs and those who did not meet this threshold. This threshold creates an easily summarized estimate of the proportion of providers from which patients are reasonably certain to receive an evidence-based treatment.

Practice Behaviors Related to Use of Psychotherapy for PTSD

To assess providers' adherence to therapeutic techniques associated with three validated PTSD psychotherapies (PE, EMDR, CPT), we used a modified version of a session behavior scale used in a Walter Reed Army Institute for Research (WRAIR) study in 2013.²³ Two items assessed treatment techniques representative of PE, two items assessed techniques associated with CPT, and one item assessed a technique unique to EMDR. For this report, we summarize the proportion of providers who reported that they “often” or “always” use therapeutic techniques associated with at least one EBP approach for PTSD. Note that providers who do not see patients with PTSD reported instead on their likelihood of using each technique if they “were to treat patients with PTSD.”

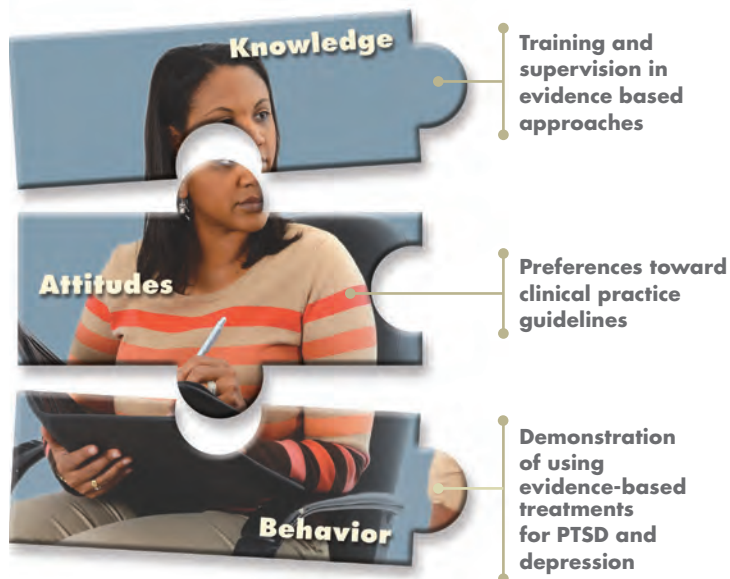
Practice Behaviors Related to Use of Psychotherapy for Depression

We used a modified version of the Psychotherapy Practice Scale to assess providers' adherence to the therapeutic techniques associated with two evidence-based approaches to depression treatment (CBT and IPT). The original scale prompted providers to consider a specific, randomly selected patient from their caseload with MDD. For ease of administration, these instructions were modified to ask providers who treat patients with depression to estimate the frequency with which they use nine distinct therapeutic techniques. Providers who do not see depressed patients were asked to estimate the likelihood that they would use each technique if they were to treat a patient with depression. Three items assessed treatment techniques representative of CBT, three assessed techniques associated with IPT, and three assessed common, but less well-supported, psychodynamic techniques. For this study, the full, 16-item Psychotherapy Practice Scale was reduced to nine items to reduce respondent burden.²⁴ For this report, we summarize the proportion of providers who reported that they “often” or “always” use the therapeutic techniques associated with either CBT or IPT with depressed patients. Note that providers who do not see patients with depression reported instead on their likelihood of using each technique if they “were to treat patients with depression.”

Medication Management for PTSD and Depression

To assess adherence to evidence-based guidelines for psychopharmacologic treatment of PTSD and MDD,²⁵ prescribing providers listed the “two most common first-line psychopharmacologic treatments” they prescribe for patients with each condition. A list of 90 common psychoactive medications—including antidepressants, anxiolytics, sedative-hypnotics, psychostimulants, and opioid analgesics—was provided for

Figure 3: Concepts Related to Provider Capacity to Deliver Evidence-Based Care



respondents to select from. To meet our criteria for “evidence-based prescriptive practice,” respondents had to select at least one antidepressant from the list for depression *and* one selective serotonin reuptake inhibitor or prazosin for PTSD.

Attitudes Toward CPGs

CPGs provide recommendations designed to improve patient care. They are developed after a systematic review of the evidence and consideration of the harm and benefit associated with a given approach.²⁶ Although the intent is to ease provider burden by succinctly recommending best practices for a given condition, some providers see CPGs as overly rigid, oversimplified, and as a threat to their clinical independence. For this study, we included the 11-item CPG Attitudes Scale from a New York State Psychiatric Association study as a proxy for provider attitudes toward evidence-based medicine and validated treatments for PTSD and MDD.²⁷ In the descriptive analyses below, scale scores are dichotomized into those who, on average, “agree” or “strongly agree” with CPG supportive statements (labeled “above threshold”) and those who fall below this threshold. Attitudes toward CPGs are entered as a continuous variable in the regression analysis, that is, the mean of all 11 items.

Analysis

We performed analyses to describe the provider sample that generally fall into three types: (1) basic univariate analyses,

(2) bivariate comparisons across pairs of variables, and (3) logistic or linear regressions to assess the contribution of sets of predictors to key dependent variables. First, univariate statistics were calculated to provide an introductory understanding of the pattern responses. For instance, the mean and standard deviation of the CPG Attitude Scale were calculated.

To assess relationships across pairs of dichotomous and continuous variables, we used independent-sample t-tests. To assess relationships across pairs of categorical variables, we used chi-square analyses. Finally, logistic and linear regressions were used to assess the relationship between a binary outcome and multiple predictor variables simultaneously. These regressions identify which predictors (if any) are most influential with respect to a specific outcome variable after controlling for the effect of all other predictor variables in the model.

RESPONDENT CHARACTERISTICS

We recruited a total of 522 mental health care professionals to participate in the survey (Table 3). Respondents included roughly equal groups (by design) of psychiatrists ($n=128$), psychologists ($n=127$), social workers ($n=132$), and licensed counselors ($n=135$). The majority of participants across professions were female (60 percent) with some variation by profession (the majority of psychiatrists—77 percent—were male).²⁸ Respondents generally worked full time. In addition, participants reported seeing the majority of their patients (77 percent on average) in outpatient settings in the most recent typical work week, and smaller percentages of patients (17 percent on average) were seen in inpatient and other settings (5 percent), such as schools, correctional facilities, or partial day programs. On average, providers reported spending the majority of their professional hours (19 percent) in a solo office setting, followed by a group office setting (15 percent). The percentage of professional hours spent by setting did vary by provider type.

As described earlier, we created an indicator of provider affiliation relative to military and VA settings, as well as the TRICARE provider network. The first group included any provider who indicated seeing patients (any number of patients) currently in a DoD or VA setting ($n=61$). The second group included those providers who did not see any current patients in a DoD or VA setting, but who reported being affiliated with the TRICARE network ($n=135$). The final group reported neither of these military affiliations ($n=520$).

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Prior Experience in the Military or in VA Settings

On average, 6 percent of respondents reported that they had served in the military.²⁹ Participating psychiatrists had the highest rates of military service, at 10 percent. More than one-third of respondents reported having family members in the armed forces. We note that it is not clear from our survey whether time spent in service was as a mental health provider or if individuals pursued their mental health care licensing following their military service.

Military and VA treatment settings each provide professional training opportunities for health care providers in the United States.³⁰ The VA in particular offers several clinical internship and fellowship opportunities for health care providers, including mental health professionals. We found that, overall, about one-third of respondents reported some experience working in some capacity (during training or in other roles) in either a military setting or in the Veterans Health Administration. There was some variation by provider type with regard to experience in military and VA settings, with

more psychiatrists reporting having worked in a military or VA setting (62.5 percent) compared to one-third of psychologists and one-fifth of social workers and licensed counselors. The average time that providers worked in military or VA settings was 4.5 years ($SD=6.06$). It should be noted that we asked about time spent in either a military or VA setting; however, these settings may differ in important ways with respect to the nature of the experience and training offered. In addition, for providers reporting having served or working in military or VA settings, their time spent in service or working in these facilities may have been in a different capacity than as a mental health provider. This is particularly true for licensed counselors who are traditionally not employed with VA health settings as mental health providers. Thus, some of these providers may have worked within military or VA settings as nonmedical counselors or in other capacities either before or after their licensing. Regardless of their professional designation within these settings; however, the providers are reporting having worked in such settings and as such likely had exposure to military and/or veteran patients and families.

Table 3: Respondent Demographic and Practice Characteristics

Respondents	All (n=522)	Psychiatrists (n=128)	Psychologists (n=127)	Social Workers (n=132)	Licensed Counselors (n=135)
Female	59.8%	22.7%	74%	80.3%	61.5%
Works full time	95.7%	98.4%	97.6%	94.7%	92.3%
Setting in which greatest number of patients seen	Solo office practice	Solo office practice	Solo office practice	"Other" setting	Group office practice
Solo office practice	18.4%	31.3%	22.8%	6.8%	13.3%
Group office practice	16.5%	15.6%	13.4%	9.8%	2.7%
Ever served in Armed Forces	6.1%	10.2%	4.7%	1.5%	8.2%
Has family in Armed Forces	38.1%	29.7%	44.9%	42.4%	35.6%
Ever worked in DoD or VA setting	34.9%	62.5%	34.7%	21.1%	22.2%
Primary setting is within ten miles of either VA or DoD	55.5%	53.9%	56.7%	59.4%	51.9%
Registered in TRICARE network	29.5%	37.5%	28.3%	27.2%	25.1%
Part of Military OneSource	5.2%	3.2%	3.2%	5.3%	8.9%
Registered in VA Veterans Patient Centered Community Care network	6.1%	5.5%	3.9%	6.8%	8.1%
Average number of years since completing training	18.0 years	26.2 years	17.0 years	16.6 years	13.9 years

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Practice Settings and Proximity to Military or VA Facilities

Respondents reported working and seeing patients in a number of different settings. Figure 4 displays the percentage of professional hours that respondents reported spending in the most recent typical work week by clinical practice setting; Table 4 summarizes the percentage of patients seen by the locus of care (outpatient versus inpatient). Geographically, respondents reported working in practice locations across the continental United States and in Hawaii, Alaska, and Puerto Rico. A little more than one-half of participating providers practiced within ten miles of either a VA or DoD facility. Figure 5 displays a map of respondents' practice locations, military treatment facility locations, and VA hospital or clinic locations. The map also includes a state-by-state indication of the veteran population as a proportion of the overall population.

Provider Activity

Across all provider types, respondents reported working an average of 48 hours per week ($SD=22.87$). They indicated spending the largest percentage of their time in direct patient care doing either medication management or psychotherapy and assessment (Table 5). Participating social workers, psychologists, and licensed counselors reported spending about half their time on psychotherapy and assessment. Participating psychiatrists reported spending a majority of their time

(59 percent) on medication management and only about 30 percent of their time on psychotherapy and assessment. Amount of participants' time spent on professional and administrative activities—such as committees, Continuing Medical Education, research, writing, training, and forensic activities—varied by provider type. For example, psychiatrists reported that they spend about 8 percent of their time on professional and administrative activities, whereas psychologists reported spending about 31 percent of their time on those activities.

Therapeutic Orientation

The primary therapeutic orientation reported by respondents also varied by provider type (Table 6). The majority of social worker and licensed counselor respondents reported that their primary therapeutic orientation was cognitive and/or behavioral. A large proportion of psychologists also identified cognitive and/or behavioral as their primary therapeutic orientation (41 percent), and others identified with integrative or eclectic approaches (30 percent). Psychiatrists generally identified biological/psychopharmacologic as their primary orientation.

Certification, Training, and Supervision in Therapeutic Techniques

Respondents indicated being certified or trained in an array of EBPs for PTSD and MDD and have been supervised by others

Figure 4: Percentage of Total Professional Hours Reported, by Clinical Setting

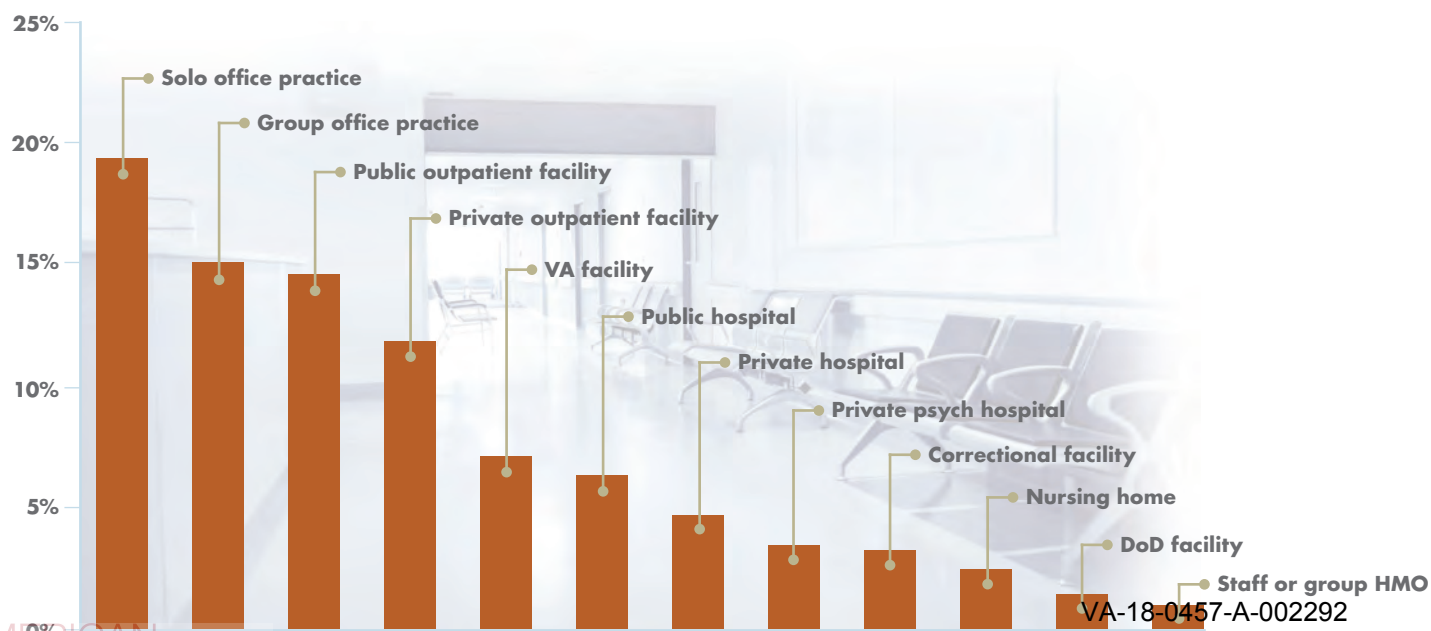


Table 4: Percentage of Patients Seen, by Respondents by Setting

	All (n=522)	Psychiatrists (n=128)	Psychologists (n=127)	Social Workers (n=132)	Licensed Counselors (n=135)
Outpatient setting	77.4	84.2	81.9	69.4	74.4
Inpatient setting	17.0	14.3	9.8	24.0	24.0
Other settings (school, prison, etc.)	5.0	1.5	8.3	6.6	5.6

in these methods. As Table 7 shows, CBT was the most common therapeutic technique respondents reported being trained to deliver, followed by IPT and CPT. Relatively fewer respondents had training and supervision in PE, EMDR, and SIT.

Assessment Behaviors

To understand the usual practice behaviors of participating providers, we asked them how often they implement a series of practices related to screening and assessment. While these screening behaviors are not necessarily linked specifically to quality or cultural competency, they do inform whether providers routinely adopt recommended approaches in their clinical settings. Figure 6 shows that the majority of respondents report often or always screening for a history of trauma, suicide risk, physical health problems, sleep issues, and pain. Only one-half reported screening for military affiliation and less than one-half report assessing stressors associated with military life. Less than one-half of the respondents reported often or always using validated screening tools to assess for such conditions as depression, PTSD, or alcohol and drug use.

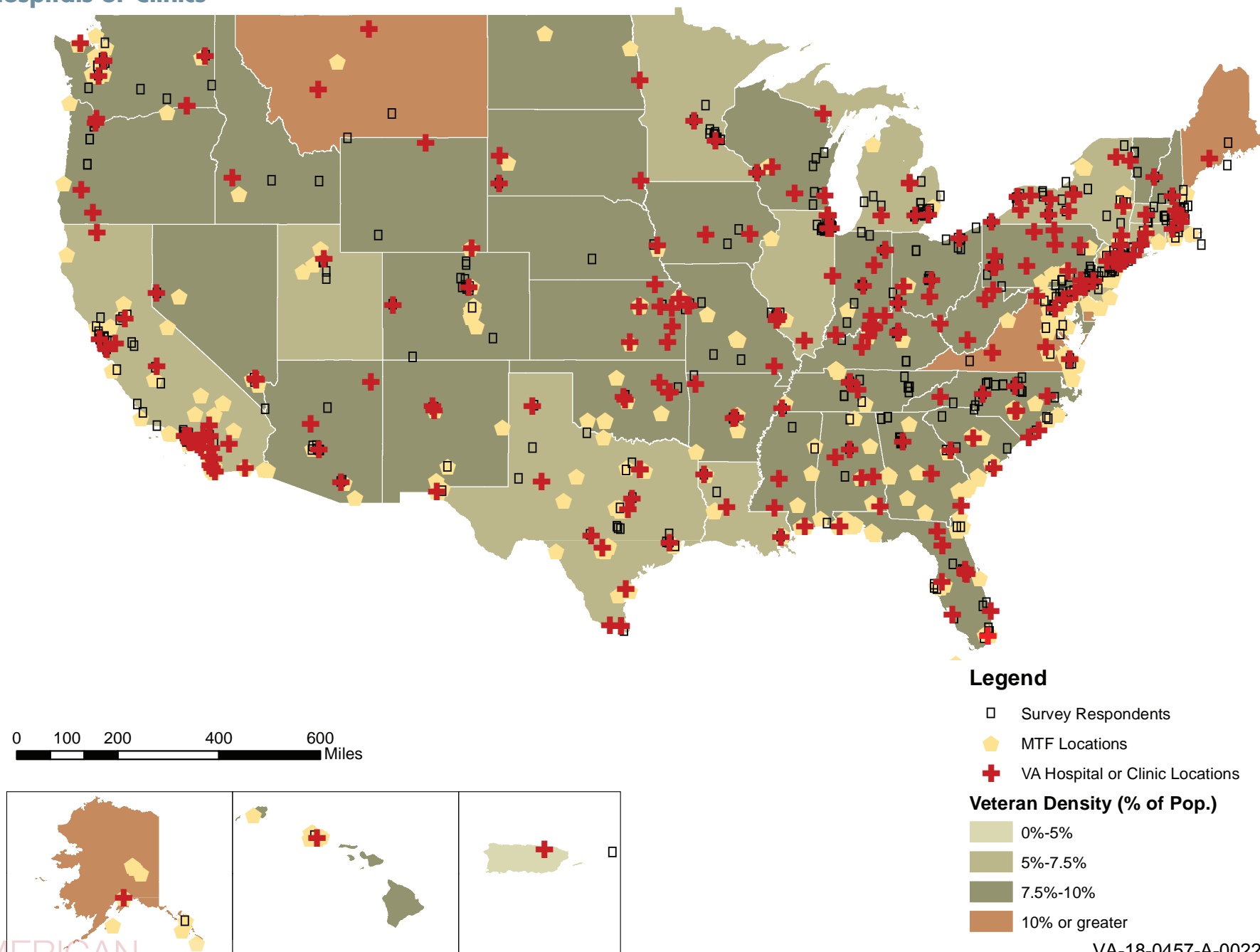
MILITARY CULTURAL COMPETENCY

In this section, we report our findings on the military cultural competency of survey respondents. Cultural competency includes their knowledge and comfort related to military culture, self-reported proficiency working with veteran and military-affiliated patients, and prior training in military culture. We also report how individual and practice characteristics are associated with these aspects of military cultural competency. Understanding which factors are related to being more “veteran friendly” can help direct military cultural competency training to the set of providers most in need. We hypothesized that military cultural competency would be low among those providers who do not already treat veteran or military-affiliated patients.

Respondents reported being either “very familiar” or “extremely familiar” on an average of 1.84 ($SD=2.7$) of the eight military knowledge items presented and reported being “mostly comfortable” or “extremely comfortable” with an average of 1.62 ($SD=1.3$) of the three comfort items. A breakdown of knowledge items can be seen in Table 8, and indicates a wide range of self-reported knowledge on different aspects of military culture, with only 15 percent reporting being very or extremely familiar with military deployment and slang terms, but 38 percent saying they were very or extremely familiar with the way behaviors learned at war can be maladaptive at home. In terms of self-reported proficiency working with veteran or military-affiliated patients, respondents reported “agree” or “strongly agree” on an average of 4.52 ($SD=3.2$) of the ten proficiency items presented. A breakdown of self-reporting proficiency can be seen in Table 9, again with some differences across the items. Of the respondents, 18 percent agreed or strongly agreed that diagnosing and treating military personnel and veterans with mental health problems is no different than diagnosing and treating civilians with mental health problems, whereas 75 percent reported they usually actively strive to understand each military and veteran client’s values and beliefs. Thirty-four percent reported receiving prior training in military culture. When these items were compiled into the overall military cultural competency score, total scores averaged 8.32 ($SD=6.4$) out of a possible 22 points. Overall, 19 percent were categorized as having “high military cultural competency” (with a total score of 15 or greater).

Although 70 percent of those working in a military or VA setting had high military cultural competency, only 24 percent of those participating in the TRICARE network and 8 percent of those without military or TRICARE affiliation met this threshold ($p<0.001$; see Table 7). Nearly one-quarter (23 percent) of those practicing within ten miles of a VA or military treatment facility met the threshold for high military cultural competency, whereas only 15 percent of those practicing more distantly from these facilities met the thresh-

Figure 5: Map of Survey Respondents' Practice Locations, Military Treatment Facility Locations, and VA Hospitals or Clinics



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Table 5: Time Spent in Typical Week, by Activity (percentage)

	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
Psychotherapy or assessment	49.7	29.7	54.6	58.6	54.9
Medication management	21.7	58.5	2.8	4.1	15.8
Professional/administrative activities	20.8	7.6	31.4	23.0	20.1
Receiving supervision/consultation	7.3	4.2	5.9	9.5	9.0
Supervising others	6.6	3.7	8.8	8.7	5.1

Table 6: Provider Primary Therapeutic Orientation (percentage)

	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
Cognitive and/or behavioral	41.2	7.8	44.1	58.3	53.3
Biological/psychopharmacologic	21.8	71.8	0.8	1.5	14.1
Integrative or eclectic	17.8	12.5	29.9	16.7	12.6
Psychodynamic/relational	10.2	5.5	11.8	9.8	13.3
Interpersonal	4.8	0.0	6.3	10.6	2.2
Acceptance and commitment	1.1	0.0	1.6	0.7	2.2
Other	3.1	2.3	5.5	2.3	2.2

Table 7: Provider-Reported Psychotherapy Training and Supervision (percentage)

	All		Psychiatrists		Psychologists		Social Workers		Licensed Counselors	
	Trained	Supervised	Trained	Supervised	Trained	Supervised	Trained	Supervised	Trained	Supervised
CBT	69.4	68.6	57.0	63.3	71.6	68.5	67.4	61.4	80.7	80.7
IPT	37.0	37.4	40.6	50.0	37.0	35.4	25.8	21.2	45.2	42.9
CPT	33.0	27.6	18.0	17.2	35.4	23.6	28.8	25.0	50.4	43.7
EMDR	18.6	17.2	12.0	14.1	20.5	15.8	13.6	12.1	28.2	26.7
PE	18.0	16.9	14.0	15.6	24.4	25.2	11.4	5.3	22.9	21.5
SIT	13.6	10.9	6.3	6.3	15.8	11.0	9.1	6.1	22.9	20.0

old ($p < 0.05$). Neither provider type nor years in practice were related to overall military cultural competency.

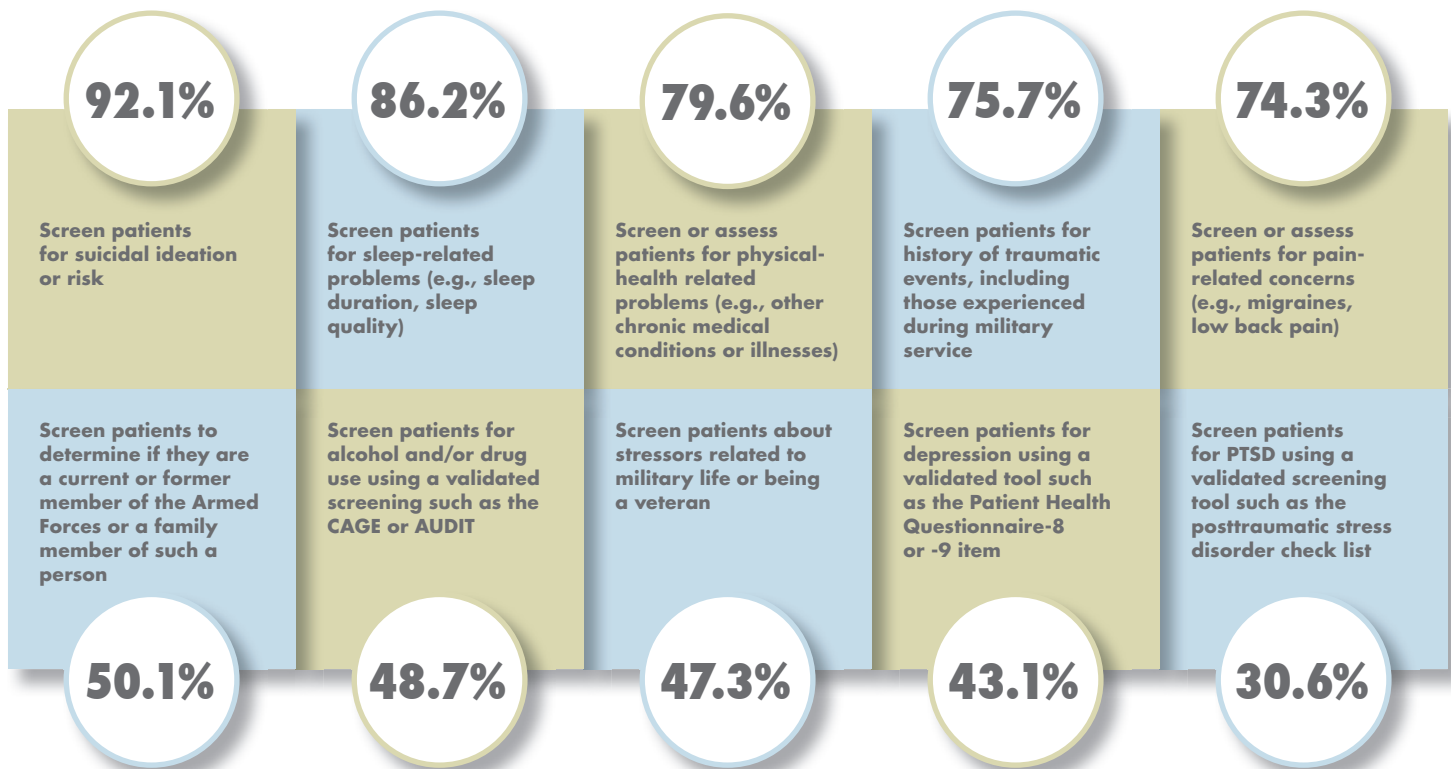
Consistent with the bivariate analyses (shown in Table 10), a logistic regression model confirmed that, relative to those working outside military or VA settings who are part of the TRICARE network, those working in military or VA settings are more likely to meet the threshold for high cultural competency, and those working outside such settings who are not part of TRICARE are less likely to meet the threshold. The remaining independent variables failed to reach significance. A linear regression predicting the continuous variable for military cultural competency showed similar results.³¹

USE OF EVIDENCE-BASED PRACTICES FOR PTSD AND MDD

In this section, we explore respondents' reported capability of delivering evidence-based care for PTSD and MDD. We report on whether participating providers were trained and inclined to implement guideline-concordant care for PTSD and MDD, and whether these providers reported using such care in their usual practice. The success of efforts to outsource mental health care for service members and veterans to civilian providers will depend, in part, on whether providers in the community are able and willing to deliver the high-quality care outlined in the VA/DoD CPGs for MDD and PTSD.³² Based on previous reviews of provider practices,³³ we expected that a substantial proportion of civilian providers would *not* be prepared to deliver high-quality mental health care.

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Figure 6: Percentage of Providers Who Endorse Performing Each Assessment Behavior



We explored the relationships between training in and use of evidence-based care and psychotherapist type (social worker, licensed professional counselor, or clinical psychologist), military affiliation (employed in a military setting, TRICARE affiliated, or non-TRICARE affiliated), number of years since graduate training, and attitudes toward CPGs. Understanding the practice and provider characteristics associated with provision of high-quality mental health care may allow policymakers to better direct care for service members seeking services outside the military and veteran health systems.

The types of services specified as “evidence-based” differ substantially between mental health specialists (hereafter referred to as “psychotherapists”) and psychiatrists. Although psychiatrists are licensed to provide both medication management and “talk” therapies for mental health conditions, most deliver more medication management than psychotherapy (see also Table 3). Psychotherapists are not licensed to provide medications and are more likely than psychiatrists to deliver “talk” therapies, including EBP’s such as CBT or PE. This divergence in practice motivates our analytic structure. Below, we report first on psychotherapists’ training in and delivery of EBP’s for PTSD and MDD. Second, we report findings on

psychiatrists’ delivery of evidence-based medication management for PTSD and MDD.

Evidence-Based Practices Among Psychotherapists

Training in Evidence-Based Psychotherapies for PTSD and MDD

Only one-third (35 percent) of psychotherapists reported that they had been trained and received supervision to deliver at least one EBP for PTSD and at least one for depression (see Figure 6). Licensed counselors (LPC/LMHCS) were most likely to report having training in EBP’s ($p < .001$). Nearly one-half (48 percent) reported being trained to deliver an EBP for PTSD and depression. One-third of clinical psychologists reported receiving training (34 percent), and only one-fourth of licensed clinical social workers (LCSW/MCSWs) indicated they were trained (23 percent). Neither attitudes toward CPGs nor years since clinical training were significantly associated with EBP training. A logistic regression model predicting EBP training confirmed the bivariate relationships described above.³⁴

Table 8: Providers Reported Knowledge of Military and Veteran Culture (percentage)

Reported Being Very Familiar or Extremely Familiar With	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
Military rank structure	21.6	25.0	25.2	15.9	20.7
Subculture of military branches	16.5	16.4	17.3	13.6	18.5
Differences and similarities between active and reserve components of the military	23.6	30.5	14.4	18.9	20.7
General and deployment-related military slang and terms	14.6	14.8	15.7	12.9	14.8
General and deployment-related stressors for service members and veterans	25.1	21.9	32.3	23.5	23.0
General and deployment-related stressors for military families	27.2	23.4	32.3	27.3	25.9
Programs and services available to support healthy adjustment for military-affiliated clients	17.8	13.3	19.7	19.7	18.5
How behaviors learned in war can be maladaptive at home	37.5	29.7	48.0	37.9	34.8

Table 9: Self-Reported Proficiency (percentage)

Reported Agree or Strongly Agree	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
I can list methods or ways of collecting a military history and related mental health information (e.g., military and veteran benefits, options or eligibility for care)	40.4	39.1	43.3	42.4	37.0
I can explain how the perceptions of mental health beliefs are influenced by military and veteran culture	54.6	46.9	61.4	56.1	54.1
I usually actively strive to understand each military and veteran client's values and beliefs	74.5	75.8	77.2	77.3	68.1
I can teach and guide colleagues on the important features of military culture	25.1	22.7	26.0	25.0	26.7
I can teach and guide colleagues on planning mental health care for military and veteran clients	28.7	26.6	30.7	27.3	30.4
I can teach and guide colleagues on effective communication skills with military and veteran clients	39.5	31.3	44.1	40.2	42.2
Collecting information on a military or veteran client's mental health is easy for me	47.3	46.9	50.4	45.5	46.7
When implementing care, I can fulfill the mental health needs of military and veteran clients	54.2	56.3	57.5	48.5	54.8
I have the skills to communicate effectively with military and veteran clients	69.3	74.2	71.7	65.2	66.7
Diagnosing and treating military personnel and veterans with mental health problems is no different than diagnosing and treating civilians with mental health problems	18.4	21.9	16.5	12.1	23.0

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Table 10: Relationship Between Cultural Competency and Provider Characteristics

Provider	Military Culturally Competent ≥ 15 (%)
All respondents	19.2
Provider type	
LPC or LMHC	17.8
LCSW or MCSW	18.2
Clinical Psychologist	21.3
Psychiatrist	19.5
	$\chi^2=0.621$, $p=\text{not significant (ns)}$
Affiliation	
Works in military or VA setting	70.5
TRICARE affiliated	23.7
Not TRICARE affiliated	7.7
	$\chi^2=133.38$, $p<.001$
Years since graduate training	
Ten years or less	20.7
More than ten years	18.4
	$\chi^2=0.389$, $p=\text{ns}$
Geographic proximity	
Within ten miles	14.7
More than ten miles	22.8
	$\chi^2=5.555$, $p<.05$

Delivery of Evidence-Based Psychotherapy to at Least Three-Quarters of Patients in the Most Recent Typical Work Week

One-third of psychotherapists (33 percent) self-reported that, in the most recent typical work week, they treated a substantial majority of their patients (≥ 75 percent) with an EBP (see Figure 6). Providers who had been trained to deliver at least one evidence-based PTSD and MDD psychotherapy (41 percent) were more likely than those without training (29 percent) to report delivering EBPs to most of their patients in the most recent typical week ($p<.05$). Providers with positive attitudes toward CPGs (45 percent) were also more likely than those with negative opinions about CPGs (31 percent) to report delivering EBPs to their patients. Among providers who self-reported delivering EBPs to most of their patients in the most recent typical week, fewer years had elapsed since their graduate training relative to providers who did not deliver EBPs to the majority of their patients (13.9 years and 16.7 years, respectively). A logistic regression model predicting self-reported delivery of EBP confirmed the bivariate relationships.³⁵

Consistent Use of Evidence-Based Psychotherapy Techniques in Session

About 30 percent of psychotherapists reported that they “often” or “always” used the psychotherapy techniques associated with at least one EBP for PTSD and MDD (see Table 11). Provider type was not related significantly to use of EBP techniques. Perhaps not surprisingly, positive attitudes toward CPGs and training in EBPs for PTSD and MDD significantly predicted frequent use of EBP techniques. Neither affiliation nor years since graduate training were significant predictors of EBP techniques. A logistic regression, conducted to estimate the independent contributions of the predictor variables, confirmed the bivariate relationships described above.³⁶

Evidence-Based Practices Among Psychiatrists

When asked to report the most common first-line medications that they would prescribe to a patient with PTSD or MDD, 89 percent of psychiatrists specified at least one of the VA/

Table 11: Relationship Between Provider Characteristics, and Training and Delivery of EBPs for PTSD and MDD

	Trained in 1+ EBPs for PTSD and MDD (%)	Reported Treating ≥75% of Patients with an EBP in the Last Typical Work Week (%)	Reported Often/Always Using EBP Techniques for PTSD and MDD (%)
All Respondents	35.0	33.0	29.4
Provider Type			
LPC or LMHC	48.2	36.3	32.6
LCSW or MCSW	22.7	31.1	22.0
Clinical Psychologist	33.9	31.5	33.9
	$\chi^2(2)=19.06, p<.001$	$\chi^2(2)=1.02, p=ns$	$\chi^2(2)=5.39, p=ns$
Affiliation			
Works in a VA or military setting	48.1	26.9	40.4
TRICARE affiliated	37.4	40.7	34.1
Not TRICARE affiliated	31.5	31.5	25.5
	$\chi^2(2)=5.50, p=ns$	$\chi^2(2)=3.56, p=ns$	$\chi^2(2)=5.81, p=ns$
Supportive of CPGs			
Below threshold	34.1	30.8	25.8
Above threshold	40.0	45.0	50.0
	$\chi^2(1)=0.77, p=ns$	$\chi^2(1)=4.61, p<.05$	$\chi^2(1)=14.40, p<.001$
Years since graduate training	$t(392)=0.64, p=ns$	$t(392)=2.36, p<.05$	$t(392)=1.59, p=ns$
Trained in 1+ EBP			
No	—	28.9	22.7
Yes	—	40.6	42.0
	—	$\chi^2(1)=5.53, p<.05$	$\chi^2(1)=16.20, p<.0001$

Providers who meet one threshold, such as culturally sensitive or competent, may not meet the other (trained in or report using evidence-based care).

DoD CPGs include as appropriate, evidence-based psychopharmacological treatments for these conditions. Psychiatrists' practice affiliation was not significantly related to their likelihood of prescribing an evidence-based medication ($\chi^2(2)=1.20$, $p=ns$). Evidence-based prescribing was also unrelated to attitudes toward CPGs ($\chi^2(2) = 2.09$, $p=ns$). However, years since graduate training were related to self-reported practices. Psychiatrists who adhered to practice guidelines for medication management of PTSD and MDD had been practicing for about five fewer years ($M=25.6$, $SD=7.93$) than those who reported not providing guideline-concordant care ($M=31.0$, $SD=9.02$; $t(126)=2.37$, $p<.05$).

Given that very few psychiatrists indicated that they would use a nonevidence-based medication management strategy ($n=14$), there was insufficient power to conduct a logistic regression predicting psychiatrist prescribing patterns with multiple independent variables.

OVERALL PROVIDER READINESS FOR VETERAN-FRIENDLY, QUALITY CARE

In this section, we explore the extent to which providers are “ready” to deliver culturally competent, high-quality care to veterans and their families. As we outlined in earlier sections, cultural competency can facilitate the development of therapeutic rapport and improve treatment receptivity, and the definition of *high-quality care* includes the use of treatments demonstrated to be effective (i.e., evidence-based). Thus, our concept of provider readiness in this study combines the domains of cultural competency and capacity to deliver high-quality care. We are particularly interested in understanding not only the

proportion of providers that meet our definition of readiness, but also in examining the factors that may be associated with such readiness. As we outlined in the previous sections, different factors have been shown to be associated with cultural competency and the use of evidence-based approaches. And, providers who meet one threshold, such as culturally sensitive or competent, may not meet the other (trained in or report using evidence-based care).

We operationalized our concept of readiness by building upon and combining the two outcomes described in the prior sections. We include providers we defined to be culturally competent (having scored 15 or greater out of a total of 22 possible on our cultural competency scale), who indicated they had been trained in an evidenced-based therapy for PTSD and MDD, and who self-reported using evidence-based treatments for PTSD and MDD. For each variable, the criteria for inclusion differed across MD and non-MD provider types due to the low numbers of psychiatrists who deliver nonmedication-based approaches. As we outlined in earlier sections, the focus for psychotherapists (non-MD providers) was on use of specific psychotherapies demonstrated to be effective for PTSD and MDD. For psychiatrists, evidence-based treatment meant selecting appropriate medications for PTSD and MDD. The previous section provides more detail on how providers perform separately on these two outcomes.

As shown in Table 12, only 13 percent of respondents met our readiness criteria. We examined associations between providers' years in practice (years since training in two categories: less than ten years, or ten years or greater), practice affiliation, proximity to military or veteran treatment facilities (within ten miles versus more than ten miles away), region (primary practice setting is in a metropolitan statistical area—defined urban or rural region), and insurance status (greater than 50 percent of patient care is not compensated through insurance). As shown, and as was confirmed in a multivariate model, we find that only providers' practice affiliation is significantly associated with readiness: Providers who work primarily in a military or VA setting were significantly more likely to meet our criteria for being culturally competent and delivering evidenced-based care for PTSD or MDD than providers who do not work in a military or VA facility, but those who indicated they were a registered provider within the TRICARE provider network were more likely to meet criteria than those who were not registered with a TRICARE provider network.

Table 12: Relationship Between Provider Characteristics and Readiness

	Culturally Competent and Reported Being Trained in 1+ EBP and Reported Often/Always Using Evidence-Based Treatment for PTSD and/or MDD (%)
All respondents	13.4
Provider type	
LPC or LMHC	13.3
LCSW or MCSW	9.8
Clinical psychologist	12.6
Psychiatrist	18.0
	$\chi^2=3.806, p=ns$
Affiliation	
Works in military or VA setting	45.9
TRICARE affiliated	17.8
Not TRICARE affiliated	5.5
	$\chi^2=75.149, p<.001$
Supportive of CPGs	
Not CPG friendly	13.2
CPG friendly	14.7
	$\chi^2=0.119, p=ns$
Years since graduate training	
Ten years or less	16.0
More than ten years	12.2
	$\chi^2=1.418, p=ns$
Geographic proximity	
Within ten miles of DoD or VA facility	15.9
More than ten miles	10.3
	$\chi^2=3.436, p=ns$

NOTE: Value and statistical tests are not shown for the associations between readiness and having greater than 50 percent of uncompensated/self-pay care because the number of providers in some cells were fewer than ten, making such tests unreliable.

As veterans and their families seek care to address mental health concerns, they will be turning to providers working across multiple sectors.

IMPLICATIONS FOR THE FUTURE

As veterans and their families seek care to address mental health concerns, they will be turning to providers working across multiple sectors. This study aimed to assess the readiness of those mental health providers working in community settings. While multiple factors may facilitate or inhibit a provider's ability to deliver high-quality care—including the system-level incentives and treatment models employed within their settings—we focused on those related to the characteristics of the providers themselves. To do so, we examined the characteristics of a convenience-based sample of mental health professionals and assessed their knowledge, attitudes, and behaviors with respect to military and veteran culture, as well as evidence-based practices for mental health problems common in veteran populations.

We find that providers vary in whether they report being knowledgeable in and comfortable with treating military- and veteran-affiliated patients. We also observe variation in the extent to which participating providers were trained in and demonstrated use of evidence-based treatments for PTSD and MDD. We found that, across our outcomes of interest, the characteristics of the provider are related to the setting in which they work.

With respect to cultural competency, respondents endorsed a high degree of knowledge on less than one-quarter of knowledge items, a high degree of comfort on about two-thirds of comfort items, and a high degree of proficiency on fewer than one-half of self-reported proficiency items. Fewer than one-fifth of respondents exceeded the threshold for a high degree of cultural competency, and as expected, those respondents were more likely to be working in DoD or VA work settings or to have reported being in the TRICARE network than not.

The majority of psychotherapists (65 percent) reported that they had not received the training and supervision necessary to deliver at least one EBP for PTSD and MDD. In other words, a psychotherapist selected from the community is unlikely to have the skills necessary to deliver high-quality mental health care to service members or veterans with these conditions.

Licensed counselors (LPC/LMHC) were more likely than other psychotherapists to report adequate training in EBPs. Further examination of differences across graduate training models may provide policy recommendations to improve training for the next generation of psychotherapists.

Training in EBPs, in turn, predicts implementation of these practices with the majority of patients. Increasing community-based psychotherapists' incentives to complete training in EBPs may improve patient access to these behavioral treatments for their conditions. At the same time, even among psychotherapists with training, only 41 percent reported delivering evidence-based care to most of their patients. Thus, training alone does not ensure delivery of high-quality care; other barriers to CPG adherence must be explored. Providers who delivered EBPs to most of their patients were comparatively recent graduates, having completed their training about three years after those who were not consistently implementing evidence-based care. This may reflect a trend among graduate programs toward an increasing emphasis on evidence-based strategies for care, or it may be that younger clinicians are more likely to pursue training and supervision in treatments that have been demonstrated through research to reduce clinical symptoms.

Among psychiatrists, the majority of respondents reported prescribing appropriate medication for MDD and PTSD. In general, most reported using specific psychotropic medications that are considered generally acceptable for these conditions. However, we were unable to assess the appropriateness of specific dosages and length of use.

When we combined responses for cultural competency and use of evidence-based approaches to examine the level of overall readiness to deliver culturally competent, evidence-based care, we found very few respondents (13 percent) met our threshold. Similar to our findings on cultural competency, providers who met this threshold were more likely to be affiliated with a DoD or VA facility than not, and more likely to be a part of the TRICARE network than not if working outside DoD or the VA. Although actual knowledge and practice behaviors were not assessed in this study, the data

gathered on respondents' perceptions of their own knowledge, attitudes, and behaviors offer important insights into how ready they are to work with veterans and service members, as well as their families.

These findings suggest that when service members, veterans, or family members seek care from providers not affiliated with DoD or the VA, they may encounter providers who are not as well prepared to deliver culturally sensitive care. However, the degree to which providers deliver evidence-based care for PTSD and MDD appears equivalent across settings, with those providers who have received training in evidence-based approaches more likely to deliver such care routinely to their patients.

Study Limitations

While this study provides important insight into the characteristics of community mental health professionals, several limitations should be noted. First, we relied upon a convenience sample. Thus, the results are not necessarily representative of all mental health professionals. While the topics of military and veteran mental health care, cultural competency, and evidence-based practice were not specifically identified in the recruitment email sent by GfK or in the introductory page of the survey, it is possible that providers more interested in these topics of military and veteran populations completed the survey. As with all surveys conducted among convenience samples, it is difficult to understand the potential bias introduced by those choosing to participate in such panels and surveys as compared to the full population of providers.

Further, while we compare providers across different types of characteristics, care should be taken in making inferences about differences across provider groups because we did not sample systematically. Future work should be designed to implement similar assessments in larger samples, ideally those that are designed to represent provider groups (defined within provider networks, professional categories, settings, etc.). Another limitation is that we rely on self-report methods to assess practice behaviors. As with all self-report surveys, there is the potential for socially desirable responses. We tried to minimize this bias by including anchor/reference periods or referring to specific types of patients (e.g., those with PTSD or MDD); however, the potential for selecting socially desirable responses may still remain.

In addition, we measured some aspects of potential care experiences for veterans and their families within this survey, such as self-reported knowledge about military culture and proficiency with various treatment approaches, but did not

include others, such as actual knowledge on how to apply specific techniques and practice behaviors for these populations. Thus, many important aspects of knowledge, attitudes, and behavior among community-based mental health providers remain to be explored. Further, other techniques—such as gathering patient-level data on symptom levels, functioning, and experiences with care (which could be implemented within rigorous performance monitoring approaches)—would help to inform the extent to which providers' techniques are actually helping patients to improve.

Recommendations and Next Steps

Despite the exploratory nature of this study, there are several implications for informing future efforts to improve the capacity of community-based providers to deliver culturally competent, high-quality care to veterans and their families.

Conduct Better Assessments of Civilian Provider Capacity

With continued emphasis on hiring more providers into the VA,³⁷ workforce development and evaluation efforts are critically needed to understand more about the size and characteristics of the mental health workforce in the United States, and

These findings suggest that when service members, veterans, or family members seek care from providers not affiliated with DoD or VA, they may encounter providers who are not as well prepared to deliver culturally sensitive care.

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While provider cultural competency may be important for engaging the population and thereby increasing access to care, other specific efforts may be needed to increase providers' use of quality therapeutic approaches.

in particular, whether the civilian sector can meet expectations regarding timeliness and quality of care. Unfortunately, at this time, there are no recent representative data on any of the specific professions within the mental health workforce.

Until such population-based data can be generated, organizations that maintain registries or provider networks of mental health professionals should conduct assessments related to their own networks, with a special focus on examining access and quality of care among those providers. Even registries or networks established specifically for military and veteran populations would benefit from an assessment of which providers have availability and appropriate capacity to render timely, culturally appropriate, high-quality care to veterans and their families. For example, while being part of such registries or networks may indicate a provider's willingness to accept military-affiliated patients, providers often place limits on the number of patients they accept under those arrangements. In this study, about 30 percent of providers reported they were part of the TRICARE network; however, TRICARE represented the primary payment source for only a small proportion (2.5 percent) of the patients treated by our participating providers in a typical week.

A related issue has to do with efforts to hire and train more providers working within DoD and the VA over the past several years. These efforts have been hampered by the ability to ensure an adequate pipeline of mental health providers, both in terms of numbers and quality, particularly in remote or rural areas. Several have pointed to the concerns about a national shortage in mental health,³⁸ and efforts to draw more providers into DoD and the VA may further deplete the civilian workforce. Again, careful study of the existing workforce may help to identify strengths and gaps and provide more information about how and where to enhance the pipeline of new professionals entering the workforce.

Assess the Impact of Trainings in Cultural Competency on Provider Capacity

In the President's 2012 Executive Order (and reinforced in new Executive Actions announced in August 2014), he called upon DoD, the VA, and the Department of Health and Human Services to collaborate in an effort to educate community-based providers about the unique needs of service members, veterans, and their families. In response to the most recent Call to Action, DoD and the VA announced an intent to disseminate their cultural competency course to civilian mental health providers. While this new initiative may help increase community-based providers' awareness of the unique issues of veterans and their families, training by itself it will not necessarily increase cultural competency or expand access or quality of care for veterans. While training may be an important underpinning for developing awareness and skills, seeing and interacting with the patient population was a significant predictor of overall competency, with providers' affiliation with DoD and VA settings and TRICARE affiliation significantly related to high military cultural competency scores in our scale.

Further, while provider cultural competency may be important for engaging the population and thereby increasing access to care, other specific efforts may be needed to increase providers' use of quality therapeutic approaches. DoD and the VA have a long history of requiring training for their providers on evidence-based approaches, as well as promulgating CPGs for the care of patients with specific conditions (including PTSD and depression), but there are few such requirements in the civilian setting. Large-scale dissemination and training efforts can be resource-intensive and require significant investment of staff time and leadership to promote participation and adherence to guidelines. Different models have been employed and many engage champions, train-the-trainer, or supportive implementation models to help disseminate information

broadly and encourage uptake. Often, these efforts also involve the development and distribution of provider resource guides, pocket tools, and other decisionmaking aids to facilitate utilization of the skills and practice recommendations. Studies that have evaluated the impact of these efforts have demonstrated success,³⁹ yet few programs that implement trainings of this nature evaluate their efficacy and long-term effectiveness. Many training and dissemination programs may show early success but adherence and use of new skills may wane as the support and infrastructure subsides.

DoD utilizes the Center for Deployment Psychology to train military mental health professionals in the evidence-based modalities. Recently, the Center began collaborating with academic organizations to bring training to civilian providers as well. Their approach includes specific focus on cultural competency, as well as evidence-based therapies, organized across three training tiers reflecting different topics and levels of intensity. Other promising programs have also begun designing and implementing more rigorous curricula on both the topics of cultural competency and specific evidence-based modalities using models shown to facilitate provider practice change.⁴⁰ Understanding the extent to which participating in such training affects providers' capability to serve this population will require well-designed evaluations of the training programs themselves, as well as rigorous studies to explore how providers implement the material in practice settings in the short and long terms.

Expand Access to Effective Trainings in Evidence-Based Approaches for PTSD and MDD

This study clearly points to the need for additional training on evidence-based approaches among the civilian mental health workforce, particularly for practitioners who completed their

formal professional training some time ago. Recent graduates in certain professions appear to be getting training in these models more often; thus, expansion to all professional training programs as well as to more mature professionals is needed. Over the past several years, numerous organizations have sought to implement training programs for practicing providers in evidence-based approaches in mental health, with varying success based upon the particular model adopted.⁴¹ As we outlined earlier, the type of training programs in military cultural competency and evidence-based approaches for PTSD and MDD currently available varies greatly—from short online courses, to lengthier in-person opportunities. Participation in these varying continuing education opportunities may help to expand provider skills and ability to implement these models; however, providers may need some additional motivation for attaining such training and then applying their new skills in routine practice.

While some of these training opportunities are available at little or no cost (such as web downloads), others may impose specific costs related to access and participation (including travel expenses). Beyond these participation fees, the participation time itself may be a cost for providers, as the time spent in training may detract from their time providing compensated patient care (particularly for providers working in independent, fee-for-service settings). Thus, strategies for facilitating low-cost access may be needed to increase provider willingness to participate. While some courses offer continuing education credits, not all provider groups and states have specific requirements for these credits and it may not be enough motivation to facilitate providers becoming trained. It should be noted that while we recommend greater access to training in evidence-based approaches for PTSD and MDD, we acknowledge that not all training may be equivalent in terms of quality and effectiveness in providing the appro-

This study clearly points to the need for additional training on evidence-based approaches among the civilian mental health workforce, particularly for practitioners who completed their formal professional training some time ago.

Improving the mental health of service members, veterans, and their families will require that the providers who treat them adopt and routinely use appropriate and effective approaches for addressing their conditions.

priate instruction and supervision in specific, evidence-based approaches. As such, rigorous evaluations will be needed to assess the extent to which training is effective in improving providers' skills and changing their practice behaviors.

Facilitate Providers' Use of Evidence-Based Approaches

Improving the mental health of service members, veterans, and their families will require that the providers who treat them adopt and routinely use appropriate and effective approaches for addressing their conditions. We found that prior training is associated with the use of evidence-based approaches; however, adoption of such techniques was not universal among those who received such training. Thus, providers may need additional motivation to use appropriate techniques in their usual practices. Supportive implementation models of training have shown success in increasing clinical skill acquisition and spreading evidence-based treatments among community providers, but other barriers to regular use may remain.⁴²

System- or practice-level performance-monitoring approaches and quality improvement techniques have been shown to improve providers' use of specific evidence-based

approaches.⁴³ These monitoring and improvement strategies may be applied more often within closely managed settings that prioritize quality—therefore, providers working in independent office practices may not be part of any such oversight other than what is provided through reimbursement mechanisms (e.g., claims adjudication processes). As such, motivating providers in private, independent settings within the civilian sector may require that health payers begin to monitor the quality of care provided more closely and consider strategies for incentivizing use of evidence-based approaches, either through altering reimbursement rates or providing preferred referral authorizations (particularly for those providers who choose not to accept any health insurance).⁴⁴

Prior research has demonstrated that there is a business case for providing access to high-quality care for all veterans with PTSD and MDD.⁴⁵ Thus, strategies for facilitating providers' use of evidence-based approaches have the potential to reduce the overall costs of such care and the burden on society associated with undertreated mental health conditions. Based on our findings, it is reasonable to expect that increasing training in and incentivizing providers' use of such techniques will begin to facilitate the delivery of high-quality care to veterans and their families.

Notes

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³¹ A logistic regression model was used to predict high cultural competency. Compared to the constant-only model, the full logistic regression model improved discrimination between those with high cultural competency and those that did not meet the threshold (Wald $\chi^2(6)=73.58$, $p<.0001$). Consistent with the bivariate analyses above, the Wald criterion confirmed that, relative to those working outside military or VA settings who are part of the TRICARE network, those working in military or VA settings are more likely to meet the threshold for high cultural competency ($OR=9.62$, $p<.0001$), and those working outside those settings who are not part of TRICARE are less likely to meet the threshold ($OR=0.36$, $p<.01$). The remaining independent variables failed to reach significance. A linear regression predicting the continuous variable for military cultural competency showed similar results.

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³⁵ A logistic regression, in which all variables were entered simultaneously, examined the independent contribution of provider type, affiliation, attitudes toward CPGs, years since graduate training, and training in EBPs to the prediction of whether the provider used EBPs with most of their PTSD and MDD patients. The full model improved discrimination relative to the intercept-only model (Wald $\chi^2(7)=28.5$, $p<.001$). Consistent with the bivariate analyses, positive attitudes toward CPGs increased the likelihood that the provider would deliver EBPs to their patients ($OR=1.08$, $p<.0001$). As the length of time since a provider's clinical education increased, the likelihood that they would deliver EBPs to their patients with PTSD and MDD declined ($OR=0.97$, $p<.01$). Finally, providers who were trained in at least one MDD and one PTSD EBP were 1.6 times more likely to deliver EBPs to the majority of their patients ($OR=1.62$, $p<.05$). Provider type and affiliation were not significantly related to self-reported delivery of EBPs in the model.

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About This Report

Ensuring that military veterans and their families have access to high-quality mental health care is a national priority. Over the past several years, the Departments of Defense and Veterans Affairs have increased the number of mental health professionals working within their facilities and have rolled out training and quality improvement initiatives designed to promote the use of evidence-based treatments. Despite these important efforts, research continues to demonstrate that many veterans prefer to seek services outside the Department of Defense and/or the Department of Veterans Affairs. Thus, providers working in the civilian sector are an increasingly important part of the overall mental health workforce addressing veterans' mental health needs.

To better understand a key aspect of our nation's ability to provide veterans and their families with access to high-quality mental health care, RAND conducted a survey of civilian mental health providers to gather information about their knowledge, attitudes, and preferences for delivering services to veterans and their families. This report provides the results of that survey. The findings and recommendations from this study should be relevant to individuals, organizations, and policy officials concerned about the capacity of the civilian health care sector to deliver culturally competent, high-quality services to veterans and their families.

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Ensuring that military veterans and their families have access to high-quality mental health care is a national priority. Over the past several years, the Departments of Defense and Veterans Affairs have increased the number of mental health professionals working within their facilities and have rolled out training and quality improvement initiatives designed to promote the use of evidence-based treatments. Despite these important efforts, research continues to demonstrate that many veterans prefer to seek services outside the Department of Defense and/or the Department of Veterans Affairs. Thus, providers working in the civilian sector are an increasingly important part of the overall workforce addressing veterans' mental health needs. To better understand a key aspect of our nation's ability to provide veterans and their families with access to high-quality mental health care, RAND conducted a survey of civilian mental health providers to gather information about their competency with military and veteran culture and their training and experience treating posttraumatic stress disorder and depression. This report provides the results of that survey. The findings and recommendations from this study should be relevant to individuals, organizations, and policy officials concerned about the capacity of the civilian health care sector to deliver culturally competent, high-quality services to veterans and their families.



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From: (b) (6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6)
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlr)/cn=recipients/cn=(b) (6)
Cc:
Bcc:
Subject: RE: Eligibility Workgroup
Date: Tue Apr 04 2017 15:11:22 CDT
Attachments: CoC Eligibility reform.pdf
Commission-on-Care_Final-Report_063016_FOR-WEB.pdf
GAO VA Healthcare Approaches for Developing Budget Neutral Eligibility Reform.pdf

Darin: Attached is draft language for an invitation to the kick-off meeting next Thursday with attachments. Feel free to edit as needed. Terrence

All: The Secretary has asked that I convene a workgroup to execute the Commission on Care's recommendation #18, to "establish an expert body to develop recommendations for VA care eligibility and benefit design." You have been asked to represent your office on the work group. The kick-off meeting is scheduled for next Thursday, April 13, 11-12pm in room 844, VACO.

As you know, eligibility determinations govern a Veterans access to healthcare within VA. This work, if executed properly, can be a key driver of eligibility for health benefits in the future. I envision beginning with this core group, to clarify objectives, outline our approach and determine additional stakeholders for inclusion.

Our task is two-pronged:

- 1) To conduct an assessment of eligibility
- 2) To develop policy recommendations for the Secretary

To get us started, several source documents are provided for your advance review:

- The Commission on Care final report issued in July 2016. (Recommendation #18 on eligibility design is separately attached)
- A copy of the GAO report entitled, "Approaches for Developing Budget-Neutral Eligibility Reform" dated March 20, 1996

Thank you for your willingness to provide your expertise to this important effort. I look forward to working with you and to your contributions.

Darin

From: Selnick, Darin
Sent: Tuesday, April 04, 2017 3:49 PM
To: (b) (6)
Subject: RE: Eligibility Workgroup

Great

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

From: (b) (6)
Sent: Tuesday, April 04, 2017 3:40 PM
To: Selnick, Darin
Subject: FW: Eligibility Workgroup

Conference room 844 is reserved for the workgroup next Thursday, 11-12pm.

Owner: (b) (6) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6)
Filename: CoC Eligibility reform.pdf
Last Modified: Tue Apr 04 15:11:22 CDT 2017

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Problem

Although VHA continues to offer the promise of health care to all veterans, its capacity to meet that promise is constrained by appropriated funding.⁶¹⁵ Congress and VA leadership must work to identify who VHA will serve, and what services it will provide, yet eligibility criteria have not been examined in 20 years.⁶¹⁶

Background

VHA's core mission is to care for veterans who has borne the battle. But its secondary mission of caring for veterans' non-service-connected health care needs is longstanding, dating back to Civil War origins. Congress has included veterans without service-connected needs among those eligible as highlighted below:

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use underutilized VHA providers and facilities, providing payment through private insurance.
- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

- In March 1865, Congress incorporated the National Home for Disabled Volunteer Soldiers and Sailors, originally intended for Union veterans who suffered economic distress from disabilities incurred during the Civil War. The National Home constructed the first hospitals for Civil War veterans in 1866, and after a series of acts of Congress, those hospitals were opened in 1887 to veterans suffering economic distress from disabilities not incurred in military service.⁶¹⁷
- The World War Veterans Act of 1924, which established the Veterans Bureau⁶¹⁸ (the predecessor to the Department of Veterans Affairs), authorized its director to provide hospitalization and related travel expenses to veterans whose services dated back as far as 1897, regardless of the type or cause of their disabilities, as long as those veterans who were unable to pay received preferential admission.⁶¹⁹
- Public Law 85-56 (1957), which codified prior VA laws and regulations, effectively expanded eligibility to veterans of future wars, providing needed hospital care for veterans with service-connected disability incurred or aggravated during war, or for any other disability if the veteran is unable to pay for hospital care.⁶²⁰

⁶¹⁵ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶¹⁶ *Ibid.*, 25.

⁶¹⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

⁶¹⁸ The Veterans Bureau consolidated the National Home and other veterans-related functions housed in different government bureaucracies.

⁶¹⁹ World War Veterans Act, 1924, Pub. L. No. 68-242, (1924).

⁶²⁰ Veterans Benefits Act of 1957, Pub. L. No. 85-56, 71 Stat. 83 (1957). That law provided separate authority in section 512 for outpatient medical treatment, which was limited to treatment for a service-connected disability.

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- In 1966, Congress expanded eligibility for hospital care to *peacetime* veterans (of service after January 1955).⁶²¹
- In 1970, Congress extended eligibility for hospital care to veterans 65 and older for a non-service-connected disability,⁶²² exempting that group of veterans from taking the then-required oath affirming their inability to defray the expense of care for non-service-connect ailments.⁶²³
- With the Veterans Health Care Expansion Act of 1973, Congress eliminated the distinction between wartime and peacetime veterans for purposes of eligibility for outpatient care, and further expanded eligibility to outpatient care. It granted veterans who are 80 percent or more service-connected disabled eligibility for treatment of any condition, and authorized others eligible for hospital care to receive outpatient care to prepare for or preclude a need for hospitalization or to complete treatment initiated during hospitalization.⁶²⁴
- Congress expanded eligibility again in 1976, authorizing hospital care for treating a non-service-connected condition of any veteran 65 or older (without regard to ability to pay), authorizing outpatient care for any disability to any veteran 50 percent or more service-connected disabled, and directing VA to ensure, by regulation, special treatment priority to service-connected veterans and others receiving benefits because of a need for aid and attendance, or being permanently housebound.⁶²⁵

Eligibility laws for veterans' health care have changed substantially during the past century, yet the commitment to serving service-connected veterans and veterans in financial need has remained constant.

Prior to enactment of the Veterans' Health Care Eligibility Reform Act of 1996,⁶²⁶ VHA was a hospital-based model with entirely different eligibility rules for hospital care than for outpatient care. The eligibility reform law was aimed at transforming access to VA care from a 1950s hospital-based model to one that erased distinctions between eligibility for hospital and outpatient care.⁶²⁷ It essentially provided that all veterans are eligible for VA hospital care and *medical services*.⁶²⁸

⁶²¹ Veterans Readjustment Benefits Act of 1966, Pub. L. No. 89-358, 80 Stat. 12 (1966).

⁶²² Pub. L. No. 91-500.

⁶²³ S. Rep. No. 91-481.

⁶²⁴ Veterans Health Care Expansion Act of 1973, Pub. L. No. 93-82, 87 Stat. (1973).

⁶²⁵ Veterans Omnibus Health Care Act of 1976, Pub. L. No. 94-581, 90 Stat. 2842 (1976). The patchwork of eligibility provisions resulting from a succession of incremental changes set the stage for development and enactment of the Veterans' Health Care Eligibility Reform Act of 1996, Pub. Law 104-262.

⁶²⁶ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁶²⁷ *Ibid.*

⁶²⁸ The term "medical services" was broadly defined to include in addition to medical examination and treatment, preventive health services; surgical services; wheelchairs, artificial limbs, and similar appliances; optometric and podiatric services; noninstitutional extended care services; and rehabilitative services (including services to restore physical, mental, and psychological functioning. Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C.

§ 1701(6),(8). VA regulations more fully set out the "medical benefits package" that VA is to provide patients, as needed; VA regulations detail that the benefits package includes services ranging from emergency care and prescription drugs to

Recognizing there could be circumstances in which VHA might lack capacity to provide timely care, Congress noted in the reform act that the requirement to provide care would be in effect only to the degree to which there were appropriated funds to pay for such care.⁶²⁹ This qualified availability of care clearly indicated veterans' health care is not an entitlement. Congress went further, though, and established a statutory patient enrollment mechanism for VA to manage access.⁶³⁰ The law specifically requires VA to establish and operate a patient enrollment system managed in accordance with statutory priorities and within any additional priority classifications established by VA. The eligibility reform act gave VA tools both to limit demand consistent with available funding and to discourage veterans from seeking VA care simply to fill an occasional need not met by a private health plan.⁶³¹ The act also requires the SECVA to manage the enrollment system such that care is timely and of acceptable quality.⁶³²

The enrollment system the department established is not being used today to calibrate supply and demand as envisioned.⁶³³ Although law and VA regulation require a system of annual patient enrollment,⁶³⁴ VHA last curtailed enrollment in 2003, and then only for veterans who were deemed eligible based on the category 8 criteria (see Table 8) that include those with higher-level incomes who lack any higher priority. In 2009, the Obama administration eased access for higher income veterans. Under that policy, veterans whose gross household income exceeds VA's current geographic income limit by 10 percent or less may enroll for VA care, subject to cost-sharing requirements.⁶³⁵ In 2014, Congress established the *Choice Program* to expand availability of care through contracts with community providers. Veterans' choice was limited by reference to distance and wait-time issues, but was otherwise broadly open to any enrolled veterans.⁶³⁶

comprehensive rehabilitative services, home health services, noninstitutional extended care services, hospice care, and pregnancy and delivery services and newborn care. Medical Benefits Package, 38 C.F.R. 17.38.

⁶²⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General 38 U.S.C. § 1710(a)(4).

⁶³⁰ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705. As explained in the report of the House Committee on Veterans Affairs which developed the legislation, "[T]he Act would...provide the VA with an important tool, the authority to design and manage access to care through a system of patient enrollment...Enrollment...would help the VA plan more effectively, so that facilities can better calculate and dedicate the resources needed to provide the care its enrollees require. The Act would direct the Secretary...to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment (or registration) system would operate. For example, the VA would be able to establish a system which simply registers patients throughout all or part of a fiscal year, or could employ a time-limited registration period. Significantly, the Act would permit the Secretary to set priorities within the specified priority classifications established in the Act. The Secretary could, for example, establish a policy which, within any priority classification, gives veterans who have previously been "enrolled" as VA patients priority over new applicants. However, the Committee expects any enrollment system to be designed and administered to assure that any veteran with a service-connected condition would receive priority treatment for that condition whether or not that veteran had enrolled for VA care." H. Rep. No. 104-690, 6-7.

⁶³¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262; 110 Stat. 3177 (1996).

⁶³² Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705(b).

⁶³³ H. Rep. No. 104-690, 16.

⁶³⁴ Enrollment, 38 C.F.R. sec. 17.36(c). VA regulations state that "[i]t is anticipated that that each year the Secretary will consider whether to change the categories and subcategories of veterans eligible to be enrolled."

⁶³⁵ Enrollment, 38 C.F.R. 17.36(b)(8)(ii),(iv).

⁶³⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014). Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, Pub. L. No. 114-41 (2015).

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Table 8. Priority Groups

Priority Group	Definition
1	<ul style="list-style-type: none"> Veterans with VA-rated service-connected disabilities 50% or more disabling Veterans determined by VA to be unemployable due to service-connected conditions
2	<ul style="list-style-type: none"> Veterans with VA-rated service-connected disabilities 30% or 40% disabling
3	<ul style="list-style-type: none"> Veterans who are former prisoners of war Veterans awarded a Purple Heart medal Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty Veterans with VA-rated service-connected disabilities 10% or 20% disabling Veterans awarded special eligibility classification under Title 38, U.S.C. § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation" Veterans awarded the Medal of Honor
4	<ul style="list-style-type: none"> Veterans who are receiving aid and attendance or housebound benefits from VA Veterans who have been determined by VA to be catastrophically disabled
5	<ul style="list-style-type: none"> Non-service-connected veterans and noncompensable service-connected veterans rated 0% disabled by VA with annual income below VA's and geographically (based on resident zip code) adjusted income limits Veterans receiving VA pension benefits Veterans eligible for Medicaid programs
6	<ul style="list-style-type: none"> Compensable 0% service-connected veterans Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki Project 112/SHAD (shipboard hazard and defense) participants Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975 Veterans of the Persian Gulf War who served between August 2, 1990 and November 11, 1998 *Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987 Veterans who served in a theater of combat operations after November 11, 1998 as follows: <ul style="list-style-type: none"> Currently enrolled veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge. **Combat veterans who were discharged between January 2009 and January 2011, and did not enroll in the VA health care during their five-year period of eligibility have an additional one year to enroll and receive care. The additional one-year eligibility period began February 12, 2015 with the signing of the Clay Hunt Suicide Prevention for America Veterans Act. <p>Note: At the end of this enhanced enrollment priority group placement time period veterans will be assigned to the highest Priority Group (PG) their unique eligibility status at that time qualifies for.</p> <p>*Note: While eligible for PG 6; until system changes are implemented you would be assigned to PG 7 or 8 depending on your income.</p> <p>*Note: While eligible for PG 6; due to system limitations, veterans will be manually assigned to PG 8c, yet eligible for the enhanced benefits</p>
7	<ul style="list-style-type: none"> Veterans with gross household income below the geographically-adjusted income limits for their resident location and who agree to pay copays

Priority Group	Definition
8	<ul style="list-style-type: none"> Veterans with gross household income above VA and the geographically-adjusted income limits for their resident location and who agrees to pay copays <p>Veterans eligible for enrollment:</p> <p>Noncompensable 0% service-connected:</p> <ul style="list-style-type: none"> Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA or geographic income limits by 10% or less <p>Non-service-connected and:</p> <ul style="list-style-type: none"> Subpriority c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status Subpriority d: Enrolled on or after June 15, 2009, whose income exceeds the current VA or geographic income limits by 10% or less <p>Veterans not eligible for enrollment:</p> <p>Veterans not meeting the criteria above:</p> <ul style="list-style-type: none"> Subpriority e: Noncompensable 0% service-connected (eligible for care of their service-connected condition only) Subpriority g: Non service-connected

Analysis

Two decades have passed since Congress last reexamined VHA eligibility and benefits, and many far-reaching changes that affect veterans' health care have occurred in that time. In more than a decade of war, 2.75 million troops have deployed to Iraq and Afghanistan⁶³⁷ where many have faced long and repeated deployments; constant risk of injury and death; and high levels of psychological disorders, substance abuse issues, and physical health problems.⁶³⁸ Post-9/11-era veterans are enrolling for VA care at historically high levels.⁶³⁹

Under current law and VA policy, enrollment is open to a relatively broad spectrum of veterans, though some veterans with higher incomes are not eligible to enroll.⁶⁴⁰ As discussed above, the law draws distinctions between those whose health problems have been adjudicated as service-connected and those whose problems are deemed non-service-connected. If Congress substantially reduced funding for VA medical care, the distinction would be important because those with service-connected issues have higher priority for enrollment. Under VA's current enrollment policy, which bars only veterans with higher incomes from receiving care, the

⁶³⁷ Defense Manpower Data Center, *Contingency Tracking System (CTS) Deployment File*, (Dec. 31, 2015).

⁶³⁸ Institute of Medicine of the National Academies, *Returning Home from Iraq and Afghanistan: Readjustment Needs of Veterans, Service Members, and Their Families*, (Washington, DC: The National Academies Press, 2013), accessed June 25, 2016, <http://www.nationalacademies.org/hmd/Reports/2013/Returning-Home-from-Iraq-and-Afghanistan.aspx>.

⁶³⁹ Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *Profile of Post-9/11 Veterans: 2014*, accessed May 27, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Post_911_Veterans_Profile_2014.pdf.

⁶⁴⁰ Veterans Health Administration, *Enrollment Determinations*, VHA Handbook 1601A.03, 9-10 (2015). Veterans with gross household income that do not exceed VA's means test threshold and a geographic means test by more than 10 percent may enroll for care, while those with higher income and no other special eligibility may not.

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statutory service-connected enrollment priority has little practical significance.⁶⁴¹ Future budget constraints could result in more restrictive enrollment criteria⁶⁴² or recurrence of lengthy wait times that hinder service-connected, disabled veterans' ability to receive timely care.

Current eligibility law does afford special status to veterans who deployed to a combat theater. It grants a 5-year window of eligibility for care to those veterans who are not otherwise eligible.⁶⁴³ All combat veterans are also eligible for readjustment counseling services at VHA Vet Centers without needing to enroll in VHA care and without time limitation.⁶⁴⁴ It is questionable, however, if the 5-year time limit takes sufficient account of continued reluctance of some veterans to seek care for behavioral health problems⁶⁴⁵ or of the difficulties of establishing service-connection years later for conditions that may be linked to wartime exposures to toxic substances.⁶⁴⁶ It is challenging for veterans to establish service-connection for health conditions that may have been caused by or associated with a long-distant exposure for which there may be no documentation. Given emerging evidence that combat exposure should be considered a risk factor for coronary heart disease,⁶⁴⁷ it has been suggested that combat exposure may not only take a toll on psychological health, but may exert a physiologic toll as well.⁶⁴⁸

Congress has attempted to remedy the challenge of documenting toxic exposures and establishing that particular illnesses are linked to wartime or other service exposure. It has, for example, enacted statutes that provide certain veterans eligibility for health care on the presumption that they were exposed to particular toxic substances.⁶⁴⁹ Congress went a step further in the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 which provided eligibility for care for several types of cancer and other specified conditions for family members of veterans who had been exposed to drinking water contaminated with industrial solvents and other toxic chemicals at the Marine Corp base.⁶⁵⁰

Congress has made only limited provision for VA to cover care for family members of certain veterans,⁶⁵¹ but with research suggesting that long combat deployments can take a

⁶⁴¹ Prior to 1996, provisions of law required VA to ensure special priority to service-connected veterans in furnishing outpatient care. 38 U.S.C. § 1712(i), repealed by § 101(c), Pub. L. No. 104-262.

⁶⁴² Enrollment, 38 C.F.R. 17.36(c)(1).

⁶⁴³ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(3), as amended by Sec. 7, Pub. L. No. 114-2 (2015), accessed June 20, 2016, <https://www.govtrack.us/congress/bills/114/hr203/text>.

⁶⁴⁴ Readjustment Counseling Service, 38 U.S.C. § 7309.

⁶⁴⁵ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶⁴⁶ Matthew S. King et al., "Constrictive Bronchiolitis in Soldiers Returning from Iraq and Afghanistan," *New England Journal of Medicine*, 365, no. 10 (2011): 222-230, accessed June 20, 2016, <http://doi.org/10.1056/NEJMoa1101388>.

⁶⁴⁷ Nancy F. Crum-Cianflone et al., "Impact of Combat Deployment and Posttraumatic Stress Disorder on Newly Reported Coronary Heart Disease Among US Active Duty and Reserve Forces," *Circulation*, 129, (2014), accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.113.005407>.

⁶⁴⁸ Rachel Lampert, "Veterans of Combat: Still at Risk When the Battle is Over," *Circulation*, 129, (2014): 1797-1798, accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.114.009286>.

⁶⁴⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(10).

⁶⁵⁰ Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Pub. L. No. 112-154, 126 Stat. 1165 (2012).

⁶⁵¹ Health Care of Persons Other Than Veterans, 38 U.S.C. §§ 1781-1787.

psychological toll on family members,⁶⁵² there may be circumstances under which it might be argued that VA should afford such family members behavioral health services. Studies indicate that longer deployments, deployment extensions, and posttraumatic stress disorder in military personnel are associated with psychological problems for the spouse.⁶⁵³ Long-term effects are unknown, yet studies suggest children may have heightened risk for psychosocial issues during a parent's deployment.⁶⁵⁴

The experience of the nation's longest war and increased options available under the Affordable Care Act (ACA), particularly to previously uninsured non-service-connected veterans, may raise new questions for policymakers.⁶⁵⁵ VHA's most recent survey of enrollees showed that 20 percent of enrollees reported that they were uninsured, down from 22 percent in 2014.⁶⁵⁶ Enrollment in VHA-provided care meets the ACA requirement for health care coverage, creating pressure to continue to provide care to those enrolled.⁶⁵⁷ Given that VHA serves large numbers who are poor or near poor and have chronic medical conditions and behavioral health problems,⁶⁵⁸ it is important to note that receiving care under an ACA plan would not necessarily be a substitute for the rich benefits afforded through VHA. In addition, adults in this population are only eligible for coverage under ACA through state expansion of Medicaid that 19 states have elected not to accept, making this option unavailable to poor or near poor veterans in many parts of the country.⁶⁵⁹

Over time Congress has expanded VA health care eligibility to increasingly more cohorts of non-service-connected veterans. There is wide variability among different cohorts in the extent to which veterans rely on VA care. Those at the higher-income levels (priority categories 7 and 8) who were generally not eligible for ambulatory care prior to 1996, for example, rely on VA for

⁶⁵² Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, accessed June 20, 2016, <http://dx.doi.org/10.1186%2F1471-244X-10-88>. Swords to Plowshares, presentation to Commission on Care, January 21, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former servicemembers. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁶⁵³ H. Thomas De Burgh et al., "The Impact of Deployment to Iraq or Afghanistan on Partners and Wives of Military Personnel," *International Review of Psychiatry*, 23, no. 2 (2011): 192-200, <http://www.ncbi.nlm.nih.gov/pubmed/21521089>.

⁶⁵⁴ Gregory H. Gorman, Matilde Eide, and Elizabeth Hisle-Gorman, accessed June 20, 2016, "Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints," *Pediatrics*, 126, no. 6 (2010): 1058-1066, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-2856>. Anita Chandra et al., "Children on the Homefront: The Experience of Children from Military Families," *Pediatrics*, 125, no. 1 (2010): 16-25, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-1180>.

⁶⁵⁵ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁶ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁵⁷ "Affordable Care Act & Veterans," Department of Veterans Affairs, accessed May 27, 2016, <http://explore.va.gov/health-care-affordable-care-act?show=all>.

⁶⁵⁸ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁹ "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update," Rachel Garfield and Anthony Damico, Kaiser Family Foundation, accessed March 29, 2016, <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/>.

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less than 22 percent of their outpatient care-needs, based on VA's most recent survey of veteran enrollees' health and use of care.⁶⁶⁰

One consideration, as suggested by a few Commissioners, is the feasibility of allowing veterans' family members and currently ineligible veterans to purchase VHA care through their health plans in areas where VHA hospitals and other facilities might otherwise need to close. In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. A related challenge is maintaining safe volume of care when patient loads decline. As an extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁶¹ Similarly, VHA may be unable to continue offer specialty care in certain areas if it forced to close facilities. Patients in a polytrauma unit for example, require a full spectrum of routine and nonroutine health care.

Closing a low-volume hospital may be the answer in some instances. But closing VHA facilities reduces the choices available to veterans. Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. See Appendix C for a further discussion of the challenge of future VHA hospital closures and an outline of suggested pilot programs.

Substantial changes have occurred since Congress last comprehensively examined eligibility for VHA care. These changes merit a reexamination of VA health care eligibility.⁶⁶² The Commission did not, however, view its charge of examining veterans' access and how best to organize VHA, locate health care resources, and deliver care in the years ahead⁶⁶³ as calling for it to make recommendations on this fundamental policy issue, and recommends that the President or Congress consider tasking another body to develop recommendations for VA care eligibility and benefit design. The Commission's work, however, has illuminated the fact that nothing in law or regulation assures a service-connected, disabled veteran of priority for care. VA can and should amend its regulations to provide for such priority, subject to a necessarily higher priority for urgent and emergent care.

Implementation

Legislative Changes

- Task another body to examine the need for changing eligibility for VA care and benefits design, which would include simplifying eligibility criteria, and may include exploring

⁶⁶⁰ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 75, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁶¹ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

⁶⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 25, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶⁶³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

pilots for expanding eligibility for nonveterans to use underutilized providers and facilities when paid for through private insurance.

VA Administrative Changes

- SECVA should amend 38 C.F.R., chapter 17 to establish that veterans with service-connected disabilities shall be afforded priority for access to care, subject to the priority dictated by clinical care needs.

Other Departments and Agency Administrative Changes

- None required.

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Commission on Care

Final Report

COMMISSION ON CARE

June 30, 2016

VA-18-0457-A-002328

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COMMISSION ON CARE

Final Report of the Commission on Care

June 30, 2016

Commission on Care
1575 I Street, NW
Washington, DC 20005



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COMMISSION ON CARE

1575 I Street, NW ▪ Washington, DC 20005

June 30, 2016

We are honored to submit to the President, through the Secretary of Veterans Affairs, in accordance with the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), the enclosed recommendations for transforming veterans' health care. We believe these recommendations are essential to ensure that our nation's veterans receive the health care they need and deserve, both now and in the future.

We worked with an absolute commitment to putting veterans at the heart of our deliberations, and believe our recommendations will create an integrated, community-based health care system for veterans that will be sustainable for the long term. During the term of the Commission on Care, we evaluated the 4,000-page *Independent Assessment Report*; held public meetings; listened to a broad range of stakeholders, including veterans and leaders of veterans service organizations; made site visits to Veterans Health Administration (VHA) facilities; and exchanged ideas with individual veterans, VA and VHA leaders, VHA employees and health care providers, members of Congress, economists, and health care experts.

Overall, the Commissioners agree with the findings of the *Independent Assessment Report*, which are consistent with the expansive body of other evidence the Commissioners have reviewed. This evidence shows that although care delivered by VA is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes. The Commissioners also agree that America's veterans deserve much better, that many profound deficiencies in VHA operations require urgent reform, and that America's veterans deserve a better organized, high-performing health care system.

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The most public and glaring deficiency was access problems. Congress attempted to solve this problem through a provision in VACAA that directed VHA to implement a temporary program allowing for greater choice. The Commission finds, however, that the design and execution of the *Choice Program* are flawed. In its place, we offer specific recommendations for standing up integrated veteran-centric, community-based delivery networks that will optimize the balance of access, quality, and cost-effectiveness.

The Commission also finds that the long-term viability of VHA care is threatened by problems with staffing, facilities, capital needs, information systems, health care disparities and procurement. Fixing these problems requires deliberate, concurrent, and sequential actions. It also requires fundamental changes in governance and leadership of VHA to guide the organization during the next two decades through the rapid changes coming in demographics, technology, and in the structure of the overall U.S. health care system.

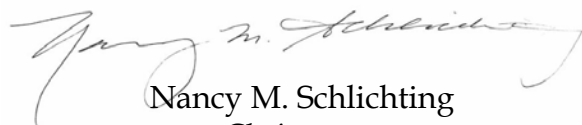
VHA has many excellent clinical programs, as well as research and educational programs, that provide a firm foundation on which to build. As the transformation process takes place, VHA must ensure that the current quality of care is not compromised, and that all care is on a trajectory of improvement. VHA has begun to make some of the most urgently needed changes outlined in the *Independent Assessment Report*, and we support this important work.

Implementing the recommendations in this report will greatly enhance VHA's ongoing reform efforts by providing both a systems-oriented framework and vitally needed changes in organizational structure. Foundational among these changes is forming a governing board to set long-term strategy and oversee the implementation of the transformation process, and building a strong, competency-based leadership system.

The remaining recommendations work in harmony to ensure veterans receive timely access to care, have options for where and how they receive care, are cared for in an environment that embraces diversity and inclusion, and are supported in making informed decisions about their own health and well-being. These recommendations are

not small-scale fixes to finite problems. Instead, they constitute a bold transformation of a complex system that will take years to fully realize, but that our country must undertake to provide our veterans with the high-quality health care they richly deserve.

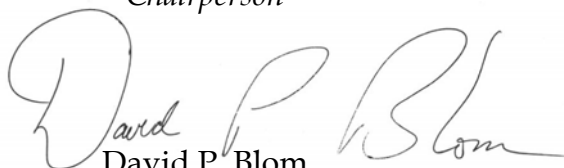
Respectfully Submitted,



Nancy M. Schlichting
Chairperson



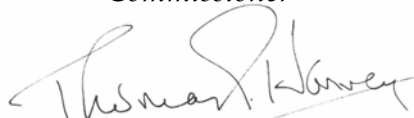
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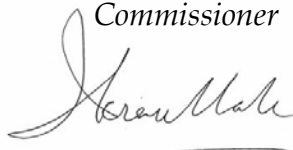
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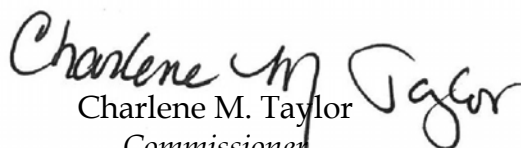
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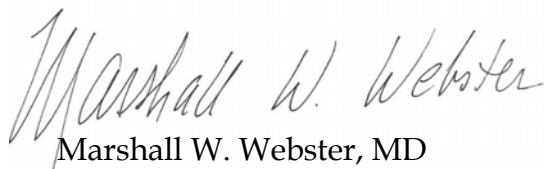
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EXECUTIVE SUMMARY

Two years ago, a scandal over VHA employees' manipulation of data systems to cover up long appointment scheduling delays made headlines and left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. The White House appointed new leadership, including the secretary of veterans affairs (SECVA) and the undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program*, to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The independent assessment included an examination of the hospital care, medical services, and other health care provided in VA medical facilities.¹ The legislation identified 12 specific areas for in-depth evaluation:

- Demographics
- Health Care Capabilities
- Care Authorities
- Access Standards
- Workflow–Scheduling
- Workflow–Clinical
- Staffing/Productivity
- Health Information Technology
- Business Processes
- Supplies
- Facilities
- Leadership

The *Independent Assessment Report* provided a detailed analysis of the assessment and associated findings. The Commission work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

In an effort to focus the Commission's recommendations and set the tone for subsequent change, the Commissioners developed a vision, a mission, and a set of values to drive reform as shown below. The vision provides the conceptual framework for the model of veterans' health care put forth in this report, and the mission and values shape the content of the recommendations.

Vision

Transforming veterans' health care to enhance quality, access, choice, and well-being.

- *Quality: Provide community-based, innovative care that drives improved outcomes.*
- *Access: Ensure timely access to the best providers for meeting veterans' health care needs.*

¹ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113–146, § 201(a)(1).

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- *Choice: Integrate health care within communities to foster convenience and efficiency.*
- *Well-Being: Support veterans in achieving optimal physical and mental health.*

Mission

Provide eligible veterans prompt access to quality health care.

Values

- Provide veteran-centric care.
- Involve all stakeholders, and especially veterans and their families, in designing the evolving future health care for veterans.
- Assimilate veterans into the greater community.
- Create community-based integrated networks to improve health care access and choice for veterans.

The recommendations in this report acknowledge that although VHA provides health care that is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes.

Some of these challenges are not exclusive to VHA, and reflect large-scale problems in the U.S. health system in general, such as acute shortages of primary care doctors and lack of health care capacity in poor and rural areas. Other challenges reflect deficiencies within VHA itself, in areas such as staffing, facilities, capital needs, information systems, healthcare disparities and procurement.

It is important to understand VA's long history as a health care provider, which has included previous cycles of crisis and renewal that offer lessons for the present. It is also important to consider how VHA can implement major reform in a manner that is sustainable. This report addresses both of these issues.

The Commission's focus on access to care clearly highlighted the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The report begins with an *Introduction* that addresses the controversy over veterans' health care and gives a brief description of the Commission's vision for improving it. There are three main recommendation sections: *Redesigning the Veterans' Health Care Delivery System*; *Governance, Leadership, and Workforce*; and *Eligibility*. Each section includes detailed discussions of the high-level areas in which change must occur in the respective areas to facilitate bold reform. The format for each discussion includes identification of the problem, the Commission's recommendations for addressing the problem, background information, analysis, and implementation steps for Congress, VA, and other agencies. This executive summary provides a brief overview of each of the recommendations.

For the ease of our readers, the appendices contain all additional content. Of particular interest are appendices on *Financing the Vision and Model, Leadership Implementation, History as a Context for Systemic Transformation, Veteran Feedback, and Additional Resources*. These and other appendices provide policymakers and those charged with implementing the plan with a clear picture of the rationale for the recommendations and the context that frames them.

Recommendations

The Commission does not intend for these recommendations to be piecemeal fixes to everyday problems. Instead, they are presented as the foundation for far-reaching organizational transformation that adheres to a systems approach. The Commission's recommendations comprise the essential elements for such transformation.

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Due to changing veteran demographics, increasing demand for VHA care in some markets and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Congress tasked VHA with creating the temporary *Choice Program*. It was designed to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

The Commission Recommends That . . .

- VHA Care System governing board (see recommendation on p. 94) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.

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- Integrated community-based health care networks be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.
- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

The recommendations above work together to support the VHA Care System, as outlined in Table 1 below.

Table 1. VHA Care System Operations

Key Component	Expectations
Choice	<ul style="list-style-type: none"> ▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	<ul style="list-style-type: none"> ▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.²

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.³ For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified “not working to top of provider licensure” as a barrier in health care provision.⁴

² RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

³ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁴ Ibid., 95.

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VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

The Commission Recommends That. . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally supported programs.

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.⁵ Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).⁶

As part of the MyVA initiative, the Secretary of Veterans Affairs has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.⁷ The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.⁸

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a revised clinical-appeals process.

⁵ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

⁶ VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷ "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, <http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx>.

⁸ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.⁹

VHA has a program of system engineering — Veterans Engineering Resource Center (VERC) — that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to identify proactively problem areas within the system and offer assistance.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*, Assessment F (Workflow—Clinical), 14 and A-2, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

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A systematic review of VHA in 2007 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.¹⁰ VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues – the Health Equity Action Plan (HEAP) – but it has not been fully implemented.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.¹¹

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

Veterans who turn to VHA to meet health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of those barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks holds the promise of markedly improving veterans' access to care. That promise cannot be realized without transformative changes to VHA's capital structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of building out the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as

¹⁰ Somnath Saha et al., *Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review*, U.S. Department of Veterans Affairs, Health Services Research & Development Service, June 2007, accessed June 22, 2016, <http://www.hsrd.research.va.gov/publications/esp/RacialDisparities-2007.pdf>.

¹¹ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

much control as possible to drive the process to ensure that all facility plans are fully integrated with the strategic vision for the VHA Care System.

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meets its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission (BRAC) process to be implemented as soon as practicable. The Commission recommends the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems; enables scheduling, billing, claims, and payment, and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.¹² VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, VHA lacks an experienced senior health care IT leader focusing on the strategic health care IT needs of veterans.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing

¹² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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and implementing a comprehensive health IT strategy and developing and managing the health IT budget.

- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.¹³

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.

¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

Governance, Leadership, and Workforce

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center, and similar problems at multiple other VA medical centers, had both direct and indirect causes. Weak governance was found to be among those indirect causes.¹⁴ As the authors of a root-cause analysis of the Phoenix scandal highlighted, “a governance gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed to the wait-time problems.¹⁵ The report authors observed, “Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors.”¹⁶ The governance limitations made evident in the Phoenix scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration’s expectations for short-term results,¹⁷ and VHA’s operating in a “dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with competing demands”¹⁸ offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act (FACA) and be structured based on the key elements included in Table 5.

¹⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁵ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

Leadership

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

High-performing organizations have healthy cultures in which diverse staff feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government. For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

The Commission Recommends That . . .

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report on it to the CVCS and the new VHA Care System board of directors (see governance discussion in the previous section).

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and

promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an OMB management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and the functions overlap or are duplicated. The role of the VISN is not clear, and the delegated responsibilities of the medical center director are not defined.

The Commission Recommends That . . .

- VHA redesign VHACO to create high-performing support functions that serve VISNs and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the CVCS with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report.

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Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

To achieve the Commission’s vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set—identical to private-sector standards—will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes to veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders’ performance not just on *what* they achieve but *how* they achieve it.

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Personnel Performance Management System

- VHA create a new performance management system appropriate for health care executives, tied to health care executive competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of

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these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veterans' care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does all of the following:
 - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
 - Promotes veteran preferences and hiring.

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- Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, due process) through simplified, sensible processes that work for managers and employees.
 - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
 - Provides due process and appeals standards to adverse personnel actions.
 - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
 - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
 - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
 - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
 - Grandfathers current employees with respect to pay and benefits.
- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

Recommendation #16: Require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Effective planning for and management of human capital are core enabling requirements for any business: If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

The Commission Recommends That . . .

- VHA hire a chief talent leader who holds responsibility for the operation's entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the chief of VHA Care System.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.

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- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

In some cases, individuals have been dismissed from military services with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury [TBI], posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

The Commission Recommends That . . .

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an OTH discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Although VHA continues to offer the promise of health care to all eligible veterans, its capacity to meet that promise is constrained by appropriated funding.¹⁹

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use

¹⁹ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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underutilized VHA providers and facilities, providing payment through private insurance.

- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

Conclusion

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, though, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient-provider engagement and in where and how care is delivered. VHA must keep pace with, and even be a leader in, these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand access to reflect not only timeliness, but care quality, and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone: Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report* emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The Commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term transformation, the Commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the nation's obligation to those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission fully acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the Commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For

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example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net. Even considering these strengths, some may question how a system beleaguered with the problems VHA faces can achieve lofty transformation goals. This is not the first time VHA has faced challenges; however, and history has demonstrated that with appropriate structure and strategies in place, transformation can be achieved and sustained.

Transformation is a difficult process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. The Commission's recommendations in some areas acknowledge VHA's efforts to begin the transformation process and suggest that where these efforts align with the Commission's recommendations, they should be sustained. Reaping the fruits of transformation will take more than a single Congress or a single 4-year administration. For this reason, the Commission strongly recommends a new governance model and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission's recommendations, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

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INTRODUCTION

Two years ago, a scandal over VHA employees manipulating data systems to cover up long delays in scheduling care left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. In response, the White House appointed new leadership, including the secretary of veterans affairs (SECVA) and undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program*, to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The Commission on Care's work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

The charge given this Commission, with its emphasis on access to care, reflects the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the Commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, however, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient-provider engagement, and in where and how care is delivered. VHA must keep pace with, and even be a leader, in these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand *access* to reflect not only timeliness, but care quality and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone; Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report*

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emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term *transformation*, the commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the obligation owed those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net.

Others may question how a system with the range of problems VHA faces can meaningfully improve, let alone realize a transformation. Mindful of its 20-year charge, the Commission notes that VA health care faced similar challenges 20 years ago and underwent a historic transformation. The long history of the VA health care system has seen highs and lows. Among the lessons in that history is that the mission—to care for those who have borne the battle—is not only powerful, but enduring. History has demonstrated that transformation can be achieved, but also that structures and strategies for sustainability must be built into the framework.

As the commission report emphasizes, transformation is difficult. It is a process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. VHA has begun some of this work; our recommendations in some areas acknowledge VHA's efforts and suggest that where they are aligned with the Commission's recommendations, they should be sustained. The fruits of the transformation, though, will not be realized over the course of a single Congress or a single 4-year administration. For this reason, the Commission, strongly recommends a new form of governance and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission recommends, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

COMMISSION RECOMMENDATIONS

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Problem

Due to changing veteran demographics, increasing demand for VHA care in some markets, and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With the passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACA), Congress tasked VHA with creating the temporary *Choice Program*. It was intended to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

The Commission Recommends That . . .

- VHA Care System governing board (see Recommendation #9) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.
- Integrated, community-based health care networks be developed with *local* VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.

Recommendations continue on next page. =>

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Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

Background

VHA has long had authority to purchase hospital care and medical services based on geographic inaccessibility or VHA's lack of a required service.²⁰ In 2013, VA moved beyond the use of individual purchased-care authorizations to regional contracting under the Patient-Centered Community Care (PC3) Program.²¹ In all cases, purchased care was a secondary means of providing care, to be used "when VA health care facilities are not feasibly available."²² Even before the creation of the *Choice Program* in 2014, some 10 percent of VHA medical spending went for purchased-care services.

When Congress enabled what became known as the *Choice Program*, it tasked VHA with implementing a fundamentally new mechanism for purchasing care. Unlike traditional purchased-care authority (which still exists), the *Choice Program* promises veterans who meet specific geographic or wait-time-related criteria that they can elect to receive treatment from within a network of a community providers.²³

Under the current *Choice Program*, however, most VHA patients are promised little or no actual choice of providers outside VHA. To be eligible for the program, VHA patients must meet the following criteria:²⁴

The Commission Recommends That . . .

<= Recommendations continued from previous page.

- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- The VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

²⁰ Contracts for Hospital Care and Medical Services in Non-Department Facilities, 38 U.S.C. § 1703(a).

²¹ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, 37, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

²² Non-VA Medical Care Program, VHA Directive 1601, (2013).

²³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014).

²⁴ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014), as amended by Construction Authorization and Choice Improvement Act, Pub. L. No. 114-19, 129 Stat. 215, (2015). The Independent Assessment proposed that VA should "Develop and implement more sensitive standards of geographic access to care. VA should compare the 'one-size-fits-all' approach of driving distance to alternative standards that are more sensitive to differences between Veteran subgroups, clinical populations, geographic regions, and individual facilities. This

- Live more than 40 miles from the closest VHA facility with a full-time primary care provider
- Cannot be seen within 30 days of the date veterans' providers indicate they need to be seen.
- Cannot be seen within 30 days of veterans' preferred appointment date if providers have not provided a specific appointment date.

This standard is difficult to reconcile with other statutory priorities for VA care.²⁵ For example, under the *Choice Program*, a veteran with severe service-incurred health conditions may have no access to providers outside VHA, yet a veteran with no service-related disabilities does have such a choice.²⁶ Implementing the *Choice Program* has posed challenges, including difficulties arising from overlapping, but fundamentally different, care-purchasing authorities. Veterans, VHA staff, and community providers²⁷ have been confused because of conflicting requirements and processes in eligibility rules, referrals and authorizations, provider credentialing and network development, care coordination, and claims management.²⁸

Adding to the confusion is the fact that VHA, facing a 90-day deadline for implementing the program, outsourced the creation and management of its provider networks to two private contractors, thus blurring lines of responsibility and leaving both patients and providers confused about who exactly holds responsibility for what. In execution, the program has aggravated wait times and frustrated veterans, private-sector health care providers participating in networks, and VHA alike.²⁹

In October 2015, VA submitted a report to Congress that proposed legislation to harmonize the different purchased-care authorities into a single approach.³⁰ VA's report also set out a plan for establishing high-performing networks. The report acknowledged that "[n]o organization can excel at every capability," and that "[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers."³¹ As further articulated by Dr. David Shulkin, USH:

assessment highlighted the importance of time spent driving, mode of transportation, traffic, and availability of needed services as key considerations in assessing geographic access to care."

²⁵ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705.

²⁶ Ibid.

²⁷ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, 43, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf. Pete Henry, retired VA medical center director, response to questions about the challenges facing field officials, email to Commission on Care staff, January 18, 2016.

²⁸ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

²⁹ "Despite \$10B 'Fix,' Veterans are Waiting Even Longer to See Doctors," Quil Lawrence, Eric Whitney, and Michael Tomsic, accessed May 16, 2016, <http://www.npr.org/sections/health-shots/2016/05/16/477814218/attempted-fix-for-va-health-delays-creates-new-bureaucracy>.

³⁰ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

³¹ Ibid., 18.

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It's become apparent that the VA alone cannot meet all the health care needs of U.S. veterans. The VA's mission and scope are not comparable to those of other U.S. health systems. Few other systems enroll patients in areas where they have no facilities for delivering care. Fewer still provide comprehensive medical, behavioral, and social services to a defined population of patients, establishing lifelong relationships with them. These realities, combined with the wait-time crisis, have led the VA to reexamine its approach to care delivery . . . [A]ddressing veterans' needs requires a new model of care: rather than remaining primarily a direct care provider, the VA should become an integrated payer and provider. This new vision would compel the VA to strengthen its current components that are uniquely positioned to meet veterans' needs, while working with the private sector to address critical access issues.³²

Analysis

VHA needs systemic transformation, and merely clarifying and simplifying the rules for purchased care, as proposed in the *Independent Assessment Report*, is not sufficient to achieve that goal. VHA must replace the arbitrary eligibility requirements and unworkable clinical and administrative restrictions of current purchased programs with the new VHA Care System, available to all enrolled veterans.

The VHA Care System is defined as VHA employed providers and facilities; Department of Defense (DoD) and other federally-funded providers and facilities; and community-based, VHA-credentialed community providers and facilities, forming integrated networks to deliver high-quality and high-access care to enrolled veterans across the United States. VHA may establish the networks with the use of national contractors or with internal resources, but networks should be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.

This new delivery model must preserve critical VHA programs and competencies that are unique to VHA or that are of higher quality or greater scope than is available in the private sector, either locally or nationally³³ They include specialized behavioral health care programs, integrated behavioral health and primary care (in patient-aligned care teams), specialized rehabilitation services, spinal cord injury centers, and services for homeless veterans.³⁴ These and similar programs and services are core competencies and special capabilities that serve the needs of combat veterans, veterans with conditions incurred or aggravated in service, and veterans reliant on safety-net services and supports.³⁵ Because of its unique capabilities and competencies, VHA should play an important role in expanding and enhancing the care of veterans across the United States by collaborating with local network providers to improve the

³² David J. Shulkin, "Beyond the VA Crisis — Becoming a High-Performance Network," *New England Journal of Medicine*, 374, (2016): 1003-1005, accessed June 15, 2016, <http://doi.org/10.1056/NEJMp1600307>.

³³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

³⁴ Special capabilities like spinal cord injury care, which draw from specialty care available in the full-service hospitals in which they are currently provided, merit continued support and investment. Thus, in instances where VHA might no longer operate a full-service hospital that had once housed a spinal cord injury center, it would need to establish community partnerships to assure veterans would continue to receive the same high quality care.

³⁵ David J. Shulkin, "Why VA Health Care Is Different," *Federal Practitioner*, 33, no. 5 (2016): 9-11, <http://www.fedprac.com/home/article/why-va-health-care-is-different/c8da5ba1261bdb726bdddcbceea81f27.html>.

availability and quality of care in areas especially needed by veterans, such as mental health and rehabilitation.

Management and Oversight

VHA Care System networks will be built out in a well-planned, phased approach overseen by the new governing board, which will determine the criteria and sequencing for the phases, to ensure effective execution of the strategy. The timing and phasing criteria may include veteran service needs, access issues, quality issues, facility issues, and IT capabilities.

The networks within the VHA Care System will require ongoing management and evaluation of their performance. This process will be the responsibility of VHA management and board, with board oversight of network performance.

The governing board will oversee the budget for the VHA Care System. Local leadership will provide input on funding, and the local networks will determine their funding needs and submit their respective requests to the chief of VHA Care System (CVCS), formerly the undersecretary of health for VHA. The governing board will recommend to Congress the budget required to implement the VHA Care System, with multiyear appropriations. The local network leaders will have the flexibility to manage their respective network budgets based upon local needs. A key element of the new system will be combining a national strategy and local flexibility for managing the budget to allow for effective decision making to ensure veterans' needs are met.

Provider Payment

Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS). MACRA is intended to move the health care industry away from a fee-for-service model to value-based payments.³⁶ Such a system is expected to drive improved quality and lower costs.³⁷

Care Administration

From a strategic perspective, service-connected disabled veterans should receive the highest priority access to the VHA Care System. This principle should guide access to all types and points of care. Veterans with limited financial means should also have high priority. If needed, cost sharing (applicable only to those who are non-service-connected disabled and not financially needy) can provide a means for offering broader choice. The current time and distance criteria for community care access (30 days and 40 miles) should be eliminated. VISN geography should also be eliminated as a factor in determining where veterans can access care. Eligible veterans should be permitted to receive care at any facility and by any provider in the VHA Care System, whether in a veteran's home VISN or not.

Choice and Care Coordination

The topic of choice was the most contentious issue considered by the Commission. Some Commissioners advocated complete choice of providers for veterans, with no requirement for

³⁶ "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, <http://www.nationalpartnership.org/issues/health/macra.html>.

³⁷ Ibid.

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care coordination by primary care physicians. Others advocated for a tightly managed model with VHA controlling access to community providers, as is done today. After considering the costs of various design options, the importance of care coordination, and the need for greater veteran access to both primary care and specialty care services, the Commission agreed to the following design principles:

- VHA will establish and credential community networks with a focus on quality of providers, access to comprehensive services, and utilization of VHA resources.
- Veterans will have complete choice of primary care providers within the VHA Care System.
- All primary care providers in the VHA Care System (including VHA providers, DoD and other federally funded providers, and community providers) will coordinate veterans' care.
- Specialty care will require a referral from a primary care provider.
- VHA will assume overall responsibility for care coordination and navigation for all enrolled veterans.

Quality of care must be a core element of network design and consistently monitored with metrics that are routinely used by the private sector. Accordingly, VHA must adopt standards that both ensure networks are composed of high-quality providers and set appropriate expectations of those providers. Critically, all providers in the networks must have fully interoperable IT platforms to allow for complete data exchange. Providers must work together to maximize patients' well-being using evidence-based protocols of care.

Lack of coordination among providers is a major quality and patient-safety issue throughout the U.S. health care system. It is important for VHA to coordinate the care it provides because it serves an especially vulnerable population that has more chronic medical conditions, behavioral health conditions, and individuals of lower socioeconomic status than the general medical population.³⁸ Veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers.³⁹

³⁸ Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, <http://doi.org/10.1001/jama.2012.196>.

³⁹ "The Impact of the Affordable Care Act on VA's Dual Eligible Population," Patricia Vandenberg et al., Department of Veterans Affairs, accessed June 2, 2016, <http://www.hsrd.research.va.gov/publications/forum/apr13/apr13-1.cfm>. Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, <http://doi.org/10.1001/jama.2012.196>. Brigham R. Frandsen et al., "Care Fragmentation, Quality, and Costs Among Chronically Ill Patients," *American Journal of Managed Care*, 21, no. 5, (2015): 355-362, accessed June 20, 2016, <http://www.ajmc.com/journals/issue/2015/2015-vol21-n5/care-fragmentation-quality-costs-among-chronically-ill-patients>. Chuan-Fen Liu et al., "Use of Outpatient Care in Veterans Health Administration and Medicare among Veterans Receiving Primary Care in Community-Based and Hospital Outpatient Clinics," *Health Services Research*, 45, no. 5 part 1, (2010): 1268-1286, accessed June 20, 2016, <http://doi.org/10.1111/j.1475-6773.2010.01123.x>.

VHA Care System will operate as outlined in Table 2 below.

Table 2. VHA Care System Operations

Key Component	Expectations
Choice	<ul style="list-style-type: none"> ▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	<ul style="list-style-type: none"> ▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Scope of Provider Networks

In setting up networks within the VHA Care System, VHA must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans' choice, yet would also consume far more financial resources (i.e., taxpayer dollars) due to increased utilization or cost shifting. Currently, money VHA spends on expanding choice is not available to spend on other programs and services vital to its mission.⁴⁰

Health plans commonly limit the size and scope of networks as a cost-management tool, offering insurance products with narrow networks (managed care plans) or more open networks (preferred provider plans). Well-managed, narrow networks can maximize clinical quality by requiring participating clinicians to adhere to evidence-based protocols of care.⁴¹ Achieving high quality and cost effectiveness may constrain consumer choice. A patient's preferred doctor, clinic, or hospital may not be part of that smaller network or the narrow network may not offer sufficient geographic access for some patients.⁴²

VHA must balance these competing considerations. In doing so, it faces a variety of options. In addition to the scope of networks, for example, is the question of whether and how VHA will play a role in steering patients to different providers within the networks. This is another area involving tradeoffs among competing values and considerations. Private-sector health plans

⁴⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 23 accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴¹ "What Tier Networks Will Mean to You," Ken Terry, accessed June 2, 2016, <http://medicaleconomics.modernmedicine.com/medical-economics/content/what-tiered-networks-will-mean-you>.

⁴² Ibid. U.S. Congress, House of Representatives, Committee on Ways and Means, Subcommittee on Health, *Hearing on "Health Care Consolidation"*, 112th Congress, 1st Session, (2011), (Statement of Paul B. Ginsburg, President, Center for Studying Health System Change, Research Director, National Institute for Health Care Reform), accessed June 2, 2016, http://waysandmeans.house.gov/UploadedFiles/Ginsburg_Testimony_9-9-11_Final.pdf.

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often require all specialty care to be preapproved through a referral from a primary care physician. Managed care plans may also use prospective and concurrent utilization review and care management for hospitalization. For prospective reviews, patients must receive approval from their health plan before being admitted to the hospital to ensure the admission is clinically appropriate. Plans may also use concurrent utilization or case management for inpatient care to ensure the care and tests ordered and the length of stay in the hospital are appropriate.⁴³

The Commission carefully weighed these issues in recommending an approach. The Commission considered the effect of cost using various configurations of VHA services and community delivered services (CDS). Options considered by the commission include the following:

- **Recommended Option:** This option provides an integrated network of VHA, DoD and other federally funded providers, and community providers, credentialed by VHA. It requires veterans to attain a referral from their primary care provider to access specialty care.
- **CDS Alternative 1:** The main difference between this option and the *Recommended Option* is primary care, inpatient medical and surgical care, and some standard specialty care would not be eligible for CDS networks and would be accessed within VHA unless the *Choice Program* distance exception applies.
- **CDS Alternative 2:** The division of care between VHA providers and CDS network providers would be the same as for *CDS Alternative 1*; however, veterans would only need to consult their primary care provider before seeking specialty care, rather than obtaining a referral.
- **CDS Alternative 3:** This option would combine the broad network in the *Recommended Option*, but would have no referral or consultation requirement; thus, it would be an extremely generous benefits package.
- **Premium Support:** Under this scenario, enrollees who are younger than 65 would choose a subsidized insurance premium with cost sharing. Access to VA services, including special services, would be eliminated.
- **Eligibility Expansion:** Under this scenario the VA health care system would expand to allow all veterans, regardless of priority group.
- **Other-Than-Honorable Discharges:** A policy change for which individuals with other-than-honorable (OTH) discharge is outlined in Recommendation #17. This option would allow temporary eligibility for VA health care to those with an OTH discharge until the adjudication process to determine long-term eligibility took place.

⁴³ Paul B. Ginsburg, "Achieving Health Care Cost Containment Through Provider Payment Reform that Engages Patients and Providers," *Health Affairs*, 32, no. 5, (2013): 929-934, accessed June 20, 2016, <http://doi.org/10.1377/hlthaff.2012.1007>. While these approaches can help keep costs down, patients, doctors and hospitals can experience the process as bureaucratic interference in clinical care. To implement utilization management, health plans usually include a strong clinical appeals process that both doctors and patients can access to question the decisions made by administrators.

Below is a more detailed summary of the Commission's *Recommended Option*. Additional information, including cost projections for all of the options above, can be found in Appendix A.

Cost Model for Commission Recommended Option

This option would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VHA. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in a substantially different way than by VHA).⁴⁴ In 2014, 68 percent of care would have been eligible for CDS networks at current VHA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network (i.e., from any provider in the VHA Care System). In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

Both CDS networks and traditional Care in the Community (CITC) are priced at Medicare allowable rates by matching Medicare fee schedule data to VA Health Service Categories.⁴⁵ A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities. For care shifting into the CDS networks, we assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance; those costs are not modeled.

We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a provider in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and

⁴⁴ Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health, and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

⁴⁵ Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

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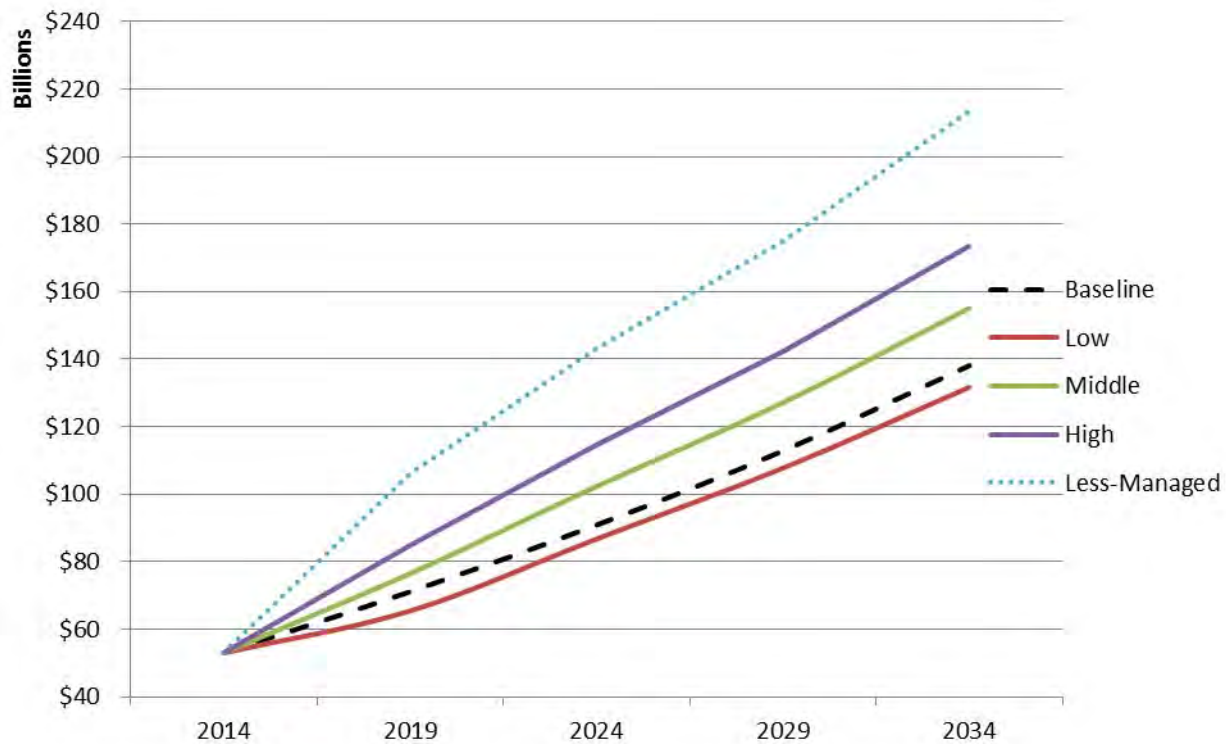
20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was formerly subject to sizable cost sharing with private insurance or Medicare and now would be subject to little, if any, cost sharing associated with VA-financed care.

There are a number of caveats associated with our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects on quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. Finally, estimates do not include administrative costs associated with CDS networks; these costs could be substantial.

Figure 1 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from \$65 billion to \$85 billion in 2019, with a middle estimate of \$76 billion. The middle estimate is moderately above the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is \$106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

This model is described more fully in Appendix A, along with models for a range of other options, some of which are previously described in this section. Consult Appendix A for more details on the technical assumptions necessary to understand the results presented here. The assumptions and caveats detailed in Appendix A play a critical role in our estimates, and any deviation from these assumptions could substantially affect the estimates.

Figure 1. Projected Costs of Recommended Option



Mitigating Risks

Choice involves tradeoffs. Reducing drive times to see a doctor may lead to longer wait times, for example, if it induces substantially more veterans to seek more care.⁴⁶ VHA reliance on contracting could also have unintended consequences for already underserved communities. Providers in such communities who join the local VHA network may decide to limit the number of Medicare and Medicaid patients they accept into their practices. In other, highly concentrated health care markets, which are increasingly common throughout the United States, VHA may not be able to contract for care in the community except at higher prices.⁴⁷ Such circumstances underscore the importance of VHA retaining the option of building its own capacity.

Policymakers must also carefully weigh concerns that leaders of seven major veterans organizations expressed in a recent joint letter in which they warned “choice should never be the ultimate goal of a health care system designed to meet the unique needs of veterans.”⁴⁸ These organizations do not support providing unfettered choice, and the VSO leaders stated that “any health care reform proposal that elevates the principle of ‘choice’ above all other clinical considerations would have severe consequences for veterans who rely on VA, resulting

⁴⁶ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 284, accessed May 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁴⁷ David M. Cutler and Fiona Scott Morton, “Hospitals, Market Share, and Consolidation,” *Journal of the American Medical Association*, 310, no. 18, (2013): 1964-1970, accessed June 20, 2016, <http://doi.org/10.1001/jama.2013.281675>.

⁴⁸ Garry J. Augustine, Disabled American Veterans et al., letter sent to Commission on Care, April 29, 2016.

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in less ‘choice’ rather than the intended desire for more health care options for many disabled veterans.”⁴⁹

The Commission has addressed this concern in several ways, including the following:

- recommendations to substantially improve VHA operations, thereby enhancing the attractiveness of using VHA providers and facilities by enrolled veterans
- VHA control of network design
- VHA Care System governing board oversight of network execution and phasing
- high standards for community provider participation, including credentialing, military competence, and quality and utilization performance
- VHA oversight of care coordination and navigation
- requirement of primary care referral for specialty care

The Commission recognizes that greater choice of provider can result in higher utilization of health care services, which increases costs. This risk can be mitigated by recommendations in this report that will produce cost savings. To incentivize cost mitigation, all cost savings associated with improved efficiency and operations should be reinvested into the VHA Care System. Examples of cost mitigation strategies include the following:

- recovering third-party payments owed to VHA more effectively
- maintaining VHA as a secondary payer when veterans have other health insurance and treatment is for non-service-connected care
- increasing cost-sharing or changes in eligibility and/or benefit design could also substantially contain the projected costs of increasing provider-choice
- reducing fixed costs of underutilized facilities and services
- managing the supply chain to produce cost savings
- improving facilities to increase provider productivity (e.g., increase in outpatient exam rooms)
- adopting information technology that improves the quality and efficiency of care

Effectively implementing and managing integrated networks will require extensive changes in the governance and leadership of VHA, as well as flexible and smart procurement policies and

⁴⁹ Ibid.

contracting authorities, as discussed elsewhere in this report. The highest priority for standing up networks should be locations where VHA quality of care is deficient or capacity is strained.⁵⁰

Where capacity constraints exist within networks, first priority for care should go to those veterans with greatest medical need, followed by service-connected disabled veterans and indigent veterans.⁵¹ VHA should develop processes and procedures for insuring that veterans have the knowledge and assistance they need to make informed health care decision and to navigate effectively through the expanding health care networks. By employing strategies proven by other managed care plans, VHA will find administrative means to guard against inappropriate treatment, wasteful spending, and fraud.

As many surgical and medical procedures that previously required inpatient hospital stays have routinely become outpatient procedures, there continues to be a substantial shift from inpatient to outpatient care.⁵² Consequently, to ensure improved access to care for veterans, the VHA Care System and long-term plans for facilities should focus on creating a robust ambulatory network and reshaping inpatient resources to match expected demand. Additionally, to inform veterans' and providers' decisions and create increased accountability for performance, all VHA and community network providers and facilities must provide transparent information on inpatient and outpatient quality, service, and access using the same performance metrics, including those used by Medicare.

Implementation

Legislative Changes

- Enact legislation amending 38 U.S. Code, Chapter 17 to consolidate existing purchased-care authorities and authorize the SECVA to furnish enrolled veterans needed hospital care and medical services through agreements with providers the SECVA deems meet quality standards the SECVA will establish. Veterans would be eligible for community care on the same basis as for VHA-furnished care, and current wait time and geographic distance criteria should no longer be applicable.

VA Administrative Changes

- Develop national policy to govern local establishment of networks, and in doing so, focus its design and long-term planning on creating a robust ambulatory capability and reshaping inpatient resources to match expected demand.
- Establish standards that community providers must meet to qualify for participation in community networks, to include becoming fully credentialed, meeting patient-access criteria, demonstrating high-quality clinical outcomes and appropriate use decisions, demonstrating military cultural competency, and having capability for interoperable data exchange.

⁵⁰ Information on what medical centers are deficient in their care is available, for example, from the VHA's own Strategic Analytics for Improvement and Learning (SAIL) data.

⁵¹ It would seem prudent to begin such phased development by piloting that effort, and limiting the scope of unfettered choice to service-connected veterans.

⁵² Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/21183845>.

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- Establish systems to ensure that all primary care providers in the VHA Care System can effectively coordinate veterans' care.
- Provide veterans navigation services for complex care needs, including information needed by patients and their families for informed decision making about treatments and providers. Navigation services should assist veterans and their families with eligibility, cost-sharing, and other administrative issues.
- Establish policies and procedures to ensure that VHA provider as well as community providers within each network, provide transparent information (using the same metrics) on care-quality, service, and access.
- Eliminate the practice of cross-country referrals if quality care is available locally.
- Employ the most current payment approaches that incentivize quality and appropriate use of health care services.

Other Department and Agency Administrative Changes

- None required.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

Problem

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.⁵³

The Commission Recommends That . . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.⁵⁴ For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified “not working to top of provider licensure” as a barrier in health care provision.⁵⁵

VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

Background

A large part of the VHA’s problem with inadequate clinical support staff derives from its difficulties in hiring, retaining, and training medical support assistants (MSAs). These individuals answer phones, schedule care, and verify health care eligibility, among other duties.

⁵³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁵⁴ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵⁵ *Ibid.*, 95.

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Congress has recently given VHA the flexibility to offer MSAs market-based pay rates.⁵⁶ VHA is changing cumbersome rules that have made hiring new MSAs exceptionally time-consuming.⁵⁷

VHA is working to resolve its problems with resource allocation in clinics. For example, the agency has committed to increasing use of clinical managers to help medical centers better match resources to patient demand. Widely used by other health care systems, clinic managers enhance operations by ensuring that telephone protocols, scheduling, and clinic workflow are operating at peak efficiency. They also ensure that staff members are assigned appropriate caseloads and are meeting productivity standards and wait time targets and that administrative staff has appropriate training in scheduling, coding, and/or documentation.

Many states have already taken the steps to ensure APRNs have full practice authority. VHA is working to do the same, which will allow a vast increase in the number of VHA clinicians available to treat patients independently.⁵⁸

To effectively manage clinician supply for the inpatient setting, administrators require accurate bed count data. Currently in VHA, data integrity of bed counts is compromised as a consequence of disclosure requirements of Congress. VHA is required by statute to complete a complicated reporting, approval, and notification process when it closes hospital beds.⁵⁹ To avoid the reporting requirements some VA medical centers count beds as unavailable indefinitely. This action can skew occupancy rates and thwart planning activities. VHA developed its guidance in part to satisfy the Millennium Act⁶⁰ and other requirements that essentially froze beds at FY 1998 levels.⁶¹

Analysis

VHA has taken a number of measures to address data integrity issues. VHA has started hiring clinical managers to assist in managing resources for effective performance. VHA has made efforts to address problems affecting supply and training of MSAs. Additionally, VHA has recently proposed a rule that would authorize full practice for APRNs working within the agency.⁶²

These measures by themselves, however, will not be sufficient to solve the current problems. VHA must ensure all facilities have enough support positions—both clerical and clinical—to

⁵⁶ Sloan D. Gibson, Deputy Secretary, Department of Veterans Affairs, presentation to Commission on Care, April 18, 2016.

⁵⁷ 38 U.S.C. § 7401(3)(A)(iii).

⁵⁸ Establishing Medication Prescribing Authority for Advanced Practice Nurses, VHA Directive 2008-049, (2008).

⁵⁹ Inpatient Bed Change Program and Procedures, VHA Handbook 1000.01, (2010).

⁶⁰ The Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545, Sec. 301. Title III of the Millennium Act prohibits the secretary from closing in any fiscal year more than 50 percent of the beds within a department medical center unless the secretary first submits to the veterans' committees a justification for such closure and waits to take action on a closure until 21 days after the submission of the report. It also requires the secretary to report annually to the veterans committees on bed closures during the preceding fiscal year.

⁶¹ Extended Care Services, 38 U.S.C. § 1710B(b) requires staffing for extended care to remain at FY 1998 levels.

⁶² "VA Proposes to Grant Full Practice Authority to Advanced Practice Registered Nurses," Department of Veterans Affairs, accessed June 3, 2016, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2793>.

enable all clinicians to work at the top of their licenses and to avoid problems with turnover, unexpected staff absences, and surges in patient demand.⁶³

VHA must have authority to pay competitive rates for the personnel it needs. This goal would be accomplished in part by adopting Recommendation #15 of this report for creating a new personnel system under Title 38 for all VHA employees. Currently, for example, clinical managers and practitioners earn far more in the private sector.⁶⁴

As VHA develops improved clinic management tools such as the Health Operations Dashboard, these tools draw from clinical data, patient data, and other sources to allow managers to make decisions using real-time data.⁶⁵ To be effective tools, the data fed into them must be accurate. Relieving VHA from some of the reporting requirements of the Millennium Act will help accomplish effective use of the dashboard for inpatient management.

Implementation

Legislative Changes

- Create a new alternative personnel system under Title 38 authority as mentioned in Recommendation #15.
- Eliminate bed reporting requirements under the Millennium Bill, and require VHA to report new beds as closed, authorized, operating, staffed, or temporarily inactive within 90 days of enactment.

VA Administrative Changes

- Develop policy to allow full practice authority for APRNs.
- Develop leadership tracks, including clinical and group practice managers, for ambulatory settings.
- Develop training programs for medical support assistants (MSAs).
- Modify policy in VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, as appropriate.

Other Department and Agency Administrative Changes

- None required.

⁶³ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 17-18, accessed June 3 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

⁶⁴ For example, Salaries.com listed a median salary for Clinic Manager III (a manager of a clinic with more than 50 physicians) in Dallas, TX, as \$94,000.⁶⁴ The pay grade assigned for this position is GS-13, which pays about \$73,800 in the first step and increases up to \$96,000. Office of Personnel Management, *Schedule 1 General Schedule*, accessed March 31, 2016, <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/pay-executive-order-2016-adjustments-of-certain-rates-of-pay.pdf>.

⁶⁵ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, presentation to Commission on Care, April 18, 2016.

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Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-supported programs.

Problem

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.⁶⁶ Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).⁶⁷

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a national revised clinical-appeals process.

As part of the MyVA initiative, the SECVA has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.⁶⁸ The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.⁶⁹

Background

VHA policy has long required medical centers to operate a patient advocate program to address patient complaints.⁷⁰ In 1996, Congress enacted an eligibility reform statute that, for the first time, gave enrolled veterans access to a uniform benefits package.⁷¹ In implementing that law, VHA conducted a systemwide review of how clinical disputes were handled and consequently instituted an external appeal system in FY 2000. The policy, as outlined in a subsequent directive, allowed VISNs to request external professional boards to conduct impartial reviews of clinical determinations.⁷² That directive also addressed a process for internal clinical appeals. It stated as policy that patients or their representatives who have disputes regarding clinical determinations or services pertaining to provision or denial of care that are not resolved at the facility level must have access to a fair and impartial review of those disputes that could result in a different and/or improved clinical outcome. That policy requires VISN directors to have written policy and procedures in place for how internal appeals are to be handled. Under this policy, VISNs still have authority to request an external review at any time during the clinical

⁶⁶ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

⁶⁷ VHA Clinical Appeals, VHA Directive 2006-057, (2006).

⁶⁸ "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, <http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx>.

⁶⁹ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷⁰ VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁷² VHA Clinical Appeals, VHA Directive 2006-057 (2006).

appeals process.⁷³ Although the directive itself expired in 2011, it continues to serve as guidance because it has not been renewed or replaced.

VHA policy directs that all facilities have a patient advocate office to manage and attempt to resolve complaints. That office, which can serve as the liaison between patients and clinicians, is generally the first stop for veterans who are dissatisfied with a clinical decision.⁷⁴ If a clinical issue is not resolved at the point of the service, it generally goes to the facility director, who is to provide veterans written notification of the facility's decision and inform veterans about the VISN's appeals process. Under the same policy directive, veterans may appeal the facility decision to the VISN director. That official, or a clinical review panel that he or she establishes, is to render a decision within 30 days (or 45 days if the director requests an external clinical review).⁷⁵ Should the VISN director agree with the facility, he or she must notify the veteran that the decision is final or may refer the matter to a VACO office to arrange for an external review.⁷⁶

The VHA process does not appear fully comparable to procedures required under other federal and federally-supported health care programs. For example, under the Affordable Care Act, health care plans are required to provide external reviews to beneficiaries whose internal appeals have been denied.⁷⁷ Unlike those and other appeals processes, veterans have no right to external review; such review is at the discretion of the VISN director. Medicare has an extensive review process for clinical disputes between its managed care organizations and beneficiaries. Beneficiaries have the right to an internal appeal with an option for an expedited review, an internal reconsideration of the initial review, an independent review, a hearing with an administrative law judge, a review by the Medicare Appeals Council and, finally, a federal district court review.⁷⁸ Medicaid has requirements for localities to review appeals from its beneficiaries and for states to offer timely access to fair hearings to determine whether managed care organizations have denied or terminated medically necessary care.⁷⁹ Although VHA's timeframe for decision making seems reasonable, the national policy makes no provision for an expedited review, unlike Medicare managed care organizations and plans providing health benefits to federal employees. VHA's policy is also silent on meeting with veterans to hear their cases much less hold hearings during any point of the appeal. Unlike Medicaid, VHA also lacks any provision for service-continuity while the matter is being appealed. The Commission recommends that VHA develop a revised clinical-appeals process that provides veterans protections at least comparable to those afforded patients under other federal and federally-supported programs, including, at a minimum, a right to an external review at the veteran's discretion.

⁷³ Ibid.

⁷⁴ VHA Patient Advocacy Program, VHA Handbook 1003.4, (2005).

⁷⁵ VHA Clinical Appeals, VHA Directive 2006-057, (2006).

⁷⁶ Ibid.

⁷⁷ "Appealing Health Plan Decisions," Department of Health & Human Services, accessed June 1, 2016, <http://www.hhs.gov/healthcare/about-the-law/cancellations-and-appeals/appealing-health-plan-decisions/index.html>.

⁷⁸ Centers for Medicare & Medicaid Services, *Managed Care Appeals Flowchart CY2016*, accessed May 26, 2016, <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Managed-Care-Appeals-Flow-Chart.pdf>.

⁷⁹ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

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Implementation***Legislative Changes***

- None required.

VA Administrative Changes

- Convene an interdisciplinary panel to assist in developing a revised clinical-appeals process and policy that includes all care provided within the VHA Care System, to include representation from Patient Care Services, MyVA's Patient Advocates and Veterans Experience Program, the Office of Equity, the National Center for Ethics in Health Care, and the Office of Access and Clinical Administration. VHA should have that panel examine and offer recommendations regarding the following:
 - Each level of review in the clinical-appeals process – from the facility's initial reconsideration to a final decision by the VISN director to assess the fairness and impartiality in those processes compared to Medicare Managed Care and Medicaid appeals processes and private-sector managed care providers' best practices.
 - Whether VHA should establish a uniform national clinical appeals process.
 - The advisability of requiring review panels consisting of individuals such as attorneys, clinicians, case managers, patient advocates, and administrators to review clinical appeals.
 - Whether hearings or judicial reviews are appropriate at any level of the appeals process.
 - Whether resolutions of clinical appeals are equitable for all types of veterans (service-connected or non-service-connected, by racial or ethnic group, by age, or gender).
 - Options for increasing veterans' awareness of the clinical-appeals process.
- Publish the new clinical appeals policy and process for comment and input by veterans, VHA business partners, and other stakeholders.
- Once the new policy is finalized, VHA must train staff on the new process.

Other Department and Agency Administrative Changes

- None required.

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

Problem

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.⁸⁰

VHA has a program of systems engineering — the Veterans Engineering Resource Center (VERC) — that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to proactively identify problem areas within the system and offer assistance.

Background

To become a truly veteran-centric care provider, VHA is working to become a learning organization.⁸¹ Learning organizations focus on worker competency rather than on rules compliance. Instead of using results to identify high- and low-performers, VHA will use this information to identify opportunities to intervene with training or other resources to improve employees' performance universally. Employees and patients should benefit from this approach because it values listening and encourages risk taking and innovation.

VA and VHA have adopted the tenets of LEAN Six Sigma as a systemic change approach to move the system forward. This methodology employs a rigorous define, measure, analyze, improve, and control approach to systemic change. LEAN, initially used by manufacturers, has been used successfully by many health care organizations.⁸² The goal of implementing LEAN practices is to eliminate waste, ensuring that any work done adds value. The MyVA plan calls for MyVA districts and the Office of Policy and Planning to ensure the transmission of best practices and the adopting of LEAN throughout the enterprise to provide a more comprehensive view of quality that balances a results-oriented approach with more process-

⁸⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow—Clinical)*, 14 and A-2 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁸¹ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.

⁸² MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 12, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

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oriented practice.⁸³ So far these efforts have been guided by trial and error, rather than directives and adopting a LEAN, process-driven model.⁸⁴ VHA must sustain its commitment to LEAN Six Sigma as a continuous improvement methodology.

VHA will have to use VERC staff and other trained staff members to ensure that principles of LEAN Six Sigma are applied at every level of the system. VERC has the mission to propose, develop, and facilitate innovative solutions to challenges within VHA health care delivery through the integration of systems engineering principles.

With VERC's reach already extending into access to care, health policy, population health, LEAN management, business systems, clinical systems, safety systems, and innovation, all other programs and initiatives become redundant or ancillary. VHA must assess its new system for best practice diffusion to ensure that selected practices are being appropriately scaled. This goal can best be achieved by collapsing all related efforts into VERC.

There are a number of emerging best practices within the health care sector that apply to all aspects of VHA – health care capabilities, staffing, access, supplies, and facilities – and involve the testing, dissemination, and application of procedures or systems that have been shown to improve approaches, processes, or systems.⁸⁵ VHA needs to have the opportunity to fully leverage and build on institutional strengths by implementing best practices.

VHA has recently developed the Diffusion of Excellence Initiative, which is designed to serve as the mechanism for improving practice through a combination of targeted national guidance and nationally-supported local best practice sharing and innovation.⁸⁶ Its organizational structure includes a governance board chaired by the USH, a Diffusion Council, and action teams responsible for implementing promising practices.

VHA also has many business lines charged with disseminating best practices information, including VERC, Systems Redesign SharePoint – Center for Improvement Education, VA Center for Innovation, MyVA – Best Practices in LEAN, MyVA Blog, MyVA Performance Improvement Hub, Knowledge Management System–Improvement in Action (I-ACT), VA Idea House, VA Pulse: Promising Practices Consortium, Evidence-based Synthesis Program (ESP), Quality Enhancement Research Initiative (QUERI), the Annual Conference on the Science of Dissemination and Implementation, and the Diffusion of Excellence Initiative.

Analysis

LEAN Six Sigma offers VHA a methodology to effect change and VERC offers VHA the agents to lead its implementation. VHA must consolidate its transformational tools, including its best

⁸³ MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 21, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

⁸⁴ The MITRE Corporation, Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow—Clinical), viii accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁸⁵ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 41, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁸⁶ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.

practice repositories within VERC. The VERC uses a systemic change process to streamline workflow and procedures by eliminating waste and redundancy to ensure that every step in the process adds value. The VERC offers services to VHA health care facilities upon request, but VHA would substantially benefit if the service was authorized to perform outreach to ensure awareness across the VHA Care System.⁸⁷

Until developing the Diffusion of Excellence Initiative, VHA lacked a uniform way to scale and optimize best practices throughout the enterprise. Although the Diffusion Initiative is initially targeting best practices from within VHA, to be successful, a long-term plan should also allow for the adoption of best practices from the private sector and other government sectors (e.g., the Medicare program related to pricing, contracting, privatization, value-based purchasing, management, and oversight). Plans should also allow for adaptation at the local and regional levels to reflect respective differences in provider supply, veteran needs, and marketplace characteristics.⁸⁸

VHA has multiple offices and sites invested in system reengineering, continuous process improvement, and best practices implementation. Repositories of best practices do not get information to the intended person or group that could benefit from the information and are dependent upon VHA employees knowing they exist.⁸⁹

VHA's National Leadership Council has proposed consolidating these best practice repositories under the VERC, which now serves within the Office of Organizational Excellence. Until recently, VERC has been underutilized because it is not known throughout the enterprise.⁹⁰

QUERI is a system that identifies evidence-based care practices that may be scaled for systemwide implementation. QUERI was integrally involved in the transformation of VHA from a largely hospital-based system to one centered on primary care⁹¹ and is now integral to the collaborative endeavor to transform VHA into a learning organization. QUERI recently released a policy brief that indicated veterans' reliance on VHA was strongly correlated to economic factors such as unemployment rates and availability of other health care coverage.⁹²

VA should use a systematic, continuous performance improvement process to improve access to care. Although many VA facilities achieve very high-performance ratings on key access and quality measures, a systematic effort is needed to improve performance. These efforts need to

⁸⁷ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

⁸⁸ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, 28, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf

⁸⁹ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

⁹⁰ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 27, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁹¹ "HSR&D Perspectives Blog, QUERI Corner: Surviving and Thriving," Amy Kilbourne, QUERI Program Director, January 20, 2015, accessed from VA Intranet, April 4, 2016, <http://vawww.blog.va.gov/hsrd/category/queri-corner/>.

⁹² Christine Yee, Austin Frakt, and Steven Pizer, U.S. Department of Veterans Affairs, "Economic and Policy Effects on Demand for VA Care," Partnered Evidence-based Policy Resource Center, Policy Brief, March 2016, accessed June 21, 2016, http://www.queri.research.va.gov/partnered_evaluation/YeeFraktPizer.pdf.

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be embedded into routine use across the VA system. The best solutions should be adjusted to reflect local needs and designed to respond to veterans' preferences, needs, and values.⁹³

A systems approach to health care is “one that applies scientific insights to understand the elements that influence health outcomes, models the relationships between those elements, and alters design, processes, or policies based on the resultant knowledge in order to produce better health at lower cost”⁹⁴ and would benefit VA greatly, especially with resources like VERC to serve as a guide.

Emerging best practices have improved health care access and scheduling in various locations and serve as promising bases for research, validation, and implementation.⁹⁵ A variety of quality improvement organizations are involved in establishing and maintaining standards in health care as well as developing measures for the monitoring and assessment of these standards, including The Centers for Medicare & Medicaid Services, the Joint Commission, the National Committee for Quality Assurance, and the National Quality Forum.⁹⁶

The tools of operations management, industrial engineering, and systems approaches are successful in increasing process gains and efficiencies. In particular, a wide range of industries have employed systems-based engineering approaches to address scheduling issues, among other logistical challenges.⁹⁷

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Consolidate all best practices and continuous improvement portals under VERC to provide a more accessible and comprehensive approach to best practice sharing and adoption.

Other Department and Agency Administrative Changes

- None required.

⁹³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 110 and 297 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁹⁴ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 27 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁹⁵ Ibid., 15.

⁹⁶ Ibid., 60.

⁹⁷ Ibid., 27-28.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

Problem

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.⁹⁸

A systematic review of VHA in 2015 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.⁹⁹ VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues—the Health Equity Action Plan (HEAP)—but it has not been fully implemented.

Background

It is time to refocus, reinforce, and repeat the message that health disparities exist and that health equity benefits everyone.¹⁰⁰

Across the nation, health care systems are raising awareness about health care equity, inequality, and disparities.¹⁰¹ The growing incidence of health care disparities and inequities is said to be ascribed to individual and collective cultural indifference on the part of health care

⁹⁸ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

⁹⁹ Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, accessed May 19, 2016, <http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf>.

¹⁰⁰ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

¹⁰¹ Centers for Disease Control and Prevention, *CDC Health Disparities and Inequalities Report – United States, 2013*, accessed April 5, 2016, <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>.

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providers and the health care system as a whole.¹⁰² A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on racial or ethnic group, gender, age, sexual orientation, military era, geographic location, religion, socioeconomic status, mental health, cognitive/sensory/physical disability, and other characteristics historically linked to discrimination or exclusion.¹⁰³

The United States is becoming increasingly diverse, with racial and ethnic minorities making up more than 36 percent of the population.¹⁰⁴ Indicators of overall health, such as life expectancy and infant mortality, have improved for most Americans; however, some minorities still face comparatively greater likelihood of preventable disease, death, and disability.¹⁰⁵

Although the country's veteran population is projected to decline from 22 million to 14.5 million by 2040, the percentage of minority veterans will increase from 20 percent to 34 percent during the same period.¹⁰⁶ Currently, African Americans make up 11 percent of the veteran population, and Hispanics, 6 percent.¹⁰⁷

Survey data show that minority veterans use VA health care more than White veterans, as shown below:¹⁰⁸

- African American: 38 percent
- Hispanic: 34 percent
- American Indian/Alaska Native: 38 percent
- White: 32 percent

¹⁰² G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," *JHSA* (2011), 146.

¹⁰³ "Office of Health Equity," U.S. Department of Veterans Affairs, accessed June 12, 2016, <http://www.va.gov/HEALTHY/index.asp>.

¹⁰⁴ "Minority Health and Health Equity – CDC," Centers for Disease Control and Prevention (CDC), accessed March 28, 2016, <http://www.cdc.gov/minorityhealth/index.html>.

¹⁰⁵ *Ibid.*

¹⁰⁶ National Center of Veterans Analysis and Statistics, *Minority Veterans 2011 Report*, May 2013, accessed April 6, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf.

¹⁰⁷ U.S. Census Bureau, *American Community Survey, Public Use Microdata Sample (PUMS)*, 2011. Department of Defense, *Population Representation in the Military Services Fiscal Year 2011 Report*, accessed April 5, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf

¹⁰⁸ Reliance projections here are based on ambulatory care utilization. Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 82, accessed May 19, 2016,

http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

Survey data on racial and ethnic minority veterans' use of VHA health care offer revealing insights on current equity issues:¹⁰⁹

- Fifty-seven percent of African Americans indicated they are more likely to use VA as their primary source of health care as compared to 45 percent of Whites.¹¹⁰
- The percentage of African Americans who reported they use VA for all or most of their care needs is 18 percent higher than the percentage of Whites who do so.¹¹¹
- A higher percentage of Whites assessed their health to be good or excellent than did African Americans.¹¹²

Analysis

VHA Office of Health Equity

VA created the OHE in 2012 to identify health care inequities, understand the cause of them, and bring to clinical practice interventions intended to reduce disparity drivers within VA. OHE partners with other VA offices, federal government offices, and nongovernment institutions with missions aimed at promoting health equity.¹¹³ OHE has substantial stakeholder involvement from minority veterans groups, including the Advisory Committee on Minority Veterans (ACMV), rural veterans groups, women veterans, and the Office of Diversity and Inclusion (ODI).¹¹⁴ A staunch internal partner and stakeholder of OHE, ODI's mission is to foster a diverse workforce and an inclusive work environment. The OHE and ODI missions intersect with ODI's special emphasis programs, intended to engage affinity groups and agencies to raise the awareness of the importance of diversity and demonstrate VA's commitment to a diversity model.¹¹⁵

OHE's foundational work included updated systematic reviews and data analyses that not only revalidated VA's previous findings on health care inequities, but also identified more areas of health care disparity among veterans. For instance, hepatitis C virus (HCV) was noted to have disparate effect on racial/ethnic minority veterans and Vietnam-era veterans. Additionally, OHE convened stakeholders and worked with the Health Equity Coalition to develop the VHA Health Equity Action Plan (HEAP), which aligns with the VHA Strategic Plan Objective 1e: Quality & Equity, which states, "Veterans will receive timely, high quality, personalized, safe effective and equitable health care irrespective of geography, gender, race, age, culture or sexual

¹⁰⁹ Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.

¹¹⁰ Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, 85, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.

¹¹¹ Ibid.

¹¹² Ibid.

¹¹³ Department of Veterans Affairs, Office of Health Equity, *US Department of Veterans Affairs Office of Health Equity Mission and Accomplishments*, accessed March 30, 2016, http://www.va.gov/HEALTHEQUITY/docs/OHE_Mission_and_Accomplishments_November_2015.pdf.

¹¹⁴ "Office of Diversity and Inclusion (ODI)," Department of Veterans Affairs, accessed May 13, 2016, <http://www.diversity.va.gov/>.

¹¹⁵ "Office of Diversity and Inclusion (ODI), Special Emphasis Programs," Department of Veterans Affairs, accessed May 17, 2016, <http://www.diversity.va.gov/programs/default.aspx>.

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orientation.”¹¹⁶ HEAP aims to address five strategic areas: awareness, leadership, health system and life experience, cultural and linguistic competency, and data that are vital for effectively implementing its mission. HEAP implementation strategies are conceptually modeled after the goals and strategies of the National Partnership for Action to End Health Disparities’ National Stakeholder Strategy for Achieving Health Equity sponsored by the U.S. Department of Health and Human Services.¹¹⁷

Despite OHE’s best efforts, HEAP was not fully implemented because VHA leadership failed to establish it as a strategic priority with adequate staffing, resources, and support, and the departure of the then USH, a champion for health equity. These factors led to the reduction of OHE staffing from 8 to 2 FTEs in FY 2013 and a realignment of OHE to several layers down in the organization. As a result of an FY 2015 budget reduction, OHE continues to operate with a two-person staff.¹¹⁸ The reduced staffing level is inadequate to meet the requirements and mission of the office.

OHE has a broad and challenging mission, particularly given the number of minority veterans who rely on VA health care, the health risks in those populations, and the health care disparities those populations experience.¹¹⁹ OHE faces serious challenges in its efforts to carry out its action plan and to realize its broad and critical mission, challenges intensified by its limited staffing and the downgrade of this office within VHA’s organization structure. These include the following:¹²⁰

- lack of quality data on vulnerable populations and disparate health outcomes
- health equity projects that have been delayed or halted due to staff and resource limitations
- lack of data on the overall impact of existing health equity initiatives at facilities
- lack of common definitions on vulnerable populations and health equity concepts

Notwithstanding its limited staffing, OHE has compiled a substantial record of accomplishments. Among its initiatives, OHE embarked in 2015 on a strategy of working collaboratively with the Quality Enhancement Research Initiative (QUERI) to advance health equity. The two collaborative efforts focus on using a population health approach to examine the distribution of diagnosed health conditions, mortality, and health care quality across the VA health care system. A fully staffed OHE would have the capability of creating additional

¹¹⁶ Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018*, accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.

¹¹⁷ “National Partnership For Action (NPA), National Stakeholder Strategy for Achieving Health Equity,” U.S. Department of Health & Human Services, accessed May 16, 2016, <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286>

¹¹⁸ Uche S. Uchendu, Executive Director, OHE, briefing to Commission on Care, December 14, 2015.

¹¹⁹ “Management Brief no. 99,” Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=eBrief-no99. Somnath Saha et al., “Racial and Ethnic Disparities in the VA Health Care System: A Systematic Review,” *Journal of General Internal Medicine*, 23, no. 5, (2008): 654–671.

¹²⁰ Uche S. Uchendu, Executive Director, Office of Health Equity, briefing to Commission on Care, December 14, 2015.

analytical tools to manage the daily health care equity program and provide needed services to advance health equity.¹²¹

Health Care Disparities Among Minority Veterans

Minority groups are at increased risk of major, life-threatening health conditions, as documented in a substantial body of research¹²² and illustrated in the table below:¹²³

Table 3. Major Health Conditions in Racial/Ethnic Minority Groups

Major Health Conditions Identified and Examined in Racial/Ethnic Minority Groups		
African Americans	Hispanics	American Indian or Alaska Natives
<ul style="list-style-type: none"> ▪ Colon Cancer ▪ HIV ▪ Chronic Kidney Disease ▪ Diabetes ▪ Stroke ▪ Venous Thromboembolism (VTE) ▪ Cancer ▪ Heart Disease 	<ul style="list-style-type: none"> ▪ Hepatitis C ▪ Cancer ▪ Heart disease 	<ul style="list-style-type: none"> ▪ Major Non-cardiac Surgery ▪ Pregnant Women with PTSD

HCV is more prominent among some racial and ethnic minority veterans and they are less likely to receive treatment for HCV. In VHA, some racial and ethnic minorities diagnosed with HCV are disproportionately more at risk for having associated liver disease (ALD). Disparities among veterans in the incidence of HCV, illustrated in the graphs below, show the important policy and resource implications for VA.¹²⁴

¹²¹ Ibid.

¹²² Andy I. Choi et al., “White/Black Racial Differences in Risk of End-Stage Renal Disease and Death,” *The American Journal of Medicine*, 122, no. 7, (2009): 672-678. Andy I. Choi et al., “Racial Differences in End-Stage Renal Disease Rates in HIV Infection with Diabetes,” *Journal of the American Society of Nephrology*, 18, no. 11 (2007): 2968-2974. Hashem B. El-Serag et al., “Racial Differences in the Progression to Cirrhosis and Hepatocellular Carcinoma in HCV-Infected Veterans,” *The American Journal of Gastroenterology*, 109, no. 9, (2014): 1427-1435. Cleo A. Samuel et al., “Racial Disparities in Cancer Care in the Veterans Affairs Health Care System and the Role of Site of Care,” *American Journal of Public Health*, 104, Supplement 4, (2014): S562-571.

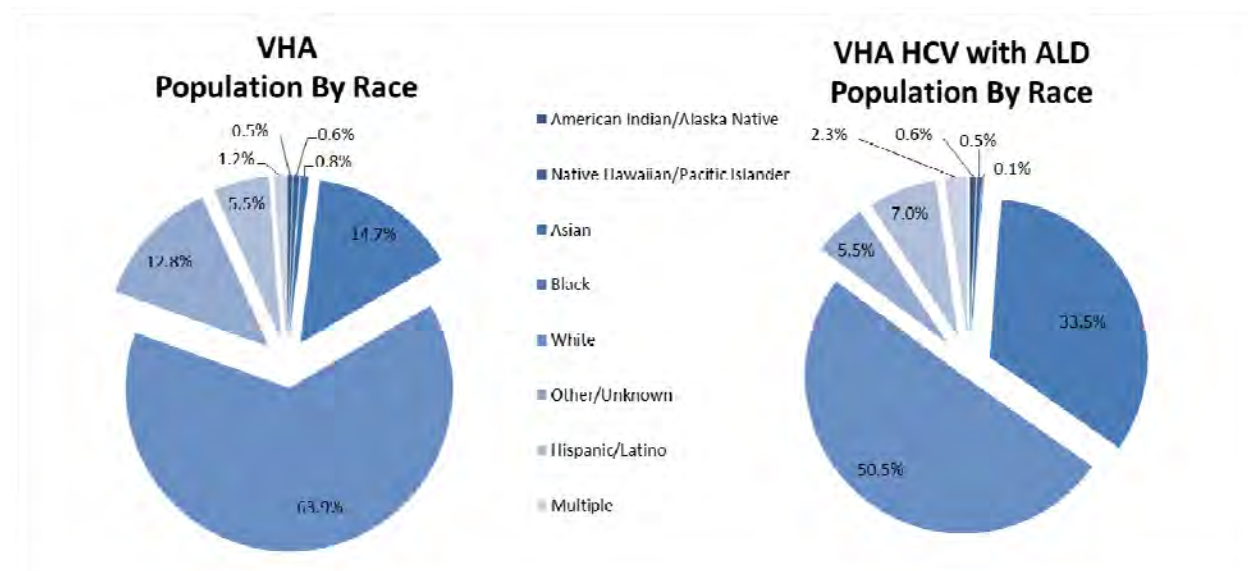
¹²³ Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, accessed May 19, 2016,

<http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf>.

¹²⁴ Department of Veterans Affairs, Office of Health Equity, *Hepatitis C Factsheet, Hepatitis C, Advanced Liver Disease & Health Care Disparities*, accessed May 25, 2016, <https://github.com/departments-of-veterans-affairs/VHA-Asset/raw/master/Hep%20C%20FACT%20SHEET%20FINAL%2010162015.pdf>.

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Figure 2. Disparities Among Veterans in the Incidence of Hepatitis C Virus



A recent review of evidence related to racial and ethnic differences in outcomes for VA patients showed moderate- and low-strength evidence suggestive of gaps in morbidity and mortality outcomes among vulnerable veteran populations with major health conditions. These data, presented in the table below, highlight targets for further research.¹²⁵

Table 4. Comparison of Health Outcomes by Race

Comparison		Worse Health Outcomes For Racial Minority Group Relative to Reference Population (usually White)
Moderate-Strength Evidence		
(based on VA data from the early 2000s)		
African American v. White	Increased end-stage renal disease among chronic kidney disease patients	
	Increased end-stage renal disease among HIV patients (with or without diabetes)	
	Decreased colon cancer survival 3 years after diagnosis	
Hispanic v. White	Increased cirrhosis and hepatocellular carcinoma among hepatitis C patients	
Low-Strength Evidence		
(each finding supported by only a single retrospective study with important methodological limitations)		
African American v. White	Increased mortality among diabetes patients	
	Increased risk of preterm birth among PTSD patients	
	Increased mortality at 2 years post-hospitalization among stroke patients	
	Decreased survival 3 years after diagnosis of rectal cancer	
American Indian or Alaskan Native v. White	Increased risk of 30-day post-op mortality after major noncardiac surgery	
	Increased risk of preterm birth among PTSD patients	
Combined other racial/ethnic minority groups v. African American	Increased injury-related death among alcohol use disorder patients	

¹²⁵ "Management Brief no. 99," Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=ebrief-no99.
VA-18-0457-A-002393

OHE's focus, health equity, is intended to combat health care disparities, namely, the differences in the preventive, diagnostic, or treatment services offered to veterans with similar health conditions. Health care disparities stem from a combination of complex factors occurring at the level of the health system, provider, and patient.¹²⁶ Health care disparities can result from biological differences among various racial/ethnic groups as well as from social disparities,¹²⁷ also termed social determinants, which stem from such factors as socioeconomic status, discrimination, education levels, housing, transportation, and crime and violence, and are causally linked to subsequent adult disease.¹²⁸ For example, poor-quality housing poses a risk of exposure to many conditions that can contribute to poor health, such as indoor allergens that can lead to and exacerbate asthma, injuries, and exposure to lead and other toxic substances.¹²⁹ Social determinants that drive health disparities among African Americans, Hispanics, American Indians, and Alaska Natives include race/ethnicity; gender; age; geographic location; religion; socio-economic status; sexual orientation; military era; disabilities, including cognitive, sensory, or physical; and other characteristics historically linked to discrimination or exclusion. Positioned in a department that also provides benefits that fall within the social determinants of health, OHE is in a unique position to improve veterans' health.

The Henry Ford Health System (HFHS) is an example of a health system that is committed to health equity and one VHA can emulate as it works to improve health equity. HFHS is a nonprofit, vertically integrated health care organization that serves the primary and specialty health care needs of residents in southeastern Michigan, including Detroit and its surrounding metropolitan area.¹³⁰ HFHS's comprehensive health equity staff has a health care equity campaign with a goal of increasing knowledge, awareness, and opportunities to ensure health care equity is understood and practiced by HFHS providers and other staff, the research community, and the community-at-large.¹³¹ The campaign is also intended to make health care equity a key, measurable aspect of clinical quality.¹³² A similar effort by VHA would create a system for tracking improvement of health equity over time and holding the organization accountable for ongoing efforts in this regard.

The VHA strategic plan for FY 2013–2018 states that veterans will receive timely, high quality, personalized, safe, effective, and *equitable* health care, irrespective of geography, gender, race, age, culture, or sexual orientation.¹³³ Although that statement signals a sensitivity to health equity, the level of funding support for the VHA office with the lead role in promoting health equity and reducing disparity calls into serious question the leadership priority and commitment to that strategic goal. VHA leadership must make health care equity a strategic

¹²⁶ Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, <http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf>.

¹²⁷ James H. Price, Molly A. McKinney, and Robert E. Braun, *Social Determinants of Racial/Ethnic Health Disparities in Children and Adolescents*, accessed April 1, 2016, <http://www.sophe.org/Sophe/PDF/Webinars/20120416151902.pdf>.

¹²⁸ Ibid.

¹²⁹ "What Drives Health," Robert Wood Johnson Foundation, Commission to Build a Healthier America, accessed April 1, 2016, <http://www.commissiononhealth.org/WhatDrivesHealth.aspx>.

¹³⁰ Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, <http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf>.

¹³¹ Ibid.

¹³² Ibid.

¹³³ Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018*, accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.

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priority by directing and funding the implementation of VHA HEAP nationwide and designating a leader and clinical champions within each VISN and VAMC, as a designated full-time equivalent (FTE), providing OHE budgetary support in FY 2017 and beyond to fully staff the office so that it can successfully achieve its mission and goals, to include providing additional needed funding to support implementation of the VHA HEAP; and ensuring OHE reports to the chief of VHA Care System (CVCS).

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Make health equity a strategic priority by directing the implementation of the VHA HEAP nationwide and designating a leader and health equity clinical champion within each VISN and VAMC for whom part of their respective FTE position descriptions includes focusing on health equity issues.
- Reestablish OHE staffing based on the 2011 VHA Health Care Equality Workgroup recommendations to enable OHE to fulfill VHA's vision to provide appropriate individualized health care to each veteran in a method that eliminates disparate health outcomes and assures health equity. Action required includes, but is not limited to, funding FTE staffing levels commensurate with the scope and size of other federal offices of health equity.
- Reinstate OHE within the office of the CVCS to underscore health equity as a priority and to position the office to champion successfully the advancement of health equity for all veterans.¹³⁴
- Monitor and evaluate the department's success in implementing HEAP.

Other Department and Agency Administrative Changes

- None required.

¹³⁴ Department of Veteran Affairs, Health Equity Coalition Request for VHA Commitment, February 2016. Principal Deputy Under Secretary of Health Memorandum, Health Equity Coalition, March 21, 2013.

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

Problem

Veterans who turn to VHA to meet their health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern ambulatory health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of these barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks, as proposed in

Recommendation #1 holds the promise of markedly improving veterans' access to care.

That promise cannot be realized without transformative changes to VHA's capital

structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of the build out of the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as much control as possible to drive the process so that all facility plans are fully integrated with the strategic vision for the VHA Care System.

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meet its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission process to be implemented as soon as practicable. The Commission recommends that the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

Background

Most VHA health care centers were designed when care was focused on inpatient hospital treatment. VA acquired some of these facilities nearly a century ago from the Public Health Service; many others were transferred from the War Department shortly after World War II.¹³⁵ The average VHA building is 50 years old – five times older than the average building age of not-for-profit hospital systems in the United States.¹³⁶ Most of its facilities were designed to meet markedly different needs than today's health care facilities. Some were tuberculosis

¹³⁵ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

¹³⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, vi, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

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sanatoriums, others for years primarily housed patients with mental health conditions.¹³⁷ Although many have been extensively renovated, the renovations themselves are now outdated, and the condition of buildings shows this strain. Independent assessments of infrastructure and facilities showed that VHA facilities average a *C minus* score,¹³⁸ meaning much of the total facilities portfolio is nearing the end of its useful life, and 70 percent of facility correction repairs are being made on Grade D facilities.¹³⁹

During the past 8 years, veteran inpatient bed days of care have declined nearly 10 percent as outpatient clinic workload has increased more than 40 percent.¹⁴⁰ Current facilities, whether they have been maintained adequately or not, often do not support contemporary ambulatory care needs, with outpatient care often housed in converted inpatient spaces.

Through its capital planning methodology, VA has identified more than \$51 billion in total capital needs during the next 10 years.¹⁴¹ Capital funding during the past 4 years has averaged just \$2 billion annually.¹⁴² If funding levels remain consistent during the next 10 years, anticipated funding would be \$25 billion to \$35 billion less than the \$51 billion capital requirement.¹⁴³ VA planning must also take account of demographic changes and population migration that have led to underutilized medical centers in some areas of the country, and a need for new capacity in others.¹⁴⁴

Analysis

New Planning Paradigm

As the department acknowledged, “VA’s health care delivery model must . . . change.”¹⁴⁵ Importantly, it recognizes that “No organization can excel at every capability,” and stated “[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers.”¹⁴⁶ The acknowledgement that VHA can best serve veterans by focusing on its core competencies and unique capabilities, while relying more heavily on purchased care holds important implications for VHA’s capital needs and capital asset management. Rather than assessing VHA’s capital needs by reference to an expectation that each VA medical center, or constellation of medical centers, must provide virtually all needed hospital and medical services, capital needs must be redefined within the framework of the VHA Care System’s high-performing integrated community health care networks. VHA must determine what services it will continue to provide directly in a given community before it can determine its respective infrastructure needs. In identifying its core competencies, unique

¹³⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

¹³⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 27, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹³⁹ *Ibid.*

¹⁴⁰ *Ibid.*, 46.

¹⁴¹ *Ibid.*, 17.

¹⁴² *Ibid.*, 18.

¹⁴³ *Ibid.*, 18.

¹⁴⁴ *Ibid.*, 59-61.

¹⁴⁵ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 18, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

¹⁴⁶ *Ibid.*

capabilities, and needed ancillary services, VHA would be setting at least a general framework through which network and local planners could assess where and how needed services would be delivered, including which would be provided directly by VHA and which through purchased care. Such a mapping exercise would be a first step in developing the integrated community health care networks.

The shape of an integrated delivery network will take different forms in each service-area, and planning and developing those local networks will necessarily require assessing VHA's physical plant and capacity in a new light. That reassessment process would inform capital planning, and must take account of at least three distinct needs: capital needs associated with buildings VA would retain; meeting new or replacement space needs; and the disposal of unused, unneeded property.

Property Divestiture

VHA's principal mission is to provide health care to veterans, yet over time it has acquired an ancillary mission: caretaker of an extensive portfolio of vacant buildings. As recently as October 2015, VA reported that its inventory includes 336 buildings that are vacant or less than 50 percent occupied, requiring it to expend patient-care funds to maintain more than 10,500,000 square feet of unneeded space.¹⁴⁷ The SECVA recently testified that it costs VA an estimated \$26 million annually to maintain and operate vacant and underutilized buildings.¹⁴⁸

VA's authority to carry out property-management is circumscribed in law,¹⁴⁹ and the department at times faces insurmountable challenges in either attempting to repurpose or divest itself of underutilized or vacant property.¹⁵⁰ In contrast to more rigid property-divestiture provisions, VA has had success in using a flexible authority to enter into long-term leases of VA property for *enhanced use*.¹⁵¹ This authority allows VA to lease underutilized capital

¹⁴⁷ Ibid., 92.

¹⁴⁸ "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, <https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2>.

¹⁴⁹ Authority for Transfer of Real Property; Department of Veterans Affairs Capital Asset Fund, 38 U.S.C. § 8118 Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122. For example, under section 8118, VA must receive at least full market value in transferring property, unless the property is transferred to an entity that provides services to homeless veterans, and any proposed transfer is subject to the requirement in section 8122 that VA first hold hearings, notify Congress in advance, and not proceed for a specified period. VA property can be determined to be "excess," though under 38 U.S.C. § 8122(d)(1), VA may not make such a declaration unless the property is not suitable for use for provision of services to homeless veterans and reviewed for possible disposal under the Property Act Disposal, administered by the General Services Administration (GSA) (40 U.S.C., subchapter III). GSA employs a rigorous, multistep process to assure that the asset is not needed by any other Federal agency. Under the Act, the agency disposing of the asset is responsible for funding disposal costs, including environmental remediation. GAO has testified that properties remain in an agency's possession for years and continue to accumulate maintenance and operations costs because of the legal requirements agencies must meet and the length of the process. (U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain*, GAO-11-520T (Washington, DC, 2011), 5, <http://www.gao.gov/products/GAO-11-520T>).

¹⁵⁰ With many properties under the protection of the National Historic Preservation Act (16 U.S.C. § 470h-3), VA faces obstacles and delays in efforts to divest itself of these properties; VACO staff report that stakeholder concerns have been obstacles.

¹⁵¹ Enhanced-Use Leases of Real Property, 38 U.S.C. §§ 8161-8169, as amended by Veterans Millennium Health Care and Benefits Act, Section 208, Pub. L. No. 106-117, 113 Stat. 1545 (1999), as in effect when GAO testified on this successful program (U.S. Government Accountability Office, *VA Real Property: VA Emphasizes Enhanced-Use Leases to* VA-18-0457-A-002398

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assets to private-sector entities for up to 75 years to develop housing for homeless and at-risk veterans and their families. Most recently, however, Congress imposed severe limits on that leasing authority.¹⁵²

Ongoing Capital Needs

Establishing a transformative new health care delivery model that relies more on purchased care will not eliminate the need for new clinics, facility renovations, and remedying VHA space deficiencies. The scope of those needs must still be determined in light of a proposed new delivery system, but they cannot be ignored. The *Independent Assessment Report* catalogued the challenges of managing and operating VA's capital program and the need to deploy best practices to improve total performance, and clearly address the importance of more modern facilities for delivering high quality care.¹⁵³

Of particular concern is an apparent breakdown in the process of bringing new clinics online and renewing the leases of existing clinics. With current law requiring congressional approval of any lease with an average annual rental of more than \$1 million,¹⁵⁴ a Congressional Budget Office (CBO) ruling¹⁵⁵ has upended the approval process and halted the leasing program.¹⁵⁶ Indicative of the scope of the problem, VHA's then USH testified in 2013 that VA, since 2008, had opened 180 leased medical facilities, 50 of which required authorization as major leases.¹⁵⁷ Currently, 24 major VA leases are in limbo.¹⁵⁸

Manage its Real Property Portfolio, GAO-09-776T (Washington, DC, 2009), <http://www.gao.gov/assets/130/122697.pdf>. For example, VA has authority to outlease its facilities for up to 3 years, but may not retain the proceeds of any such leasing (Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122(a)(1)). U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain*, GAO-11-520T (Washington, DC, 2011), 5, <http://www.gao.gov/products/GAO-11-520T>.

¹⁵² Before the sunset of that authority in 2011, VA could enter into such a long-term lease if (1) at least part of the property's use would contribute to VA's mission, (2) the lease would not be inconsistent with that mission; and (3) the lease would enhance the use of the property (Enhanced-Use Leases, 38 U.S.C. § 8162(a)(2)). Congress reauthorized enhanced-use leasing, but limited it to a single use: the development of supportive-housing for veterans who are homeless or at risk of homelessness (Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Sec. 211, Pub. L. No. 112-154, 126 Stat. 1165 (2012).)

¹⁵³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁵⁴ Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104.

¹⁵⁵ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., 42 (June 27, 2013) (Statement of Robert A. Sunshine, Deputy Director, Congressional Budget Office), accessed June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

¹⁵⁶ *Ibid.* CBO maintains that the structure of VHA's lease transactions—the lease of a facility, designed by and built for VHA, and for which payments retire most or all of the debt over the life of the lease—is in the nature of a governmental purchase, and, as such, the full cost of acquiring the facility should be budgeted up front, rather than spread over the duration of the lease. As budget rules generally require that Congress offset that aggregate cost, CBO's position has had the effect of blocking what had previously been a manageable funding process.

¹⁵⁷ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., 44 (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

¹⁵⁸ "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, <https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2>.

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One of the primary benefits of leasing is that it can provide flexibility and speed.¹⁵⁹ But the time VHA has required to execute a lease, from planning through to activation, has taken almost 9 years in the case of a major lease,¹⁶⁰ in contrast with private-sector expectations of build-to-suit leases that often take fewer than 3 years.¹⁶¹

In acknowledging the magnitude of the challenges associated with VA's capital program and the budget constraints within which VA is operating, the *Independent Assessment Report* includes a suggestion that transformative options be considered, to include alternative vehicles for capital delivery such as public-private partnerships.¹⁶²

Capital Asset Management

Capital asset management itself requires reengineering. Facilities-related functions are dispersed through VA, resulting in a lack of accountability for outcomes, a mismatch between planning efforts and funding decisions, and separation of project execution and facilities management,¹⁶³ suggesting a need for transformative changes in operations.¹⁶⁴

In its work to foster transformation, department officials have recognized many organizational and process challenges that require priority attention, including the need to realign its infrastructure, identify new (private) sources of financing, streamline investment decision making and contracting, and improve the management of capital projects.¹⁶⁵ Organizational change aimed at streamlining and better aligning core processes is vital to effective operation of VA's facilities programs.

Capital-Asset Imperatives

The planning and development of a new delivery model centered on establishing integrated networks of care has major implications for identifying, planning for, and realizing VHA's capital needs. Greater reliance on community care, inherent in that model, establishes a new set of imperatives, specifically, a need for

- facility realignment
- more effective means of repurposing or other divestiture of unneeded buildings and land
- new, more effective tools to meet VHA's need for new clinic capacity and major construction
- more effective management of VHA's capital needs

¹⁵⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 159, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁶⁰ Ibid., 159-160.

¹⁶¹ Ibid., 160.

¹⁶² Ibid., vii-ix, 34.

¹⁶³ Ibid., vi, 20.

¹⁶⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, K-5, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁶⁵ Interviews of VA staff by Commission on Care staff, April 2016.

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Facility Realignment

VA planning must closely examine the role of, and future for, individual facilities, in light of a transformative new delivery model. For more than a quarter century, VHA leaders have cited the need for medical center mission changes, realignments, disposal of unneeded buildings, and where indicated, hospital closures.¹⁶⁶ The critical importance of transforming VA health care delivery gives new urgency to providing tools to realign VHA's care-delivery infrastructure. The Commission recognizes that the SECVA does have authority to "consolidate, eliminate, abolish, or redistribute the functions of . . . [VA] facilities, and to carry out an administrative reorganization" of a field facility.¹⁶⁷ But that authority may generally not be unilaterally exercised.¹⁶⁸ In addition, despite VA's having established two previous commissions to address the need for facility realignment, leaders have had only limited success in achieving that objective. The exercise of SECVA's broad authority to reorganize is tempered by the prerogatives and fiscal authority held by Congress. Congress has rejected legislation that proposed a process to reassess the future of individual VA facilities,¹⁶⁹ reflecting concerns over veterans losing access to care and the potential of constituents losing employment. Such concerns can be addressed. To be successful, a capital asset realignment process must be conducted on a systemwide basis within a framework that provides for sound planning; the exercise of objective, independent expertise; and a reliable mechanism for implementation. Congress can look to and adapt a proven model¹⁷⁰ — the military base realignment and closure (BRAC) process — to meet those objectives and achieve marked improvements in access to care.

Congress should enact legislation, based on DoD's BRAC model, to establish a VHA capital asset realignment process to more effectively align VHA facilities and improve veteran's access to care. Creating a robust capital asset realignment process is vital because previous capital divestiture efforts have failed.¹⁷¹ This process should offer a level of rigor far beyond what currently exists for repurposing and selling capital assets. It should require VHA to employ criteria set by the VHA Care System governing board (see Recommendation #9) to conduct locally-based analyses of capital assets, based on national process criteria. Information generated would be used to assist an independent commission, established under the

¹⁶⁶ "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com*, accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578>.

¹⁶⁷ Authority to Reorganize Offices, 38 U.S.C. § 510.

¹⁶⁸ Authority to Reorganize Offices, 38 U.S.C. § 510(c). In instances where a reorganization would reduce employment by 15 percent or more at a facility, VA must provide Congress a detailed plan and justification, and must defer implementation for at least 45 days.

¹⁶⁹ Veterans Millennium Health Care and Benefits Act, H.R. 2116, 106th Cong. (1999). Section 107 of House-passed H.R. 2116 would have established a mechanism for VA to cease providing hospital care at medical centers which were no longer providing high quality, efficient hospital care because of factors such as aging physical plant, functional obsolescence, and low utilization, and to redirect funds instead toward establishment of enhanced-service programs. In taking up H.R. 2116, the Senate did not adopt that provision, and it was not included in the Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545 (1999), accessed January 12, 2016, <https://www.gpo.gov/fdsys/pkg/PLAW-106publ117/html/PLAW-106publ117.htm>

¹⁷⁰ Defense Base Closure and Realignment Commission, *Defense Base Closure and Realignment Act of 1990 (as amended through FY 05 Authorization Act)*, accessed June 23, 2016, <http://www.brac.gov/docs/BRAC05Legislation.pdf>.

¹⁷¹ "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com*, accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578>.

legislation, in making recommendations regarding realignment and capital asset needs.¹⁷² The independent commission would conduct a thorough, one-time process, to include making site visits and holding hearings to inform recommendations that would constitute a proposed national realignment plan. The VHA Care System governing board would review, and adopt or make recommendations to revise, the independent commission's recommended realignment plan. The commission would then empower the VHA Care System governing board to implement the recommendations unless, within a specified timeframe, Congress disapproves the entire plan on an up or down vote. The Commission on Care envisions that after the completion of a realignment carried out under such proposed legislation and in the course of ongoing VHA transformation, the VHA Care System governing board would make all additional facility alignment decisions, to meet veterans' needs and to fully integrate with the strategic vision for the VHA Care System.

Repurposing and Divestiture of Unneeded Buildings and Land

Maintaining health care facilities to provide state-of-the-art care requires ongoing financial support. Bearing the additional cost of maintaining outdated, vacant, and unused buildings diminishes operating funds needed for patient care, and yields no benefit. Even taking unused buildings offline and placing them in *mothball status*, requires tens of millions of dollars in basic building maintenance.¹⁷³ If VA could sell, repurpose, or otherwise divest itself of unused or underutilized buildings in a timely, cost-effective manner, it would free funds for the purposes for which they are appropriated.¹⁷⁴

Enhanced-use leasing authority has in the past provided VHA a viable tool that prevents the need for such unnecessary spending, while permitting development of vacant property for uses compatible with VHA's mission, and effective use of the proceeds, whether in cash or in kind.¹⁷⁵ This leasing mechanism has been put to particularly effective use in leveraging an asset that VHA can no longer use, but which has development potential, as consideration for an asset it may need, such as clinic space. But limiting enhanced-use leasing to a single use that may not be feasible in many locations precludes effective use of a valuable capital-alignment tool.

In many instances, however, the condition or remote location of VHA buildings does not lend itself to enhanced-use leasing. Given the need to dispose of a large inventory of vacant

¹⁷² The process should take into account the community health needs assessments (CHNA) that not-for-profit hospitals are required to carry out under current law, (Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119, sec. 9007(a) (2010)) and opportunities to engage community providers in collaborative partnerships. This provision requires tax-exempt hospitals to create a hospital community health needs assessment every three years. This hospital CHNA is developed alongside community stakeholders. The community health needs assessment requirements include: demographic assessment identifying the community the hospital serves; a community health needs assessment survey of perceived healthcare issues; quantitative analysis of actual health care issues; appraisal of current efforts to address the healthcare issues; and formulation of a 3-year plan under which the community comes together to address those remaining issues collectively.

¹⁷³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 49, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁷⁴ *Ibid.*, B-13.

¹⁷⁵ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), accessed June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

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buildings for which there is no realistic prospect of their being repurposed, a streamlined divestiture process is needed.

Meeting Clinic Capacity and Other Infrastructure Needs

Developing a new delivery model and establishing a thorough realignment process may shrink VHA's future capital needs but will not eliminate them. As congressional budget rules have frustrated VHA efforts to lease needed clinic space, it is critical that VHA and Congress find models or remedies to establish new ambulatory care space and renew leases of existing clinics. Congress and VHA should work together to find the means to meet VHA's need for new clinic capacity. Given an impasse in congressional authorization of VA clinic leasing based on build-to-lease contracts, VA should explore the feasibility of restructuring those arrangements. VA should explore an arrangement that remedies the concern that it is entering into capital leases. Such an approach, for which VA provides the builder with space needs rather than a complete design, would have the additional benefit of bringing projects on line much sooner. Absent an effective solution to meeting VA's ongoing need for clinic space, Congress must be willing, as it was in passing VACAA, to take extraordinary steps¹⁷⁶ to overcome a funding challenge, and, in this instance to waive, or suspend for at least 5 years, the operation of current congressional authorization and scorekeeping requirements governing major medical leases.

In addition to severe leasing challenges, current statutory spending limits make it difficult for VHA to modernize and renovate its aging facilities.¹⁷⁷ Notably, minor construction funds, available for "constructing, altering, extending, and improving"¹⁷⁸ any VA facility, are limited to \$10 million,¹⁷⁹ yet such projects may require substantially more given the age and condition of many VA buildings. Congress last lifted the threshold of what constitutes a major medical facility project – the amount above which a project requires specific authorization – more than a decade ago.¹⁸⁰ The Commission believes that with the tight controls a governing board would exercise, that threshold should be lifted substantially, providing needed flexibility to carry out minor construction projects.

As VHA works more closely with community providers and participates in discussions regarding community health needs, it should be open to opportunities to discuss and potentially work toward joint efforts at meeting infrastructure needs.¹⁸¹

¹⁷⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 stat. 1754, sec. 803 (2014).

¹⁷⁷ VA Office of Inspector General, *Veterans Health Administration: Review of Minor Construction Program*, 8, accessed June 3, 2016, <http://www.va.gov/oig/pubs/VAOIG-12-03346-69.pdf>.

¹⁷⁸ Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242 Div. J., Title II, Department of Veterans Affairs (2015).

¹⁷⁹ A major medical facility project is one involving a total expenditure of more than \$10 million. Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(a)(3)(A).

¹⁸⁰ Sec. 812 of the Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. No. 109-461, 120 Stat. 3403 (2006), raised the threshold as to what constitutes a major medical facility project from more than \$7 million to more than \$10 million.

¹⁸¹ One such public-private model, such as under discussion in Omaha, NE, where talks have centered on private donors' partially funding construction of a replacement medical center, necessarily poses challenges, but merits exploration and support. ("VA Exploring Public-Private Plan for New Facility," Lincoln Journal Star, accessed June 3, 2016, http://journalstar.com/news/state-and-regional/nebraska/va-exploring-public-private-plan-for-new-facility/article_6a90778e-6962-545f-a86a-3f27930bd84e.html.) Although Congress must ultimately provide apt facilities for VA care-delivery, the law has long authorized the SECVA to accept gifts or donations, for purposes of facility

Capital Asset Management

The Commission fully recognizes that VHA has much to do on its own to more effectively meet its capital asset needs. At the core, leaders must strengthen and streamline the capital asset programs' management and operation, to include better aligning the component elements; streamlining the leasing program, contracting, and investment decisions; managing and streamlining project delivery for construction and renovation; and adopting a facility (or building) life-cycle-model planning tool. These are all important elements of needed system transformation.

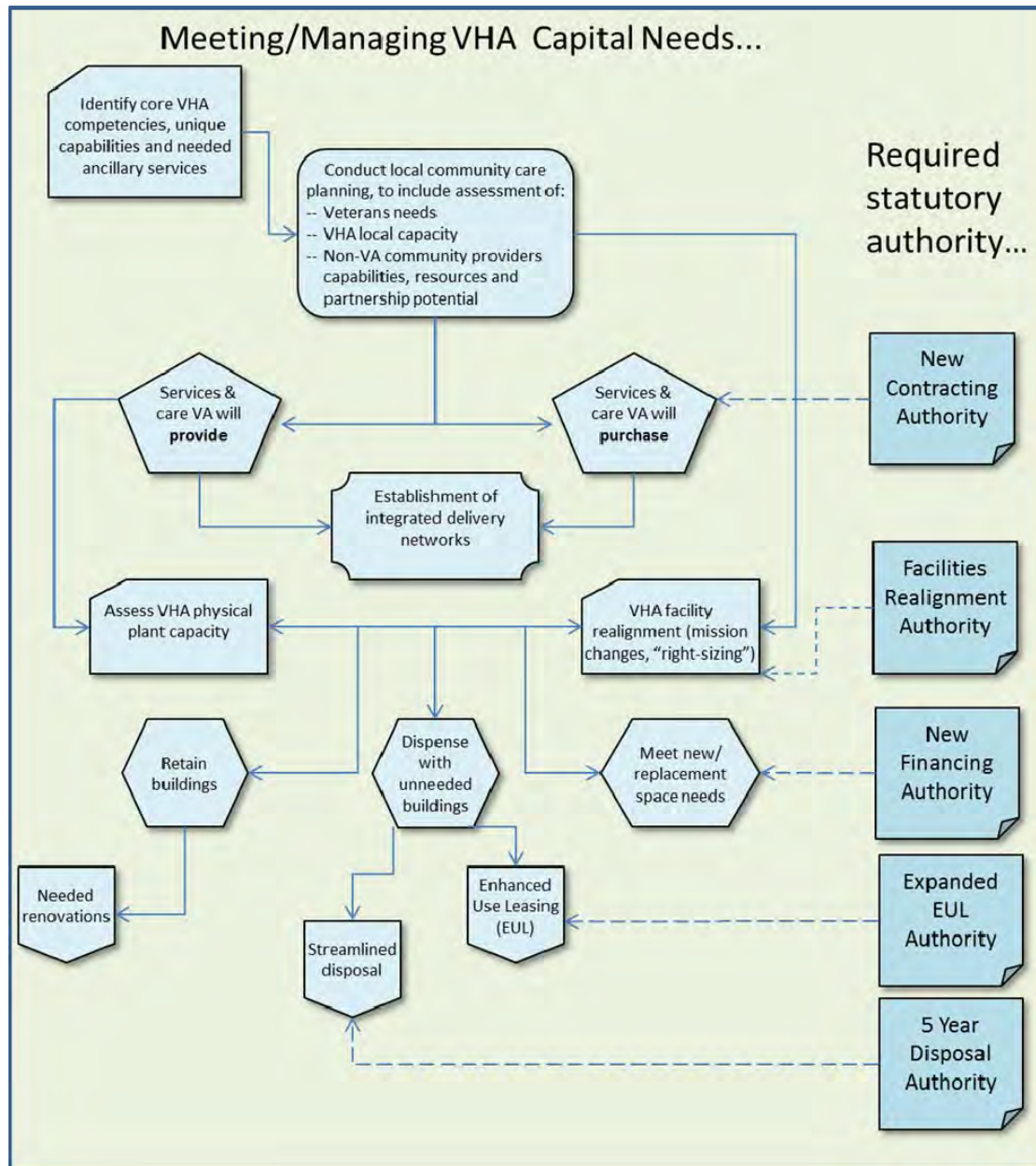
As depicted in Figure 3, meeting and managing VHA's capital-asset needs require an integrated approach that requires congressional support to tackle the multiple capital-asset challenges facing VHA. The Commission's recommendations for meeting and managing those interrelated capital-asset needs are set forth in the *Implementation* section following Figure 3.

construction. (Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(e)) Nevertheless, new legislative authority would almost assuredly be needed to permit development of public-private partnerships that provide new platforms for the construction of new or replacement medical facilities. For example, H.R. 5099 would establish a pilot program permitting VA to enter into public-private partnership agreements to plan, design, and construct new VA facilities using private donations. To Establish a Pilot Program on Partnership Agreements to Construct New Facilities for the Department of Veterans Affairs, H.R. 5099, 114th Cong. (2016), <https://www.congress.gov/bill/114th-congress/house-bill/5099>.

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Figure 3. The Complicated Process of Meeting and Managing VHA's Capital-Needs

**Implementation****Legislative Changes**

- Provide VA new, more flexible authorities to realign facilities, meet capital-asset needs, and divest itself of unneeded buildings.
- Establishing a VHA capital asset realignment process that provides (notwithstanding any other law) for more effectively aligning VHA facilities with the objective of improving the access, quality, and cost-effectiveness of VA care, and provides for:

- Establishing an independent commission (empowered to hold public hearings, make site visits, and have full access to VHA analyses and data) charged with developing a national capital asset realignment plan that would include recommendations to the VHA Care System governing board (see Recommendation #9) for systemwide facility realignment (to include changes in facility mission, facility downsizing, integration of facilities, and closures), with the rationale for each recommended change.
- The proposed plan would identify (a) the criteria used in developing realignment recommendations, (b) proposals for reinvestment and savings/cost avoidance resulting from the realignment, (c) the projected care improvements that would result, and (d) mechanisms to minimize the adverse effects on displaced employees, to include assuring that, to the extent feasible, VA retrain and reemploys displaced employees.
- The VHA Care System governing board would be empowered to adopt or alter the proposed realignment plan, and to implement the final plan unless, within a specified timeframe, Congress disapproves the plan as a whole on an up-or-down vote.
- Waive or suspend for at least 5 years current authorization and scorekeeping requirements governing major medical facility leases under 38 U.S.C. § 8104.
- Amend 38 U.S.C. § 8104 to lift the threshold of what constitutes a major medical facility project from \$10 million to \$50 million.
- Amend pertinent provisions of 38 U.S.C. § 8161, and what follows, to reinstate and extend for 10 years the authority in prior law (as in effect on December 30, 2011) for VHA to enter into enhanced-use leases for any use that is not incompatible with VA's mission.
- Provide the VHA Care System governing board authority to promulgate regulations that for a period of not more than 5 years, and notwithstanding any other law, would ease the divestiture of unneeded vacant VHA buildings, to include (a) shifting to a third party the cost of meeting environmental requirements, (b) allowing VHA to retain the proceeds of any property sale, and (c) creating a streamlined process to address historic preservation considerations.

VA Administrative Changes

- None required.

Other Department and Agency Administrative Changes

- None required.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

Problem

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems and other health care providers; enables scheduling, billing, claims, and payment; and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.¹⁸²

VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, currently within VHA, there is no experienced senior health care IT leader focusing on the strategic health care IT needs of veterans and VHA staff.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing and implementing a comprehensive health IT strategy and developing and managing the health IT budget.
- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Background

A fully functional electronic health record (EHR) can improve the quality of patient care, help avert medical errors, and improve communication among providers and with patients.¹⁸³ Starting in the 1970s, VHA became a leader in the development of EHR technology with VistA and a computerized patient record system (CPRS).¹⁸⁴ Full implementation of the EHR, together with other reforms, helped improve the quality of care at VHA.¹⁸⁵ During the last decade, VHA has not been able to maintain an IT advantage.¹⁸⁶ Although in the past most VHA clinicians

¹⁸² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁸³ "Does health information technology improve quality of care?" Robert Wood Johnson Foundation, accessed May 20, 2016, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71333.

¹⁸⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 29-30, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

¹⁸⁵ Phillip Longman, *Best Care Anywhere: Why VA Care Is Better Than Yours* (3rd ed., Berrett-Koehler Publishers, Inc., 2012). Jonathan B. Perlin, Robert M. Kolodner, and Robert H. Roswell, "The Veterans Health Administration: Quality, Value, Accountability, and Information as Transforming Strategies for Patient-Centered Care," *The American Journal of Managed Care* (November 2004), 828-836, accessed June 3, 2016, <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.476.450&rep=rep1&type=pdf>.

¹⁸⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, vi, accessed April 5, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

have had a high opinion of the clinical applications and databases enabled by VistA and CPRS, a lack of upgrades has put VHA's EHR at risk of becoming obsolete.¹⁸⁷ Many large U.S. health care systems that were early adopters of homegrown EHR systems found themselves in similar circumstances and have since purchased and migrated to commercial off-the-shelf (COTS) products.¹⁸⁸ DoD recently made the same choice.¹⁸⁹

To achieve the Commission's vision of a health care system that delivers quality, access, choice, and veteran well-being, VHA requires effective, robust, and modern information technology systems. A robust EHR system would allow veterans and clinical providers to send, receive, find, and use electronic health information in a manner that is appropriate, secure, timely, and reliable. It would be seamlessly interoperable with other systems including DoD, private-sector providers, and with other VA enterprise systems such as those in the Veterans Benefits Administration (VBA). It would support VHA clinical workflow, evidence-based practice, and patient safety. It would provide clinicians, patients, and administrators the data, analytic power, and user interfaces required to monitor the effectiveness of care and improve it over time. A robust IT system for VHA should include more than just the EHR, however, extending to all the systems and tools required to facilitate and automate business processes that support access and veterans' care. These capabilities include an effective scheduling system, telephone systems, mobile applications, telehealth, financial management systems, human resources systems, and other systems that enable community care.

To realize such a transformation of IT in a system as complex as VHA requires exceptional leadership and staff, sufficient budget, a robust change management plan, effective systems for accountability and quality control, and efficient and agile contracting.¹⁹⁰ Presently, VHA appears to lack a majority of these factors required for success.¹⁹¹

Analysis

Leadership and Staff

Prior to 2006, VHA had a chief health informatics officer responsible for the VHA electronic record system and for coordinating with VA on IT systems. The programmers in VHA worked closely with the clinicians who used the tool to create a system that met their needs.¹⁹² VHA was able to prioritize clinical needs and patient safety requirements within its overall budget and plan for IT spending; however, there was no specific budget line item for the electronic health

¹⁸⁷ Ibid., 29-30.

¹⁸⁸ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

¹⁸⁹ "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

¹⁹⁰ LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

¹⁹¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 41, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁹² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

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record system or related technology, and there was limited central oversight or accountability for information technology infrastructure.

VA's IT budget was centralized in 2006, and the Office of Information and Technology (OIT) was assigned to deliver, operate, and manage IT and its budget, across the department. With this change, VHA's needs became only one of the priorities that OIT has had to accommodate and VHA's priorities have not always prevailed.¹⁹³

To ensure that clinical needs and patient safety are a priority, many large health care systems, such as DoD, Cleveland Clinic, Geisinger, and Kaiser Permanente, have a medical CIO (i.e., CMIO) who manages and advocates for the clinical IT needs of the organization. A CMIO ensures that clinicians are involved in the selection of any IT systems they use to perform their job functions and provide patient care, including EHRs. Clinicians involved in the selection and deployment of an IT system are more likely to feel ownership of it and fully adopt its use. The CMIO usually reports to the health system's CEO or CMO, and working in concert with these individuals and the organization's CIO, makes sure that health information needs are prioritized and funded.¹⁹⁴

VA does not have staff with the necessary expertise to execute large-scale IT projects. Previous system implementations have failed because VA did not have individuals with adequate experience to effectively plan and manage system development and deployment. If VA had an adequate system and skilled staff to monitor and identify program and contracting problems affecting the progress of prior IT implementations, effective and timely decisions could have been made to either redirect or terminate VA IT projects that ultimately failed. To avoid repeating these previous IT implementation failures, VA needs to develop effective oversight systems and develop in-house staff with the expertise to oversee, fully support, manage, and execute complex integrated IT programs.¹⁹⁵

Given all of these critical needs, the Commission believes that it is essential for VHA to have a CIO with health care expertise and substantial experience, reporting to the chief of VHA Care System. The VHA CIO will be responsible for managing the complex implementation of a state-of-the-art comprehensive information system platform to support the new integrated VHA Care System, with the functionality, interoperability, and data management capabilities to support the delivery and coordination of high-quality health care for veterans. The CIO will need to work closely with clinical and operational leaders on the effective execution of the new system, and will also need to collaborate with the VA CIO to ensure the integration and coordination of the health care information system and the Veterans Benefit Administration system.

¹⁹³ Ibid., 10.

¹⁹⁴ "CMIOs Help Hospitals Make Tech Transitions," Naseem S. Miller, accessed May 13, 2016, <https://www.acep.org/content.aspx?id=79744>.

¹⁹⁵ Department of Veterans Affairs Office of the Inspector General, *Review of the Awards and Administration of Task Orders Issues by the Department of Veterans Affairs for the Replacement Scheduling Application Development Program*, accessed May 25, 2016, <http://www.va.gov/oig/52/reports/2009/VAOIG-09-01926-207.pdf>.

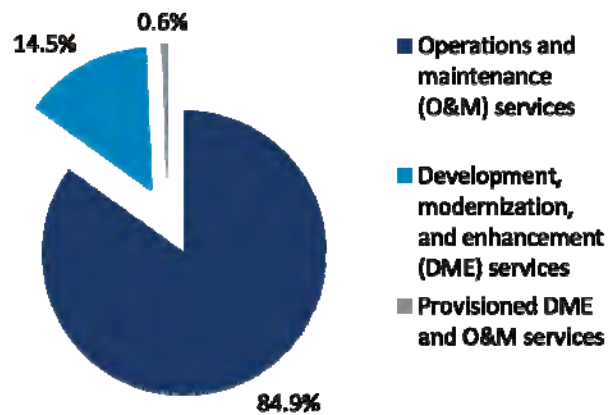
Budget

The 1-year budget appropriations cycle makes it difficult to secure multiyear funding for long-term development and important IT projects.¹⁹⁶ The budget process is disconnected from total lifecycle IT costs.¹⁹⁷ That disconnect has grown wider with a change in law¹⁹⁸ under which Congress provides VHA advanced medical care appropriations—in effect a 2-year budget—while health IT funding remains 1-year money.¹⁹⁹ As the Congressional Research Service (CRS) testified,

*providing an advance appropriation for some VHA accounts and funding IT accounts under a regular appropriation act could create a situation whereby, for example, VHA could not purchase computer software although it has procured medical equipment that needs software. Another example would be the difficulty of procuring IT infrastructure to support opening of a new community-based outpatient clinic (CBOC).*²⁰⁰

Spending on new systems and upgrades to existing systems now represents only 15 percent of VA's total IT budget (see Figure 4),²⁰¹ meaning that essential upgrades like a new scheduling package and EHR modernization have not had the funding or focus required to succeed. Clinical users have become increasingly frustrated by the lack of any clear advances with VistA during the past decade. Numerous VHA clinicians have experience with commercial EHR systems and want the same level of features, modern clinical capabilities, integration, and mobility they see emerging in the commercial marketplace.²⁰²

Figure 4. VA IT Spending



In July 2015, DoD awarded a \$4.3 billion, 10-year contract to overhaul the Pentagon's electronic health records for millions of active-duty military members and retirees. Officials estimate that

¹⁹⁶ "Coming in 2016: Cloud Legislation," Aisha Chowdhry and Adam Mazmanian, accessed January 12, 2016, <https://fcw.com/articles/2015/12/22/cloud-bill-2016.aspx>.

¹⁹⁷ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.

¹⁹⁸ Veterans Health Care Budget Reform and Transparency Act of 2009, Pub. L. No. 111-81, 123 Stat. 2137 (2009).

¹⁹⁹ With the Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235 (December 16, 2014), Congress expanded advanced appropriations to additional VA program accounts.

²⁰⁰ U.S. Congress, House of Representatives, Committee on Veterans Affairs, *Funding the U.S. Department of Veterans Affairs of the Future: Hearing before the Committee on Veterans Affairs U.S. House of Representatives*, 111th Congress, 1st Sess., April 29, 2009, 60, accessed June 3, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-111hhrg49914/pdf/CHRG-111hhrg49914.pdf>.

²⁰¹ Department of Veterans Affairs, *Information Technology Agency Summary*, accessed May 25, 2016, <https://itdashboard.gov/drupal/summary/029>.

²⁰² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

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during its potential 18-year life, the contract could be worth just less than \$9 billion.²⁰³ The recent Senate appropriations bill for VA OIT allots \$63 million toward development and modernization of VA's existing EHR (i.e., VistA Evolution).²⁰⁴ Assuming that VA's implementation of a new COTS EHR would be similar in size and scope to DoD's EHR implementation, VA would be short \$3.67 billion in funding for a new COTS EHR, given the current funding amount of \$63 million per year. VA will require a substantial increase in IT funding to support the successful implementation of a new comprehensive COTS EHR.

Robust Change Plan

Because VistA has been customized at each medical center, there are few standard data elements. The varied algorithms lead to a complex, heterogeneous mix of hardware and software that impedes system changes and new capabilities and raises operations and maintenance costs.²⁰⁵ Due to excessive project management overhead, a complex legacy IT infrastructure that is difficult to modernize, and more than 130 variations of the primary software system deployed across VHA medical facilities, the implementation of improved IT capabilities in the last 10 years has been extremely limited.²⁰⁶ VA is currently weighing whether to continue to modernize VistA or purchase a COTS health information technology platform. The Commission recommends moving to a COTS program.

Whether VHA moves forward with the purchase of a COTS product, as recommended by the Commission, or continues attempting to modernize VistA, VHA must effectively manage the change process. At present, a lack of standard clinical documentation has made it harder to develop effective clinical decision-support systems and hinders EHR information exchange among VA Medical Centers (VAMC), between VA and non-VA facilities (including those of DoD), and between VA and individual veterans. Shared data must be well labeled in a way that the receiving system can identify and properly ingest such data. An electronic medical record can contain as many as 100,000 different data fields. The lack of data standards presents challenges to using comparable data for analysis and disparities among the 130 tailored local instances of VistA, complicating information sharing, data aggregation, and analytics.²⁰⁷ VHA has not established comprehensive semantic definitions for data elements through the use of standard nomenclatures, terminologies, and code sets. Doing so is required to ensure consistency and integration across multiple systems, leverage follow-on IT products, and facilitate analytics for clinical decision making.²⁰⁸

The Office of the National Coordinator (ONC) for Health IT, under HHS, is responsible for advancing national connectivity and interoperability of health information technology. The

²⁰³ "Cerner wins \$4.3 billion DoD contract to overhaul electronic health records," Amy Brittain, *The Washington Post*, accessed May 25, 2016, https://www.washingtonpost.com/national/health-science/cerner-wins-dod-contract-to-overhaul-electronic-health-records/2015/07/29/7fbfccfa-35f5-11e5-b673-1df005a0fb28_story.html.

²⁰⁴ S. Rept. 114-237 – Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, 2017, accessed May 25, 2016, <https://www.congress.gov/congressional-report/114th-congress/senate-report/237/1>.

²⁰⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²⁰⁶ *Ibid.*, 41.

²⁰⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, vi, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁰⁸ *Ibid.*, viii.

ONC developed the National Interoperability Roadmap with the goal of being able to use electronic health information exchange, so information can follow a patient where and when it is needed, across organizational, health IT developer, and geographic boundaries. The roadmap lays out a clear path to catalyze the collaboration of stakeholders who are going to build and use the health IT infrastructure.²⁰⁹ VA's intent to expand veteran care to more community providers through the creation of locally-integrated health care networks will mean that it is important for VHA to follow the ONC roadmap and standards. Following this roadmap includes using the continuity of care document to exchange data, which was established by ONC and is followed by community health care providers. VA OIT is currently collaborating with the ONC on VA's plans for interoperability and has committed VA to following the roadmap.²¹⁰

VHA does not yet have a robust, detailed strategy and roadmap for IT initiatives across VHA that integrates veteran access to scheduling via phone, telehealth, and mobile apps.²¹¹ National deployment of the VistA Scheduling Enhancement and the veteran mobile scheduling Veteran Appointment Request app, are initial steps to prepare for the implementation of new COTS electronic medical system with a scheduling package.

To resolve the underlying systemic issues with VistA scheduling, VA awarded a contract for the implementation of VA's new COTS medical appointment scheduling system in August 2015.²¹² This system is a COTS scheduling solution that, when implemented, is expected to move VHA from primarily a face-to-face appointment model to a coherent, resource-based system with broad opportunities for improved services for VA stakeholders.²¹³ Deployment is awaiting the final decision on whether VHA will continue with VistA or purchase a full COTS product.

COTS Solution

The current VistA/computerized patient records systems are based on a tightly integrated, monolithic architecture and design with numerous and diverse functional components and associated interdependencies. These characteristics impose barriers to modernizing the respective systems. In addition, the high cost of infrastructure operation and maintenance (85 percent of the total IT budget) reduces funding available for new development efforts.²¹⁴ Maintenance and data sharing are further complicated because most VAMCs have customized their local versions of VistA, leading to approximately 130 different versions of VistA across the country.²¹⁵

²⁰⁹ "A Shared Nationwide Interoperability Roadmap Version 1.0," HealthIT.gov, accessed March 29, 2016, <https://www.healthit.gov/policy-researchers-implementers/interoperability>.

²¹⁰ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²¹¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 44, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²¹² "\$623M Medical Appointment Scheduling System (MASS) Contract," G2Xchange, accessed May 3, 2016, <https://www.g2xchange.com/statics/623m-medical-appointment-scheduling-system-mass-contract>.

²¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 40, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²¹⁴ *Ibid.*, vi.

²¹⁵ *Ibid.*, vi.

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VHA relies on a VistA scheduling package to provide veterans with access to health care. The system is antiquated, highly inefficient, does not optimally support processes or allow for efficient scheduling of appointments. A report on scheduling published by the Northern Virginia Technology Council (NVTC) in October 2014, showed that VA's exam-scheduling processes are not enabled by state-of-the-art technologies or consistently applied standard operating procedures.²¹⁶ To improve this situation, VHA has developed, and is in the process of a national roll out of, VistA scheduling enhancements, which provides an improved user interface (i.e., graphic user interface or GUI). Although the new GUI will help veterans gain access to care by implementing better scheduling procedures, it does not address the need that managers, planners, and administrators have for accurate and timely data on clinic use.²¹⁷ For instance, VHA's new health care operations dashboard shows that more than 55 percent of clinic slots in VHA go unused each day.²¹⁸ However when questioned about this data, VHA notes that it is not correct.²¹⁹ The underlying VistA scheduling software does not allow accurate representation of clinician time toward each clinic stop. As a result, whether data is presented in a dashboard or a new GUI tool, as long as the underlying data cannot be captured accurately, then VHA will not have the information it needs to effectively manage the supply of clinic slots.²²⁰

VA's financial management information technology system is woefully outdated and VA has previously wasted approximately \$500 million in two failed attempts to replace it. Given VA's lack of an integrated finance and logistics IT system, VA has no method to perform commitment accounting.²²¹ VA's current financial management system does not support streamlining and automation of VA's revenue cycle.²²²

Community care processes currently include eligibility determinations, referrals and authorizations, care coordination, network management, claims, and customer service.²²³ VA's information technology systems limitations often demand manual processes to support community care that can reduce the timeliness and accuracy of data and obscure the true state of VHA's activities. Relying on manual processes slows collections and payment activities and introduces errors and waste into the process.²²⁴ Barriers to automation are multifactorial,

²¹⁶ Ibid., 39-40.

²¹⁷ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

²¹⁸ Crystal Wilson, Office of Analytics and Business Intelligence, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.

²¹⁹ Joe Francis, Director of Clinical Analytics and Reporting, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.

²²⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

²²¹ Jan R. Frye, *Letter to Secretary McDonald, March 19, 2015*, accessed May 17, 2016, http://extras.mnginteractive.com/live/media/site36/2015/0522/20150522_025126_WhistleblowerMemo.pdf.

²²² Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, 24, accessed May 24, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf.

²²³ Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.

²²⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 42, accessed March 28, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

including confusing eligibility rules governing which veterans may receive care outside VHA and for what conditions, in what circumstances, and which services may be billed to third-party insurers.²²⁵ In addition, there are multiple authorities for purchasing community care—all with different business rules²²⁶ and reimbursement rates, as well as antiquated financial management information systems that are not standardized to private-sector processes. All of these impediments are exacerbated by workers throughout the revenue cycle who are poorly compensated and marginally trained, experience high turnover, and work in environments with a continuous 20 percent vacancy rate;²²⁷ thus, they cannot effectively manage certain business practices such as insurance verification and ensuring clinicians complete necessary coding documentation.²²⁸

Many large U.S. health care systems that originally developed in-house EHRs have since purchased and migrated to COTS EHRs.²²⁹ DoD recently made the same choice, deciding to replace its homegrown EHR with a COTS product to take advantage of private-sector innovation and have an EHR that communicates with private-sector systems. For a system in which 60 to 70 percent of military health care takes place outside the DoD,²³⁰ this was an important business consideration that is also consistent with VHA's long term direction. Very large IT programs with purpose-built systems and labor-driven business models are shifting rapidly toward more open source, COTS systems. Large proprietary IT solutions are increasingly being replaced by less risky, agile, and open-source solutions or IT as-a-service models, and getting away from client-server models.²³¹

Interoperability

VHA's EHR issues stymie interoperability among VHA facilities as well as between VHA and DoD and other non-VHA providers. Multiple assessments noted the lack of interoperability resulted in incomplete patient records with potentially substantial implications for veterans and VHA. Incomplete records introduce unnecessary clinical risk, complicate the transition from

²²⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I (Business Processes)*, 19-20, accessed April 26, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²²⁶ Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.

²²⁷ Healthcare Talent Management, Veterans Health Administration, email to Commission on Care, April 11, 2016. Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America's Veterans*, accessed April 25, 2016, <http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf>.

²²⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I, Business Processes*, I3-I4, accessed November 24, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²²⁹ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

²³⁰ "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

²³¹ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

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DoD to VHA care, and inhibit VHA's ability to bill and collect revenue in an accurate and timely manner.²³²

As GAO reported in August 2015, VA and DoD have taken initial steps to increase interoperability between their existing electronic health record systems.²³³ They have deployed the Joint Legacy Viewer (JLV), which provides a patient-centric, integrated view of a patient's health data from VA, DoD, and community health partners on one screen. It has been available at all VA medical centers since October 2014 and currently has more than 70,000 users.²³⁴ The JLV is a positive step in supporting coordination of care among VA, DoD, and community partners, but it only allows for providers to view veterans'/service members' medical records and does not yet allow for the other agencies' medical records to be updated by providers.²³⁵

VA's next evolution in interoperability with DoD and community partners is the deployment of their Enterprise Health Management Platform (eHMP). eHMP is intended to provide VA streamlined access to complete patient history from VA, DoD, and community health partners in a single, reliable, customizable, and secure interface that is easy to use. It is reported to deliver a modern, web-based user interface and supporting infrastructure and is intended to replace the Computerized Patient Record System (CPRS) as VA's primary point-of-care application. The national rollout of eHMP is expected to be completed by December 2017.²³⁶

VHA does not have everything that is needed in an IT system to manage the business and clinical aspects of care in the community and support the overall veteran experience in an expanded community network. To address these gaps and provide health care well into the future, VA intends to develop in house a comprehensive and interoperable digital health platform (DHP). The DHP is intended to seamlessly integrate all of VHA's core processes, including scheduling, supply chain management, billing, and claims. Through consolidation of more than 40 contact center systems and more than 130 versions of the VistA EHR and clinical procurement/inventory systems, the DHP is designed to enable VHA's operation as a holistic, platform business and greatly reduce the cost of system maintenance across the IT enterprise.²³⁷

Because there is no unique patient identifier, problems exist with "1) accessing and integrating information from different providers and provider computer systems, 2) aggregating and providing a lifelong view of a patient's information, and 3) supporting population-based research and development."²³⁸ To accurately match veteran patient data that is exchanged between VA and non-VA providers, both organizations need to use the same unique patient

²³² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 44, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²³³ "Electronic Health Records: VA and DOD Need to Establish Goals and Metrics for Their Interoperability Efforts," U.S. Government Accountability Office, accessed April 1, 2016, <http://www.gao.gov/products/GAO-16-184T>.

²³⁴ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²³⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, A-35, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²³⁶ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²³⁷ LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²³⁸ "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPVU-508.pdf>.

identifier. This practice is currently not used.²³⁹ Each health care system uses a unique patient identifier number, but it is specific to that system.²⁴⁰ VA uses patients' social security numbers as unique identifiers; whereas, due to stricter security standards required by HIPPA privacy laws that community providers must adhere to, many non-VA providers use other personally identifiable information (e.g., first name, last name, date of birth, and phone number) to match patient identities between record systems. Studies have shown that patient identification error rates range from 7-20 percent.²⁴¹ For VA to accurately identify patients and their records, a unique national patient identifier is essential.

The security of electronic records is an ongoing concern. One in three Americans had health care records breached in 2015.²⁴² Recent hacks of U.S. hospital health care systems through the use of ransomware, viruses that hold systems hostage until victims pay for a key to regain access, further highlight the need for enhanced VA cybersecurity.²⁴³ VA's OIG has repeatedly identified the same weaknesses and deficiencies in VA's information security program in its annual FISMA audit reports.²⁴⁴ Although VA has recently made some progress in developing policies and procedures to address current security gaps, OIG's FY 2015 audit concluded that information security is still a *material weakness* for VA and that VA must take comprehensive measures to mitigate security vulnerabilities affecting VA's mission-critical systems.²⁴⁵ For sharing of veteran data to be secure, only the designated correct parties can have access to patients' data.²⁴⁶ Interoperability increases the risk to veterans' health records.²⁴⁷ Cybersecurity guidelines and best practices are being developed by HHS in response to the requirements in the recently enacted Cybersecurity Information Sharing Act;²⁴⁸ however, security protocols also cannot impede health information exchange with VA community providers and health systems. VA OIT needs to be involved in the health information exchange planning discussions, which

²³⁹ "Interoperability 2015: Current State and Next Steps", Kent Gale, KLAS Research, accessed March 9, 2016, <http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0>.

²⁴⁰ "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPAVU-508.pdf>.

²⁴¹ "The Right Fit: How We Solve the Puzzle of Interoperability," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, <http://www.futureofhealthcarenews.com/telemedicine/the-right-fit-how-we-solve-the-puzzle-of-interoperability>.

²⁴² "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, <http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records>.

²⁴³ "Virus Infects Medstar Health System's Computers, Forcing an Online Shutdown," John Woodrow Cox, Karen Turner and Matt Zapotosky, accessed March 28, 2016, https://www.washingtonpost.com/local/virus-infects-medstar-health-systems-computers-hospital-officials-say/2016/03/28/480f7d66-f515-11e5-a3ce-f06b5ba21f33_story.html?hpid=hp_local-news_medstar-health-virus-345pm%2Fstory.

²⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, A-24, accessed May 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁴⁵ Department of Veterans Affairs, Office of the Inspector General, *Federal Information Security Modernization Act Audit for Fiscal Year 2015*, accessed May 25, 2016, <http://www.va.gov/oig/pubs/VAOIG-15-01957-100.pdf>.

²⁴⁶ "Interoperability 2015: Current State and Next Steps; Market Immaturity Highlights Opportunity," Kent Gale, KLAS Research, accessed March 9, 2016, <http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0>.

²⁴⁷ Jon White, M.D., The Office of the National Coordinator for Health Information Technology, briefing to Commission on Care, December 15, 2015.

²⁴⁸ "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 17, 2016, <http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records>.

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are currently handled solely within VHA, so that VA OIT can assist in removing impediments to health information exchange.²⁴⁹

Veterans currently have to opt in (i.e., provide consent) to allow VA to share their health information with non-VHA/community care providers. Although the technology is in place for VA to exchange patient health information with more than 100 health information exchange partners, only a fraction of data can be exchanged in these networks because, due to lack of awareness, only 3 percent of veterans have opted in to allow VA to share their health information.²⁵⁰ The standard industry policy is to have patients opt out of having their health data shared with their other health care providers. VA is prohibited from taking this approach because statutory language in 38 U.S.C. § 7332 prohibits VA from disclosing information relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia, except when required in emergencies, without written authorized consent from the patient.²⁵¹

In response to this limitation, VA approved and submitted Legislative Proposal VHA-10 (10P-07), Authority for the Department of Veterans Affairs (VA) to Release Patient Information under 38 U.S.C. § 7332 to Health Care Providers for Treatment of Shared Patients in 2013. The proposal allows veterans to opt out of sharing their data with VA community providers instead of having to opt in. The proposal was approved by OMB and was included in the president's 2015 Budget. VHA provided a briefing to a Senate Veterans Affairs Committee staff in April 2015 on this legislative proposal. A House Bill was introduced, but it limited the opt-out option to the *Choice Program*. VA's Office of Congressional and Legislative Affairs responded back to Congress that the bill should be expanded to include all external purchased care options (i.e., community providers) thus directly supporting more veterans.²⁵²

Collaboration between VA OIT and VHA is paramount to transforming VHA's health IT infrastructure. Such collaboration would be most effectively achieved by establishing an IT leader for VHA who is focused on ensuring that the strategic and operational IT needs of VHA clinicians, staff, and veterans are met. Current OIT leadership is in the process of modernizing VA's IT management processes, to include putting in place IT account managers (ITAMs) for each of the agency's departments, including VHA.²⁵³ An account manager is neither senior enough, nor has the level of expertise and experience, to manage the complexity of the VHA IT system. VHA's extensive IT needs require a VHA CIO with authority over the health IT budget and the execution of the health IT strategy. VA needs a robust process for IT investment decisions, especially those relating to VHA's health strategy. The VHA CIO would work with the CVCS and the VA CIO to define the health IT strategy and key IT acquisitions/projects and ensure that health IT funding is aligned and committed to the execution of VHA's health IT

²⁴⁹ Jamie Bennett, VLER Health Program Manager, phone call with Commission on Care Staff, March 2, 2016.

²⁵⁰ Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015

²⁵¹ 38 U.S.C. § 7332 Subchapter III - Protection of Patient Rights Sec. 7332 - Confidentiality of certain medical records.

²⁵² Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015.

²⁵³ "OI&T Enterprise Strategy: Putting Veterans First," LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.

strategy. Rolling out a new system takes multiple years, and VA must commit to funding system deployments to completion.

The modernization of VHA's IT infrastructure requires a substantial increase in and reallocation of VA's IT budget to implement it. The budget process for VA health care IT funding should be the same as the process for VHA medical care funding. That shift can be accomplished by establishing a separate line item for *health* IT within VA's IT appropriation, and providing for advanced appropriations for that account. In addition, there is also a potential supplementary role for government-wide IT legislation. For example, H.R. 4897, the Information Technology Modernization Act of April 2016, would create a \$3.1 billion revolving fund for upgrading outdated federal IT systems.²⁵⁴

The Commission strongly recommends that VA purchase a comprehensive COTS health IT platform, and implement all information systems with minimal customization. VHA leadership is in the process of assessing whether VistA is the best solution to support veterans' future health care needs or whether a new EHR, such as a COTS product or open-source EHR, should be used.²⁵⁵ The decision to choose a COTS product would be consistent the approach adopted by DoD and by other large health systems that have moved away from homegrown solutions to commercial and open-source products. It would allow VHA to focus energy on excellent patient care as a core competency and shift the IT development and maintenance risk of software products to external vendors with more expertise in this area.²⁵⁶ It is also likely to accelerate interoperability as vendors continue to offer IT solutions that meet meaningful use standards and the roadmap published by ONC.

A COTS product must be able to execute key functionalities required by VHA. These requirements include one standard version of an EHR across all VHA sites of care; interoperability within VA, such as with Veterans Benefit Administration (VBA), and between VHA and DoD, and community providers; robust security; and the ability to accommodate a national unique patient identifier. This system must also be a robust clinical management tool that supports VHA clinical workflow and has a customizable interface for clinical users, allows for evidence-based clinical order sets and patient safety features like automated medication reconciliation, has robust analytic capability for both clinical and administrative functions, and enables automated abstraction and reporting of performance measures.

The system must also seamlessly support administrative functions like scheduling, patient intake, eligibility determination, referrals, and patient out-of-pocket expense determination. The system must enable effective business operations in billing coding, automated claims processing, and all aspects of supply chain management. This COTS purchase should include a scheduling package. Improvements in scheduling should dramatically increase access and satisfaction, as well as data quality, productivity, and operational reporting capabilities.

²⁵⁴ "Two IT Modernization Bills Could See Movement in Congress," Aisha Chowdhry, accessed April 28, 2016, <https://washingtontechnology.com/articles/2016/04/22/it-bills-congress.aspx>.

⁷³ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²⁵⁶ "DoD awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

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Broadening and improving scheduling capabilities will provide more opportunities for veterans to become active partners in their own care.²⁵⁷

For VHA to transition to a COTS product, the new VHA CIO must develop and implement a strategy that will allow the current nonstandard data to effectively roll into a new system, engage clinical-end users and internal experts in the procurement and transition process, ensure effective cybersecurity, and limit spending on the current systems to fund only critical changes required for continued operations. Finally, this plan should be coordinated with ONC and DoD.

Implementation

Legislative Changes

- Provide a specific appropriation to fully fund the complete development and deployment of the comprehensive COTS electronic health platform, recognizing this will require significant resources above the current annual appropriation and funding to support VHA's IT transformation; including funds that ensure appropriate training of all staff, recognize loss of staff productivity during implementation, and provide proper maintenance and upgrades of VA IT infrastructure in preparation for new and successor technologies.
- Establish within the Department's IT appropriation a line item for health IT, and provide for advanced appropriations for that account, consistent with the overall VHA IT strategy.
- Amend section 38 U.S.C. §7332, to authorize VA to share protected health information under the same rules as all other HIPAA protected information.

VA Administrative Changes

- Hire a CIO for the VHA IT transformation. The CIO should report to the CVCS, with secondary reporting responsibility to VA CIO.
- Establish a transformation strategy that addresses all of the following needs (as directed by the VHA CIO):
 - standardizes data elements in the current IT systems through the use of standard nomenclatures, terminologies and code sets in order to promote the transition to a COTS EHR and to support interoperability²⁵⁸
 - develops a robust cybersecurity plan for VHA IT infrastructure, in coordination with VA CIO and Chief Information Security Office, which addresses both current systems and defines
 - the requirements for new systems

²⁵⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 46, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁵⁸ *Ibid.*, 55.

- collaborates with the Office of the National Coordinator for Health IT on national interoperability standards and implementation
- limits any continued VistA development and associated spending to only those upgrades required to keep VistA functioning until a new system is in place
- Plan and implement procurement of a comprehensive COTS electronic health platform that executes all of the following requirements:
 - establishes one logical version of an electronic health record platform in VHA²⁵⁹
 - standardizes evidenced-based, best practice clinical order sets across VHA
 - incorporates effective analytic capabilities to drive health and business outcomes and offers the ability to interface with other tools for data management and presentation²⁶⁰
 - modernizes appointment scheduling so that it accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veterans²⁶¹
 - accomplishes a coordinated IT infrastructure for appointment scheduling, coding, billing, claims payment, third party collections, and other core VHA business processes, including the following specific capabilities: integration across patient intake, medical records, coding, and billing systems; single sign-on capability; automated first-party claims matching; real-time estimate of out-of-pocket patient expenses; and automation to support algorithmic edits and claims correction²⁶²
 - supports the business processes required to implement integrated community care networks, including eligibility determinations, referrals and authorizations, care coordination, network management, claims and customer service
 - promotes full interoperability with IT systems across VA (including VBA and National Cemetery Administration) and between VA and DoD
 - supports the development of full interoperability with integrated community care network facilities and providers

²⁵⁹ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²⁶⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, viii, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁶¹ The Independent Budget, *The Independent Budget—Veterans Agenda for the 114th Congress: Policy Recommendations for Congress and the Administration*, accessed May 17, 2016, http://www.independentbudget.org/2016/IB_FY16.pdf.

²⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 49, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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- enables automated abstraction and reporting of quality performance measures including process and outcome measures of clinical quality, access measures, and cost effectiveness that are the same as the private sector
- includes functionality to use a national unique patient identifier
- integrates supply chain and financial systems with the electronic health records to provide accurate operational data²⁶³
- Streamline its current IT procurement processes so that IT procurement is expeditious, including lengthier contract vehicles with more options, the use of indefinite delivery indefinite quantity vehicles, blanket purchase agreements, time and material contracts, and flexible contract structures to allow for the onboarding of emerging technologies in a competitive fashion.
- Increase health IT expertise within VHA.

Other Department and Agency Administrative Changes

- CMS and federal health care providers should collaborate to develop a national unique patient identifier standard. CMS should require health care providers to use these identifiers as a condition of participation in Medicare and HHS should require federally qualified health centers to use them as a condition of participation. The President should require all federal health care providers to adopt the standard.

²⁶³ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Problem

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.²⁶⁴

Background

Health systems nationwide, under pressure from reforms driven by the Affordable Care Act, are looking at every aspect of their business to maximize cost savings, while maintaining quality services.²⁶⁵ This effort includes examining the supply chain for ways to save money.²⁶⁶

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.
- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

²⁶⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁶⁵ Bob Kehoe, "Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness," *Health Facility Management Magazine*, 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.

²⁶⁶ "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, <http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends>. "5 Ways Supply Chain Can Reduce Rising Health Care Costs," Jasmine Pennie, accessed April 28, 2016, <http://hitconsultant.net/2013/05/13/5-ways-supply-chain-can-reduce-rising-health-care-costs/>.

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Price competition achieved through technology and aggressive management of supply chain efficiencies by retailers such as Walmart and Amazon are held up as just the kind of disruption that health care requires.²⁶⁷ Health care organizations as diverse as Kaiser Permanente, Cleveland Clinic, Stanford Medicine, and Johns Hopkins Health System have taken on the challenge of transforming their supply chains, realizing savings of as much as hundreds of millions of dollars.²⁶⁸ VHA, which in FY 2014 spent approximately \$3.4 billion on clinical supplies, medical devices, and prosthetic appliances, has an opportunity to realize similar savings.²⁶⁹

Opportunities for efficiency in the supply chain include reducing pricing for purchases and lowering operating costs of procurement processes. To achieve price savings, organizations must have detailed information on what products they use, understand and reduce variability in the products purchased, and aggressively negotiate pricing, usually by consolidating purchases to a small number of preferred vendors who are willing to offer volume discounts and improve service delivery. On the operations side, cost savings are achieved by managing inventory lifecycle and restocking processes; order management; and the logistics of shipping, receiving, and transportation to drive down costs and lower waste and breakage. In health care, it also pays to ensure that clinical staff, both nurses and doctors, are treating patients rather than conducting inventory checks or ordering and collecting supplies.²⁷⁰ To be successful in managing the supply chain in health care, a partnership with clinical staff is key. Variability in device and supply purchases can be driven by clinician preferences and thus, to reduce variability, clinicians must be engaged in analyzing product options and examining data on product effectiveness to determine what products to use with patients.²⁷¹

VHA has a successful internal model of aggressive supply chain management that can serve as a model for improving the management of medical, surgical and other supplies: the VHA Pharmacy Benefits Management Service (PBM). PBM has taken a systems approach to

²⁶⁷ John Agwunobi and Paul London, "Removing Costs from the Health Care Supply Chain: Lessons from Mass Retail," *Health Affairs*, 28, no 5, (2009): 1336-1342, accessed April 26, 2016, <http://content.healthaffairs.org/content/28/5/1336>.

²⁶⁸ "In Age of Mergers, Hospitals Get Strategic with Medical Supply Purchasing," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/age-mergers-hospitals-get-strategic-medical-supply-purchasing>. "Supply Chain Management," Cleveland Clinic, accessed April 27, 2016, <http://my.clevelandclinic.org/services/supply-chain-management>. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering>.

²⁶⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 47, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁰ "EY Provider Post: Choosing Your Innovation Pathway," EY, accessed April 26, 2016, <http://www.ey.com/US/en/Industries/United-States-sectors/Health-Care/Provider-Post--Choosing-your-innovation-pathway>.

²⁷¹ "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, <http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends>. "Strategic Supply Chain Management," Lee Ann Jarrow, accessed April 28, 2016, <http://www.hhnmag.com/articles/4522-strategic-supply-chain-management>. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering>.

managing pharmaceutical supplies, logistics, and prescribing.²⁷² PBM has largely solved the internal contracting deficiencies in VA by consolidating its activities under just two contracting organizations that oversee all national-level contracts for pharmaceuticals. PBM also applies effective mechanisms to drive standardization of supplies through a national formulary, clinical guidelines for prescribers and utilization review, and feedback to help clinicians identify outlier prescribing practices.²⁷³ Vital to the success of this program is the involvement of clinicians and pharmacists in a vertically integrated model of engagement and decision making through facility-level, Veterans Integrated Service Network (VISN)-level, and national-level PBM committees that contribute to formulary and clinical guideline decisions and manage utilization review with local clinicians.²⁷⁴ PBM also has a sophisticated web of communications, education, and engagement efforts to ensure clinical leaders across the system are helping drive PBM policy and practices.²⁷⁵ As a result, 90 percent of purchases are acquired through pharmaceutical prime vendor contracts.²⁷⁶

PBM, taking advantage of standardized industry nomenclature and bar codes for pharmaceuticals, has implemented automated dispensing, distribution, and ordering processes, including VA's Consolidated Mail Outpatient Pharmacy (CMOP).²⁷⁷ The use of CMOP, a system of seven highly automated pharmacies that process more than 460,000 prescriptions every work day, results in exceptional accuracy and lower processing costs than would result if filling prescriptions at each VAMC.²⁷⁸ Eighty percent of prescriptions in VHA are filled through CMOP,²⁷⁹ which has been recognized for the last 6 years as the best or one of the best mail order pharmacies in the country meeting or exceeding customer satisfaction scores of health care systems like Kaiser Permanente and on-line pharmacies like Express Scripts and Walgreens Online Pharmacy.²⁸⁰ Customer service, veteran satisfaction, and patient safety delivered through team-based care are a hallmark of the mission of PBM,²⁸¹ and are a useful reminder of the principles that must drive any successful transformation of supply chain management in VHA.

²⁷² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 19, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷³ *Ibid.*, 20.

²⁷⁴ VHA Formulary Management Process, VHA Handbook 1108.08 (2009).

²⁷⁵ Clinical Pharmacy Services, VHA Handbook 1108.11, 28-30 (2015). The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 32-34, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁷ *Ibid.*

²⁷⁸ "VA Mail Order Pharmacy," U.S. Department of Veterans Affairs, accessed April 29, 2016, http://www.pbm.va.gov/PBM/CMOP/VA_Mail_Order_Pharmacy.asp.

²⁷⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁸⁰ "U.S. Pharmacy Study – Mail Order (2015)," J.D. Power, accessed April 29, 2016, <http://www.jdpower.com/ratings/study/U.S.-Pharmacy-Study-Mail-Order/631ENG2>.

²⁸¹ "Pharmacy Benefits Management Services," U.S. Department of Veterans Affairs, accessed April 29, 2016, <http://www.pbm.va.gov/PBM/index.asp>.

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Analysis

VHA's supply chain for clinical supplies, medical devices, and related services is inadequate compared to the agency's pharmacy organization or to best practices in leading hospital systems.

*Its contracting processes are bureaucratic and slow, which can delay veterans access to care. Purchasing processes are cumbersome which has driven VHA staff to work arounds and exacerbates the variation in prices VA pays for products. Utilization is difficult to measure or manage given a lack of data which likely leads to significant avoidable expense for VA.*²⁸²

Leadership and Organizational Structure and Function

Best-in-class supply chain organizations typically have a single group responsible for the strategy, sourcing, procurement, and logistics of clinical supplies and medical devices. The organization is typically led by an executive-level leader, such as a chief supply chain officer (CSCO), and personnel are aligned along product categories to develop and use deep expertise in the products and suppliers they manage.²⁸³ In contrast, the organizational structure for contracting, logistics, and supply management in VA and VHA is complex and duplicative.²⁸⁴ Four contracting entities are located within VA central office but report to two different management offices within VA's office of acquisition, logistics, and construction (OALC).²⁸⁵ Procurement personnel within VHA's regional contracting and VISN offices report to VHA's national office of procurement. In contrast, facility-based and VISN logistics personnel report to their local VAMC or VISN director and not to the national VHA logistics office.²⁸⁶ To further complicate the management picture, clinical supplies are managed by the logistics organization, yet medical devices are managed by the Prosthetics and Sensory Aid Service (PSAS)²⁸⁷ (see Figure 5). In most health care organizations, the supply chain chief operating officer and their integrated supply chain group manages the procurement and distribution of all clinical supplies and medical devices.²⁸⁸ This is not the case in VA. Senior leaders in VA's and VHA's supply chain organizations and field-based supply chain personnel indicate current organizational structure is too complex and should be simplified.

*National supply chain leaders expressed lack of clarity regarding the scope of responsibilities of the entities for which they are responsible, which has led to some tension and what one leader described as a 'turf war.' Others described a vacuum of ownership and accountability, and lack of clarity on roles and responsibilities.*²⁸⁹

²⁸² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, v, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁸³ Ibid., 57-58.

²⁸⁴ Ibid., ix.

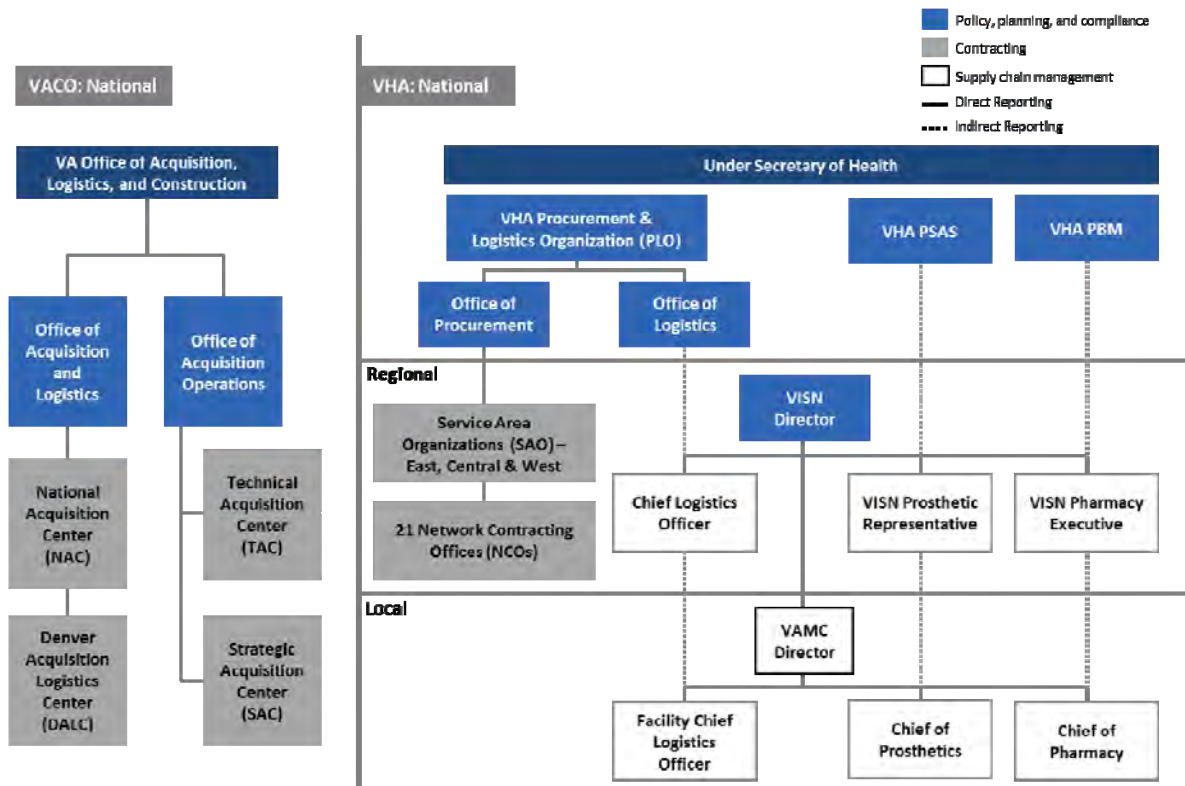
²⁸⁵ Ibid., 96-97.

²⁸⁶ Ibid., 47-50.

²⁸⁷ Ibid., 58.

²⁸⁸ Ibid.

²⁸⁹ Ibid., 55.

Figure 5. Organizations Comprising VA's Supply Chain²⁹⁰

Notes: Some VISNs may have different reporting relationships with facility prosthetics staff.

The separation of clinical supplies and prosthetics/medical devices causes issues in coordinating products needed for procedures. Frontline staff members indicate the time it takes to procure simple items through contracting (1 to 3 months) is problematic. For example, heart valve surgery may be delayed because some heart valves cost more than the micro-purchase threshold (\$3,000), thus the purchase must be made through the contracting process.²⁹¹ Medical center staff consistently expressed concern that VHA procurement offices are not responsive to the needs of a health care organization and do not communicate effectively with them,²⁹² findings borne out by low customer satisfaction scores given to these organizations.²⁹³

There is great overlap and redundancy in procurement and logistics functions in VA and VHA and the reporting structures are not aligned to ensure that the needs of veteran patients and their clinical providers are met. In an environment with limited sharing of best practices and a lack of transparent, open communications, the current complicated reporting structures impede customer-service quality and effectiveness. The original intent behind the current structure was to consolidate and strengthen purchasing power through the establishment of national contracts; however implementation of the vision has been poor and the result has been a

²⁹⁰ Ibid., 49.

²⁹¹ Ibid., 67.

²⁹² Ibid., 68.

²⁹³ Ibid., 69.

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complicated, bureaucratic system filled with redundancies.²⁹⁴ These broken processes serve as a precursor for catastrophic systems failures.²⁹⁵

There is an immediate need to consolidate and streamline procurement and logistics for medical and surgical supplies under one leader in VHA, the VHA chief supply chain officer (CSCO), who would be accountable for transforming VHA supply chain management. As identified under MyVA, medical and surgical supply chain management is the first priority but the rest of the supply chain needs to be addressed by the CSCO in a staged approach. The VERC or other experts in business process engineering must be engaged to create a vertically aligned organizational structure with clear delegated responsibilities at each level of the organization to create an efficient and responsive procurements and logistics process which the VHA CSCO would lead.

Clinical Engagement and Value Analysis

*In contrast to pharmaceuticals, usage of clinical supplies and medical devices is not strictly monitored or managed in VA. In general, physicians and nurses can choose whichever products they believe are best for patients and the supply chain organization's role is to make those items available.*²⁹⁶

VHA does not have a means to determine what supplies should be standardized or a feedback loop administrators and staff use to assess whether standards were being used when they did exist.²⁹⁷ As a result, limited product standardization has been achieved across VHA, despite VHA establishment of national standardization user groups in 2001 responsible for identifying items for standardization based on national procurement data.²⁹⁸ To date, national product standardization has been achieved in only a limited number of categories.²⁹⁹ Since 2011,

*VHA required that medical centers establish Clinical Product Review Committees (CPRCs) to: (i) review and approve the use of new clinical items and reusable medical equipment (RME) at each medical center; (ii) maintain a list of approved expendable clinical supplies and RME by establishing and maintaining a Medical/Surgical Supply Formulary; and (iii) ensure compliance with nationally standardized contracts and blanket purchase agreements. In all sites visited, CPRCs exist and meet regularly but reviews were generally formalities.*³⁰⁰

²⁹⁴ Ibid., 47-50.

²⁹⁵ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

²⁹⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 54, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁹⁷ Ibid., xii.

²⁹⁸ VHA Handbook 1761.1, Standardization of Supplies and Equipment Procedures, July 2003.

²⁹⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 81, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁰ Ibid., 82.

Under this 2011 policy, the establishment of VISN oversight committees was also required to provide accountability and feedback to the local committees, but these committees were apparently never established.³⁰¹

VHA, with the engagement of the Veterans Engineering Resource Center (VERC), is making progress on clinician alignment to accomplish value-based purchasing decisions for medical and surgical supplies. VERC has recently rolled out a national clinical product review committee (CPRC-E) e-portal to better organize this function. This portal provides a central system and standard processes for all new product requests and approvals to inform the procurement processes.³⁰²

In the area of medical and surgical supplies, clinician preference can drive variability in procurement and utilization. As has been done in VHA for pharmaceutical prescribing, a similar system to engage and align clinicians must be undertaken for medical devices and surgical supplies. VERC has started this process, but requires further funding and leadership support to fully implement a clinician-driven sourcing process. Current and future leaders of VA and VHA must ensure that VERC continues to receive the funding support and leadership engagement it needs to fully accomplish this transformation with support and direction from a VHA CSCO.

Information Technology, Data Standards, and Analytics

Information technology systems, data systems, and analytical capability for finance, inventory management, and purchasing impede VHA's ability to effectively manage its supply chain.³⁰³ VHA needs greater "end-to-end visibility into the operational and financial performance of their supply chain" and more effective means to accomplish supply chain budgeting, forecasting, inventory management and automation of at least some key supply chain functions.³⁰⁴

*VA lacks visibility into supplies and devices spending at the level of granularity usually seen in the private sector. For example, in the private sector, it is typically possible to measure clinical supply spend and utilization at the service, patient, or physician level. However, this is not possible in VHA because it does not capture such data. Therefore, supplies spend per case can only be calculated in aggregate, which is relatively meaningless and does not allow for fair comparison across hospitals, services, or physicians. This inhibits VA's ability to manage utilization and to understand fully the impact of product standardization efforts.*³⁰⁵

VERC is working to reduce the more than 130 versions of VistA in place across the country so that the same data sets can be tracked and reported.³⁰⁶ Funding was approved by OIT for the Future Transformation Tool (FTT) graphical user interface that will standardize product names

³⁰¹ Ibid., 54.

³⁰² Heather Woodward-Hagg, PhD, email to Commission on Care, March 17, 2016.

³⁰³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁴ Ibid.

³⁰⁵ Ibid., 60.

³⁰⁶ Ibid.

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and provide data integration across all of VHA. Point of Use Solution, a commercial off the shelf supply management software product, has been purchased to achieve better inventory and demand management control and has been deployed to 32 percent of facilities, as of April 2016.³⁰⁷

True sustainment of a clinician driven process cannot be achieved with fragmented information systems that do not communicate. Leaders at all levels of the organization are not able to effectively identify and manage procurement requirements or provide effective feedback to clinicians on utilization. Similarly, automated inventory control, ordering, billing, and payment cannot occur without a seamless information technology infrastructure. With a current IT system in which fiscal, supply chain, and clinical informatics systems do not interface, the hopes of moving to automated processes for supply ordering, equipment life cycle management, and vendor communications cannot be realized. A plan for the transformation of supply chain management, developed by a VHA CSCO with support from VERC, must be fully integrated with planning and procurement within OI&T and fully financed to accomplish these important goals.

Policy and Procedures

Ninety-eight percent of all clinical supplies are acquired using purchase cards³⁰⁸ and 75 percent of what VHA spends on clinical supplies is made through this purchase mechanism.³⁰⁹ This is not a surprise given that the standard contracting process can take anywhere from 150 to 180 days to complete,³¹⁰ yet use of purchase cards is inefficient as this mechanism does not take advantage of economies of scale and potential cost savings an organization the size of VHA can achieve through price negotiations and strategic sourcing.³¹¹ It can also be contrary to law, as use of purchase cards often necessitates orders be split to remain under the \$3,000 purchase card limit.³¹² An analysis of purchase records showed that 38 percent of supply orders were made through standing vendor contracts which is in stark contrast to the private sector benchmark of aiming to complete 80-90 percent of supply purchases from master contracts with negotiated price discounts.³¹³ Indeed, the private sector trend in health care has been for hospitals and health care systems to form alliances in “group purchasing organizations” to achieve the scale that VHA naturally enjoys.³¹⁴ Weaknesses in logistic management have been recognized in VHA for some time and still remain.³¹⁵ For instance, a review of logistics business

³⁰⁷ Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.

³⁰⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁹ Ibid., xii.

³¹⁰ Ibid., x.

³¹¹ U.S. Government Accountability Office, *Strategic Sourcing: Improved and Expanded Use Could Save Billions in Annual Procurement Costs*, accessed April 28, 2016, <http://www.gao.gov/assets/650/648644.pdf>.

³¹² U.S. Department of Veterans Affairs, Office of Inspector General, *Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System*, accessed April 28, 2016, <http://www.va.gov/oig/pubs/VAOIG-11-00826-261.pdf>.

³¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xii, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³¹⁴ Bob Kehoe, “Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness,” *Health Facility Management Magazine*, 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.

³¹⁵ U.S. Government Accountability Office, *Veteran’s Health Care: VHA Has Taken Steps to Address Deficiencies in Its Logistics Program, but Significant Concerns Remain*, accessed April 28, 2016, <http://www.gao.gov/assets/660/653886.pdf>.

practices at 17 VHA medical facilities in 2014 showed that none of the facilities achieved 100 percent compliance on the factors assessed, and the rate of noncompliance ranged from 53 to 88 percent, depending on the business metrics examined.³¹⁶

VA is inhibited by a failure to update its acquisition regulations to take advantage of modernization made in 2014 to the governmentwide regulations to promote simplified purchasing procedures.³¹⁷

VERC initiatives to improve VHA supply chain are intended to standardize business processes and address the great price variations for the purchasing of medical and surgical supplies. A national medical surgical prime vendor (MSPV) contract has been established. This development has several advantages to include (a) increased ability to leverage pricing negotiations; (b) standardized pricing; (c) elimination of redundant contract development, bidding, and selection; and (d) future ability to integrate with CPRC E-Portal.³¹⁸ VA has established a goal for 85 percent of all orders in FY 2016 be made under the prime vendor contract and has made 1,100 contracting officers available to meet demand against the contract.³¹⁹ As of April 2016, an estimated \$24.4 million in supply chain costs had already been avoided since January.³²⁰

The establishment of a new MSVP contract in April 2016, the assignment of 1,100 staff to support its use, and the expectation communicated to the field that 85 percent of all purchases be made from the contract are important steps in the right direction. For efficient ordering processes to take hold and be sustained across VHA, all of the policies and procedures from the bedside (or surgical suite) to the head contracting office must be reworked to align with the desired business outcomes. Reworking policies and procedures must occur together with appropriate training and communication at all levels of the organization. Each staff member involved in the procurement process must be held accountable for meeting the new requirements and expectations assigned to them. Updating the VA Acquisition Regulation (VAAR) is just one small piece of such a transformational change. The VERC or others with appropriate experience in aligning business processes within government should be assigned responsibility to finish developing and implementing plans for such a transformation under the direction of a VHA CSCO.

Contracting

Analysis of the *Independent Assessment Report* confirmed issues with the responsiveness of contracting. For example, at one facility, if a request was submitted to contracting that was incomplete or inaccurate, it took on average 21 to 39 days from the date of initial submission to

³¹⁶ U.S. Department of Veterans Affairs, *VA Supply Chain News*, Issue 13, Jan/Feb 2015.

³¹⁷ Jonathan Miller, Director of Logistics Operations, VHA Procurement & Logistics Office, phone call with Commission on Care, December 9, 2015.

³¹⁸ Heather Woodward-Hagg, PhD, Acting Director, Veterans Engineering Resource Center, phone call with Commission on Care, March 18, 2016.

³¹⁹ Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.

³²⁰ Ibid.

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receive the first response from contracting requesting, for example, additional information or paperwork.³²¹ This problem appears to be a widespread.

In another instance, interviews conducted as part of the independent assessment showed that VA vendor contracting processes to order equipment valued at less than \$3,000, for example, scalars for dentistry, can be confusing and lengthy, leading to shortages in equipment and delays in clinic as equipment is located. Delays in sterile processing were also indicated by providers as an issue pertaining to equipment availability.³²²

Communication with contracting is another substantial challenge within VHA. In surveys that assessed the effectiveness of VA's contracting organization, VHA employees' customers rated the communications received from contracting officials the lowest of all contracting dimensions that were evaluated.³²³ Several interviewees recommended that VA provide more clarity on the status of contracting requests to help them plan and schedule care.³²⁴

Individuals in contracting believed that VAMC staff members were responsible for some of the delays in the contracting process. They reported that requests submitted to them from VAMCs were often incomplete or unclear and that facilities were poor at forecasting demand for items, leading to unpredictable peaks in demand for contracting services that exceeded their capacity. The VHA Procurement and Logistics Organization (PLO) and facilities are seeking to address these challenges by placing contract liaisons in facilities to better support contracting officer representatives throughout the process.³²⁵

Contracting compliance analysis showed substantial opportunity for improvement. Analysis of purchase order data showed that 38 percent of purchases were made on a government contract, 27 percent were made at open-market prices, and 34 percent did not have a source type specified.³²⁶ Private-sector organizations typically aim to buy 80 to 90 percent of their clinical supplies and medical devices on some type of negotiated contract.³²⁷

Interviews and observations undertaken as part of the independent assessment revealed that there are two primary reasons for VHA's relatively high share of open-market purchasing. First, in contrast to pharmaceutical purchasing, VHA's supply purchasing systems are not integrated

³²¹ The consulting team based this on an IFCAP/eCMS transmission log received during a VAMC site visit (2015). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²² Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 91, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

³²³ The consulting team derived this from a VHA procurement metrics book. McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 69, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²⁴ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²⁵ Ibid.

³²⁶ Ibid., xii.

³²⁷ Ibid.

with contract or pricing catalogs. Therefore, the purchasing process relies on buyers (often clinical staff) to research whether an item is on contract and through which contract a purchase should be made. Because of that complexity, several buyers reported that they bypass this step and buy products through the channel that is most familiar and convenient, for example, by replicating previous orders to their usual supplier, despite changes that may have occurred (new contracts and pricing arrangements, for example). Second, VHA has limited ability to monitor and drive compliance with the contract hierarchy because the required data are not captured electronically. In fact, more than 60 percent of all clinical supply items do not have a contract number listed.³²⁸

VHA's fragmented inventory management systems and processes also create challenges. VHA's current inventory management does not have a feedback loop to link inventory to product use, contracting, ordering, and vice versa. This lacking information prevents optimal use of the MSPV contract program and creates missed opportunities to establish more effective volume-based national or regional contracts. It also leads to peaks and troughs in demand for contracting services, which can overwhelm contracting's capacity.³²⁹

There are pockets of good performance and innovation in VHA that could be replicated across its supply chain. The *Independent Assessment Report* notes that the Denver Acquisition and Logistics Center (DALC) is a bright spot within VHA's supply chain organization in its acquisition and distribution of select devices such as hearing aids to veterans. It has developed an integrated operating model that brings together clinicians, contracting, finance, logistics, and program management. That integrated team makes decisions around product and supplier selection based on a holistic view of what is best for veterans and for VHA.³³⁰

Talent Management

VHA is unable to hire good talent to manage its supply chain. In 2014, 20 to 30 percent of logistics positions were unfilled, and 20 percent of medical supply aide jobs were vacant.³³¹ The causes were identified as lengthy time-to-hire, nonexistent internal career progression ladders for these individuals, and inability to provide competitive pay due to position downgrades made by OPM under Title 5.³³² Examples of recent downgrades include supply technician, mail manager, administrative officer, and materials handler.³³³

*It is well known in the health care industry that there is a shortage of supply chain talent currently. The private sector organizations interviewed during this assessment stated that they are recruiting more highly trained individuals than they did in the past and, because of competition for talent, are paying them more than they used to. This may be contributing to VHA's recruitment and retention challenges.*³³⁴

In Recommendation #15, the application of the more than 60-year old standards and processes used in the Title 5 personnel system does not serve the needs of a modern health care delivery

³²⁸ Ibid.

³²⁹ Ibid.

³³⁰ Ibid., xiii.

³³¹ Ibid.

³³² Ibid.

³³³ Ibid., 87.

³³⁴ Ibid., 88.

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organization. Health care supply chain management is a recognized field of study and a valued component of leadership teams at the highest performing health care organizations. For VHA to compete for top leadership talent in this field and frontline staff, logistics and procurement personnel must be included in a new excepted personnel system for VHA under Title 38 (see Recommendation #15).

To address talent management issues, VERC has established a new VA Acquisition Academy (VAAA) Supply Chain Management School.

*The mission of the Supply Chain Management School is to provide best-in-class education, training, professional development, and certification of the VA supply chain workforce. VAAA's competency-based curriculum addresses general and technical skills, VA-specific functional areas, and core activities for VA logistics professionals. Emphasis is on translating theory, fundamentals, and concepts to practical application with realistic VA-based scenarios utilizing hands-on application of problem-solving skills.*³³⁵

The supply chain management school is organized under VAAA which has been recognized by external organizations to offer high quality training.³³⁶

Implementation

Legislative Changes

- Establish a new excepted personnel system under Title 38 to permit VHA to compete effectively with the private sector for personnel required to run a complex health care system, including staff to manage and operate a modern supply chain system.

VA Administrative Changes

- Establish an executive position for supply chain management, a VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- Transform policy and procedures for supply chain management in parallel with identification and procurement of new management software: new software should support the new processes and not the existing, poorly organized business processes and requirements.
- Establish a staged process for the transformation of all supply chain operations in VHA under the direction of a VHA CSCO, with support from VERC.
- Reconcile the VAAR with the Federal Acquisition Regulation (FAR) to ensure the VAAR aligns with recent updates to the FAR to permit streamlined acquisition processes.
- Provide consistent and standardized training to ensure those developing and administering contracts have updated information regarding FAR and VAAR

³³⁵ "Message from the Vice Chancellor," Veterans Affairs Acquisition Academy, accessed April 28, 2016, <http://www.acquisitionacademy.va.gov/schools/scm/message.asp>.

³³⁶ "VA Acquisition Academy Recognized as a 2016 Learning Elite Organization," U.S. Department of Veterans Affairs, accessed May 13, 2016, <http://www.acquisitionacademy.va.gov/rss/index.xml#20160413b>.

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regulations as well as a thorough understanding of their responsibilities under the new approach to supply chain management and how to carry out these duties.

Other Department and Agency Administrative Changes

- None required.

Governance, Leadership, and Workforce

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

Problem

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center (VAMC), and similar problems at multiple other VAMCs, had both direct and indirect causes. Weak governance was found to be among those indirect causes.³³⁷ As the authors of a root-cause analysis of the Phoenix scandal highlighted, “a governance gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed to the wait-time problems.³³⁸ The report authors observed, “Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors.”³³⁹ The governance limitations made evident in the Phoenix scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration’s expectations for short-term results,³⁴⁰ and VHA’s operating in a “dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act and be structured based on the key elements included in Table 5.
- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term to allow for continuity and to protect the CVCS from political transition. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

³³⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³³⁸ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.

³³⁹ Ibid.

³⁴⁰ Ibid.

competing demands”³⁴¹ offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

Background

VHA, as an agency within a cabinet department, is accountable to the secretary of Veterans Affairs (SECVA) and to the President. This framework, when it works well, can provide VHA access to, and support from, the President and White House staff. Like other executive branch agencies, VA and VHA undergo Office of Management and Budget (OMB) oversight; must win OMB approval of proposed rulemaking, budgets, IT development, and performance plans; and are also subject to governmentwide regulation of such areas as procurement, personnel, and property management. VHA health care and operations are subject to close congressional scrutiny.³⁴² VHA undergoes oversight from several independent bodies, including the internal Office of the Inspector General audits and external Government Accountability Office audits.

Within VA, VHA participates in the VA Executive Board (VAEB) and Senior Review Group, which are designated as the principal governance bodies of the department.³⁴³ VAEB serves as the department’s risk-governance board and determines VA’s strategic direction. VAEB oversees the department’s planning, programming, budgeting, and execution. Notwithstanding certain strengths inherent in this framework, VHA governance can be paralyzed by bureaucratic decision-making processes and competing stakeholder concerns.³⁴⁴

Among its principal recommendations, the *Independent Assessment Report* calls for “establishing a governance board to develop fundamental policy, define the strategic direction, insulate VHA leadership from direct political intervention, and ensure accountability for the achievement of established performance measures.”³⁴⁵

Analysis

In recent years, VHA leadership priorities and strategic direction have been unclear. Leaders have been consumed by crisis and by responding to congressional demands, creating a reactive, rather than proactive environment.³⁴⁶ Additionally, the leadership vision has lacked continuity.³⁴⁷ The SECVA and deputy secretary of Veterans Affairs may exercise oversight of

³⁴¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³⁴² “Legislation,” U.S. House of Representatives, House Committee on Veterans’ Affairs, accessed June 15, 2016, http://veterans.house.gov/legislation?type=hearing&tid=All&tid_1=All&page=3. Over the course of calendar year 2015, the House Veterans Affairs Committee and its subcommittees alone held 18 oversight hearings relating to the Veterans Health Administration, with VHA and/or VA officials testifying as often as three times in a month.

³⁴³ Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014).

³⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 26, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³⁴⁵ *Ibid.*, 23.

³⁴⁶ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 52-54.

³⁴⁷ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, vi-viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Linda Belton, former VHA VISN Director and Director of National Center for Organizational Development, written submission to the Commission on Care Staff, January 19, 2016.

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VHA and try to impose accountability, but incumbents do not necessarily have experience in federal health care administration or delivery.³⁴⁸ The SECVA has often lacked independent information and metrics on VHA performance, and the oversight, risk management, and compliance functions of VHA report to the undersecretary for health (USH) or to lower officials in VHA.³⁴⁹

Previous studies, dating back 20 years,³⁵⁰ have proposed fundamental change in VHA's governance and government structure, to include a proposal that it be restructured as a government corporation.³⁵¹ The earliest rationale for making VHA a government corporation was based on the view that the system needed a new service-delivery strategy,³⁵² and envisioned specific legislation to permit the corporation to operate more expansively under a wide range of reforms.³⁵³ Although the authors of the 1996 report presented a VHA government

³⁴⁸ Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Under Secretary of Health, 38 U.S.C. § 305. While statute requires the USH of VHA to be appointed “solely on the basis of demonstrated ability in the medical profession, in health-care administration and policy formulation, or in health-care fiscal management; and on the basis of substantial experience in connection with the programs of the Veterans Health Administration or programs of similar content and scope” there is no such selection criteria for the VA Secretary or VA Deputy Secretary. Of the eight men to hold the position of Secretary of Veterans Affairs, only one, James Peake would qualify to be USH (“United States Secretary of Veterans Affairs,” Wikipedia, accessed June 15, 2016, https://en.wikipedia.org/wiki/United_States_Secretary_of_Veterans_Affairs#List_of_Secretaries_of_Veterans_Affairs) and of the six men to hold the position of DEPSECVA, none would qualify to be USH.

³⁴⁹ Department of Veterans Affairs, *2014 Functional Organizational Manual v2.0: Description of Organization Structure, Missions, Functions, Tasks, and Authorities*, 57-58, accessed June 15, 2016, http://www.va.gov/ofcadmin/docs/va_functional_organization_manual_version_2.0a.pdf.

³⁵⁰ Veterans Benefits Improvement Act of 1994, Pub. L. No. 103-446, 108 Stat. 4645 (1994). In 1994, Congress in sec. 1104 of Public Law 103-446 called for an independent examination of the justifiability of establishing an alternative government structure to provide health care services for veterans, culminating in the 1996 report.

³⁵¹ Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. A government corporation has been described as “a government agency that is established by Congress to provide a market-oriented public service and to produce revenues that meet or approximate its expenditures.” Kevin R. Kosar, Congressional Research Service, *Federal Government Corporations: An Overview*, 2, accessed June 15, 2016, <https://fas.org/sgp/crs/misc/RL30365.pdf>. Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report* September 22, 2015. Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce*, accessed June 15, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>. Commission on the Future for America's Veterans, *Preparing for the Next Generation*, 3, accessed June 15, 2016, http://s3.amazonaws.com/siteninja/site-ninja1-com/1438121489/original/2014-05_Commission-Report-on-America-Veterans.pdf. That task force study, for example, called for an independent governance model and stated that “the operational structure of VHA does not lend itself to progress. Due to its size, governmental structure and geographic extension it does not readily foster innovation and faces challenges in addressing the politics of changing demographics and ancient facilities.” The study report states, “VHA provides excellence in care in spite of its operations/governance structure, not because of it.”

³⁵² Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. The strategy was premised in part on the view that VHA would be operating in a resource-constrained environment and lacked the resources it would need to invest in making significant changes.

³⁵³ Ibid. The 1996 report proposed such measures as providing VHA authority to seek additional revenue streams, to include billing and keeping funds from Medicare, Medicaid, and other government sources; authorizing it to invest nonappropriated funds; developing a trust fund for deposit of Medicare taxes by active-duty personnel; incorporating VHA as a Federal Employee Health Benefits Plan selection; allowing it to become part of health maintenance organization (HMO) networks and open HMO enrollment to veterans; changing appropriation law to create

corporation as a means of achieving specific objectives, those objectives were largely met (though ultimately not fully sustained) by reforms within existing government structures and processes set in place by former USH Kenneth W. Kizer.³⁵⁴

Nearly 20 years later, the report analyzing the root causes of delayed care at the Phoenix and other VA centers proposed creation of “governance mechanisms to bridge ‘Secretary suite’ leadership transitions and provide more stable strategy, oversight, and stewardship.”³⁵⁵ Explaining that “the study team feels that the complexity of this organization requires a more stable and professionalized governance model that more closely resembles the governance of large health care systems in the private sector,”³⁵⁶ the study authors proposed the creation of a board-of-directors-type oversight board to set the strategy for the organization, define priorities, provide operational oversight, and review budget requests. “The board would . . . create a body that would be the steward of the organizational vision, providing institutional memory and continuity as senior political appointees transition.”³⁵⁷

Frequent turnover of the USH is a critical problem. Recently, each USH has served for only a relatively short period, leaving office with a change in administration or sooner. This pattern has deprived VHA of vitally needed sustained leadership and has likely contributed to short-term decision making. VHA history shows a connection between longer tenure and transformative accomplishment.³⁵⁸ As testimony to the Commission from three former USHs would indicate, brevity of tenure tends to limit leaders’ strategic horizon and create a pattern of leadership discontinuity. Because transformative change can only be realized through many years of focused leadership, VHA and those who depend on it cannot afford the senior leadership turnover routinely associated with a change in administration.

The complex, sustainable transformation VHA needs will take years to implement. To succeed, VHA needs strong, consistent leadership and a governance framework that can assure effective development and execution of transformation plans over time. The current governance structure emphasizes operational, rather than strategic priorities; experience has shown it to be incapable of sustaining transformational change. Establishing a well-designed, overarching-governance model would provide an opportunity to achieve objectives shared by both the executive and legislative branches.

To be effective, a VHA Care System governance model should be empowered with a governing board that exercises fiduciary-like responsibilities (not subject to the Federal Advisory Committee Act) to carry out the following key functions:

multiyear/no-year appropriations; reforming human resources management practices for increased flexibility in hiring and firing, compensation, leave, and other functions; and reforming; and reforming procurement and contracting.

³⁵⁴ Ibid., 46, 48. The Klemm report saw a VHA corporation as having greater capacity to focus on strategic as well as short term goals; greater results orientation; greater flexibility; greater capacity to replicate and develop best practices; upgraded staff competence and expertise at senior levels; and greater political independence.

³⁵⁵ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 59.

³⁵⁶ Ibid.

³⁵⁷ Ibid.

³⁵⁸ See Dr. William S. Middleton, Chief Medical Director (1955-1963) and Dr. Kenneth W. Kizer, Under Secretary for Health (1994-1999).

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- select the chief of VHA Care System (CVCS) and recommend the appointment of the CVCS to the President
- provide long-term, strategic direction for VHA Care System and establish priorities, milestones, and timelines
- oversee, direct, and make critical decisions regarding the transformation process
- review and approve major operational, business, and organizational plans
- set VHA Care System performance objectives and provide annual reports to Congress and the President on VHA Care System performance
- review and make decisions regarding VHA's budget request, and independently assess and report to Congress on the adequacy of VHA budgets

New governance and changes to assure continuity of leadership are critical to meeting the needs of VHA and veterans who depend on it. At the core of this foundational recommendation, the Commission calls for establishing a VHA board of directors,³⁵⁹ referred to as the VHA Care System governing board, which is independent of department leadership to provide governance, strategic direction, decision making, and oversight of VHA Care System's operations and transformation. Table 5 provides details regarding the governing board.

Table 5. Overview of VHA Care System Governing Board

Detailed Outline for VHA Care System Governing Board	
Voting Members	The President, the majority leader of the Senate, speaker of the House, the minority leaders of the Senate and House would each appoint two members. In addition, the SECVA would serve on the Board as a voting member.
Qualifications	Members would be selected to achieve collectively broad experience, expertise, and leadership, such as experience in senior management of large, private, integrated health care systems; clinical expertise; extensive experience with federal government health care systems; extensive experience with (though not current employment in) VHA; expertise in federal medical facility construction and leasing, and commercial property transactions; expertise in government contracting; expertise in federal health care budgeting and finance; expertise in health equity and disparities; and veterans' representation. Because of the importance of veterans' representation, at least one of each congressional leader's two appointees would be a veteran; at least one of the appointees of the President would be a veteran who receives VHA care.

³⁵⁹ Michael A. Froomkin, "Reinventing the Government Corporation," *University of Illinois Law Review*, (1995): 543, accessed June 15, 2016, <http://osaka.law.miami.edu/~froomkin/articles/reinvent.htm>. Congress need not create a government corporation to meet VHA's governance needs. The Commission notes that Congress has created entities it has called government corporations that are not predominantly commercial enterprises, rely on appropriations, and do not have the potential to become self-sustaining. A principal intention behind assigning this status and title has been to provide insulation from central management oversight agencies and the application of general management laws. When the corporation relies in whole or in part on appropriations, Congress retains the power of the purse, and the means of exercising it on matters large and small, and through formal and informal means.

Detailed Outline for VHA Care System Governing Board	
Terms	Governing board members would serve staggered terms of up to 7 years, with the governing board members electing a chair and vice chair from among the membership (other than the SECVA, who would not be eligible to serve as the chair) for 3-year terms.
Personnel Matters	Compensation would be at a rate equal to the daily equivalent of annual pay prescribed for level IV of the executive level. ³⁶⁰
Funding	Congress would provide a specific budget for the operation of the governing board as a separate account within VA's appropriations.
Relationship to the CVCS	Relationship to the CVCS: The governing board would provide the President its recommendation for a chief of VHA Care System (CVCS); the President would appoint that executive to a 5-year term; the governing board would annually review the CVCS's performance and be empowered to reappoint that official to a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. The CVCS can be removed by mutual agreement of the President and the governing board.
Staff	The chairperson would determine the size and compensation of the permanent staff of the board, including an executive director responsible for governing board operations and a chief of staff. The director of the proposed transformation office within VHA would report to the chairperson through the CVCS.
Powers	<p>The board would have the power to do the following:</p> <ul style="list-style-type: none"> ▪ Select the CVCS and recommend the candidate to the President. ▪ Review the performance of the CVCS on an annual basis. ▪ Reappoint the CVCS to a second 5-year term. ▪ Remove the CVCS with the mutual agreement of the President. ▪ Direct and exercise decision-making authority regarding the transformation process and operations related to the transformation process. ▪ Establish priorities, milestones, and timelines for the transition process. ▪ Review and approve major new initiatives; major operational and organizational plans (including plans regarding capital asset and facility management); strategic and business plans; and goals and metrics for operational performance and established priorities. ▪ Oversee and manage facility and capital asset strategies and operations. ▪ Review, approve, and/or amend VHA's budget requests, and independently assess and comment on pertinent elements of the President's budget, as deemed appropriate.
Reporting	The board would report annually to the President and Congress on VHA's progress toward transformation.

Navigating transformation of one of the largest agencies in the federal government requires not only extraordinary leadership, but steady, sustained, long-range-focused governance. A governing board structured to provide continuity of membership—as the Commission proposes through staggered terms among members—is vital. A second critical step toward assuring such continuity would be to address the tenure of the CVCS and the process for selecting candidates for that position.³⁶¹ VHA, Congress, and the President would be better served by a VHA leader who holds a 5-year term of office, with the governing board empowered to reappoint that leader to a second 5-year term.

³⁶⁰ The rate of compensation provided for members of the Commission on Care.

³⁶¹ Under Secretary of Health, 38 U.S.C. § 305. Current law provides that the Under Secretary is appointed by the President with the advice and consent of the Senate. When a vacancy in that position occurs or is anticipated, the Secretary is to convene a commission (the composition of which is set forth in the statute) which is to recommend at least three individuals to the Secretary, who is to forward those names, with any comments the Secretary considers appropriate, to the President.

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It is important that that the CVCS report to the board and function as a chief executive officer of VHA. Although the Commission envisions that the President would appoint this official, it is critical that the governing board be empowered to recommend to the President an individual for appointment when the office becomes vacant. This would replace the framework in current law that requires the establishment of a new commission convened solely to carry out the task of recommending candidates to the President.³⁶²

A governing board must be tailored to the unique needs of VHA.³⁶³ It should include members of appropriate expertise and experience to provide strategic guidance and continuity of leadership and it should possess authority to exercise the powers needed to realize and sustain a VHA transformation.³⁶⁴

Although some might consider Congress to be VA or VHA's board of directors and might question the appropriateness of establishing a VHA board of directors, this governance model does not diminish Congress's role. Instead, a board that would report periodically to congressional committees would provide a level of close oversight and health care expertise that would complement, and in many ways enhance, Congress's work.

A change in governance alone will not bring about successful transformation. This recommendation must be instituted in concert with many other Commission recommendations. For example, a board will require data, and data systems, to carry out its responsibilities, and establishing these and other appropriate systems, as addressed throughout this report, is key to empowering a board to drive and sustain transformation.

Implementation

Legislative Changes

- Amend 38 U.S.C., Chapter 3 to establish a VHA Care System governing board.
 - Amend 38 U.S.C. § 305 – which currently provides in subsection (a) for the President to appoint the USH by and with the advice and consent of the Senate, and subsection (c) for the establishment of a commission to provide recommendations for appointees for USH when a vacancy is expected or has occurred – as follows:
 - Amend subsection (a) to provide for the President to appoint the CVCS to a 5-year term of office.
 - Repeal subsection (c) of that section.
 - Provide instead for the governing board to recommend a CVSC candidate.
 - Authorize the governing board to reappoint the CVSC to a second 5-year term.

VA Administrative Changes

- None required.

³⁶² Under Secretary of Health, 38 U.S.C. § 305.

³⁶³ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 60.

³⁶⁴ The Board is not an advisory body, and as such would not be subject to the Federal Advisory Committee Act.

Other Departments and Agency Administrative Changes

- None required.

Leadership

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

Problem

High-performing organizations have healthy cultures in which diverse staff members feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government.³⁶⁵ For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

The Commission Recommends That . . .

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report to the chief of the VHA Care System and the new VHA Care System governing board (also included in Recommendation #12).

Background

Healthy organizations successfully align, execute, and renew themselves through learning and innovation.³⁶⁶ They are characterized by a high level of trust, accountability, and ownership among staff; high functioning, empowered teams; and an environment that provides psychological safety and open communication, focuses on the needs of customers, and instills pride in performance.³⁶⁷ An inclusive workplace where diversity is valued, staff feel empowered and supported, are treated with fairness, and cooperation and open communication helps engage employees and drive organizational performance.³⁶⁸ Engaged

³⁶⁵ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 56, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

³⁶⁶ "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, <http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage>.

³⁶⁷ [http://organizationalhealth.vssc.med.va.gov/Resource percent20Library/Forms/AllItems.aspx](http://organizationalhealth.vssc.med.va.gov/Resource%20Library/Forms/AllItems.aspx)

³⁶⁸ "Diversity & Inclusion; Federal Workforce At-A-Glance," U.S. Office of Personnel Management, accessed May 13, 2016, <https://www.opm.gov/policy-data-oversight/diversity-and-inclusion/federal-workforce-at-a-glance/>.

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employees who are dedicated to their work and attached to the organization and its mission support a healthy organization.³⁶⁹

Companies that have a healthy organizational culture or engaged staff outperform those that do not. Companies that score in the top 25 percent of organizational health metrics outperform comparable companies in the bottom 25 percent by more than two-fold.³⁷⁰ Similarly, high employee engagement is correlated with better staff and customer experiences that include higher patient satisfaction, higher staff retention, better safety and quality, higher productivity and lower absenteeism.³⁷¹ Companies with engaged employees outperform those without by more than 200 percent.³⁷² Leaders and supervisors play a key role in establishing and sustaining employee engagement and in establishing a positive environment and culture that supports a healthy organization.³⁷³

Analysis

VHA staff and leaders are highly dedicated to the mission of VA and to serving veterans.³⁷⁴ This dedication is arguably VHA's greatest strength, and it can be leveraged to create and sustain positive change.³⁷⁵ There are substantial impediments to moving VHA forward, however, as noted in the *Independent Assessment Report*. There is a pervasive lack of trust throughout the organization.³⁷⁶ Staff perceives VHA to be bureaucratic and political and to lack a systems orientation.³⁷⁷ Employees want to work for an organization that is accountable and efficient, but instead they operate in a bureaucratic, siloed, and political organization.³⁷⁸ The culture creates risk aversion in staff, and when cultural factors are measured in VHA, none of the metrics align with the definition of a healthy organization.³⁷⁹ Staff find the work environment at VA challenging, with no connection to leadership, and feel they receive little positive

³⁶⁹ U.S. Office of Personnel Management, *Strategic Plan FY2014-2018: Recruit, Retain, and Honor*, 22, accessed January 25, 2016, <https://www.opm.gov/about-us/budget-performance/strategic-plans/2014-2018-strategic-plan.pdf>. Office of Management and Budget, *Memorandum for Heads of Executive Departments and Agencies: Strengthening Employee Engagement and Organizational Performance*, M-15-04, December 23, 2014, accessed May 16, 2016, <https://www.whitehouse.gov/sites/default/files/omb/memoranda/2015/m-15-04.pdf>.

³⁷⁰ "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, <http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage>.

³⁷¹ U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015, 4. Melissa Bottrell, *Ethics Quality Helps Build Healthy Organizations*, VHA Organizational Health, Volume 19, Summer 2013, 4-5, accessed January 25, 2016, http://www.ethics.va.gov/docs/integratedethics/art_bottrell_orghealth_v19_2013.pdf.

³⁷² U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015, 4. Dee Ramsel, Improving VHA's Culture: A Presentation Before the National Leadership Council, Veterans Health Administration, December 2015, 7-9. U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change*, 6, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.

³⁷³ Dee Ramsel, "Improving VHA's Culture. A Presentation Before the National Leadership Council, Veterans Health Administration," December 2015, 7-9.

³⁷⁴ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 43, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

³⁷⁵ *Ibid.*, 44.

³⁷⁶ *Ibid.*, 47.

³⁷⁷ *Ibid.*, 46.

³⁷⁸ *Ibid.*, 46.

³⁷⁹ *Ibid.*, 49-51.

reinforcement or clear feedback on performance.³⁸⁰ As demonstrated in the Federal Employee Viewpoint Survey for 2015, VHA staff does not believe top leaders lead (only 47 percent positive³⁸¹) and only 65 percent have a positive view of their immediate supervisor compared to 70 percent in other large federal agencies.³⁸²

Through the review of available documents and briefings from key staff, the Commission found VA and VHA have a number of activities intended to support a positive environment and culture in VHA (see Table 6), but the efforts are not systematic, integrated, or broadly deployed.³⁸³ The efforts are under-resourced to achieve success. Specifically, the effort lacks mandatory positions at the facilities to lead these efforts and has no requirements on the VHA Central Office (VHACO) program offices to participate in the efforts.³⁸⁴ At the same time, the efforts are duplicative in that multiple offices communicate similar, but distinct messages to field staff and leaders. VHA appears to lack systematic mechanisms to ensure leaders at all levels of the organization have the knowledge, skills, and ability to create an effective culture; metrics are not comprehensive or aligned with a single-change model; and leaders in VHACO and the field are not consistently held accountable for their actions in support of a positive organizational culture.³⁸⁵

*Table 6. Cultural Transformation Efforts in VA and VHA*³⁸⁶

Program/Initiative	Responsible Office
Servant Leadership	VHA National Center for Organizational Development
Leaders Developing Leaders	MyVA
Just Culture	VHA National Center for Patient Safety
Civility, Respect, and Engagement in the Workplace (CREW)	VHA National Center for Organizational Development
Organizational Transformation Pilot	MyVA
Employee Engagement Playbooks	MyVA
VHA Voices	VHA Office of Patient Centered Care and Cultural Transformation

³⁸⁰ Ibid., 53 and 60.

³⁸¹ U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change*, 47, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.

³⁸² Ibid.

³⁸³ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 29-31. Dee Ramsel, Virginia Ashby Sharpe, Veterans Health Administration, conference call with staff of the Commission on Care, November 9, 2015.

³⁸⁴ See “Ethical Leadership, Fostering an Ethical Environment and Culture,” National Center for Ethics in Health Care, U.S. Department of Veterans Affairs, accessed June 22, 2016, <http://www.ethics.va.gov/integratedethics/elc.asp>. “Stop the Line for Patient Safety Initiative,” U.S. Department of Veterans Affairs, accessed June 22, 2016, <http://www.qualityandsafety.va.gov/StoptheLine/StoptheLine.asp>. “VHA Center for Organizational Development,” U.S. Department of Veterans Affairs, accessed from VA Intranet, May 16, 2016, http://vaww.va.gov/NCOD/Organizational_Health.asp. U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015.

³⁸⁵ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 13-14. Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan, Network Director and Medical Center Director*, November 20, 2015.

³⁸⁶ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 29-31.

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VHA must rebuild a high-performing, healthy culture by cultivating greater employee collaboration, ownership, and accountability to accomplish its mission.³⁸⁷ This cultural transformation needs to occur at all levels of the organization (VA, VHACO, veterans integrated service network [VISN], VA medical center, and community-based outpatient clinic). To achieve transformation in VHA, create a healthy environment and culture, and sustain staff engagement, the solution must start with leaders. Leaders must understand and believe in the powerful effect they have on the climate and culture in their organization. Change occurs one employee at a time. Leaders at all levels must commit to this change process. They must be inspired by top executives and embrace the values and mission of VHA and then, in turn, inspire their teams, engaging with individual employees to make change. Leaders must be given the roadmap and tools to make such change and then be supported with training, coaching, and feedback to achieve success. They must also be held accountable for their personal behavior and for the actions they take to positively influence the environment and culture of their unit or facility. Leaders should not be on their own in this transformation. Fellow leaders, outside experts, national program offices, and VA and VHA top executives must provide them with incentives, support, feedback, coaching, and, when needed, admonishment to support this cultural transformation.

To align leaders at all levels with expectations for the cultural transformation, all leaders must understand the role they play in the process. VHA must create standards for the behavior and actions leaders adopt to accomplish the transformation and widely publicize the standards among leaders and staff to establish uniform expectations across the organization and a single vision of cultural transformation. The CVCS and other senior leaders must model and reinforce these behaviors to further embed expectations. These behaviors and actions should be integrated into leadership assessment tools such as a 360 evaluation, performance management frameworks, and coaching guides to ensure expected behaviors and actions are reinforced across the leadership development and advancement system. The strategy must include the development of tools, training, guidelines, and operating procedures that create a living curriculum to support leaders in developing and deploying these new skills and behaviors. Finally, to ensure leaders at all levels implement the behaviors and actions, the strategy must establish both explicit rewards and sanctions. The rewards and recognition (nonmonetary) should liberally acknowledge and publicize leaders and staff who embody the very best standards of behaviors and actions that support a positive organizational culture. At the same time, leaders and staff at all levels must clearly understand what behavior and actions are not acceptable and be held accountable through disciplinary action if they cross these boundaries. Expectations and repercussions should be clearly articulated.

VA and VHA have a number of competing models of organizational health and staff engagement. The models are not integrated with one another or with an overall leadership competency model. Some models are robust, coupling abundant resources and training, while others are not. To create a clear focus for engagement and organizational health and guide

³⁸⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 55 accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

transformation effectively, one model must be selected for use in VHA. To do so, VHA must establish a cross functional executive team to make this decision. The team should include all of the stakeholder offices involved in current efforts, but none of them should lead the effort, to avoid parochial interests driving decisions. Once a single model is selected, the executive team must then outline a clear strategy, involving and engaging the offices in VHA with relevant expertise and resources to support the execution, and put forward a single strategic plan. Consequently, each of those offices must also be required to stand down its own efforts that are not part of this new model going forward and align its work and budget behind a single focused model and strategy. Tools, training, and communication to support broad deployment must be part of the strategy, and the CVCS and the executive team must present a compelling, transparent rationale for what the model is, why it was selected, and how it is to be deployed. All leaders and staff members in the organization must understand their roles in cultural transformation and what is expected of them.

The strategy must establish and articulate a clear set of behaviors and actions expected of staff to ensure their alignment around the transformation. The standards should be incorporated into the hiring process to ensure that VHA is hiring into the new culture and avoids a poor fit from the start. These behavioral expectations must be articulated clearly in the on-boarding process and reinforced on an ongoing basis in performance evaluations, reviews, and individual development plans. Leaders at all levels of the organization must also reinforce these behavioral expectations with staff and be provided with tools, messages, and communication support to accomplish this. Leaders must also recognize and reward the positive examples of the desired behaviors and sanction the worst examples, up to and including discipline and removal.

The change strategy should also recognize that cultural transformation and staff engagement go beyond individual leader and staff behaviors. Systems and processes at both the local and national level can impede the realization of the positive organizational culture desired. As such, the transformation strategy must also anticipate changing systems and processes as an explicit component of transformation. Leaders at all levels must establish mechanisms to elicit staff concerns and have quality improvement tools in place to address them, such as LEAN Six Sigma. Line staff must be engaged as part of the solution to these system issues. Leaders should be transparent about these issues and publicly track and report on progress.

To ensure the effective execution of this strategy, specific responsibilities must be assigned to program offices. The program offices must also support the VISN and facilities in their transformation effort by developing the standards and guidance for them to use and making program office expertise available to support coordination, coaching, and sharing of best practices across the institution. The program offices must be held accountable for supporting the application of these same standards and process within VHACO.

Standards for facility implementation must include a funded, full-time equivalent employee to support each major facility director³⁸⁸ and be the point person to coordinate efforts with VHACO and other facilities. Facilities may take the opportunity to consolidate related functions that currently exist in the facility. Each facility must have a local mechanism, such as an organizational health council, to integrate and drive transformation locally. But this does not

³⁸⁸ This equates to one person at each of the approximately 141 VHA health care systems led by a facility director.

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mean the facility should create yet another committee or oversight group to accomplish the transformation. Instead, facilities must look to existing leadership structures and activities, consolidating similar efforts to create an efficient process.

Finally, the executive team must oversee the development of a consolidated and meaningful set of metrics, using community standards where available, to track cultural transformation, organizational health and staff engagement. The metrics should not only measure the desired outcomes but also provide insights to leaders on how to fix problems by providing sufficient detail and specificity to offer this insight. Once deployed, the metrics should be used by the executive team and responsible program offices to identify under-performing facilities and to provide additional expertise, resources, and support to help those facilities improve. If, after much support, the continuing behavior and actions of the leaders at the under-performing facility are identified as the cause of the long-term culture problem, these individuals must be removed from leadership positions in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Develop and implement a strategy for cultural transformation.
- Establish a cross-functional senior executive team reporting directly to the CVCS with long-term responsibility for creating, executing, and tracking the cultural transformation.
- Align frontline staff in support of the cultural transformation strategy.
- Require standards and a strategy for execution of the cultural transformation from every program office and facility and these efforts must be fully funded.
- Develop consolidated, meaningful metrics for organizational health and staff engagements with input from experts and field users.

Other Department and Agency Administrative Changes

- None required.

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

Problem

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an Office of Management and Budget management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Background

*Our Corps does two things for America: We make Marines and we win our nation's battles. Our ability to successfully accomplish the latter depends upon how well we do the former.*³⁸⁹

Effective leaders are required for organizational success. Thus, attracting, growing, and advancing leaders is a key business imperative across all sectors.³⁹⁰ The most urgent human capital management need worldwide, according to one survey, is the development of leadership talent.³⁹¹ This need is driven by a changing workforce that is motivated more by passion than by monetary incentives, a rapid advance in knowledge that quickly creates obsolescence, and technology drivers that change business practices over months instead of years.³⁹² Investing in new supervisors and emerging leaders is critically important because

³⁸⁹ U.S. Marine Corps, *Sustaining the Transformation*, Foreword, accessed June 9, 2016, [http://www.marines.mil/Portals/59/Publications/MCRP percent206-11D percent20Sustaining percent20the percent20Transformation.pdf](http://www.marines.mil/Portals/59/Publications/MCRP%20206-11D%20Sustaining%20the%20Transformation.pdf).

³⁹⁰ Jim Collins, *Good to Great: Why Some Companies Make the Leap . . . And Others Don't* (New York, NY: HarperCollins Publishers, Inc., 2001), 17-40. Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015).

³⁹¹ Deloitte Consulting LLP and Bersin by Deloitte, *Global Human Capital Trends 2014: Engaging the 21st Century Workforce*, 25, accessed June 10, 2016, http://dupress.com/wp-content/uploads/2014/04/GlobalHumanCapitalTrends_2014.pdf.

³⁹² *Ibid.*, 3.

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employees report that when they quit a job they leave their supervisors and not their organization.³⁹³ In an organization like VHA, with more than 300,000 employees but only a bit more than 200 executives, VHA's 28,000 supervisors are responsible for leading the staff.³⁹⁴

Going back to at least 1998, the federal civilian sector has had difficulty identifying and promoting individuals with leadership skills.³⁹⁵ Staff members who can produce results and meet organizational objectives are promoted into supervisory and leadership positions.³⁹⁶ Yet, the skills needed to be a successful leader are different than those needed to be a successful technical expert. Today, soft skills such as empathy, effective listening, and team coaching are valued in leaders.³⁹⁷ The most effective leaders are those who consistently display integrity, high moral character, and the ability to inspire others.³⁹⁸ An effective leadership system develops leaders at all levels, from frontline supervisor to executives, and does so in all dimensions of leadership: "knowing, doing, and being."³⁹⁹

Analysis

In a review of VHA's approach to leadership development, the *Independent Assessment Report* noted the current system was not sufficient to meet VHA's need for high-quality, prepared leaders.⁴⁰⁰ VHA lacks a comprehensive approach to leadership development that would include formal structured programs such as networking, reflection, goal setting, learning, mentoring, experiential learning, and a clear career ladder. As a result, leaders are unable to fully prepare

³⁹³ "People Leave Managers, Not Companies," Victor Lipman, accessed June 10, 2016, <http://www.forbes.com/sites/#/sites/victorlipman/2015/08/04/people-leave-managers-not-companies/#78b15df216f3>.

³⁹⁴ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 21-23, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

³⁹⁵ U.S. Merit Systems Protection Board, Office of Policy and Evaluation Perspectives, *Federal Supervisors and Strategic Human Resources Management*, accessed June 10, 2016, <http://www.mspb.gov/netsearch/viewdocs.aspx?docnumber=280538&version=280868&application=ACROBAT>.

³⁹⁶ Ibid. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

³⁹⁷ Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. "Creating and Retaining Great Leaders," Dominique Jones, accessed June 10, 2016, <http://www.hrreview.co.uk/analysis/analysis-hr-news/dominique-jones-creating-and-retaining-great-leaders/60419>. "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, <http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success>.

³⁹⁸ Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015). "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, <http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success>. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

³⁹⁹ Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. U.S. Marine Corps, *Sustaining the Transformation*, accessed June 9, 2016, http://www.marines.mil/Portals/59/Publications/MCRP_percent206-11D_percent20Sustaining_percent20the_percent20Transformation.pdf.

⁴⁰⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

for future roles.⁴⁰¹ Although VHA does have some components of a development program, the activities are not connected to a career path and not well coordinated. Comprehensive development efforts are impeded by the use of multiple competing competency models in VA that make it impossible to align assessment and development with a cohesive standard. Emerging leaders are left to navigate career progression largely on their own and may be stymied because development opportunities are cancelled due to budget restrictions. Even when promising young leaders complete the current activities, gaps remain in their experience and training because the training programs are not coordinated.⁴⁰² As a result, VHA does not have a robust pipeline of young leaders ready to take on higher-level responsibilities.⁴⁰³

Included in the *Independent Assessment Report* is a recommendation that VA stabilize, grow, and empower leaders. This recommendation includes suggestions to fill current vacancies with high-quality leaders, improve the attractiveness of the roles, ensure leaders are prepared to assume their roles, and create a comprehensive strategy that connects top performers to leadership opportunities and development plans.

There is little concrete information in the assessment to suggest how VA and VHA should accomplish these objectives. The commission examined VA's and VHA's current work to assess whether they have created plans to operationalize the leadership development recommendations articulated in the *Independent Assessment Report*.

Neither VA nor VHA has rationalized the multiple competency models within the department. A competency model is the core driver informing recruitment, development, assessment, and advancement in any comprehensive approach to leadership development and management.⁴⁰⁴ Having a cogent competency model is a prerequisite to a coherent strategy.⁴⁰⁵ Leading a health care organization requires specialized knowledge and skills not required of leaders in other fields.⁴⁰⁶ Thus, any competency model applied in VHA must include health care specific components. Health care executive competencies embrace such topics as an understanding of ethics in health care, management of self-governing professionals (e.g., physicians, nurses), the technical knowledge of health care regulation and operational management, and leading change, in addition to other leadership skills and knowledge.⁴⁰⁷

The current models used in VHA do not reference external benchmarks, and they are not health care specific. VHA plans to continue to use the High Performance Development Model (HPDM) as its competency model.⁴⁰⁸ HPDM was developed by VHA and is not benchmarked to private-sector competency models for health care executives. VHA plans to use the model to drive

⁴⁰¹ Ibid.

⁴⁰² Ibid., 38.

⁴⁰³ Ibid., 37.

⁴⁰⁴ The American College of Healthcare Executives, *ACHE Healthcare Executive: 2016 Competencies Assessment Tool*, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf.

⁴⁰⁵ Ibid.

⁴⁰⁶ Ibid.

⁴⁰⁷ Ibid. "Joint Medical Executive Skills," Joint Medical Executive Skills Program, U.S. Department of Defense, accessed May 16, 2016, http://www.au.af.mil/au/awc/awcgate/leadership/med_exec_skills.htm. "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁰⁸ "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

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position requirements, performance management, and training content.⁴⁰⁹ The plan mentions coordination with VA Learning University but provides no detail.⁴¹⁰ The plan also does not provide specific information about how the use of HPDM will link to formal recruitment, performance assessment, and advancement of leaders.⁴¹¹

VHA is working to understand the current career progression of candidates who move into field-based executive positions. VHA field leaders are cultivated from within VHA with about 98 percent advancing from lower-level field positions such as associate director, service chief, or chief of staff.⁴¹² As a result, field senior executives often lack outside experience and first-hand knowledge of alternative management methods.⁴¹³ Most companies look for a mix of internal and external hires, and the circumstances of the organization often drive the mix.⁴¹⁴ For instance, Henry Ford Health System, a successful growing company with a robust internal leadership development program has set a target of 70 percent internal promotions and 30 percent external hires.⁴¹⁵

The VHA pool of internal candidates is also deficient in racial and ethnic diversity with striking under-representation of women of color in all of the positions that constitute the pipeline for medical center director positions (see Figures 6 and 7).⁴¹⁶ VHA leadership development programs have failed to effectively recruit and advance under-represented minorities with a striking over-representation of White men in the leadership class that feeds the senior executive service (see Table 7).⁴¹⁷ Minority women shoulder the biggest burden of formal mentoring within the organization.⁴¹⁸ VHA also has the lowest representation of veterans among its staff (31 percent) compared to Veterans Benefit Administration (52 percent) and National Cemetery Administration (74 percent). The number of veterans among doctors and dentists in VHA is only about 14 percent of the employees.⁴¹⁹ Among leaders, 22 percent of senior executives are veterans and a similar number (23.8 percent) populate the leadership pipeline.⁴²⁰

⁴⁰⁹ Ibid.

⁴¹⁰ Ibid.

⁴¹¹ Ibid.

⁴¹² Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A*, November 23, 2015.

⁴¹³ Ibid.

⁴¹⁴ Eric Krell, “Staffing Management: Look Outside or Seek Within?” *HR Magazine*, January/February 2015.

⁴¹⁵ “NCHL Health Leadership Competency Model,” National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

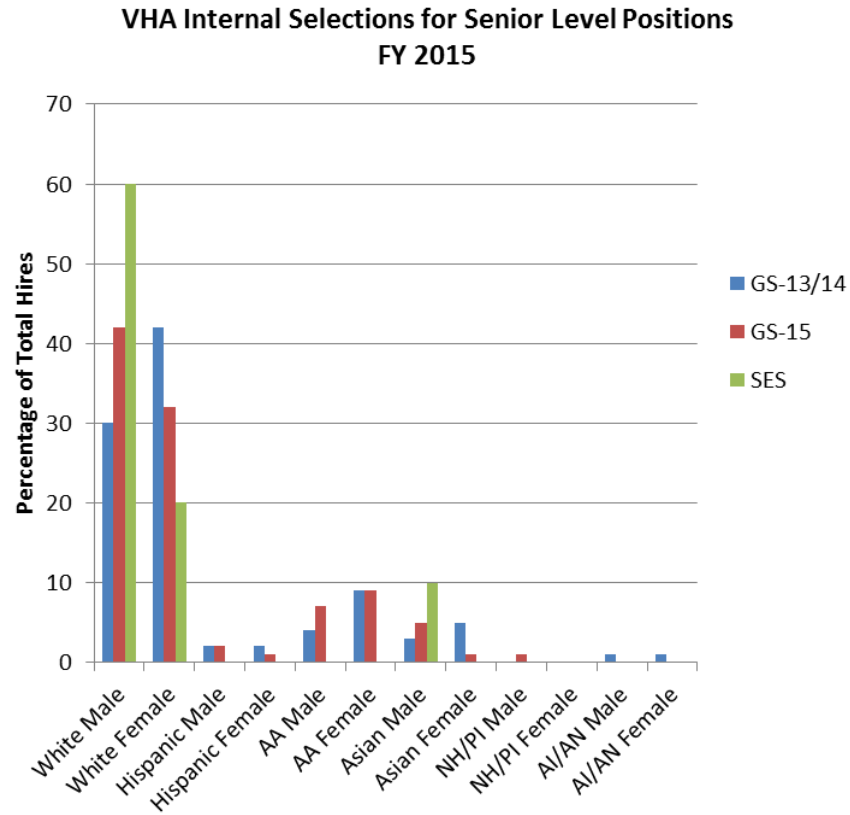
⁴¹⁶ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

⁴¹⁷ Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A*, November 23, 2015.

⁴¹⁸ Ibid.

⁴¹⁹ Health Care Talent Management Office from PAID and NOA, September 17, 2015: Path to Medical Center Director, Healthcare Leadership Talent Institute.

⁴²⁰ VHA Health Care Talent Management Office, provided to Commission on Care for employees in VHA as of September 30, 2015 by request, March 8, 2016.

Figure 6. Diversity of Senior-Level Hires in VHA

AA = African American

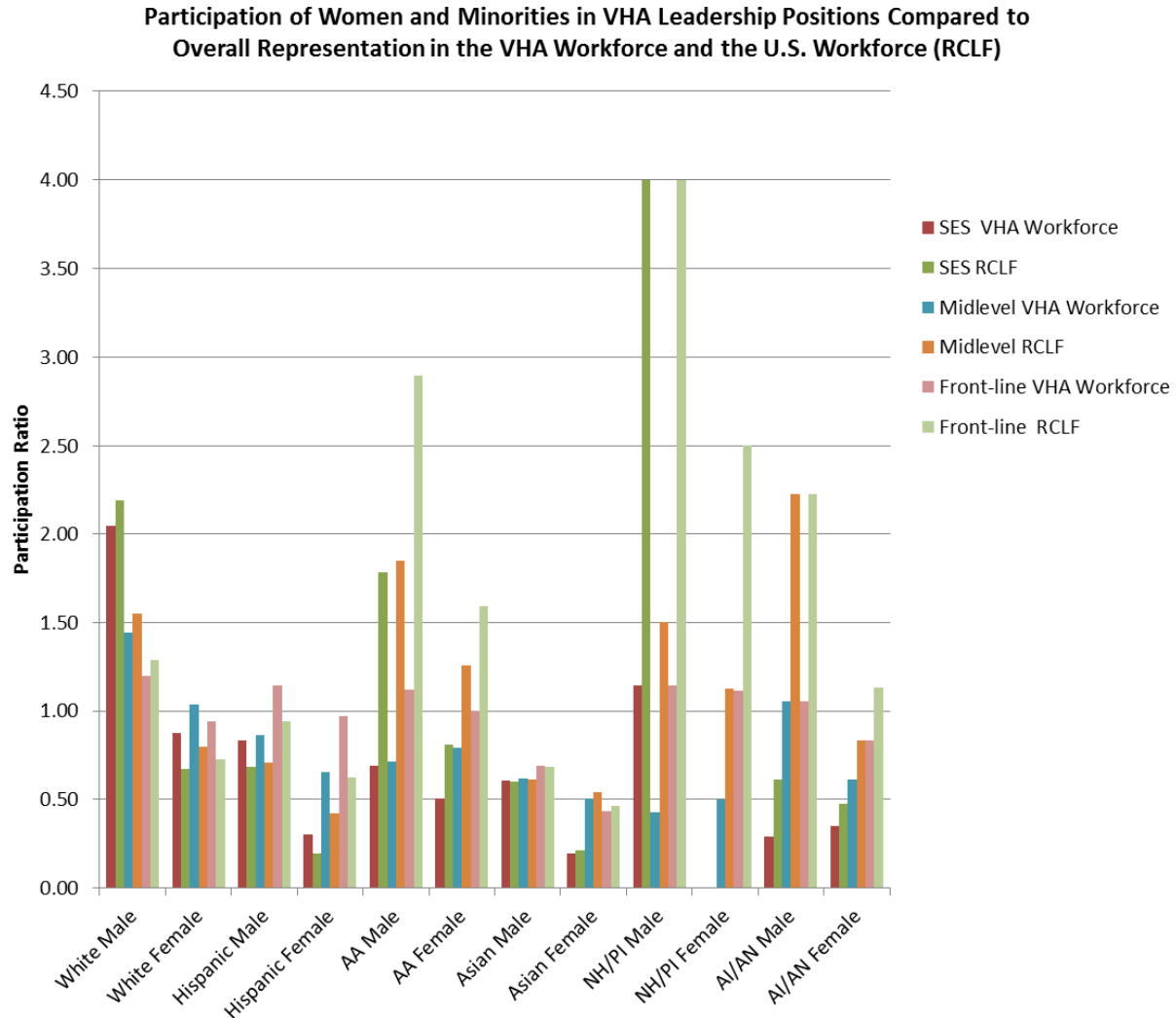
NH/PI = Native Hawaiian/Pacific Islander

AI/AN = American Indian/Alaska Native

Note: In FY 2015, VHA failed to select many candidates from diverse racial and ethnic backgrounds for senior executive positions. These data were drawn from the VHA annual equal employment opportunity (EEO) report.

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Figure 7. Minority Women are Under Represented in Higher-Level Positions in VHA



AA = African American

NH/PI = Native Hawaiian/Pacific Islander

AI/AN = American Indian/Alaska Native

Note: Women and particularly minority women are under-represented in comparison to their participation in the U.S. workforce (relevant civilian labor force [RCLF]) and their participation in the VHA workforce at higher levels in the organization. Some minority men are also under-represented in high-level positions. These data were derived from the VHA annual EEO report.

Table 7. White Males are Over Represented in VHA SES Development Program, HCLDP

	TCF 2015 (N)	GHATP 2014 (N)	Facility LEAD 2015 (N)	VISN/CO LEAD 2015 (N)	HCLDP 2015 (N)	VHA Workforce
White Male	35% (78)	30% (14)	19% (160)	22% (69)	41% (151)	23%
White Female	16% (35)	28% (13)	41% (342)	41% (127)	39% (144)	36%
African American Male	15% (33)	9% (4)	8% (66)	8% (24)	4% (14)	9%
African American Female	19% (42)	15% (7)	22% (180)	16% (50)	6% (23)	15%
Hispanic/Latino Male	4% (10)	4% (2)	3% (23)	4% (11)	1% (5)	3%
Hispanic/Latina Female	3% (7)	2% (1)	3% (29)	3% (10)	1% (4)	4%
Asian Male	4% (9)	2% (1)	1% (9)	>1% (2)	2% (7)	3%
Asian Female	2% (5)	9% (4)	2% (16)	4% (13)	3% (12)	5%
Native Hawaiian/Pacific Islander Male	0% (0)	0% (0)	>1% (3)	0% (0)	0% (0)	>1%
Native Hawaiian/Pacific Islander Female	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	>1%
American Indian/Alaska Native Male	2% (4)	0% (0)	>1% (1)	>1% (2)	1% (3)	1%
American Indian/Alaska Native Female	0% (0)	0% (0)	1% (7)	1% (4)	1% (3)	1%

Note: VHA offers career development opportunities from entry-level programs (TCF and GHATP) to an SES preparatory curriculum (HCLDP). Overall, White men make up about 23% of VHA employees but are over-represented in the HCLDP program at 41%. African American and Hispanic men and women are under-represented in the same program.

TCF= Technical Career Field; GHATP=Graduate Healthcare Administration Training Program; LEAD=Leadership, Effectiveness, Accountability, and Development; HCLDP=Health Care Leadership Development Program.

No evidence was presented to indicate that career progression mapping is occurring for positions within VHA central office, where high-quality leaders are also required.⁴²¹

⁴²¹ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

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VHA has much work to do to produce an effective leadership management system. Recruitment, retention, development and advancement are key processes that require immediate and sustained attention from VHA leaders. Without substantial changes, high-potential staff will continue to struggle to understand their career trajectory. Without a driving competency model and coordinated training to guide advancement, hiring decisions will continue to be made without uniform standards against which to measure applicants and new executive hires will continue to struggle to understand VHA and their role in leading it. Without the committed engagement and support of the chief of VHA Care System (CVCS) and the other top VHA executives for the leadership management system and their direct communications about and modeling of the leadership competencies, VHA will continue to flounder. As a result, veterans will be denied the high-performing health system they deserve.

Executive Commitment

The long-term success of any enterprise rests on having excellent leaders in key positions and sustaining them over time. To accomplish this goal, leadership management, development, and recruitment must be a core responsibility and a priority for VHA senior executives. To start, VA must include the goal of achieving an effective leadership management system in VHA as a component of the department's management agenda in the annual budget. The goal is a robust, high-quality, diverse leadership team in VHA. VA needs to establish a credible operational plan and accountability mechanisms for meeting this goal. Executive leaders are then held accountable for attaining the leadership management goals, including personally investing time in meeting diversity targets, recruitment plans, and succession planning objectives. These targets are to be reviewed in the individual performance of top leaders as well as in the Office of Management and Budget's ongoing review of the department's management objectives. Executive leaders need to also set and communicate clear expectations for the behavior of leaders and staff and to invest their own time in mentoring, coaching, and developing subordinate leaders and promising staff, including under-represented populations. They must be visible and role-model leadership competencies in meetings, training, and new-hire orientations. They must take an interest in developing leaders and help create opportunities for them to gain leadership experience and competencies. The CVCS and senior executives must keep in mind that their sole role is not to manage crises or to oversee a process or to manage up. Rather, their primary role is to lead their people. Their time and attention must reflect that priority.

Leadership Model

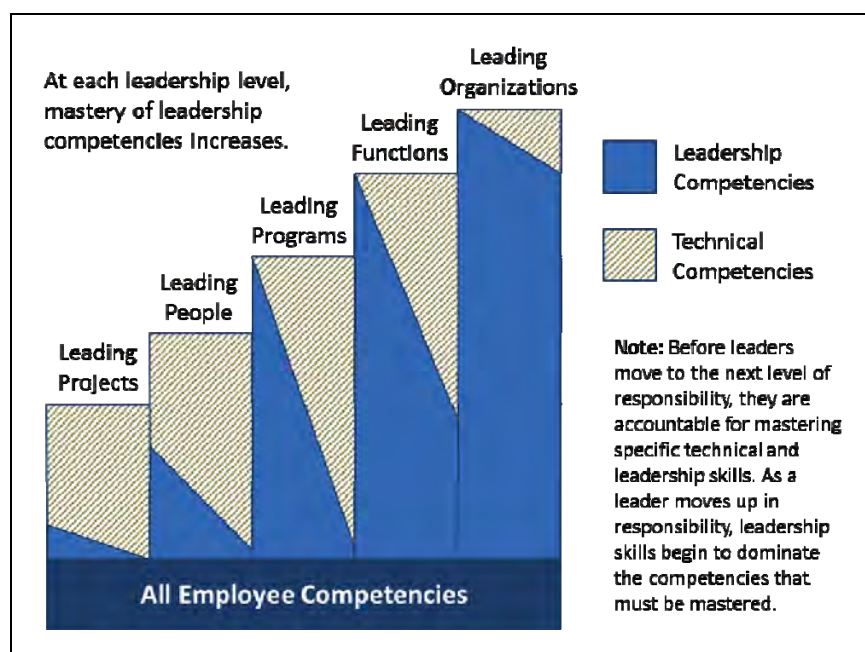
To establish clear leadership standards to guide hiring, development, and the advancement of leaders, VHA needs to adopt one benchmarked health care competency model. Currently, VHA is subject to the Office of Personnel Management executive core qualifications, HPDM, and standards for servant leadership. Although all of the models have value, none provide a clear trajectory for high-potential staff to follow, and they do not provide opportunities for VHA to intersect with leaders in the private sector. VHA must stop using these varied competency models and instead adopt a single model that is benchmarked to private-sector standards. The Commission is not making a recommendation about which model VHA should choose. Rather VHA should apply the criteria below to select a model around which to base its leadership development program:

- The standard must embrace leading through ethics and values, demonstrating character and concern for others, and creating a strong organizational culture.
- The standard must be health care based and describe the knowledge, skills, ability, and leadership bearing and behaviors that health care leaders must master to be effective.
- The standard must be a robust competency model including aligned training and tools to permit quick implementation.
- The model must describe different career tracks and the mastery requirements for key points in each career track. Key career tracks such as VISN director, facility director, and VHA Central Office (VHACO) program executive should fit into the competency model.
- A career path must specify the competencies that require mastery before moving to a higher position.
- VHA may need to enhance the model with competencies in care and services to Veterans and knowledge of military occupational health.

Training and Assessment

VHA needs to develop assessment tools based on the competency model, including 360, 180, self-assessment, and supervisory review processes. Leaders and developing leaders should be required to use at least one of the assessments each year and to apply the results to identifying their training and development needs. Findings from the assessments should be rolled into an individual development plan (IDP) for each leader or developing leader and enrollment in a leadership course should require a documented need from one of these assessments.

Figure 8. At Each Leadership Level, Mastery of Leadership Competencies Increases



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Training must be mapped against the competency model career track. All current leadership training should be mapped against the model. Gaps should be identified and filled with commercially available, or where needed, internally developed training. This training should include leadership competencies for the care of veterans, including an understanding of military occupational health, combat injuries and exposure, combat readjustments, and military sexual trauma. (See Appendix H for descriptions of such training material.) VHA should look for opportunities to partner with Department of Defense and the private sector to provide joint training and development opportunities to fill some of the identified gaps. VHA must develop one or more face-to-face training series that allow high-potential candidates to complete all the competencies required to move to the next career stage. As VHA strengthens its partnership with community providers and health systems, executive and high-potential training resources from VHA should be made available to community health care leaders and VHA should join training offered by these private-sector partners.

Based on the benchmarked competency model, VHA should collaborate with Academic Affiliates to establish two new programs. The first is to create opportunities for VHA physicians to gain masters-level training in health care management to prepare them to lead a medical facility. Second, VHA should work to create rotations in VHA for external physicians who are completing graduate health care management programs. Like academic affiliate residency training programs, VHA should collaborate with academic medicine to establish, fund, and run these programs with the goal that all participants rotate in management positions in VHA or VHA-partnered private-sector systems for six or more months during their training. Graduates of such programs would be candidates for recruitment into the VHA leadership pipeline and would encumber a pay-back commitment to VHA for any direct funding provided.

All training should include formal assessment to assure that learners have mastered the material and this mastery should be noted in their IDPs and training record.

As part of the leadership development model, experiential learning opportunities and formal coaching are critical to executive learning. Individual and group coaching standards and programs must be established for all developing and new leaders. A program for senior leaders to pair them with private-sector health care leaders must also be supported. VHA must establish rotation opportunities for developing leaders to rotate for substantial periods (e.g., 3 to 18 months) in not-for-profit hospital systems. This program could be structured as a certificate program that the employee and VHA jointly fund and include a payback commitment on the part of the trainee. Similar rotations from the private sector into VHA should be developed with health care system partners to help develop private-sector competencies in care for veterans and inject private-sector approaches into VHA.

Apply the Leadership Model

VHA is required to apply the competency model in all hiring decisions for executive career field positions. Thus all functional statements must be based on the model, all interview protocols must incorporate the competencies, and all candidates who are not internally certified to the standard of the job must undergo an assessment by a board to ensure they meet the position requirements. Conversely, internal candidates must be required to demonstrate mastery of the competencies before qualifying to apply for a position. VHA must adopt the strategies of executive recruiters to identify and recruit needed experts outside of government with the

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competencies VHA seeks. Recruiters can look to the pipelines the Commission has recommended building to bring military treatment facility commanders and other senior leaders and private sector experts into VHA as a network for identifying additional recruits. Executive recruiters can particularly help ensure diverse candidates are identified for open positions.

VHA will require competency assessments and IDPs for all existing executives, potential executives, and new hires. Current leaders and new hires who have an identified gap in any competency must have it included in their IDP and be required to fill these deficiencies by a specific deadline or face demotion or dismissal. Completion of IDP development opportunities is required for advancement in grade or promotion to higher position within the leadership pipeline.

VHA will aggressively manage its leadership candidate pool by identifying and tracking all high-potential individuals. Diversity statistics should be tracked and diversity in this pool actively managed. This pool of candidates derives from annual ratings as well as leadership development program graduates. Supervisors and executive leaders must provide ongoing coaching for higher positions to this pool of developing leaders. VHA must identify anticipated succession needs and offer development opportunities that would help prepare candidates for these anticipated openings. Once the positions are open, individuals in the high-potential pool must receive notices of new job postings and detail opportunities that provide experience into higher positions. Candidates who agree to be in this pool should be required to enter into formal mentoring relationships with leaders outside their chain of command to further advance their career development. For highest-level positions (VISN director, facility director, VHACO chief officer) a formal pool of approved or precertified candidates should be established.

To expand the perspectives and management experience in its leadership pipeline, VHA must develop explicit strategies to on-ramp diverse candidates at critical midcareer transition points. This process includes creating pathways for retiring commanders and other senior officers of military treatment facilities to compete effectively for leadership positions in VHA. To increase VHA understanding of private-sector health care, VHA must develop midcareer entry points for private-sector candidates. This could be accomplished through the use of temporary hiring authority and the ability to convert these positions to permanent staff positions if leadership competencies standards have been met by the candidates. Such opportunities can be modeled on efforts recently announced by DoD and, wherever practicable, should be developed collaboratively with DoD to establish the legal and policy requirements for implementing these programs. Finally, the current graduate health administration training program (GHATP) program should be expanded to include more schools and programs with diverse trainees. This expansion must allow high-performing residents to continue to convert to full time positions.

On-boarding

A formal on-boarding process should be instituted for all new executive hires. In addition to the transactional knowledge the individual will need, on boarding should establish the expectations for what it means for that executive to be successful in VHA. The values of the organization and the expectations for ethical practice must be conveyed by the CVCS and the top leadership team. A formal assessment of knowledge and skills should be made during on-boarding and an IDP established to cover the probationary period of new hires if any deficiencies are identified.

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Completion of the IDP is required for continued employment. All new leadership hires should be assigned a coach based on their individual needs. Within their first 6 months of employment, the undersecretary for health and Secretary should meet with these new executives to build a relationship with them and hear their fresh perspectives on the performance of VHA.

Stabilize Leadership

VHA should immediately stabilize its leadership ranks by authorizing VA medical center and veterans integrated services network (VISN) director details to last up to a year with no restrictions on an acting leader competing for the permanent position. VHA should also create flexible capacity by creating more assistant-level positions (e.g., assistant director, assistant VISN chief medical officer, assistant nurse executive, deputy chief officer). These individuals would comprise the pool of potential leaders and also allow for cross filling positions that are empty due to development assignments, training, or other leadership development opportunities.

Implementation

Legislative Changes

- Establish direct-hire authority from the graduate health care administration training program, military treatment facility, and private-sector fellow pools, clarifying application of merit-system principles, including approaches to managing veterans' preference in these programs.
- Establish Intergovernmental Personnel Act authority for VHA to include the for-profit private sector; this could be done as a pilot program with a report to Congress before considering whether to make the authority permanent.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.
- Aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: All hires and promotions are required to demonstrate these competencies.
- Require a formal on-boarding process for HPDM 3 and 4 leaders at all levels that reinforces the leadership competency model.
- Take immediate steps to stabilize the continuity of leadership by extending the length of authorized details to extend the continuity of leadership at medical centers and allow leaders detailed to a position to compete for a permanent appointment to the position by removing the non-compete requirements.

COMMISSION RECOMMENDATIONS

- Establish the competency model in regulation and include requirements for its use in hiring, promotion and dismissal and clarify the application of veterans' preference in executive development.

Other Department and Agency Administrative Changes

- None required.

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Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Problem

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and their functions overlap or are duplicative. The role of the Veterans Integrated Service Network (VISN) is not clear, and the delegated responsibilities of the medical center director are not defined.

Background

A prerequisite of a successful, high-performing system is having strong leaders and a strong leadership system.⁴²² An organization's leadership system is "the way leadership is exercised, formally and informally, throughout the organization; the basis for key decisions and the way they are made, communicated, and carried out."⁴²³ It includes "structures and mechanisms for making decisions; ensuring two-way communication; selecting and developing leaders and managers; and reinforcing values, ethical behavior, directions, and performance expectations."⁴²⁴ In an organization the size of VHA, with a budget of \$69 billion,⁴²⁵ more than 300,000 employees, and more than 1,000 sites of care,⁴²⁶ strong leadership systems are essential.

The Commission Recommends That . . .

- VHA redesign VHA Central Office (VHACO) to create high-performing support functions that serve Veterans Integrated Service Networks (VISNs) and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the chief of VHA Care System with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report (also included in Recommendation #10).

⁴²² Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 50.

James Collins, *Good to Great: Why Some Companies Make the Leap and Others Don't*, (New York, NY: HarperCollins, 2001), 17-64.

⁴²³ Ibid.

⁴²⁴ Ibid.

⁴²⁵ Department of Veterans Affairs, *VA 2017 Budget Request: Fast Facts*, accessed March 10, 2016, <http://www.va.gov/budget/docs/summary/FY2017-FastFactsVAsBudgetHighlights.pdf>.

⁴²⁶ "About VHA," Department of Veterans Affairs, accessed February 5, 2016, <http://www.va.gov/health/aboutVHA.asp>.

In the last successful reorganization of VHA in 1995,⁴²⁷ the organizational design and functional roles of the leadership system were organized into clear structures with clear functions. The VISNs were responsible for operations⁴²⁸ and VHACO program offices were responsible for policy, guidelines, and outcomes.⁴²⁹ The National Leadership Board (made up of VISN directors and all program office leaders) was responsible for collective, fact-based decision making and the Friday Hotline call was used to communicate leadership priorities and decisions directly to VA medical center (VAMC) leadership. A negotiated performance measurement system based on consistent, benchmarked, outcome-focused metrics⁴³⁰ was also established that was supported by centralized functions that benefit from economies of scale.⁴³¹ As part of the reorganization, VHA experienced a reduction in staff and consolidation of VHACO offices to create a flat, agile leadership system.⁴³² Because this functional matrix was not sustained, VHA now faces the challenge of reinstituting an effective leadership system.

Analysis

Twenty years after the Kizer reorganization, VHA has a very different leadership system, under which it “is intensely, unnecessarily complex due to a lack of clear operating model, limited role clarity, fragmentation of authority, and overlapping responsibilities.”⁴³³ The *Independent Assessment Report* included the following findings about the VHA operating model:⁴³⁴

- VHACO has grown rapidly since 2009 from 753 in FY 2009 to 1,990 in FY 2014.
- The VISNs’ ability to manage and support their regions is heavily hampered by resourcing restrictions and direct VHACO control over VAMC operations.
- The VAMCs’ operating model suffers from powerful silos, which prevent an effective end-to-end mission focus.
- VA’s increasingly top-down management style, coupled with poor prioritization and the external political environment, result in a lack of clarity around strategic direction, reactivity to external headwinds, and flawed efforts to standardize.

VHACO has grown rapidly in the past few years.⁴³⁵ The growth in central office was driven in part by new ideas, new priorities, and new crises being addressed through the creation of new

⁴²⁷ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco, CA: Berrett-Koehler Publishers, Inc., 2012), 54.

⁴²⁸ Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 35. Kizer, Kenneth W and Ashish Jha, “Restoring Trust in VA Health Care,” *New England Journal of Medicine*, 371, (2014): 295-297.

⁴²⁹ Ibid.

⁴³⁰ Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 61-72.

⁴³¹ Ibid., 33.

⁴³² Ibid., 60. Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation of the Veterans Healthcare System*, Objective 3 and 17, 1996.

⁴³³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 95, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁴³⁴ Ibid.

⁴³⁵ Ibid., 98.

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offices and new staff infrastructure to support it.⁴³⁶ A portion of the growth came from the centralization of functions that were previously managed in the field such as business office functions. The final component has come from the duplication in VHA of offices in which decision-making authority rests with VA, such as communications and regulatory management. VHA has also duplicated functions and responsibilities between two or more offices in VHA, such as primary care, surgery, mental health, and geriatrics and extended care. This increased growth in staff and offices has resulted in more complex and lengthy decision processes, often with little clarity as to whom ultimate responsibility for decisions or follow up falls.⁴³⁷

One symptom of the top-down management is VHACO control of budgeting and resource management. “Support funding is outside local control” and the “increasing share of Specific Purpose funding hinders” local leaders in their ability to use resources effectively.⁴³⁸ In FY 2015, specific-purpose funds were spread across more than 450 line items,⁴³⁹ taking money away from general purpose funding and restricting how this money can be used. Both VHACO and Congress have been complicit in taking control away from medical center directors through these budget controls.⁴⁴⁰ For instance, the congressional appropriation to fund VHA for 1998 included only five appropriation line items; medical care, medical administration, construction major, construction minor, and medical and prosthetic research.⁴⁴¹ In contrast, the budget request to Congress for FY 2016 included 12 budget categories relevant to VHA with some of those accounts having four or five subcategories.⁴⁴² In his testimony before the Commission and Congress, Secretary McDonald made the point that such fragmentation of the VHA budget and the prohibition to reallocate across budget categories without first receiving Congressional approval was an impediment to effective and agile management of the department.⁴⁴³ Greater Congressional control of VHA spending is understandable in light of VA’s lack of adequate management systems and data analytic capabilities to track expenditures in real time⁴⁴⁴ and report them to Congress and central office. The only means available to hold the medical centers

⁴³⁶ Ibid., 96-99.

⁴³⁷ Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health*, (Washington, DC, Veterans Health Administration, February 2015), 7-9.

⁴³⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership)*, 102, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴³⁹ Ibid., 107.

⁴⁴⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership)*, 102-108, accessed June 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴⁴¹ PL 105-65, October 27, 1997.

⁴⁴² Department of Veterans Affairs Fiscal Year 2016 Budget Submission, Volume II Medical Programs and Information Technology, Accessed June 10, 2016, <http://www.va.gov/budget/products.asp>.

⁴⁴³ On January 21, 2016, Secretary of Veterans Affairs, Robert A. McDonald, provided the following testimony before the U.S. Senate Committee on Veteran’s Affairs “Flexible Budget Authority: We need flexible budget authority to avoid artificial restrictions that impede our delivery of care and benefits to Veterans. Currently, there are over 70 line items in VA’s budget that dedicate funds to a specific purpose without adequate flexibility to provide the best service to Veterans. These include limitations within the same general areas, such as health care funds that cannot be spent on health care needs and funding that can be used for only one type of Care in the Community program, but not others. These restrictions limit the ability of VA to deliver Veterans with care and benefits based on demand, rather than specific funding lines.” accessed June 10, 2016,

<http://www.veterans.senate.gov/imo/media/doc/VA%20Sec%20Testimony%2001.21.2016.pdf>

⁴⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 105, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

accountable was to fund the priority initiatives as separate budget lines or indicate allocations to be made under the specific-purpose process.

To fix the overly complex and bureaucratic structure of VHA, the *Independent Assessment Report* suggests that VHA “redesign (its) operating model to create clarity for decision-making authority, prioritization, and long-term support.”⁴⁴⁵ VHA must take a systems approach to reorient its leadership operations, restructuring and re-orienting VHACO program offices to ensure all of the following:⁴⁴⁶

- fact based, innovative decision making that is responsive to the field, other offices, and external stakeholder requirements
- feedback mechanisms to incorporate system learning into policy development and operational guidance
- communication mechanisms to effectively share information across offices and reach VISN and facilities to explain expectations and tie decisions to organizational values and goals
- effective execution of policy decisions through expert coaching, deployment of resources, and guidance based on external benchmarks and sharing of internal best practices
- analytic capability and infrastructure to effectively monitor progress and outcomes of all organizational priorities

Such a reorientation will involve a different skill set and expertise than currently required in VHACO. Transformation will call for recruiting new expertise, making advancement decisions based on these new competencies, reinforcing them through recognition and performance assessment, and developing new skills in current staff through training and coaching. This skill set includes a high level of technical expertise relevant to the program office; the ability to build relationships with external stakeholders; demonstrated skills in coaching, staff development, and training; certification in quality improvement methodologies; analytic capabilities to develop and track metrics; and the ability to lead transformational change. VHA must fully fund the retraining and the hiring of skilled staff in VHACO to accomplish this transformation.

For the VHACO program offices to work effectively with one another and with the field, the specific authority of each office must also be defined. Where overlap and confusion exists between offices, programs must be combined and streamlined or eliminated with a corresponding reduction in force. In changing the structure and orientation of VHACO program offices, VHA leadership can take the opportunity to align functions to achieve its stated priority of patient-centered care. In a fully aligned operating structure, business processes from the VAMC front line to central office must be organized to deliver important

⁴⁴⁵ Ibid., ix.

⁴⁴⁶ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 7, 34, and 50.

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patient outcomes rather than aligned in professional silos. For instance, instead of having an office of nursing, one for social work, and a lead for physician assistants, business offices should be aligned around the work they do together, like patient aligned care teams, to deliver positive outcomes for veterans.

The administrative operations of VHACO should also be flattened. Senior staff should be speaking directly to other senior staff to discuss and make decisions rather than relying on bureaucratic, paper-based processes as a means of negotiation: It is neither a healthy culture nor an efficient process. At the same time, VHACO needs to take full advantage of being a large-scale enterprise by centralizing functions such as acquisition package development, recruitment package development, and account reconciliation so that staff is not required in each program office to take on these occasional but complex activities. The net savings resulting from this reorganization and delayering of the bureaucracy must be reinvested in the transformation process.

VISNs must also examine the skills needed to take on an expanded role as facilitators, coaches, and guides in improving services and sharing best practices across facilities. VISNs are critical players in the feedback loop between service delivery and VHACO to identify ineffective processes, problems, and emerging issues that need to be raised to VHACO for help in clearing away barriers to effective operations. Similar to VHACO, VISNs must define the new skill set required by their staffs and establish these requirements in hiring, promotion, and performance evaluation as well as training and coaching staff to develop these competencies. Finally, the chief of VHA Care System (CVCS) should establish a required staffing ratio for the VISN office and reduce the staffing in VISNs that exceed this standard.

A new operating model also means that medical center directors must control the budget, staff, supplies, and infrastructure required to deliver needed health care. This model includes consolidation of budget lines and new authority and expanded authority to reallocate funds across the remaining budget categories. To manage the new VHA Care System and ensure that facility and network directors have the local control needed to make decisions about how to deliver services, fewer restrictions should be placed on the VHA budget. To start, specific-purpose funds must no longer be used to direct obligations at facilities. Congress should also work with the administration to reduce the number of budget lines and specific spending authorities back to a simpler system like that used in 1998. To support these changes and create transparency, medical centers should be accountable for their expenditure of funds by ensuring accurate, complete, and timely cost accounting. This last requirement, however, can only be met if it is supported by effective financial management data systems and fully trained staff and leadership who understand how to use such systems.

To support the leaders, program offices, and the field in this transformation, the CVCS must establish a transformation office that has appropriate expertise in business process reengineering and is fully funded to conduct this work. Existing offices with the requisite expertise, including the Office of Strategic Integration and the Veterans Engineering Resource Center (VERC), should be rolled into the transformation office. This office would oversee transformation and incubate new initiatives with the goal of incorporating them into regular work of other program offices once the new initiative is established. This mechanism, if used consistently, would prevent VHA from growing new offices as new priorities arise.

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Finally, as part of cultural change within the leadership system, the CVCS, VISN directors, and program office leaders must promote open and productive dialogue among themselves about problems and solutions. To accomplish this goal, leaders must address both the culture within the leadership ranks, as well as establish systems and processes that support identification and discussion of problems. The CVCS must model this behavior by inviting input on problems and rewarding leaders when they bring issues forward, including rewarding them with access to expertise, staff, and money; removing barriers; and aligning other leaders in support of solutions.

In its work to oversee change in VHA, the transformation office will create an implementation plan for transformation, identifying key strategies and milestones. This plan will drive data collection, development of strategic goals and supporting objectives to encourage effective planning, accountability, and the ability to unearth critical gaps that need to be addressed. The transformation office will require each new initiative to establish a project plan and provide periodic reports that include all of the following components: tactic/action, initiative owner, cost (i.e., operational, equipment, contracts), number of FTEs, start and completion dates, outcome measures, strategic drivers, and milestone.⁴⁴⁷ The President's Management Agenda Scorecard will serve as the evaluation model. The Office of Management and Budget created this tool to evaluate new initiatives and track progress on outcomes over time with regular spotlight reports (red, yellow, green) to leadership.⁴⁴⁸

Implementation

Legislative Changes

- Simplify the VHA budget to include fewer accounts while at the same time requiring more transparent and detailed accounting of VHA expenditures.

VA Administrative Changes

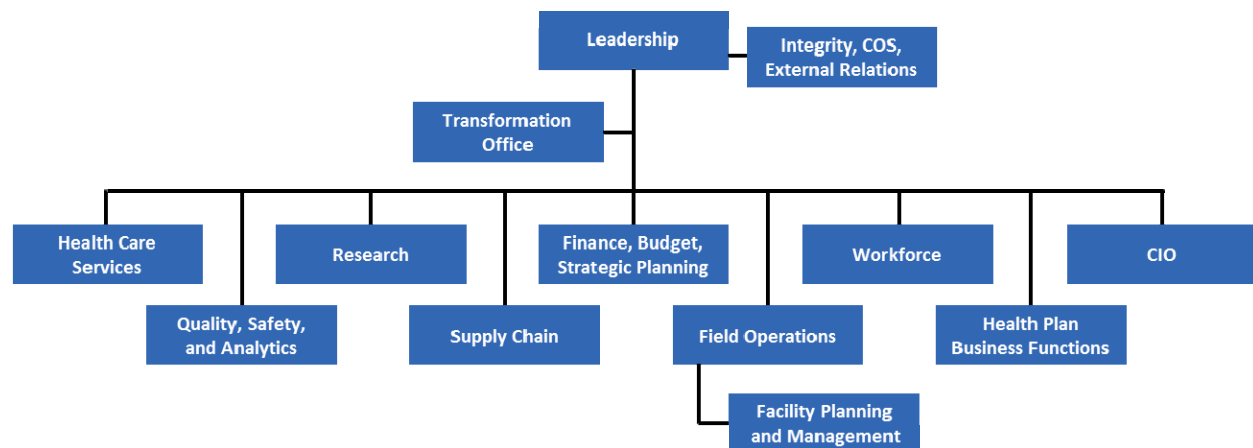
The following administrative changes are a priority during the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B. Responsibility for establishing a transformation plan with milestones, timelines, and evaluation of outcomes is assigned to the transformation office that the Commission recommends be established in VHA.

- Eliminate duplication within VHA and consolidate program offices to create a flat structure. Figure 9 is one model of an organizational chart for accomplishing this goal. This organizational chart shows how VHA can be streamlined to mirror the structure of large private-sector hospital systems. Figure 10 is the current VHA organizational chart, provided as a point of comparison and to emphasize the cumbersome nature of the current structure.

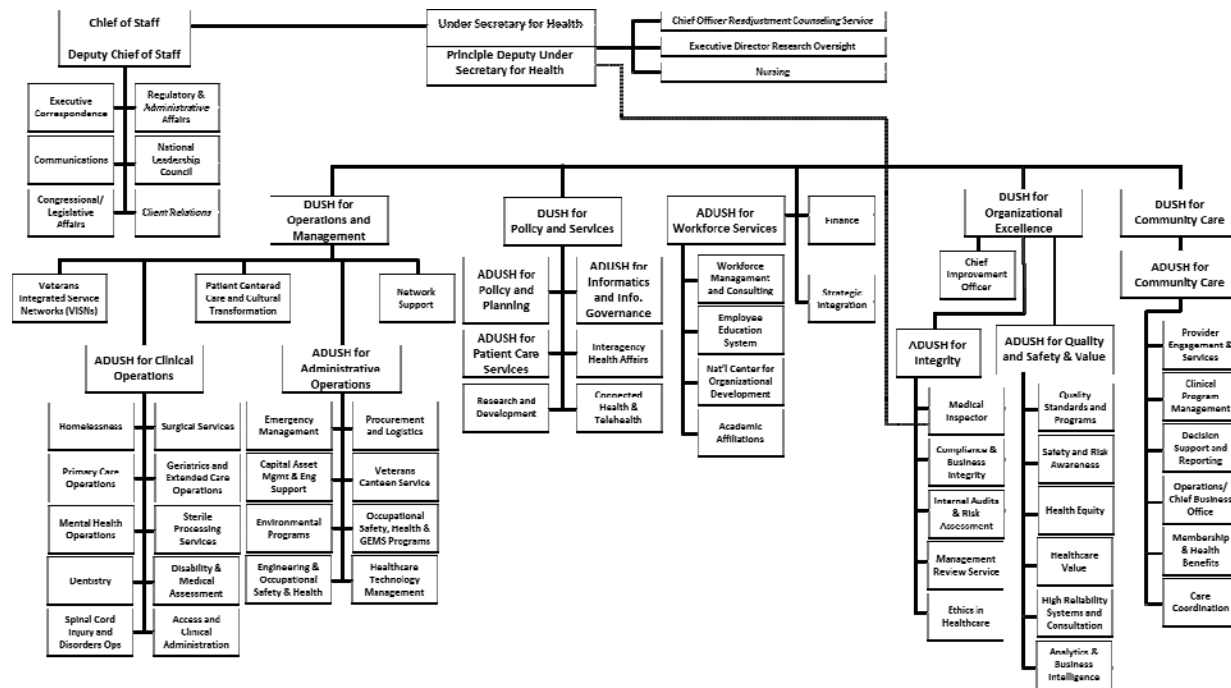
⁴⁴⁷ For example, see "VA Faith-based and Community Initiative President Management Agenda Scorecard," September 30, 2008,

⁴⁴⁸ "Office of Federal Financial Management President's Management Agenda," Office of Management and Budget, accessed June 15, 2016, https://www.whitehouse.gov/omb/financial_fia_pma/.

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Figure 9. Proposed VHA Organizational Chart⁴⁴⁹

Note: This organizational chart is an example of how to align VHA functions to create a flatter organization, remove duplication, and streamline decision making as discussed throughout this section of the report. Of note, the placement of the Transformation Office, CIO, and supply chain in this diagram is consistent with recommendations made by the Commission elsewhere in this report. In this chart, COS is chief of staff.

Figure 10. Current VHA Organizational Chart⁴⁵⁰

⁴⁴⁹ Modified from Appendix C, Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health*, (Washington, DC, Veterans Health Administration, February 2015), 41.

⁴⁵⁰ Ibid.

COMMISSION RECOMMENDATIONS

- Eliminate the duplication of functions between VHA and VA by closing VHA offices as needed.
- Create innovative organizational structures that are aligned to patient's needs rather than professional silos, to support clinical care.
- Undertake a reduction-in-force in VHACO that facilitates delayering and efficiency in communication and decision making.
- Establish a transformation office implementation plan to ensure effective and comprehensive implementation of the transformation across VHA. The transformation plan is to capture all of the transformation activities recommended in the Commission report, establish specific timelines and milestones for accomplishing each objective, and report on both progress and outcomes at least quarterly to VHA leadership and the governing board. Periodic evaluation of the effect of these change initiatives on internal and external stakeholders would also be appropriate.
- Clarify the roles and responsibilities of VISNs and facilities and implement a change strategy to orient staff and leaders to these new expectations. Establish effective leadership communication mechanisms to promote transparency, dialogue, and collaboration among VHACO offices and with the field.

Other Department and Agency Administrative Changes

- None required.

Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

Problem

To achieve the Commission's vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set, identical to private-sector standards, will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes for veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders' performance not just on *what* they achieve but *how* they achieve it.

Background

One of the criteria for performance excellence in health care is the measurement, analysis, and improvement of organizational performance.⁴⁵¹ Performance measurement is used to track daily operations, overall organizational performance, and progress in achieving organizational objectives and action plans. Performance measurement is also used to benchmark organizational performance against internal and external standards.

Organizational performance measurement is not the same as workforce performance management.⁴⁵² Workforce performance management is intended to reinforce intelligent risk taking, help focus the workforce on the needs of patients and other customers, and support

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Workforce and Leadership Performance Management System

- VHA create a new performance management system appropriate for health care leaders, tied to health care leadership competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

⁴⁵¹ Baldrige Performance Excellence Program, 2015-2016 *Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.

⁴⁵² *Ibid.*, 20.

health care delivery and the achievement of action plans.⁴⁵³ Although there is a relationship between organizational performance measurement and workforce performance management, they are not synonymous processes.

Workforce performance management is made up of much more than just clinical outcome measures. As noted by the American College of Healthcare Executives (ACHE), performance evaluations of hospital CEOs must also evaluate leadership traits such as judgment, communication, and diplomacy.⁴⁵⁴ Furthermore, ACHE emphasizes the inclusion of individual professional objectives in performance plans, such as promoting ethical behavior, supporting diversity and inclusion within the organization, or fostering effective medical staff relationships.⁴⁵⁵ ACHE and other leading practitioners⁴⁵⁶ emphasize that performance management is not a plan or an event, but rather a continuous, ongoing process and conversation among the leaders and their reviewers. A workforce performance management system must also make meaningful distinctions among individuals⁴⁵⁷ and promote high performance through rewards, recognition, and incentive practices.⁴⁵⁸ Ideally, when coupled with a leadership competency model and development program, workforce performance management should also help to identify high-performing potential leaders and provide guidance to the workforce on how to move up in the leadership ranks.⁴⁵⁹ As deployed in FY 2015 and evaluated by the *Independent Assessment Report*, VHA's performance management system failed to effectively achieve any of these objectives.⁴⁶⁰

Analysis

One of the findings in the *Independent Assessment Report* was that “hundreds of operational performance measures overwhelm leaders and this, combined with limited transparency and inconsistent data availability, makes it difficult to focus on what is most important.” More than 300 measures spanned everything from critical clinical metrics to political priorities introduced to address the most recent crisis. VHA reports that it was tracking approximately 500 measures,

⁴⁵³ Ibid.

⁴⁵⁴ “Policy Statement: Evaluating the Performance of Hospital or Health System CEO,” November 2013 (revised), American College of Healthcare Executives, accessed February 18, 2016, <https://www.ache.org/policy/ceo-perf.cfm>.

⁴⁵⁵ Ibid.

⁴⁵⁶ Ibid. NeuroLeadership Institute’s “Reengineering Performance Management: How Companies are Evolving Beyond Ratings” webinar, scheduled on January 14, 12-1.

⁴⁵⁷ “Implementing FCAT-M Performance Management Competencies: Differentiating Performance,” Office of Personnel Management, Performance Management: Performance Management Cycle, accessed June 10, 2016, <https://www.opm.gov/policy-data-oversight/performance-management/performance-management-cycle/developing/differentiating-performance/>.

⁴⁵⁸ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization’s Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.

⁴⁵⁹ Office of Personnel Management. Proficiency Levels for Leadership Competencies. <https://www.opm.gov/policy-data-oversight/proficiencylevelsforleadershipcompetencies/>. “Joint Medical Executive Skills Institute,” Health.mil: The official website of the Military Health System and the Defense Health Agency, accessed June 13, 2016, <https://www.jmesa.army.mil/documents.asp>, National Center for Healthcare Leadership. NCHL Healthcare Leadership Competency Model. <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁶⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 78-79, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

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including 156 related to access, 29 measuring employee engagement, 18 on high-performing networks, 250 best practice measures, and seven related to trust.⁴⁶¹

Distinct from performance measurement, the performance management process⁴⁶² is a cycle that begins with clear input from top leadership on the priorities of the organization, followed by clear targets, performance tracking, reviews, and rewards. The *Independent Assessment Report* noted that, “Individual performance management processes are hindered by targets inconsistent with the VHA mission, delayed implementation, lack of meaningful performance dialogue, and limited rewards.”⁴⁶³ Many of the same system flaws that impede effective organizational performance also impede individual success. Performance plans are released late in the performance cycle,⁴⁶⁴ metrics are hard to track in real time and lack the detail required for individual performance assessment,⁴⁶⁵ and few plans are written to support shared accountability and team-based solutions. In addition, participants observed that the current senior executive performance agreements and rating process (a) do not result in meaningful distinctions in performance between individuals, (b) do not drive meaningful conversations about individual performance, (c) and do not consistently focus on key health care metrics of quality, safety, patient experience, operational efficiency, finance, and human resources.⁴⁶⁶ The *Independent Assessment Report* notes that the rewards currently offered to employees do not motivate them to work toward exceptional performance.⁴⁶⁷

Information provided to the Commission indicates that VHA has taken action to address some of these findings. First, the USH has reestablished a performance accountability workgroup (absent for a number of years) comprising leaders from the field and VHACO to provide oversight and direction to the performance measurement process.⁴⁶⁸ The workgroup has been charged with aligning metrics to each level of VHA, dramatically simplifying metrics, and increasing the capacity of the organization to focus on measures that truly matter.⁴⁶⁹ The group has created an aspirational vision of a performance measurement system that describes cascading accountability from the top of the organization with health system outcomes (reported annually) through strategic measures (reported quarterly), to tactical measures (reported monthly) to transactional measures (reported in real time).⁴⁷⁰ It is critical that these aspirations become policy.

⁴⁶¹ Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.

⁴⁶² McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 78, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁴⁶³ Ibid., 82.

⁴⁶⁴ Ibid., 82.

⁴⁶⁵ Ibid., 84.

⁴⁶⁶ Ibid., 84.

⁴⁶⁷ Ibid., 87.

⁴⁶⁸ David Shulkin, *Charter of the Performance Accountability Workgroup*, (Washington, DC, Veterans Health Administration, September 22, 2015).

⁴⁶⁹ Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.

⁴⁷⁰ Ibid.

Starting in the 1990s, VHA has used performance measurement, benchmarking, and reporting internally to motivate higher clinical quality performance by individuals and teams.⁴⁷¹ As a large, national health care system, internal benchmarking can be a valid method to drive change, yet both internal and external audiences may ask how well VHA performance compares to that of private-sector providers. VHA currently posts some patient quality, safety, and outcome measures on both its website and on the Department of Health and Human Services (HHS) Hospital Compare website.⁴⁷² These measures allow patients to evaluate the quality of care they receive from VA and make informed health care decisions. They include measures of timely and effective health care; measures of readmissions; complications of death, surgical complication measures and health-care related infection measures; survey data of patient experiences; and other measures required of hospitals participating in Medicare.⁴⁷³ Former USH Kizer believes this reporting is insufficient, noting

*the VA health care system has become increasingly insular and inward-looking. It now has little engagement with private-sector health care, and too often it has declined to make its performance data public. For example, it contributes only a small proportion of its data to Hospital Compare and has declined to participate in other public performance reporting forums such as the Leapfrog Group's efforts to assess patient safety.*⁴⁷⁴

The Commission has reviewed VHA's principal measurement approach, Strategic Analytics for Improvement and Learning Value Model (SAIL) and has determined that although it is modelled on private-sector approaches to measurement and rating, measures are not exactly the same as those reported in the private sector and consequently impede direct benchmark comparisons of VHA to the private sector. Updating these measures so they are consistent with the private sector will be especially important as integrated delivery networks are established and more care is received in the community, as they will allow for making objective comparisons.

Measurement, analysis, and improvement of organizational performance work together as a key system.⁴⁷⁵ The USH has signed a new organizational chart for VHA that acknowledges the interconnection of these elements by establishing an office for organizational excellence that encompasses all of these functions.⁴⁷⁶ To be effective, not only must all of the various units within this office work together but also they must work with personnel in the field to coach and develop their ability to effectively apply performance measurement and improve organizational performance.

⁴⁷¹ "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation?" Ashish K. Jha, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, September 2006, accessed April 21, 2016, <https://psnet.ahrq.gov/perspectives/perspective/31/what-can-the-rest-of-the-health-care-system-learn-from-the-vas-quality-and-safety-transformation>.

⁴⁷² "Quality of Care: How Does Your Medical Center Perform?" Medical Center Performance Search (MCPS), U.S. Department of Veterans Affairs, accessed May 16, 2016, <http://www.va.gov/qualityofcare/apps/mcps-app.asp>.

⁴⁷³ Title XVIII of the Social Security Act 42 U.S.C. § 1395 et seq.

⁴⁷⁴ Kenneth Kizer and Ashish Jha, *Restoring Trust in VA Health Care*, N Engl J Med 2014; 371:295-297, July 24, 2014

⁴⁷⁵ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.

⁴⁷⁶ See the proposed organizational chart at end of Recommendation #12.

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These improvements in performance measurement do not appear to be mirrored on the performance management side of the equation. The draft FY 2016 performance plan template for network directors and medical center directors,⁴⁷⁷ although more streamlined than in previous years, continues to reflect confusion of performance measurement and performance management. It also continues to distribute all of the organization's key (and not so key) priorities under OPM executive core qualifications of leading change, leading people, business acumen, building coalitions, and results driven. The new, streamlined performance measures described above could be considered results-driven; however, the rest of the plan continues to be a confusing presentation of instructions to field leaders, restatements of policy, and performance objectives for action plans. Only the last category is appropriate for workforce performance management.⁴⁷⁸ The Corporate Senior Executive Management Office has implemented a new online performance management data tool that allows for tracking and assessment of the performance management process for senior executive service and equivalent leaders in VA.⁴⁷⁹

To improve performance measurement and organizational performance, the *Independent Assessment Report* recommends that VHA focus and simplify organizational performance measurement to clarify accountability, actively support the mission, and promote continuous improvement. Specifically, VHA must create a simplified, focused, balanced scorecard that reduces the total number of metrics to about 20; establish metrics that support cross-functional collaboration; cascade metrics down the organizational hierarchy; and make data tracking transparent, timely, broadly available, credible, reliable, and meaningful down to the lowest level of the organization. Furthermore, leaders should support continuous improvement, problem-solving, and the exchange of best practices across the organization rather than focusing on only correcting poor performance.⁴⁸⁰ The Commission broadly agrees with this approach to performance measurement. In addition, the Commission emphasizes that VHA customers and stakeholders require public reporting of clinical quality measures that are the same as, and therefore directly comparable to, measures used by the private sector. Although VHA may require an enhanced set of measures that reflects services not broadly deployed in the private sector, or for which measures do not yet exist, a minimum set that are the same as private-sector measures must be used by VHA. As VHA expands integration of care with the community, the use of the same measures as the private sector will be important so that direct comparisons can be made of care delivered inside VHA and that delivered under contract or partnership agreement by the VHA community care network.

VHA also requires a cohesive, integrated personnel performance management system that is specific to the knowledge, skills, and abilities required of health care leaders; includes

⁴⁷⁷ Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan Template*, Network Directors and Medical Center Director, November 20, 2015.

⁴⁷⁸ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.

⁴⁷⁹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁴⁸⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 81, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

accountability to key organizational outcomes; but also assesses organizational and professional objectives. A new personnel performance management system must be free of OPM requirements for executive core qualification and certification process and instead be benchmarked to the private sector⁴⁸¹ and consistent with the new leadership competency model. Congress required DoD to establish independent competency standards for the Commanders of Military Treatment Facilities (MTFs) and should consider doing the same for VHA.⁴⁸² This new performance management model must be based on both evaluation of leadership competencies and demonstrated success in delivering on strategic priorities. To break with current perceptions of the rating scales, it would be helpful to establish a new rating scale for the performance management system. Once the new system is developed, VHA must conduct training to describe the system, rating process, and expectations for both participants and raters.

A performance management system must also address the responsibilities of the rater. This includes clearly establishing written performance requirements for subordinates that are both timely (i.e., prior to the start of the rating period) and meaningful. Raters must be required to provide continuous feedback and assessment throughout the year to recognize and reward progress and outstanding achievements as well as to coach and trouble shoot when needed. The CVCS must establish this expectation by clearly communicating what is required of raters, and most importantly, by modeling the behavior. Finally, raters must provide meaningful ratings that distinguish achievement based on objective performance and demonstrated leadership skills. For instance, the Cleveland Clinic has moved to a system of forced rankings for which the top 10 percent of performers are celebrated and the bottom 10 percent are given intensive coaching or, if justified, sanctioned.⁴⁸³ To accomplish the last point, raters themselves must be given feedback and oversight to understand how their approach to rating compares to other leaders in the organization. If raters' assessments are not consistent with rating standards, their supervisor must bring this issue to their attention and include it in the performance assessment they receive.

The newly established performance management data tool can be used to support the performance management process. The submission of written performance plans (or failure to do so) can be tracked and reported; and the quality of those plans can be audited to provide feedback to raters. Final ratings and a comparison of raters can be conducted and provided to all of the executive raters in the organization. Finally, such a tool can also be used to identify and track high performers who deserve further investment and development as leaders from VHA.

⁴⁸¹ The American College of Healthcare Executives, *2016 Competencies Assessment Tool*, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf. "NCHL Health Leadership Competency Model™," National Center for Healthcare Leadership, accessed May 16, 2016 <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁸² Department of Defense Appropriations Act of 1999, Pub. L. No 105-262, Section 8052 (1998): "None of the funds appropriated in this Act may be used to fill the commander's position at any military medical facility with a health care professional unless the prospective candidate can demonstrate professional administrative skills."

⁴⁸³ Delos M. (Toby) Cosgrove, MD, CEO, Cleveland Clinic, statement during Commission on Care public meeting, March 22, 2016.

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Implementation***Legislative Change***

- Obtain legislative relief from the requirement to use the OPM executive core qualifications system of competencies and ratings and tied to new Title 38 pay authority for health care leaders (see Recommendation #15).

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Establish a workgroup and engage outside experts to create a new performance management system for VHA leaders that is appropriate for health care executives.
- Establish standards and processes to hold raters accountable for creating meaningful distinctions in performance between subordinate leaders.
- The new Office for Organizational Excellence should work with experts to reorganize their internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Other Department and Agency Administrative Changes

- None required.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

Problem

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans, and must become a strategic priority throughout the organization, because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veteran's care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Background

Cultural competence is the ability of health care organizations and their providers to understand and respond effectively to the cultural, language, and in VA's case, military service experience brought by the patient to the health care encounter. It has been endorsed as a viable skill set to reduce, if not eliminate, the rate at which health care disparities occur. VHA has recognized the problem of health disparities among its patient population and has taken steps to address it by tasking certain internal offices with building cultural and military competence throughout the organization. For example, VHA established the Office of Health Equity (OHE) and charged it with championing the efforts to identify, understand, and address health care disparities among veterans.

Analysis

There are seven essential strategies for promoting and sustaining organizational and systemic cultural competence. These strategies include the following:⁴⁸⁴

- Provide executive-level support and accountability.
- Foster patient, community, and stakeholder participation and partnerships.
- Conduct organizational cultural competence assessments.
- Develop incremental and realistic cultural competence action plans.

⁴⁸⁴ Miriam E. Delphin-Rittmon et al., "Seven Essential Strategies for Promoting and Sustaining Systemic Cultural Competence," *Psychiatric Quarterly*, 84, (2013), 53-64.

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- Ensure linguistic competence.
- Diversify, develop, and retain a culturally competent workforce.
- Develop an agency strategy for managing staff and patient grievances.

VA has taken some steps to address cultural and military competence strategies, but these programs are not sufficient to address the breadth and depth of the problem. These strategies will not take hold and become fully ingrained in VHA's culture unless VHA leadership makes them a key priority and commits the resources and on-going, comprehensive training required to build cultural competencies across the entire VHA workforce.

Military Competency

In addition to addressing the needs of minority veterans and vulnerable veterans populations, VA must address military-specific needs and ensure that all providers in the VHA Care System have sufficient military competency (i.e., knowledge of specific issues and health care needs of those who served in the military). VHA's Office of Academic Affiliations developed a *Clinician Pocket Card* for providers that includes questions for clinicians to ask veterans about their military health history.⁴⁸⁵ The *Pocket Card* and similar resources should be given to all VHA and community providers to leverage during veteran patient medical assessments and appointments. In addition, VA's Office of Public Health (OPH) provides information on VA health care programs for veterans who were exposed to environmental and occupational hazards during military service, such as Agent Orange, chemicals leading to Gulf War veterans' illnesses, and Camp Lejeune water contamination.⁴⁸⁶ This military exposure information should be leveraged in VA's cultural competency strategy.

Health care disparities often result from patients' lack of trust in their health care provider; therefore, enhancing the patient-provider relationship is paramount in overcoming these disparities. Stereotypical thinking on the part of providers about certain patient groups, including veterans, may unwittingly influence their prognosis.⁴⁸⁷ Specific reasons for the increase of health care disparities in the military population include the following:

- the cultural norms of the military are such that to admit or display any signs of perceived weakness, especially related to mental health issues, discourages military personnel and veterans from seeking medical care and treatment
- changes in the demographical makeup of the civilian population result in similar changes to the military population
- a small but gradual increase in the number of foreign born personnel who have joined the ranks of the military

⁴⁸⁵ Department of Veterans Affairs, Office of Academic Affiliations, *Military Health History: Pocket Card for Health Professions Trainees and Clinicians*, accessed June 12, 2016, <http://www.va.gov/oaa/archive/Military-Health-History-Card-for-print.pdf>.

⁴⁸⁶ "Public Health: Military Exposures," U.S. Department of Veterans Affairs Intranet, accessed June 12, 2016, <http://vaww.publichealth.va.gov/exposures/index.asp>

⁴⁸⁷ G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," JHHSA (2011), 148.

- a disengaged provider culture that may have become more immersed in the medical culture than the military culture

VA must make cultural and military competence a strategic priority, provide the resources needed to execute the strategy, and hold leadership and providers, both within VHA and community partners, accountable for strategy implementation and integration into VA's culture.

Women

Women are the fastest growing group within the veteran population.⁴⁸⁸ As of 2011, approximately 1.8 million (8 percent) of the 22.2 million veterans were women. Data indicate that by 2020 women veterans will comprise nearly 11 percent of the total veteran population. As the number of women veterans increases, VHA continues to prepare for an increasing demand for women veterans' health care needs.⁴⁸⁹ To address the health disparities affecting women veterans, VHA must provide high-quality, equitable care on par with that of men, deliver that care in a safe and healing environment, provide seamless coordination of services, and actively recognize women as veterans.⁴⁹⁰

In the past, VHA found gaps in its ability to provide comprehensive primary care for women veterans because many primary care providers had little or no exposure to women patients and women were often referred outside of primary care for gender-specific care. To close these gaps, VHA has implemented women's health comprehensive primary care clinic models with the goal of providing complete primary care from one designated women's health provider (DWHP) at one site. An analysis of FY 2012 data revealed that women assigned to DWHPs had more positive overall experiences with care and were more satisfied on six composite scores including access, communication, shared decision making, self-management support, comprehensiveness, and office staff.⁴⁹¹ VA has substantially reduced gender gaps in care,⁴⁹² but women veterans still encounter challenges when accessing care. VHA leadership must support the future planning of women's services and programming so that women veterans receive the highest quality health.⁴⁹³

LGBT Equity

In its systemwide implementation of cultural competency, VHA should leverage best practices from an area in which the agency is already an equity leader: treatment of LGBT patients. Every year since 2007, the Human Rights Campaign has published a Health Equality Index (HEI) report that aims to measure the quality of health care for LGBT patients based on core criteria

⁴⁸⁸ "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, <http://www.womenshealth.va.gov/>.

⁴⁸⁹ U.S. Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care*, April 2015, accessed June 12, 2016, http://www.womenshealth.va.gov/WOMENSHEALTH/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf.

⁴⁹⁰ Patricia M. Hayes, Chief Consultant Women's Health Services, VHA Office of Patient Services, briefing to the Commission on Care, October 19, 2015.

⁴⁹¹ Ibid.

⁴⁹² Ibid.

⁴⁹³ "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, <http://www.womenshealth.va.gov/>.

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that require health care systems to couple strong policies with appropriate training.⁴⁹⁴ In 2016, VAMCs made up 20 percent of all HEI participants. Among participating VAMCs, 84 percent were designated with *Leader* status.⁴⁹⁵ VHA hospitals publicize that discrimination against LGBT patients and employees is prohibited. Senior managers are registered for HEI training. And equal visitation rights are granted to families and friends of LGBT patients. VHA hospitals play a critical role in promoting patient care equality in states where VHA is the only Equality Leader.⁴⁹⁶ VHA should create strong policies and mandatory training, like that used to promote health equity for LGBT patients, to address equity issues for racial and ethnic minorities and women.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- VHA Care System providers should be required to ask patients about their military health history and incorporate veterans' responses into patients' treatment plans.
- VHA leadership should support the future planning of women's services and programming so that women veterans receive the highest quality health care.
- VHA should leverage the best practices developed in support of LGBT equity and implement them across VHA.
- VHA Care System providers should be required to attend comprehensive, on-going cultural and military competency training.

Other Department and Agency Administrative Changes

- None required.

⁴⁹⁴ "How the VA is leading the way on LGBT patient care," Andrew Park, The Week, February 25, 2014, accessed June 12, 2016, <http://theweek.com/articles/450361/how-v-a-leading-way-lgbt-patient-care>.

⁴⁹⁵ "Office of Health Equity: Healthcare Equality Index," U.S. Department of Veterans Affairs, accessed June 15, 2016, http://www.va.gov/HEALTHYEQUITY/Healthcare_Equality_Index.asp

⁴⁹⁶ "How the VA is leading the way on LGBT patient care," Andrew Park, The Week, February 25, 2014, accessed June 12, 2016, <http://theweek.com/articles/450361/how-v-a-leading-way-lgbt-patient-care>.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

Problem

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

Background

During the 1990s, Congress passed the Government Performance and Results Act⁴⁹⁷ to correct shortcomings in the way government was managed and assessed in an effort to bring modern business management practices into the federal government. The law was updated in 2011,⁴⁹⁸ yet one essential

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does all of the following:
 - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
 - Promotes veteran preferences and hiring.
 - Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, due process) through simplified, sensible processes that work for managers and employees.
 - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
 - Provides due process and appeals standards to adverse personnel actions.
 - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
 - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
 - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
 - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
 - Grandfathers current employees with respect to pay and benefits.
- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

⁴⁹⁷ Government Performance and Results Act of 1993, Pub. L. No. 103-62, 107 Stat. 285 (1993).

⁴⁹⁸ GPRA Modernization Act of 2010, Pub. L. No. 111-352, 124 Stat. 3866 (2011).

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component of modernizing the management of federal programs is still missing: reform of human capital management.⁴⁹⁹

The Civil Service Act was initially passed in 1883 and revised in 1978.⁵⁰⁰ The *general schedule*, which governs the pay and job classification process, was codified by regulation in 1949. The U.S. workforce, including the federal workforce, has changed dramatically since these laws and regulations were implemented. As noted in a recent report from the Partnership for Public Service, “the personnel system, designed more than 60 years ago, now governs more than 2 million workers and is a relic of a bygone era, reflecting a time when most federal jobs were clerical and required few specialized skills.”⁵⁰¹ As of 2013, nearly two-thirds of federal employees work in professional or administrative positions focused on knowledge-based work, with the Department of Veterans Affairs accounting for the largest percentage of such workers.⁵⁰²

The Partnership for Public Service calls for broad reform of the civil service system, noting that the

*the federal workforce has become an island disconnected from the larger talent market for knowledge-based professional and administrative occupations that are mission critical. . . . Federal employee pay . . . is not tied to the broader labor market, making it harder to compete with the private sector for talent. That disconnect is exacerbated by a job classification system that describes a workplace from the last century.*⁵⁰³

This system lacks mechanisms for rewarding top performers, demoting or firing poor performers, and holding managers accountable.⁵⁰⁴ The unnecessarily complex hiring system is difficult for applicants to navigate and makes it challenging for hiring managers to identify the most qualified candidates, hindering the ability to bring in experienced candidates from the private sector.⁵⁰⁵

*The civil service system has become a maze of rules and procedures that are not perceived as rational by the people who serve in government or by the general public. . . . Rigid policies . . . are now a burden on a government that needs to encourage flexibility and innovation to meet rapidly changing and difficult challenges.*⁵⁰⁶

⁴⁹⁹ U.S. General Accountability Office, Office of the Comptroller General, *Human Capital – A Self-Assessment Checklist for Agency Leaders*, accessed April 11, 2016, <http://www.gao.gov/assets/80/76520.pdf>. U.S. General Accountability Office, *Transforming the Civil Service: Building the Workforce of the Future – Results of a GAO Sponsored Symposium*, accessed April 11, 2016, <http://www.gao.gov/assets/200/197256.pdf>.

⁵⁰⁰ The Pendleton Civil Service Reform Act of 1883, Pub. L. No. 16, 22 Stat. 403 (1883).

⁵⁰¹ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵⁰² Ibid. The Department of Defense in total has more knowledge workers but the numbers for each service are reported independently and are below the total for the VA workforce.

⁵⁰³ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵⁰⁴ Ibid.

⁵⁰⁵ Ibid.

⁵⁰⁶ Ibid.

The General Accounting Office (GAO) also continues to point to human capital management as a high-risk area across government.⁵⁰⁷ DoD has proposed walking away from the Title 5 civil service system to support modernization of human capital management,⁵⁰⁸ President Barack Obama has repeatedly called for a commission to overhaul and modernize the civil service,⁵⁰⁹ and Congress is considering whether the time is right for civil service reform.⁵¹⁰

VHA currently uses three different personnel systems: Title 5 (the civil service/general schedule system) for senior executive service (SES) and other, mostly nonclinical, employees; Title 38 for physicians, dentists, and other specified health care professionals;⁵⁰⁹ and Title 38 Hybrid for allied health professionals such as pharmacists and licensed physical therapists.⁵¹⁰ Each system has its own set of requirements, procedures, and rules for the employees under its respective authority.⁵¹³ Currently, about two-thirds of VHA employees serve in the Title 38 Hybrid occupations.⁵¹⁴

VHA is not alone in having an excepted service system. More than a dozen agencies have special legislative authority to create a personnel system to fit their particular needs, including the Federal Bureau of Investigation, National Institutes of Health, National Security Agency, U.S. Public Health Service, Defense Intelligence Agency, U.S. Nuclear Regulatory Commission, and National Aeronautics and Space Administration.⁵¹¹ In an acknowledgement of the failure of the general schedule process to meet the needs of certain professions, OPM has also instituted governmentwide direct hiring authority for difficult-to-recruit positions, including medical officer, nurse, pharmacist, radiologic technician, and information technologist – all positions critically important to VHA’s mission success.

Modernizing human capital management is a global imperative for the private sector as well, with 92 percent of participants in one assessment of 7,000 businesses noting that a new approach to human resources is a critical organizational priority in 2016.⁵¹² According to a report from Deloitte, which examined broad human resource (HR) trends, “HR is redesigning almost everything it does – from recruiting to performance management to onboarding to reward systems” to learning and development.⁵¹³ Younger workers are driving many of these

⁵⁰⁷ U.S. GAO, *Federal Workforce—Human Capital Management Challenges and the Path to Reform, Testimony Before the Subcommittee on Federal Workforce U.S. Postal Service and the Census, Committee on Oversight and Government Reform, House of Representatives, Statement of Robert Goldenkoff*, GAO-14-723T, July 15, 2014, Washington, DC, 2014, accessed June 12, 2016, <http://www.gao.gov/assets/670/664772.pdf>.

⁵⁰⁸ “Draft Proposal Calls for Major Revamp of DoD Civilian Personnel System,” Jared Serbu, Federal News Radio, accessed April 8, 2016, <http://federalnewsradio.com/defense/2015/09/draft-proposal-calls-major-revamp-dod-civilian-personnel-system/>.

⁵⁰⁹ “Obama’s Budget Touts Progress Within Federal Workforce, but Offers It Nothing New,” Eric Katz, Government Executive, accessed April 8, 2016, <http://www.govexec.com/management/2016/02/obamas-budget-touts-progress-within-federal-workforce-offers-it-nothing-new/125815/>. The Office of Management and Budget, *Fiscal Year 2016 Budget of the U.S. Government*, accessed May 13, 2016, <https://www.whitehouse.gov/sites/default/files/omb/budget/fy2016/assets/budget.pdf>.

⁵⁰⁹ “Brace Yourselves: Congress Preps Civil Service Reform,” Andy Medici, Federal Times, accessed April 8, 2016, <http://www.federaltimes.com/story/government/management/oversight/2015/01/19/congress-civil-service-reform/21458717/>.

⁵¹⁰ Ibid.

⁵¹¹ See, e.g., 38 U.S.C. § 7401(1).

⁵¹² See, e.g., 38 U.S.C. § 7401(3).

⁵¹³ Joleen Clark, Jack Hetrick, and Donna Schroeder, “Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers,” Alternative Personnel System (2014).

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changes with expectations for meaningful work, learning opportunities, and career progression.⁵¹⁴ These workers have been choosing the federal government in diminishing numbers, with only 6 percent of federal employees currently younger than 30 years of age (compared to 23 percent of the civilian workforce).⁵¹⁵ In VHA, millennials (those 34 and younger) make up only 15 percent of the workforce, but are disproportionately over-represented among staff that quit VHA, at 20 percent.⁵¹⁶

As of January 2016, VHA had a vacancy rate of 16 percent for all positions, despite filling more than 40,000 positions in FY 2015.⁵¹⁷ VHA faces the additional challenge that 40 percent of its overall workforce is eligible for retirement in the next few years.⁵¹⁸ This problem occurs in the face of acknowledged national shortages of physicians⁵¹⁹ and geographic misalignment of the current health care workforce that leaves many localities short of needed providers.⁵²⁰ Taken together, this information makes clear that excellence in human capital management continues to be a business imperative for VHA.

Analysis

The human resource function within VHA needs a fundamental overhaul to increase responsiveness, efficiency, and customer service, as well as to align its orientation to the business needs of VHA.⁵²¹ Medical center directors do not receive the support they need from HR to accomplish hiring, disciplining, and planning for succession of employees.⁵²² During exit interviews, staff members who leave VHA cite barriers to career growth, insufficient professional development, a lack of promotions, and poor on-boarding and training as reasons for departing.⁵²³ In a recent national survey of VA employees, improving end-to-end hiring, recognizing stellar job performance, and providing professional development and career

⁵¹⁴ U.S. GAO, *The Excepted Service: A Research Profile*, GAO/GGD-97-92, accessed April 12, 2016, <http://www.gao.gov/assets/80/79968.pdf>.

⁵¹⁵ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 12, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵¹⁶ Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.

⁵¹⁷ “VA Struggles to Fill Medical Center Positions in Arizona, Across Nation,” Danika Worthington, Arizona Daily Sun, accessed April 5, 2016, http://azdailysun.com/news/local/va-struggles-to-fill-medical-center-positions-in-arizona-across/article_a14e6937-ecc1-5415-9391-7a6d759e5025.html.

⁵¹⁸ Joleen Clark, Jack Hetrick, and Donna Schroeder, *Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers*, *Alternative Personnel System* (2014).

⁵¹⁹ IHS Inc., *The Complexities of Physician Supply and Demand: Projections from 2013-2025*, accessed April 12, 2016, <https://www.aamc.org/download/426242/data/ihsreportdownload.pdf>.

⁵²⁰ “Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations,” U.S. Department of Health and Human Services, Health Resources and Services Administration, accessed April 12, 2016, <http://www.hrsa.gov/shortage/>.

⁵²¹ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, x, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵²² Ibid., vii.

⁵²³ Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.

planning ranked, numbers one, six, and nine respectively as top priorities for improving the employee experience at VA.⁵²⁴

The Civil Service System Does Not Support a High-Performing Health System.

Recruitment in VHA operates in an incredibly complex environment. Federal rules and regulations make HR more challenging than it is in the private sector.⁵²⁵ For example, interviews in 2014 with more than 500 VHA hiring managers and HR staff members pointed to the top problems with Title 5 recruitments as OPM classification standards, grading of position descriptions, position characterization, and the ranking and rating process.⁵²⁶ The group specifically noted that there are many staff positions required in a health care delivery system that do not translate into a general schedule occupational series; therefore, when the positions are graded, the grade and salary is too low to compete with the private sector. Examples of such positions are custodial workers (hospital employees need to apply antiseptic cleaning techniques, but general custodians do not) and general facilities and equipment maintenance (hospital employees need to understand the maintenance of such items as specialized medical equipment, positive pressure rooms, and sterile plumbing systems that are not requirements for general plant maintenance at an office building).⁵²⁷ In another example, VHA managers noted that the OPM classification standard for supply chain positions rendered VHA unable to compete for local talent because the assigned grade was too low.⁵²⁸

The general schedule system also has been identified as a barrier to career advancement.⁵²⁹ Clerical staff members in particular often cannot advance in pay and responsibility without leaving their positions and moving into a different job series.⁵³⁰ Similarly, frontline customer service staff under the general schedule cannot receive advanced steps within the grade for better performance or completing job-related certifications or degrees, unlike nurses and allied health professionals who can receive advances in pay for these accomplishments.⁵³¹

The hiring process in VHA is acknowledged to take too long.⁵³² “HR is expected to fill a position within 60 calendar days . . . but process requirements, even if perfectly executed, take about 49

⁵²⁴ “MyVA, Putting Veterans First,” MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.

⁵²⁵ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵²⁶ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People. Powerpoint of findings, July 29, 2014.

⁵²⁷ Veterans Health Administration, “Leading Access Scheduling Initiative – People, Assessment of Hiring Barriers,” VHA Classification Workgroup, 2014.

⁵²⁸ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xiii, accessed December 28, 2015, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

⁵²⁹ Ibid.

⁵³⁰ “Classification and Qualification: Classifying General Schedule Positions,” U.S. Office of Personnel Management, accessed November 24, 2015, <https://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/>.

⁵³¹ Pay Administration, VA Directive 5007 (2002). Staffing, VA Directive 5005 (2002).

⁵³² McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 109, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

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to 62 days.” Hiring timelines can span 4-8 months compared to private-sector hiring that takes between 0.5 and 2 months.⁵³³

This finding was echoed in a Northern Virginia Technology Council report on information technology challenges in VA that indicated across the board hiring of needed staff proceeds too slowly. “The causes are complex, but much of the delay can be traced to redundant, inconsistent, and inefficient hiring processes.”⁵³⁴ One driver of extended VHA hiring times is the government background checks and the licensing and credential review for clinical staff that is managed through VetPro, an internet-enabled data bank for credentialing VHA personnel.⁵³⁵

Although addressing recruiting and hiring problems will not be easy, doing so is essential to maintaining VHA’s workforce.⁵³⁶ An internal VHA workgroup that examined HR concluded that a complete break with Title 5 and a reworking of current Title 38 hiring authority is required, stating:

*The existing Personnel system does not meet today’s market or demand. With VHA’s tremendous volume of occupations to hire and significant turn-over rate in critical positions, it is necessary to promote an efficient organizational system to be able to hire qualified candidates as quickly as possible. The current classification system led to disparity across the systems and only looks at the duties of the position versus the qualifications of the person. The VHA hiring system must be agile and attractive to recruit those that just graduated or are entering the workforce... An agency specific excepted employment system would allow VHA to meet the unique staffing demands that are required of a complex health care organization.*⁵³⁷

VHA is Not Competitive in Pay for Many Positions

Many VHA staff have substantially lower earning potential than their private-sector counterparts. Despite a generous benefits package and the possible opportunities for greater work-life balance, and for research and teaching in a system that serves the important role of caring for the nation’s veterans, lower salaries reduce VHA’s competitive edge in the marketplace when trying to attract top talent.⁵³⁸ For example, although VHA is often able to provide physicians an entry salary that is comparable or better than industry standards, physicians’ long-term earning potential is dramatically less in VHA than that of their private-sector peers. “At the top of the salary ranges, VHA providers made less than their counter parts

⁵³³ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow-Clinical)*, 45-49, accessed May 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁵³⁴ Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America’s Veterans*, 12, accessed April 25, 2016, <http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf>.

⁵³⁵ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 37, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵³⁶ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵³⁷ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report*, August 2014.

⁵³⁸ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 39, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

by up to \$310,000 and on average, \$74,631. The only specialties for which VHA physicians made equal to or more than industry averages were anesthesiology, nephrology, ophthalmology, and psychiatry.”⁵³⁹ In another example of barriers to competitive pay, current provisions in law limit VA to a 60 percent level of market pay compensation for allied health professionals, even when recruitment failures demonstrate the need to offer higher salaries.⁵⁴⁰ As noted above in the discussion on classification, failure to appropriately classify positions also leads to a salary that is not competitive with private-sector health care organizations for positions such as customer service personnel.

In the area of educational debt repayment relief, VHA lags behind other federal and state agencies that use such programs to fill critical physician shortages in medically under-served areas.⁵⁴¹ VHA can offer up to a maximum of \$60,000 for 2 years (\$30,000 per year). HRSA National Health Service Corps (NHSC) runs three programs: the NHSC loan repayment program that provides up to \$50,000 in loan payments, the Student-to-Student Loan Repayment Program for up to \$120,000, and the State Loan Repayment Program with each state establishing loan amounts that are administered by HRSA.⁵⁴² These amounts range broadly from \$80,000 in Arizona and Arkansas, \$90,000 in Colorado, \$100,000 in Georgia and Alabama, and \$190,000 in California.⁵⁴³

Clinic Staffing Is Impaired by Current Law, Regulation, and Policy

Successfully reallocating staff to meet veterans’ needs in a rapidly evolving health care environment is difficult in VHA. The *Independent Assessment* recommended that VHA use extended clinic hours and weekend clinics to better optimize space and increase access to care for veterans.⁵⁴⁴ VA policy currently prohibits full-time VA physicians from receiving fee-basis compensation from the same VA facility in which they are salaried, although they can, under certain circumstances, receive fee-basis appointments at other VA facilities.⁵⁴⁵

These restrictions can make it hard to meet policy requirements for night and weekend schedules⁵⁴⁶ without reducing staffing on inpatient units or under-resourced primary care clinics. Use of alternative work schedules and overtime pay for physicians to meet local patient demands should be under control of local medical center directors.

⁵³⁹ Ibid., 40.

⁵⁴⁰ Increases in Rates of Basic Pay, 38 U.S.C. § 7455.

⁵⁴¹ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report*, August 2014.

⁵⁴² “Loan Repayment Program,” U.S. Department of Health and Human Services, National Health Service Corps, accessed June 9, 2016, <http://nhsc.hrsa.gov/loanrepayment/>.

⁵⁴³ “Physician Loan Repayment Guide,” Jimmy Karnezis, accessed April 13, 2016, <https://www.credible.com/blog/physician-loan-repayment-guide/>.

⁵⁴⁴ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 136, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵⁴⁵ VA Handbook 5005, pt. II, ch. 3, § A, para. 3b.

⁵⁴⁶ Extended Hours Access for Veterans Requiring Primary Care Including Women’s Health and Mental Health Services at Department of Veterans Affairs Medical Centers and Selected Community Based Outpatient Clinics, VHA Directive 2013-001 (2013).

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VHA Staff Receive Inadequate Training Including at Initial Hire

Leading practices include providing mandatory onboarding training that introduces policies, procedures, and necessary skills. Onboarding programs include various activities that expose new hires to the culture of the organization and expectations based on roles and responsibilities. A report released by the Society for Human Resources Management suggests, “Formal orientation programs help new employees understand many important aspects of their jobs and organizations, including the company’s culture and values, its goals and history and its power structure.”⁵⁴⁷ To make up for inadequate on-boarding and to fill current staff’s understanding of VA, VHA is providing VA 101 training for current employees, with 60 facilities having completed the training in FY 2015.⁵⁴⁸ Employees in VA continue to desire a wide array of training, including customer service training, professional development, peer-to-peer training, hands-on training, and role-specific training.⁵⁴⁹

HR Professionals Must Focus on People and Business Priorities Not Compliance

VHA job candidates indicate they have unsatisfactory recruiting experiences, noting failures in timely follow-up and communication.⁵⁵⁰ VA human resources management and administration indicate that VA HR professionals do not exhibit a uniform level of competency, frequently do not understand the employee recruitment process end-to-end, and fail to provide high quality consultative support to managers with respect to all HR functions, but particularly in the area of progressive discipline and firing of employees.⁵⁵¹ Currently HR professionals in VA are largely focused on compliance with a complex set of rules,⁵⁵² rather than adding true value to the organization and being able to be full partners in accomplishing VHA business objectives. Resolving these staffing issues would render the overall HR function more effective.

VHA must become the employer of choice to attract and retain the very best health care workforce. To help it accomplish this goal, VHA requires competitive pay and flexible hiring and talent management processes. VHA cannot achieve that goal within its current personnel systems. A uniform alternative personnel system under Title 38 for all VHA human capital management would accomplish all of the following:

- Meet the unique staffing demands of a health care delivery organization.
- Allow market-based compensation and pay-setting latitude using broad pay bands to support staff growth and progression within their job. VHA must consider total compensation (with benefits), as compared to market rates because the government provides many more benefits than private-sector organizations. Consequently, VA may

⁵⁴⁷Talya Bauer, Society for Human Resource Management, *Onboarding New Employees: Maximizing Success*, 2010, 9-10, accessed May 13, 2016, <https://www.shrm.org/about/foundation/products/documents/onboarding-percent20epg-percent20final.pdf>.

⁵⁴⁸ Veterans Health Administration, *Blueprint for Excellence: Fiscal Year 2015 Results: Communicating Accomplishments*, presented to the National Leadership Committee, March 22, 2016.

⁵⁴⁹ “MyVA, Putting Veterans First,” MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.

⁵⁵⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁵¹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁵² Ibid.

pay less than private-sector employers for a position, but the total compensation (with benefits) may end up being equivalent to private-sector total compensation.

- Allow flexibility in the processes used to hire staff including direct hiring when needed.
- Support career planning and professional development through the application of competency models and training specific for health care as part of position management.
- Simplify the management tasks for supervisors and hiring managers who will only need to know one set of rules and processes instead of four.
- Simplify the job of HR professionals who will only need to know one set of rules and processes instead of four.
- Allow development and training of the HR workforce in VHA to focus on only one personnel system to create true end-to-end hiring expertise.
- Reduce competition within government where shortages of HR professionals create competition for Title 5 trained HR professionals.
- Create streamlined and uniform standards and approach to discipline and dismissal.
- Create fairness among staff in sick leave, vacation pay, salary, awards and bonuses, and compensatory time off.
- Support flow of staff between the field and VHA Central Office (VHACO) under a single personnel system.

Establishing a new human capital management system in VHA will neither be easy nor quick, nor will it be a panacea that alone will fix all that is wrong with recruitment, retention, development, and advancement. In designing and implementing a new system, VHA must take full advantage of private-sector resources and expertise in human resource management and ensure that the new system is built to be compatible with the private-sector. As VHA moves toward greater integration of care delivery, with networks of community providers, compatibility in personnel systems and a resulting greater flow of employees between VHA and community sites can help create closer linkages between the two parts of the care delivery system.

Implementation

Legislative Changes

- Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.
- Update student loan reimbursement limits to be competitive with other federally administered programs and market conditions.

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- Establish an appeals process that provides staff appropriate due process that is based on the regulatory standards for the new alternative personnel system.

VA Administrative Changes

- Eliminate barriers to creating hiring pools for positions with frequent turnover (e.g., extend the length of time over which candidates can continue to be hired from a completed certification until all of the qualified candidates are hired or have declined offers).
- Eliminate barriers to initiating a recruitment process when vacancies are anticipated; positions need not be empty before recruitment ensues. In some cases, hires should also be made before the departure of key personnel to allow for on-the-job training and mentoring of the replacement.
- Benchmark credentialing to private-sector processes and consider outsourcing the process as much as practicable through centralized mechanisms.
- Release market pay and total compensation information to the field for all job categories using commercially available data and information, at least every 2 years.

Other Department and Agency Administrative Changes

- OPM should continue to oversee and administer benefits for VHA but not impose any of the other existing conditions or requirements on the management of the new alternative personnel system. The new personnel system should be governed by the new legislative requirements and those established during the anticipated rulemaking process in VA. These requirements include market-based pay, performance awards, or performance and disciplinary processes other than those imposed under Title 38.

Recommendation #16: Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Problem

Effective planning for and management of human capital are core enabling requirements for any organization. If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

Background

As recognized by GAO, “to attain the highest level of performance and accountability, federal agencies depend on three enablers: people, process, and technology. The most important of these is people, because an agency’s people define its character and its capacity to perform.”⁵⁵³ Human capital management, although often viewed as a cost, must be viewed as an investment in business success.⁵⁵⁴ For too long, VA human capital management has been undervalued and under resourced. A 1993 report from GAO outlined many of the same deficiencies found in 2016: a focus on compliance instead of outcomes, a lack of proactive human capital planning and management, and a weak system of rewards and incentives to attract and retain qualified personnel.⁵⁵⁵

Today, VA Human Resources and Administration (HRA) shares responsibility for human capital management with VHA. Neither organization has been able to establish a high-performing, effective, human capital management system. For VHA to transform to a high-performing organization, human capital management must do the same.

Analysis

VA “needs a fundamental overhaul of the core support functions (including human resources) . . . to increase responsiveness and efficiency and improve customer service. These functions should be aligned with the needs of the VHA organizations delivering care to

The Commission Recommends That . . .

- VHA hire a chief talent leader who holds responsibility for the operation’s entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the CVCS.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.
- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

⁵⁵³ U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders*, GAO/OCG-00-14G, version 1, September 2000, 3, accessed June 10, 2016, <http://www.gao.gov/assets/80/76520.pdf>.

⁵⁵⁴ Ibid.

⁵⁵⁵ U.S. General Accountability Office, *Management of VA: Improved Human Resource Planning Needed to Achieve Strategic Goals*, GAO/HRD-93-10, March 1993, accessed June 10, 2016, <http://www.gao.gov/assets/220/217512.pdf>.

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Veterans.”⁵⁵⁶ Governance and responsibility for human capital management is fragmented and complicated.⁵⁵⁷ Medical center directors appear to be largely on their own in addressing human capital management needs, without competent and timely assistance to support hiring employees, planning for succession, and taking disciplinary actions.⁵⁵⁸ Recruiting takes too long and is cumbersome because information is not shared freely among the various organizational components.⁵⁵⁹ Candidates are not treated with respect, experience lengthy intervals between contacts from VA, fail to receive timely follow-up once candidates are selected, and experience a lengthy on-boarding process.⁵⁶⁰ Human capital management also fails to effectively support the disciplinary process, which is perceived as too long and too difficult.⁵⁶¹ Insufficient resources are devoted to training,⁵⁶² leaving VHA vulnerable to failure.

VA requires a comprehensive redesign of the human resources function to be more responsive, more efficient, and more focused on customer service.⁵⁶³ Transforming HR will require “redesigning key processes, shifting the mindset of [human resources] staff from compliance to effectiveness, training [human resources] and its customers on key roles and responsibilities, and rationalizing its technology systems.”⁵⁶⁴

Some progress has been made in updating human capital management functions. VA is in the process of implementing new talent management software to provide better process management and analytics.⁵⁶⁵ HRA has also started a new HR Academy.⁵⁶⁶ The academy is intended to demonstrate alignment between training resources and competency requirements⁵⁶⁷ and to describe the experience needed to advance to the next position level in human resources.⁵⁶⁸ VA instituted a new online senior executive service performance management system that permits real-time tracking of the performance management process and analysis of

⁵⁵⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁵⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁵⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, L3, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁵⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 109, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁶⁰ *Ibid.*, 110.

⁵⁶¹ *Ibid.*, 61.

⁵⁶² *Ibid.*, 67.

⁵⁶³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, L5, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁶⁴ *Ibid.*

⁵⁶⁵ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁶⁶ *Ibid.*

⁵⁶⁷ Department of Veterans Affairs, HR Academy, *TMS User eIDP Checklist*, accessed January 25, 2016, www.vahracademy.va.gov/docs/TMSUserIDPChecklist.pdf.

⁵⁶⁸ “VA HR Academy: Resources,” Department of Veterans Affairs, accessed January 25, 2016, www.vahracademy.va.gov/resources.asp. Department of Veterans Affairs, *VA HR Competency Model Reference Guide*, accessed January 25, 2016, www.vahracademy.va.gov/docs/VAHRCompetencyModelReferenceGuide.pdf.

performance outcomes;⁵⁶⁹ however, HR specialists must still use as many as 30 different IT systems that do not communicate with each other to do their work.⁵⁷⁰ Although some new systems have been purchased, life cycle funding for them is not guaranteed by the Office of Information and Technology and no concrete plan has been approved to replace and consolidate the many current systems that are not interoperable. In addition, funding support for HRA initiatives overall are not planned, allocated, and maintained at consistent levels year-to-year in the departmental budget, impeding long term transformation.⁵⁷¹

A VHA workgroup was formed with HR subject matter experts and leadership to identify hiring barriers and develop recommendations for improvements. The workgroup fielded a survey in July 2014 to gather broad input from VHA on the deficiencies in the management of human capital in VHA. These experts concluded that VHA should move to a new alternative personnel system under Title 38.⁵⁷² (See Recommendation #15.)

Substantial deficiencies in human capital management still remain in VA. The funding mechanism to support the departments' human capital management does not support long-range planning and effective program implementation. The lines of authority and management for human capital management professionals do not permit consistency in the quality and skill of the human capital management professionals hired and promoted, nor does the reporting structure allow HRA to hold human capital management staff accountable for effective service delivery. The investment in human capital management information technology systems has been inadequate for decades.⁵⁷³

Top leadership, including the SECVA, DEPSECVA, and CVCS, must make the transformation of human resources a top priority as demonstrated by investing their personal time in human capital management transformation; reviewing and endorsing a transformation plan including the funding required to accomplish it; receiving regular progress updates; and engaging in problem-solving sessions with human capital management leaders to refine and advance transformation efforts. Top leadership must demonstrate to other leaders that human capital management transformation is an organizational priority by disseminating clear goals for transformation in planning documents, communicating expectations for change that are clear to all key employees, and sharing successes with subordinate leaders and employees. The CVCS must ensure that the executive who leads the human capital management function has the demonstrated knowledge, skills, and experience in human capital management to competently lead the function and make this individual part of the executive leadership team on par with other key functions like finance and clinical operations. (See suggested organization chart in Recommendation #12.)

⁵⁶⁹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁷⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 24, 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁷¹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁷² Ibid.

⁵⁷³ Ibid.

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The SECVA, DEPSECVA, and CVCS must engage subordinate leaders in the transformation process by ensuring the needs of these leaders have informed the transformation solutions; that subordinate leaders are assigned specific responsibilities under the transformation plan; and they are held accountable by the CVCS for outcomes. They must also ensure that the HR transformation and ongoing HR function is adequately resourced to be successful.

The VA HRA and VHA Workforce Management Office must engage change management experts to undertake a review of human resource business processes, management structures, funding, and technology needs to create a transformation agenda and human capital management plan. As VHA is shifting to a new alternative personnel system under Title 38, the human capital management plan should consolidate in VHA the HR functions, responsibility, and authority required to hire, manage, develop, reward, and discipline staff and consider whether functions such as benefit management remain with HRA or move to VHA. Furthermore, the plan should address all of the following issues:

- need for a chief of talent management
- consistency with benchmark standards of private-sector health care systems
- key organizational structures and roles and responsibilities of VA and VHA in human capital management that are clearly defined and consistent with benchmark organizations
- the full life cycle of human capital management (i.e., planning, recruitment, hiring, retention, development, performance management, and discipline), which should be supported effectively by human capital management and fully meet the needs of managers and staff
- federal sharing authority and the ability to outsource human capital management functions to the private sector are addressed
- IT investments and analytical capability to provide meaningful, timely data to managing staffing, performance tracking, and accountability
- meaningful performance metrics and risk management indicators that are established for human capital management⁵⁷⁴
- funding and full-time equivalent employee staffing for human capital functions that meet private-sector benchmark standards for health care
- knowledge, skills, and ability required of human capital management professionals at each grade and within each series, which should be clearly defined, and a requirement to assess current staff, new hires, and promotions against this standard, which should include procedures for dismissal

⁵⁷⁴ U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders*, GAO/OCG-00-14G, version 1, September 2000, 34, accessed June 10, 2016, <http://www.gao.gov/assets/80/76520.pdf>.

Once completed, this analysis and draft plan must be shared widely within the department to gain feedback and input, and it must be shared with OPM, OMB, and Congress. After incorporating feedback and finalizing the plan, HRA should engage change management experts to fully implement the transformation agenda and new human capital management plan. Implementation will require funding contributions from VA and VHA that the SECVA must mandate.

HRA must develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 Hybrid, Title 38 7306, and SES). This process must include clear standards, guidelines, and training for supervisors and managers on how to implement the new progressive discipline process. All managers and supervisors and human capital management professionals must complete the training, and VA must establish a process for ensuring that new supervisors and managers complete the training on an ongoing basis. HRA must develop HR staff to be effective coaches so they can provide the coaching and support that managers need as they embark on disciplinary procedures to ensure timely and effective interventions.

VHA supervisors and managers must be held accountable for applying these procedures when poor performance or conduct occurs. To enable accountability, VHA must have a technology infrastructure to actively track and manage poor performance (annual ratings and disciplinary actions) that both human capital managers and supervisors can use to keep track of issues.

The Commission notes GAO is launching a comprehensive audit of human capital management functions in VA to be delivered to Congress in September 2016.⁵⁷⁵ The review and resulting recommendations will provide further insights to promote meaningful transformation of human capital management in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Employ HR and change management experts to undertake a review of its business processes, management structures, funding, technology, and the legal authority needed in HR to create a transformation agenda and human capital management plan.
- Require VHA to allocate budget to fully support the change plan and ongoing HR operations.

⁵⁷⁵ Ms. Frieda Stenzel, lead investigator, U.S. Government Accountability Office, during an initial meeting with VACO HR&A about a new study being undertaken by GAO, December 18, 2015. The study is intended to 1) assess VHAs capacity to perform its workforce planning and talent management, and 2) evaluate the effectiveness of VHAs human capital functions.

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- Develop and implement an effective progressive discipline process for all staffing authorities.

Other Department and Agency Administrative Changes

- None required.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

Problem

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

The Commission Recommends That . . .

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an other-than-honorable discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

In some cases, individuals have been dismissed from military service with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury, posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

Background

Veteran status is the basis for eligibility for all VA benefits,⁵⁷⁶ and under law a veteran is a person who has met three criteria: active-duty military service (subject to specified exceptions), 2 years of continuous service, and discharge or separation from the military under conditions other than dishonorable.⁵⁷⁷ The military characterizes discharges into one of five categories: honorable, general (under honorable conditions), OTH, bad conduct (adjudicated by a general court or special court-martial), and dishonorable.⁵⁷⁸

Congress has established specific bars to VA benefits. Those barred by statute include deserters, individuals sentenced by a general court-martial, and conscientious objectors who refused to perform military duty.⁵⁷⁹ VA regulations interpret the phrase "discharged or released . . . under conditions other than dishonorable" to mean that a discharge or release because of one of the following offenses is considered to have been issued under dishonorable conditions:

(1) acceptance of an OTH discharge to escape trial by general court-martial, (2) mutiny or

⁵⁷⁶ Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁷⁷ Veterans Benefits, 38 U.S.C. § 101(2).

⁵⁷⁸ Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁷⁹ Certain Bars to Benefits, 38 U.S.C. § 5303(a).

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spying, (3) an offense involving moral turpitude, (4) willful and persistent misconduct, and (5) certain homosexual acts involving aggravating circumstances.⁵⁸⁰

Limited exceptions to those statutory and regulatory bars permit VA to award of benefits. A claimant may be granted benefits if VA determines that the claimant was insane at the time of the offense leading up to discharge.⁵⁸¹ Benefits may be granted based on a prior period of other-than-dishonorable service for individuals with two or more periods of service.⁵⁸²

Former service members with an OTH discharge as a result of a regulatory (rather than a statutory) bar are eligible for VA care for service-incurred conditions.⁵⁸³ Former service members with OTH discharges are not recognized as veterans, so they will be routinely denied treatment unless they initiate, and prevail in, an adjudication conducted by the Veterans Benefits Administration as to the character of their discharge. No routine mechanism exists to trigger adjudication to determine if such a discharge is not dishonorable. In many instances, the character of an individual's discharge is predicated on behaviors that resulted from, or are linked to, behavioral health conditions that had their origin in service, yet VA regulation bars the individual from receiving benefits.⁵⁸⁴

Analysis

Veterans' benefits are understood to be earned. The principle has been described as follows: In harsh environments in which lives may be on the line, serious breaches of conduct that interfere with the military mission should rightfully brand the offender for life and should likewise prohibit them from being eligible for the special military benefits and entitlements reserved for honorable and meritorious service.⁵⁸⁵

Some argue the offender's mental state at the time of the misconduct must be taken into account when considering veteran status.⁵⁸⁶ For example, many service members have experienced combat and sustained psychological wounds of war that manifest behaviors that lead to military discipline.⁵⁸⁷ VA regulations not only fail to account for the role of those psychic wounds, but are themselves overbroad, weak discriminators as to what is truly dishonorable service. To illustrate, commentators have identified two regulatory bars as particularly problematic: those based on moral turpitude,⁵⁸⁸ and willful and persistent misconduct.⁵⁸⁹ Neither of those two regulatory terms, which originated in 1944,⁵⁹⁰ are defined; neither provides

⁵⁸⁰ Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸¹ Certain Bars to Benefits, 38 U.S.C. § 5303(b).

⁵⁸² Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁸³ Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).

⁵⁸⁴ Certain Bars to Benefits, 38 U.S.C. § 5303(a). Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸⁵ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 12-13, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁸⁶ *Ibid.*, 13.

⁵⁸⁷ *Ibid.*

⁵⁸⁸ Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸⁹ *Ibid.*

⁵⁹⁰ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the

criteria or examples of what is or is not covered. Both are ambiguous and susceptible to subjective judgment,⁵⁹¹ with great potential for different VA regional offices reaching different outcomes on the same facts.⁵⁹² VA officials have acknowledged that these terms are broad and imprecise,⁵⁹³ and advocates have documented the resultant disparities in VA adjudicative decisions.⁵⁹⁴

The only specific mental-health exception to the bar-to-benefits rules — that the person was insane at the time of the commission of offense⁵⁹⁵ — is very limited. VA regulations define the term *insane*, as follows:

*An insane person is one who, while not mentally defective or constitutionally psychopathic, except when a psychosis has been engrafted upon such basis condition, exhibits, due to disease, a more or less prolonged deviation from his normal method of behavior; or who interferes with the peace of society; or who has so departed (become antisocial) from the accepted standards of the community to which by birth and education he belongs as to lack the adaptability to make further adjustments to the social customs of the community in which he resides.*⁵⁹⁶

VA's Office of General Counsel (OGC), in a now almost 20-year old precedential opinion, has construed that regulation narrowly. Responding to a request for an opinion regarding the parameters for behavior that would constitute insanity under the regulation, the General Counsel advised, as follows:

*The question of insanity arises in numerous legal proceedings, and its meaning may vary according to the jurisdiction and the object or purpose of the proceeding. However, in all contexts, the term indicates a condition involving conduct which deviates severely from the social norm. Black's Law Dictionary, at 794, states that '[t]he term is more or less synonymous with . . . psychosis, which itself has been defined as "a mental disorder characterized by gross impairment in reality testing' or, in a more general sense, as a mental disorder in which 'mental functioning is sufficiently impaired as to interfere grossly with the . . . capacity to meet the ordinary demands of life.'"*⁵⁹⁷

Armed Forces," *Military Law Review*, 214, Winter, (2012): 160-192, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁹¹ Ibid., 164, 186.

⁵⁹² Ibid., 10, 172. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable*, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁵⁹³ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 67, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁹⁴ Ibid., 68-70.

⁵⁹⁵ Characters of Discharge, 38 C.F.R. 3.12(b).

⁵⁹⁶ Determinations of Insanity, 38 C.F.R. 3.354(a).

⁵⁹⁷ "Office of General Counsel: Opinions Year 1997," U.S. Department of Veterans Affairs, accessed June 15, 2016, <http://www.va.gov/ogc/opinions/1997precedentopinions.asp>. Vet. Aff. Op. Gen Couns. Prec. 20-97, VAOPGCPREC 20-97, 1997, accessed June 15, 2016, <http://www.va.gov/ogc/docs/1997/Prc20-97.doc>.

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As understood by VA OGC at the time, *insanity*, with its emphasis on gross impairment, and as reflected in practice,⁵⁹⁸ is a highly restrictive standard. That narrow standard is also limiting with respect to the range of symptoms that could be considered under the *insanity* exception: gross cognitive impairment or gross impairment in capacity to function in daily life. That limited range effectively excludes behaviors associated with a widely prevalent service-related condition, PTSD. Those behaviors, which often lead to disciplinary actions, include aggressive behavior, substance-abuse,⁵⁹⁹ impulsivity, and risk-taking (including sensation seeking, aggressive driving, interpersonal violence, and self-injurious or suicide-related behavior).⁶⁰⁰ Research has shown that combat veterans with PTSD and other psychiatric diagnoses have a heightened risk of misconduct outcomes.⁶⁰¹ Other than its *insanity* rule, the regulations provide no specific opportunity to consider mental health as a likely cause of, or mitigating factor in, disciplinary issues leading to an individual's discharge.

The following are illustrative examples of how these regulations have worked in practice:

- John, a service member with multiple deployments to Iraq and Afghanistan and 7 years of service, received an OTH discharge after self-medicating with marijuana. He was denied VA treatment for PTSD.⁶⁰²
- Tim, a rifleman with two purple hearts and four campaign ribbons for service in Vietnam, was sent to combat while still 17 years old, and had a nervous breakdown and suicide attempt before his 18th birthday. He was sent back to Vietnam involuntarily for a second tour, and had a third nervous breakdown that led to an AWOL and OTH discharge. He was denied service connection for PTSD because the nature of his discharge.
- Tom, a combat infantryman in the first Gulf War, on his return, started experiencing symptoms of PTSD and attempted suicide. He was denied leave to be with his family,

⁵⁹⁸ Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable,"* accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁵⁹⁹ Deirdre MacManus et al., "Aggressive and Violent Behavior Among Military Personnel Deployed to Iraq and Afghanistan: Prevalence and Link with Deployment and Combat Exposure," *Epidemiologic Reviews*, 37, no. 1, (2015): 196-212, <http://doi.org/10.1093/epirev/mxu006>.

Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, <http://dx.doi.org/10.1186%2F1471-244X-10-88>.

⁶⁰⁰ Lisa M. James, Thad Q. Strom, and Jennie Leskela, "Risk-Taking Behaviors and Impulsivity Among Veterans With and Without PTSD and Mild TBI," *Military Medicine*, 179, no. 4, (2014): 357 – 363, <http://publications.amsus.org/doi/pdf/10.7205/MILMED-D-13-00241>.

⁶⁰¹ Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, <http://dx.doi.org/10.1186%2F1471-244X-10-88>.

⁶⁰² Swords to Plowshares, presentation to Commission on Care, January 21, 2016, accessed June 25, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former service members.

but left anyway. After a 60-day absence, he returned and was given an OTH discharge. He was denied services for 20 years.⁶⁰³

In short, the VA regulation used to determine whether the character of a veteran's OTH discharge is disqualifying does not take into account behavioral health problems associated with military service. As a result, former service members who were discharged for disciplinary problems that cannot be disassociated from PTSD or other behavioral health disorders are routinely barred from VA treatment for those disorders.

Individuals with PTSD and traumatic exposure are at heightened risk of substance abuse,⁶⁰⁴ depression,⁶⁰⁵ homelessness,⁶⁰⁶ premature mortality,⁶⁰⁷ and suicide.⁶⁰⁸ Access to VA health care is vital to successful reintegration of combat-traumatized veterans into society because it provides "the only reservoir of combat PTSD expertise."⁶⁰⁹

The importance of early access to needed treatment for behavioral health conditions like PTSD cannot be overstated,⁶¹⁰ yet many former service members are reluctant to seek treatment for behavioral health problems.⁶¹¹ Those with unfavorable discharge records who finally come forward to seek medical care must not only initiate a request for a character of discharge adjudication, but be prepared to confront a lengthy process if they elect to do so.⁶¹²

⁶⁰³ Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁶⁰⁴ Kipling M. Bohnert et al., "The Association Between Substance Use Disorders and Mortality among a Cohort of Veterans with Posttraumatic Stress Disorder: Variation by Age, Cohort, and Mortality Type," *Drug and Alcohol Dependence*, 128, no. 1-2, (2013): 98-103, <http://www.sciencedirect.com/science/article/pii/S0376871612003328>.

⁶⁰⁵ Leo Sher, Maria Dolores Braquehais, and Miquel Casas, "Posttraumatic Stress Disorder, Depression, and Suicide in Veterans" *Cleveland Clinic Journal of Medicine*, 79, no. 2 (2012): 92-97, <http://doi.org/10.3949/ccjm.79a.11069>.

⁶⁰⁶ Eve B. Carlson et al., "Traumatic Stressor Exposure and Post-Traumatic Symptoms in Homeless Veterans," *Military Medicine*, 178, no. 9, (2013): 970-973, <http://doi.org/10.7205/MILMED-D-13-00080>.

⁶⁰⁷ Joseph A. Boscarino, "Posttraumatic Stress Disorder and Mortality Among U.S. Army Veterans 30 Years After Military Service," *Annals of Epidemiology*, 16, no. 4 (2005): 248-256, <http://www.sciencedirect.com/science/article/pii/S1047279705001109>.

⁶⁰⁸ Holly J. Ramsawh et al., "Risk for Suicidal Behaviors Associated with PTSD, Depression, and their Comorbidity in the U.S. Army," *Journal of Affective Disorders*, 161, no. 1, (2014): 116-122, <http://www.sciencedirect.com/science/article/pii/S0165032714001189>.

⁶⁰⁹ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 14, accessed June 20, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁶¹⁰ Ronald C. Kessler, "Posttraumatic Stress Disorder: The Burden to the Individual and to Society," *Journal of Clinical Psychology*, 5, Suppl. 5, (2000): 4-12, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/10761674>.

⁶¹¹ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶¹² Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable*, 74-78, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

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Several generations of former service members were exposed to combat trauma and continue to live with the psychological wounds of war. Lack of access to treatment for those who sustained psychological wounds that went untreated and were manifest in undesirable behavior in service is concerning. Although Congress could address this concern, VA has the means to remedy the problem without congressional action by amending its own regulations. VA could afford former service members needed treatment for their conditions when they are able to establish that their health problems were incurred in service.⁶¹³ In other circumstances, when it is likely an individual could establish eligibility for VA care, current regulation permits the individual to receive the care on the basis of a tentative eligibility determination.⁶¹⁴ This regulation permits VA to provide treatment without prior adjudication of the character of discharge.

VA should revise its regulations to lift the immediate bar to health care for former service members who have an OTH discharge. VA should award tentative eligibility for health care to at least some former service members who have an OTH discharge. The criteria for awarding tentative eligibility for care could include service in a combat theater, more than a single enlistment, duration of service, or some combination thereof. This approach would allow VA to provide meaningful access to treatment without delay for those likely to be granted eligibility. For health care purposes, VA should also revise its regulations by recognizing that the severe punishment of characterizing a person's service as OTH is not justified when extenuating circumstances (to include behavioral health issues at the time) explain or mitigate that misconduct that resulted in the OTH discharge.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Amend 38 C.F.R. 17.34 to provide for tentative eligibility determinations applicable to individuals with OTH discharges who have had substantial honorable service, including service in a combat theater.
- Amend of 38 C.F.R. 3.12(d) to provide for recognition of extenuating circumstances that show, for purposes of health care eligibility, that service was not OTH.

Other Departments and Agency Administrative Changes

- None required.

⁶¹³ Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).

⁶¹⁴ Tentative Eligibility Determinations, 38 C.F.R. 17.34.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Problem

Although VHA continues to offer the promise of health care to all veterans, its capacity to meet that promise is constrained by appropriated funding.⁶¹⁵ Congress and VA leadership must work to identify who VHA will serve, and what services it will provide, yet eligibility criteria have not been examined in 20 years.⁶¹⁶

Background

VHA's core mission is to care for veterans who has borne the battle. But its secondary mission of caring for veterans' non-service-connected health care needs is longstanding, dating back to Civil War origins. Congress has included veterans without service-connected needs among those eligible as highlighted below:

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use underutilized VHA providers and facilities, providing payment through private insurance.
- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

- In March 1865, Congress incorporated the National Home for Disabled Volunteer Soldiers and Sailors, originally intended for Union veterans who suffered economic distress from disabilities incurred during the Civil War. The National Home constructed the first hospitals for Civil War veterans in 1866, and after a series of acts of Congress, those hospitals were opened in 1887 to veterans suffering economic distress from disabilities not incurred in military service.⁶¹⁷
- The World War Veterans Act of 1924, which established the Veterans Bureau⁶¹⁸ (the predecessor to the Department of Veterans Affairs), authorized its director to provide hospitalization and related travel expenses to veterans whose services dated back as far as 1897, regardless of the type or cause of their disabilities, as long as those veterans who were unable to pay received preferential admission.⁶¹⁹
- Public Law 85-56 (1957), which codified prior VA laws and regulations, effectively expanded eligibility to veterans of future wars, providing needed hospital care for veterans with service-connected disability incurred or aggravated during war, or for any other disability if the veteran is unable to pay for hospital care.⁶²⁰

⁶¹⁵ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶¹⁶ *Ibid.*, 25.

⁶¹⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

⁶¹⁸ The Veterans Bureau consolidated the National Home and other veterans-related functions housed in different government bureaucracies.

⁶¹⁹ World War Veterans Act, 1924, Pub. L. No. 68-242, (1924).

⁶²⁰ Veterans Benefits Act of 1957, Pub. L. No. 85-56, 71 Stat. 83 (1957). That law provided separate authority in section 512 for outpatient medical treatment, which was limited to treatment for a service-connected disability.

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- In 1966, Congress expanded eligibility for hospital care to *peacetime* veterans (of service after January 1955).⁶²¹
- In 1970, Congress extended eligibility for hospital care to veterans 65 and older for a non-service-connected disability,⁶²² exempting that group of veterans from taking the then-required oath affirming their inability to defray the expense of care for non-service-connect ailments.⁶²³
- With the Veterans Health Care Expansion Act of 1973, Congress eliminated the distinction between wartime and peacetime veterans for purposes of eligibility for outpatient care, and further expanded eligibility to outpatient care. It granted veterans who are 80 percent or more service-connected disabled eligibility for treatment of any condition, and authorized others eligible for hospital care to receive outpatient care to prepare for or preclude a need for hospitalization or to complete treatment initiated during hospitalization.⁶²⁴
- Congress expanded eligibility again in 1976, authorizing hospital care for treating a non-service-connected condition of any veteran 65 or older (without regard to ability to pay), authorizing outpatient care for any disability to any veteran 50 percent or more service-connected disabled, and directing VA to ensure, by regulation, special treatment priority to service-connected veterans and others receiving benefits because of a need for aid and attendance, or being permanently housebound.⁶²⁵

Eligibility laws for veterans' health care have changed substantially during the past century, yet the commitment to serving service-connected veterans and veterans in financial need has remained constant.

Prior to enactment of the Veterans' Health Care Eligibility Reform Act of 1996,⁶²⁶ VHA was a hospital-based model with entirely different eligibility rules for hospital care than for outpatient care. The eligibility reform law was aimed at transforming access to VA care from a 1950s hospital-based model to one that erased distinctions between eligibility for hospital and outpatient care.⁶²⁷ It essentially provided that all veterans are eligible for VA hospital care and *medical services*.⁶²⁸

⁶²¹ Veterans Readjustment Benefits Act of 1966, Pub. L. No. 89-358, 80 Stat. 12 (1966).

⁶²² Pub. L. No. 91-500.

⁶²³ S. Rep. No. 91-481.

⁶²⁴ Veterans Health Care Expansion Act of 1973, Pub. L. No. 93-82, 87 Stat. (1973).

⁶²⁵ Veterans Omnibus Health Care Act of 1976, Pub. L. No. 94-581, 90 Stat. 2842 (1976). The patchwork of eligibility provisions resulting from a succession of incremental changes set the stage for development and enactment of the Veterans' Health Care Eligibility Reform Act of 1996, Pub. Law 104-262.

⁶²⁶ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁶²⁷ *Ibid.*

⁶²⁸ The term "medical services" was broadly defined to include in addition to medical examination and treatment, preventive health services; surgical services; wheelchairs, artificial limbs, and similar appliances; optometric and podiatric services; noninstitutional extended care services; and rehabilitative services (including services to restore physical, mental, and psychological functioning. Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C.

§ 1701(6),(8). VA regulations more fully set out the "medical benefits package" that VA is to provide patients, as needed; VA regulations detail that the benefits package includes services ranging from emergency care and prescription drugs to

Recognizing there could be circumstances in which VHA might lack capacity to provide timely care, Congress noted in the reform act that the requirement to provide care would be in effect only to the degree to which there were appropriated funds to pay for such care.⁶²⁹ This qualified availability of care clearly indicated veterans' health care is not an entitlement. Congress went further, though, and established a statutory patient enrollment mechanism for VA to manage access.⁶³⁰ The law specifically requires VA to establish and operate a patient enrollment system managed in accordance with statutory priorities and within any additional priority classifications established by VA. The eligibility reform act gave VA tools both to limit demand consistent with available funding and to discourage veterans from seeking VA care simply to fill an occasional need not met by a private health plan.⁶³¹ The act also requires the SECVA to manage the enrollment system such that care is timely and of acceptable quality.⁶³²

The enrollment system the department established is not being used today to calibrate supply and demand as envisioned.⁶³³ Although law and VA regulation require a system of annual patient enrollment,⁶³⁴ VHA last curtailed enrollment in 2003, and then only for veterans who were deemed eligible based on the category 8 criteria (see Table 8) that include those with higher-level incomes who lack any higher priority. In 2009, the Obama administration eased access for higher income veterans. Under that policy, veterans whose gross household income exceeds VA's current geographic income limit by 10 percent or less may enroll for VA care, subject to cost-sharing requirements.⁶³⁵ In 2014, Congress established the *Choice Program* to expand availability of care through contracts with community providers. Veterans' choice was limited by reference to distance and wait-time issues, but was otherwise broadly open to any enrolled veterans.⁶³⁶

comprehensive rehabilitative services, home health services, noninstitutional extended care services, hospice care, and pregnancy and delivery services and newborn care. Medical Benefits Package, 38 C.F.R. 17.38.

⁶²⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General 38 U.S.C. § 1710(a)(4).

⁶³⁰ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705. As explained in the report of the House Committee on Veterans Affairs which developed the legislation, "[T]he Act would...provide the VA with an important tool, the authority to design and manage access to care through a system of patient enrollment...Enrollment...would help the VA plan more effectively, so that facilities can better calculate and dedicate the resources needed to provide the care its enrollees require. The Act would direct the Secretary...to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment (or registration) system would operate. For example, the VA would be able to establish a system which simply registers patients throughout all or part of a fiscal year, or could employ a time-limited registration period. Significantly, the Act would permit the Secretary to set priorities within the specified priority classifications established in the Act. The Secretary could, for example, establish a policy which, within any priority classification, gives veterans who have previously been "enrolled" as VA patients priority over new applicants. However, the Committee expects any enrollment system to be designed and administered to assure that any veteran with a service-connected condition would receive priority treatment for that condition whether or not that veteran had enrolled for VA care." H. Rep. No. 104-690, 6-7.

⁶³¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262; 110 Stat. 3177 (1996).

⁶³² Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705(b).

⁶³³ H. Rep. No. 104-690, 16.

⁶³⁴ Enrollment, 38 C.F.R. sec. 17.36(c). VA regulations state that "[i]t is anticipated that that each year the Secretary will consider whether to change the categories and subcategories of veterans eligible to be enrolled."

⁶³⁵ Enrollment, 38 C.F.R. 17.36(b)(8)(ii),(iv).

⁶³⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014). Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, Pub. L. No. 114-41 (2015).

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Table 8. Priority Groups

Priority Group	Definition
1	<ul style="list-style-type: none"> Veterans with VA-rated service-connected disabilities 50% or more disabling Veterans determined by VA to be unemployable due to service-connected conditions
2	<ul style="list-style-type: none"> Veterans with VA-rated service-connected disabilities 30% or 40% disabling
3	<ul style="list-style-type: none"> Veterans who are former prisoners of war Veterans awarded a Purple Heart medal Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty Veterans with VA-rated service-connected disabilities 10% or 20% disabling Veterans awarded special eligibility classification under Title 38, U.S.C. § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation" Veterans awarded the Medal of Honor
4	<ul style="list-style-type: none"> Veterans who are receiving aid and attendance or housebound benefits from VA Veterans who have been determined by VA to be catastrophically disabled
5	<ul style="list-style-type: none"> Non-service-connected veterans and noncompensable service-connected veterans rated 0% disabled by VA with annual income below VA's and geographically (based on resident zip code) adjusted income limits Veterans receiving VA pension benefits Veterans eligible for Medicaid programs
6	<ul style="list-style-type: none"> Compensable 0% service-connected veterans Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki Project 112/SHAD (shipboard hazard and defense) participants Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975 Veterans of the Persian Gulf War who served between August 2, 1990 and November 11, 1998 *Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987 Veterans who served in a theater of combat operations after November 11, 1998 as follows: <ul style="list-style-type: none"> Currently enrolled veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge. **Combat veterans who were discharged between January 2009 and January 2011, and did not enroll in the VA health care during their five-year period of eligibility have an additional one year to enroll and receive care. The additional one-year eligibility period began February 12, 2015 with the signing of the Clay Hunt Suicide Prevention for America Veterans Act. <p>Note: At the end of this enhanced enrollment priority group placement time period veterans will be assigned to the highest Priority Group (PG) their unique eligibility status at that time qualifies for.</p> <p>*Note: While eligible for PG 6; until system changes are implemented you would be assigned to PG 7 or 8 depending on your income.</p> <p>*Note: While eligible for PG 6; due to system limitations, veterans will be manually assigned to PG 8c, yet eligible for the enhanced benefits</p>
7	<ul style="list-style-type: none"> Veterans with gross household income below the geographically-adjusted income limits for their resident location and who agree to pay copays

Priority Group	Definition
8	<ul style="list-style-type: none"> ▪ Veterans with gross household income above VA and the geographically-adjusted income limits for their resident location and who agrees to pay copays <p>Veterans eligible for enrollment:</p> <p>Noncompensable 0% service-connected:</p> <ul style="list-style-type: none"> – Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA or geographic income limits by 10% or less <p>Non-service-connected and:</p> <ul style="list-style-type: none"> – Subpriority c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority d: Enrolled on or after June 15, 2009, whose income exceeds the current VA or geographic income limits by 10% or less <p>Veterans not eligible for enrollment:</p> <p>Veterans not meeting the criteria above:</p> <ul style="list-style-type: none"> – Subpriority e: Noncompensable 0% service-connected (eligible for care of their service-connected condition only) – Subpriority g: Non service-connected

Analysis

Two decades have passed since Congress last reexamined VHA eligibility and benefits, and many far-reaching changes that affect veterans' health care have occurred in that time. In more than a decade of war, 2.75 million troops have deployed to Iraq and Afghanistan⁶³⁷ where many have faced long and repeated deployments; constant risk of injury and death; and high levels of psychological disorders, substance abuse issues, and physical health problems.⁶³⁸ Post-9/11-era veterans are enrolling for VA care at historically high levels.⁶³⁹

Under current law and VA policy, enrollment is open to a relatively broad spectrum of veterans, though some veterans with higher incomes are not eligible to enroll.⁶⁴⁰ As discussed above, the law draws distinctions between those whose health problems have been adjudicated as service-connected and those whose problems are deemed non-service-connected. If Congress substantially reduced funding for VA medical care, the distinction would be important because those with service-connected issues have higher priority for enrollment. Under VA's current enrollment policy, which bars only veterans with higher incomes from receiving care, the

⁶³⁷ Defense Manpower Data Center, *Contingency Tracking System (CTS) Deployment File*, (Dec. 31, 2015).

⁶³⁸ Institute of Medicine of the National Academies, *Returning Home from Iraq and Afghanistan: Readjustment Needs of Veterans, Service Members, and Their Families*, (Washington, DC: The National Academies Press, 2013), accessed June 25, 2016, <http://www.nationalacademies.org/hmd/Reports/2013/Returning-Home-from-Iraq-and-Afghanistan.aspx>.

⁶³⁹ Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *Profile of Post-9/11 Veterans: 2014*, accessed May 27, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Post_911_Veterans_Profile_2014.pdf.

⁶⁴⁰ Veterans Health Administration, *Enrollment Determinations*, VHA Handbook 1601A.03, 9-10 (2015). Veterans with gross household income that do not exceed VA's means test threshold and a geographic means test by more than 10 percent may enroll for care, while those with higher income and no other special eligibility may not.

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statutory service-connected enrollment priority has little practical significance.⁶⁴¹ Future budget constraints could result in more restrictive enrollment criteria⁶⁴² or recurrence of lengthy wait times that hinder service-connected, disabled veterans' ability to receive timely care.

Current eligibility law does afford special status to veterans who deployed to a combat theater. It grants a 5-year window of eligibility for care to those veterans who are not otherwise eligible.⁶⁴³ All combat veterans are also eligible for readjustment counseling services at VHA Vet Centers without needing to enroll in VHA care and without time limitation.⁶⁴⁴ It is questionable, however, if the 5-year time limit takes sufficient account of continued reluctance of some veterans to seek care for behavioral health problems⁶⁴⁵ or of the difficulties of establishing service-connection years later for conditions that may be linked to wartime exposures to toxic substances.⁶⁴⁶ It is challenging for veterans to establish service-connection for health conditions that may have been caused by or associated with a long-distant exposure for which there may be no documentation. Given emerging evidence that combat exposure should be considered a risk factor for coronary heart disease,⁶⁴⁷ it has been suggested that combat exposure may not only take a toll on psychological health, but may exert a physiologic toll as well.⁶⁴⁸

Congress has attempted to remedy the challenge of documenting toxic exposures and establishing that particular illnesses are linked to wartime or other service exposure. It has, for example, enacted statutes that provide certain veterans eligibility for health care on the presumption that they were exposed to particular toxic substances.⁶⁴⁹ Congress went a step further in the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 which provided eligibility for care for several types of cancer and other specified conditions for family members of veterans who had been exposed to drinking water contaminated with industrial solvents and other toxic chemicals at the Marine Corp base.⁶⁵⁰

Congress has made only limited provision for VA to cover care for family members of certain veterans,⁶⁵¹ but with research suggesting that long combat deployments can take a

⁶⁴¹ Prior to 1996, provisions of law required VA to ensure special priority to service-connected veterans in furnishing outpatient care. 38 U.S.C. § 1712(i), repealed by § 101(c), Pub. L. No. 104-262.

⁶⁴² Enrollment, 38 C.F.R. 17.36(c)(1).

⁶⁴³ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(3), as amended by Sec. 7, Pub. L. No. 114-2 (2015), accessed June 20, 2016, <https://www.govtrack.us/congress/bills/114/hr203/text>.

⁶⁴⁴ Readjustment Counseling Service, 38 U.S.C. § 7309.

⁶⁴⁵ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶⁴⁶ Matthew S. King et al., "Constrictive Bronchiolitis in Soldiers Returning from Iraq and Afghanistan," *New England Journal of Medicine*, 365, no. 10 (2011): 222-230, accessed June 20, 2016, <http://doi.org/10.1056/NEJMoa1101388>.

⁶⁴⁷ Nancy F. Crum-Cianflone et. al., "Impact of Combat Deployment and Posttraumatic Stress Disorder on Newly Reported Coronary Heart Disease Among US Active Duty and Reserve Forces," *Circulation*, 129, (2014), accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.113.005407>.

⁶⁴⁸ Rachel Lampert, "Veterans of Combat: Still at Risk When the Battle is Over," *Circulation*, 129, (2014): 1797-1798, accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.114.009286>.

⁶⁴⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(10).

⁶⁵⁰ Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Pub. L. No. 112-154, 126 Stat. 1165 (2012).

⁶⁵¹ Health Care of Persons Other Than Veterans, 38 U.S.C. §§ 1781-1787.

psychological toll on family members,⁶⁵² there may be circumstances under which it might be argued that VA should afford such family members behavioral health services. Studies indicate that longer deployments, deployment extensions, and posttraumatic stress disorder in military personnel are associated with psychological problems for the spouse.⁶⁵³ Long-term effects are unknown, yet studies suggest children may have heightened risk for psychosocial issues during a parent's deployment.⁶⁵⁴

The experience of the nation's longest war and increased options available under the Affordable Care Act (ACA), particularly to previously uninsured non-service-connected veterans, may raise new questions for policymakers.⁶⁵⁵ VHA's most recent survey of enrollees showed that 20 percent of enrollees reported that they were uninsured, down from 22 percent in 2014.⁶⁵⁶ Enrollment in VHA-provided care meets the ACA requirement for health care coverage, creating pressure to continue to provide care to those enrolled.⁶⁵⁷ Given that VHA serves large numbers who are poor or near poor and have chronic medical conditions and behavioral health problems,⁶⁵⁸ it is important to note that receiving care under an ACA plan would not necessarily be a substitute for the rich benefits afforded through VHA. In addition, adults in this population are only eligible for coverage under ACA through state expansion of Medicaid that 19 states have elected not to accept, making this option unavailable to poor or near poor veterans in many parts of the country.⁶⁵⁹

Over time Congress has expanded VA health care eligibility to increasingly more cohorts of non-service-connected veterans. There is wide variability among different cohorts in the extent to which veterans rely on VA care. Those at the higher-income levels (priority categories 7 and 8) who were generally not eligible for ambulatory care prior to 1996, for example, rely on VA for

⁶⁵² Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, accessed June 20, 2016, <http://dx.doi.org/10.1186%2F1471-244X-10-88>. Swords to Plowshares, presentation to Commission on Care, January 21, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former servicemembers. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁶⁵³ H. Thomas De Burgh et al., "The Impact of Deployment to Iraq or Afghanistan on Partners and Wives of Military Personnel," *International Review of Psychiatry*, 23, no. 2 (2011): 192-200, <http://www.ncbi.nlm.nih.gov/pubmed/21521089>.

⁶⁵⁴ Gregory H. Gorman, Matilde Eide, and Elizabeth Hisle-Gorman, accessed June 20, 2016, "Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints," *Pediatrics*, 126, no. 6 (2010): 1058-1066, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-2856>. Anita Chandra et al., "Children on the Homefront: The Experience of Children from Military Families," *Pediatrics*, 125, no. 1 (2010): 16-25, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-1180>.

⁶⁵⁵ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁶ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁵⁷ "Affordable Care Act & Veterans," Department of Veterans Affairs, accessed May 27, 2016, <http://explore.va.gov/health-care-affordable-care-act?show=all>.

⁶⁵⁸ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁹ "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update," Rachel Garfield and Anthony Damico, Kaiser Family Foundation, accessed March 29, 2016, <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/>.

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less than 22 percent of their outpatient care-needs, based on VA's most recent survey of veteran enrollees' health and use of care.⁶⁶⁰

One consideration, as suggested by a few Commissioners, is the feasibility of allowing veterans' family members and currently ineligible veterans to purchase VHA care through their health plans in areas where VHA hospitals and other facilities might otherwise need to close. In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. A related challenge is maintaining safe volume of care when patient loads decline. As an extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁶¹ Similarly, VHA may be unable to continue offer specialty care in certain areas if it forced to close facilities. Patients in a polytrauma unit for example, require a full spectrum of routine and nonroutine health care.

Closing a low-volume hospital may be the answer in some instances. But closing VHA facilities reduces the choices available to veterans. Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. See Appendix C for a further discussion of the challenge of future VHA hospital closures and an outline of suggested pilot programs.

Substantial changes have occurred since Congress last comprehensively examined eligibility for VHA care. These changes merit a reexamination of VA health care eligibility.⁶⁶² The Commission did not, however, view its charge of examining veterans' access and how best to organize VHA, locate health care resources, and deliver care in the years ahead⁶⁶³ as calling for it to make recommendations on this fundamental policy issue, and recommends that the President or Congress consider tasking another body to develop recommendations for VA care eligibility and benefit design. The Commission's work, however, has illuminated the fact that nothing in law or regulation assures a service-connected, disabled veteran of priority for care. VA can and should amend its regulations to provide for such priority, subject to a necessarily higher priority for urgent and emergent care.

Implementation

Legislative Changes

- Task another body to examine the need for changing eligibility for VA care and benefits design, which would include simplifying eligibility criteria, and may include exploring

⁶⁶⁰ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 75, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁶¹ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

⁶⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 25, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶⁶³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

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pilots for expanding eligibility for nonveterans to use underutilized providers and facilities when paid for through private insurance.

VA Administrative Changes

- SECVA should amend 38 C.F.R., chapter 17 to establish that veterans with service-connected disabilities shall be afforded priority for access to care, subject to the priority dictated by clinical care needs.

Other Departments and Agency Administrative Changes

- None required.

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APPENDIX A: FINANCING THE VISION AND MODEL

Estimating the Cost of Alternative Policy Proposals

This chapter presents estimates of the costs of allowing veterans access to expanded community care through integrated networks, as well as a range of other options. In the *Recommended Option*, the one chosen by the Commission and described in Recommendation #1, veterans would be eligible to receive community care for primary and standard specialty care with a referral from any primary care doctor in the VHA Care System. Special emphasis care, care provided in a distinctive fashion by VHA, is not included in community networks.

In addition to the *Recommended Option*, we considered three alternatives that are based on a similar concept of integrated networks, but which have potential costs that could vary dramatically due to differences in the openness of access to community care and the breadth of services eligible. We also estimated the costs of three options that differ in focus from the integrated network options, including options that move selected services entirely to the community, set up a premium support model, and expand access to all Priority 8 veterans. Finally, we estimated costs for two additional policies: expanding nurse navigator/care coordinator staff to help guide and coordinate veterans' care in the integrated networks of expanded community care and granting temporary eligibility for VA health care to those with other-than-honorable discharges.

Baseline Projections

We used projections from the Enrollee Health Care Projection Model (EHCPM) produced by VHA and Milliman as the baseline upon which to build our estimates. However, with the exception of the options involving premium support and an expansion of Priority 8 enrollment, we use separate analyses and not the EHCPM to derive the estimates. Costs of VA care are modeled as the product of utilization and cost per unit of care (unit cost). Utilization is dependent on both enrollment in, and reliance on, the VA health care system, total demand for health care, and other factors. Enrollment measures how many people enroll to receive VA health care, and reliance is the percentage of their medical care that enrollees receive through VA or VA-financed community care. Unit costs measure the cost of each health care service. Unit costs can be calculated for care in VA facilities, for care outside of VA facilities, or for both, depending on the scenario being estimated.

Utilization

Utilization depends on enrollment, reliance, total demand for health care, and characteristics of the health care system, such as medical technology and practice patterns. We discuss enrollment and reliance in further detail below, but overall demand for health care is similarly important. Enrollment, reliance, and overall demand each have a multiplicative effect on

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utilization and total costs. For example, if enrollment increases by 10 percent, costs will increase by 10 percent (assuming new enrollees have the same characteristics as existing enrollees). Thus, it is important to consider carefully the effect of any policy change on enrollment, reliance, and overall demand for health care. Each of these factors is subject to effects by policies that make care more convenient, less expensive, or less restricted.

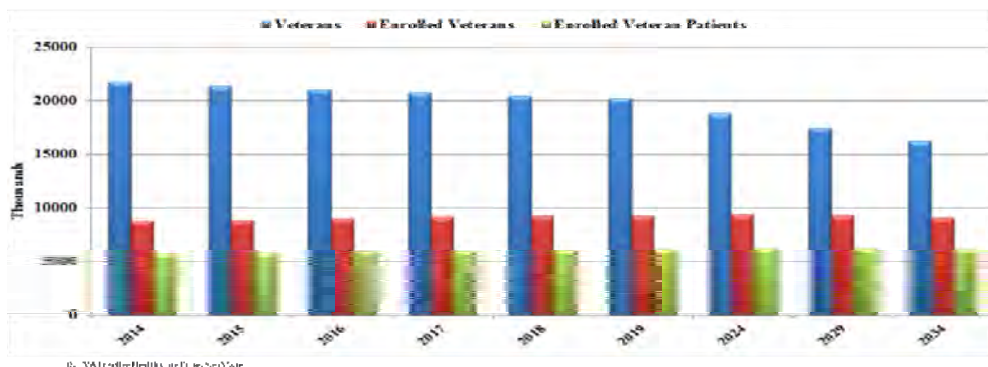
Enrollment

Currently there are 22 million veterans, 9 million of whom have enrolled and 7 million of whom are eligible to enroll but have not done so. Even though the number of veterans is decreasing, projected numbers of enrollees and patients should remain relatively stable during the next 20 years. Younger veterans enroll at particularly high rates, and once enrolled, they remain continuously enrolled until death.

This enrollment trend is subject to change based on various inputs. Enrollment rates are projected based on current policy, and if policy changes, the number of enrollees and patients will change. For example, an increase in cost sharing would likely decrease enrollment and the number of patients, yet easing access to care would likely increase enrollment and the number of patients. Changes to other health insurance policies outside of VA can also affect enrollment and the number of patients (for example, changes to the Affordable Care Act).

Figure A-1. Changes in Number of Veterans, Enrollees over a 20-year Period

Veterans, Enrollees, and Patients FY 2014-2034



Reliance

On average, enrolled veterans receive 34 percent of their health care through VHA, and approximately 80 percent of enrollees have other health insurance in addition to VA health care. Many factors affect reliance rates including, age, income, service-connected disabilities, distance from VA facilities, cost-sharing levels, and characteristics of other insurance options. Any policy that affects the cost of receiving VA care, the convenience of receiving VA care, the cost or convenience of other health insurance held by enrollees, or demographic or health characteristics of enrollees, is likely to change reliance. Any increase in reliance will increase

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costs to VHA, and the effect can be very large. In the absence of a policy change, VHA predicts that reliance will decline slightly from 34 percent to 32 percent during the next 20 years.

Unit Cost

Unit cost measures how much a particular service, procedure, or drug costs to provide. Unit costs can measure the cost of the unit of care in the VHA system or in the community, depending on where veterans receive care. We used unit cost projections from the EHCPM for 78 Health Care Service Categories (HSCs). The unit of measurement depends on the service. Examples include office visits, pathology procedures, vision exams, and inpatient surgical days. Unit cost projections reflect anticipated changes in price inflation and health care practice patterns, as well as historical trends. EHCPM projects separate unit costs, depending on whether veterans receive a service in a VA facility, in the community at historic Care in the Community (CITC) rates, or in the community at Medicare allowable rates. Any policy that affects the quantity of care provided in VA facilities, as opposed to the community, will have an effect on the total cost of care. If veterans receive care in the community, the rate of provider reimbursement will also affect costs.

Baseline Cost Projections

The baseline cost projections, produced by the EHCPM, show how cost will change in the future. They incorporate projected changes in enrollment, reliance, unit costs, and other factors. The projections reflect current policy with regard to enrollment eligibility and VA health care benefits, with the exception of the *Choice Program*, which is assumed to continue for veterans living more than 40 miles away from a VA medical care facility.⁶⁶⁴

We based the projections on assumptions about inflation and anticipated effects of changes in health care practice on the cost of VA health care in the next 20 years. New military conflicts, policies, legislation, regulations, and external factors, such as economic recession, can occur and change projected demand for VA health care during this period. The projections do not include requirements for several activities/programs not projected by the VA EHCPM, including nonrecurring maintenance; readjustment counseling; state-based, long-term services and support programs; and some components of the CHAMPVA program.

In the absence of any policy changes, costs increase from \$53 billion in 2014 to \$125 billion in 2032. This growth is largely due to inflation and how health care practices are expected to change over time, which reflects factors that affect the cost of both VA and non-VA health care. These trends increase the cost of VA health care regardless of changes in enrollment growth and demographics. Within enrollment, the increasing number of enrollees adjudicated for service-connected disabilities by the Veterans Benefit Administration (VBA) is the most significant driver of cost increases. Enrollees will likely increase their reliance to reflect the substantially higher reliance of enrollees in the service-connected Priorities 1-3.

These baseline estimates, along with our scenario estimates presented below, carry some key limitations. First, the EHCPM does not track capacity at VA facilities. We assume health care

⁶⁶⁴ Veterans qualifying based on wait times or excessive travel burdens are not included.

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utilization will increase or decrease at the average unit cost, when in fact it is the marginal cost that would be relevant for cost estimates. This marginal cost could be smaller or larger than the average cost, depending on existing capacity. Although we did make some assumptions about fixed and variable unit costs when care leaves VA facilities in our policy estimates below, precise estimates are not possible given data availability. Second, the EHCPM does not consider health care capacity in local communities. For these and other reasons, the EHCPM is best for the near future and for policy scenarios that do not stray dramatically from current policy. A 2008 RAND review of the EHCPM highlighted these limitations, which are particularly important for analyzing policy changes such as expanded community care.⁶⁶⁵ In light of the types of policy choices VHA is likely to consider in the future, it would be particularly beneficial for VHA to collect and incorporate the data necessary to mitigate these limitations. Due both to these limitations and to the general uncertainty regarding any long-term changes in the health care system, we suggest focusing attention on the 2019 estimates of the scenarios below, as 2019 is the first year to incorporate the fully phased-in effects of the scenarios.

Policy Estimates

In this section, we present results for the *Recommended Option* and three alternative options for expanding access to providers outside of VA through integrated networks. These options expand community care for different categories of care and vary by whether referrals are required to receive specialty care. We present estimates for several other scenarios we examined, each with a design or focus that differs from the integrated network options. Finally, we estimate costs for two other policies discussed in this report: (1) expanding the use of nurse navigators to help patients coordinate their care in VA and in the community, and (2) expanding eligibility to all veterans with an other-than-honorable (OTH) discharge until the adjudication process is complete to determine whether they will remain eligible.

Community-Delivered Services Networks

This section describes the *Recommended Option* and the first three alternative options. At least initially, all care currently provided by VA would continue to be provided by VA. In addition, expanded community care, also called Community-Delivered Services (CDS), will be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA. CDS will focus on tertiary and quaternary care, and may include primary care and all standard specialty care, depending on the scenario considered. CDS will not include special-emphasis care and some types of specialty care provided in a distinctive fashion by VHA. The network of CDS providers that VA will coordinate varies by community. To make the flow of service both appropriate and smooth in operation, there will be navigators who will help guide veterans to the best and most appropriate providers inside and outside VA.

The Commission's recommendation to create the VHA Care System (see p. X) considers the ways in which health plans can vary the size and scope of networks as a means of managing costs. It highlights that broad, open networks offer greater choice, but narrow, well-managed

⁶⁶⁵ Katherine M. Harris, James P. Galasso, and Christine Eibner, "Review and Evaluation of the Enrollee Health Care Projection Model," RAND Corporation, Santa Monica, CA, 2008.

networks potentially result in lower costs. It discusses ways in which, after networks are designed, VHA could exercise additional cost controls by steering patients to different providers within the networks. Finally, the recommendation regarding the VHA Care System emphasizes that access and local needs are important considerations in setting up the integrated networks, and that governance of the networks should be a process of ongoing management and evaluation.

In the estimates that follow, we assume that networks are designed and governed in a way that gives major consideration to cost, choice, and access. We assume that management of the integrated networks would be an iterative process that involves continual evaluation of resulting outcomes, including cost outcomes, and that networks would be adjusted in light of those outcomes. We also assume that local communities and services with poor access would require more community providers and/or expanded capacity within VHA than those that already have adequate access. Finally, we assume that the networks will be integrated, relatively narrow, and well-managed with the aim of controlling costs effectively. One exception is that for the *Recommended Option*, we added an estimate that assumes less-managed, broader networks to illustrate that costs are sensitive to network size and management.

Technical Assumptions for Community-Delivered Services Options

We based our estimates on utilization and unit cost data and projections for 78 HSCs that we obtained from the VHA Office of Policy and Planning. Starting from a base year of 2014, we projected utilization and unit costs through 2034. For HSCs that are eligible for CDS networks, we assume a certain fraction of care, depending on the option, shifts from VA facilities to the networks. We assume traditional CITC will be offered and used at baseline levels.⁶⁶⁶ We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks. All effects are phased in during the first 5 years.

Both CDS networks and CITC are priced at Medicare allowable rates by matching Medicare fee schedule data to VA HSCs.⁶⁶⁷ A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities.

For care shifting into the CDS networks, we use data on the components of HSC unit costs that we obtained from the VA Allocation Resource Center. We assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. These portions, which together averaged approximately 10 percent of care in 2014, form our proxy for the portion of unit costs that VA will not be able to shed in scenarios for which, on net, care leaves VA facilities for CDS networks. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance. These costs are not part of the EHCPM, and costs and/or savings associated with changes to facilities and nonrecurring maintenance are not included in our estimates.

⁶⁶⁶ CITC accounted for approximately 11 percent of modeled expenditures in the base year 2014.

⁶⁶⁷ Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

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Improving access, choice, and/or quality of services is likely to induce greater reliance and enrollment in the VA system. Although reliance and enrollment increases result in greater budgetary costs for VA, it is important to note that these increases do not represent societal costs or costs to the government. The VA budgetary cost increases may be associated with reductions in out-of-pocket expenses and improved health care benefits for patients, as well as savings to Medicare, Medicaid, and other government programs. Our cost estimates are confined solely to the VA budget.

Approximately 52 percent of eligible veterans have enrolled in VA health care, and enrolled veterans receive 34 percent of health care through VA. There is little data from which to anticipate how reliance and enrollment might change under the scenarios, and our estimates use wide ranges of assumptions for these parameters. In forming our assumptions, we consider a variety of factors, such as insurance coverage and other characteristics of eligible veterans (both enrolled and unenrolled), survey responses of veterans (both enrolled and unenrolled) on use and reasons for lack of use of VA health care, and research on take-up of health insurance coverage.⁶⁶⁸ We are confident that enrollment and reliance would increase more with greater patient choice and access. For all options, we present low, middle, and high estimates.

In addition to increases in reliance and enrollment, reduced cost sharing, increased convenience of receiving community care, and the removal of a requirement to get a referral for specialty care can increase the total amount of medical care that a patient receives. Depending on the option considered, some health care is subject to reduced cost sharing from levels typical of private insurance coverage and Medicare to the very small levels of cost sharing found in the VA system. We assume utilization increases for health care subject to lower cost sharing and/or removal of a requirement to get a referral, with our estimates based in part on the literature examining how cost sharing affects health care demand.⁶⁶⁹

Caveats

There are a number of caveats associated with all of our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. New enrollees are assumed to cost slightly less than existing enrollees for *CDS Alternative 3* and the

⁶⁶⁸ Examples of sources include: the 2014 American Community Survey; the 2010 National Survey of Veterans; the 2015 Survey of Veteran Enrollees' Health and Use of Health Care; Katherine Baicker, William J. Congdon and Sendhil Mullainathan, "Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics," *The Milbank Quarterly*, 90(1) (2012), 107-134.

⁶⁶⁹ Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," Washington, DC, 2008. Willard G. Manning, Joseph P. Newhouse, Naihua Duan, Emmett B. Keeler, Arleen Leibowitz, and M. Susan Marquis, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review* 77(3) (1987), 251-77.

same as existing enrollees in the *Recommended Option* and *CDS Alternatives 1 and 2*.⁶⁷⁰ Finally, we do not estimate any administrative costs associated with CDS networks other than the additional RN care managers hired to handle the increased clinical and administrative burden of expanded community care. These additional, nonmodeled administrative costs could be substantial.

Commission Recommended Option

The *Recommended Option* would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA or a third-party administrator. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in VA in a distinct fashion).⁶⁷¹ In 2014, 68 percent of care would have been eligible for CDS networks at current VA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network. In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a doctor in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and 20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was

⁶⁷⁰ Assumptions based on previous analysis by VHA and Milliman.

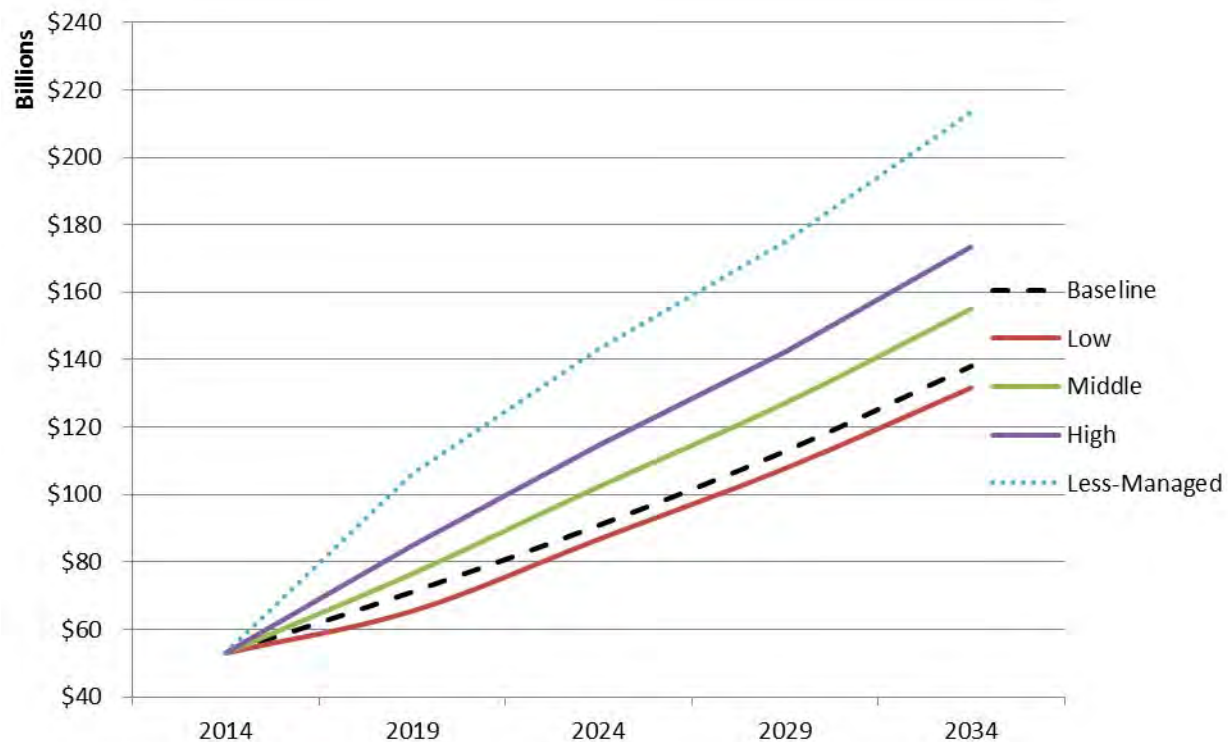
⁶⁷¹ Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

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formerly subject to sizable cost sharing with private insurance or Medicare, and now it would be subject to little if any cost sharing associated with VA-financed care.

Figure A-2 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from \$65 billion to \$85 billion in 2019, with a middle estimate of \$76 billion. The middle estimate is moderately above the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is \$106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

Figure A-2. Projected Costs of Recommended Option



APPENDIX A

FINANCING THE VISION AND MODEL

COST ESTIMATES Commission on Care Scenarios							
	Brief Description	Utilization Increase	Enrollment Increase (low, middle, high)	Reliance (low, middle, high)	Cost FY 2014 Actual (billions)	Cost FY 2019 Projected (billions)	Cost FY 2034 Projected (billions)
Baseline	2014 Actual		9,078,615	34%	\$53	\$ 71	\$ 138
Recommended (low)	Referral Based Care in VHCS (68% of current VHA care eligible as CDS)	+20% of new demand in CDS Care	5%	40%	\$	65	\$ 132
Recommended (middle)	same	same	15%	50%	\$	76	\$ 155
Recommended (high)	same	same	20%	60%	\$	85	\$ 173
Recommended (less-managed)	same	same	50%	60%	\$	106	\$ 213
Alternative 1 (low)	Similar to Recommended but primary care, inpatient med and surg and some standard specialty care not eligible for CDS remain in VHA (47% of care eligible for CDS)	+20% of new demand in CDS Care	0%	10%	\$	66	\$ 128
Alternative 1 (middle)	same	same	5%	35%	\$	73	\$ 140
Alternative 1 (high)	same	same	10%	50%	\$	78	\$ 151
Alternative 2 (low)	Similar to Alternative 1 but primary care coordinator must only be consulted; no referral required (47% of care eligible for CDS)	+20% CDS eligible Care	5%	60%	\$	97	\$ 191
Alternative 2 (middle)	same	same	10%	80%	\$	123	\$ 243
Alternative 2 (high)	same	same	20%	100%	\$	154	\$ 307
Alternative 3 (low)	Similar to Alternative 2 but primary care, inpatient med/surg and specialty care eligible for CDS and no consult required	+20% CDS eligible Care	75% (level)	80%	\$	167	\$ 320
Alternative 3 (middle)	same	same	85% (level)	90%	\$	206	\$ 395
Alternative 3 (high)	same	same	95% (level)	100%	\$	250	\$ 479
Keep Selected Services (low)	Move most standard ambulatory specialty care to community	+20% of new demand in CDS Care	0%	10%	\$	64	\$ 128
Keep Selected Services (middle)	same	same	4%	25%	\$	70	\$ 136
Keep Selected Services (high)	same	same	8%	40%	\$	75	\$ 145
Premium Support	Enrollees under age 65 can choose a subsidized insurance premium with cost sharing in lieu of VHA care	42% of enrollees <65 choose premium support	6%		\$	82	\$ 158
Eligibility Expansion	Allow all eligible veterans to enroll	increase to 30% market share among priority 8	5%		\$	72	\$ 140
Initiatives	Nurse navigators for CDS care				\$	71	\$ 138
	Make veterans with Other than Honorable Discharges Temporarily Eligible for VA Health Care While Claims are Adjudicated				\$	72	\$ 139

Additional Sample Cost Models

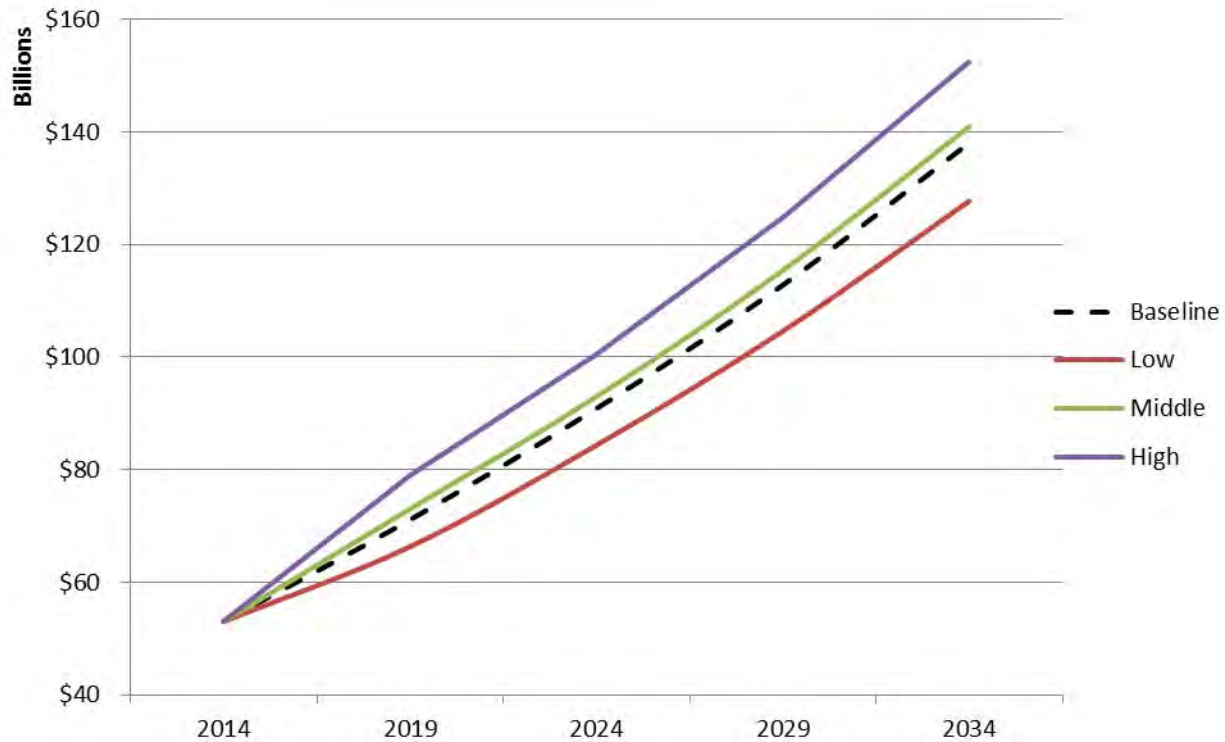
CDS Alternative 1

CDS Alternative 1 is similar to the Commission's *Recommended Option* above. The main difference is that a narrower subset of services is available in the CDS networks. Primary care, inpatient medical and surgical care, and some standard specialty care are not eligible for CDS networks and must be accessed within VA. The CDS network for *CDS Alternative 1* would focus on tertiary and quaternary care; it would not include primary care, some specialty care, inpatient medical and surgical care, and special-emphasis care (care that is provided in VA in a distinct fashion). In 2014, 47 percent of care would have been eligible for CDS networks.

Because less care is eligible for CDS networks than in the *Recommended Option*, less care will shift to CDS networks, reliance increases will be smaller, and enrollment increases will be smaller. We assumed that 50 percent of eligible care shifts from VA facilities to CDS networks. We modeled increases in reliance of 10, 35, and 50 percent, which correspond to reliance rates of approximately 37, 46, and 51 percent. These reliance increases pertain only to CDS care, not CDS-eligible care provided in VA facilities. We modeled enrollment increases of 0, 5, and 10 percent. As in the *Recommended Option*, we assume newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks.

Figure A-3 displays estimates for CDS Alternative 1. Estimates range from \$66 billion to \$78 billion in 2019, with a middle estimate of \$73 billion. As in the *Recommended Option*, the middle estimate is close to the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to Medicare allowable rates for CDS networks and CITC offsets these effects.

Figure A-3. Projected Costs of CDS Alternative 1



CDS Alternative 2

Like *CDS Alternative 1*, CDS care in *Alternative 2* would focus on tertiary and quaternary care. CDS networks would not include primary care, special-emphasis care, inpatient medical and surgical care, and some types of specialty care.

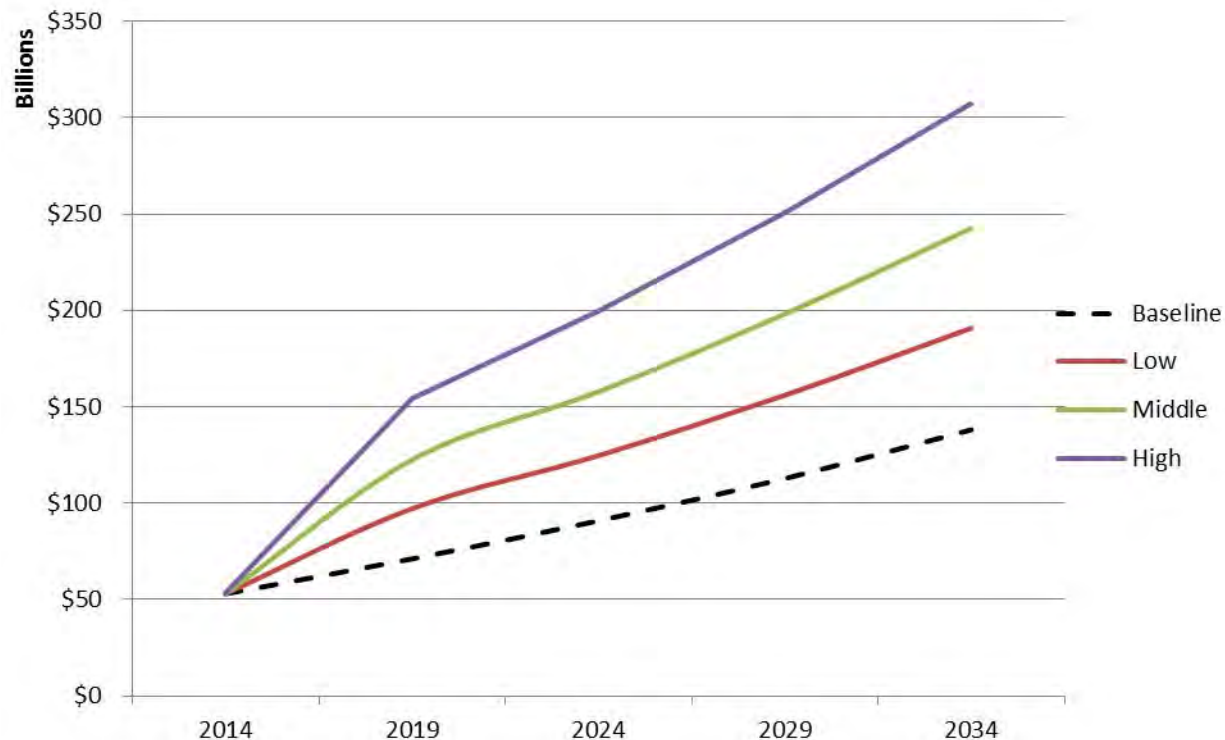
This option differs from the *Recommended Option* and *CDS Alternative 1* in that veterans must consult their VHA primary care provider in some way before seeking specialty care, but they *do not* need a referral to receive CDS eligible care whether they receive it in or out of VA. Some specialty care, all primary care, and all special-emphasis care are only provided in VA unless the veteran is eligible for traditional CITC. However, after the primary care consultation, the choice of whether to seek eligible care in CDS networks is entirely up to the veteran. As in *CDS Alternative 2*, the care eligible for CDS networks comprised 47 percent of total modeled expenditures in 2014.

We expect reliance increases to be relatively high, and we apply these reliance increases to CDS eligible care regardless of where veterans receive it because referrals are not required for any CDS eligible care. Further, we expect enrollment increases to be higher than the *Recommended Option* and *CDS Alternative 1* because the absence of a referral requirement makes this a more attractive policy for potential enrollees. We model reliance rates of 60, 80, and 100 percent for care eligible for CDS networks; enrollment increases of 5, 10, and 20 percent; 70 percent of VA facility care shifting into CDS networks; and a 20 percent utilization increase for CDS eligible care.

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Estimates are displayed in Figure A-4. In 2019, the baseline projection is \$71 billion. *CDS Alternative 2* estimates range from \$97 billion to \$154 billion, with a middle estimate of \$123 billion. The potential for considerable reliance and enrollment increases could push costs substantially higher than the baseline.

Figure A-4. Projected Costs of CDS Alternative 2



CDS Alternative 3

CDS Alternative 3 differs from *Alternative 2* in two main ways. First, a broader array of care is eligible for CDS networks. CDS would include primary and standard specialty care, including inpatient medical and surgical care. It would not include special-emphasis care (care that is provided in VA in a distinct fashion). This array of eligible care is the same as that for the *Recommended Option*, and comprised 68 percent of total modeled expenditures in 2014. Second, enrollees do not need to consult with a primary care doctor in order to access CDS eligible care.

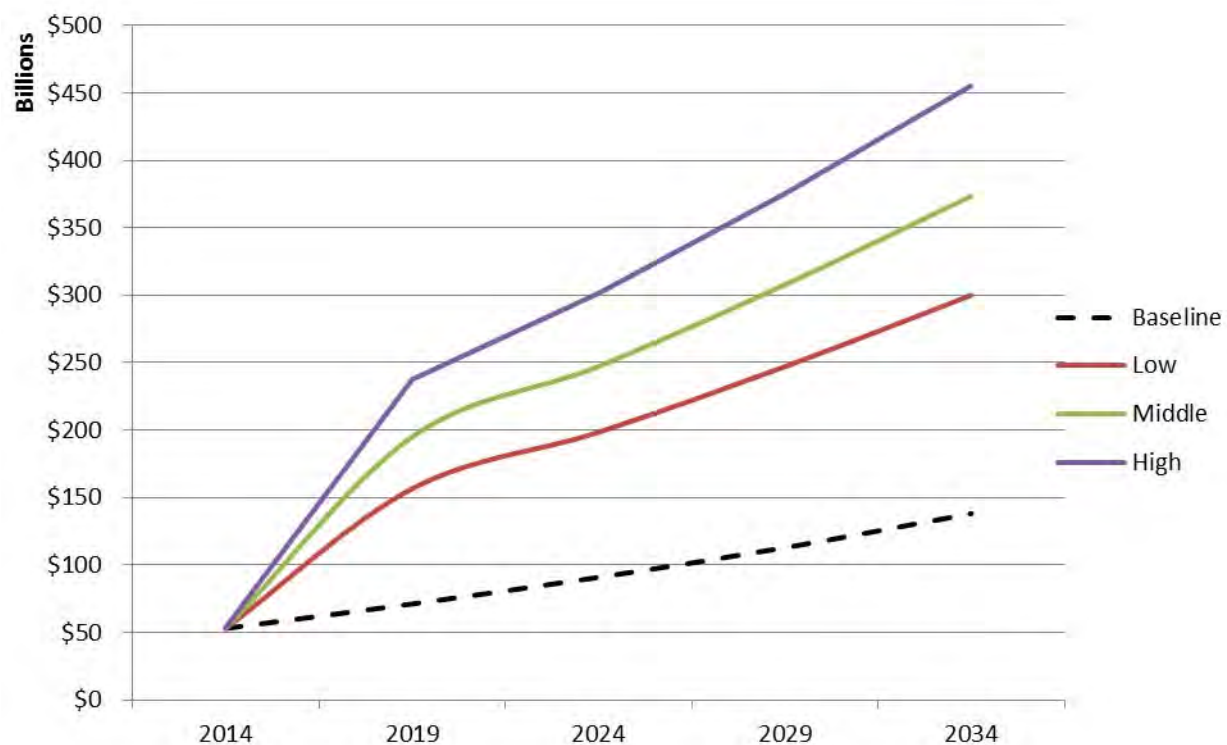
CDS Alternative 3 would offer an extremely generous benefits package for patients. With no referral or consultation, no premiums, and little if any copayments, patients would have access to a robust network of high-quality providers in their area. Although care within VA facilities would be available, no clinical contact would be necessary for those seeking care in CDS networks. Even within VA facilities, care is more attractive because patients would no longer need to consult their primary care doctors to receive specialty care. The benefits of this option contrast with the 10 to 30 percent cost sharing typical in Medicare and private coverage, the low

provider reimbursements, stigma and access barriers often associated with Medicaid,⁶⁷² and the requirements for referrals and/or prior authorizations that are widespread among health insurance plans. Few veterans would have reason to turn down such an attractive option.

Consequently, we model high ranges for reliance, enrollment, and care shifting into CDS networks. We model reliance rates of 80, 90, and 100 percent for all CDS eligible care; enrollment shares of 75, 85, and 95 percent; and a 70-percent rate of eligible care shifting from VA facilities to CDS networks. We apply the reliance increases to all care eligible for CDS networks, even if the care is provided in VA facilities or traditional CITC, because this option eliminates the need for consultations with primary care doctors for all CDS eligible care. Additionally, we assume that the total amount of CDS eligible care received by veterans from any provider and payer increases by 20 percent due to the lack of a referral requirement and/or reduced cost sharing.

Estimates are displayed in Figure A-5. In 2019, when effects are fully phased-in, estimated costs range from \$156 billion to \$237 billion, with a middle estimate of \$195 billion. This compares to a baseline projection of \$71 billion. Although estimates are highly uncertain, a key takeaway is that this option could result in very large cost increases relative to the baseline scenario, *Recommended Option*, and CDS Alternatives 1 and 2.

Figure A-5. Projected Costs of CDS Alternative 3



⁶⁷² Yu-Chu Shen and Stephen Zuckerman, "The Effect of Medicaid Payment Generosity on Access and Use among Beneficiaries," *Health Services Research* 40, no. 3 (2005), 723-44. Jennifer Stuber and Karl Kronebusch, "Stigma and Other Determinants of Participation in TANF and Medicaid," *Journal of Policy Analysis and Management* 23, no. 3 (2004), 509-530.

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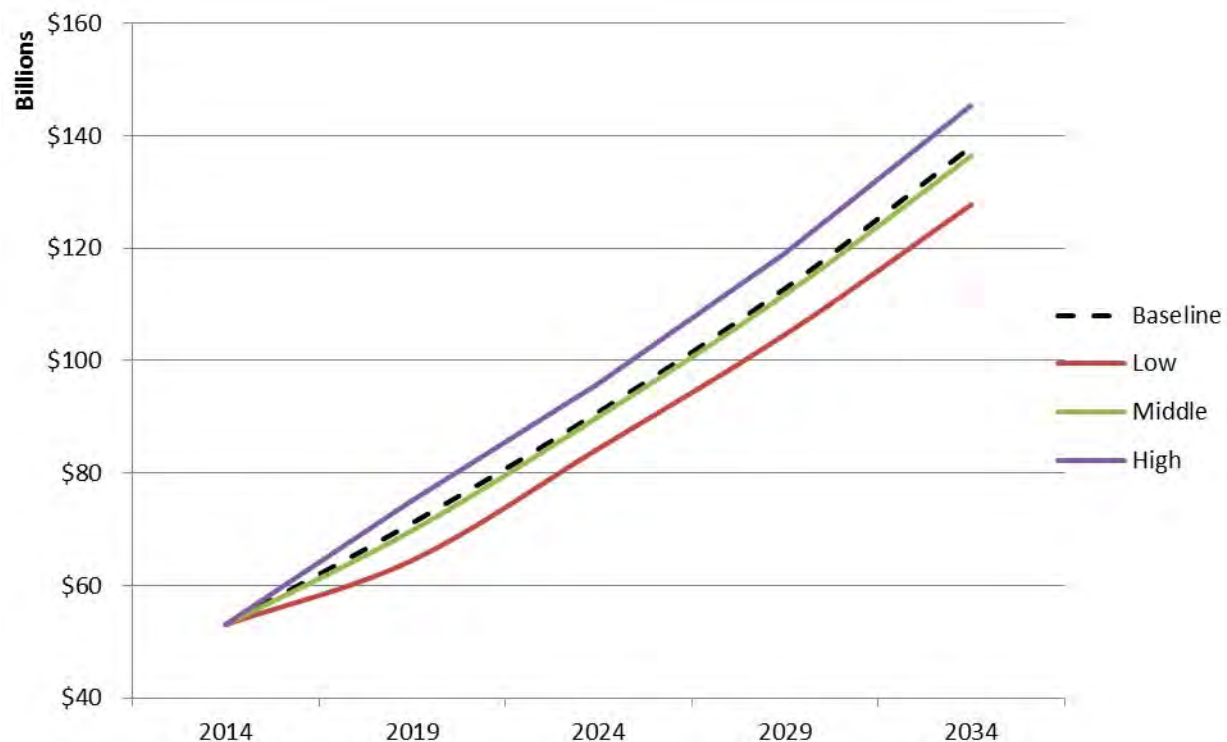
Keep Selected Services

The *Keep Selected Services (KSS)* scenario would move most standard ambulatory specialty care entirely into the community, yet keep the remainder of care entirely within VA facilities or traditional CITC. Although VA would no longer provide most standard ambulatory specialty care in VA facilities, it would continue to provide primary care, inpatient care, and special-emphasis care in VA facilities, including long term services and supports, prosthetics and orthotics services, inpatient and outpatient mental health and substance abuse, inpatient medical and surgical care, prescription drugs, medication management, recreational therapy, and immunizations. Under this scenario, approximately 35 percent of the cost of care currently provided in VA would be provided solely in the community. Providers in the community would receive Medicare rates.

We modeled increases in reliance of 10, 25, and 40 percent, which correspond to reliance rates of approximately 37, 43, and 48 percent. These reliance increases pertain only to care that moves into the community. We modeled enrollment increases of 0, 4, and 8 percent.

Estimates are displayed in Figure A-6. In 2019, when effects are fully phased-in, estimated costs range from \$64 billion to \$75 billion, with a middle estimate of \$70 billion. This estimate compares to a baseline projection of \$71 billion. Although estimates are highly uncertain, a key takeaway is that even with expanded community care, cost increases are constrained when veterans cannot choose whether they receive care in VA facilities or in the community.

Figure A-6. Projected Costs of Keep Selected Services Scenario



Premium Support⁶⁷³

Under the *Premium Support* (PS) scenario, all current and future enrollees younger than age 65 can choose a subsidized insurance premium with cost sharing (for some priorities) in lieu of their current VHA benefit. Enrollees electing the premium and cost sharing subsidy no longer have access to any VA services, including the special services VA offers. Under this scenario, there is an annual election period, and VA actively engages with enrollees to make a decision. Enrollees ages 65 and older receive no additional benefit options.

For those enrollees choosing the subsidized insurance program, the cost sharing varies by priority level: 10 percent for priorities 1 and 2; 20 percent for priorities 3 and 4; 30 percent for priorities 5 and 6; and 40 percent for priorities 7 and 8. Veterans would buy *Silver* policies on the state individual insurance exchanges, and VA would provide additional cost sharing assistance to meet the target subsidy. If enrollees purchased plans offered with lower cost sharing, such as *Gold* (20 percent cost sharing) or *Platinum* plans (10 percent cost sharing), the additional premium costs would likely exceed the cost of purchasing a Silver plan and subsidizing the cost sharing. The cost estimates did not consider the potential effect of adding a large number of veterans on exchange plans. Were VA to do this, considerations for veteran morbidity as well as the proposed cost sharing subsidies would need to be accounted for within the purchase of state exchange plans from commercial insurers.

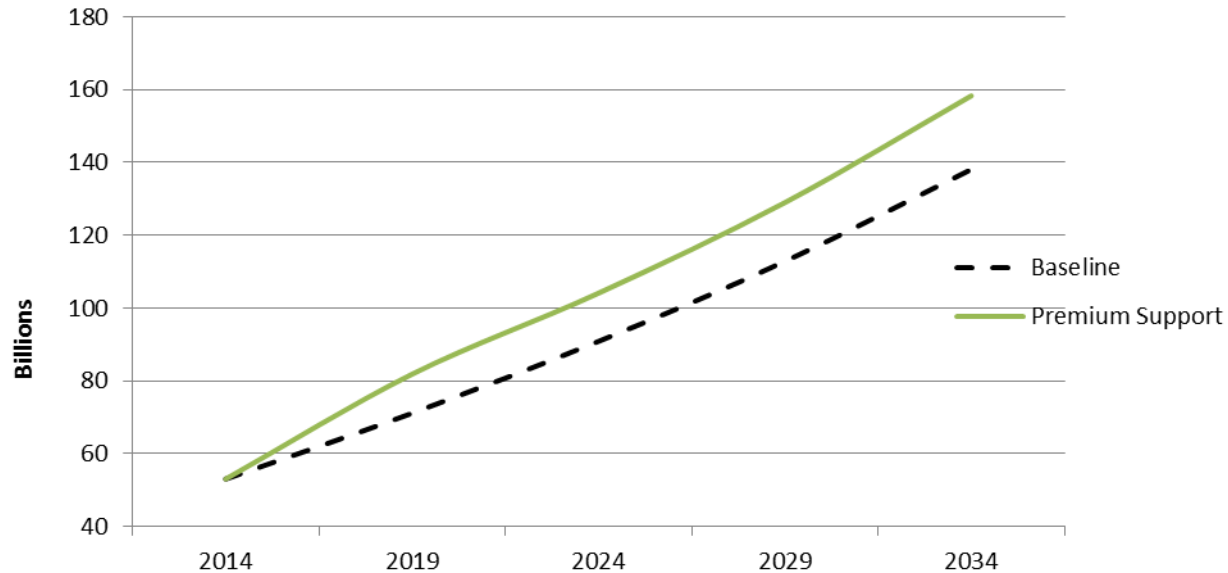
To determine participation rates in the subsidized premium program, we summarized enrollees' FY 2014 baseline data into cost brackets by attaching 2015 EHCPM unit costs to workload and then summarizing the total cost of workload provided to each enrollee. Overall, 42 percent of enrollees younger than age 65 were assumed to select the subsidized premium option, but the model assigned different rates of participation depending on enrollees' priority level and historical VA utilization. Enrollees with little to no costs were assumed to participate in the program at a higher rate as compared to those who had larger levels of VA costs. Participation rates for priority 5 veterans were assumed to be half the rates set for other priority levels. This assumption was made because many of these lower-income enrollees already have the option of participating in a highly subsidized state exchange plan with low cost sharing. It is also assumed that offering this option will motivate additional nonenrolled veterans to enroll to receive the subsidized premium plan. To estimate this effect, we analyzed the proportion of veterans by priority level with either no insurance or individual insurance plans, as reported in recent years of data captured by the American Community Survey (ACS). We estimated that this potential subsidy would lead to an additional 577,000 enrollees over the projection period.

Finally, it is assumed that the subsidized premium plan serves as a primary payer and does not supplement other coverage available to the enrollee, such as Medicare or employer sponsored insurance.

⁶⁷³ Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.

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Figure A-7. Projected Costs of Premium Support Scenario



Eligibility Expansion⁶⁷⁴

Under the *Eligibility Expansion* (EE) scenario, the VA health care system expands to allow all veterans to enroll in VA health care. In 2014, half of veterans eligible under priorities 1-7, 8b,⁶⁷⁵ and 8d were enrolled, representing a 50 percent *market share*,⁶⁷⁶ with the highest market share among those with service-connected priorities. The market share among Priorities 8a and 8c was an estimated 21 percent, reflecting enrollment from before suspension began in January 2003 and from enrollees who initially enrolled in another priority and later transitioned to Priorities 8a and 8c. If the suspension of new priority 8 enrollment had never occurred, we estimate that the market share would be 28 percent in 2014 and 30 percent in 2021 under natural growth and priority transition rates.

Under a scenario of lifting priority 8 enrollment suspension beginning in FY 2017, we estimate that the market share would climb steadily during a 5-year phase-in period to reach 30 percent in 2021, which equates to 464,000 new priority 8 enrollees. The market share is not expected to reach the level observed among other priorities because Priority 8 veterans have higher incomes, are not service-connected disabled, are more likely to have employer-sponsored coverage and individually purchased health plans, and are less likely to be uninsured relative to other priorities. Further, regression analysis of market shares among veterans in census data demonstrated that higher income veterans, nondisabled veterans and veterans with employer-sponsored health insurance are all less likely to enroll. To develop the cost estimates, newly

⁶⁷⁴ Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.

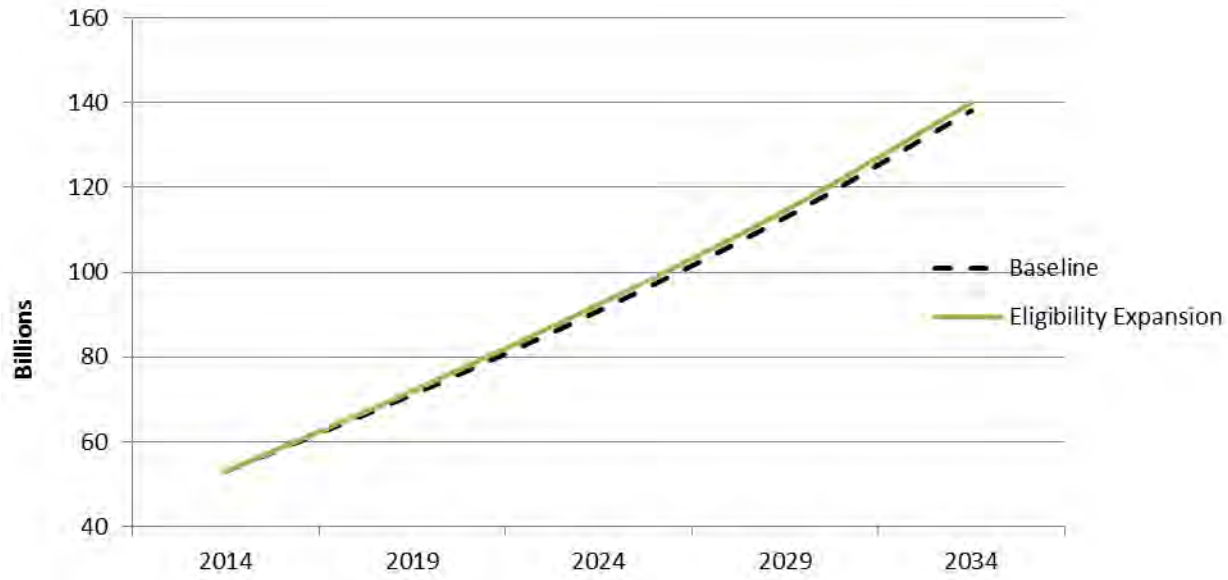
⁶⁷⁵ Priority 8b and 8d were enrolled on or after June 15, 2009 and have incomes that exceed the current VA or geographic income limits by 10 percent or less.

⁶⁷⁶ Market share is the percentage of veterans who are enrolled in VHA out of all veterans. This differs from the enrollment share, which is the percentage of eligible enrollees who are enrolled.

eligible priority 8 veterans are assumed to have the same morbidity and reliance as current priority 8 enrollees.

By 2032, based on the estimated market share, we project an additional 368,000 priority 8 enrollees with an additional \$1.8 billion in costs.

Figure A-8. Projected Costs of Eligibility Expansion Scenario



Additional Cost Factors

Nurse Navigators

VHA already has a robust care manager program that largely overlaps with the proposed nurse navigators in the CDS scenarios. VHA patient aligned care teams (PACTs) were created to coordinate care and maintain long-term relationships with patients. Most PACTs exist in a primary care setting, but there are also special-emphasis PACTs, such as those for spinal cord injury and disorders, geriatrics, and HIV care. All patients may choose to be assigned to a primary care PACT, and the vast majority do so: There are approximately 5.3 million unique patients in primary care PACTs out of a total of 5.8 million.

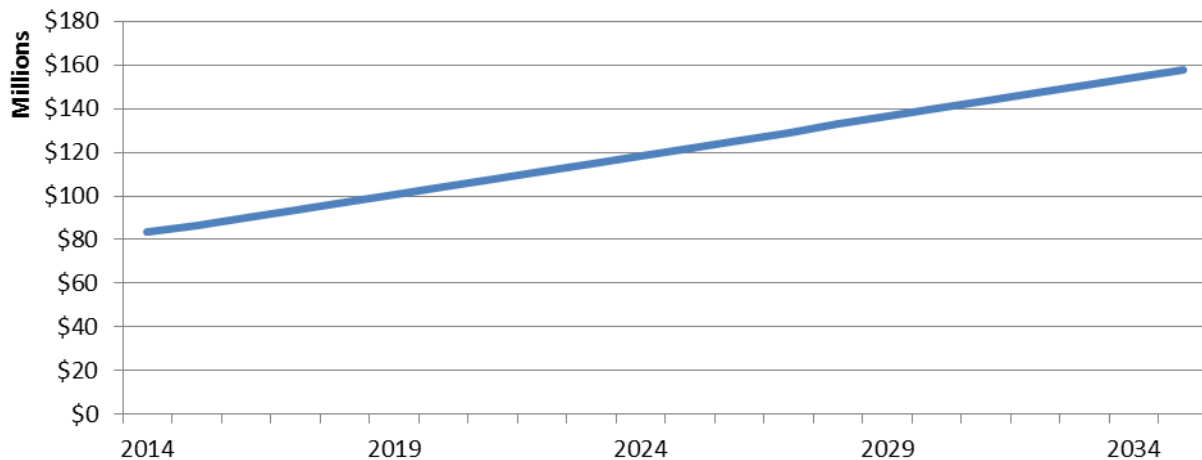
The primary care PACT typically consists of a provider, an RN care manager, a clinical associate, and a clerk. This team is assigned to a panel of approximately 1,200 patients. There are also expanded team members who are assigned to multiple panels, such as clinical pharmacy specialists, nutritionists, and behavioral health professionals. The RN care manager is the lynchpin of the primary care PACT.

One of the tasks of the care manager is to coordinate care received in VHA facilities with care received in the community. Because this coordination role would increase with the CDS scenarios, we provide a notional estimate for expanding the number of care managers to account for the additional administrative and clinical burden of an increase in community care.

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Based on discussions with VHA primary care operations and policy staff, we assume that one additional RN care manager per five panels would be necessary to handle a substantial increase in community care such as that associated with the CDS scenarios.⁶⁷⁷ Based on 2014 data on the number of patients in PACTs and the recommended panel size, we estimate that 882 RN care managers would need to be hired if the CDS scenarios were fully phased in. Incorporating the average total compensation of RN care managers (\$94.4 thousand in FY 2014) and inflating costs using the projected patient population and personnel inflation trend from the EHCPM, we generate the following cost estimates. These estimates are assumed to be fully phased in. The cost of this policy is \$100 million in 2019 and rises to \$158 million in 2034.

Figure A-9. Cost of Hiring Additional RN Care Managers



Other-than-Honorable Discharges

We also consider a policy for which those with an OTH discharge are made temporarily eligible for VA health care while their claims are adjudicated. The adjudication process would determine whether these individuals would remain eligible for care or would lose eligibility. Adjudication would be based on the reason for the discharge. For example, if the discharge were due to behavior associated with a mental health condition caused by serving in the military, that person would likely be positively adjudicated. However, the specific criteria for adjudicating cases still needs to be determined.

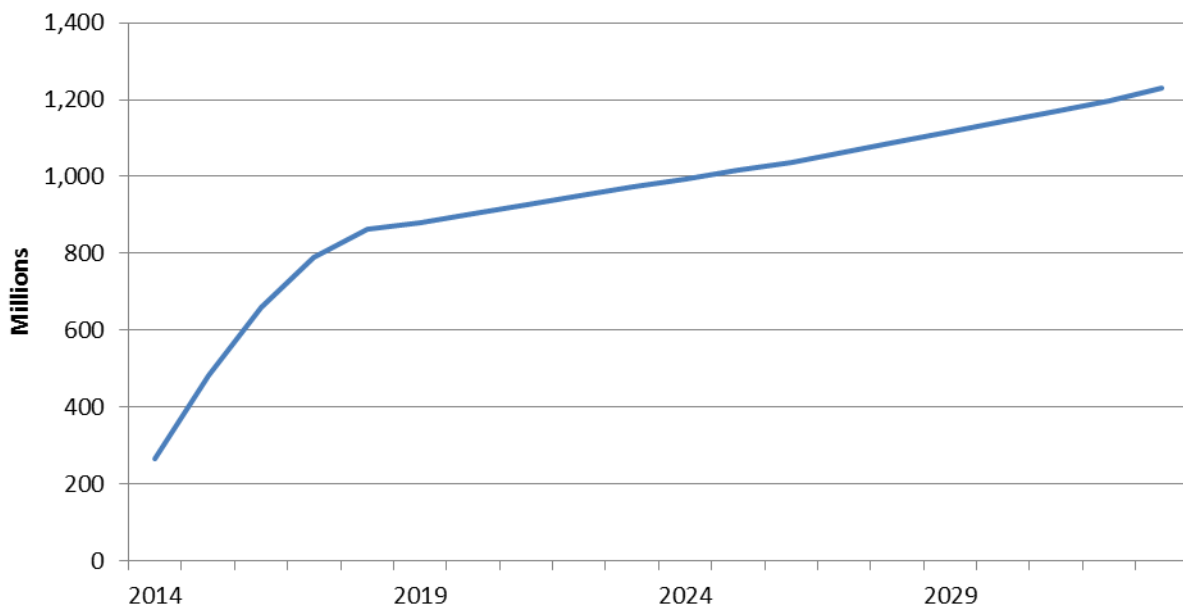
To model the cost of this proposal, we assume all people with an OTH discharge who would otherwise be eligible for VHA care are initially eligible. We assume that, consistent with the rest of the population, 73 percent of veterans with an OTH discharge are eligible for VA health care based on income and disability criteria. During a period of 5 years, their cases are examined, and 50 percent are positively adjudicated. Whether this number is actually higher or lower than 50 percent will depend on the exact details of the policy as well as the specific circumstances of veterans with an OTH discharge. In our model, the number of eligible veterans with an OTH discharge who enroll increases during the first 5 years as they become aware of the new rules. It

⁶⁷⁷ These estimates would differ depending on the CDS option pursued, but we provide a single notional estimate to give a sense of the magnitude of costs involved.

increases to 52 percent, which is the enrollment share of veterans who are currently eligible. In reality, this rate could be higher or lower for those with an OTH discharge if they are different from those who are already eligible. We assume costs per patient are similar to other veterans of the same age.

The cost of this policy increases from \$264 million in 2014 to \$1.23 billion in 2033. Fully phased-in, the cost is \$864 million in 2019. The shape of the cost curve reflects increasing enrollment during the first 5 years as veterans learn about the new rule and sign up. It also reflects adjudications as all enrolled veterans are initially eligible and then their eligibility is adjudicated during the 5 years. These calculations reflect estimates that the number of veterans with an OTH discharge for active duty military has fallen from a high of 8.8 percent in 2002 to 2.1 percent in 2015. We assume that the rate continues at 2.1 percent of discharges throughout the projection window.

Figure A-10. Projected Costs of Temporarily Covering Veterans with OTH Discharges



Conclusion

The estimated cost of allowing veterans to receive expanded community care through integrated networks varies dramatically depending on the specifics of the policy, including which categories of care are eligible for the community and whether referrals are required to access specialty care. We estimate that the *Recommended Option*, which provides increased community care that is reimbursed at Medicare allowable rates but maintains referrals for specialty care, increases costs modestly, assuming that networks are narrow and well-managed with cost as a major consideration. *CDS Alternative 1*, which offers a more restricted array of services eligible for CDS care, yet maintains a referral requirement, does not substantially increase costs. However, *CDS Alternative 3* and to a lesser degree *Alternative 2*, which eliminate the need for referrals for standard specialty care, potentially lead to very high costs. The estimated costs of the other scenarios range from small to substantial, though these costs would

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ultimately depend on the details of the proposals (e.g., the premium support schedule). Finally, we find that the costs of introducing expanded nurse navigators/care coordinators and making those with OTH discharge temporarily eligible are comparatively modest.

APPENDIX B: LEADERSHIP IMPLEMENTATION

Table B-1. Organizational Health and Cultural Transformation

Action	Responsible	Timeline
That VHA create a comprehensive, coordinated, sustainable cultural transformation effort by aligning programs and activities around a single, benchmarked concept.		
Establish the charter for the cross-functional SE team responsible for cultural transformation.	SECVA/DEPSECVA or CVCS depending on level	Now (0-6 mos)
Assess cultural transformation models and decide on a single model.	Chartered SE team	Now (0-6 mos)
Create an execution strategy for cultural transformation.	Chartered SE team	Now (0-6 mos)
Develop communication strategy and materials and release.	Chartered SE team	Near (18 mos)
That VHA aligns leaders at all levels in support of the cultural transformation strategy.		
Establish a subcommittee under the SE team to drive leadership transformation.	Chartered SE team	Near (6 mos)
Establish leadership standards for behaviors and actions.	Chartered SE team Subcommittee	Near (6-9 mos)
Publicize the standard.	Chartered SE team Subcommittee/CVCS/HTM	Near (12 mos)
Develop assessment tools.	SE Subcommittee/NCOD, NCEHC, HTM	Near (12-24 mos)
Establish expectations (in policy) for use of leadership standards in IDPs, performance review, hiring, promotions.	HTM/CVCS	Near (12-36 mos)
Provide coaching to the standard.	(Current HCM office responsible)	Near (24 mos)
Collect standards, training, support materials into a living curriculum for leaders.	EES/HTM	Near (24 mos)
Modify VA Directive 5021 (Employee/Management Relations) to include unacceptable behavior and unacceptable performance standards related to organizational transformation responsibilities of leaders and update table of penalties to correspond.	HRA/HTM	Future (36 mos)
That VHA align frontline staff in support of the cultural transformation strategy.		
Establish subcommittee to support staff transformation.	Chartered SE team	Near (9 mos)
Establish behavioral expectations/requirements for staff.	Subcommittee	Near (9-18 mos)
Develop hiring tools against the staff standard.	Subcommittee	Near (18-36 mos)
Establish requirements (in policy) for use of the standard for IDP, performance reviews, advancement in grade/promotions.	HTM/HRA/nursing and similar/unions	Near (18-36 mos)

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Action	Responsible	Timeline
Support leaders and supervisors at all levels of the organization to communicate and reinforce these standards with staff (see align leaders, above).	(Policy owner)	Near (18 mos)
Establish program office and VAMC standards and strategy for execution.		
Establish subcommittee to develop VAMC and PO execution standards.	Chartered SE team	Near (18 mos)
Establish execution strategy and policy requirements.	Chartered SE team Subcommittee/NCEHC/ NCOD	Near (18-36 mos)
Develop consolidated, meaningful metrics with input from experts and field users.		
Assign responsibility for metric development.	Chartered SE team/CVCS	Near (6 mos)
Develop and test metrics.	Organizational Excellence	Near (6-18 mos)
Deploy metrics.	Chartered SE team/CVCS/ (policy owner)	Near (18 mos)
Identify outliers and intervene.	SE team/CVCS/(policy owner)	Near (24 mos)

Table B-2. *Recruitment, Retention, Development, and Advancement*

Action	Responsible	Timeline
VHA executives are required to make the leadership system a top priority for funding, strategic planning, and investment of their own time and attention.		
Establish a VHA leadership management goal for inclusion in the 2018 budget with specific targets, including diversity targets.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (3 mos)
Submit the leadership management goal to VA for inclusion in the budget submission for 2018.	VHA OPP and CVCS	Now (3 mos)
Adopt VHA leadership management goal and submit to OMB/White House.	VA OPP and SECVA	Now (3 mos)
Establish an operational plan and accountability mechanisms for meeting these goals.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (4 mos)
Include yearly targets in the performance plan of the CVCS and SES members.	VHA NLC subcommittee on performance planning	Now (4 mos)
Schedule regular communication (at least quarterly) to the field that speaks to mission, vision, values, and expectations for ethical behavior.	CVCS	Now – ongoing
Schedule regular meetings with VHACO and field senior staff that allows for a discussion of mission, vision, values and expectations for ethical behavior.	CVCS	Now – ongoing
Develop opportunities for developing leaders to participate in the leadership and management decisions and processes of VHA.	CVCS /ask NLC executive committee to develop and implement a plan	Now (6 mos)
Adopt and implement a comprehensive system for leadership development and management.		
Convene a group to review ACHE and the National Center for Health Care Executives and devise a benchmarked model that meets the needs of health care executives in VHA as well as the private sector.	NCEHC with NCOD, & Human Capital Management; report to the NLC subcommittee for leadership development	Now (6 mos)
Create career tracks for key positions based on this new competency model.	HTM	Near (within 12 mos)
Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.		
Develop assessment tools (360, 180, self-assessment, supervisory) to support the competency model.	HTM with support as required from other offices, e.g., NCOD, EES	Near (within 18 mos)
Assess existing training against the model and identify gaps.	EES	Near (18 mos)
Develop and implement a plan to fill these gaps.	EES/reporting to NLC to ensure funding	Near (plan 20 mos – fill gaps 36 mos depending on \$)

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Action	Responsible	Timeline
Assess opportunities to share additional leadership training with DoD and create a plan to implement it.	HEC/JEC	Near (9 mos)
Develop and fund a face-to-face training to fulfill competencies for critical career positions.	EES	Near (24 mos)
Develop a masters level training program for clinical leaders in partnership with academic medicine.	EES/Academic Affiliations	Near (36 mos)
Establish sharing agreements with non-profit institutions to permit the exchange of executives for extended rotations.	EES/Academic Affiliations	Near (18 mos)
Create an experiential learning program to parallel the competency model.	EES, HTM reporting to the leadership development subcommittee of the NLC	Near (24 mos)
Establish a coaching program.	HTM/EES	Near (18 mos)
Incorporate tracking of competency assessment, training, coaching, and IDP completion into an appropriate IT platform (e.g., TMS).	HRA/EES/Workforce Management and Consulting	Near (18 mos)
VHA is required to aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: all hires and promotions are required to demonstrate these competencies.		
Create functional statements for all key positions based on the competency model.	HTM	Near (18 mos)
Create interview questions incorporating competencies for all key positions.	HTM	Near (12 mos)
Establish a process for certifying internal candidates for advancement to the next position.	Human Capital Management	Near (18 mos)
Incorporate the tracking of competency achievement with performance ratings and create a tracking mechanisms and pool of high potential candidates.	Human Capital Management	Near (18 mos)
Create regulatory requirements for the use of the competency model in hiring, promotion, development opportunities, and discipline; and incorporate procedures for veterans preferences.	Human Capital Management in VHA	Near (36 mos)
Establish an IDIQ, PBA or similar contract for executive recruitment.	Human Capital Management	Now (6 mos)
Establish requirement in policy for all ECF, SES / SES equivalent to complete IDP.	Human Capital Management	Future (following regulatory change)
Create on-ramp for retiring MTF.	Human Capital Management / DoD Coordination	Now (6 mos)
Expand (GHATP) program.	EES	Now (6 mos)
Establish a plan for developing and managing the candidate pool.	NLC subcommittee for leadership	Now (6 mos)
Require a formal on boarding process for leaders at all levels that re-enforces the leadership competency model.		
Establish an onboarding curriculum and process.	Human Capital Management, EES, HTM	Now and Near (18 mos)

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APPENDIX B
LEADERSHIP IMPLEMENTATION

Action	Responsible	Timeline
VHA is required to take immediate steps to stabilize the continuity of leadership.		
Extend authority for length of details and ability to compete for the detail position.	Human Capital Management	Now (6 mos)
Establish and fund assistant level positions in all key career development tracks.	CVCS	Now (18 mos)

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Table B-3. Organizational Structure and Function

Action	Responsible	Timeline
Eliminate duplication within VHA and consolidate program offices to create a flat structure.		
Eliminate the duplication of functions between VHA and VA by closing VHA offices.		
Create innovative organizational structures to support clinical delivery that are aligned to patient's needs rather than professional silos.		
Undertake a reduction-in-force (RIF) in VHACO that promotes delayering and efficiency in communication and decision making.		
Publish a new organizational chart consistent with Figure 9.	CVCS	Now (1 mos)
Prepare an initial RIF for offices eliminated.	VHA Human Capital Management	Now (3 mos)
Engage VERC (or other resources with expertise in business process reengineering) to re-design the processes and structures with remaining offices to ensure end-to-end support for field function and to further reduce duplication; including clinical function re-organization.	Transformation Office/ VERC	Near (3-12 mos)
Each program office in collaboration with VERC or other transformation resources identifies areas of "stop work" with staffing and budget savings.	Transformation Office/ PO/ CVCS	Near (3-12 mos)
Publish clear roles, responsibilities and expectations that apply to all VHACO offices.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VHACO staff to the new expectations for the role of VHACO.	Transformation Office/ EES	Now (1 mos)
Develop training curriculum to support VHACO staff in developing the skills and competencies required.	Transformation Office/ EES	Near (18 mos)
Develop an engagement strategy to inspire VHACO staff to embrace their new role and tie to in-service training roll out.	Transformation Office/ CVCS	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VHACO employees.	Transformation Office/ EES	Now (6 mos)
Adopt customer service training in VHACO and roll it out; include as part of new employee on-boarding in VHACO.	Transformation Office/ EES	Near (12 mos)
Draft basic competencies for VHACO program staff (e.g., customer service, quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ Each PO	Near (18 mos)
Acquire, configure, and train PO staff on data analytics infrastructure to support program office and field tracking of key performance metrics.	Office of Organizational Excellence/OIT	Near (18 mos)

APPENDIX B
LEADERSHIP IMPLEMENTATION

Action	Responsible	Timeline
Clarify and specifically define the roles and responsibilities of the VISNs and facilities, pushing decision making down to the lowest level.		
Publish clear roles, responsibilities and expectations that apply to the VISNs.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VISN staff to the new expectations for the role of VISN.	Transformation Office/ EES	Now (1 mos)
Develop an engagement strategy to inspire VISN staff to embrace their new role and tie to in-service training roll out.	VISN directors	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VISN employees.	Transformation Office/ EES	Now (6 mos)
Draft basic competencies for VISN staff (e.g., quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ each PO	Near (18 mos)
Gain agreement from Congress to institute three appropriation lines only: medical, major construction, research.	CVCS/SECVA/OMB	Near (12 mos)
Eliminate segregation of specific-purpose funds to the VISNs and facilities.	CVCS/Office of Finance	Now (6 mos)
Modernize financial management system (FMS) to permit effective cost accounting and tracking of priority spending.	OIT/Office of Finance	Future (36 mos)
Develop training to support effective use of FMS to permit effective account tracking and reporting and roll it out.	Finance/EES	TBD post procurement
Establish quarterly spend reports covering all priority areas (e.g., NRM, IT, facility minor, purchased care, mental health, women's health, administration) by facility and release to Congress and the public.	Finance Office	TBD post procurement
Delegate decisions in recruitment, retention and advancement (e.g., hiring bonus, retention bonus, market pay) for staffing to the facility.	CVCS/HCM	Now (1 mos)
Delegate training and travel decisions.	CVCS/EES/OAA	Now (1 mos)
The USH establishes leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue and collaboration.		
Improve communication with field leadership and frontline employees through the liberal use of social media, town halls and other direct engagement channels with a dedicated champion to help the USH and senior staff in this endeavor.	CVCS	Now (3 mos)
Reestablish in-person leadership conferences, at least semi-annually, to foster communication and relationship building between VHACO, VISN and facility leadership.	CVCS/EES/NLC	Now (6 mos)
Add behavioral competencies to performance plans that promote effective communication amongst leaders.	CVCS	Near (12 mos)

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Action	Responsible	Timeline
Establish expectations and requirements for program office leaders to communicate the USH leadership messages, coordinate PO communications with the USH and with one another.	CVCS	Now (3 mos)
Establish a transformation office with broad authority and a supporting budget to accomplish the change.		
Establish the new transformation office in the organizational chart, populate with expertise in business process re-engineering, and fund initially using savings from closure and consolidation of offices in VHACO and a budget reduction to all other VHACO offices.	CVCS	Now (6 mos)
Create a Transformation Office strategic plan to educate and provide guidance to the new initiatives and support the goals of VA and VHA.	Transformation Office	Near (3-6 mos)
Create a new initiative implementation plan to include follow-on priorities, tasks and milestones. The Transformation Office will support the operation and the plan moving forward.	Transformation Office	Near (3-6mos)
The Transformation Office will be responsible for evaluating all new initiatives and programs using the President's Management Agenda Scorecard or a model that emulates its rating standards of Green represents success; yellow for mixed results; and red for unsatisfactory. These ratings are indicative of standards of success or failure.	Transformation Office	Near (3-6mos)

Table B-4. Performance Metrics and Management

Action	Responsible	Timeline
Create a new performance management system for VHA leaders appropriate for health care executives.		
Establish a workgroup and engage outside experts to create the new performance management system that is benchmarked to private-sector models, is consistent with the new leadership competency model, and recognizes both leadership competencies and success in delivering strategic priorities. The model should include a new rating scale.	Transformation Office/Human Capital Management	Now (6 mos)
Develop and conduct training on the new performance management system for all participants to describe the system, rating process, and expectations.	Human Capital Management	Near (6-12 mos)
Establish a mechanism to capture performance assessment outcomes and track and manage high-potential staff.	Human Capital Management/HRA	Now (3 mos)
Establish a project plan to deliver annual guidance on performance plans at least a month in advance of the new fiscal year (i.e., at the start of the new rating period).	Human Capital Management/CVCS/Sec/OMB	Now (3 mos)
Hold raters accountable for creating meaningful distinctions between leaders.		
Provide training to raters on the application of the new performance management system and expectations for ratings.	Human Capital Management	Future (12 mos)
Require raters to establish plans for subordinates that are timely and meaningful; track and provide feedback on meeting this goal.	Human Capital Management/HRA	Now (3 mos)
By modeling the behavior and communicating the requirement, establish expectations that raters, and secondary-level raters, engage in continuous dialogue and coaching with subordinates about performance throughout the year, not just at mid-year and at the end of the rating period.	CVCS	Now (3 mos)
Establish oversight and feedback process for raters and incorporate this into the raters performance evaluation.	Human Capital Management/CVCS	Now (12 mos)
Provide coaching to raters and focused reviews if their rating profile doesn't provide meaningful distinctions in performance.	Supervisors	Near (12 mos)

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Table B-5. Leadership Implementation: Human Capital Management

Action	Responsible	Timeline
VA re-align HR functions and processes to be consistent with best practice standards of high-performing health care systems.		
Charge HRA to undertake an HR transformation study and ensure budget and solicitation of customer requirements.	SECVA/DEPSECVA	Now (0-6 mos)
Engage HR and change management experts to develop a benchmark human capital management plan for VA.	HRA	Now (0-6 mos)
Circulate new human capital plan for feedback and finalize.	HRA with input from VHA, Congress, OPM, OMB, SECVA/DEPSECVA, CVCS	Now (6 mos)
That VA and VHA leaders make transformation of Human Capital management a priority, with adequate attention, funding and continuity of vision.		
Endorse human capital management plan and ensure alignment of budget, IT system funding, training resources, and accountability mechanisms to support it.	SECVA/DEPSECVA and CVCS, as applicable	Near (9 mos)
Employ HR and change management experts to fully implement the transformation agenda and the new human capital management plan.	HRA	Near (12-30 mos)
Create an HR IT technology plan.	HRA & OIT	Near (9 mos)
Establish meaningful measures and risk indicators for VA human capital management.	HRA	Future (24 mos)
Incorporate HR measures into systematic reporting to leadership; and as appropriate into performance plans for key subordinate leaders.	HRA, DEPSECVA, CVCS as appropriate	Near (18 mos)
VA develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 Hybrid, Title 38 7306, and SES).		
Develop clear standards, guidelines, and training on progressive discipline.	HRA (with support from OPM)	Now (6 mos)
Managers, supervisors and HR professionals complete training.	SECVA/ DEPSECVA and CVCS (HTM office)	Near (12 mos)
Train HR staff to be coaches in progressive discipline.	HRA	Now (6-12 mos)
Establish performance metrics for HR professionals and client feedback mechanisms to ensure effective coaching and support for progressive discipline process.	HRA	Near (12 mos)
Establish performance expectations for VA supervisors and managers to apply the progress discipline process.	SECVA/ DEPSECVA, CVCS	Near (12 mos)

APPENDIX C: PILOT PROJECTS FOR EVALUATING EXPANDED CARE

As discussed in Recommendation #18, some Commissioners support the idea of developing pilot programs to test the feasibility of avoiding VA hospital closures by allowing veterans' spouses and currently ineligible veterans to purchase VA care in selected areas.

Problem

In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. This trend is driven by four main factors: (a) the overall decline in the size of veterans population, (b) the migration of veterans away from some parts of the country, such as New England and the Upper-Midwest, (c) the general trend in health care toward less intensive use of acute-care hospital beds, and (d) increased use of purchased care, which now accounts for 27 percent of all appointments.

A related challenge is maintaining safe volume of care when patient loads decline. As extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁷⁸

Simply closing a low-volume hospital is sometimes the answer. But closing a local VA hospital may mean that area veterans will have reduced access not only to routine, but also to specialty care related to their military service, such as for spinal cord or traumatic brain injuries. In many areas, such care is not available or is in short supply outside VHA.

At the same time, it may not be clinically feasible for VHA to engage in highly specialized care if it lacks the ability to offer other forms of care in the same setting. Patients in a polytrauma unit for example, require a full-spectrum of routine and nonroutine health care.

Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. Toward that end, VHA could develop pilot programs to test the feasibility of enabling veterans' spouses and currently ineligible veterans in these areas to purchase VHA care through their health plans. These pilots could be tested in conjunction with the growth of the high-performance, integrated VHA networks recommended elsewhere in this report. These networks will allow VHA far more flexibility than in the past to expand or contract its local capacity in different markets as appropriate.

⁶⁷⁸ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

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Background***Current Nonveteran Access to VHA Care***

VHA already treats many nonveterans. VHA estimates it treated 694,120 unique nonveteran patients at a total cost of \$1.9 billion in 2015,⁶⁷⁹ or 3.6 percent of total VHA obligations.⁶⁸⁰

By far the largest subgroup within the nonveteran patient population are participants in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA beneficiaries are the dependents of permanently and totally disabled veterans, survivors of veterans who died from service-connected conditions or while on active duty, or spouses of veterans who at the time of death were rated permanently and totally disabled from a service-connected condition.

Congress authorized CHAMPVA in 1973. The authorization specifies that VHA is the secondary payer for those with Medicare Part A and B coverage. In cases for which VA medical facilities are equipped to provide the care, VA may use facilities not being used for the care of veterans to provide services to the dependent or survivor.

Congress has also directed VHA to offer specific health care services to many other classes of nonveterans. These include mental health and counseling services for family caregivers of seriously injured veterans of post-9/11 service. Several provisions of law also authorize VA care for certain family members of veterans who were exposed to toxic substances. In the case of veterans with 50 percent or more service-connected disability, VHA must provide by law “consultation, professional counseling, marriage and family counseling, training and mental health services as are necessary in connection with” the veteran’s treatment.⁶⁸¹

Analysis

Others who have developed strategic plans for the long-term future of VA health care have recommended expanding upon these precedents, specifically by allowing currently ineligible veterans and the spouses of veterans to purchase VHA care.⁶⁸² In effect, providing such care would allow VHA to operate as an accountable care organization, capable of receiving reimbursement from patients covered by Medicare, Medicaid, as well as by private insurance plans. Among the potential benefits envisioned are the following:

- optimizing patient safety, productivity, and cost-effectiveness by ensuring sufficient patient volumes in currently under-utilized facilities
- preserving mission critical veterans’ programs that would otherwise need to be terminated in many parts of the country
- optimizing the integration of VHA and non-VHA care within communities

⁶⁷⁹ Allocation Resource Center, information provided to Commission on Care, December 8, 2015.

⁶⁸⁰ Department of Veterans Affairs, “Volume II: Medical Programs and Information Technology Programs, Congressional Submission, FY 2016 Funding and FY 2017 Advance Appropriations,” accessed May 27, 2016, <http://www.va.gov/budget/products.asp>.

⁶⁸¹ Counseling, Training, and Mental Health Services for Immediate Family Members and Caregivers, 38 U.S.C. § 1782.

⁶⁸² Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce*, accessed May 27, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>.

APPENDIX C
PILOT PROJECTS FOR EVALUATING EXPANDED CARE

- providing a *public option* for health care to a wider range of veterans as well as nonveterans in communities where health care choices are currently limited
- bringing in new sources of revenue to contribute to the funding for veterans' healthcare

The pilot projects described below would specifically evaluate whether such a strategy will allow VHA to optimize the quality and cost-effectiveness of its health care system by avoiding low volumes of routine and specialty care in certain sections of the country. These pilot projects would also allow VHA to evaluate whether such a strategy could provide new revenues for sustaining the VA health system while providing other benefits to veterans and the public at large.

The chart below sketches six possible pilot projects designed to test different specific policy configurations. The configurations include projects in which VA care is marketed to health care plans on fee-for-service (FFS) basis, and plans in which VA facilities are markets to health care plans as Accountable Care Organizations that provide integrated health services to a fixed population of insured patients for a fixed cost.

*Demonstration Projects to Assess VHA's Capability to Treat
Nonveteran Spouses and Ineligible Priority 8 Veterans*

	Eligibility	Capitation/Fee For Service	Timing
Demonstration 1: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) With Private Insurance	FFS	Years 2-7
Demonstration 2: FFS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance	FFS	Years 2-7
Demonstration 3: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) with private insurance	FFS	Years 3-8
Demonstration 4: FSS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance and/or Medicare	FFS	Years 3-8
Demonstrations 5 and 6: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses	Enrollment: May choose higher cost plan with more coverage and less copayment; lower cost option with less coverage and higher copayments.	Years 4-9

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	Eligibility	Capitation/Fee For Service	Timing
Demonstrations 7 and 8: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses with private insurance and/or Medicare	Enrollment: May choose higher cost plan with more coverage and less copayment; or lower cost option with less coverage and higher copayments. Pilot sites would be deemed Accountable Health Care Organizations for Medicare Advantage plans.	Years 5-10

Certification of Access: Any participating VHA facility must certify that its waiting times for primary care, specialty care and behavioral health are less than 30 days.

Site selection: Sites should include facilities in different regions with various population densities (urban, suburban, rural) and levels of service complexity. VHA may also consider such factors as stability of medical center leadership, and whether local markets are underserved or subject to high degrees of market concentration among either providers or payers.

Assumptions

- Many provisions are subject to Congressional authorization.
- Participating VHA facilities will be able to retain any “profit” associated with treatment of new users without offset;
- Congress will (preferably) waive the current prohibition on Medicare funding federal health care programs,
- VHA will not be subject to proving “level of effort” in order to receive Medicare funds

Assessment

After the first year of operations, VHA will assess these projects according the following criteria:

- Was access to care or patient satisfaction among veterans already enrolled in the system affected by the demonstration?
- What was the level of patient satisfaction among new users purchasing VA care?
- Did VHA cover the costs of delivering care to its patients purchasing care? If so, what were its net revenues and how were they used?
- If VHA collected Medicare funds, did funding cover costs of delivering care?

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PILOT PROJECTS FOR EVALUATING EXPANDED CARE

- Were there administrative challenges in opening the VHA to new users? If so, what lessons were learned?
- How did VHA promote the demonstration project to those eligible?
- What are the recommended strategies for further implementation?
- Were there non-financial benefits to treatment of new users, such as diversifying case mix, providing sufficient volume to allow certain VHA services to remain available, or keeping scarce health professionals employed in an area that is medically underserved?
- How did the demonstrations affect the overall quality of care, market structure, pricing, and range of health care options available to both veterans and nonveterans in the surrounding community?

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APPENDIX D:

HISTORY AS A CONTEXT FOR SYSTEMIC TRANSFORMATION

History provides opportunities to see the problems and challenges facing VHA today through the lens of recurring themes from the past. Veterans' health care has, over the course of its history, been marked by periods of both progress and problems. Understanding the challenges of the past and the solutions used to address them provides context for building a plan for reforming veterans' health care in a manner that is flexible and sustainable.

Challenges and Growth

The federal government's role as a care provider for veterans has evolved, paralleling, to some extent, medicine's evolution. Prior to World War I, the only benefits afforded then-eligible veterans were pensions and domiciliary care (which involved only incidental medical treatment), provided under the National Home for Disabled Volunteer Soldiers and Sailors established after the Civil War.⁶⁸³

World War I brought real change. At the time, no single agency was responsible for the anticipated deluge of sick and wounded soldiers. The more than 200,000 wounded who returned home from battle quickly exceeded capacity of the U.S. Public Health Service (PHS), the National Home, and other agencies. According to one account of the period, "[c]haos and confusion reigned for more than two years . . . [n]ew hospital construction languished," and "[b]y 1921, veterans' care had become a national embarrassment."⁶⁸⁴ At the recommendation of a presidential committee, Congress passed legislation in 1921 to consolidate the several veterans-related bureaucracies into a single Veterans Bureau, to which the President Warren Harding transferred 57 PHS hospitals. A new administrator, Frank T. Hines, proposed care and treatment of veterans' non-service-connected ailments when facilities and bed space were available. Congress adopted the proposal in the World War Veterans Act of 1924.⁶⁸⁵

Under Hines' tenure, VA grew from 64 to 91 hospitals, nearly doubling bed capacity. Civil Service Commission personnel rules and low pay led to generally poor quality VA physicians, yet Congress rebuffed VA proposals to set up a VA Medical Corps.⁶⁸⁶ With many physicians having left VA to serve in World War II or for more lucrative practice, the VA health care system was left critically understaffed.⁶⁸⁷

⁶⁸³ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 4.

⁶⁸⁴ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 13-14.

⁶⁸⁵ *Ibid.*, 19.

⁶⁸⁶ *Ibid.*, 21.

⁶⁸⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 149.

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World War II and the need to care for millions of service members, including 671,000 wounded, highlighted the problems facing VA. Scathing reports of shoddy veterans' care, including an exposé characterizing veterans' hospitals as backwaters of medicine, magnified the problems.⁶⁸⁸

Congressional hearings led to a shakeup in leadership and General Omar Bradley was appointed to head the agency, with its network of 97 hospitals, and a need for more.⁶⁸⁹ Dr. Paul Magnuson, who served as VA's chief medical director (CMD) from 1948 to 1951, later described the conditions at the time:

The majority of Veterans Administration hospitals were stuck in far off places, some of them on Indian reservations, others as much as fifty miles from the nearest through-line railway stop. The doctors were all full-time Civil Service employees, hemmed in by regulations and practically forbidden to do any research, attend any medical meetings or otherwise keep in touch with scientific progress. Operating rooms closed at noon so everybody could spend the afternoon happily doing required paperwork, while patients waited days and weeks for surgery.⁶⁹⁰

With President Harry Truman's statement that "the Veterans Administration will be modernized," new VA leadership worked with Congress to pass far-reaching legislation, Public Law 293, which created a VA Department of Medicine and Surgery (DM&S), and freed VA physicians, dentists, and nurses from the Civil Service Commission and its rules.⁶⁹¹ Within weeks, the chief medical director of the new DM&S issued a policy memorandum that outlined a cooperative affiliation agreement between VA and medical schools under which deans' committees would recommend consultants and attending physicians for appointment to VA, and residency-training programs would be established at VA hospitals. The law, and Policy Memorandum #2, broke a recruitment logjam and enabled the short-staffed department to hire medical professionals needed for the dozens of new VA hospitals being built. Soon after, medical students and residents began working in 32 VA hospitals. The reforms instituted under Bradley and his team were palpable,⁶⁹² with the physician staff at VA hospitals increasing from 2,300 (1,700 of whom were detailed by the military) in June 1945 to 4,000 full-time staff a year later.⁶⁹³ By 1948, VA had 125 hospitals in operation with 60 medical school affiliations and 2,000 residents.⁶⁹⁴

After this turn-around, Bradley left to become Army Chief of Staff, and under his successor, "who did not enjoy the same level of prestige and support that Bradley did . . . VA quickly

⁶⁸⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 22.

⁶⁸⁹ *Ibid.*, 23-25.

⁶⁹⁰ *Ibid.*, 22.

⁶⁹¹ "31: The President's News Conference," Harry S. Truman Library & Museum, accessed June 3, 2016, <http://trumanlibrary.org/publicpapers/viewpapers.php?pid=38>.

⁶⁹² James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 27.

⁶⁹³ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 214.

⁶⁹⁴ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 28.

reverted to its pre-Bradley ways and remained that way for the next forty years,”⁶⁹⁵ according to one account.

By the early 1950s, the veteran population had grown to more than 20 million.⁶⁹⁶ VA was operating 162 hospitals, with an average census of more than 104,000 patients.⁶⁹⁷ A VA historian observed that “waiting lists contained 22,613 applicants awaiting admission, none of whom were service-connected, although some of the latter were hospitalized in other than VA hospitals.”⁶⁹⁸ At the time, non-service-connected veterans seeking care had to state under oath that they could not afford to pay for hospitalization, and admission was granted only when beds were available in VA or other federal hospitals.⁶⁹⁹ Critics called for reducing free medical care of non-service-connected veterans, and questioned whether some were getting care that they could afford. This issue led VA to institute a policy of formal counseling under which hospitals would supply the veterans with an estimated cost of care to assist them in determining their ability to pay.⁷⁰⁰

In contrast to the generous Bradley-era funding, the 1950s funding cuts necessitated layoffs, bed-closures, and moth-balling of newly constructed hospital wards.⁷⁰¹ During this period, annual debates over the DM&S budget centered on the number of beds VA should operate. VA leaders contended that the number should be 125,000, yet the director of the Bureau of the Budget (the predecessor to the Office of Management and Budget [OMB]) asserted 87,000 was sufficient.⁷⁰²

The expiration of the incumbent CMD’s term led to the appointment in 1955 of medical educator Dr. William Middleton, dean of the Wisconsin Medical School, and a long-time member of a VA special medical advisory group. One of his first acts as CMD was to champion medical research in VA and broaden its scope to include geriatric research. Soon after, Congress began earmarking funds for VA research, and expanded DM&S’ statutory role to include medical research.⁷⁰³ During Middleton’s tenure, from 1955 to 1963, VA research funding grew from some \$6 million to more than \$30 million.⁷⁰⁴ Middleton’s work laid the foundation for a research program long recognized for pioneering important medical technologies, including medical use of radioisotopes, dialysis, cardiac pacemakers, liver transplantation, as well as seminal studies that documented the benefits of coronary artery bypass surgery and drug treatment of hypertension.⁷⁰⁵ The program also stood out for its capacity to design and rapidly implement large-scale cooperative trials, first mounted in the 1950s with successful evaluation

⁶⁹⁵ Ibid., 29.

⁶⁹⁶ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 254.

⁶⁹⁷ Ibid.

⁶⁹⁸ Ibid.

⁶⁹⁹ Ibid., 253.

⁷⁰⁰ Ibid., 253-254.

⁷⁰¹ Ibid., 256.

⁷⁰² Ibid., 258.

⁷⁰³ Ibid., 262-263.

⁷⁰⁴ Ibid., 263-264.

⁷⁰⁵ Stanley Zucker et al., “Veterans Administration Support for Medical Research: Opinions of the Endangered Species of Physician-Scientists,” *The FASEB Journal*, 18, no. 13, (2004): 1481-1486, <http://doi.org/10.1096/fj.04-1573lfe>.

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of chemotherapy for tuberculosis.⁷⁰⁶ Working on issues relevant to veterans, VA researchers developed functional electrical stimulation systems to allow patients to move paralyzed limbs, helped develop the first ankle-foot prosthesis, and launched the largest-ever trial of psychotherapy to treat posttraumatic stress disorder.⁷⁰⁷

Middleton expanded the VA educational program. In addition to growing the number of medical residents it helped train, VA provided training to a large share of clinical psychologists, graduate dentists, student nurses, occupational and physical therapists, social work students, and dietetic interns. Middleton instituted numerous advances in VA care such as introducing outpatient care for preadmission workups and post-hospital treatment that allowed earlier release from inpatient stays. He moved VA away from operating hospitals for specific diseases (as had been done for tuberculosis and mental illness).⁷⁰⁸

The enactment of Medicare in 1965 raised questions about the effect that program would have on the VA health care system. The House Veterans Affairs Committee sent a questionnaire to a group of 10,000 veterans explaining the new program and asking the veteran to if they preferred VA care or treatment in a community hospital under Medicare.⁷⁰⁹ Some 59 percent responded, and nearly two-thirds of respondents preferred VA.⁷¹⁰ At the time, the policy governing those eligible for VA care based on financial need was that Medicare benefits were to be considered in determining an individual's ability to pay for needed care.⁷¹¹

The enactment of Medicare and other changes in health care in 1977, led to a commission being established by the National Academy of Sciences (NAS) which issued a report pursuant to a congressional directive to evaluate the VA health care system. Among its findings, the commission reported that VA had a surplus of acute beds and recommended that new facilities be constructed only after examining bed availability in the community. It also recommended that underutilized VA hospitals be closed or converted to long-term care facilities, and resources redistributed to permit a shift from inpatient to outpatient care. The NAS commission also recommended that VA experiment with models for community-based integrated care.⁷¹² The commission's recommendation for integrating the VA system into the nation's civilian health care program⁷¹³ provoked objection, particularly in Congress.⁷¹⁴ Hearings produced sharp rejections of the NAS commission findings and its call to end VA's role in providing health care to veterans.

⁷⁰⁶ Ibid.

⁷⁰⁷ Veterans Health Administration, *History of VA Research Accomplishments*, accessed June 3, 2016, http://www.research.va.gov/researchweek/press_packet/Accomplishments.pdf.

⁷⁰⁸ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 265-267.

⁷⁰⁹ Ibid., 390.

⁷¹⁰ Ibid.

⁷¹¹ Ibid.

⁷¹² *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs*, 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.

⁷¹³ J. William Hollingsworth and Philip K. Bondy, "The Role of Veterans Affairs Hospitals in the Health Care System," *New England Journal of Medicine*, 322, no. 10, (1990): 1851-1857, <http://doi.org/10.1056/NEJM199006283222605>.

⁷¹⁴ *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs*, 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.

The VA of the 1970s and 1980s is remembered as bureaucratic, reliant on paper health care records, and driven by patient admissions (on which budgets were based).⁷¹⁵ The quality of VA care was also an issue. Complaints from Vietnam veterans and critical media accounts fueled outrage, and led to the view that the system was broken. The question, how to fix it, reopened an earlier dialogue around making VA a cabinet-level department, a view strongly supported by veterans service organizations (VSOs) and veterans' leaders in the House of Representatives. In 1988, after years of debate, and opposition from administration offices and advisors, President Reagan signed legislation creating a Department of Veterans Affairs.⁷¹⁶ The new department, with DM&S now renamed the Veterans Health Services and Research Administration (to emphasize its research legacy in such fields as infectious disease, pacemaker technology, and prosthetics), employed some 194,000 people with a \$12 billion budget.⁷¹⁷

Facing an aging veteran population⁷¹⁸ expected to overwhelm the system by 2010, the new secretary, Edward Derwinski, in 1989 requested Congress establish an independent commission to review the alignment and mission structure of VA's hospitals. Congress rebuffed the request after VSOs, suspecting a plan to close hospitals, lobbied against it.⁷¹⁹ Derwinski created his own "Commission on the Future Structure of Veterans Health Care" that was to review all VA hospitals and recommend needed mission changes. Instead, the so-called Mission Commission called for expanding eligibility law to enable veterans to obtain the full continuum of VA health care services. Although the commission identified the need for fundamental restructuring of the VA health care system, the subject was soon overtaken by national health reform proposals, and what role VA might have under a universal coverage system.⁷²⁰

Dr. James Holsinger, a new under secretary for health (USH), made care quality a top goal and issued a Blueprint for Quality tool in 1992, setting the stage for more far-reaching changes instituted by his successor, Dr. Kenneth Kizer. Care quality, a perennial topic, had led to the previous under secretary's resignation following reports of multiple veterans' deaths under questionable circumstances at VA's North Chicago medical center.⁷²¹ Two years later, Derwinski lost his job after creating ire among veterans' organizations in response to his proposed pilot program to open two VA hospitals to poor, rural nonveterans.⁷²²

⁷¹⁵ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 30-31.

⁷¹⁶ Ibid., 33-40.

⁷¹⁷ Ibid., 50.

⁷¹⁸ As the General Accounting Office reported in 1990, "The Department of Veterans Affairs (VA) faces a major challenge: planning how to meet the long-term care needs of a rapidly aging veteran population. The number of veterans 65 years old and over is projected to grow to 9 million by 2000—a 50percent increase over the 1988 level.

U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), accessed June 20, 2016, <http://www.gao.gov/assets/150/149139.pdf>.

⁷¹⁹ U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), 51, accessed June 20, 2016, <http://www.gao.gov/assets/150/149139.pdf>.

⁷²⁰ U.S. Government Accountability Office, *Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Care Reform*, GAO/HEHS-95-14 (Washington, DC, 1994), accessed June 20, 2016, <http://archive.gao.gov/f0902a/153054.pdf>.

⁷²¹ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 53.

⁷²² "Angry Veterans Groups Say They Made Bush Oust Agency's Head," Eric Schmitt, accessed June 3, 2016, <http://www.nytimes.com/1992/09/29/us/angry-veterans-groups-say-they-made-bush-oust-agency-s-head.html>.

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Transformational Leadership

VA's second secretary, Jesse Brown, brought his passion as a veterans advocate to the department's leadership.⁷²³ Among Brown's most important early acts was selecting Dr. Kenneth Kizer, a prominent California physician-administrator and educator, from among 90 candidates identified by a search committee for the USH post.⁷²⁴ With experience heading the California department of public health, Kizer saw health care as a system, and data as a tool to improve it.⁷²⁵

Kizer, in essence, launched a major reengineering of the VA health care system through better use of information technology, measurement and reporting of performance, integration of services, and realigned payment policies.⁷²⁶ His vision was large and bold, underscored by his belief that "we have to be able to demonstrate that we have an equal or better value than the private sector, or frankly we should not exist."⁷²⁷ At VA, Kizer found a workforce trapped in a micro-managerial, command-and-control system in which there was little accountability.⁷²⁸ He set the tone for what was to come at a meeting with senior managers at which he stated,

*The old culture must give way to a new culture . . . that is based on innovation and creativity; a culture based on personal initiative and individual and collective accountability; a culture that is based on outcomes and heightened productivity; and a culture that is committed to change.*⁷²⁹

Among his first steps was the development of what was to become a Vision for Change, a new organizational model to restructure both field operations and central office management. At its core was the creation of 22 veterans integrated service networks, or VISNs, (replacing four regions which had been responsible for overseeing 40 to 45 hospitals each), with decision making shifted away from VA Central Office (VACO) to the new VISN directors. VISNs were to be the basic budgetary and planning unit, and to have staffs of no more than 7 to 10 employees.⁷³⁰ Each VISN was in charge of all the care provided to veterans in that network, and each was funded on a capitated basis rather than based on historical costs.⁷³¹ The VACO structure would be marked by its *flatness*, foregoing a tiered hierarchy.⁷³²

⁷²³ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 89.

⁷²⁴ *Ibid.*, 92.

⁷²⁵ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 50-51.

⁷²⁶ Ashish K. Jha et al., "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care," *New England Journal of Medicine*, 348, no. 22, (2003): 2218-2227, accessed June 20, 2016, <http://doi.org/10.1056/NEJMsa021899>.

⁷²⁷ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 51.

⁷²⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 97-8.

⁷²⁹ *Ibid.*, 105.

⁷³⁰ *Ibid.*, 110.

⁷³¹ "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation," Ashish K. Jha, accessed June 3, 2016, <https://psnet.ahrq.gov/perspectives/perspective/31>.

⁷³² James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 111.

The system Kizer and his team inherited was characterized by a multitude of problems.⁷³³ Kizer and his team literally reengineered the veterans' health care system based on a set of transformation strategies: to create management accountability, integrate and coordinate services, improve the quality of care, align system finances with desired outcomes, and modernize information management.⁷³⁴

Kizer also launched a technological revolution in VHA with deployment of a powerful electronic medical record,⁷³⁵ and development of systems such as medication bar-coding to tackle medical errors and ensure patient safety.⁷³⁶

Some of Kizer's successes involved winning support within the administration and from Congress for bold initiatives. He won a critical concession from OMB that VA savings could be reinvested into VA, permitting his transformation efforts to be funded through internal cost-savings rather than new funding,⁷³⁷ and garnered support from Congress for a dramatic reduction of acute care beds and for closing massive regional offices.⁷³⁸ These steps and congressional passage of legislation to reform health care eligibility laws paved the way for establishing universal primary care in VA and developing community-based clinics across the country.⁷³⁹

Sweeping Reform

During a 5-year period, Kizer dramatically changed almost every major VHA management system and improved operational performance through the use of performance measures and contracts. He closed nearly 29,000 acute care beds, merged 52 medical centers into 25 multi-campus facilities, reduced staffing by almost 26,000, opened more than 300 community-based outpatient clinics, and treated 24 percent more patients. In addition to bringing measurable quality into VA health care, Kizer achieved marked reductions in waiting times and medical errors.⁷⁴⁰

Kizer's tenure brought dramatically improved quality, service, and operational efficiency to VHA yet threatened powerful interests. As he noted, "...places like Florida, Arizona, and the

⁷³³ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 316, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷³⁴ Ibid., 318-323.

⁷³⁵ VA in 2006 won the Harvard Innovations in Government Award for its VistA system. James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 211.

⁷³⁶ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 157-165.

⁷³⁷ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 323, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷³⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 128-129.

⁷³⁹ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 319-320, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷⁴⁰ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 170.

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Sun Belt States were not getting their fair share [of funds] and their elected officials were unhappy about it. People from Pennsylvania and Illinois and New York were not about to give their money away, so there was this big disconnect.”⁷⁴¹ Kizer’s team developed a capitation system to more equitably allocate funds across the system. Aware of the political ramifications, he implemented incremental changes during a 2- to 3-year period to make them as painless as possible. But the congressional goodwill he had enjoyed unraveled when Kizer and his VISN directors began cutting and consolidating facilities to accommodate VISN funding cuts. The threat of hospital mergers and consolidations ultimately led several senators to block his confirmation to a second term.⁷⁴²

Under new eligibility reform law, all veterans became *eligible* for VA health care, though its authors did not envision that the system could or would serve all eligible individuals, or even all who might someday seek VA care. The law’s priority-based enrollment system was intended to give VA a tool to align demand for care with its funding level.⁷⁴³ The law instead unleashed political pressure to expand enrollment, opening the door to an influx of veterans who historically had not been VA health care users and many of whom were already covered under military retirement benefits, private insurance, or Medicare.⁷⁴⁴ That expansion led to a tremendous demand for prescription drug benefits by new enrollees and in 2003, Secretary Tony Principi ended enrollment for higher income (category 8) veterans “to keep the system solvent.”⁷⁴⁵ At about the same time, other related pressures led Principi to establish an advisory body, the Capital Asset Realignment for Enhanced Services (CARES) Commission, to develop a comprehensive capital asset plan. Principi cited the age of VA facilities and the changes in medical practice, but also reminded a congressional oversight committee of a 1999 Government Accountability Office finding that “maintaining obsolete or duplicative structures diverts \$1 million a day, every day, every year, away from the care of veterans.” Principi did not want to repeat Kizer’s experience and hoped to avoid political backlash.⁷⁴⁶

The CARES Commission released a final report in February 2004 that recommended relatively few actual facility closures, though it proposed substantial facility mission changes at a number of facilities.⁷⁴⁷ As the then USH later recounted, “CARES, like so many things in Washington, was well-intended, but it was derailed politically once it began moving toward actual targeted action within specific congressional districts.”⁷⁴⁸

Despite such defeats, Principi and VA under secretaries following Kizer met formidable challenges, left legacies, and saw the veterans’ health care system continue to be heralded for several years.⁷⁴⁹ A cascade of other events muddled, and even blackened, VHA’s reputation:

⁷⁴¹ Ibid., 133-134.

⁷⁴² Ibid., 168-169.

⁷⁴³ Veterans Affairs Comm., Veterans’ Health Care Eligibility Reform Act of 1996, H. R. Rep. No. 104-690 (1996), accessed June 3, 2016, <https://www.congress.gov/congressional-report/104th-congress/house-report/690/1>.

⁷⁴⁴ James Rife, *Not Your Father’s VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 193.

⁷⁴⁵ Ibid., 194.

⁷⁴⁶ Ibid., 195.

⁷⁴⁷ Ibid., 196.

⁷⁴⁸ Ibid.

⁷⁴⁹ “The Best Care Anywhere,” Phillip Longman, *Washington Monthly*, accessed June 3, 2016,

accounts of veterans' suicides (and an alleged cover-up); incompetent surgeries and patient deaths at a high-visibility VA medical center (VAMC); failed software acquisitions;⁷⁵⁰ hard-hitting inspector general audit reports on issues such as system flaws, quality of care issues, and lack of timely care that fueled congressional oversight and other constraints. The 2014 scandal that erupted at the Phoenix VAMC represented a decisive turning point and set the stage once again for transforming veterans' health care.

Among initial steps on that long road to transforming the system, the Senate in July 2014 unanimously confirmed Robert A. McDonald, former chief executive officer of Proctor & Gamble, as secretary of veterans affairs. With a business career of delivering better results, McDonald, along with DEPSECVA Sloan Gibson and USH Dr. David Shulkin, has been working to improve VA's health care system and service delivery, and to set a framework for long-term reform. Days after McDonald's confirmation, Congress passed the Veterans Access, Choice, and Accountability Act of 2014, omnibus legislation to improve veterans' access to care. This legislation established the *Choice Program*, mandated an independent assessment of VHA, and established the Commission on Care.

<http://www.washingtonmonthly.com/features/2005/0501.longman.html>. "Revamped Veterans Health Care Now a Model," Gilbert Gaul, accessed June 3, 2016, <http://www.washingtonpost.com/wp-dyn/content/article/2005/08/21/AR2005082101073.html>. "The Best Medical Care in the U.S.: How Veterans Affairs Transformed Itself—and What it Means for the Rest of Us," Catherine Arnst, accessed June 3, 2016, <http://www.bloomberg.com/bw/stories/2006-07-16/the-best-medical-care-in-the-u-dot-s-dot>.

⁷⁵⁰ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 216-217.

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APPENDIX E: THE EVOLVING HEALTH CARE INDUSTRY

Health care has evolved in major ways since the federal government began providing care to veterans after the Civil War, and it will continue to evolve substantially in the future. There are a number of factors that drive evolution in health care, such as population and lifestyle changes, changes within the various health care professions, medical and information systems technology, and systems changes in management and operations.⁷⁵¹ IBM Center for Applied Insight reports that there are 18 trends to watch in health care.⁷⁵² These trends closely encompass those highlighted below. The categories in which the trends fall mirror key topic addressed in the Commission's report to include data system interoperability (10 trends), consumer technology (two trends), health care providers (two trends), government regulations (two trends), and human resources and leadership (two trends). With health care changing so rapidly, and in so many different ways, it is imperative that veterans' health care continually evolve to remain aligned with current and future trends. This section highlights key trends that, based on past experience and current practice, will likely shape health care in the future, were considerations in formulating the Commission's recommendations, and will likely affect transformation of veterans' health care.

Emergence of Large Health Care Systems

The health care industry is moving away from stand-alone community hospitals that serve the needs of a local constituency to large, multiple-campus health care systems.⁷⁵³ The industry will see more high profile mergers and acquisitions in the second half of 2016.⁷⁵⁴ The December 2015 Health Research Institute's report indicates that well-known health care systems may have a market advantage as Americans are willing to travel further for care from a well-known system. This may explain the development and affiliation for Mayo Clinic in Arizona and Florida, and Cleveland Clinic opening in Florida. The report also states that although people are willing to drive for care they are not willing to pay prices higher than the local market. Because of increasing use of outpatient services and same-day surgery, facilities within these health care systems require fewer inpatient beds.⁷⁵⁵ With the advancement of psychotropic drugs, the perceived need for large mental hospitals has declined.⁷⁵⁶ Because of shorter recovery stays, increased outpatient services, telemetry and other monitoring programs, and new medical inventions, hospitals are now built as smaller facilities with parts or sections that can be quickly

⁷⁵¹ Lynn Etheredge, Stanley B. Jones, and Lawrence Lewin, "What is Driving Health System Change?" *Health Affairs*, 15, 4, (1996): 93-104.

⁷⁵² "Healthcare Internet of Things 18 Trends to watch in 2016," Bill Chamberlain, IMB Center for Applied Insights, March 1, 2016, accessed June 20, 2016, <https://ibmcai.com/2016/03/01/healthcare-internet-of-things-18-trends-to-watch-in-2016>.

⁷⁵³ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed April 29, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

⁷⁵⁴ Ibid.

⁷⁵⁵ Ibid.

⁷⁵⁶ "How Release of Mental Patients Began," Richard Lyons, accessed May 1, 2016, <http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all>.

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modified for future changes and medical advances.⁷⁵⁷ VHA will need to consider this trend in evaluating its current physical plant and planning for future facility needs.

Management Changes

As health care systems become increasingly complex, there is a need to manage these institutions using current management theories and models.⁷⁵⁸ During the past few decades, hospital and health care management changed from being managed by a traditional top-down model to continuous quality improvement models that respond to issues such as staff satisfaction, medication errors, safety matters, and wasteful use of supplies. To address errors, hospitals have implemented Six Sigma principles. To address waste, hospitals have implemented LEAN principles. Embracing these changes in management approach and implementing Six Sigma and LEAN principles will support VHA's transformational process.

Health Care Payment

The health care industry is in the midst of transforming its payment model away from a fee-for-service model to value-based payments, a system that drives improved health outcomes.⁷⁵⁹ This transformation is tied to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which health care experts expect to shape care delivery and payment reform across the U.S. health care system over the coming decades. Congress created MACRA as a transformative law to fast track the health care system's transition from a traditional fee-for-service payment model to new risk-bearing, coordinated care models.⁷⁶⁰ Because this legislation is still in rulemaking, it is premature for the Commission to weigh in on its potential effect on VA. The MACRA legislation expands the trend toward creation of accountable care organizations (ACOs) and bundled payments for care. ACO models have been reported to drive reduced hospitalization and generate cost savings.⁷⁶¹

Specialty Care Facilities

With changes in the federal payment for hospitals, some high-cost and longer-stay care treatments have been moving out of community hospitals to specialty hospitals. For example, long-term acute care hospitals primarily treat patients on ventilators; rehabilitation facilities treat short-term, post-acute patients who need primarily physical and occupational therapy services for orthopedic or stroke incidences; and cancer hospitals provide innovative treatments for Stage 4 cancer. As a result, community hospitals may no longer need beds to take care of these special patients. VHA will need to consider this trend in planning integrated care networks and evaluating its facility needs in conjunction with these networks.

⁷⁵⁷ "The Small Hospital of the Future," Shati Matambanadzo, accessed May 3, 2016, <http://www.healthcaredesignmagazine.com/article/small-hospital-future>.

⁷⁵⁸ "How to Solve the Cost Crisis in Health Care," Robert S. Kaplan and Michael E. Porter, accessed May 2, 2016, <https://hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care>.

⁷⁵⁹ "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, <http://www.nationalpartnership.org/issues/health/macra.html>.

⁷⁶⁰ "MACRA: Disrupting the health care system at every level," Deloitte, accessed June 23, 2016, <http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/macra.html>.

⁷⁶¹ "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, Inquisitr: Medicine, accessed May 2, 2016, <http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/>.

Outpatient Care and Lifestyle-oriented Venues for Care

With improvements in surgical procedures, many surgeries that required post-surgery hospital stays are now routinely performed in outpatient settings.⁷⁶² Many nonsurgical procedures are being performed in outpatient clinics as well, such as medical imaging, cardiac catheterization, substance abuse treatment, gastrointestinal screening and cancer treatment.⁷⁶³ As care that was once provided only in hospitals is now provided in specialized medical clinics, care that was once provided only in physicians' offices is now being provided in alternative settings. As reported in Health Affairs, "another health care trend consumers are using to save both time and money is that rather than making appointments with their doctors, they are choosing to use walk-in clinics."⁷⁶⁴ Many of these clinics are located in pharmacies, retail chains, or supermarkets, allowing consumers quick, convenient, less-costly care.⁷⁶⁵ Do-it-yourself health care is also a trend, with increasingly more people taking responsibility for their health care. Consumers are using smart phone apps to monitor vital signs, medication adherence, and even urinalysis.⁷⁶⁶ As part of a commitment to continuous improvement, VHA will need to consider alternative venues as it creates integrated health care networks.

Medical Technology

Medical technology companies create life-changing innovation, and "advanced medical devices and diagnostics allow people to live longer, healthier and more productive lives."⁷⁶⁷ In fact, during the past 30 years, medical advancements helped add five years to U.S. life expectancy and reduce fatalities from heart disease, stroke, and breast cancer by more than half.⁷⁶⁸ These advancements also yield savings across the health care system by replacing more expensive procedures, reducing hospital stays, and allowing people to return to work more quickly.⁷⁶⁹ Ensuring veterans receive care that employs cutting-edge technology will be an important part of establishing integrated care networks.

Telemedicine

According to the American Telemedicine Association, "telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status."⁷⁷⁰ Telemedicine includes a growing variety of applications and

⁷⁶² Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/21183845>.

⁷⁶³ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

⁷⁶⁴ "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, accessed May 2, 2016, <http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/>.

⁷⁶⁵ Ibid.

⁷⁶⁶ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

⁷⁶⁷ "Value of Medical Technology," Advanced Medical Technology Association, accessed May 2, 2016, <http://advamed.org/page/74/value-in-medical-technology>.

⁷⁶⁸ "Value of Medical Innovation," HealthCare Institute of New Jersey, accessed May 2, 2016, <http://hinj.org/value-of-medical-innovation/>.

⁷⁶⁹ Ibid.

⁷⁷⁰ "What is Telemedicine," American Telemedicine Association, accessed May 2, 2016, <http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VwFrqfkrJaQ>.

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services using two-way video, email, smart phones, wireless tools, and other forms of telecommunications technology. The use of telemedicine has spread rapidly and is now becoming integrated into hospitals, specialty departments, home health agencies, private physician offices, as well as consumers' homes and workplaces. The following are examples of how telehealth is being used:

- A specialist assisting the primary care physician in rendering a diagnosis might use interactive video or store-and-forward transmission of diagnostic images or information.
- Home-use devices might be used to remotely collect information such as vital signs, blood glucose, or heart electrocardiogram data and transfer it in real time to a home health agency or a remote diagnostic testing facility for interpretation.
- Consumers' internet and wireless devices might be used to obtain specialized health information or participate in online peer-to-peer support groups.

VHA already excels in the use of telehealth and should expand upon its work in this area.

Midlevel Practitioners

During the past few decades, new categories of health care professionals have become increasingly commonplace in hospital settings. For example, hospitalists, physicians who specialize in the practice of hospital medicine, take over when the community-based physician admits his/her patient to the hospital.⁷⁷¹ The hospitalist does not perform the surgery but rather takes on the monitoring of the hospital services needed by the patient. Another example is medical technicians, who monitor the specialized medical equipment and devices that previously were under the purview of nurses in specialty units such as intensive care units. The growing physician shortage has led to reliance on mid-level health care providers. According to the Centers for Medicare and Medicaid Services' National Provider Identifier dataset, there were approximately 106,000 practicing nurse practitioners and 70,000 practicing physician assistants in 2010.⁷⁷² Provider trends may play into ways VHA can address its current staffing shortage.

Electronic Patient Health Information

Health records have undergone transformation from free-form physician notes of the 17th century to electronic health records (EHRs) of the 21st century. Today, providers are using clinical applications such as computerized physician order entry systems; EHRs; and radiology, pharmacy, and laboratory systems to track patient care and progress. Health plans are providing access to claims and care management, as well as member self-service applications.⁷⁷³ These advances allow the medical workforce to be more mobile and efficient (i.e., physicians can check patient records and test results from wherever they are). Though their use comes with

⁷⁷¹ "Definition of a Hospitalist and Hospital Medicine," Society of Hospital Medicine, accessed May 2, 2016, http://www.hospitalmedicine.org/Web/About_SHM/Hospitalist_Definition/Web/About_SHM/Industry/Hospital_Medicine_Hospital_Definition.aspx.

⁷⁷² "The Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the United States," Agency for Healthcare Research and Quality, accessed May 2, 2016, <http://www.ahrq.gov/research/findings/factsheets/primary/pcwork2/index.html>.

⁷⁷³ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

inherent potential security and privacy risks, they will surely play a substantial role in shaping future health care.⁷⁷⁴ Interoperability of these sources of patient information will be a continuing key issue in private-sector, military, and veterans' healthcare organizations.

Population Health

Population health refers to considering incidence and prevalence of diseases in a given area to determine if the area or the environment is contributing to the illness. Physicians and other health care providers may look at a region's demographics to determine what types of care are needed within the population. For example, if 65 percent of the region is older than age 65, then a series of wellness programs that address the chronic care concerns of this population may be needed. From a population health perspective, communities and their respective populations are as important as the individual patients who comprise them when it comes to keeping residents healthy. For VHA, population health issues may revolve around populations of veterans who served in particular wars and operations and the respective injuries and illnesses associated with them.

Geriatric Care

In the United States and Western Europe the birth rate has slowed⁷⁷⁵ and people are living longer.⁷⁷⁶ Demographic researchers report that if an American makes it to age 65, he/she should have about 17 to 20 additional years of life.⁷⁷⁷ Nursing homes and assisted living facilities are now seeing increasingly more of residents' first-time admissions occurring at age 80 or older. Some congregate care retirement facilities report that even with admission in the 80s, the average life expectancy is another 12 or 13 years.⁷⁷⁸ The aging population accounts for increasingly more hospital admissions, and as a result, hospitals rely on more revenue from Medicare.⁷⁷⁹ The VHA beneficiary population mirrors the general U.S. population, and older veterans receiving care through VHA may be sicker than their private-sector counterparts.

Chronic Disease Care

Chronic conditions now account for more than 50 percent of the death rate. Acute problems had previously been the primary causes of death.⁷⁸⁰ Even HIV/AIDS has moved away from being considered an immediate death sentence, and now, with proper treatment, is considered by

⁷⁷⁴ "Summary of the HIPAA Privacy Rule," U.S. Department of Health and Human Services, accessed May 2, 2016, <http://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/>.

⁷⁷⁵ "Fact Sheet: The Decline in U.S. Fertility," Mark Mather, accessed May 2, 2016, <http://www.prb.org/publications/datasheets/2012/world-population-data-sheet/fact-sheet-us-population.aspx>.

⁷⁷⁶ National Center for Health Statistics, *Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities*, accessed May 2, 2016, <http://www.cdc.gov/nchs/data/abus/abus15.pdf>.

⁷⁷⁷ National Center for Health Statistics, *Life Expectancy at Birth, at Age 65, and at Age 75, by Sex, Race, and Hispanic Origin: United States, Selected Years 1900-2010*, accessed May 2, 2016, <http://www.cdc.gov/nchs/data/abus/2011/022.pdf>.

⁷⁷⁸ Kathleen Harris, *CCRC Resident Demographics and Health Care Utilization: An Analysis*, accessed May 3, 2016, <http://www.avpowell.com/docs/Fall1997.pdf>.

⁷⁷⁹ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

⁷⁸⁰ "Chronic Disease Overview," Centers for Disease Control and Prevention, accessed May 2, 2016, <http://www.cdc.gov/chronicdisease/overview/>.

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most to be a chronic disease.⁷⁸¹ The Centers for Disease Control reports that since 2014, more Americans are dying as a result of chronic conditions and diseases than from acute diseases. Most chronic diseases result from lifestyle choices. Lifestyle diseases result from choices that individuals make.⁷⁸² Health care systems invest resources in addressing lifestyle-related issues caused by behaviors such as smoking, using opiates, and overeating.⁷⁸³ Lifestyle diseases such as cancer caused by smoking, addiction caused by drug use, and diabetes caused by obesity, are costly to treat.⁷⁸⁴ Because lifestyle diseases change over time, they are important to consider in thinking about the future of veterans' healthcare. Treating chronic diseases can be costly because care is ongoing, and assuming this trend continues to become more prominent, it will affect the cost of care and how it is provided.⁷⁸⁵

Needs-based Health Care

The Affordable Care Act requires all not-for-profit hospitals to complete a survey of the community (community health needs assessment, or CHNA) to show what entities in the community will address identified needs (asset mapping) and then report on how the hospital will address these needs in a community health care implementation program (CHIP).⁷⁸⁶ Starting in 2016, hospitals must post these reports on their websites and conduct these evaluations every 3 years thereafter. Monitoring community health needs can lead to preventing or stopping the spread of disease. For example, scarcity of quality food has been documented to result in poor school attendance and increased illness.⁷⁸⁷ Some Americans simply have not been exposed to how to prepare vegetables and fruits because they live in areas that are called *food deserts*, where healthy foods are not readily available. Identifying such needs and how they will be addressed can help improve health for specific populations.⁷⁸⁸ In Washington, DC, such a health assessment led to new treatments and protocols for addressing the appearance of a rare strain of tuberculosis brought in by a group of legal immigrants.⁷⁸⁹ Using CHNA and CHIP could be part of VHA's ongoing planning process.

⁷⁸¹ Steven G. Deeks, Sharon R. Lewin, and Diane V. Havlir, "The End of AIDS: HIV Infection as a Chronic Disease," *Lancet*, 382, 9903, (2013): 1525-1533.

⁷⁸² "Lifestyle Choices: Root Causes of Chronic Diseases," Cleveland Clinic, accessed May 2, 2016, https://my.clevelandclinic.org/health/transcripts/1444_lifestyle-choices-root-causes-of-chronic-diseases.

⁷⁸³ D. B. Resnik, "Responsibility for Health: Personal, Social, and Environmental," *Journal of Medical Ethics*, 33, 8, (2007): 444-445.

⁷⁸⁴ "How to Save a Trillion Dollars," Mark Bittman, accessed May 2, 2016, <http://opinionator.blogs.nytimes.com/2011/04/12/how-to-save-a-trillion-dollars/>.

⁷⁸⁵ "Why We Need Public Health to Improve Healthcare," National Association of Chronic Disease Directors, accessed May 2, 2016, <http://www.chronicdisease.org/?page=WhyWeNeedPH2impHC>.

⁷⁸⁶ "New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act," Internal Revenue Service, accessed May 2, 2016, <https://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501%28c%29%283%29-Hospitals-Under-the-Affordable-Care-Act>.

⁷⁸⁷ "Hunger In Our Schools: Breakfast Is A Crucial 'School Supply' For Kids In Need," Tom Nelson, accessed May 2, 2016, <http://blogs.usda.gov/2015/03/03/hunger-in-our-schools-breakfast-is-a-crucial-school-supply-for-kids-in-need/>.

⁷⁸⁸ "The Capital's Food Deserts," Jeremy Moorhead, accessed May 3, 2016, <http://eatocracy.cnn.com/2012/03/14/the-capitals-food-deserts/>.

⁷⁸⁹ District of Columbia Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration, *District of Columbia HIV/AIDS, Hepatitis, STD, and TB (HAHSTA) Annual Report: 2010*, accessed May 3, 2016,

http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2010_Annual_Report_FINAL_0_0.pdf.

Behavioral Health

Treatment for mental health, now more commonly referred to as behavioral health, has changed dramatically since a 1968 federal law required individuals be cared for in the least restrictive environment.⁷⁹⁰ This law led to an expectation that most patients would receive care in out-patient facilities. Recently legislation was passed that requires insurance companies to increase the amount of payment for behavioral health, which could add more patients to the health care system.⁷⁹¹ VHA is a leader in mental health treatment and should continue to be a trendsetter in this regard.

Preventive Medicine

Traditionally, physicians were trained to cure illness and to restore the sick to health. The trend, however, is changing, and physicians are now trained in prevention and are more active participants in the prevention of illness.⁷⁹² Additionally, insurance and Medicare now cover preventive care and annual physicals, further supporting prevention.⁷⁹³ Preventive medicine is a key component of integrated health care and will need to be considered as VHA works to transform veterans' healthcare.

Pharmacy Changes

Health Affairs reports that "in 2015 . . . an alarming trend of new high-cost specialty pharmaceuticals entered the market. . . . Overall drug spending increased 12.2 percent last year, the highest rate of increase in more than a decade."⁷⁹⁴ Escalating drug prices account for some of this increase, including more than 3,500 generic drugs that at least doubled in price from 2008–2015 and about 400 drugs that increased in cost 1000 percent.⁷⁹⁵ Newly emerging and very expensive developments in the area of genomic medication also contribute to the increase. "One way to combat skyrocketing prices will be biosimilar drugs. These drugs are near substitutes for original brand drugs and could bring significant price discounts."⁷⁹⁶ Because many of VHA's beneficiaries seek only prescription benefits, prescription drug trends will be important to consider in the transformation process.

⁷⁹⁰ "How Release of Mental Patients Began," Richard Lyons, accessed May 2, 2016,

<http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all>.

⁷⁹¹ "Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)," Substance Abuse and Mental Health Services Administration, accessed May 2, 2016, <http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>.

⁷⁹² "Opinion 8.075 – Health Promotion and Preventive Care," American Medical Association, accessed May 2, 2016, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8075.page>.

⁷⁹³ "Preventive Services Covered Under the Affordable Care Act," U.S. Department of Health and Human Services, accessed May 2, 2016, <http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/>.

⁷⁹⁴ Anne Martin et al., "National Health Spending In 2014: Faster Growth Driven By Coverage Expansion And Prescription Drug Spending," *Health Affairs*, 35, 1, (2016): 150-160.

⁷⁹⁵ "Generic Drug Prices Quickly on the Rise," Anthony L. Komaroff, accessed May 2, 2016, <http://www.spokesman.com/stories/2016/feb/18/generic-drug-prices-quickly-on-the-rise/>.

⁷⁹⁶ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

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APPENDIX F: THE COMMISSION'S PROCESS

Commission Meetings

From September 2015 to June 2016, the Commission held convened 12 sessions of public meetings (26 days). The content addressed at each meeting is listed in the following table.

September 21-22, 2015

Assessment A: Demographics	RAND Corporation <ul style="list-style-type: none"> Christine Eibner
Assessment B: Health Care Capabilities	RAND Corporation <ul style="list-style-type: none"> Peter Hussey, PhD
VA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> Bob McDonald, Secretary Sloan Gibson, Deputy Secretary David Shulkin, MD, Under Secretary for Health
Assessment C: Care Authorities	RAND Corporation <ul style="list-style-type: none"> Michael D. Greenberg
Assessment I: Business Processes	Grant Thornton LLP <ul style="list-style-type: none"> Lane Jackson Aamir Syed Sharif Ambrose
Assessment E: Scheduling Workflow	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Alex Harris Pooja Kumar
Assessment F: Clinical Workflow	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Gretchen Berlin
Assessment G: Staffing/Productivity/Time Allocation	Grant Thornton LLP <ul style="list-style-type: none"> Peter Erwin, PhD Hillary Peabody Erik Shannon
Assessment J: Supplies	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Robin Roark, MD
Assessment K: Facilities	McKinsey & Company <ul style="list-style-type: none"> Vivian Riefberg John Means

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September 21-22, 2015 (continued)

VHA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning
Assessment Leadership	CMS Alliance to Modernize Health care <ul style="list-style-type: none"> Stephen Kirin Jay Schnitzer, PhD, MD McKinsey & Company <ul style="list-style-type: none"> Vivian Riefberg
Assessment H: Health IT	MITRE Corporation <ul style="list-style-type: none"> Aparna Durvasula Glenn Himes McKinsey & Company <ul style="list-style-type: none"> Celia Huber Vivian Riefberg

October 6, 2015

Eligibility	Veterans Health Administration <ul style="list-style-type: none"> Stephanie Mardon, Chief Business Officer Kristin Cunningham, Director, Business Policy Affairs
2014 Choice Act/2015 Enhancement to Choice/Care in the Community, Current State	Veterans Health Administration <ul style="list-style-type: none"> Stephanie Mardon, Chief Business Officer Kristin Cunningham, Director, Business Policy Affairs
Future State of VA Community Care/ Care in the Community	Veterans Health Administration <ul style="list-style-type: none"> Joe Dalpiaz, Director, VISN 17 Baligh Yehia, MD, Senior Health Advisor to the Secretary of Veterans Affairs Gene Migliaccio, Deputy Chief Business Officer, Managed Care
Academic Affiliations	Veterans Health Administration <ul style="list-style-type: none"> Robert Jesse, MD, Chief, Office of Academic Affiliations Karen Sanders, MD, Deputy Chief, Office of Academic Affiliation Long-Term Care Richard Allman, MD, Chief Consultant, Geriatrics and Extended Care Services

October 19–20, 2015

Independent Assessment, Perspective on VA Health Care, and Q&A/Panel Discussion	<ul style="list-style-type: none"> ▪ Brett Giroir, MD, Senior Fellow, Health Policy Institute, Texas Medical Center ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE ▪ Jonathan Perlin, MD, Chief Medical Officer and President, Clinical Services at Hospital Corporation of America
Women's Health	Veterans Health Administration <ul style="list-style-type: none"> ▪ Patricia Hayes, PhD, Chief Consultant, VA Women's Health Services
Mental Health	Veterans Health Administration <ul style="list-style-type: none"> ▪ David Carroll, Executive Director, Mental Health Operations ▪ Harold Kudler, MD, Chief Mental Health Consultant
Homelessness	Veterans Health Administration <ul style="list-style-type: none"> ▪ Anne Dunn, Deputy Director, VHA Homeless Program Office
Assessment D: Access	Institute of Medicine <ul style="list-style-type: none"> ▪ Michael McGinnis, MD ▪ Marianne Hamilton Lopez
VACAA Section 203	Northern Virginia Technology Council <ul style="list-style-type: none"> ▪ Ken Mullins
Scheduling	Veterans Health Administration <ul style="list-style-type: none"> ▪ Michael Davies, MD, Executive Director of Access and Clinic Administration Program
MyVA Support Services Excellence Overview	Department of Veterans Affairs <ul style="list-style-type: none"> ▪ Bob Snyder, Executive Director, MyVA Task Force ▪ Tom Muir, Director, Support Services

November 16–17, 2015

Health Care Economics/Finance	<ul style="list-style-type: none"> ▪ Mark Yow, Acting Chief Financial Officer, VHA ▪ Paul Mango, McKinsey & Company ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE
Academic Affiliations	Association of American Medical Colleges <ul style="list-style-type: none"> ▪ Atul Grover, PhD, MD, Chief Public Policy Officer ▪ John E. Prescott, MD, Chief Affiliations Officer ▪ Matthew Schick, JD, Director, Government Regulations & Regulatory Counsel
VHA Clinical Matters	Veterans Health Administration <ul style="list-style-type: none"> ▪ Lucille Beck, PhD, Deputy Chief Patient Care Services Officer, Rehab and Prosthetic Services ▪ Donna Gage, PhD, RN, Chief Nursing Officer

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December 14-16, 2015

Minority Affairs and Health Equity	Department of Veterans Affairs <ul style="list-style-type: none"> Barbara Ward, Director, Center for Minority Affairs Veterans Health Administration <ul style="list-style-type: none"> Uchenna S. Uchendu, MD, Executive Director, Office of Health Equity
Framework for the Future of Veterans Health	<ul style="list-style-type: none"> Garry Augustine, Disabled American Veterans Carl Blake, Paralyzed Veterans of America Carlos Fuentes, Veterans of Foreign Wars Ray Kelley, Veterans of Foreign Wars
Veteran Service Organizations	<ul style="list-style-type: none"> Louis Celli, The American Legion Renee Campos, Military Officers Association of America
National Health Information Operability	<ul style="list-style-type: none"> Dr. Jon White, Deputy National Coordinator, Department of Health and Human Services
DoD I Procurement: Lesson Learned/Interagency Program Office	<ul style="list-style-type: none"> Chris Miller, Program Executive Officer, Defense Health Care Management Systems, Department of Defense
Health Information Exchange	<ul style="list-style-type: none"> Elaine Hunolt, Do-Director Interoperability Office, Veterans Health Administration Dr. Harry Leider, Chief Medical Officer, Walgreens James Wood, VP-Federal, Walgreens Mariann Yeager, Chief Executive Officer, The Sequoia Project
Vision for OI&T/Collaboration with VHA	<ul style="list-style-type: none"> LaVerne Council, Chief Information Officer, Department of Veterans Affairs
Leadership and Transformation	<ul style="list-style-type: none"> Charles Rossotti, Former Commissioner, Internal Revenue Service

January 19 and 21, 2016

VHA Leadership	<ul style="list-style-type: none"> Dr. Michael Kussman, former Undersecretary for Health, Veterans Health Administration Dr. Kenneth Kizer, former Undersecretary for Health, Veterans Health Administration
Labor Perspectives	American Federal of Government Employees <ul style="list-style-type: none"> Marilyn Park National Association of Veterans Affairs Physicians and Dentists <ul style="list-style-type: none"> Samuel Spagnolo Nurses Organization of Veterans Affairs <ul style="list-style-type: none"> Joan Clifford Sharon Johnson

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January 19 and 21, 2016 (continued)

Behavioral Health	<ul style="list-style-type: none"> Association of Veterans Affairs Psychologist Leaders <ul style="list-style-type: none"> Thomas Kirchberg Russell Lemle Edgardo Padin-Rivera Antonette Zeiss American Psychiatric Association <ul style="list-style-type: none"> Jenny L. Boyer Association of Veterans Affairs Social Workers <ul style="list-style-type: none"> LeAnn Bruce Jerry Satterwhite
Homeless Veterans	<ul style="list-style-type: none"> Keith Armstrong, San Francisco Veterans Affairs Health care System
Other-Than-Honorable Discharges	<ul style="list-style-type: none"> Branford Adams

February 8-9, 2016

Construction Management	<ul style="list-style-type: none"> Lisa Freeman, Medical Center Director, Palo Alto Health care System
VISN and Field Leadership Perspectives	<ul style="list-style-type: none"> Joleen Clark, Former Network Director, VISN 8 Jon Gardner, Former Medical Center Director, Tucson VA Medical Center Lisa Freeman, Medical Center Director, Palo Alto Health care System
Implementation of the <i>Choice Program</i>	<ul style="list-style-type: none"> Billy Maynard, President HealthNet Federal Service David J. McIntyre, Jr., President and Chief Executive Officer, TriWest Healthcare Alliance
Update on VHA	<ul style="list-style-type: none"> Dr. David Shulkin, Undersecretary for Health, Veterans Health Administration
Determining Feasibility	<ul style="list-style-type: none"> Patrick Ryan, Former Staff Director and Chief Counsel, House Veterans Affairs Committee

February 29 – March 1, 2016

Economist Briefing	<ul style="list-style-type: none"> Gideon Lukens, PhD, Staff Economist Jamie Taber, PhD, Staff Economist
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March 21-23, 2016

Conversation with HVAC Chairman	<ul style="list-style-type: none"> Rep. Jeff Miller (R-FL)
Conversation with HVAC Member	<ul style="list-style-type: none"> Rep. Beto O'Rourke (D-TX)
Veterans Health Administration	<ul style="list-style-type: none"> Dr. David Shulkin, Undersecretary for Health Barbara Manning, Office of Policy and Planning Lyn Stoesen, Office of Policy and Planning

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March 21-23, 2016 (continued)

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Merideth Randles, FSA, MAAA, Milliman, Inc.
- Jamie Taber, PhD, Staff Economist

April 18-19, 2016

Veterans Service Organizations

- Garry Augustine, Disabled American Veterans
- Peter Dickinson, Disabled American Veterans
- Verna Jones, American Legion
- Rick Weidman, Vietnam Veterans of America
- Bill Rausch, Got Your 6
- Ray Kelley, Veterans of Foreign Wars
- Rene Campos, Military Officers Association of America

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Jamie Taber, PhD, Staff Economist

VA Leadership

Department of Veterans Affairs

- Bob McDonald, Secretary
- Sloan Gibson, Deputy Secretary

Community Care

- Baligh Yehia, MD, Assistant Deputy Under Secretary for Community Care, VHA

May 9-11, 2016

VA Office of General Counsel

- Leigh Bradley, General Counsel
- Jessica Tanner, Staff Attorney

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Jamie Taber, PhD, Staff Economist

June 7-8, 2016

No speakers

Commission Workgroups

The Commission on Care organized itself into workgroups in order to complete an analysis of relevant issues, consider options, and suggest recommendations to the full Commission for debate. The Commission formed five workgroups with each responsible for sections of the Independent Assessment or other topics taken on by the group. In establishing each workgroup an effort was made to balance perspectives and expertise, although Commissioners expressed interests were also taken into account in forming the membership of each group. The membership of each workgroup and the topics taken on by each is summarized in Table F-1.

Table F-1. Workgroup Structure and Topics

WORKGROUP NAME	TOPICS	MEMBERSHIP	
Health Care Alignment	<ul style="list-style-type: none"> ▪ Demographics ▪ Health care Capabilities ▪ Care Authorities ▪ Access Standards ▪ Governance 	<ul style="list-style-type: none"> ▪ Blecker ▪ Johnson ▪ Longman ▪ Selnick 	<ul style="list-style-type: none"> ▪ Gorman ▪ Khan ▪ McClenney
Health Care Operations	<ul style="list-style-type: none"> ▪ Access Standards ▪ Workflow Scheduling ▪ Workflow Clinical ▪ Staffing Productivity 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Harvey ▪ Longman ▪ Webster 	<ul style="list-style-type: none"> ▪ Gorman ▪ Hickey ▪ Taylor
Health Care Data, Tools & Infrastructure	<ul style="list-style-type: none"> ▪ Health IT ▪ Business Processes ▪ Supplies ▪ Facilities 	<ul style="list-style-type: none"> ▪ Blom ▪ Harvey ▪ Steele 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Johnson ▪ Taylor
Health Care Leadership	<ul style="list-style-type: none"> ▪ Organizational Health ▪ Leadership Systems 	<ul style="list-style-type: none"> ▪ Blecker ▪ Hickey ▪ Selnick ▪ Steele 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ McClenney ▪ Schlichting
Health Care Trends	<ul style="list-style-type: none"> ▪ Market Trends ▪ Technology ▪ Financing ▪ Vision 	<ul style="list-style-type: none"> ▪ Blom ▪ Johnson ▪ Schlichting 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Khan ▪ Webster

Each workgroup, together with any staff assigned to it, reviewed the findings and recommendations of the Independent Assessment and the Integrated Report; investigated external benchmarks and best practice models; heard testimony in public meetings (with the full Commission); met in workgroup session with VA employees, leaders, former staff and external experts to gather additional insights and explore relevant questions. Commissioners reviewed white papers and strawman proposals prepared by staff and by one another. Based on the assessments and group deliberations, each workgroup developed recommendations for consideration by the full Commission. Details of the process and outputs from each workgroup are described in the following sections.

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Health Care Alignment Workgroup

The alignment workgroup organized its work around six main topics: governance, realignment of facilities and services, medical sharing, eligibility, other than honorable discharges, and the organization of provider networks. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic was introduced through a summary paper or summary points which then were used as the basis for a conference call or a face-to-face discussion. For most topics, subsequent calls were held to discuss more detailed papers or to re-visit outstanding issues not yet resolved.

Commissioners also reviewed draft papers and provided additional feedback, revisions, and comments through written comments. The papers were finalized for inclusion in the draft Commission report for discussion on April 19. A summary of the work completed on each topic is provided in the table below.

Table F-2. Alignment Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E=email review M=face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Governance	11/17/2015	M	Vivian Riefberg	9/22/2015	F
	1/7/2016	C	Stephen Kirin	9/22/2015	F
	1/28/2016	C	Jay Schnitzer	9/22/2015	F
	2/18/2016	C	Paul Light	10/30/2015	S
	3/3/2016	C	Charles Rossotti	12/16/2015	F
	3/10/2016	C	Michael Kussman	1/19/2016	F
	3/17/2016	C	Ken Kizer	1/19/2016	F
	4/7/2016	C	Jeff Miller	3/21/2016	F
Realignment of Facilities and Services	1/7/2016	C	Vivian Riefberg	9/22/2015	F
	1/28/2016	C	John Means	9/22/2015	F
	3/10/2016	C			
	3/17/2016	C			
	4/7/2016	C			
Medical Sharing	1/28/2016	C	Atul Gover	11/16/2015	F
	3/3/2016	C	John Prescott	11/16/2015	F
	3/10/2016	C	Mathew Schick	11/16/2015	F
	3/17/2016	C			
	4/7/2016	C			
Eligibility	11/17/2015	M	Christine Eibner	9/21/2015	F
	12/10/2015	C	Michael Greenberg	9/21/2015	F
	1/28/2016	C	Pat Vandenberg	9/21/2015	F
	2/25/2016	C	Stephenie Mardon	10/6/2015	F
	3/10/2016	C	Kristin Cunningham	10/6/2015	F
	3/17/2016	C	Gail Wilensky	10/19/2015	F
	4/7/2016	C	Michael McGinnis	10/20/2015	F
			Marianne Hamilton Lopez	10/20/2015	F
			Michael Kussman	1/19/2016	F
			Jeff Miller	3/21/2106	F

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E=email review M=face-to-face meeting	Date	Expert	Date	Type
Other-Than-Honorable Discharge	1/28/2016	C	Bradford Adams	1/20/2016	F
	2/18/2016	C			
	3/10/2016	C			
	3/17/2016	C			
	4/7/2016	C			
Organization of Provider Networks	1/28/2016	C	Peter Hussey	9/21/2015	F
	2/25/2016	C	Joe Dalpiaz	10/6/2015	F
	3/10/2016	C	Baligh Yehia	10/6/2015	F
	3/17/2016	C	Gene Migliaccio	10/6/2015	F
	4/7/2016	C	Michael Kussman	1/19/2016	F
			Jon Gardner	2/8/2016	F
			Billy Maynard	2/8/2016	F
			David McIntrye	2/8/2016	F
			Jeff Miller	3/21/2016	F
			Beto O'Rourke	3/22/2016	F

Health Care Operations Workgroup

The health care operations workgroup was organized around five main topics: access standards, scheduling, clinical workflow, staffing (HR), and productivity. The workgroup (select Commissioners and support staff) first met face-to-face on October 7, 2015 to: introduce the staff, review guiding principles and business rules, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics was discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research on the four main topics; and cover other issues that may have come up during sessions (i.e., Best Practices) or from questions posed by Commissioners. To supplement the Commission conferences, the workgroup held teleconferences to cover additional research or present information from subject matter experts or emailed informational briefs and write-ups for review before a workgroup teleconference. Feedback from the Commissioners was addressed and the potential recommendations were refined. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

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Table F-3. Health Care Operations Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting	Date	Expert	Date	Type
Access Standards	10/20/2015	M	Stephanie Mardon	10/6/2015	F
	12/3/2015	C	Kristin Cunningham	10/6/2015	F
	2/25/2016	C	Institute of Medicine	10/13/2015	S
	4/27/2016	C	Institute of Medicine	10/20/2015	F
Scheduling	10/7/2015	M	McKinsey Co	9/22/2015	F
			Stephanie Mardon	10/6/2015	F
			Kristin Cunningham	10/6/2015	F
			Dr. Michael Davies	10/14/2015	S
			Gary Monder	10/14/2015	S
			Steve Green	10/14/2015	S
			Michael McGinnis	10/14/2015	S
			Ken Mullins	10/14/2015	S
			Marianne Hamilton Lopez	10/14/2015	S
			Institute of Medicine	10/20/2015	F
			Dr. Michael Davies	10/20/2015	F
			Dr. Michael Davies	11/18/2015	W
Clinical Workflow	10/27/2015	C	McKinsey & Co.	9/22/2015	F
	2/18/2016	C	Nora Socci	12/29/2015	S
	4/6/2016	C	Diane Pulphus	2/3/2016	S
			Hugh Scott	2/26/2016	S
Staffing	11/4/2015	C	McKinsey Co	9/22/2015	F
	12/3/2015	C	Dr. Jonathan Perlin	10/19/2015	F
	1/20/2016	M	Barbara Ward	12/7/2015	S
	2/18/2016	C			
	2/25/2016	C			
	4/6/2016	C			
Productivity	12/15/2015	M	McKinsey Co	9/22/2015	F
			Gene Migliaccio	10/6/2015	F
			Boston VAMC	12/7/2015:	S
			Dr. Michael Charness		
			Melanie Gilhern		
			Meredith Walker		
Best Practices	1/6/2016	C	Dr. Melanie Vielhauer		
			Rosemary Conlon		
	1/6/2016	C	McKinsey Co	9/22/2015	F
	1/20/2016	M	Dr. Theresa Cullen	12/2/2015	W
	2/25/2016	C	Dr. Daniel Bochicchio	12/3/2015	S
	3/14/2016	E	David Atkins	1/5/2016	S
			Linda Lipson	1/5/2016	S
			Amy Kilbourne	1/5/2016	S
			Bob Monte	1/5/2016	S
			Rachel Goffman	1/5/2016	S
			Dr. Daniel Bochicchio	1/20/2016	S
			Barbara Meadows	2/25/2016	W
			Barbara Meadows	3/17/2016	W

Health Care Data, Tools & Infrastructure Workgroup

The Health Care Data, Tools & Infrastructure (DTI) workgroup organized its work around four main topics: Health Information Technology, Business Processes, Supplies and Facilities. DTI first met face to face on October 7, 2015 to: introduce the staff, review the charge of DTI, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics were discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research via white papers on the four main topics; and cover other issues that may have come up during sessions or from questions posed by Commissioners. To supplement the Commission face-to-face meetings, the workgroup held teleconferences to cover additional research or present information from subject matter experts. Feedback from the Commissioners was incorporated into the white papers and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

Table F-4. Data, Tools & Infrastructure Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call		S=met with staff		
	E= email review		W=met with workgroup		
	M= face-to-face meeting		F=full Commission testimony		
	Date	Type	Expert	Date	Type
Health IT	10/7/2015	M	MITRE Co	9/22/2015	F
	11/18/2015	C	Dr. Brett Giroir	10/19/2015	S
	12/2/2015	C	LaVerne Council,	10/27/15	HVAC
	3/7/2016	C	Chris Miller, Brian Burns		Hearing
	3/14/2016	C	Brookings Institution	11/6/2015	S
	3/21/2016	M	LaVerne Council	11/25/2015	S
	4/4/2016	C & E	Dr. Theresa Cullen	12/2/2015	W
			Chris Miller	12/15/2015	F
			Chuck Hume	12/15/2015	F
			Elaine Hunolt	12/15/2015	F
			Jim Wood	12/15/2015	F
			Mariam Yeager	12/15/2015	F
			LaVerne Council	12/15/2015	F
			Jamie Bennett	3/2/2016	S
			Margaret Donahue	3/11/2016	S
			Kai Miller	4/12/2016	S
Business Processes	10/20/2015	M	SecVA Bob McDonald	9/21/2015	F
	10/26/2015	M			
	3/14/2016	C			
	3/21/2016	M			
	4/4/2016	C			

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WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting	Date	Expert	Date	Type
Supplies (Pharmaceutical & Medical Devices)	10/7/2015	M	McKinsey Co	9/21/2015	F
	10/26/2015	M	Jonathan Miller	12/4/2015	S
	2/23/2016	E	Tucker Taylor	12/4/2015	S
	2/24/2016	C			
	3/7/2016	C			
	3/14/2016	C			
	3/21/2016	M			
Facilities	10/7/2015	M	Bob McDonald	9/21/2015	F
	11/18/2015	M	Jim Sullivan	11/11/2015	S
	12/2/2015	C	Mark W. Johnson	12/21/2015	S
	12/22/2015	M	Kyle Reinhardt	12/22/2015	S
	2/16/2016	E	Thom Kurmel	12/22/2015	S
	2/17/2016	C	Rick Bond	12/22/2015	S
	2/24/2016	C & E	John Bulick	12/22/2015	S
	3/7/2016	C	John Kay	12/22/2015	S
	3/14/2016	C	Jim Sullivan	2/16/2016	S
	3/21/2016	M	Ed Bradley	2/16/2016	S
	4/4/2016	C	Jim Sullivan	2/17/2016	W
	4/11/2016	C	Jim Sullivan	3/15/2016	S
	4/27/2016	C			
Other	11/5/2015	E			
	11/6/2015	E			
	3/11/2016	E			

Health Care Leadership Workgroup

The leadership workgroup organized its work around five main topics: organizational health and cultural transformation and four leadership system issues: recruitment, retention, development and advancement; organizational structure and function; performance management and performance measurement; and human capital management. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic received an evidence review and summary which was the basis for a conference call or a face-to-face discussion. On a few topics, Commissioners or staff heard directly from VA staff or outside experts to inform the deliberation. Then, in a second meeting on the topic, the Commissioners debated a strawman proposal and alternative recommendations based on the evidence review and the prior Commission discussion. Feedback from the Commissioners was incorporated into the strawman and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. The papers were finalized and presented to the full Commission for deliberation and feedback on March 22, 2016. A summary of the work completed on each topic is provided in the table below.

APPENDIX F
THE COMMISSION'S PROCESS

Table F-5. Leadership Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Organizational Health and Cultural Transformation	12/2/2015	C	Stephen Kirin	9/23/2015	F
	12/9/2015	C	Jay Schnitzer	9/23/2015	F
	2/9/2016	M	Vivian Riefberg	9/23/2015	F
	2/17/2016	C	Dee Ramsel	11/9/2015	S
	3/11/2016	E	Ashby Sharpe	11/9/2015	S
			Ken Berkowitz	11/9/2015	S
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
Recruitment, Retention, Development, and Advancement	11/17/2015	M	Stephen Kirin	9/23/2015	F
	11/25/2015	C	Jay Schnitzer	9/23/2015	F
	2/17/2016	C	Vivian Riefberg	9/23/2015	F
	2/24/2016	C	Volney Warner	11/9/2015	S
	3/9/2016	C	Lisa Red	11/17/2015	W
	3/11/2016	E	Payton Rica-Lewis	11/17/2015	W
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Georgia Coffey	2/22/2016	S
			David Perry	2/24/2016	S
			Audrey Oatis-Newsome	2/24/2016	S
Organizational Structure and Function	10/27/2015	C	Stephen Kirin	9/23/2015	F
	2/9/2016	M	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Charles Rossotti	12/16/2015	F
			Michael Kussman	1/19/2016	F
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Robin Hemphill	3/4/2016	S
Performance Management and Performance Measurement	11/4/2015	C	Stephen Kirin	9/23/2015	F
	11/12/2015	C	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Peter Almenoff	10/30/2015	S
			Joe Francis	1/8/2016	S
			Carolyn Clancy	1/8/2016	S
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Noel Baril	3/9/2016	S

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WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Human Capital Management	12/15/2015	M	Stephen Kirin	9/23/2015	F
	12/23/2015	C	Jay Schnitzer	9/23/2015	F
	3/11/2016	E	Vivian Riefberg	9/23/2015	F
			Sam Retherford	12/15/2015	W
			Joleen Clark	2/8/2016	F
Leadership Vision	1/6/2016	C			
	1/21/2016	M			
	2/3/2016	C			
	2/4/2016	E			
Leadership Pre-amble	3/14/2016	E			

Site Visits

Background

In the coming decades there will be increased demand for accountability in health care and increased emphasis on health care outcomes and measurements, and VHA will need to rise to meet these expectations to survive and remain competitive in the demanding and turbulent health care environment.⁷⁹⁷ The changing nature of health care organizations, including pressure to reduce costs, improve the quality of care, and meet stringent guidelines, has forced health care professionals to reexamine how they evaluate performance.⁷⁹⁸ Although many health care organizations have long recognized the need to look beyond financial measures when evaluating performance, many still struggle with what measures to select and how to use the results of those measures.⁷⁹⁹

As the nation's largest health care system in 2016, VHA employs more than 305,000 health care professionals and support staff at more than 1,000 sites of care, including hospitals, community-based outpatient clinics (CBOCs), nursing homes, domiciliaries, and 300 Vet Centers.⁸⁰⁰ Given the scope of this health care system, the Commission recognized the importance of direct lines of communication and interaction with VHA leaders, staff, and patients, to include conducting facility site visits. Commissioners conducted facility site visits to their local VA facilities to assist in the evaluation of the findings identified by the *Independent Assessment Report*, to contribute to an environmental scan of the VHA, and to inform the development of recommendations.⁸⁰¹

Scope of Site Visits

In January and February 2016, most of the 15 Commissioners conducted site visits to the VA medical centers (VAMCs) and CBOCs proximal to their respective residences. The Commissioners approached these site visits with a collaborative and information-seeking tone with the purpose of having open discussions with VAMC leadership, staff, and patients.

Individual Commissioners visited 12 VAMC facilities or CBOCs in 7 out of 19 Veteran Integrated Service Networks (VISNs). Additionally, all the Commissioners who attended the February 29, 2016, meeting in Dallas, TX, toured the Dallas VAMC.

⁷⁹⁷ Kenneth W. Kizer, M.D., M.P.H./Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation for the Veterans Healthcare System*, accessed March 1, 2016, <http://www.va.gov/healthpolicyplanning/rxweb.pdf>.

⁷⁹⁸ Kicab Castaneda-Mendez/Quality Digest, *Performance Measurement in Health Care*, accessed, March 1, 2016, <http://www.qualitydigest.com/magazine/1999/may/article/performance-measurement-health-care.html#>.

⁷⁹⁹ Ibid.

⁸⁰⁰ Department of Veterans Affairs, Undersecretary for Health, accessed March 1, 2016, <http://vaww.ush.va.gov/>.

⁸⁰¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, v, accessed March 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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Table F-6. VA Facility Site Visit Locations

VISN	VISN Name	VA Facility
2	VISN 2	VA Hudson Valley Health Care System (Montrose, NY)
6	VA Mid-Atlantic Health Care Network	Fredericksburg Community-based Outpatient Center, (Fredericksburg, VA)- part of Hunter Holmes McGuire VA Medical Center, Richmond, VA
7	VA Southeast Network	Ralph H. Johnson VA Medical Center (Charleston, NC) Wm. Jennings Bryan Dorn VA Medical Center (Columbia, SC)
10	VA Health Care System	VA Ann Arbor Health care System (Ann Arbor, MI) John D. Dingell VA Medical Center (Detroit, MI)
17	VA Heart of Texas Health Care System	Dallas VA Medical Center (Dallas, TX)
21	Sierra Pacific Network	Southern Nevada Health care System (Las Vegas, NV) VA Northern California Health Care System (Mather, CA) VA Palo Alto Health Care System (Palo Alto, CA)
22	Desert Pacific Health Care Network	Greater Los Angeles Health care System (Los Angeles, CA) VA San Diego Health care System (San Diego, CA)

The Commissioners were provided with a generic basic agenda as guidance, though they had the latitude to determine their own agendas as appropriate for the locations they visited. The model agenda included the following activities: a welcome and overview of the VA health care facility; tour of the facility; veteran discussion session (informal or formal); VHA employee session (e.g., informal or small group discussion); a discussion with the facility leadership, and were provided the recommended questions listed below:

- What does the medical center do well?
- What unique resources can the medical center draw on?
- What do others see as the strengths of the medical center?
- What could the medical center improve?
- Where does the medical center have fewer resources than others?
- What are others likely to see as weaknesses of medical center?
- What opportunities are open to the medical center?
- What trends could the medical center take advantage of?
- How can the medical center turn its strengths into opportunities?
- What threats could harm the medical center?
- What obstacles does the medical center face?
- What threats do the medical center's weaknesses expose it to?

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- What is the impact of MyVA?
- How do employees view working at VA compared to two or three years ago? If there is a change, what is driving it?
- In your view, what is the most important factor affecting patient satisfaction with the care you provide?
- In your view, has there been a change in the perception of the quality of care provided by the medical center? If so, what might be driving this different perception?

Once the Commissioners completed their visits, they provided the data they gathered to Commission staff to be organized in a strengths-weaknesses-opportunities-threats (SWOT) analysis framework. A SWOT analysis is a simple but useful framework for analyzing the four factors as they are faced by an organization. It helps organizations develop strengths, minimize threats, and take the greatest advantage of available opportunities.⁸⁰²

Findings

VHA leadership and staff enthusiastically shared their time, insights, perspective, and data on organizational and operational processes with the Commissioners. The site visits provided insight and reinforced the findings of the *Independent Assessment Report*.

Confirming what the *Independent Assessment Report* stated, the Commissioners found VHA facilities' staff members exhibit a deep commitment to serving veterans, but that VHA's health care facilities deliver strikingly different patient experiences, apply inconsistent business processes, and differ widely on key measures of performance and efficiency.⁸⁰³ Based on Commissioners' observations of weaknesses, challenges, and threats related to daily operations, VAMC staff members appear to be searching for suitable solutions. Anecdotal responses provided to the Commissioners illuminated the following systemic problem areas at the VAMCs:

- Care authorities: health care capabilities (i.e., purchased care)
- Staffing: productivity (i.e., human resources), health care capabilities, access standards, clinical workflow
- Leadership: staffing, productivity (i.e., human resources)
- Facilities: health care authorities (i.e., patient-centered community care)

Data from Commissioners' observation notes were organized into a SWOT analysis chart based on the common themes of the Commissioners' facility site visits. The purpose of this exercise was to gather information to inform the Commission's recommendations and to confirm or

⁸⁰² "SWOT Analysis," Mind Tools, accessed March 15, 2016, https://www.mindtools.com/pages/article/newTMC_05.htm.

⁸⁰³ "Veterans Integrated Service Networks (VISN)," Department of Veterans Affairs, VHA, accessed March 14, 2016 <http://www.va.gov/directory/guide/division.asp?dnum=1>.

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dispute the findings of the *Independent Assessment Report*. The Commissioner site visit inputs are summarized in the table below.

Table F-7. SWOT Analysis of Commissioner Site Visit Observations

Strengths	Weaknesses	Opportunities	Threats
<ul style="list-style-type: none"> ▪ VA medical center workforce customer service and dedication ▪ Research and national databases ▪ Veterans service – connected services and programs ▪ Partnerships with medical schools and training programs 	<ul style="list-style-type: none"> ▪ Inefficient/ineffective HR policies ▪ High levels of staffing vacancies ▪ Lack of clinical space; inefficient configurations of clinical space ▪ Poor access to VA care for rural veterans ▪ Lack of an effective financial system to provide real-time payment process to veterans Choice and Purchased Care Programs ▪ Lack of effective VHA leadership workforce ▪ Lack of capacity/access to appointments in VHA ▪ Insufficient federal government health care appropriation rules 	<ul style="list-style-type: none"> ▪ Modernization of VA IT ▪ Customer service training/standards ▪ Strategic focus on VHA core mission ▪ Local funding flexibility from Congress ▪ New vision and mission for VHA health care ▪ Process/systems reengineering ▪ Recruitment of outside leader candidates and retention of high-performing VHA leaders 	<ul style="list-style-type: none"> ▪ Misalignment between Congress's health care operational plans for veterans and VHA strategic health care plans ▪ Competing stakeholders health care interests ▪ Office of Personnel Management outdated standards/policies ▪ Insufficient VHA leadership development ▪ Insufficient IT funding ▪ The physician shortages around the nation has severely impacted the care of patients

Conclusions

Fundamental transformation of VHA is needed to ensure optimal delivery of veteran-centered, high-quality care. Essential to laying the path to excellence and strategic planning is a comprehensive understanding of the current state as well as the opportunities and threats facing the system. A robust connection between leaders in VHA Central Office and leaders in the field is critical to meet the needs of the veteran population served.

As part of the strategic planning process, VA/VHA leadership should make recurring site visits to VHA facilities, including VAMCs, VISN headquarters, and CBOCs to obtain current insight of the following critical areas: health care trends, health care operations, facility management and renovation/replacement, business processes and contracting, and other trends or issues affecting VAMCs. VA/VHA leaders should use performance management tools and activities to ensure the strategic goals are being met in an effective and efficient manner. It is a constant challenge to continuously and reliably measure the pulse of the organization. Site visits promote a healthy culture of sharing and building an understanding of organizational mission.

APPENDIX G: VETERAN FEEDBACK

In addition to the more than 4,000-page *Independent Assessment Report*, the Commission examined dozens of other reports, studies, and presentations as cited in the hundreds of footnotes dispersed throughout this Final Report. Collectively, these many sources provide a wealth of information on the challenges VHA confronts in realizing a vision for veterans' healthcare that leverages the strengths of VA and capitalizes on the potential non-VA providers offer.

A key source the Commission considered was the views of veterans themselves. Given the Commission's brief tenure, it was not possible to conduct a survey representative of the views of millions of veterans receiving health care from VHA. Instead, the Commission encouraged veterans to offer feedback on their health care experiences and the work of the Commission through its website. Many veterans service organizations (VSOs) also provided views representing their members in open sessions with the Commission and in formal letters and position statements directly to the Commission.

The feedback offered by veterans through the Commission's web site covered a range of health care topics, such as whether and to what extent care should be privatized, how much choice veterans should have in deciding on their care, and their assessment of the quality of care received. Not surprisingly, veterans (including a few who were also VA employees) are quite passionate about their views on health care. For the most part, veterans' feedback from the web site expressed opposition to efforts to *privatize* VHA, although a few did want more access to non-VA providers. The *Choice Program* was frequently criticized for long delays in appointments, convoluted or misapplied eligibility criteria, and issues with how providers should be reimbursed for treatment and how much the veteran should pay. When the quality of care was noted, on balance veterans praised the care received from VHA, with a few disappointed, especially when care was outsourced to non-VA providers. Because the feedback was unstructured, veterans could offer any observations they found pertinent.

The Disabled American Veterans (DAV) shared with the Commission a compendium of more than 4,000 verbatim comments on veterans' health care experiences gathered from their members during April 2016. The DAV reviewed the comments and categorized 82 percent of the comments as "overall positive experiences."⁸⁰⁴ The Commission staff reviewed the comments from DAV, with findings consistent to DAV's.

⁸⁰⁴ Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.

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VA Efforts to Gather Input on Veterans Views on Health Care

Like most institutions that provide products and services to customers, VA/VHA solicits input from veterans on their health care needs and their views on specific services VA/VHA provides. Surveys, focus groups, and in-depth interviews are the more typical means for gathering input from veterans. On occasion, VA, like most agencies, encourages veterans and others to submit comments on a particular aspect of VA services and benefits.⁸⁰⁵

The following sections describe the more typical methods employed by VA/VHA to gather input from veterans.

VHA Survey of Veterans' Health and Use of VHA

Conducted by the assistant deputy undersecretary for policy and planning, the survey of veteran enrollees' health and use of health care (Survey of Enrollees) is an annual survey of more than 40,000 veterans who are enrolled in VA's health care system. The Survey of Enrollees was initially designed to give VHA the information it needed to predict the demand for services in the future. The data are used to develop health care budgets and to assist VA with its annual enrollment decisions. Over the years, the data have also been used to analyze policy decisions, provide insights into specific populations and their perspectives, and inform management decisions affecting delivery of care. In addition to collecting basic demographic information, the survey explores insurance coverage, use of health care inside and outside of VA, pharmaceutical use, attitudes and perceptions about VHA services, perceived health status, and trends in smoking among veterans enrolled in the VHA system.⁸⁰⁶

Survey of Healthcare Experiences of Patients⁸⁰⁷

The Survey of Healthcare Experiences of Patients (SHEP) program was initiated in 2002 in an effort to create standardized survey instruments administered monthly to assess ambulatory and inpatient care. In an effort to standardize its survey instruments with other health care providers, SHEP now employs the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey methodology for VHA's primary care and inpatient medical and surgical services. These surveys are supported in the public domain by the CAHPS Consortium, Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, and National Committee for Quality Assurance. Although SHEP deployed the standardized CAHPS surveys,

⁸⁰⁵ "Quality of Care Feedback Form," Department of Veterans Affairs, accessed June 20, 2016, <http://www.va.gov/QUALITYOFCARE/apps/contact.asp>. As an example, the VA web site provides a Quality of Care feedback page for veterans and others to enter comments on the care a veteran received.

⁸⁰⁶ Westat, 2015 Survey of Veteran Enrollees' Health and Use of Health Care, accessed June 6, 2016, http://www.va.gov/healthpolicyplanning/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁸⁰⁷ For more details on SHEP and VHA's recent initiatives to expand the scope of the program, see "Health Services Research & Development, Commentary: Listening to Veterans about Access to Care," Steven M. Wright, VHA Office of Analytics and Business Intelligence, U.S. Department of Veterans Affairs, accessed June 20, 2016, <http://www.hsrd.research.va.gov/publications/forum/nov15/default.cfm?ForumMenu=nov15-1>.

the access questions were limited and did not evaluate the full scope of services used by veterans.

VHA intends to expand the SHEP program with additional surveys in 2016 and beyond. These surveys will focus on satisfaction with various specialty care services and experience with community care available through the Veterans Access, Choice, and Accountability Act of 2014. VHA has also launched a survey that focuses on new veteran enrollments and their experience with first clinic appointments.

Veteran Insights Panel

VHA also established a Veteran Insights Panel, comprising more than 3,200 veterans that are representative of users of VA health care.⁸⁰⁸ VHA interacts with the panel through email notification and a special access website (mobile device enabled). This approach provides VHA an opportunity to engage panel members in direct discussions, including real time feedback via live chat, about important themes and issues, and survey development and testing. The panel can be engaged collaboratively with operational program offices and researchers to prompt direct discussions with our veterans.

Voices of Veterans: On-going Research

Initiated in the spring of 2014, the VA Center for Innovation (VACI) sponsors an on-going effort to employ human-centered design (HCD)⁸⁰⁹ concepts in a pilot to explore veterans' experience with VA through the eyes of 40 veterans across a range of demographics and locations.⁸¹⁰ The pilot had two goals:

- To test the usefulness and application of an HCD methodology within the context of VA.
- To better understand veterans' experiences interacting with VA, identify pain points in the present day service delivery model, and explore opportunities to transform these interactions into a more veteran-centered experience.

Developing Veteran Personas

As a part of this pilot, VACI set out to identify high-level trends in ways veterans seek out assistance, use technology, take advantage of services, and react to challenging interactions. Based on these patterns, VACI created a set of four profiles, or personas, that represent the

⁸⁰⁸ Ibid.

⁸⁰⁹ Human-centered design (HCD) is a discipline in which the needs, behaviors and experiences of an organization's customers (or users) drive product, service, or technology design processes. It is a practice used heavily across the private sector to build a strong understanding of users, generate ideas for new products and services, test concepts with real people, and ultimately deliver easy-to-use products and positive customer experiences. HCD is a multi-disciplinary methodology which draws from the practices of ethnography, cognitive psychology, interaction and user experience design, service design, and design thinking. It is closely tied to "user-centered design," which applies parallel processes to technology projects, and "service design" which address the service specific experiences.

⁸¹⁰ U.S. Department of Veterans Affairs, Center for Innovation, *Toward a Veteran-Centered VA: Piloting Tools of Human-Centered Design for America's Vets, Findings Report, July 2014*, accessed June 20, 2016, http://www.innovation.va.gov/docs/Toward_A_Veteran_Centered_VA_JULY2014.pdf.

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kinds of users within the set of 40 veterans engaged in the pilot (see Table G-1). Each persona is an archetype based on commonalities observed among veterans who exhibited similar behaviors and approaches to accessing VA services. They are not categorized by positive or negative experiences, but by shared expectations and needs. These personas were designed to help VHA begin to understand that it is serving users who are seeking not just different services, but also varied degrees of contact, support, information, and so forth. For this exercise, VACI assessed veterans' modes of communication, channels, frequency, stated and observed needs, reactions to service experiences, military service, and analyzed observed behavior and service experiences.

*Table G-1. Veteran Profiles Developed by the VA Center for Innovation*⁸¹¹

THE LIFER	THE TRANSACTIONAL
<p>Frequently use VA services and plans to continue doing so. Look to VA to play a supporting, community-building role in life. Grateful for VA benefits, but get frustrated when problems arise which break up the continuity of care—like when doctors change too frequently and when they cannot get transportation to VA facilities. Generally, try to speak highly of VA and wants to contribute to making it work better for fellow veterans.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA cares and takes the time to understand veteran's needs and story ▪ That cost of VA services won't rise ▪ That veteran can reach someone at VA anytime <p>Needs</p> <ul style="list-style-type: none"> ▪ Does not want to tell story over and over, especially after using VA for so long ▪ Wants to know what is going on with services and especially benefits ▪ Likes patient, nurturing health care 	<p>Joined the military largely based on the promise of the opportunities it would provide in life. Plan to use VA services to "get life on track" post-service. Tend to be in the younger generation of veterans (OEF, OIF, OND). Often engaged in the veteran community, see other veterans as allies, and advocates in helping folks understand and use their benefits. Will share frustrations if feels like VA is not helping as promised.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA will deliver on its promises and help veteran access the benefits earned ▪ That VA has benefits available to veterans families ▪ That it will be a headache, and veterans will have to figure it out on their own with the help of network <p>Needs</p> <ul style="list-style-type: none"> ▪ Accurate expectations ▪ Financial support at times, especially for family ▪ To feel a part of a community

⁸¹¹ Ibid.

THE JUST-IN-CASE	THE INFREQUENT
<p>Proud of service, but does not need VA and plans on using it only as a backup. Mature and organized by nature, has all papers in order with VA and have a good idea of services for which they are eligible. Grateful for the benefits available, but see working with VA as a tradeoff for time and will likely only lean on VA as a backup plan.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That will likely never need VA benefits ▪ That VA will be there if needed ▪ That there are benefits available to family ▪ That private benefits are of higher quality and greater ease <p>Needs</p> <ul style="list-style-type: none"> ▪ Peace of mind ▪ To be assured that all documents are in order ▪ To easily get in touch with one person about one question 	<p>Does not think very much about VA. Have used VA benefits in lifetime, yet often years will go by between those interactions. This might be because these veterans live in places where it is difficult to access VA services, because veterans are financially comfortable, or because it seems like too much hassle. Tend to prefer quick interaction—a short phone call or a few clicks on a website.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA is slow—like any bureaucracy ▪ That VA is for “other, injured veterans who need it more” ▪ That someone will tell veterans when and if they are eligible for something <p>Needs</p> <ul style="list-style-type: none"> ▪ To be able to quickly navigate processes ▪ To be reminded every few years of how VA might be able to help

Vantage Point: VA’s Official Blog

In addition to surveys, focus groups, and town-hall sessions, VA instituted a blog on its website and invites veterans and others interested in veterans matters to submit guest posts of potential interest to others in the community. Like most blogs, the content offered is vetted by the VA. Since 2010, Vantage Point includes hundreds of contributors with articles on various health care topics.⁸¹²

Veterans’ Views Gathered by VSOs

Like VHA, the VSOs solicit input from their membership and other stakeholders on a variety of topics and issues relevant to veterans. Occasionally surveys and polls are undertaken, but most VSO efforts to gather input take place at the grassroots level during town halls, chapter meetings and other gatherings. While these venues often suffer from self-selection bias and non- or under-represented participant samples, these are nevertheless an important source of timely information on topics of interest and concern to veterans. What follows is a selection of VSO efforts to gather input on issues important to veterans.

⁸¹² “Vantage Point: Official Blog of the U.S. Department of Veterans Affairs,” Department of Veterans Affairs, accessed June 20, 2016, <http://www.blogs.va.gov/VAntage/>.

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The DAV Veterans Pulse Survey (2015)

In mid-2015 the DAV surveyed a nationally representative sample of veterans to solicit their views on issues important to veterans.⁸¹³ The survey includes questions on various aspects of veterans' healthcare. The survey consists of a national probability sample of 1,701 veterans intended to represent the veteran population in the United States. Oversampling occurred in certain subgroups, such as female veterans and veterans age 18-40 to allow for more precision in the response estimates for these subgroups.

Veterans of Foreign Wars Our Care Veterans Survey (2015)

In the fall of 2015, the Veterans of Foreign Wars of the U.S. (VFW) published a report on its veterans 2015 Health Care Options, Preferences and Expectations Survey.⁸¹⁴ In response to the intensified debate over reform of veterans' healthcare, the VFW launched a survey in the summer of 2015 designed to evaluate veterans' options, expectations, and preferences when seeking health care. The survey did not just focus on VA services, but sought to paint a picture of how the veterans' community at large interacts within the American health care infrastructure, and the choices they make in today's health care marketplace. According to the VFW report, 1,847 veterans responded to the survey, with 92 percent eligible for care and 83 percent of those eligible reporting that they utilize VA health care.⁸¹⁵ Respondents' average age was 65, with about two-thirds Vietnam War veterans.

VFW Survey of Women Veterans (2016)

In an effort to identify barriers women veterans face when accessing their earned veterans' benefits and services, the VFW has commissioned a survey of women veterans that will guide the VFW's policy priority goals for women veterans.⁸¹⁶ Though the survey data collection phase is completed, results have not been published prior to release of the Commission's Final Report.

⁸¹³ Disabled American Veterans (DAV), *The DAV Veterans Pulse Survey: A landmark study of the attitudes and perceptions of America's veterans*, accessed June 20, 2016, <https://www.dav.org/wp-content/uploads/DAV-Pulse-Report-Final.pdf>. The survey was conducted on behalf of DAV by GfK Knowledge Networks, Inc. using their KnowledgePanel® survey participants in November 2015.

⁸¹⁴ Veterans of Foreign Wars, *Our Care: A Report on Veterans' Options, Preferences and Expectations in Health Care*, September 22, 2015, accessed June 20, 2016, http://www.vfw.org/uploadedFiles/VFW.org/VFW_in_DC/VFWOurCareReport2015.pdf.

⁸¹⁵ Ibid., 4.

⁸¹⁶ "VFW Survey of Women Veterans: Help Hold the VA Accountable," Veterans of Foreign Wars, December 22, 2015, accessed June 20, 2016, <http://www.vfw.org/News-and-Events/Articles/2015-Articles/VFW-Survey-of-Women-Veterans/>.

The American Legion Survey of Patient Health Care Experiences (2014)

This survey of 3,116 opt-in, self-reported veterans focuses on satisfaction and levels of perceived benefits with VA's posttraumatic stress disorder/traumatic brain injury (PTSD/TBI) programs, including alternative and complementary treatments.⁸¹⁷

Survey questions include veteran status; gender; era of service; number of times deployed; diagnosis of TBI and/or PTSD; availability of appointments; time and distance to care facilities; treatment type (therapy, medication and complementary and alternative medicine); reported symptoms; efficacy of treatment; and side effects.

The American Legion Women Veterans Survey Report (2011)

This survey of 3,012 women veterans, and the resulting report, was prepared by ProSidian Consulting, LLC on behalf of The American Legion. The survey assessed the perceptions of and satisfaction with women veterans' health care and other benefits delivered to women veterans through the VA system. Additionally, the survey sought to determine the factors driving women veterans' decision to use the VA system as opposed to other private or public health care systems.⁸¹⁸

Iraq and Afghanistan Veterans of America Member Survey (2015)

During the first half of 2015, 1,501 Iraq and Afghanistan Veterans of America members completed a wide-ranging on-line survey covering such issues as employment, education, GI Bill usage, health (including mental health), VA utilization, VA benefits, reintegration and more. The survey was composed of approximately 300 questions, with respondents answering only questions relevant to their experiences. Health care topics included percent enrollment in and reliance on VA care; health insurance coverage by type; and experience rating for VA care. Usage percent and experiencing rating for the VA *Choice Program* was also covered separately.⁸¹⁹

The 2015 Wounded Warrior Project® Alumni Survey

This web-enabled, opt-in survey of 23,200 Wounded Warrior Project (WWP) members measures a series of outcome domains within the following general topics about WWP Alumni: background information (military experiences and demographic data), physical and mental well-being, and economic empowerment.⁸²⁰ This WWP membership survey has been conducted annually since 2010. As it has done in prior years, Westat conducts the survey and population-

⁸¹⁷ "Legion survey to measure effectiveness of PTSD/TBI treatment," The American Legion, July 29, 2015, accessed June 20, 2016, <http://www.legion.org/pressrelease/229354/legion-survey-measure-effectiveness-ptsdtbi-treatment>.

⁸¹⁸ ProSidian Consulting, LLC, *The American Legion Women Veterans Survey Report*, March 9, 2011, accessed June 20, 2016, http://www.legion.org/documents/legion/pdf/womens_veterans_survey_report.pdf.

⁸¹⁹ "Media Advisory: IAVA to Release Groundbreaking Veterans Survey," Iraq and Afghanistan Veterans of America (IAVA), May 23, 2016, accessed June 20, 2016, <http://iava.org/press-release/media-advisory-iava-to-release-groundbreaking-veterans-survey-2/>.

⁸²⁰ Westat, *2015 Wounded Warrior Project Survey, Report of Findings*, August 14, 2015, accessed June 20, 2016, https://www.woundedwarriorproject.org/media/2118/2015_wwp_alumni_survey_full_report.pdf.

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weights the reported results, to include adjustments for potential non-response bias, to be representative of the WWP membership base (approximately 59,000).

Right to Care: Voices of Swords to Plowshares' Veteran Community (2015)

The Swords to Plowshares, Institute for Veteran Policy interviewed in-person or by phone 22 veterans.⁸²¹ Although the topics were established in advance, Swords to Plowshares characterized these interviews as individual “conversations” with a preselected group of veterans. The veterans were chosen to represent a cross-section of combat eras and VHA usage levels. The topics covered included: navigating VA care, reliance on VA and non-VA care, comprehensiveness of care, and rating quality of care. The study includes extensive verbatim comments from veterans on these topics.

Comments from Veterans About Their Experiences as Users of VHA (DAV, 2016)

During April 2016, DAV reached out to veterans around the United States and asked them to share their experiences with the VA health care system. As a result, DAV received (as of April 2016) more than 4,000 responses from veterans sharing their own stories about the care they received from VHA.⁸²² The Commission’s review of the material showed that a majority of the veterans’ comments were positive in nature. DAV’s own analysis concluded that 82 percent of the comments could be categorized as “overall positive experiences.”

Other Surveys on Veterans Issues

In addition to efforts by VA and VSOs to gather feedback from veterans on their health care, other organizations have also addressed veterans’ health care issues.

Concerned Veterans for America Survey of Veterans' Healthcare (November, 2014)

The Concerned Veterans for America commissioned The Tarrance Group to conduct a national survey of 1,000 veterans during November 2014.⁸²³ This survey used a random, demographically representative sample of veterans. Four survey items addressed health care, including: knowledge of any problems at VA; need for reform of veterans’ healthcare; importance of more choice (or options) in health care for veterans; and importance of best possible veterans care, even if outside VA.

⁸²¹ Megan Zottarelli, *RIGHT to CARE: Voices of Swords to Plowshares' Veteran Community*, Swords to Plowshares, Institute for Veterans Policy, April 2016.

⁸²² Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.

⁸²³ Concerned Veterans for America, *Fixing Veterans Health Care*, A Bipartisan Policy Taskforce, accessed June 20, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>.

Vet Voice Foundation Survey of Veterans (October, 2015)

Chesapeake Beach Consulting and Lake Research Partners conducted 800 phone (landline and cell) interviews of veterans during October 2015. The results were population weighted by demographics. Topics included rating the job VA hospitals are doing in their area and the extent they favor/oppose privatizing some of VA's health care.

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APPENDIX H: ADDITIONAL RESOURCES

The VHA health care system is immense and complex. This report provides background for the areas for which the Commission has made recommendations, yet this information is but a glimpse at the intricacies of veterans' health care. The resources below may serve as a starting point for those who would like to develop a deeper understanding of the topic than the Commission could address in this report.

Independent Assessment Report

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow – Scheduling)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow – Clinical)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

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Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

Veteran Health Competency Resources

American Nurses Foundation

The American Nurses Foundation, the philanthropic arm of the American Nurses Association, is launching an innovative web-based PTSD Toolkit for registered nurses. The toolkit provides easy to access information and simulation based on gaming techniques on how to identify, assess and refer veterans suffering from PTSD. www.nurseptsdtoolkit.org

American Osteopathic Association

The American Osteopathic Association (AOA) represents osteopathic physicians, many of whom are in primary care practice, and essentially all of whom treat America's veterans and their families. The AOA is raising awareness in the osteopathic community about the importance of having a comprehensive understanding of the unique physical and mental health care needs of our service members, veterans, and their families. The AOA is committed to ensuring that medical students, physicians, and other health care providers understand that an individual's physical and/or mental health condition may be linked to his or her military experience.

www.osteopathic.org/inside-aoa/public-policy/Pages/federal-initiatives.aspx

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Center for Deployment Psychology

The Center for Deployment Psychology of the Uniformed Services University of the Health Sciences, Department of Medical and Clinical Psychology offer a wide variety of on-line courses and other resources to help uniformed clinical providers, VHA providers, and community clinicians provide care consistent with the needs and experience of military service members, veterans and their families.

<http://deploymentpsych.org/online-courses>

<http://deploymentpsych.org/military-culture-course-modules>

Rural Clergy Training Program

The Rural Clergy Training Program, an initiative of the VHA National Chaplain Center and the Office of Rural Health, offers training and information to clergy providing pastoral services to veterans and their families.

http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December_2015.pdf

Swords to Plowshares Combat to Community Training

Swords to Plowshares is nationally recognized for its expertise in providing comprehensive services and promoting and protecting the rights of veterans. Swords to Plowshares' *Combat to Community*® training is a series of accredited cultural competency curricula developed by its Institute for Veteran Policy team with the purpose of educating the community to address the reintegration challenges veterans face and the unique skill sets they acquire in service. The training was developed for law enforcement, first responder, mental health, and service professionals to teach:

- Commonly shared attitudes, values, goals, and practice that often characterize service in the military
- Recruitment and retention strategies for veteran employment
- How deployment, combat experience, service related injuries, and disability can impact veterans
- How veteran or military family status can inform interactions and services
- Potential resources to refer veterans and families to for supportive services

The training incorporates knowledge developed by experts in the fields of veteran culture and direct services with practical tools and resources to increase understanding and improve interactions with veterans.

<https://www.swords-to-plowshares.org/combat-to-community>

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VA Military Culture Training Courses on TMS

The resources below are available to VA employees and contractors. Versions of these courses should be made available to community providers through an alternative to TMS that allows outside providers to access the training.

- **Military Culture Training for Health Care Professionals – Organization and Roles (VA 19332)**

The first module of this online course provides an overview of the differences between the explicit and implicit features of military culture and describes the characteristics of implicit military culture. The next module identifies four sources of information about implicit military culture and describes six defining characteristics of warrior ethos. The learner is provided information about the influence of military guiding ideals and values on the lives of service members and veterans. The final module offers an overview regarding the connotations of implicit military culture on the health care professional.

- **Military Culture Training for Health Care Professionals: Self-Awareness and Military Ethos (VA 19333)**

This online course, sponsored by the Department of Veterans Affairs and Department of Defense, helps health care professionals understand the role that military culture plays in the lives of those they serve. The course is comprised of four modules: 1) Self-Assessment and Introduction to Military Ethos, 2) Military Organization and Roles, 3) Stressors and Their Impact, and 4) Treatment Resources and Tools.

- **Military Culture Training for Health Care Professionals: Stressors & Resources (VA 19334)**

This online course offers the learner an explanation of how stress can be either helpful or harmful depending on the nature of the provoking stressor and the availability of resources. The four phases of modern operational deployment cycles is presented in great detail in module 3. The next two modules describe the characteristic operational stressors and the spectrum of operational stress states and outcomes experienced by service members and their families during each deployment cycle phase.

- **Military Culture Training for Health Care Professionals: Treatment Resources, Prevention & Treatment (VA 19335)**

This online course in the military culture curriculum outlines the military culture impact on patient care and the health care professional's role and explains the range of DoD and VA psychological health services. The course also provides information on interpreting military culture knowledge into patient assessment and treatment. Finally, the learner is exposed to the military culture implications of VA/DoD clinical practice guidelines relevant to the care of service members and veterans and the strategies for identifying current military culture relevant patient and health care professional resources.

- **Military Cultural Awareness (NFED 1341520)**

This military cultural awareness online course provides a common foundation for all VA employees. This course offers an overview of common military culture and courtesies, roles and ranks within the military, differences between the branches of the armed services, some of the conflicts in which veterans have served, and why this information

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is important in helping VA employees better serve the needs of veterans and their families. After taking this course, participants will understand the perspective of the veterans they serve by having a greater awareness of the military experience, and the customs and courtesies that are common in the military environment.

- **PTSD 101: Understanding Military Culture When Treating PTSD (VA 9494)**
This online web-based course is part of the PTSD 101 education series which is presented by subject-matter experts to increase provider knowledge related to the assessment and treatment issues of PTSD. Each course specifically addresses trauma events, treatments, or special population issues, not normally addressed in general therapy protocols. This course is specifically designed to familiarize clinicians with military culture, terminology, demographics, and stressors. It also provides an overview of programs offered by DoD for managing combat or operational stress, as well as implications for assessment and treatment.
- **Why Military Culture Matters (Mobile Accessible) (VA 16353)**
This independent online study activity is designed to help the learner better connect with veterans and understand how veterans' military experiences influence their health. This course is formatted to be accessible using a VA networked mobile device.

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APPENDIX I: ENABLING DOCUMENTS

Veterans Access, Choice, and Accountability Act of 2014

TITLE II—HEALTH CARE ADMINISTRATIVE MATTERS

SEC. 201. INDEPENDENT ASSESSMENT OF THE HEALTH CARE DELIVERY SYSTEMS AND MANAGEMENT PROCESSES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) INDEPENDENT ASSESSMENT. —

(1) ASSESSMENT. — Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into one or more contracts with a private sector entity or entities described in subsection (b) to conduct an independent assessment of the hospital care, medical services, and other health care furnished in medical facilities of the Department. Such assessment shall address each of the following:

(A) Current and projected demographics and unique health care needs of the patient population served by the Department.

(B) Current and projected health care capabilities and resources of the Department, including hospital care, medical services, and other health care furnished by non-Department facilities under contract with the Department, to provide timely and accessible care to veterans.

(C) The authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Department facilities, including whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care.

(D) The appropriate system-wide access standard applicable to hospital care, medical services, and other health care furnished by and through the Department, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation.

(E) The workflow process at each medical facility of the Department for scheduling appointments for veterans to receive hospital care, medical services, or other health care from the Department.

(F) The organization, workflow processes, and tools used by the Department to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.

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(G) The staffing level at each medical facility of the Department and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics, which may include an assessment of any of the following:

(i) The case load of, and number of patients treated by, each health care provider at such medical facility during an average week.

(ii) The time spent by such health care provider on matters other than the case load of such health care provider, including time spent by such health care provider as follows:

(I) At a medical facility that is affiliated with the Department.

(II) Conducting research.

(III) Training or supervising other health care professionals of the Department.

(H) The information technology strategies of the Department with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by Department, especially those strategies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Department in Department or non-Department facilities.

(I) Business processes of the Veterans Health Administration, including processes relating to furnishing non-Department health care, insurance identification, third-party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows:

(i) To avoid the payment of penalties to vendors.

(ii) To increase the collection of amounts owed to the Department for hospital care, medical services, or other health care provided by the Department for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate.

(iii) To increase the collection of any other amounts owed to the Department with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate.

(iv) To increase the accuracy and timeliness of Department payments to vendors and providers.

(J) The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Department, including the following:

(i) The prices paid for, standardization of, and use by the Department of the following:

(I) Pharmaceuticals.

(II) Medical and surgical supplies.

(III) Medical devices.

(ii) The use by the Department of group purchasing arrangements to purchase pharmaceuticals, medical and surgical supplies, medical devices, and health care related services.

(iii) The strategy and systems used by the Department to distribute pharmaceuticals, medical and surgical supplies, medical devices, and health care related services to Veterans Integrated Service Networks and medical facilities of the Department.

(K) The process of the Department for carrying out construction and maintenance projects at medical facilities of the Department and the medical facility leasing program of the Department.

(L) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.

(2) PARTICULAR ELEMENTS OF CERTAIN ASSESSMENTS. —

(A) SCHEDULING ASSESSMENT. — In carrying out the assessment required by paragraph (1)I, the private sector entity or entities shall do the following:

(i) Review all training materials pertaining to scheduling of appointments at each medical facility of the Department.

(ii) Assess whether all employees of the Department conducting tasks related to scheduling are properly trained for conducting such tasks.

(iii) Assess whether changes in the technology or system used in scheduling appointments are necessary to limit access to the system to only those employees that have been properly trained in conducting such tasks.

(iv) Assess whether health care providers of the Department are making changes to their schedules that hinder the ability of employees conducting such tasks to perform such tasks.

(v) Assess whether the establishment of a centralized call center throughout the Department for scheduling appointments at medical facilities of the Department would improve the process of scheduling such appointments.

(vi) Assess whether booking templates for each medical facility or clinic of the Department would improve the process of scheduling such appointments.

(vii) Assess any interim technology changes or attempts by Department to internally develop a long-term scheduling solutions with respect to the feasibility and cost effectiveness of such internally developed solutions compared to commercially available solutions.

(viii) Recommend actions, if any, to be taken by the Department to improve the process for scheduling such appointments, including the following:

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(1) Changes in training materials provided to employees of the Department with respect to conducting tasks related to scheduling such appointments.

(II) Changes in monitoring and assessment conducted by the Department of wait times of veterans for such appointments.

(III) Changes in the system used to schedule such appointments, including changes to improve how the Department –

(aa) measures wait times of veterans for such appointments;

(bb) monitors the availability of health care providers of the Department; and

(cc) provides veterans the ability to schedule such appointments.

(IV) Such other actions as the private sector entity or entities considers appropriate.

(B) MEDICAL CONSTRUCTION AND MAINTENANCE PROJECT AND LEASING PROGRAM ASSESSMENT. – In carrying out the assessment required by paragraph (1)(K), the private sector entity or entities shall do the following:

(i) Review the process of the Department for identifying and designing proposals for construction and maintenance projects at medical facilities of the Department and leases for medical facilities of the Department.

(ii) Assess the process through which the Department determines the following:

(1) That a construction or maintenance project or lease is necessary with respect to a medical facility or proposed medical facility of the Department.

(II) The proper size of such medical facility or proposed medical facility with respect to treating veterans in the catchment area of such medical facility or proposed medical facility.

(iii) Assess the management processes of the Department with respect to the capital management programs of the department, including processes relating to the methodology for construction and design of medical facilities of the Department, the management of projects relating to the construction and design of such facilities, and the activation of such facilities.

(iv) Assess the medical facility leasing program of the Department.

(3) TIMING. – The private sector entity or entities carrying out the assessment required by paragraph (1) shall complete such assessment not later than 240 days after entering into the contract described in such paragraph.

(b) PRIVATE SECTOR ENTITIES DESCRIBED. – A private entity described in this subsection is a private entity that –

(1) has experience and proven outcomes in optimizing the performance of the health care delivery systems of the Veterans Health Administration and the private sector and in health care management; and

(2) specializes in implementing large-scale organizational and cultural transformations, especially with respect to health care delivery systems.

(c) PROGRAM INTEGRATOR. —

(1) IN GENERAL. — If the Secretary enters into contracts with more than one private sector entity under subsection (a), the Secretary shall designate one such entity that is predominately a health care organization as the program integrator.

(2) RESPONSIBILITIES. — The program integrator designated pursuant to paragraph (1) shall be responsible for coordinating the outcomes of the assessments conducted by the private entities pursuant to such contracts.

(d) REPORT ON ASSESSMENT. —

(1) IN GENERAL. — Not later than 60 days after completing the assessment required by subsection (a), the private sector entity or entities carrying out such assessment shall submit to the Secretary of Veterans Affairs, the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and the Commission on Care established under section 202 a report on the findings and recommendations of the private sector entity or entities with respect to such assessment.

(2) PUBLICATION. — Not later than 30 days after receiving the report under paragraph (1), the Secretary shall publish such report in the Federal Register and on an Internet website of the Department of Veterans Affairs that is accessible to the public.

(e) NON-DEPARTMENT FACILITIES DEFINED. — In this section, the term “non-Department facilities” has the meaning given that term in section 1701 of title 38, United States Code.

SEC. 202. COMMISSION ON CARE.

(a) ESTABLISHMENT OF COMMISSION. —

(1) IN GENERAL. — There is established a commission, to be known as the “Commission on Care” (in this section referred to as the “Commission”), to examine the access of veterans to health care from the Department of Veterans Affairs and strategically examine how best to organize the Veterans Health Administration, locate health care resources, and deliver health care to veterans during the 20-year period beginning on the date of the enactment of this Act.

(2) MEMBERSHIP. —

(A) VOTING MEMBERS. — The Commission shall be composed of 15 voting members who are appointed as follows:

(i) Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a veteran.

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(ii) Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a veteran.

(iii) Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a veteran.

(iv) Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a veteran.

(v) Three members appointed by the President, at least two of whom shall be veterans.

(B) QUALIFICATIONS. — Of the members appointed under subparagraph (A) —

(i) at least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code;

(ii) at least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000;

(iii) at least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)));

(iv) at least one member shall be familiar with the Veterans Health Administration but shall not be currently employed by the Veterans Health Administration; and

(v) at least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.

I DATE. — The appointments of members of the Commission shall be made not later than 1 year after the date of the enactment of this Act.

(3) PERIOD OF APPOINTMENT. —

(A) IN GENERAL. — Members shall be appointed for the life of the Commission.

(B) VACANCIES. — Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(4) INITIAL MEETING. — Not later than 15 days after the date on which eight voting members of the Commission have been appointed, the Commission shall hold its first meeting.

(5) MEETINGS. — The Commission shall meet at the call of the Chairperson.

(6) QUORUM. — A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(7) CHAIRPERSON AND VICE CHAIRPERSON. — The President shall designate a member of the commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.

(b) DUTIES OF COMMISSION. —

(1) EVALUATION AND ASSESSMENT. — The Commission shall undertake a comprehensive evaluation and assessment of access to health care at the Department of Veterans Affairs.

(2) MATTERS EVALUATED AND ASSESSED. — In undertaking the comprehensive evaluation and assessment required by paragraph (1), the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201, including any findings, data, or recommendations included in such assessment.

(3) REPORTS. — The Commission shall submit to the President, through the Secretary of Veterans Affairs, reports as follows:

(A) Not later than 90 days after the date of the initial meeting of the Commission, an interim report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(B) Not later than 180 days after the date of the initial meeting of the Commission, a final report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(c) POWERS OF THE COMMISSION. —

(1) HEARINGS. — The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

(2) INFORMATION FROM FEDERAL AGENCIES. — The Commission may secure directly from any Federal agency such information as the Commission considers necessary to carry out this section. Upon request of the Chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

(d) COMMISSION PERSONNEL MATTERS. —

(1) COMPENSATION OF MEMBERS. —

(A) IN GENERAL. — Each member of the Commission who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily

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equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission.

(B) OFFICERS OR EMPLOYEES OF THE UNITED STATES. — All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES. — The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(3) STAFF. —

(A) IN GENERAL. — The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(B) COMPENSATION. — The Chairperson of the Commission may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(4) DETAIL OF GOVERNMENT EMPLOYEES. — Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES. — The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals that do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(e) TERMINATION OF THE COMMISSION. — The Commission shall terminate 30 days after the date on which the Commission submits the report under subsection (b)(3)(B).

(f) FUNDING. — The Secretary of Veterans Affairs shall make available to the Commission from amounts appropriated or otherwise made available to the Secretary such amounts as the Secretary and the Chairperson of the Commission jointly consider appropriate for the Commission to perform its duties under this section.

(g) EXECUTIVE ACTION. —

(1) ACTION ON RECOMMENDATIONS. — The President shall require the Secretary of Veterans Affairs and such other heads of relevant Federal departments and agencies to

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implement each recommendation set forth in a report submitted under subsection (b)(3) that the President —

(A) considers feasible and advisable; and

(B) determines can be implemented without further legislative action.

(2) REPORTS. — Not later than 60 days after the date on which the President receives a report under subsection (b)(3), the President shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives and such other committees of Congress as the President considers appropriate a report setting forth the following:

(A) an assessment of the feasibility and advisability of each recommendation contained in the report received by the President.

(B) For each recommendation assessed as feasible and advisable under subparagraph (A) the following:

(i) Whether such recommendation requires legislative action.

(ii) If such recommendation requires legislative action, a recommendation concerning such legislative action.

(iii) A description of any administrative action already taken to carry out such recommendation.

(iv) A description of any administrative action the President intends to be taken to carry out such recommendation and by whom.

H.R. 4437: Extension of Deadline for Submittal of Final Report by Commission on Care

[114th Congress Public Law 131]

[[Page 130 STAT. 292]]

Public Law 114-131

114th Congress

An Act

To extend the deadline for the submittal of the final report required by the Commission on Care.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. 38 USC 1701; EXTENSION OF DEADLINE FOR SUBMITTAL OF FINAL REPORT BY COMMISSION ON CARE.

COMMISSION ON CARE FINAL REPORT

Section 202(b)(3)(B) of the Veterans Access, Choice, and Accountability Act of 2014, 128 Stat. 1775 (Public Law 113-146; 128 Stat. 1773) is amended by striking “Not later than 180 days after the date of the initial meeting of the Commission” and inserting “Not later than June 30, 2016”.

Approved February 29, 2016.

DEPARTMENT OF VETERANS AFFAIRS
CHARTER OF THE
COMMISSION ON CARE

1. OFFICIAL DESIGNATION: Commission on Care
2. AUTHORITY: The Commission on Care established as required by section 202 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Public Law 113-146, and operates under the provisions of the Federal Advisory Committee Act (FACA), as amended, 5 U.S.C. App. 2.
3. OBJECTIVES AND SCOPE OF ACTIVITIES: The Commission on Care (the "Commission") is established to examine the access of Veterans to health care from the Department of Veterans Affairs (VA) and strategically examine how best to organize the Veterans Health Administration (VHA), locate health care resources, and deliver health care to Veterans during the 20-year period beginning on the date of the enactment of VACAA, August 7, 2014.
4. DUTIES OF THE COMMISSION:
 - A. Evaluation and Assessment: In accordance with section 202(b)(1), the Commission shall undertake a comprehensive evaluation and assessment of access to health care at VA.
 - B. Matters Evaluated and Assessed: In undertaking the comprehensive evaluation and assessment required by section 202(b)(1) of VACAA and paragraph (4)(A) above, the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201 of VACAA, including any findings, data, or recommendations included in such assessment.
 - C. Reports: In accordance with section 202(b)(3) of VACAA, submit an interim report not later than 90 days after the initial meeting of the Commission to the President, through the Secretary of Veterans Affairs, and a final report not later than 180 days after the initial meeting of the Commission. The reports shall include (i) the findings of the Commission with respect to the evaluation and assessment required by section 202(b)(1); and (ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through VHA.
5. OFFICIAL TO WHOM THE COMMISSION REPORTS: The Commission reports to the President, through the Secretary of Veterans Affairs.

VA is responsible for ensuring the reporting requirements of Section 6(b) of the FACA are fulfilled.

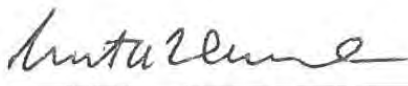
COMMISSION ON CARE FINAL REPORT

6. OFFICE RESPONSIBLE FOR PROVIDING THE NECESSARY SUPPORT FOR THE COMMISSION: VHA is responsible for providing support to the Commission.
7. ESTIMATED ANNUAL OPERATING COSTS AND STAFF-YEARS: Annual operating cost for the Commission is estimated at \$3,600,000 per year, including compensation of members and staff, in accordance with section 202(d) of VACAA. All members will receive travel expenses and a per diem allowance in accordance with the Federal Travel Regulations for any travel made in connection with their duties as members of the Commission. Approximately 15 FTE are anticipated.
8. DESIGNATED FEDERAL OFFICER: The Designated Federal Officer (DFO) or an Alternate DFO, full-time or permanent part-time VA employees, will be present at all meetings, including subcommittee meetings. The DFO will work with the Commission Chair to schedule the meetings and develop meeting agendas. The DFO is authorized to adjourn any meeting when he or she determines it is in the public interest to do so.
9. ESTIMATED NUMBER AND FREQUENCY OF MEETINGS: The Commission will meet at the call of the Chair for the duration of the Commission. The Commission may hold such hearings, sit and act at such times and places, and take such testimony, and receive such evidence as the Commission considers advisable to carry out its duties under section 202 of VACAA. A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.
10. DURATION: The Commission is subject to the termination date as specified below in section 11.
11. TERMINATION: The Commission shall terminate 30 days after the date on which the Commission submits the final report required by section 202(b)(3)(B) of VACAA.
12. MEMBERSHIP: The Commission shall be composed of 15 voting members who are appointed as Special Government Employees and described in paragraph (A) below for the life of the Commission and have the qualifications described in paragraph (B) below:
 - A. APPOINTMENT AUTHORITY:
 - i. Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a Veteran.
 - ii. Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a Veteran.

- iii. Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a Veteran.
 - iv. Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a Veteran.
 - v. Three members appointed by the President, at least two of whom shall be Veterans.
- B. QUALIFICATIONS: Of the members appointed under 12(A) –
- i. At least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of Veterans under 38 U.S.C. 5902;
 - ii. At least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000;
 - iii. At least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined by in section 1905(1)(2)(B) of the Social Security Act (42 U.S.C. 1396d(1)(2)(B));
 - iv. At least one member shall be familiar with VHA but shall not be currently employed by VHA; and
 - v. At least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.
- C. CHAIRPERSON AND VICE CHAIRPERSON: The President shall designate a member of the Commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.
- D. VACANCIES: If a vacancy occurs, it shall be filled in the same manner as the original appointment.
13. SUBCOMMITTEES: The Commission is authorized to establish subcommittees, with DFO approval, to perform specific projects or assignments as necessary and consistent with its mission. The Commission Chair shall notify the Secretary, through the DFO, of the establishment of any subcommittee, including its function, membership, and estimated duration. Subcommittees will report back to the Commission.
14. RECORDKEEPING: Records of the Committee shall be handled in accordance with General Records Schedule 26 or other approved agency records disposition schedules. Those records shall be available for public inspection and copying, subject to the Freedom of Information Act 5, U.S.C. 552.

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15. DATE CHARTER IS FILED:

Approved:  Date 7/14/15
Robert A. McDonald
Secretary of Veterans Affairs



APPENDIX J: COMPOSITION OF THE COMMISSION

Nancy M. Schlichting, Chairperson

Appointed by President Barack Obama

Nancy M. Schlichting is Chief Executive Officer of Henry Ford Health System (HFHS), a nationally recognized \$5 billion health care organization with 27,000 employees and recipient of the 2011 Malcolm Baldrige National Quality Award, 2011 John M. Eisenberg Patient Safety Quality Award, and 2004 Foster G. McGaw Award. She is credited with leading the health system through a dramatic financial turnaround and for award-winning patient safety, customer service and diversity initiatives.

Schlichting joined HFHS in 1998 as its Senior Vice President and Chief Administrative Officer, served as Executive Vice President and Chief Operating Officer, President and CEO of Henry Ford Hospital and was named President and CEO of the System in 2003. Her career in health care administration spans over 35 years of experience in senior level executive positions.

Schlichting serves on several national and community boards including The Kresge Foundation, Walgreens Boots Alliance, the Federal Reserve Bank of Chicago – Detroit Branch, the Detroit Regional Chamber, the Detroit Economic Club, and the Downtown Detroit Partnership. Nancy is also a Fellow of the American College of Healthcare Executives.

In 2015, Schlichting was honored as one of the 100 Most Influential People in Healthcare by Modern Healthcare magazine, the eighth time she received this recognition. She was also named to the Top 25 Women in Healthcare by Modern Healthcare, the fourth time she received this recognition and the only Michigander named to the list. Her other awards include: NCHL Gail L. Warden Leadership Excellence award, ACHE Senior-Level Healthcare Executive Regent's Award, AHA/HRET 2014 TRUST Award, Becker's Hospital Review "40 of the Smartest People in Healthcare-2014," Crain's Detroit Business "2012 Newsmaker of the Year," HealthLeaders Media "20 People Who Make Healthcare Better-2012," and most recently was named one of "Crain's 100 Most Influential Women in Michigan."

Author of the acclaimed book, *Unconventional Leadership*, Schlichting is a highly regarded expert and accomplished speaker on strategic leadership, quality, patient/family-centered care, and diversity.

Schlichting received her A.B. in Public Policy Studies, Magna Cum Laude from Duke University and her M.B.A. from Cornell University. She has also been the recipient of honorary doctoral degrees from Walsh College, Eastern Michigan University and Central Michigan University.

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Delos M. (Toby) Cosgrove, MD, Vice Chairperson*Appointed by Speaker of the House John Boehner*

Toby Cosgrove, CEO of Cleveland Clinic, presides over a \$6.2 billion health care system comprising Cleveland Clinic, eight community hospitals, 16 family health and ambulatory surgery centers, Cleveland Clinic Florida, the Lou Ruvo Center for Brain Health in Las Vegas, Cleveland Clinic Toronto, and Cleveland Clinic Abu Dhabi. His leadership has emphasized patient care and patient experience, including the reorganization of clinical services into patient-centered, organ- and disease-based institutes. He launched major wellness initiatives for patients, employees, and communities. Under his leadership, Cleveland Clinic has consistently been named among America's top four hospitals by U.S. News & World Report and is one of only two hospitals named among America's 99 Most Ethical Companies by the Ethisphere Institute.

Cosgrove was a surgeon in the U.S. Air Force and served in Da Nang, Republic of Vietnam, as the chief of U.S. Air Force casualty staging flight. He received the Bronze Star and the Republic of Vietnam Commendation Medal.

He has published nearly 450 journal articles, book chapters, one book, and 17 training and continuing medical education films. He performed more than 22,000 operations and earned an international reputation for expertise in all areas of cardiac surgery, especially valve repair. As an innovator, Cosgrove has 30 patents filed for developing medical and clinical products used in surgical environments.

Cosgrove received his medical degree from the University of Virginia School of Medicine in Charlottesville, VA, and completed his clinical training at Massachusetts General Hospital, Boston Children's Hospital, and Brook General Hospital in London. He received a BA in biology from Williams College in Williamstown, MA.

Michael A. Blecker*Appointed by House Minority Leader Nancy Pelosi*

Michael Blecker has been associated with Swords to Plowshares since 1976 and has served as Executive Director since 1982. The agency was started in 1974 by returning Vietnam veterans and VISTA volunteers assigned to the VA regional office in San Francisco.

In the 1980s, when homelessness exploded, Swords to Plowshares started a transitional housing program with funding support from VA and the city and county of San Francisco. Swords to Plowshares continues to provide housing, employment, case management, and benefits advocacy for veterans from offices in San Francisco and Oakland. In 2005, the Iraq Vet Project (IVP) was established to help veterans of those wars and to shape policies affecting them. Recognizing Swords to Plowshares' long and effective history of challenging and shaping public policy with regard to veterans, in 2011, the IVP became known as the Institute for Veterans Policy.

Under Blecker's leadership, Swords to Plowshares' annual budget has grown from \$75,000 to nearly \$16 million. He has a nationwide reputation for dedicated service and as an authority on

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veterans' services and veterans' rights. He served on the Advisory Committee on Homeless Veterans (2002-2007), which advises the Secretary of Veterans Affairs. He is cofounder of both the National Coalition for Homeless Veterans and the California Association of Veterans' Service Agencies. He has served on the Congressional Commission on Service Members and Veterans Transition Assistance, the California Senate Commission on Homeless Veterans, the San Francisco Mayor's Homeless Planning Committee, the National Agent Orange Settlement Advisory Board, The Agent Orange Information Center, and the Veterans Speakers Alliance.

Blecker served in the U.S. Army as a combat infantryman in Vietnam in 1968-69 with the 101st Airborne Division, achieving the rank of E-5. He received an AB degree in criminology from University of California, Berkeley and a JD degree from New College of California Law School.

David P. Blom

Appointed by Speaker of the House John Boehner

David Blom has been instrumental in the development and growth of the OhioHealth system. He has served as president of OhioHealth's central Ohio hospitals – Grant Medical Center, Riverside Methodist Hospital, and Doctors Hospital – while also serving as executive vice president and chief operating officer of OhioHealth. He was named president and CEO of OhioHealth in March 2002. He has a track record of achievement with a solid understanding of complex issues facing health care delivery. He has expertise in leading strategic initiatives, managing and developing human capital, improving profitability, and improving quality of care and customer experience.

Blom maintains many professional and community affiliations, currently serving as a board member of the Voluntary Hospitals of America (VHA), a member and treasurer of Columbus' Downtown Development Corporation (CDDC), member of the Columbus Partnership, and member of the local World President's Organization (WPO). In 2001, he was named a Top 100 Business Leader by Smart Business and in 2012 CEO of the Year by Columbus CEO Magazine.

He received a BA from Ohio State University and an MA in health care administration from The George Washington University.

David W. Gorman

Appointed by President Barack Obama

David Gorman is a retired, combat-disabled veteran of the Vietnam War, who was appointed executive director of the Disabled American Veterans (DAV) National Service and Legislative Headquarters in Washington, DC in 1995. His responsibilities include oversight of the DAV National Service, Legislative, and Voluntary Service Programs. He is the organization's principal spokesperson before Congress, the White House, and the U.S. Department of Veterans Affairs.

Gorman entered the U.S. Army in 1969 and served with the 173rd Airborne Brigade, the famed "Sky Soldiers" of the Vietnam War. During a campaign to secure an area in Central Vietnam

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where U.S. forces suffered extremely high casualties, Mr. Gorman was severely wounded. His wounds required amputation of both legs.

Discharged from the Army in 1970, he immediately joined the DAV and is currently a life member of the DAV's National Amputation Chapter and DAV Chapter 39 in Greer, SC.

Gorman retired from his post executive director at the Washington Headquarters for Disabled American Veterans and now resides in Simpsonville, SC. Gorman attended Cape Cod Community College.

The Honorable Thomas E. Harvey, Esq.

Appointed by Senate Majority Leader Mitch McConnell

Thomas Harvey is a Vietnam combat veteran whose decorations include the Silver Star, the Purple Heart and 12 others for valor and service. In Vietnam, he spent a year as a company commander with the 173rd Airborne brigade and a year and a half as an advisor with the Vietnamese Airborne Division.

A lawyer by training, Harvey has spent much of his professional career working with veterans and issues of concern to them. He has served as Chief Counsel and Staff Director of the Senate Veterans Affairs Committee, Deputy Administrator of the Veterans Administration, and Assistant Secretary for Congressional Affairs of the Department of Veterans Affairs. Following 5 years with a major Wall Street law firm, Harvey came to Washington, DC, in 1977 as a White House fellow, serving as an assistant to ADM Stansfield Turner, then director of the Central Intelligence Agency. He has also served in the Department of Defense and as General Counsel and Congressional Liaison of the United States Information Agency. For 5 years, he was Senior Counselor of the Institute of International Education, which administers the Fulbright Program on behalf of the U.S. Department of State, as well as a number of other international educational exchange programs.

He currently serves on the boards of the Milbank Memorial Fund, the focus of which is public health policy, and of the Art Students League of New York, where he studies watercolor painting. He holds both BA and JD degrees from the University of Notre Dame and a LLM degree from the New York University School of Law.

Maj. Stewart M. Hickey, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Since 2011, Stewart Hickey has served as American Veterans (AMVETS) National Executive Director, operating the nation's fourth largest congressionally chartered veterans service organization and its subordinate organizations, and the daily advocacy of issues affecting veterans, national security, foreign affairs, and the economy.

Previously, Hickey was chief executive officer for the Hyndman (Pennsylvania) Area Health Center, a multisite community health center providing medical and dental services to several counties of Pennsylvania, West Virginia, and Maryland. His health care administration experience includes serving as chief human resources officer and chief operating officer of

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Western Maryland Hospital Center in Hagerstown, Maryland, a 123-bed Joint Commission on Accreditation of Healthcare Organizations accredited, long-term care and sub-acute hospital with rehabilitation, occupational therapy, physical therapy, and respiratory care.

Hickey enlisted in the U.S. Marine Corps Reserve in February 1977, in Cumberland, MD, as an infantryman, and transferred to platoon leaders class in the summer of 1978. He served in Operation Desert Storm and Desert Shield and was awarded a Bronze Star Medal with Combat "V" for his achievements as commanding officer, Company D, Third Tank Battalion, Task Force RIPPER, 1st Marine Division, I Marine Expeditionary Force, Saudi Arabia from September 1990 to February 1991. His military education includes the Basic School, Armor Officer Basic, Amphibious Warfare School, Armor Officer Advanced Course, and Marine Corps Command and Staff College.

Hickey resides on his family farm in Cumberland Valley Township in McConnellsburg, PA. He and his wife, Ellen, have five children: Monroe, Ali, Charles, Andrew, and Bryce. Three of his sons, Andrew, Monroe, and Charles, followed their father's path and currently serve in the U.S. military.

Hickey received a BA in history from Penn State University and an MA in management from Webster University.

Rear Adm. Joyce M. Johnson, DO, US PHS (ret.)

Appointed by President Barack Obama

Joyce Johnson is a physician with senior public health leadership experience in civilian and military sectors.

Johnson served in the U.S. Public Health Service (Rear Admiral, Upper Half). Her last active-duty assignment was with the U.S. Coast Guard as Director, Health and Safety ("surgeon general"). She managed the Coast Guard's health care system, including 150 sickbays and clinics, and coordinated both medical and behavioral health care for the beneficiary population. She also had responsibility for the Coast Guard's safety and work-life programs. She held a Top Secret security clearance.

Other government assignments included senior scientific and management positions with the Food and Drug Administration (pharmaceutical safety and post-market surveillance) and the Substance Abuse and Mental Health Services Administration. She has held clinical positions at the National Institute of Mental Health and the Department of Veterans Affairs. At the Centers for Disease Control and Prevention, she was an Epidemiologic Intelligence Service (EIS) Officer and staff epidemiologist in the Center for Infectious Disease.

In the private sector, Johnson served as vice president, health sciences and chief medical officer for a large research organization, where she managed a portfolio of government contracts, including laboratory and social sciences research, and held a top secret security clearance.

Johnson is an osteopathic physician board certified in psychiatry and public health/preventive medicine. She is also a certified clinical pharmacologist and certified addiction specialist. In

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addition to her medical degree, she earned a master's degree in hospital and health administration. She has been conferred six honorary doctoral degrees. She is a Distinguished Life Fellow of the American Psychiatric Association.

Johnson has extensive international health experience on all seven continents. She has particular interests in global mental health, health systems development, infectious disease, and disaster relief. She has led five Flag Expeditions with the Explorers Club. For more than a decade she has been a consultant to the National Science Foundation on the health care system in Antarctica.

Johnson recently coauthored the book, *Lizard Bites and Street Riots, Travel Emergencies and Your Health, Safety and Security*, and writes a monthly medical column. She is a Clinical Professor and Adjunct Professor at Georgetown University. She has served on expert committees including the Committee on Substance Abuse in the Military, National Academy of Medicine. She is active in numerous professional associations including the American Psychiatric Association, serving on the Committee on Psychiatric Dimensions of Disasters; the American Osteopathic Association, serving on the Bureau of International Osteopathic Medicine; and the Explorers Club, serving on the Medical Committee.

The Honorable Ikram U. Khan, MD

Appointed by Senate Minority Leader Harry Reid

Ikram Khan currently, he is president and 50-percent partner of Quality Care Consultants, LLC, founded in March 1992. The company provides consultant services in health care strategy and policy development for employers and other health care organizations. The company assists clients in development and implementation of wellness and disease-management programs. The company also develops quality improvement initiatives and techniques and assists in development and implementation of programs for cost-effective utilization of medical resources. Major emphasis is on clinical outcomes and data monitoring analysis.

Khan is a member the United States Institute of Peace (USIP) Board of Directors; he was nominated by President George Bush, and confirmed by the U.S. Senate on June 5, 2008. He is also currently a member of the Nevada Homeland Security Commission, having been appointed by the Governor of Nevada.

He was nominated by President Clinton and confirmed by the U.S. Senate to serve as member of The Board of Regents Uniformed Services University of Health Sciences, an advisory board to U.S. Secretary of Defense (1999-2006).

Khan also served as Special Advisor on Healthcare to Former Nevada Governor Gibbons, was a member of the Nevada Academy of Health (appointed by Nevada Governor Gibbons), and is a past member of the Nevada Academy of Health Sciences (appointed by Nevada Governor Kenny Guinn). He is past member of Nevada Governor's Commission for Medical Education, Research and Training and was a member of the Nevada State Board of Medical Examiners for eight years. Dr. Khan received "Special Congressional Recognition" for invaluable community service in 1994 and a Congressional citation—"U.S. Senate - Honoring Dr. Ikram Khan"—on April 25, 1994.

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Khan currently serves as member on the board of trustees at Sunrise Hospital Las Vegas-a 600 bed hospital. He has received recognition as “Most Influential Man in Southern Nevada” in 2000. He is also a recipient of a Las Vegas Chamber of Commerce community achievement award (October 1999), and a “Distinguished Community Service Award” from Anti-defamation League of B’nai B’rith (1994).

November 30, 1999 was declared “Dr. Ikram U. Khan Day” by the Governor of the State of Nevada, Mayor of Las Vegas, and the Board of Commissioners of Clark County.

During the course of his practice as General Surgeon, Khan has served in multiple leadership positions at various hospitals in Las Vegas.

Ikram Khan is president of quality Care Consultants LLC in Las Vegas Nevada. He received a doctor of medicine and surgery (MBBS) degree from University of Karachi, Pakistan.

Khan received a Doctor of Medicine and Surgery (MB, BS) in August 1972 from the University of Karachi, Pakistan. He completed post-graduate surgical residency in General Surgery in New York from 1974 through 1978, and practiced as a General Surgeon in Las Vegas through 2005.

Phillip J. Longman

Appointed by Senate Minority Leader Harry Reid

Phil Longman is a director at New America, a public policy institute. He is also a senior editor at the Washington Monthly and a lecturer at Johns Hopkins University, where he teaches a course in health care policy.

Longman has written extensively on issues related to health care delivery system reform, including in his book *Best Care Anywhere* (currently in its third edition). The book chronicles the quality transformation of the Veterans Health Administration during the 1990s and applies its lessons to the broader U.S. health care system.

Longman received a BA in philosophy from Oberlin College.

Col. Lucretia M. McClenney, USA (ret.)

Appointed by House Minority Leader Nancy Pelosi

Lucretia McClenney is a consultant with the Department of Defense Vietnam War Commemoration Office and Executive Coach with the Brookings Institute Executive Education Program. Previously she served as director of the Department of Veterans Affairs Center for Minority Veterans. As director, she served as the principal advisor to the Secretary of Veterans Affairs on policies and programs affecting minority veterans. Prior to her appointment, she served as special assistant to the assistant secretary for policy, planning, and preparedness, Department of Veterans Affairs (VA). She led the department’s emergency exercise planning, training, and evaluation program, and served as liaison to other government agencies. She has served on numerous working groups to include the congressionally mandated National Commission on VA Nursing, Task Force on Employment of Women at VA, and as the Secretary

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of Veterans Affairs' representative on the American Red Cross Board of Governors and Disaster and Chapter Services Committee.

Serving 30 years in the Army, McClenney retired as a colonel in November 2001. She served in various medical treatment facilities and on staffs worldwide serving as director, population health integration team, TRICARE management activity; chief nurse, European regional medical command and deputy commander for nursing, Landstuhl Regional Medical Command; deputy commander for nursing, Moncrief Army Community Hospital, Fort Jackson, South Carolina; assistant deputy for human resources, Office Of The Assistant Secretary Of The Army for Manpower and Reserve Affairs, the Pentagon; chief ambulatory nursing, Walter Reed Army Medical Center; senior policy analyst, Office of the Secretary of Defense (Health Affairs), The Pentagon; and member of the President's National Health Care Reform Task Force.

McClenney's military and civilian awards/decorations include the Legion of Merit (two oak leaf clusters), Defense Meritorious Service Medal, Meritorious Service Medal (seven oak leaf clusters), Army Commendation Medal (two oak leaf clusters), Navy Commendation Medal, Army Achievement Medal, Army Good Conduct Medal, the Army Staff Identification Badge, Office of the Secretary of Defense Staff Identification Badge, the coveted "9A" designator, in recognition of numerous achievements at the pinnacle of nursing excellence, and The Outstanding Civilian Service Medal for her significant contribution to the mission of the United States Army and Department of Defense in assisting with the production of the book, *For Children of Valor – Arlington National Cemetery*. Her professional affiliations include the Association of Military Surgeons of the United States, Sigma Theta Tau, National Nursing Honor Society, Alpha Kappa Alpha Sorority, Inc., Top Ladies of Distinction, Inc., The ROCKS, Inc., the Order of Military Medical Merit, Past President, Federal Health Care Executives Interagency Institute Alumni Association, and former Board Member of the Bon Secours Health Care System and Chair, Quality Committee.

She is a graduate of the Command and General Staff College and the United States Army War College Fellowship Program at George Washington University, Washington, DC. She is also a graduate of the Johnson & Johnson-Wharton's Fellows Program in Management for Nurse Executives, Wharton School of Business, University of Pennsylvania; Federal Health Care Executives Interagency Institute at George Washington University, Washington, DC; Leadership VA 2004; and Brookings Institute Executive Fellowship Program. She received a BSN from Murray State University and an MS in psychiatric/mental health nursing from Catholic University.

Capt. Darin S. Selnick, USAF (ret.)

Appointed by Speaker of the House John Boehner

Darin Selnick is an independent consultant who provides a variety of services to organizations in the areas of government and community relations, business development, and veterans' issues. He is currently the senior veterans affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He also volunteers his time as Chairman of the West Los Angeles Veterans Home Support Foundation and as the Vice President of Development for the GI Film Festival.

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From 2001–2009, Selnick was an appointee at the Department of Veteran Affairs. From 2004–2009 he served as the director of the center for faith-based and community initiatives. In this role he was responsible for the management and operations of the Center and was the VA liaison to the White House Office of faith-based and community initiatives. From 2001–2004 he served as Special Assistant to the Secretary and Associate Dean, VA Learning University. In this role he was responsible for providing program and operational oversight of VA Learning University.

Selnick is a retired Air Force officer who attained the rank of Captain. He has been very active in veterans' issues and joined the Jewish War Veterans in 1994. Since that time he has taken various leadership positions and is the past department commander of the Department of California. Mr. Selnick is also a member of the American Legion, AMVETS, Air Force Association, and National Association of Uniformed Services.

Darin Selnick currently serves as senior veterans' affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He lives in Oceanside, CA. Selnick is retired from the U.S. Air Force. He received a BS in health science from California State University, Northridge and an MA in political science/public management from Midwestern State University.

Lt. Gen. Martin Steele, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Martin Steele enlisted in the Marine Corps in January 1965 and rose from private to three-star general, culminating his military career in August 1999 as the deputy chief of staff for plans, policies, and operations at Headquarters, U.S. Marine Corps, in Washington, DC. A decorated combat veteran with 34½ years of service, he is a recognized expert in the integration of all elements of national power (diplomatic, economic, informational, and military) with strategic military war plans and has served as an executive strategic planner/policy director in multiple theaters across Asia. His extraordinary career was chronicled as one of three principals in the award winning military biography, *Boys of '67*, by Charles Jones.

Upon his retirement from active duty in 1999, he served as president and CEO of the Intrepid Sea-Air-Space Museum in New York City. Currently, Steele serves as The Associate Vice President for Veterans Partnerships, the Executive Director, Military Partnerships, and Co-chair of the Veterans Reintegration Steering Committee at the University of South Florida in Tampa, Florida. Additionally, Steele is the chairman and CEO of Steele Partners, Inc., a strategic advisory and leadership consulting company. He has led a philanthropic transition program assisting exiting Marines into private-sector jobs throughout the country, at no cost to the Marine participants, the Marine Corps, or the companies that provide employment opportunities.

Steele serves proudly on several boards across the country. He is currently the Chairman of the Board, Marine Corps Scholarship Foundation. He was appointed to the Board of Directors of Florida is for Veterans, Inc., a not for profit, state legislated organization designed to assist both Veterans and businesses throughout Florida in not only hiring Veterans but also developing entrepreneurship programs designed for veterans. He is a member of Fisher House Foundation;

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chairman of the advisory committee, Stability Institute; advisory committee member, Call of Duty Endowment; advisory board member, Stay in Step Foundation; advisory council member, Operation Helping Hand; member, Veterans Advantage; board member, University of Arkansas Veterans Resource and Information Center; and advisory committee member, Jesse Lewis Choose Love Movement.

Steele is a graduate of the University of Arkansas where he obtained a bachelor's degree in history and was recognized as a distinguished graduate of the Fulbright College of Arts and Sciences. He is a recipient of the 2013 Arkansas Alumni Award Citation of Distinguished Alumni, which recognizes exceptional professional and personal achievement and extraordinary distinction in a chosen field. He also holds master's degrees from Central Michigan University, Salve Regina College, and Naval War College.

Charlene M. Taylor

Appointed by House Minority Leader Nancy Pelosi

Charlene Taylor joined Kaiser Permanente in 1997 as the director of specialty services for the Permanente Medical Group at South Sacramento. In 2002 she became the service director for Kaiser Foundation Hospitals, responsible for perioperative and perinatal services at South Sacramento. In 2008, she was promoted to chief nursing officer at the Sacramento Medical Center where she was responsible for a 287-bed tertiary acute care hospital that conducted more than 11,000 operations per year. There, she oversaw 800 full-time employees and a budget of \$150 million. Taylor was promoted to chief operating officer in 2010 and retired from Kaiser Permanente in 2013.

Before working for Kaiser Permanente, Taylor served as assistant hospital administrator for Sutter Health at the Sutter Amador Hospital from 1988 to 1997. She is a member of the Veterans of Foreign Wars, Reserve Officers Association, and the Society of Air Force Nurses.

Taylor's patriotic and adventurous nature led her to join the Air Force as a reserve officer at the age of 40, rising to the rank of Lieutenant Colonel. She was commissioned as a Captain in the United States Air Force (Reserve Command) in October 1993, earning her flight nurse wings in 1994. She subsequently was selected to be a flight nurse instructor followed by a promotion to evaluator status. Her last squadron assignment was that of chief nurse at the 349 AMDS, Travis Air Force Base.

In addition to years of experience conducting aeromedical evacuation missions throughout the world, Taylor was activated in support of Operation Enduring Freedom from March 2003 to March 2004. In January 2005 she was selected to be the chief nurse of the 379th Expeditionary Aeromedical Squadron in support of Operation Iraqi Freedom. While transporting the injured out of Mosul, Iraq in a C-130, the aircraft took enemy fire, landing without casualties. Due to the demands of her civilian position, Taylor transferred to inactive status in the Air Force Reserve Command. Taylor is the recipient of two Meritorious Service medals, Expert Marksmanship (2), and multiple other medals.

Taylor currently serves on the Veterans Board. In 2012 she was appointed to the Board by Gov. Jerry Brown and approved by the Senate. She became chair in 2014 and continues to serve

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in that role. The California Veterans Board serves as an advocate for veterans affairs, identifying needs and working to ensure and enhance the rights and benefits of California veterans and their dependents.

Taylor is a diploma nurse graduate from the Kaiser Foundation School of Nursing. She continued her education receiving a BSN from the State University of New York in Albany, New York. She earned a master's degree in nursing administration from the University of California, San Francisco.

Taylor lives in Elk Grove, CA.

Marshall W. Webster, MD

Appointed by Senate Minority Leader Harry Reid

Marshall Webster is a senior vice president of the University of Pittsburgh Medical Center (UPMC), and a distinguished service professor of surgery at the University of Pittsburgh. A graduate of Penn State University and the Johns Hopkins Medical School, he trained in surgery at the University of Pittsburgh, and subsequently served 2 years as a surgeon on active duty in the U.S. Navy.

Webster returned to the University of Pittsburgh as a faculty vascular surgeon, including initially, a part-time attending staff position at the Pittsburgh VA Medical Center for 3 years. He has held the Mark M. Ravitch Chair in Surgery, and has had a long academic career of clinical practice, research, and service in varied administrative leadership roles. From 2002–2012, he was an executive vice president of UPMC, president of UPMC's physician services division, and president of the University of Pittsburgh Physicians, the clinical practice plan of the university faculty.

His current focus is primarily strategic development: building clinical relationships and care models throughout the region with a large number of community hospitals and providers. Webster has oversight of UPMC's graduate medical education program, which sponsors a substantial number of resident rotations at the Pittsburgh VA Medical Center. He recently served for 2 years as the interim chair of the Department of Anesthesiology at UPMC. He has had a long-standing interest in patient safety and quality initiatives, and recently completed a 6-year term on the board of the Pennsylvania Patient Safety Authority.

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APPENDIX K: COMMISSION STAFF

Susan M. Webman, Esq.
Executive Director

Michael Bargmann.....	Program Analyst
Robert Burke, PhD	Program Analyst
Donald Cicotte.....	Program Analyst
Pauline Cilladi-Rehrer	DFO
John Clinton	Staff Assistant
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Christopher Danns	Program Analyst
Stephen Dillard.....	Program Analyst, ADFO
Susan Edgerton.....	Program Analyst
Beth Engiles.....	Program Analyst
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Wilmya Goldsberry	Program Analyst
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Jamie Taber, PhD.....	Program Analyst
SaKeithia Taylor	Staff Assistant
Linda (Yvonne) Williams	Staff Assistant

DFO – Designated Federal Officer

ADFO – Assistant Designated Federal Officer

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APPENDIX L: ACRONYM LIST

ACRONYM	DEFINITION
ACA	Affordable Care Act
ACHE	American College of Healthcare Executives
APRN	Advanced Practice Registered Nurse
BRAC	Base Realignment and Closure
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARES	Capital Asset Realignment for Enhanced Services
CDS	Community Delivered Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CITC	Care in the Community
CMD	Chief Medical Director
CMIO	Chief Medical Information Officer
CMOP	Consolidated Mail Outpatient Pharmacy
COTS	Commercial Off-The-Shelf
CPRC	Clinical Product Review Committee
CPRS	Computerized Patient Record System
CVA	Concerned Veterans for America
CVCS	Chief of VHA Care System
DAV	Disabled American Veterans
DEPSECVA	Deputy Secretary, Department of Veterans Affairs
DHP	Digital Health Platform
DM&S	Department of Medicine and Surgery
DoD	Department of Defense
DUSH	Deputy Under Secretary for Health
ECF	Executive Career Fields
EES	Employee Education System
EEO	Equal Employment Opportunity

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ACRONYM	DEFINITION
EHCPM	Enrollee Health Care Projection Model
eHMP	Enterprise Health Management Platform
EHR	Electronic Health Record
FFS	Fee-for-Service
FY	Fiscal Year
GAO	Government Accountability Office
GHATP	Graduate Health Administration Training Program
GUI	Graphic User Interface
HCD	Human-Centered Design
HEC	Healthcare Executive Council
HPDM	High Performance Development Model
HR	Human Resources
HRA	Human Resources and Administration
HSC	Health Service Category
HTM	Healthcare Talent Management
IAVA	Iraq and Afghanistan Veterans of America
IDIQ	Indefinite Delivery/Indefinite Quantity
IDN	Integrated Delivery Network
IDP	Individual Development Plan
IT	Information Technology
JC	Joint Commission
JEC	Joint Executive Committee
JLV	Joint Legacy Viewer
MSA	Medical Support Assistant
MTF	Military Treatment Facility
NAS	National Academy of Sciences
NCEHC	National Center for Ethics in Health Care
NCOD	National Center for Organization Development
NLC	National Leadership Council
NVTC	Northern Virginia Technology Council
OAA	Office of Academic Affiliations

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APPENDIX L
ACRONYM LIST

ACRONYM	DEFINITION
OEF	Operation Enduring Freedom
OGC	Office of General Counsel
OI&T	Office of Information and Technology
OIF	Operation Iraqi Freedom
OMB	Office of Management and Budget
ONC	Office of the National Coordinator
OND	Operation New Dawn
OPM	Office of Personnel Management
OTH	Other Than Honorable (Discharge)
PACT	Patient Aligned Care Team
PC3	Patient-Centered Community Care
PG	Priority Group
PHS	U.S. Public Health Service
PO	Program Office
PTSD	Posttraumatic Stress Disorder
QUERI	Quality Enhancement Research Initiative
RCLF	Relevant Civilian Labor Force
RIF	Reduction in Force
SCI	Spinal Cord Injury
SECVA	Secretary, Department of Veterans Affairs
SE	Senior Executive
SES	Senior Executive Service
SHEP	Survey of Healthcare Experiences of Patients
TBI	Traumatic Brain Injury
TMS	Talent Management System
USH	Under Secretary for Health
VA	U.S. Department of Veterans Affairs
VACAA	Veterans Access, Choice, and Accountability Act of 2014
VACI	VA Center for Innovation
VACO	VA Central Office
VAEB	VA Executive Board

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ACRONYM	DEFINITION
VAMC	VA Medical Center
VERC	Veterans Engineering Resource Center
VFW	Veterans of Foreign Wars of the U.S.
VHA	Veterans Health Administration
VHACO	VHA Central Office
VISN	Veterans Integrated Service Network
VSO	Veterans Service Organization
WWP	Wounded Warrior Project



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United States General Accounting Office

Testimony

Before the Committee on Veterans' Affairs, U.S. Senate

For Release on Delivery
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Wednesday, March 20, 1996

VA HEALTH CARE

Approaches for Developing Budget-Neutral Eligibility Reform

Statement of David P. Baine, Director
Health Care Delivery and Quality Issues
Health, Education, and Human Services Division



VA-18-0457-A-002637

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss proposals to reform eligibility for Department of Veterans Affairs (VA) health care benefits. Eligibility reform would present a significant challenge even with unlimited resources. But with the Congress and VA facing increasing pressures to limit VA health care spending as part of governmentwide efforts to reduce the budget deficit, this challenge has become even greater.

Over the past several years, we have conducted a series of reviews that have detailed problems in the administration of VA's outpatient eligibility provisions, compared VA benefits and eligibility with those of other public and private health benefits programs, and assessed VA's role in a changing health care marketplace. My comments this morning are based primarily on the results of those reviews and ongoing work for this Committee.¹

Specifically, we will discuss

- the problems VA's current eligibility and contracting provisions create for veterans and providers,
- the relationship between inappropriate admissions to VA hospitals and VA eligibility provisions,
- legislative proposals to reform VA eligibility and contracting rules and their potential impact on the deficit, and
- options for achieving budget-neutral eligibility reform.

Summary

In summary, VA health care has gradually evolved from a system primarily providing hospital care to veterans injured during wartime service to a system increasingly focused on the treatment of low-income veterans with medical conditions unrelated to military service. For most veterans, eligibility for veterans' health benefits is still limited primarily to hospital-related care.

Budget-neutral reforms of VA eligibility provisions could enable VA to function more like a private insurer and provider. Unlike private insurance, VA does not have a well-defined, uniform benefit package and does not guarantee the availability of covered services. In addition, a VA facility is not allowed to provide a noncovered service even if it has the resources to provide the care and the veteran is willing to pay for it. This often places VA physicians in the position of having to either (1) ignore the

¹A list of related GAO products is in app. II.

law and provide noncovered services for free or (2) turn away veterans even though VA may have the space and resources to provide the needed health care services.

Generally, VA's current eligibility provisions create uneven and uncertain access to VA health care and limit VA's ability to meet veterans' health care needs. Veterans with similar medical needs, service status, and incomes may get treated or turned away depending on what type of care they seek and where and when they seek care. This frustrates veterans, who cannot understand what services they can get from VA, and VA physicians and administrative staff, who have to interpret the subjective eligibility provisions.

During the past year, four major bills were introduced to reform VA eligibility. These bills would eliminate the current restrictions on veterans' eligibility for outpatient care, essentially making all 26.4 million veterans eligible for comprehensive outpatient care, whereas fewer than 1 million are currently eligible. In addition, the bills would increase the number of veterans in the mandatory category for comprehensive outpatient care (that is, the category for which the law says VA "shall" or "must" provide covered services) from 465,000 to between 9 million and 11 million. The bills generally would not address most of the other problems with current VA eligibility provisions, such as the lack of guaranteed funding.

Although we support the need for reform, we do not believe any of the four major eligibility reform proposals achieves budget neutrality. For example, making all 26.4 million veterans eligible for comprehensive outpatient care would likely generate significant new demand for both outpatient and inpatient care. These increases are likely to come both from VA users previously unable to obtain all of their health care services from VA and from veterans seeking care from VA for the first time.

In addition, the synergistic effects of other needed changes in the VA health care system will likely heighten the effects of eligibility expansions on future demand for care. For example, VA's plans to make its health care more accessible to veterans will probably generate new demands for care. Generally, when VA opens a new outpatient clinic, a large proportion of the users are new to the VA system. In addition, current VA users living near the new clinic tend to use VA services more often. Similarly, actions taken to improve customer service, such as installation of bedside telephones, reducing waiting times, and establishing primary care teams, will likely attract new users.

Nine out of 10 veterans have other public or private insurance that they typically use to purchase care from private sector providers. As a result, changes in the VA system to expand benefits, improve accessibility, and improve customer service will put VA in more direct competition with private sector providers and insurers. Because the proposed eligibility expansions would offer 9 million to 11 million veterans comprehensive free care, VA could gain a strong competitive advantage over private sector providers.

Because the bills would not provide for major new sources of revenue to help pay for the expanded services, their enactment would place considerable pressure on the Congress to appropriate additional funds to meet the increased demand. It would be particularly problematic for the Congress not to appropriate funds to meet the health care demands of the large group of veterans who would be added to the mandatory category for comprehensive outpatient care.

VA and the Congressional Budget Office (CBO) have arrived at starkly different assessments of the potential budgetary impact of the proposal included in the House of Representatives' budget reconciliation package last year. VA concluded that the bill would be budget neutral and might save \$268 million a year.² By contrast, CBO estimated that the bill could add \$3 billion or more to the deficit.

We find CBO's arguments more compelling for two principal reasons. First, CBO's estimate predicts that significant increases in demand for outpatient care would likely result from enactment of the bill, whereas VA estimates no increase. Second, VA's cost analysis is sensitive to a series of assumptions. Changing the assumptions can quickly turn a potential savings into a potential cost increase. For example, VA assumed that it would divert 20 percent of hospital patients to outpatient care through eligibility reform and that 7 days of hospital care would be avoided for every patient diverted. One to 3 days seems a more likely length of stay for patients who do not need a hospital level of care but are admitted to VA hospitals just to provide them services they are not eligible to receive as outpatients. Avoiding an average of 3 days of hospital care, rather than 7, would turn a claimed savings of \$268 million into a cost increase of \$167 million under VA's formula.

In addition, VA has provided little evidence to support its assumption that eligibility reform would enable it to divert 20 percent of its hospital

²The eligibility reform provisions were later dropped during the House and Senate Conference.

patients to outpatient clinics. In fact, studies done by VA and others show little evidence to link nonacute admissions to problems with VA eligibility provisions. Generally, nonacute admissions result from conservative physician practices and the lack of outpatient care capabilities. Unlike the private sector, where insurers often require policyholders to obtain approval from an external reviewer before they are admitted to hospitals, VA has no preadmission certification program. While hundreds of millions of dollars may be saved by reducing inappropriate admissions to VA hospitals, we believe that such savings should not be “spent” before administrative actions, such as establishment of an external preadmission certification program, are in place to ensure that nonacute admissions are, in fact, reduced.

Although the current proposals are not budget neutral, many approaches could be used to help design budget-neutral eligibility reform. These approaches include

- increasing veterans’ cost sharing or allowing VA to sell noncovered services to veterans;
- establishing uniform, but more limited, benefit packages; and
- expanding eligibility for some veterans but reducing or eliminating eligibility for others.

Through the use of a combination of these approaches, we believe budget-neutral eligibility reform can and should be developed.

Background

For fiscal year 1996, VA sought an appropriation of about \$17 billion to maintain and operate 173 hospitals, 376 outpatient clinics, 136 nursing homes, and 39 domiciliaries. VA facilities are expected to provide inpatient hospital care to 930,000 patients, nursing home care to 35,000 patients, and domiciliary care to 18,700 patients. In addition, VA outpatient clinics are expected to handle 25.3 million outpatient visits. The Congressional Budget Resolution, however, would essentially freeze the VA medical care appropriation at the fiscal year 1995 spending level—\$16.2 billion—for the next 7 years. Final action on VA’s fiscal year 1996 appropriation is pending.

The VA health care system consists of (1) a health benefits program and (2) a health care delivery program. The two programs are closely intertwined. For example, VA outpatient clinics are not allowed to use available resources to provide services to many veterans because (1) the services, such as prosthetics, are not covered under the veterans’ health

care benefits and (2) the clinics are not permitted under the law to sell such noncovered services to veterans.

In administering the veterans' health benefits program, VA's responsibilities are similar to those of the Health Care Financing Administration (HCFA) in administering Medicare benefits and to those of private health insurance companies in administering health insurance policies. For example, VA is responsible for determining (1) which benefits veterans are eligible to receive, (2) whether and how much veterans must contribute toward the cost of their care, (3) whether the health care services veterans need are covered under their benefits, and (4) where veterans obtain covered services (that is, whether they must use VA-operated facilities or can obtain needed services from other providers at VA expense). Similarly, VA, like HCFA and private insurers, is responsible for ensuring that the health benefits provided to its "policyholders"—veterans—are (1) medically necessary and (2) provided in the most appropriate care setting (such as a hospital, nursing home, or outpatient clinic).

In operating a health care delivery program, VA's role is similar to that of the major private sector health care delivery networks, such as those operated by Columbia/Hospital Corporation of America and Humana. For example, VA strives to ensure that its facilities (1) provide care of an acceptable quality, (2) are used to their optimum capacity, (3) are located where they are accessible to its target population, (4) provide good customer service, (5) offer potential patients services and amenities comparable to competing facilities, and (6) operate effective billing and collection systems.

Significant Changes Occurring in the Veteran Population

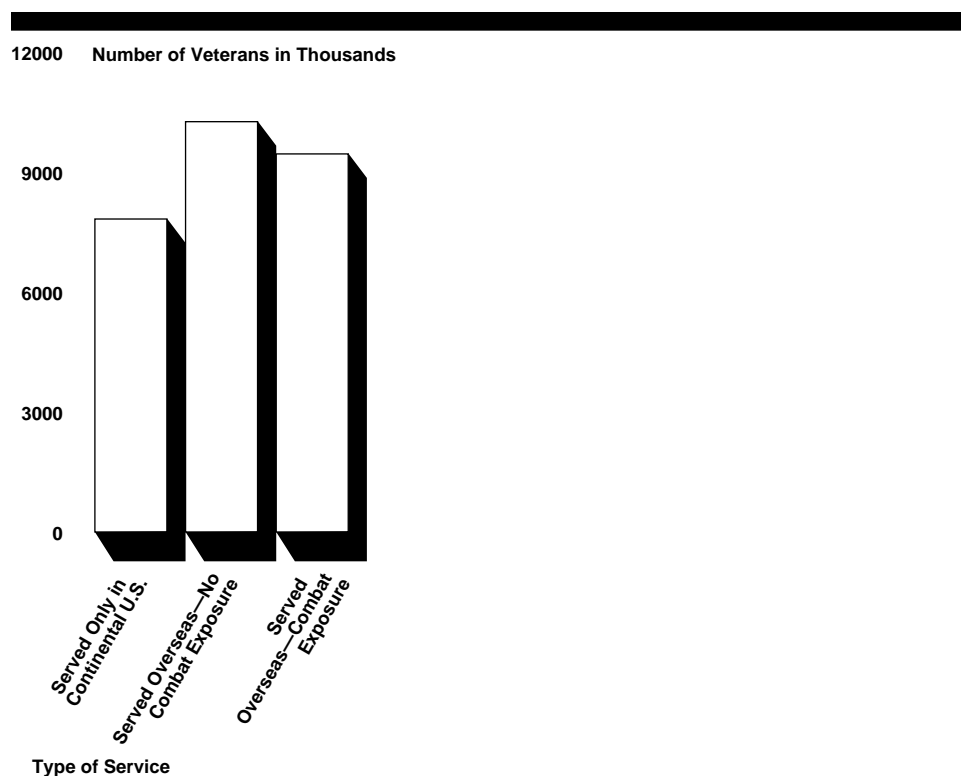
The veteran population, which totaled about 26.4 million in 1995, is both declining and aging. Between 1990 and 2010, VA projects the veteran population will decline 26 percent. The decline will be most notable among veterans under 65 years of age—from about 20.0 million to 11.5 million. By contrast, the number of veterans aged 85 and older will increase more than eight-fold. At that time, veterans aged 85 and older will make up about 6 percent of the veteran population.

Coinciding with the overall decline in the number of veterans is a decline in the percentage of veterans who served during wartime. VA projects the total number of wartime veterans to decline from 21 million in 1990 to 13.6 million in 2010. Even more dramatic is the shift in the number of wartime veterans by period of service. By 1995, deaths of World War II

veterans had accelerated to the point that Vietnam-era veterans outnumbered World War II veterans by about 826,000. By 2010, Persian Gulf veterans are expected to outnumber both Korean War and World War II veterans.

Most veterans who served during wartime had no combat exposure. About 35 percent of U.S. veterans were actually exposed to combat. (See fig. 1.)

Figure 1: Combat Exposure of Veterans, 1992

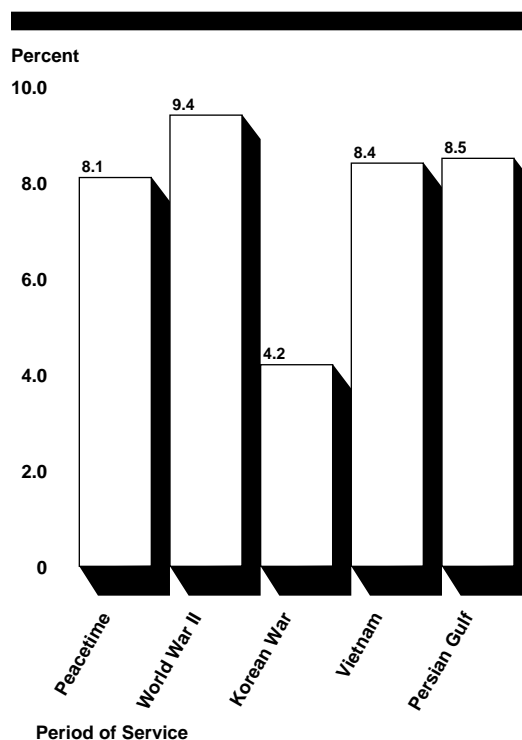


Source: Based on data from VA's National Survey of Veterans (Washington, D.C.: National Center for Veteran Analysis and Statistics, VA, 1995).

About 8.3 percent of veterans have compensable service-connected disabilities. Surprisingly, veterans who served during peacetime are almost twice as likely to have service-connected disabilities as veterans of the

Korean War and only slightly less likely to have service-connected disabilities than Vietnam-era veterans. (See fig. 2.)

Figure 2: Veterans With Service-Connected Disabilities, by Period of Service, 1994



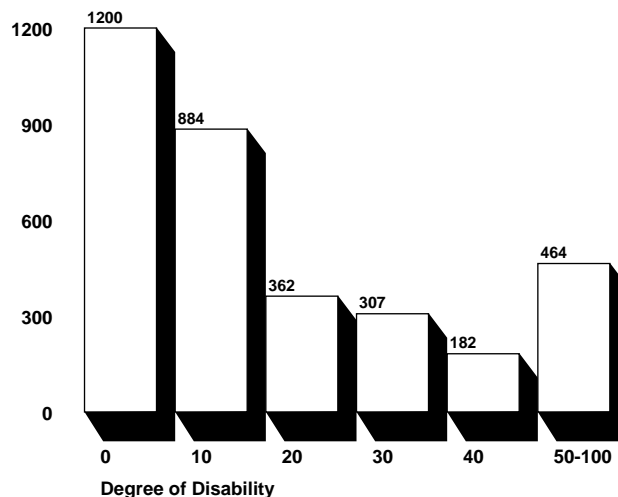
Source: Data are from the Annual Report of the Secretary of Veterans Affairs, Fiscal Year 1994 (Washington, D.C.: 1995).

Of the more than 2.2 million veterans with compensable service-connected disabilities, over half have disability ratings of 10 or 20 percent. Of the remaining veterans with service-connected disabilities, about 488,000 had disabilities rated at 30 or 40 percent.³ (See fig. 3.)

³A service-connected disability is one that results from an injury or disease or other physical or mental impairment incurred or aggravated during military service. VA determines whether veterans have service-connected disabilities and, for those with such disabilities, assigns ratings of from 0 to 100 on the basis of the severity of the disability. These ratings form the basis for determining both the amount of compensation paid to the veterans and the types of health care services for which they are eligible.

Figure 3: Veterans With Service-Connected Disability Ratings, by Degree of Disability, 1994

1500 Number of Veterans in Thousands



Note: Numbers include an estimated 1.2 million veterans with noncompensable service-connected disabilities.

Source: Data are from the Annual Report of the Secretary of Veterans Affairs, Fiscal Year 1994.

Eligibility for VA Health Care Benefits

Any person who served on active duty in the uniformed services for the minimum amount of time specified by law and who was discharged, released, or retired under other than dishonorable conditions is currently eligible for VA health care benefits. Although all veterans meeting the basic requirements are “eligible” for hospital, nursing home, and at least some outpatient care, the VA law establishes a complex priority system—based on such factors as the presence and extent of any service-connected disability, the incomes of veterans with nonservice-connected disabilities, and the type and purpose of care needed—to determine which services are covered and which veterans receive care within available resources.

The distinction between covered and noncovered services in discussing veterans’ health benefits is important because VA facilities are generally restricted to providing “covered” services to veterans. As a result, VA facilities are not allowed to provide other services directly to veterans or

others even if they have the capacity to provide the services and the patient agrees to pay for them.⁴

Certain veterans, commonly referred to as Category A, or mandatory care category, veterans, have the highest priority for hospital and nursing home care. More specifically, VA must provide hospital care, and, if space and resources are available, may provide nursing home care to veterans who

- have service-connected disabilities,
- were discharged from the military for disabilities that were incurred or aggravated in the line of duty,
- are former prisoners of war,
- were exposed to toxic substances or ionizing radiation,
- served in the Mexican Border Period or World War I,
- receive disability compensation,
- receive nonservice-connected disability pension benefits, and
- have incomes below the means test threshold (as of January 1995, \$20,469 for a single veteran or \$24,565 for a veteran with one dependent, plus \$1,368 for each additional dependent).

For higher-income veterans who do not qualify under these conditions, VA may provide hospital and nursing home care if space and resources are available. These veterans, commonly known as Category C, or discretionary care category, veterans, must pay a part of the cost of the care they receive.

VA also provides three basic levels of outpatient care benefits:

- comprehensive care, which includes all services needed to treat any medical condition;
- service-connected care, which is limited to treating conditions related to a service-connected disability; and
- hospital-related care, which provides only the outpatient services needed to (1) prepare for a hospital admission, (2) obviate the need for a hospital admission, or (3) complete treatment begun during a hospital stay.

Separate mandatory and discretionary categories apply to outpatient care. Only veterans with service-connected disabilities rated at 50 percent or higher (about 465,000 veterans) are in the mandatory category for comprehensive outpatient care. All veterans with service-connected

⁴Studies by the VA Office of Inspector General indicate that about 56 percent of the discretionary care outpatient visits VA facilities provide are for noncovered services that the veterans were not eligible to receive.

disabilities are in the mandatory care category for treatments related to their disabilities; they are also eligible for hospital-related care of nonservice-connected conditions, but, with the exception of veterans with disabilities rated at 30 or 40 percent, they are in the discretionary care category. Most veterans with no service-connected disabilities are eligible only for hospital-related outpatient care and, with few exceptions, are in the discretionary care category.

Table 1 summarizes VA eligibility provisions.

Table 1: Mandatory and Discretionary VA Health Care Benefits

Veteran category	Hospital care	Outpatient care	Nursing home care
Service-connected disabilities rated 50-100%, for any condition	Mandatory	Mandatory	Discretionary
Service-connected disabilities rated 0-40%, for a service-connected condition	Mandatory	Mandatory	Discretionary
Discharged for disability	Mandatory	Mandatory	Discretionary
Service-connected disabilities rated 30-40%, for a nonservice-connected condition	Mandatory	Mandatory, limited to hospital-related care	Discretionary
Pensioner or has income under \$12,855	Mandatory	Mandatory, limited to hospital-related care	Discretionary
Injured in VA	Mandatory	Mandatory, limited to hospital-related care	Discretionary
Prisoner of war	Mandatory	Discretionary	Discretionary
World War I or Mexican Border Period veteran	Mandatory	Discretionary	Discretionary
Pensioner receiving aid and attendance payments	Mandatory	Discretionary	Discretionary
Service-connected disabilities rated 0-20%, for a nonservice-connected condition	Mandatory	Discretionary, limited to hospital-related care	Discretionary
Nonservice-connected, with an income of \$12,855-\$20,470 (no dependents)	Mandatory	Discretionary, limited to hospital-related care	Discretionary
Exposed to Agent Orange or radiation, or Medicaid-eligible	Mandatory	Discretionary, limited to hospital-related care	Discretionary
Nonservice-connected with income over \$20,470	Discretionary, with copayment	Discretionary, with copayment, limited to hospital-related care	Discretionary, with copayment

Source: Based on data from Independent Budget for Department of Veterans Affairs, Fiscal Year 1996, prepared by the major veterans' service organizations.

Eligibility for VA Health Care Has Evolved

Eligibility for VA health care has undergone a gradual evolution since the 1930 establishment of VA. Initially, the only veterans eligible for VA health

care were those (1) with injuries incurred during wartime service or (2) incapable of earning a living because of a permanent disability, tuberculosis, or neuropsychiatric disability suffered after their wartime service.

Originally, eligibility was for hospital and domiciliary care only. Eligibility for hospital care was later expanded to include veterans injured during other than combat duty and subsequently to all veterans without service-connected disabilities.

When outpatient care was added to the VA system, eligibility was initially limited to veterans with service-connected disabilities. It was not until 1960 that VA was first authorized to treat veterans with nonservice-connected disabilities on an outpatient basis. In that year, P.L. 86-639 authorized outpatient treatment for a nonservice-connected disability in preparation for, or to complete treatment of, hospital care. So concerned was the then Administrator of Veterans Affairs about the potential implications of this change that he wrote:

“The possible adverse effects of the proposed legislation should also, I believe, be considered. This bill would for the first time mean that non-service-connected veterans would be receiving outpatient treatment even though we have endeavored to make revisions which would relate this only to hospital care. The outpatient treatment of the non-service-connected might be an opening wedge to a further extension of this type of medical treatment.”

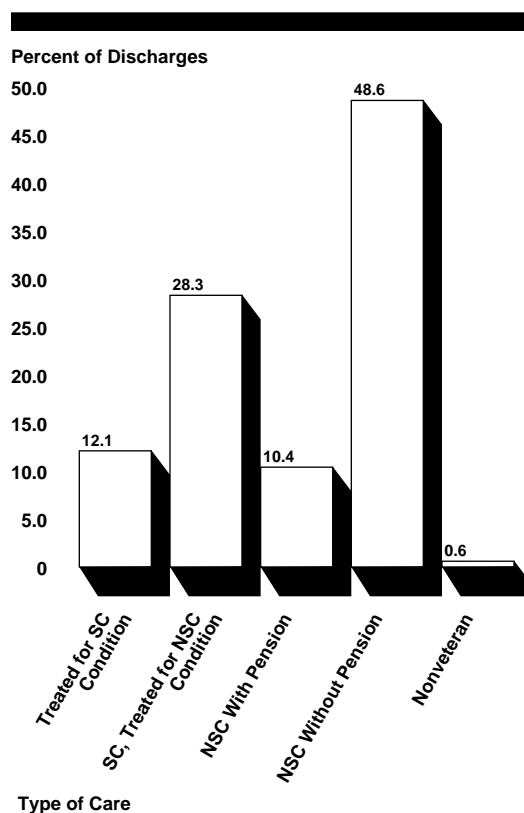
Thirteen years later, the Veterans Health Care Expansion Act of 1973 (P.L. 93-82) further extended outpatient treatment for veterans with nonservice-connected disabilities, authorizing outpatient treatment for any disability to “obviate the need of hospital admission.” Although there have been a number of further revisions to outpatient eligibility since 1973, most veterans’ eligibility for ambulatory care services continues to be restricted to hospital-related care.

VA System Increasingly Focuses on Veterans With No Service-Connected Disabilities

With the gradual evolution of VA eligibility, the VA system now provides a wide range of inpatient, outpatient, and long-term care services to veterans both with and without service-connected disabilities. VA has gradually shifted from a system primarily providing treatment for veterans with service-connected disabilities incurred in wartime to a system increasingly focused on the treatment of low-income veterans with medical conditions unrelated to military service. For example, in fiscal year 1995, only about

12 percent of VA hospital patients were treated for service-connected disabilities. By contrast, about 59 percent of the patients treated had no service-connected disabilities. (See fig. 4.)

Figure 4: VA Hospital Users by Purpose of Treatment, FY 1995



Note: SC = service connected; NSC = nonservice connected.

Source: Data are from draft tables prepared for VA's Annual Report of the Secretary of Veterans Affairs, Fiscal Year 1995, expected to be issued in April 1996.

VA Options as a Health Care Provider Are Limited

VA has limited authority to (1) buy health care services from non-VA providers and (2) sell health care services either to veterans or others. Generally, veterans can use their health benefits only in VA-operated health care facilities. There are several exceptions that allow VA to purchase care from non-VA providers:

- VA-operated nursing home and domiciliary care is augmented by contracts with community nursing homes and by per diem payments for veterans in state-operated veterans' homes.
- VA pays private sector physicians and other health care providers to provide services to certain veterans when the services needed are unavailable within the VA system or when the veterans live too far from a VA facility (commonly referred to as fee-basis care). The authorization to use fee-basis physicians is primarily limited to service-connected veterans.
- VA pays for hospitalization in non-VA facilities in medical emergencies. Patients are expected to transfer to VA hospitals when their conditions stabilize.
- Veterans treated in VA facilities can be provided scarce medical specialist services from other public and private providers through sharing agreements and contracts between VA and non-VA providers.
- VA hospitals have limited authority to contract with other providers for specialized medical resources, including equipment, personnel, or techniques, that because of costs, limited availability, or unusual nature are unique in the medical community.

Similarly, as a health care provider, VA can sell health care services only on an exception basis. Specifically, VA hospitals and outpatient clinics can sell

- health care services to the Department of Defense (DOD) and other federal health care facilities and
- specialized medical resources to nonfederal hospitals, clinics, and medical schools.⁵

VA cannot, however, sell health care services directly to either veterans or nonveterans.

VA Eligibility Provisions Frustrate Veterans and Limit VA's Ability to Meet Veterans' Health Care Needs

Unlike public and private health insurance, the VA health benefits program does not (1) have a well-defined benefit package or (2) entitle veterans to, or guarantee the availability of, covered services. Similarly, as a health care provider, VA, unlike private sector providers, is severely limited in its ability to both buy health care services from and sell health care services to individuals and other providers. These differences help make VA's eligibility provisions a source of frustration for veterans, VA physicians, and VA's administrative staff. The problems created by these provisions include the following:

⁵Medical resources can be sold to DOD and the private sector only if the sale does not adversely affect health care services available to veterans.

- Veterans are often uncertain about what services they are eligible to receive and what right they have to demand that VA provide them.
- Physicians and administrative staff find the eligibility provisions hard to administer.
- Veterans have uneven access to care because the availability of covered services is not guaranteed.
- Physicians are put in the untenable position of having to deny needed, but noncovered, health care services to veterans.

Because of these problems, veterans may be unable to consistently obtain needed health care services from VA facilities.

Veterans Are Uncertain About What Services Are Covered

Because public and private insurance policies generally have a defined benefit package, both policyholders and providers know in advance what services are covered and what, if any, limitations apply to the availability of services. Defined benefit packages also preserve insurers' flexibility in responding to funding constraints by allowing them to adjust covered benefits on the basis of funds available. An insurer might offer multiple policies with varying benefits, but individuals with the same policy have the same benefits.

Like private insurance, VA essentially offers multiple health benefit "policies" with varying benefits. Unlike private insurance, however, veterans with the same "policy" will not necessarily receive the same services. Only those veterans whose "policy" covers all medically necessary care—primarily those veterans with service-connected disabilities rated at 50 percent or more—have clearly defined, uniform benefits. Because coverage of outpatient services for most veterans varies on the basis of their medical conditions, a veteran may be eligible to receive different services at different times. For example, if a veteran with no service-connected disabilities is scheduled for admission to a VA hospital for elective surgery, he or she is eligible to receive any outpatient service needed to prepare for the hospital admission, including a physical examination with X rays and blood tests. However, if the same veteran sought a routine physical examination from a VA outpatient clinic, he or she would not be eligible for an examination, X rays, or blood tests because there is no apparent need for hospital-related care.

Because of the lack of a well-defined benefit package, veterans are often confused by VA's complex eligibility provisions. The services they can get from VA depend on such factors as the presence and extent of any

service-connected disability, income, period of service, and the seriousness of the condition. To further add to veterans' confusion about which health care services they are eligible to receive from VA, title 38 of the U.S. Code specifies the types of medical services that cannot be provided on an outpatient basis. For example, VA outpatient clinics cannot provide

- prosthetic devices, such as wheelchairs, crutches, eyeglasses, and hearing aids, to veterans not eligible for comprehensive outpatient services;
- dental care to most veterans unless they were examined and had their treatments started while in a VA hospital; and
- routine prenatal care and delivery services through the VA health care system.

Outpatient Eligibility Requirements Are Difficult to Administer

Veterans are not the only ones confused by VA eligibility provisions. Those tasked with applying and enforcing the provisions daily—VA physicians and administrative staff—express similar frustration in attempting to interpret the provisions. Although the criterion to obviate the need for hospitalization is most often cited as the primary source of frustration, VA administrative staff must also enforce a series of other requirements, which add administrative costs not typically incurred under other public or private insurance programs.

VA has broadly defined the statutory eligibility criterion relating to obviating the need for hospitalization. Guidance to medical centers says that eligibility determinations

“shall be based on the physician’s judgment that the medical services to be provided are necessary to evaluate or treat a disability that would normally require hospital admission, or which, if untreated would reasonably be expected to require hospital care in the immediate future.”

To assess medical centers’ implementation of this criterion, we used medical profiles of six veterans developed from actual medical records and presented them to 19 medical centers for eligibility determinations.⁶ At these 19 centers, interpretations of the criterion ranged from permissive (care for any medical condition) to restrictive (care only for certain medical conditions). In other words, from the veteran’s perspective, access to VA care will depend greatly on which medical center he or she

⁶VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 16, 1993).

visits. For example, if one veteran we profiled had visited all 19 medical centers, he would have been determined eligible by 10 centers but ineligible by 9 others.

Officials at VA's headquarters and medical centers agreed that the criterion to obviate the need for hospital admission is an ambiguous and inadequately defined concept. A headquarters official stated that because the term has no clinical meaning, its definition can vary among physicians or even with the same physician. A medical center official noted that the criterion

"is so vaguely worded that every doctor can come up with one or more interpretations that will suit any situation . . . Having no clear policy, we have no uniformity. The same patient with the same condition may be denied care by one physician, only to walk out of the clinic the next day with a handful of prescriptions supplied by the doctor in the next office."

With thousands of VA physicians making eligibility decisions each working day, the number of potential interpretations is, to say the least, very large.

In addition to interpreting the obviate-the-need criterion, VA physicians or administrative staff must evaluate a series of other eligibility requirements before deciding whether individual veterans are eligible for the health care services they seek. For example, they must

- determine whether the disability for which care is being sought is service connected or aggravating a service-connected disability, because different rules apply to service-connected and nonservice-connected care;
- determine the disability rating for veterans with service-connected disabilities because the outpatient services they are eligible for and their priority for care depend on their rating; and
- determine the income and assets of veterans with no service-connected disabilities because their eligibility for (and priority for receiving) care depends on a determination of their ability to pay for care.

Availability of Outpatient Care Is Uneven

Under private health insurance, Medicare, and Medicaid, the availability of covered services is guaranteed. For example, all beneficiaries who meet the basic eligibility requirements for Medicare are entitled to receive all medically necessary care covered under the Medicare part A benefit package. Similarly, those Medicare beneficiaries who enroll for part B benefits are entitled to receive all medically necessary care covered under the part B benefit package. As an entitlement program, Medicare spending

increases as utilization increases, creating guaranteed access to covered services.

Under the VA health care system, however, being in the mandatory care category does not entitle veterans to, or guarantee the availability of, needed services. The VA health care system is funded by a fixed annual appropriation; once appropriated funds have been expended, the VA health care system is not required to, and in fact is not allowed to, provide additional health care services—even to veterans in the mandatory care category. Although title 38 of the U.S. Code contains frequent references to services that “shall” or “must” be provided to mandatory care group veterans, in practical application the terms mean that services “shall” or “must” be provided if adequate resources have been appropriated to pay for them. Being in the mandatory care category essentially gives veterans a higher priority for treatment than veterans in the discretionary care category.

In effect, veterans, rather than the government, assume a significant portion of the financial risk in the VA health care system because there is no guarantee that sufficient funds will be appropriated to enable the government to provide services to all veterans seeking care. Historically, however, sufficient funds have been appropriated to meet the health care needs of all veterans in the mandatory care category and most of those in the discretionary care categories.

Because the provision of VA outpatient services is conditioned on the availability of space and resources, veterans cannot be assured that health care services are available when they need them. Even veterans in the mandatory care category are theoretically limited to health care services that can be provided with available space and resources. If demand for VA care exceeds the capacity of the system or of an individual facility to provide care, then health care services are rationed.

The Congress established general priorities for VA to use in rationing outpatient care when resources are not available to care for all veterans. VA delegated rationing decisions to its medical centers; that is, each must independently make choices about when and how to ration care.

Using a questionnaire, we obtained information from VA’s 158 medical centers on their rationing practices. In fiscal year 1991, 118 centers reported that they rationed outpatient care for nonservice-connected

conditions, and 40 reported no rationing. Rationing generally occurred because resources did not always match veterans' demands for care.⁷

When the 118 centers rationed care, they also used differing methods. Some rationed care according to economic status, others by medical service, and still others by medical condition. The method used can greatly affect who is turned away. For example, rationing by economic status will help ensure that veterans of similar financial means are served or turned away. On the other hand, rationing by medical service or medical condition helps ensure that veterans with similar medical needs are treated the same way.

The 118 medical centers' varying rationing practices resulted in significant inconsistencies in veterans' access to care both among and within centers. For example, higher-income veterans frequently received care at many medical centers, while lower-income veterans or those who also had service-connected disabilities were turned away at other centers. Some centers that rationed care by either medical service or medical condition sometimes turned away lower-income veterans who needed certain types of services while caring for higher-income veterans who needed other types of services.

Restrictions on Providing Noncovered Services Adds to Frustration

One major source of frustration for VA facilities is their inability to provide needed health care services to veterans when those services are not covered under their veterans' benefits. Unlike private sector physicians, who can generally provide any available outpatient service to any patient willing to pay, VA facilities and physicians are generally unable to provide noncovered services to veterans. In the private sector, physicians and clinics can sell their services to any person regardless of whether the service is covered by insurance. Essentially, the patient assumes the financial responsibility for any services not covered under his or her health insurance or for any charges that exceed insurance coverage.

Although VA health care facilities are primarily restricted to use by veterans, VA actually has greater authority to sell health care services to nonveterans through sharing agreements than it does to sell these same services to veterans. Specifically, VA hospitals and clinics cannot, under current law, sell veterans those services not covered under their veterans' health care benefits even if they (1) have public or private insurance that

⁷VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 16, 1993).

would pay for the care or (2) agree to pay for the services out of their own funds.

Some Veterans' Health Conditions Go Untreated

In a 1993 review, we examined veterans' efforts to obtain care from alternative sources when VA medical centers did not provide it.⁸ Through discussions with 198 veterans turned away at six medical centers, we learned that 85 percent obtained needed care after VA medical centers turned them away. Most obtained care outside the VA system, but some veterans returned to VA for care, either at the same center that turned them away or at another center.

The 198 veterans turned away needed varying levels of medical care. Some had requested medications for chronic medical conditions, such as diabetes or hypertension. Others presented new conditions that were as yet undiagnosed. In some cases, the conditions, if left untreated, could be ultimately life threatening, such as high blood pressure or cancer. In other cases, the conditions were potentially less serious, such as psoriasis.

Studies Do Not Show Strong Link Between Eligibility Provisions and Nonacute Admissions

VA hospitals too often serve patients whose care could be more efficiently provided in alternative settings, such as an outpatient clinic or nursing home. VA, the major veterans' service organizations, and the Vice President's National Performance Review attribute many of the inappropriate admissions to VA's eligibility provisions, citing (1) studies showing that over 40 percent of admissions could have been avoided through use of outpatient care and (2) anecdotes, such as the one about a patient who had to be admitted to the hospital to get a pair of crutches. Our review, however, found little basis for linking most inappropriate hospitalizations to VA eligibility provisions.

In 1985, we reported that about 43 percent of the days of care medical and surgical patients spent in the VA hospitals reviewed could have been avoided.⁹ Since then, a number of studies by VA researchers and VA's Office of Inspector General (IG) have found similar problems.

For example, a 1991 VA-funded study of admissions to VA acute medical and surgical bed sections estimated that 43 percent (+/- 3 percent) of

⁸VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (GAO/HRD-93-123, July 14, 1993).

⁹Better Patient Management Practices Could Reduce Length of Stay in VA Hospitals (GAO/HRD-85-52, Aug. 8, 1985).

admissions were nonacute. Nonacute admissions in the 50 randomly selected VA hospitals studied ranged from 25 to 72 percent. The study suggested several reasons why there is a higher rate of nonacute admissions to VA hospitals than private sector hospitals, including the following:

- VA facilities do not have the necessary financial incentives to make the transition to outpatient care.
- VA, unlike the private sector, does not have formal mechanisms to control nonacute admissions, such as mandatory preadmission review.
- VA, unlike the private sector, has a significantly expanded social mission that may influence the use of patient resources.¹⁰

A 1993 study by VA researchers reported similar findings. At the 24 VA hospitals studied, 47 percent of admissions and 45 percent of days of care in acute medical wards were nonacute; 64 percent of admissions and 34 percent of days of care in surgical wards were nonacute.

Reasons cited for nonacute admissions and days of care included nonavailability of outpatient care, conservative physician practices, inadequate discharge planning, and social factors. The authors suggested that VA establish a systemwide utilization review program. VA, however, has not established either an internal utilization review requirement or contracted for external reviews.

We recently testified that establishing preadmission certification procedures similar to those used by private health insurers could save VA hundreds of millions of dollars by reducing nonacute admissions to VA hospitals. We noted that all fee-for-service health plans participating in the Federal Employees Health Benefits Program are required to operate a preadmission certification program to help limit nonacute admissions and days of care. VA's Under Secretary for Health announced plans to implement a preadmission certification program at the same hearing.¹¹

Although the VA study also cited eligibility as contributing to some inappropriate admissions and days of care, the study identified only minor changes needed in VA eligibility provisions. Specifically, it recommended

¹⁰For example, VA facilities may admit patients who travel long distances for care or keep veterans in the hospital longer than medically necessary because they lack a social support system to assist them after they are discharged.

¹¹Testimony before the Subcommittee on VA, HUD, and Independent Agencies, Senate Committee on Appropriations, on March 8, 1996.

changes in the law to (1) allow veterans with nonservice-connected disabilities to be placed in VA-supported community nursing homes without first being admitted to a VA hospital and (2) allow prosthetic devices to be furnished to veterans on an outpatient basis.

Trying to link the studies discussed here to VA eligibility provisions is, in our view, inappropriate because the studies did not contain the types of data needed to make such a link. In other words, the studies did not determine whether the patients inappropriately admitted to VA hospitals had service-connected or nonservice-connected disabilities, whether they were in the mandatory or discretionary care category for outpatient care, or whether they would have been eligible to receive the services they needed on an outpatient basis. Had such information been included in the studies, it would be possible to determine whether a higher incidence of nonacute admissions occurred for veterans in the discretionary care category for outpatient care than for those in the mandatory care category.¹²

Similarly, while the anecdotes VA cites represent real limitations in VA eligibility provisions that need to be addressed, VA lacks data to show how many inappropriate hospital admissions resulted from the limitations. For example, how many of the approximately 7,000 patients admitted to VA hospitals in fiscal year 1994 for fractures of the arms and legs were treated on an outpatient basis and then admitted for the purpose of providing crutches? Only 765 of the 7,000 admissions were for 1 day, the most likely length of stay for patients admitted to enable VA to give them a pair of crutches or other routine outpatient care.

Studies by the VA IG show limited enforcement of outpatient eligibility provisions. VA's IG estimated that over half of the outpatient visits of veterans in the discretionary care category were to receive services that were not covered under the veterans' VA benefits. This suggests that VA physicians are more likely to "stretch" the outpatient benefit to provide crutches to veterans with broken legs than to admit the veteran to the hospital for that purpose.

¹²This is a limitation in how the study can be used, not a deficiency in how the study was conducted.

Proposed Bills Would Eliminate Restrictions on Outpatient Eligibility, but Other Problems Would Continue

Eligibility reform proposals introduced during the past year would eliminate the restrictions on veterans' access to outpatient care. In doing so, however, the proposals would likely generate significant new demand for VA outpatient care services. In addition, the bills generally do not address the other provisions in current law that contribute to inappropriate use of VA health care resources and uneven access to health care services. (See table 2.)

Table 2: Key Provisions of VA Eligibility Reform Proposals

Key provisions	Bill/sponsor			
	S. 1345 (VA)	S. 1563 (veterans' service organizations)	H.R. 1385 (Montgomery/Edwards)	H.R. 2491 (House Veterans' Affairs)
Creates an entitlement to VA care/guarantees availability of care	No	No	No	No
Expands the number of veterans in the mandatory care category	Yes	Yes	Yes	Yes
Creates a uniform benefit package/eliminates obviate-the-need provision	Yes	Yes	Yes	Yes
Reforms contracting provisions	Yes	No	No	Yes
Other provisions	<ul style="list-style-type: none"> — Expands the definition of covered services to include virtually any necessary inpatient or outpatient care, drugs, supplies, or appliances — Allows VA to retain a portion of third-party recoveries 	<ul style="list-style-type: none"> — Includes nursing home care as mandatory service — Mandatory care category would include catastrophically disabled veterans — Allows adult dependents to become eligible for VA care, provided they reimburse VA — Allows VA to bill and retain collections from Medicare 	<ul style="list-style-type: none"> — Requires VA to provide veterans similar access regardless of their home state — Allows VA to use a system of enrollment and priorities for care — Allows VA to retain a portion of third-party recoveries to expand outpatient care 	<ul style="list-style-type: none"> — Requires VA to establish a system of annual enrollment based on priorities for care — Creates a new category of priority for catastrophically disabled veterans

Bills Would Create a Uniform Benefit Package

Each of the four major bills introduced during the past year would create a uniform benefit package by eliminating the obviate-the-need restriction on

coverage of outpatient care. The bills would make all 26 million veterans eligible for comprehensive outpatient services. In addition, the four bills would expand the number of veterans in the mandatory care category for comprehensive outpatient care from about 465,000 to 9 million to 11 million veterans.

Eliminating the obviate-the-need restriction on access to ambulatory care would simplify administration of health care benefits because VA physicians would no longer need to determine whether a patient would likely end up in the hospital if he or she was not treated. Eliminating the restriction would also promote greater equity by reducing the inconsistencies in eligibility decisions. Finally, eliminating the restriction would make benefits more understandable by essentially making veterans eligible for the full continuum of inpatient and outpatient care.

Other Major Restrictions Not Addressed in Most Bills

Most of the bills do not address the other major restrictions on VA eligibility and the ability of VA to provide noncovered services to veterans. Specifics follow:

- VA would continue to be unable to provide noncovered services directly to veterans under all of the bills. Because all veterans would become eligible for comprehensive outpatient services, there would be fewer noncovered services.
- Current restrictions on provision of dental, prenatal, and maternity care would not be changed under any of the proposals.
- S. 1345 would remove the restriction on direct admission of veterans with no service-connected disabilities to community nursing homes.
- All of the bills would retain the discretionary funding of VA health care. H.R. 1385 would, however, require VA to ensure that veterans have reasonably similar access to VA health care regardless of where they live.
- Only H.R. 1385 specifically addresses the uneven availability of VA care. That bill would require VA to expand its capacity to provide outpatient care and allocate resources to its facilities in a way that would give veterans access to care that is reasonably similar regardless of where they live. The other bills do not address the uneven availability of VA health care services caused by resource limitations, VA's limited provider network, and inconsistent VA rationing policies.

Appendix I contains a more detailed description of the major provisions of the four bills.

Eligibility Reform Bills Not Likely to Be Budget Neutral

By making all 26.4 million veterans eligible for comprehensive outpatient care, the four bills would likely generate significant new demand for both outpatient and inpatient care. The increased demand could be heightened by the synergistic effects of other changes in the VA health care system to improve access and customer service and expand contracting.

The bills would, however, provide little or no new sources of revenue to offset the costs of the new services. This would put increased pressure on the Congress to appropriate funds to meet the health care demands generated through eligibility expansions, particularly for the 9 million to 11 million additional veterans who would be placed in the mandatory care category for comprehensive outpatient benefits. Although VA and CBO arrived at strikingly different conclusions about the budgetary effects of the bills, we find CBO's arguments more compelling because they address the potential increased demand.

Bills Represent a Major Expansion of Outpatient Eligibility

Under the four bills, over 26 million veterans would become eligible to receive services that currently are available primarily to the approximately 465,000 veterans with service-connected disabilities rated at 50 percent or higher. Even many veterans who rely on other health care coverage for most of their needs are likely to attempt to take advantage of added VA benefits such as prescription drugs, which are not typically covered under other health insurance. Medicare does not cover outpatient prescription drugs, making VA an attractive alternative. Medicare-eligible veterans already make significant use of VA outpatient prescriptions even with the current eligibility limitations.¹³ Removing the restrictions on access to outpatient care would likely significantly increase demand for outpatient prescriptions.

Another area where workload would likely increase dramatically is prosthetic devices, such as eyeglasses, contact lenses, and hearing aids. In addressing the restriction in current law on provision of crutches to veterans with broken legs, the four bills would also eliminate the restriction on provision of other prosthetic devices, such as eyeglasses, contact lenses, and hearing aids. H.R. 2491 would, however, give the Secretary of Veterans Affairs the authority to restrict the provision of eyeglasses, contact lenses, and hearing aids.

¹³Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans (GAO/HEHS-95-13, Oct. 24, 1994).

Other Improvements in VA Health Care System Could Heighten Increased Demand

If concurrent changes are made in the accessibility of VA health care services, in VA customer service, and in the extent to which veterans are allowed to use private providers under contract to VA, the impact of eligibility reforms on demand for VA care will likely be heightened. As it strives to make the transition from a hospital-based system to an ambulatory-care-based system, VA is attempting to bring ambulatory care closer to veterans' homes. Because distance is one of the primary factors affecting veterans' use of VA health care, actions to give veterans access to outpatient care closer to their homes, either through expansion of VA-operated clinics or through contracts with community providers, will likely increase demand for services.

Similarly, our reports over the past 5 years have identified continuing problems in VA customer service, including long waiting times, poor staff attitudes, and lack of such amenities as bedside telephones. As part of its response to the National Performance Review, VA has developed detailed plans to improve customer service that include installing bedside telephones, reducing waiting times, and training staff. These efforts are likely to help VA retain current users and will likely attract new users as VA's reputation for customer service improves.

Finally, increased contracting with private sector providers closer to veterans' homes could attract new users. Both S. 1345 and H.R. 2491 would expand VA's authority to contract with private sector providers. Such contracting might enable veterans to use the same physicians, clinics, and hospitals they use now but have VA rather than their private insurance or Medicare pay for the care.

Bills Would Provide Few New Sources of Revenues

Three of the bills—H.R. 2491, S. 1345, and S. 1563—would provide new sources of revenue, but they would not offset the costs of eligibility expansions. The provisions in those bills, which would allow VA to retain certain third-party recoveries, would not be used to offset VA appropriations and therefore would not change the budgetary impact of these reform proposals. The bills essentially assume that eligibility reform will not require new sources of revenue because they will generate significant savings by making it possible for VA to treat on an outpatient basis 20 to 40 percent of veterans currently in VA hospitals. These savings would then be used to pay for the increased outpatient workload generated by the patients diverted to outpatient care. There is, however, little evidence to suggest that eligibility reform alone will result in significant numbers of veterans being diverted to outpatient care.

Controlling Budgetary Increases Would Be Difficult

Expanding the number of veterans in the mandatory care category while retaining current resource constraints might force rationing of care to veterans in the mandatory care group. Expanding the mandatory care category would place great pressure on the Congress to fully fund services for veterans in the mandatory care category. Historically, the Congress has fully funded both VA's mandatory and discretionary workload.

Considering the significant portion of VA resources currently used to provide services to veterans in the discretionary care category and the limited data VA provides the Congress on which to base funding decisions, it would be exceedingly difficult for the Congress to appropriate funds for the care of only a portion of the veterans in the mandatory care category. About 15 percent of veterans using VA medical centers have no service-connected disabilities and have incomes that place them in the discretionary care category for both inpatient and outpatient care. But VA does not differentiate between services provided to veterans in the mandatory and discretionary care categories in justifying its budget request. As a result, the Congress has little basis for determining which portion of VA's discretionary workload to fund.

Although two proposals (H.R. 2491 and H.R. 1385) propose establishment of an enrollment process, such a process may jeopardize VA's safety net mission. Because low-income veterans are typically the fourth highest priority for care in the proposed enrollment process, reforms that provide a richer benefit package or increase the number of higher-priority veterans, or a combination of both, could reduce funds available to treat low-income veterans.

For example, under the new definition of health care in S. 1345, veterans in the top three priority categories would be in the mandatory care category for virtually any service offered by VA. Further, VA would be required to provide comprehensive care to about 3 million veterans previously eligible for limited outpatient care. Under the VA proposal, about 1.8 million veterans currently eligible for limited outpatient care would be placed in the highest-priority group for comprehensive care. The VA proposal would also place veterans with noncompensable service-connected disabilities (estimated to number about 1.2 million) above low-income veterans with no service-connected disabilities in the priority ranking of veterans in the mandatory care category.¹⁴

¹⁴Other proposals generally would not provide a special status to such "0 percent" veterans—those with noncompensable service-connected disabilities.

Only after the needs are met for the top three priority categories could VA fund care for low-income veterans. We are concerned that sufficient funds might not be available to fulfill VA's safety net mission after meeting the expanded demands for care of higher-priority veterans. Because most of the reform proposals do not address the uneven availability of VA services, however, the increased demand for care generated by eligibility expansions would likely heighten the problems VA already faces in trying to equitably distribute available resources.

CBO's Cost Estimate Is More Compelling Than VA's

VA and CBO estimated the budgetary impact of H.R. 2491, the most modest of the reform proposals, with strikingly different results:

- VA concluded that because the bill was similar to the administration's proposal, it would be budget neutral, generating net savings of \$268 million that could be reinvested to expand outpatient care or construct new facilities.
- CBO estimated that the bill could add \$3 billion or more to the deficit annually.

A number of problems have been identified with both cost estimates that reduce their usefulness in assessing the potential impact of the bill on VA's budget. We agree with CBO's overall conclusion, however, that any broad expansion in benefits will generate significant new demand for VA health care that could potentially add billions to the budget deficit.

VA's Estimate Is Based on Questionable Assumptions

VA did not adequately consider the increased demand for outpatient care likely to be generated by the eligibility expansions, incorrectly assumed a strong link between inappropriate admissions to VA hospitals and VA eligibility provisions that would be addressed through the reform proposals, and made a number of questionable assumptions in its calculations.

VA developed a complex formula for estimating the cost effects of eligibility reform based on its overall assumption that eligibility reform would enable it to divert 20 percent of its hospital patients to outpatient care. The results, however, are sensitive to a series of assumptions about such things as how many veterans are inappropriately admitted to VA hospitals because of restrictions on outpatient eligibility; how long, on average, those veterans stay in the hospital; and how eligibility reform would affect demand for outpatient care. We have the following concerns

about VA's assumptions or how they were used in VA's calculations of savings to be realized from eligibility reforms:

Eligibility reform would enable VA to eliminate 20 percent of hospital admissions. One argument frequently used to promote the need for eligibility reform is that the obviate-the-need provision prevents VA from providing care in the most cost-effective setting. The presumed savings from removing the restrictions on access to ambulatory care services would then be used to offset the costs of expanded benefits.

We agree that significant savings can accrue from shifting a sizable portion of VA's inpatient services to other settings. But we do not believe that current eligibility provisions prevent VA from shifting much of its current inpatient services to ambulatory care settings.

The same obviate-the-need provision discussed earlier as making it difficult for VA physicians to determine whether to provide outpatient care for certain conditions makes it clear that care can be provided to any veteran, regardless of income or other factors, if it would prevent a hospital admission. The eligibility provisions, for example, allow VA to perform cataract surgery on an outpatient basis to obviate the need for inpatient care. Accordingly, we do not believe it would be appropriate to assume that the management inefficiencies that have prevented VA from effectively implementing the provision and shifting care to outpatient settings for over 20 years would be eliminated and the planned savings actually realized.

Actions such as the preadmission certification program previously discussed could, however, generate savings that could be used to offset the costs of eligibility reform.

An average of 7 days of hospital care would be saved for every patient diverted to outpatient care. This assumption is not sound given VA's argument that the patients it would be diverting were admitted in order to provide them routine outpatient care. Because the inpatients VA expects to shift to outpatient care are essentially self-care patients with no acute medical need, VA would most likely be drawing from patients with the shortest lengths of stay—such as veterans admitted to provide them crutches or as a prerequisite to placement in a community nursing home. In fiscal year 1994, about 37 percent of VA medical and surgical patients had 1- to 3-day stays. We believe it would be more reasonable to assume

the average length of stay of patients to be diverted to outpatient care to be 1 to 3 days.

Changing the assumption about average length of stay dramatically alters VA's savings estimates. Substituting 3 days for VA's assumption of a 7-day average length of stay would change VA's projected savings of \$268 million from eligibility reform into an overall increase in VA costs of almost \$167 million.

Because the less sick patients would be shifted to outpatient care, the costs of treating patients remaining in the hospital would increase by 10 percent per admission. Although VA's formula originally included this adjustment, VA did not include the calculation in its savings estimates. Including this adjustment would turn VA's projected savings of \$268 million into a cost increase of \$51 million.

An increase in demand would not occur for outpatient care other than demand generated by veterans shifted from inpatient to outpatient care. VA anticipates limited new demand because, according to headquarters officials, the administration proposal and H.R. 2491 were designed to give VA added flexibility, not to attract new users. Although headquarters officials anticipate few new users, medical centers are already aggressively pursuing new users.

CBO's Conclusions Appear Sound

CBO estimated that the eligibility reform provisions of H.R. 2491 could increase the deficit by \$3 billion or more annually if the Congress fully funds the increased demand for outpatient care that the eligibility expansions would likely generate. CBO's estimates were based in part on tables contained in what at the time was VA's newly released 1992 National Survey of Veterans. VA claimed that CBO misinterpreted one of the tables in the survey—which VA acknowledged was confusing—and raised concerns about CBO's methodology and the accuracy of its projections.

After reviewing VA's concerns, CBO determined that any problem in interpreting the survey data did not affect its overall conclusion that the bill would not be budget neutral because the expanded eligibility would generate significant new demand. CBO assumes in conducting budgetary impact analyses that if demand increases under a discretionary program, funds will be appropriated to meet that demand. CBO estimated that the cost of providing outpatient care to the 10.5 million veterans who are currently eligible only for hospital-related outpatient care would far outweigh the savings from shifting inpatients to outpatient care. Further,

CBO concluded that VA could incur significant costs under provisions that expand VA's authority to provide prosthetic devices on an outpatient basis. Finally, CBO noted that the bill could increase costs by billions more if the induced demand for outpatient care resulted in corresponding increases in demand for hospital care.

Approaches for Developing Budget-Neutral Eligibility Reforms

The cost of eligibility reform depends on a number of factors, including the benefits covered, the number of veterans offered the benefits, and the extent to which veterans are expected to pay for or contribute toward the cost of their health care benefits. The current reform proposals would essentially make all 26 million veterans eligible for comprehensive inpatient and outpatient care with little or no change in the system's sources of revenue. Three basic approaches could be used, individually or in combination, to develop budget-neutral eligibility reform. These are (1) set limits on covered benefits, (2) limit the number of veterans eligible for health care benefits, and (3) generate increased revenues to pay for expanded benefits. Another approach would be to allow VA to "reinvest" savings achieved through efficiency improvements in expanded benefits.

Set Limits on Covered Benefits

One way to control the increase in workload likely to result from eligibility expansions would be to develop one or more defined benefit packages patterned after public and private health insurance. This would narrow the range of services veterans could obtain from VA, allowing workload to be reduced by the eliminated services to offset the workload from increased demand for other services. Like private health insurers, VA could adjust the benefit package annually on the basis of the availability of resources.

Creating a defined benefit package could result in some veterans receiving a narrower range of services than they receive now, while others would receive additional benefits. This approach would essentially take some benefits away from veterans with the greatest service-connected disabilities and give additional benefits to veterans with lesser service-connected disabilities and to veterans with no service-connected disabilities.

One option for addressing this problem is to establish separate benefit packages for different types of veterans. For example, veterans with disabilities rated at 50 percent or higher might continue to be entitled to any needed outpatient service, while a narrower package of outpatient benefits—perhaps excluding such items as eyeglasses, hearing aids, and

prescription drugs—could be provided to higher-income veterans with no service-connected disabilities.

Limit the Number of Veterans Eligible for VA Health Care

Another way to develop budget-neutral eligibility reform would be to pay for expanded eligibility for some veterans by restricting or eliminating eligibility for others. Under current law, all veterans are eligible for VA hospital and nursing home care and at least some outpatient care, but there is a complex set of priorities for care based on such factors as presence and degree of service-connected disability, period of service, and income. In practical application, however, these priorities have little effect on the VA health care system. In preparation of VA budget justifications, no distinction is made between veterans in the mandatory and discretionary care categories, let alone those in different priority groups within the mandatory and discretionary care categories. Two of the reform bills (H.R. 1385 and H.R. 2491) would authorize VA to control demand for VA services through the use of priorities for care and an enrollment process.

Among the approaches that could be used to limit the number of veterans taking advantage of expanded benefits is to limit VA eligibility to those veterans who lack other public or private insurance. Exceptions could be made for treatment of service-connected disabilities and for services not covered under veterans' public or private insurance. Such an approach might help target available funds toward those veterans most in need.

The Congress would face a difficult choice, however, in determining whether VA health care is (1) a benefit of service that should be available regardless of alternate coverage or (2) a safety net available only to those who lack health care options.

Limiting eligibility of veterans with nonservice-connected disabilities to those whose income is below the current, or some new, means test limit would allow VA to retarget some resources currently used to provide services to higher-income veterans. Because about 15 percent of VA users have incomes above the means test threshold, eliminating their eligibility would make additional resources available to offset increased demand for outpatient services by veterans in higher-priority categories. Such veterans could be allowed to purchase services from VA facilities on a space-available basis.

Another way to limit the number of veterans eligible for expanded VA benefits is to restrict enrollment in VA health care to current VA users. This

approach could limit the potential “woodwork” effect and thereby reduce the costs of eligibility reforms. While current users might increase their use of VA health care in response to expanded benefits, most such veterans already obtain those services they are unable to get from VA from private sector providers through their public and private insurance. As a result, this approach might enable those higher-income veterans with nonservice-connected disabilities already using VA services to shift all of their care to VA, while veterans who had not previously used VA services but would like to start using them would essentially be shut out of the system. This would include veterans with higher priorities for care, such as those with service-connected disabilities and low incomes. Similarly, restricting enrollment to current users might prevent VA from fulfilling its safety net mission by denying care to veterans whose economic circumstances change.

Generate Increased Revenues

Several approaches could be used to generate additional revenues to pay for expanded benefits. These include increased cost sharing, authorizing recoveries from Medicare, and allowing VA to retain funds from third-party recoveries.

Increase Veteran Cost Sharing

Increased veteran cost sharing could help offset the costs of increased demand. For example, through contracting reform, VA might be authorized to sell veterans any available health care service not covered under their current veterans’ benefits without changing existing eligibility provisions. In other words, veterans could purchase, or use their private health insurance to purchase, additional health care services from VA.

Such an approach would not eliminate the problems VA physicians have in interpreting the obviate-the-need provision. But it would lessen the importance of the decision. Physicians would no longer be forced to turn away veterans needing health care services. Instead, obviate-the-need decisions would determine who would pay for needed health care services, the government or the veteran. In addition, VA could issue regulations interpreting the obviate-the-need provision. Because uninsured veterans may be unable to pay for many additional health care services, an exception could be made to help such veterans pay for additional health care services.

A second approach for offsetting the costs of eligibility expansions through cost sharing could be to impose new cost-sharing requirements for existing services. For example, VA could be authorized to increase cost

sharing for nursing home care—a discretionary benefit for all veterans—either through increased copayments or estate recoveries. Recoveries could be used to help pay for benefit expansions. Similarly, copayments and deductibles for hospital and outpatient care could be adjusted to be more comparable with other public and private sector programs.

Cost sharing could also be increased by redefining the mandatory care group. In other words, the income levels for inclusion in the mandatory care category could be lowered or copayments imposed for nonservice-connected care provided to veterans with service-connected disabilities of 0 to 20 percent.

Authorize Recoveries From Medicare

Proposals have been made in the past few years to authorize VA recoveries from Medicare either for all Medicare-eligible veterans or for those with higher incomes. For example, S. 1563 would allow VA to bill and retain recoveries from Medicare. Such proposals, though, appear to offer little promise for offsetting the costs of eligibility expansions. First, many of the services, such as hearing aids and prescription drugs, that Medicare-eligible veterans are likely to obtain from VA are not Medicare-covered services. Second, the proposals would not require VA to offset the recoveries against its appropriation. As a result, it would not affect VA's budget request. Authorizing VA recoveries from Medicare could, however, further jeopardize the solvency of the Medicare trust fund and increase overall federal health care costs. Such an action would essentially transfer funds between federal agencies while adding administrative costs.

Allowing VA to bill and retain recoveries from Medicare would create strong incentives for VA facilities to shift their priorities toward providing care to veterans with Medicare coverage. VA facilities would essentially receive duplicate payments for care provided to higher-income Medicare beneficiaries, unless recoveries were designated to fund services or programs for which VA did not receive an appropriation. For example, if VA were authorized to sell noncovered services to veterans and did not receive an appropriation for such services, then veterans should be allowed to use their Medicare benefits to help pay for the services just as they would use their private health insurance.

Allow VA to Retain a Portion of Third-Party Recoveries

Proposals, such as the ones contained in S. 1345 and H.R. 1385, that would allow VA to retain a portion of recoveries from private health insurance beyond what it needs to finance its recovery program would not reduce VA's budget request and therefore would not generate the revenues needed

to offset the costs of expanded benefits. Just as allowing VA to retain Medicare recoveries would essentially result in duplicate payments unless they were earmarked for some purpose other than to pay for care covered by an appropriation, proposals to allow VA to retain a portion of its third-party recoveries would essentially result in duplicate payments.

Reinvest Savings From Efficiency Improvements

During the past 5 to 10 years, GAO, VA's IG, the Veterans Health Administration, and others identified numerous opportunities to improve the efficiency of the VA health care system and enhance revenues from sales of services to nonveterans and care provided to veterans. Savings from such initiatives could be "reinvested" in the VA health care system to help pay for eligibility expansions.

VA has historically used savings from efficiency improvements to fund new programs. For example, VA is allowing its facilities to reinvest savings achieved by consolidating administrative and clinical management of nearby facilities into providing more clinical programs. Similarly, VA allows medical centers to use savings from efficiency improvements to fund access points.

Through establishment of a preadmission certification requirement similar to those used by many private health insurers, VA could reduce nonacute admissions and days of care in VA hospitals and save hundreds of millions of dollars. While such inappropriate admissions and days of care to a large extent are unrelated to problems with VA eligibility provisions, savings resulting from administrative actions to address the problem could nonetheless be targeted to pay for expanded benefits.

Actions to reinvest savings from efficiency improvements would, however, limit VA's ability to contribute to deficit reduction.

Conclusions

The VA health care system was neither designed nor intended to be the primary source of health care services for most veterans. It was initially established to meet the special care needs of veterans injured during wartime and those wartime veterans permanently incapacitated and incapable of earning a living. Although the system has evolved since that time, even today it focuses on meeting the comprehensive health care needs of only about 465,000 of the nation's 26.4 million veterans. In other words, its primary mission is to meet the comprehensive health care needs of veterans with service-connected disabilities rated at 50 percent or more.

For other veterans, the system is primarily intended to provide treatment for their service-connected disabilities and to serve as a safety net to provide health care to veterans with limited access to health care through other public and private programs.

Because 9 out of 10 veterans now have other public or private health insurance that meets their basic health care needs, few veterans today need to rely on VA as a safety net. Rather, most of them turn to private sector providers for all or most of their care, using VA either not at all or to supplement their use of private sector health care.

Reforms of VA eligibility that would significantly expand veterans' eligibility for comprehensive care in VA facilities would significantly alter VA's health care mission and place VA in more direct competition with the private sector. To the extent veterans are given expanded benefits that are either free or have lower cost sharing than other public and private health insurance, the VA system will gain a clear competitive advantage over its private sector competitors. Coupling eligibility reform with other changes, such as improved accessibility and customer service, could heighten the increased demand for VA services. Because most veterans currently use private sector providers, any increased demand generated by eligibility expansions would come largely at the expense of those providers.

For most veterans, VA eligibility reform might provide an additional option for health care services or additional services not covered under their public or private insurance. For those veterans who do not have public or private health insurance, however, eligibility reform is more important. It could improve their access to comprehensive health care services, including preventive health care services.

Historically, the Congress has fully funded VA's mandatory and discretionary care workload. The four eligibility reform bills that have been introduced could significantly increase demand for VA health care services, putting pressure on the Congress to increase VA appropriations to fully fund at least the demand generated by the 9 million to 11 million veterans added to the mandatory care category for comprehensive free outpatient services.

If the Congress decides not to fully fund VA's anticipated workload, VA would be faced with developing rationing policies that would ensure the funds appropriated are directed toward those veterans with the highest priorities for care. This would likely entail turning away many of the

veterans currently using VA health care. Depending on the level of funding, those turned away could include low-income uninsured veterans. The funds needed to meet the increased demand for routine health care services could also jeopardize VA's ability to provide specialized services, such as treatment of spinal cord injuries, not available through other programs.

Eligibility reforms should focus on strengthening VA's safety net mission while preserving its ability to provide specialized services veterans may be unable to obtain through their public and private insurance. Several approaches could be pursued to develop budget-neutral reforms that would also limit the extent to which the government competes with the private sector. These approaches generally involve placing limits on the number of veterans given expanded benefits, narrowing the range of benefits added, or increasing cost sharing to offset the costs of added benefits.

Mr. Chairman, this concludes my prepared statement. We will be happy to answer any questions that you or other Members of the Committee may have.

Contributors

For more information on this testimony, please call Jim Linz, Assistant Director, at (202) 512-7110. Terry Saiki, Evaluator-in-Charge, also contributed to the preparation of the statement.

Appendix I

Key Provisions of Selected Proposals to Reform Eligibility for VA Health Care

This appendix contains a synopsis of the key provisions in the four major eligibility reform bills introduced during the past year.

The Department of Veterans Affairs Improvement and Reinvention Act of 1995

The Department of Veterans Affairs Improvement and Reinvention Act of 1995 (S. 1345) was introduced at the administration's request on October 19, 1995. In addition to reforming VA health care eligibility, S. 1345 would expand VA contracting authority and amend VA housing and education benefits. The eligibility reform provisions would do the following:

- Previous provisions covering hospital care, outpatient care, respite care, pharmaceuticals, supplies, equipment, appliances, and other material and services would be combined into a new "health care" provision. Health care would be defined as "the most appropriate care and treatment for the patient furnished in the most appropriate setting."
- All veterans would be eligible for the expanded benefits offered under the new definition of health care.
- The current fixed categories of eligibility would be replaced by a priority system.
- The highest-priority groups of veterans in the mandatory category for comprehensive care would be expanded to include veterans (1) with any compensable service-connected disability, (2) who are former prisoners of war, (3) whose discharge or release was for disabilities incurred or aggravated in the line of duty, and (4) who are receiving disability compensation.
- VA would be allowed to provide, subject to available funding, comprehensive health care services to lower-priority veterans.
- The obviate-the-need-for-hospitalization criterion for outpatient care would be eliminated.
- The discretionary nature of VA funding would be retained by making the availability of services subject to annual appropriations.

The administration's proposal would also expand VA contracting authority. It would allow VA to share (purchase or sell) health care resources with health plans, insurers, organizations, institutions, or any other entity or individual who furnishes any health care resource. Under current law, such sharing agreements are limited to medical schools, health care facilities, and research centers.

Finally, S. 1345 would allow VA to retain a greater portion of its third-party collections. Currently, VA must return all third-party collections, less the

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administrative costs of collection activities, to the Treasury. Under the administration's proposal, VA would be allowed to retain an additional 25 percent of recoveries to be distributed to its health care facilities.

S. 1563

S. 1563 was introduced at the request of the veterans' service organizations (vso) on February 7, 1996. The vsos' highest priority, according to vso representatives, is eligibility reform that authorizes a full range of medical services for veterans currently in the mandatory category for hospital care, and funding to ensure the availability of those services. As a practical matter, the vsos did not attempt to include all of the eligibility reforms recommended in their 1996 Independent Budget in this year's proposal. In the scaled-back version, S. 1563 would

- add catastrophically disabled veterans to the mandatory category for comprehensive health care;¹⁵
- expand the mandatory care category (Category A) for hospital care to apply to outpatient, nursing home, domiciliary, and long-term care;
- allow VA to treat adult dependents of veterans, provided they reimburse VA for the cost of their care;
- broaden VA's authority to provide primary and preventive health care services;
- require VA to provide prosthetic appliances and aids for veterans in the mandatory care category who are blind or hearing-impaired;
- authorize VA facilities to participate as Medicare providers and retain reimbursements from Medicare;
- require VA to maintain current capacity in specialized services for mandatory care category veterans, including those with spinal cord dysfunction, blindness, and mental illness; and
- eliminate the obviate-the-need provision, making all veterans eligible for comprehensive outpatient care.

Some reforms described in their 1996 Independent Budget for VA were not included in S. 1563. vso representatives said these initiatives will be retained for future consideration. For example, the vsos also recommended that the Congress

- switch VA health care funding from a discretionary to a mandatory spending account,
- authorize VA to provide pre- and postnatal care for women veterans,

¹⁵"Catastrophically disabled" is defined in S. 1563 as any veteran whose expenditures for hospital and nursing home care exceed 7.5 percent of his or her gross adjusted income for federal income tax purposes during the preceding year.

Appendix I
Key Provisions of Selected Proposals to
Reform Eligibility for VA Health Care

- provide investment funds to improve VA's infrastructure, and
- allow VA medical centers to conduct marketing activities.

The Veterans Health Care Reform Act of 1995

Introduced April 4, 1995, by Congressmen Edwards and Montgomery, the Veterans Health Care Reform Act of 1995 (H.R. 1385) would, on a temporary basis for the period ending September 30, 1999,

- expand the mandatory care category for comprehensive outpatient medical treatment to include all veterans in the mandatory care category for hospital care (core group) other than those with noncompensable service-connected disabilities (nursing home and dental services would remain discretionary);
- require VA to expand its capacity to provide outpatient care and allocate resources to its facilities in a way that would give veterans access to care that is reasonably similar regardless of where they live;
- include preventive health services and prosthetic appliances in the definition of services that are provided to core group veterans;
- include home health services in the definition of services that may be provided to core group veterans;
- authorize the Secretary of Veterans Affairs to use systems of patient prioritization and to set up a system of enrollment of eligible veterans;
- allow VA to retain a portion of third-party recoveries to expand outpatient care; and
- require VA to ensure that any veteran with a service-connected disability is provided all benefits to which he or she is entitled.

Like the administration's proposal, H.R. 1385 would not shift VA funding from a discretionary to a mandatory account. That is, availability of benefits would still be dependent upon available funding—benefits would not be guaranteed. In addition, VA would be required to ensure that its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans is not reduced.

The Veterans Reconciliation Act of 1995

In October 1995, the House approved a budget reconciliation package (H.R. 2491) that contained a Veterans' Affairs Committee proposal—the Veterans Reconciliation Act of 1995. The bill would, among other provisions, reform eligibility for VA health care to

- subject provision of care to amounts provided in advance in appropriations, thus retaining VA's discretionary funding;

Appendix I
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- expand the mandatory care category for comprehensive outpatient care to include all veterans in the mandatory category for hospital care except those with noncompensable service-connected disabilities;
- remove the obviate-the-need criterion and other limitations on the provision of outpatient care, making all veterans eligible for comprehensive outpatient care;
- retain nursing home care as a discretionary benefit for all veterans;
- require VA to establish a system of annual patient enrollment based on priorities for enrollment contained in the bill;
- create a new category of priority for veterans who are catastrophically disabled; and
- expand VA contracting and sharing authority.

Appendix I
Key Provisions of Selected Proposals to
Reform Eligibility for VA Health Care

Appendix II

Related GAO Products

VA Health Care: Opportunities to Increase Efficiency and Reduce Resource Needs (GAO/T-HEHS-96-99, Mar. 8, 1996).

VA Health Care: Issues Affecting Eligibility Reform (GAO/T-HEHS-95-213, July 19, 1995).

VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-147, May 9, 1995).

VA Health Care: Retargeting Needed to Better Meet Veterans' Changing Needs (GAO/HEHS-95-39, Apr. 21, 1995).

VA Health Care: Barriers to VA Managed Care (GAO/HEHS-95-84R, Apr. 20, 1995).

Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Reform (GAO/HEHS-95-14, Dec. 23, 1994).

Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans (GAO/HEHS-95-13, Oct. 24, 1994).

Veterans' Health Care: Implications of Other Countries' Reforms for the United States (GAO/HEHS-94-210BR, Sept. 27, 1994).

Health Security Act: Analysis of Veterans' Health Care Provisions (GAO/HEHS-94-205FS, July 15, 1994).

Veterans' Health Care: Efforts to Make VA Competitive May Create Significant Risks (GAO/T-HEHS-94-197, June 29, 1994).

Veterans' Health Care: Most Care Provided Through Non-VA Programs (GAO/HEHS-94-104BR, Apr. 25, 1994).

VA Health Care: A Profile of Veterans Using VA Medical Centers in 1991 (GAO/HEHS-94-113FS, Mar. 29, 1994).

VA Health Care: Restructuring Ambulatory Care System Would Improve Service to Veterans (GAO/HRD-94-4, Oct. 15, 1993).

Appendix II
Related GAO Products

VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (GAO/HRD-93-94, July 29, 1993).

VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (GAO/HRD-93-123, June 30, 1993).

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All

The SECVA has asked that I convene a Tiger Team to execute the Commission on Care's recommendation #18, to "establish an expert body to develop recommendations for VA care eligibility and benefit design." You have been selected by your leadership to represent your office on the Tiger Team.

The kick-off meeting is scheduled for next Thursday, April 13, 11am-12pm in room 844, VACO. As you know, eligibility determinations govern a Veterans access to healthcare within VA. This work, if executed properly, can be a key driver of eligibility for health benefits in the future. I envision beginning with this core group, to clarify objectives, outline our approach and determine additional stakeholders for inclusion.

Our task is two-pronged:

- 1) To conduct an assessment of healthcare eligibility and benefits
- 2) To develop policy recommendations for the SECVA

To get us started, several source documents are provided for your advance review:

- The Commission on Care final report issued in July 2016. (Recommendation #18 on eligibility design is separately attached)
- A copy of the GAO report entitled, "Approaches for Developing Budget-Neutral Eligibility Reform" dated March 20, 1996

Thank you for your willingness to provide your expertise to this important effort. I look forward to working with you and to your contributions.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-(b) (6)

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Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Problem

Although VHA continues to offer the promise of health care to all veterans, its capacity to meet that promise is constrained by appropriated funding.⁶¹⁵ Congress and VA leadership must work to identify who VHA will serve, and what services it will provide, yet eligibility criteria have not been examined in 20 years.⁶¹⁶

Background

VHA's core mission is to care for veterans who has borne the battle. But its secondary mission of caring for veterans' non-service-connected health care needs is longstanding, dating back to Civil War origins. Congress has included veterans without service-connected needs among those eligible as highlighted below:

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use underutilized VHA providers and facilities, providing payment through private insurance.
- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

- In March 1865, Congress incorporated the National Home for Disabled Volunteer Soldiers and Sailors, originally intended for Union veterans who suffered economic distress from disabilities incurred during the Civil War. The National Home constructed the first hospitals for Civil War veterans in 1866, and after a series of acts of Congress, those hospitals were opened in 1887 to veterans suffering economic distress from disabilities not incurred in military service.⁶¹⁷
- The World War Veterans Act of 1924, which established the Veterans Bureau⁶¹⁸ (the predecessor to the Department of Veterans Affairs), authorized its director to provide hospitalization and related travel expenses to veterans whose services dated back as far as 1897, regardless of the type or cause of their disabilities, as long as those veterans who were unable to pay received preferential admission.⁶¹⁹
- Public Law 85-56 (1957), which codified prior VA laws and regulations, effectively expanded eligibility to veterans of future wars, providing needed hospital care for veterans with service-connected disability incurred or aggravated during war, or for any other disability if the veteran is unable to pay for hospital care.⁶²⁰

⁶¹⁵ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶¹⁶ *Ibid.*, 25.

⁶¹⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

⁶¹⁸ The Veterans Bureau consolidated the National Home and other veterans-related functions housed in different government bureaucracies.

⁶¹⁹ World War Veterans Act, 1924, Pub. L. No. 68-242, (1924).

⁶²⁰ Veterans Benefits Act of 1957, Pub. L. No. 85-56, 71 Stat. 83 (1957). That law provided separate authority in section 512 for outpatient medical treatment, which was limited to treatment for a service-connected disability.

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- In 1966, Congress expanded eligibility for hospital care to *peacetime* veterans (of service after January 1955).⁶²¹
- In 1970, Congress extended eligibility for hospital care to veterans 65 and older for a non-service-connected disability,⁶²² exempting that group of veterans from taking the then-required oath affirming their inability to defray the expense of care for non-service-connect ailments.⁶²³
- With the Veterans Health Care Expansion Act of 1973, Congress eliminated the distinction between wartime and peacetime veterans for purposes of eligibility for outpatient care, and further expanded eligibility to outpatient care. It granted veterans who are 80 percent or more service-connected disabled eligibility for treatment of any condition, and authorized others eligible for hospital care to receive outpatient care to prepare for or preclude a need for hospitalization or to complete treatment initiated during hospitalization.⁶²⁴
- Congress expanded eligibility again in 1976, authorizing hospital care for treating a non-service-connected condition of any veteran 65 or older (without regard to ability to pay), authorizing outpatient care for any disability to any veteran 50 percent or more service-connected disabled, and directing VA to ensure, by regulation, special treatment priority to service-connected veterans and others receiving benefits because of a need for aid and attendance, or being permanently housebound.⁶²⁵

Eligibility laws for veterans' health care have changed substantially during the past century, yet the commitment to serving service-connected veterans and veterans in financial need has remained constant.

Prior to enactment of the Veterans' Health Care Eligibility Reform Act of 1996,⁶²⁶ VHA was a hospital-based model with entirely different eligibility rules for hospital care than for outpatient care. The eligibility reform law was aimed at transforming access to VA care from a 1950s hospital-based model to one that erased distinctions between eligibility for hospital and outpatient care.⁶²⁷ It essentially provided that all veterans are eligible for VA hospital care and *medical services*.⁶²⁸

⁶²¹ Veterans Readjustment Benefits Act of 1966, Pub. L. No. 89-358, 80 Stat. 12 (1966).

⁶²² Pub. L. No. 91-500.

⁶²³ S. Rep. No. 91-481.

⁶²⁴ Veterans Health Care Expansion Act of 1973, Pub. L. No. 93-82, 87 Stat. (1973).

⁶²⁵ Veterans Omnibus Health Care Act of 1976, Pub. L. No. 94-581, 90 Stat. 2842 (1976). The patchwork of eligibility provisions resulting from a succession of incremental changes set the stage for development and enactment of the Veterans' Health Care Eligibility Reform Act of 1996, Pub. Law 104-262.

⁶²⁶ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁶²⁷ *Ibid.*

⁶²⁸ The term "medical services" was broadly defined to include in addition to medical examination and treatment, preventive health services; surgical services; wheelchairs, artificial limbs, and similar appliances; optometric and podiatric services; noninstitutional extended care services; and rehabilitative services (including services to restore physical, mental, and psychological functioning. Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C.

§ 1701(6),(8). VA regulations more fully set out the "medical benefits package" that VA is to provide patients, as needed; VA regulations detail that the benefits package includes services ranging from emergency care and prescription drugs to

Recognizing there could be circumstances in which VHA might lack capacity to provide timely care, Congress noted in the reform act that the requirement to provide care would be in effect only to the degree to which there were appropriated funds to pay for such care.⁶²⁹ This qualified availability of care clearly indicated veterans' health care is not an entitlement. Congress went further, though, and established a statutory patient enrollment mechanism for VA to manage access.⁶³⁰ The law specifically requires VA to establish and operate a patient enrollment system managed in accordance with statutory priorities and within any additional priority classifications established by VA. The eligibility reform act gave VA tools both to limit demand consistent with available funding and to discourage veterans from seeking VA care simply to fill an occasional need not met by a private health plan.⁶³¹ The act also requires the SECVA to manage the enrollment system such that care is timely and of acceptable quality.⁶³²

The enrollment system the department established is not being used today to calibrate supply and demand as envisioned.⁶³³ Although law and VA regulation require a system of annual patient enrollment,⁶³⁴ VHA last curtailed enrollment in 2003, and then only for veterans who were deemed eligible based on the category 8 criteria (see Table 8) that include those with higher-level incomes who lack any higher priority. In 2009, the Obama administration eased access for higher income veterans. Under that policy, veterans whose gross household income exceeds VA's current geographic income limit by 10 percent or less may enroll for VA care, subject to cost-sharing requirements.⁶³⁵ In 2014, Congress established the *Choice Program* to expand availability of care through contracts with community providers. Veterans' choice was limited by reference to distance and wait-time issues, but was otherwise broadly open to any enrolled veterans.⁶³⁶

comprehensive rehabilitative services, home health services, noninstitutional extended care services, hospice care, and pregnancy and delivery services and newborn care. Medical Benefits Package, 38 C.F.R. 17.38.

⁶²⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General 38 U.S.C. § 1710(a)(4).

⁶³⁰ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705. As explained in the report of the House Committee on Veterans Affairs which developed the legislation, "[T]he Act would...provide the VA with an important tool, the authority to design and manage access to care through a system of patient enrollment...Enrollment...would help the VA plan more effectively, so that facilities can better calculate and dedicate the resources needed to provide the care its enrollees require. The Act would direct the Secretary...to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment (or registration) system would operate. For example, the VA would be able to establish a system which simply registers patients throughout all or part of a fiscal year, or could employ a time-limited registration period. Significantly, the Act would permit the Secretary to set priorities within the specified priority classifications established in the Act. The Secretary could, for example, establish a policy which, within any priority classification, gives veterans who have previously been "enrolled" as VA patients priority over new applicants. However, the Committee expects any enrollment system to be designed and administered to assure that any veteran with a service-connected condition would receive priority treatment for that condition whether or not that veteran had enrolled for VA care." H. Rep. No. 104-690, 6-7.

⁶³¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262; 110 Stat. 3177 (1996).

⁶³² Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705(b).

⁶³³ H. Rep. No. 104-690, 16.

⁶³⁴ Enrollment, 38 C.F.R. sec. 17.36(c). VA regulations state that "[i]t is anticipated that that each year the Secretary will consider whether to change the categories and subcategories of veterans eligible to be enrolled."

⁶³⁵ Enrollment, 38 C.F.R. 17.36(b)(8)(ii),(iv).

⁶³⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014). Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, Pub. L. No. 114-41 (2015).

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Table 8. Priority Groups

Priority Group	Definition
1	<ul style="list-style-type: none"> ▪ Veterans with VA-rated service-connected disabilities 50% or more disabling ▪ Veterans determined by VA to be unemployable due to service-connected conditions
2	<ul style="list-style-type: none"> ▪ Veterans with VA-rated service-connected disabilities 30% or 40% disabling
3	<ul style="list-style-type: none"> ▪ Veterans who are former prisoners of war ▪ Veterans awarded a Purple Heart medal ▪ Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty ▪ Veterans with VA-rated service-connected disabilities 10% or 20% disabling ▪ Veterans awarded special eligibility classification under Title 38, U.S.C. § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation" ▪ Veterans awarded the Medal of Honor
4	<ul style="list-style-type: none"> ▪ Veterans who are receiving aid and attendance or housebound benefits from VA ▪ Veterans who have been determined by VA to be catastrophically disabled
5	<ul style="list-style-type: none"> ▪ Non-service-connected veterans and noncompensable service-connected veterans rated 0% disabled by VA with annual income below VA's and geographically (based on resident zip code) adjusted income limits ▪ Veterans receiving VA pension benefits ▪ Veterans eligible for Medicaid programs
6	<ul style="list-style-type: none"> ▪ Compensable 0% service-connected veterans ▪ Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki ▪ Project 112/SHAD (shipboard hazard and defense) participants ▪ Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975 ▪ Veterans of the Persian Gulf War who served between August 2, 1990 and November 11, 1998 ▪ *Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987 ▪ Veterans who served in a theater of combat operations after November 11, 1998 as follows: <ul style="list-style-type: none"> – Currently enrolled veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge. – **Combat veterans who were discharged between January 2009 and January 2011, and did not enroll in the VA health care during their five-year period of eligibility have an additional one year to enroll and receive care. The additional one-year eligibility period began February 12, 2015 with the signing of the Clay Hunt Suicide Prevention for America Veterans Act. <p>Note: At the end of this enhanced enrollment priority group placement time period veterans will be assigned to the highest Priority Group (PG) their unique eligibility status at that time qualifies for.</p> <p>*Note: While eligible for PG 6; until system changes are implemented you would be assigned to PG 7 or 8 depending on your income.</p> <p>*Note: While eligible for PG 6; due to system limitations, veterans will be manually assigned to PG 8c, yet eligible for the enhanced benefits</p>
7	<ul style="list-style-type: none"> ▪ Veterans with gross household income below the geographically-adjusted income limits for their resident location and who agree to pay copays

Priority Group	Definition
8	<ul style="list-style-type: none"> ▪ Veterans with gross household income above VA and the geographically-adjusted income limits for their resident location and who agrees to pay copays <p>Veterans eligible for enrollment:</p> <p>Noncompensable 0% service-connected:</p> <ul style="list-style-type: none"> – Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA or geographic income limits by 10% or less <p>Non-service-connected and:</p> <ul style="list-style-type: none"> – Subpriority c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority d: Enrolled on or after June 15, 2009, whose income exceeds the current VA or geographic income limits by 10% or less <p>Veterans not eligible for enrollment:</p> <p>Veterans not meeting the criteria above:</p> <ul style="list-style-type: none"> – Subpriority e: Noncompensable 0% service-connected (eligible for care of their service-connected condition only) – Subpriority g: Non service-connected

Analysis

Two decades have passed since Congress last reexamined VHA eligibility and benefits, and many far-reaching changes that affect veterans' health care have occurred in that time. In more than a decade of war, 2.75 million troops have deployed to Iraq and Afghanistan⁶³⁷ where many have faced long and repeated deployments; constant risk of injury and death; and high levels of psychological disorders, substance abuse issues, and physical health problems.⁶³⁸ Post-9/11-era veterans are enrolling for VA care at historically high levels.⁶³⁹

Under current law and VA policy, enrollment is open to a relatively broad spectrum of veterans, though some veterans with higher incomes are not eligible to enroll.⁶⁴⁰ As discussed above, the law draws distinctions between those whose health problems have been adjudicated as service-connected and those whose problems are deemed non-service-connected. If Congress substantially reduced funding for VA medical care, the distinction would be important because those with service-connected issues have higher priority for enrollment. Under VA's current enrollment policy, which bars only veterans with higher incomes from receiving care, the

⁶³⁷ Defense Manpower Data Center, *Contingency Tracking System (CTS) Deployment File*, (Dec. 31, 2015).

⁶³⁸ Institute of Medicine of the National Academies, *Returning Home from Iraq and Afghanistan: Readjustment Needs of Veterans, Service Members, and Their Families*, (Washington, DC: The National Academies Press, 2013), accessed June 25, 2016, <http://www.nationalacademies.org/hmd/Reports/2013/Returning-Home-from-Iraq-and-Afghanistan.aspx>.

⁶³⁹ Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *Profile of Post-9/11 Veterans: 2014*, accessed May 27, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Post_911_Veterans_Profile_2014.pdf.

⁶⁴⁰ Veterans Health Administration, *Enrollment Determinations*, VHA Handbook 1601A.03, 9-10 (2015). Veterans with gross household income that do not exceed VA's means test threshold and a geographic means test by more than 10 percent may enroll for care, while those with higher income and no other special eligibility may not.

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statutory service-connected enrollment priority has little practical significance.⁶⁴¹ Future budget constraints could result in more restrictive enrollment criteria⁶⁴² or recurrence of lengthy wait times that hinder service-connected, disabled veterans' ability to receive timely care.

Current eligibility law does afford special status to veterans who deployed to a combat theater. It grants a 5-year window of eligibility for care to those veterans who are not otherwise eligible.⁶⁴³ All combat veterans are also eligible for readjustment counseling services at VHA Vet Centers without needing to enroll in VHA care and without time limitation.⁶⁴⁴ It is questionable, however, if the 5-year time limit takes sufficient account of continued reluctance of some veterans to seek care for behavioral health problems⁶⁴⁵ or of the difficulties of establishing service-connection years later for conditions that may be linked to wartime exposures to toxic substances.⁶⁴⁶ It is challenging for veterans to establish service-connection for health conditions that may have been caused by or associated with a long-distant exposure for which there may be no documentation. Given emerging evidence that combat exposure should be considered a risk factor for coronary heart disease,⁶⁴⁷ it has been suggested that combat exposure may not only take a toll on psychological health, but may exert a physiologic toll as well.⁶⁴⁸

Congress has attempted to remedy the challenge of documenting toxic exposures and establishing that particular illnesses are linked to wartime or other service exposure. It has, for example, enacted statutes that provide certain veterans eligibility for health care on the presumption that they were exposed to particular toxic substances.⁶⁴⁹ Congress went a step further in the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 which provided eligibility for care for several types of cancer and other specified conditions for family members of veterans who had been exposed to drinking water contaminated with industrial solvents and other toxic chemicals at the Marine Corp base.⁶⁵⁰

Congress has made only limited provision for VA to cover care for family members of certain veterans,⁶⁵¹ but with research suggesting that long combat deployments can take a

⁶⁴¹ Prior to 1996, provisions of law required VA to ensure special priority to service-connected veterans in furnishing outpatient care. 38 U.S.C. § 1712(i), repealed by § 101(c), Pub. L. No. 104-262.

⁶⁴² Enrollment, 38 C.F.R. 17.36(c)(1).

⁶⁴³ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(3), as amended by Sec. 7, Pub. L. No. 114-2 (2015), accessed June 20, 2016, <https://www.govtrack.us/congress/bills/114/hr203/text>.

⁶⁴⁴ Readjustment Counseling Service, 38 U.S.C. § 7309.

⁶⁴⁵ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶⁴⁶ Matthew S. King et al., "Constrictive Bronchiolitis in Soldiers Returning from Iraq and Afghanistan," *New England Journal of Medicine*, 365, no. 10 (2011): 222-230, accessed June 20, 2016, <http://doi.org/10.1056/NEJMoa1101388>.

⁶⁴⁷ Nancy F. Crum-Cianflone et al., "Impact of Combat Deployment and Posttraumatic Stress Disorder on Newly Reported Coronary Heart Disease Among US Active Duty and Reserve Forces," *Circulation*, 129, (2014), accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.113.005407>.

⁶⁴⁸ Rachel Lampert, "Veterans of Combat: Still at Risk When the Battle is Over," *Circulation*, 129, (2014): 1797-1798, accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.114.009286>.

⁶⁴⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(10).

⁶⁵⁰ Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Pub. L. No. 112-154, 126 Stat. 1165 (2012).

⁶⁵¹ Health Care of Persons Other Than Veterans, 38 U.S.C. §§ 1781-1787.

psychological toll on family members,⁶⁵² there may be circumstances under which it might be argued that VA should afford such family members behavioral health services. Studies indicate that longer deployments, deployment extensions, and posttraumatic stress disorder in military personnel are associated with psychological problems for the spouse.⁶⁵³ Long-term effects are unknown, yet studies suggest children may have heightened risk for psychosocial issues during a parent's deployment.⁶⁵⁴

The experience of the nation's longest war and increased options available under the Affordable Care Act (ACA), particularly to previously uninsured non-service-connected veterans, may raise new questions for policymakers.⁶⁵⁵ VHA's most recent survey of enrollees showed that 20 percent of enrollees reported that they were uninsured, down from 22 percent in 2014.⁶⁵⁶ Enrollment in VHA-provided care meets the ACA requirement for health care coverage, creating pressure to continue to provide care to those enrolled.⁶⁵⁷ Given that VHA serves large numbers who are poor or near poor and have chronic medical conditions and behavioral health problems,⁶⁵⁸ it is important to note that receiving care under an ACA plan would not necessarily be a substitute for the rich benefits afforded through VHA. In addition, adults in this population are only eligible for coverage under ACA through state expansion of Medicaid that 19 states have elected not to accept, making this option unavailable to poor or near poor veterans in many parts of the country.⁶⁵⁹

Over time Congress has expanded VA health care eligibility to increasingly more cohorts of non-service-connected veterans. There is wide variability among different cohorts in the extent to which veterans rely on VA care. Those at the higher-income levels (priority categories 7 and 8) who were generally not eligible for ambulatory care prior to 1996, for example, rely on VA for

⁶⁵² Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, accessed June 20, 2016, <http://dx.doi.org/10.1186%2F1471-244X-10-88>. Swords to Plowshares, presentation to Commission on Care, January 21, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former servicemembers. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁶⁵³ H. Thomas De Burgh et al., "The Impact of Deployment to Iraq or Afghanistan on Partners and Wives of Military Personnel," *International Review of Psychiatry*, 23, no. 2 (2011): 192-200, <http://www.ncbi.nlm.nih.gov/pubmed/21521089>.

⁶⁵⁴ Gregory H. Gorman, Matilde Eide, and Elizabeth Hisle-Gorman, accessed June 20, 2016, "Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints," *Pediatrics*, 126, no. 6 (2010): 1058-1066, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-2856>. Anita Chandra et al., "Children on the Homefront: The Experience of Children from Military Families," *Pediatrics*, 125, no. 1 (2010): 16-25, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-1180>.

⁶⁵⁵ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁶ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁵⁷ "Affordable Care Act & Veterans," Department of Veterans Affairs, accessed May 27, 2016, <http://explore.va.gov/health-care-affordable-care-act?show=all>.

⁶⁵⁸ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁹ "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update," Rachel Garfield and Anthony Damico, Kaiser Family Foundation, accessed March 29, 2016, <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/>.

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less than 22 percent of their outpatient care-needs, based on VA's most recent survey of veteran enrollees' health and use of care.⁶⁶⁰

One consideration, as suggested by a few Commissioners, is the feasibility of allowing veterans' family members and currently ineligible veterans to purchase VHA care through their health plans in areas where VHA hospitals and other facilities might otherwise need to close. In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. A related challenge is maintaining safe volume of care when patient loads decline. As an extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁶¹ Similarly, VHA may be unable to continue offer specialty care in certain areas if it forced to close facilities. Patients in a polytrauma unit for example, require a full spectrum of routine and nonroutine health care.

Closing a low-volume hospital may be the answer in some instances. But closing VHA facilities reduces the choices available to veterans. Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. See Appendix C for a further discussion of the challenge of future VHA hospital closures and an outline of suggested pilot programs.

Substantial changes have occurred since Congress last comprehensively examined eligibility for VHA care. These changes merit a reexamination of VA health care eligibility.⁶⁶² The Commission did not, however, view its charge of examining veterans' access and how best to organize VHA, locate health care resources, and deliver care in the years ahead⁶⁶³ as calling for it to make recommendations on this fundamental policy issue, and recommends that the President or Congress consider tasking another body to develop recommendations for VA care eligibility and benefit design. The Commission's work, however, has illuminated the fact that nothing in law or regulation assures a service-connected, disabled veteran of priority for care. VA can and should amend its regulations to provide for such priority, subject to a necessarily higher priority for urgent and emergent care.

Implementation

Legislative Changes

- Task another body to examine the need for changing eligibility for VA care and benefits design, which would include simplifying eligibility criteria, and may include exploring

⁶⁶⁰ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 75, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁶¹ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

⁶⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 25, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶⁶³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

pilots for expanding eligibility for nonveterans to use underutilized providers and facilities when paid for through private insurance.

VA Administrative Changes

- SECVA should amend 38 C.F.R., chapter 17 to establish that veterans with service-connected disabilities shall be afforded priority for access to care, subject to the priority dictated by clinical care needs.

Other Departments and Agency Administrative Changes

- None required.

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Commission on Care

Final Report

COMMISSION ON CARE

June 30, 2016

VA-18-0457-A-002699

3722

COMMISSION ON CARE

Final Report of the Commission on Care

June 30, 2016

Commission on Care
1575 I Street, NW
Washington, DC 20005



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COMMISSION ON CARE

1575 I Street, NW ▪ Washington, DC 20005

June 30, 2016

We are honored to submit to the President, through the Secretary of Veterans Affairs, in accordance with the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), the enclosed recommendations for transforming veterans' health care. We believe these recommendations are essential to ensure that our nation's veterans receive the health care they need and deserve, both now and in the future.

We worked with an absolute commitment to putting veterans at the heart of our deliberations, and believe our recommendations will create an integrated, community-based health care system for veterans that will be sustainable for the long term. During the term of the Commission on Care, we evaluated the 4,000-page *Independent Assessment Report*; held public meetings; listened to a broad range of stakeholders, including veterans and leaders of veterans service organizations; made site visits to Veterans Health Administration (VHA) facilities; and exchanged ideas with individual veterans, VA and VHA leaders, VHA employees and health care providers, members of Congress, economists, and health care experts.

Overall, the Commissioners agree with the findings of the *Independent Assessment Report*, which are consistent with the expansive body of other evidence the Commissioners have reviewed. This evidence shows that although care delivered by VA is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes. The Commissioners also agree that America's veterans deserve much better, that many profound deficiencies in VHA operations require urgent reform, and that America's veterans deserve a better organized, high-performing health care system.

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The most public and glaring deficiency was access problems. Congress attempted to solve this problem through a provision in VACAA that directed VHA to implement a temporary program allowing for greater choice. The Commission finds, however, that the design and execution of the *Choice Program* are flawed. In its place, we offer specific recommendations for standing up integrated veteran-centric, community-based delivery networks that will optimize the balance of access, quality, and cost-effectiveness.

The Commission also finds that the long-term viability of VHA care is threatened by problems with staffing, facilities, capital needs, information systems, health care disparities and procurement. Fixing these problems requires deliberate, concurrent, and sequential actions. It also requires fundamental changes in governance and leadership of VHA to guide the organization during the next two decades through the rapid changes coming in demographics, technology, and in the structure of the overall U.S. health care system.

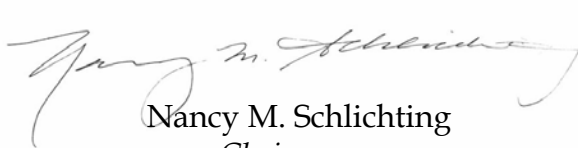
VHA has many excellent clinical programs, as well as research and educational programs, that provide a firm foundation on which to build. As the transformation process takes place, VHA must ensure that the current quality of care is not compromised, and that all care is on a trajectory of improvement. VHA has begun to make some of the most urgently needed changes outlined in the *Independent Assessment Report*, and we support this important work.

Implementing the recommendations in this report will greatly enhance VHA's ongoing reform efforts by providing both a systems-oriented framework and vitally needed changes in organizational structure. Foundational among these changes is forming a governing board to set long-term strategy and oversee the implementation of the transformation process, and building a strong, competency-based leadership system.

The remaining recommendations work in harmony to ensure veterans receive timely access to care, have options for where and how they receive care, are cared for in an environment that embraces diversity and inclusion, and are supported in making informed decisions about their own health and well-being. These recommendations are

not small-scale fixes to finite problems. Instead, they constitute a bold transformation of a complex system that will take years to fully realize, but that our country must undertake to provide our veterans with the high-quality health care they richly deserve.

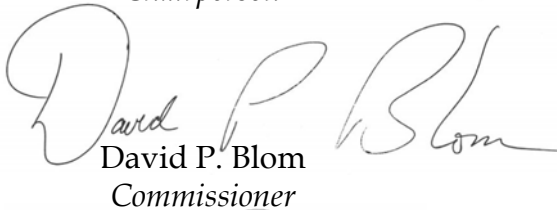
Respectfully Submitted,



Nancy M. Schlichting
Chairperson




Delos M. Cosgrove, MD
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David P. Blom
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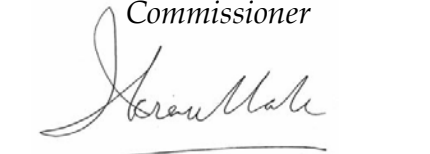
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EXECUTIVE SUMMARY

Two years ago, a scandal over VHA employees' manipulation of data systems to cover up long appointment scheduling delays made headlines and left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. The White House appointed new leadership, including the secretary of veterans affairs (SECVA) and the undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program*, to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The independent assessment included an examination of the hospital care, medical services, and other health care provided in VA medical facilities.¹ The legislation identified 12 specific areas for in-depth evaluation:

- Demographics
- Health Care Capabilities
- Care Authorities
- Access Standards
- Workflow–Scheduling
- Workflow–Clinical
- Staffing/Productivity
- Health Information Technology
- Business Processes
- Supplies
- Facilities
- Leadership

The *Independent Assessment Report* provided a detailed analysis of the assessment and associated findings. The Commission work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

In an effort to focus the Commission's recommendations and set the tone for subsequent change, the Commissioners developed a vision, a mission, and a set of values to drive reform as shown below. The vision provides the conceptual framework for the model of veterans' health care put forth in this report, and the mission and values shape the content of the recommendations.

Vision

Transforming veterans' health care to enhance quality, access, choice, and well-being.

- *Quality: Provide community-based, innovative care that drives improved outcomes.*
- *Access: Ensure timely access to the best providers for meeting veterans' health care needs.*

¹ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113–146, § 201(a)(1).

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- *Choice: Integrate health care within communities to foster convenience and efficiency.*
- *Well-Being: Support veterans in achieving optimal physical and mental health.*

Mission

Provide eligible veterans prompt access to quality health care.

Values

- Provide veteran-centric care.
- Involve all stakeholders, and especially veterans and their families, in designing the evolving future health care for veterans.
- Assimilate veterans into the greater community.
- Create community-based integrated networks to improve health care access and choice for veterans.

The recommendations in this report acknowledge that although VHA provides health care that is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes.

Some of these challenges are not exclusive to VHA, and reflect large-scale problems in the U.S. health system in general, such as acute shortages of primary care doctors and lack of health care capacity in poor and rural areas. Other challenges reflect deficiencies within VHA itself, in areas such as staffing, facilities, capital needs, information systems, healthcare disparities and procurement.

It is important to understand VA's long history as a health care provider, which has included previous cycles of crisis and renewal that offer lessons for the present. It is also important to consider how VHA can implement major reform in a manner that is sustainable. This report addresses both of these issues.

The Commission's focus on access to care clearly highlighted the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The report begins with an *Introduction* that addresses the controversy over veterans' health care and gives a brief description of the Commission's vision for improving it. There are three main recommendation sections: *Redesigning the Veterans' Health Care Delivery System*; *Governance, Leadership, and Workforce*; and *Eligibility*. Each section includes detailed discussions of the high-level areas in which change must occur in the respective areas to facilitate bold reform. The format for each discussion includes identification of the problem, the Commission's recommendations for addressing the problem, background information, analysis, and implementation steps for Congress, VA, and other agencies. This executive summary provides a brief overview of each of the recommendations.

For the ease of our readers, the appendices contain all additional content. Of particular interest are appendices on *Financing the Vision and Model, Leadership Implementation, History as a Context for Systemic Transformation, Veteran Feedback, and Additional Resources*. These and other appendices provide policymakers and those charged with implementing the plan with a clear picture of the rationale for the recommendations and the context that frames them.

Recommendations

The Commission does not intend for these recommendations to be piecemeal fixes to everyday problems. Instead, they are presented as the foundation for far-reaching organizational transformation that adheres to a systems approach. The Commission's recommendations comprise the essential elements for such transformation.

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Due to changing veteran demographics, increasing demand for VHA care in some markets and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Congress tasked VHA with creating the temporary *Choice Program*. It was designed to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

The Commission Recommends That . . .

- VHA Care System governing board (see recommendation on p. 94) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.

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- Integrated community-based health care networks be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.
- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

The recommendations above work together to support the VHA Care System, as outlined in Table 1 below.

Table 1. VHA Care System Operations

Key Component	Expectations
Choice	<ul style="list-style-type: none"> ▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	<ul style="list-style-type: none"> ▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.²

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.³ For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified “not working to top of provider licensure” as a barrier in health care provision.⁴

² RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

³ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁴ Ibid., 95.

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VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

The Commission Recommends That. . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally supported programs.

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.⁵ Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).⁶

As part of the MyVA initiative, the Secretary of Veterans Affairs has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.⁷ The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.⁸

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a revised clinical-appeals process.

⁵ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

⁶ VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷ "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, <http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx>.

⁸ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.⁹

VHA has a program of system engineering — Veterans Engineering Resource Center (VERC) — that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to identify proactively problem areas within the system and offer assistance.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*, Assessment F (Workflow—Clinical), 14 and A-2, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

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A systematic review of VHA in 2007 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.¹⁰ VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues—the Health Equity Action Plan (HEAP)—but it has not been fully implemented.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.¹¹

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

Veterans who turn to VHA to meet health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of those barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks holds the promise of markedly improving veterans' access to care. That promise cannot be realized without transformative changes to VHA's capital structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of building out the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as

¹⁰ Somnath Saha et al., *Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review*, U.S. Department of Veterans Affairs, Health Services Research & Development Service, June 2007, accessed June 22, 2016, <http://www.hsrd.research.va.gov/publications/esp/RacialDisparities-2007.pdf>.

¹¹ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

much control as possible to drive the process to ensure that all facility plans are fully integrated with the strategic vision for the VHA Care System.

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meets its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission (BRAC) process to be implemented as soon as practicable. The Commission recommends the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems; enables scheduling, billing, claims, and payment, and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.¹² VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, VHA lacks an experienced senior health care IT leader focusing on the strategic health care IT needs of veterans.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing

¹² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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and implementing a comprehensive health IT strategy and developing and managing the health IT budget.

- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.¹³

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.

¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

Governance, Leadership, and Workforce

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center, and similar problems at multiple other VA medical centers, had both direct and indirect causes. Weak governance was found to be among those indirect causes.¹⁴ As the authors of a root-cause analysis of the Phoenix scandal highlighted, “a governance gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed to the wait-time problems.¹⁵ The report authors observed, “Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors.”¹⁶ The governance limitations made evident in the Phoenix scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration’s expectations for short-term results,¹⁷ and VHA’s operating in a “dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with competing demands”¹⁸ offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act (FACA) and be structured based on the key elements included in Table 5.

¹⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁵ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

Leadership

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

High-performing organizations have healthy cultures in which diverse staff feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government. For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

The Commission Recommends That . . .

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report on it to the CVCS and the new VHA Care System board of directors (see governance discussion in the previous section).

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and

promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an OMB management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and the functions overlap or are duplicated. The role of the VISN is not clear, and the delegated responsibilities of the medical center director are not defined.

The Commission Recommends That . . .

- VHA redesign VHACO to create high-performing support functions that serve VISNs and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the CVCS with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report.

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Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

To achieve the Commission’s vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set—identical to private-sector standards—will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes to veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders’ performance not just on *what* they achieve but *how* they achieve it.

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Personnel Performance Management System

- VHA create a new performance management system appropriate for health care executives, tied to health care executive competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of

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these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veterans' care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does all of the following:
 - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
 - Promotes veteran preferences and hiring.

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- Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, due process) through simplified, sensible processes that work for managers and employees.
 - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
 - Provides due process and appeals standards to adverse personnel actions.
 - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
 - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
 - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
 - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
 - Grandfathers current employees with respect to pay and benefits.
- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

Recommendation #16: Require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Effective planning for and management of human capital are core enabling requirements for any business: If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

The Commission Recommends That . . .

- VHA hire a chief talent leader who holds responsibility for the operation's entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the chief of VHA Care System.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.

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- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

In some cases, individuals have been dismissed from military services with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury [TBI], posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

The Commission Recommends That . . .

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an OTH discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Although VHA continues to offer the promise of health care to all eligible veterans, its capacity to meet that promise is constrained by appropriated funding.¹⁹

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use

¹⁹ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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underutilized VHA providers and facilities, providing payment through private insurance.

- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

Conclusion

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, though, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient-provider engagement and in where and how care is delivered. VHA must keep pace with, and even be a leader in, these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand access to reflect not only timeliness, but care quality, and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone: Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report* emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The Commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term transformation, the Commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the nation's obligation to those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission fully acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the Commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For

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example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net. Even considering these strengths, some may question how a system beleaguered with the problems VHA faces can achieve lofty transformation goals. This is not the first time VHA has faced challenges; however, and history has demonstrated that with appropriate structure and strategies in place, transformation can be achieved and sustained.

Transformation is a difficult process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. The Commission's recommendations in some areas acknowledge VHA's efforts to begin the transformation process and suggest that where these efforts align with the Commission's recommendations, they should be sustained. Reaping the fruits of transformation will take more than a single Congress or a single 4-year administration. For this reason, the Commission strongly recommends a new governance model and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission's recommendations, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

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INTRODUCTION

Two years ago, a scandal over VHA employees manipulating data systems to cover up long delays in scheduling care left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. In response, the White House appointed new leadership, including the secretary of veterans affairs (SECVA) and undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program*, to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The Commission on Care's work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

The charge given this Commission, with its emphasis on access to care, reflects the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the Commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, however, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient-provider engagement, and in where and how care is delivered. VHA must keep pace with, and even be a leader, in these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand *access* to reflect not only timeliness, but care quality and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone; Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report*

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emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term *transformation*, the commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the obligation owed those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net.

Others may question how a system with the range of problems VHA faces can meaningfully improve, let alone realize a transformation. Mindful of its 20-year charge, the Commission notes that VA health care faced similar challenges 20 years ago and underwent a historic transformation. The long history of the VA health care system has seen highs and lows. Among the lessons in that history is that the mission—to care for those who have borne the battle—is not only powerful, but enduring. History has demonstrated that transformation can be achieved, but also that structures and strategies for sustainability must be built into the framework.

As the commission report emphasizes, transformation is difficult. It is a process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. VHA has begun some of this work; our recommendations in some areas acknowledge VHA's efforts and suggest that where they are aligned with the Commission's recommendations, they should be sustained. The fruits of the transformation, though, will not be realized over the course of a single Congress or a single 4-year administration. For this reason, the Commission, strongly recommends a new form of governance and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission recommends, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

COMMISSION RECOMMENDATIONS

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Problem

Due to changing veteran demographics, increasing demand for VHA care in some markets, and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With the passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACA), Congress tasked VHA with creating the temporary *Choice Program*. It was intended to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

The Commission Recommends That . . .

- VHA Care System governing board (see Recommendation #9) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.
- Integrated, community-based health care networks be developed with *local* VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.

Recommendations continue on next page. =>

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Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

Background

VHA has long had authority to purchase hospital care and medical services based on geographic inaccessibility or VHA's lack of a required service.²⁰ In 2013, VA moved beyond the use of individual purchased-care authorizations to regional contracting under the Patient-Centered Community Care (PC3) Program.²¹ In all cases, purchased care was a secondary means of providing care, to be used "when VA health care facilities are not feasibly available."²² Even before the creation of the *Choice Program* in 2014, some 10 percent of VHA medical spending went for purchased-care services.

When Congress enabled what became known as the *Choice Program*, it tasked VHA with implementing a fundamentally new mechanism for purchasing care. Unlike traditional purchased-care authority (which still exists), the *Choice Program* promises veterans who meet specific geographic or wait-time-related criteria that they can elect to receive treatment from within a network of a community providers.²³

Under the current *Choice Program*, however, most VHA patients are promised little or no actual choice of providers outside VHA. To be eligible for the program, VHA patients must meet the following criteria:²⁴

The Commission Recommends That . . .

<= Recommendations continued from previous page.

- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- The VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

²⁰ Contracts for Hospital Care and Medical Services in Non-Department Facilities, 38 U.S.C. § 1703(a).

²¹ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, 37, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

²² Non-VA Medical Care Program, VHA Directive 1601, (2013).

²³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014).

²⁴ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014), as amended by Construction Authorization and Choice Improvement Act, Pub. L. No. 114-19, 129 Stat. 215, (2015). The Independent Assessment proposed that VA should "Develop and implement more sensitive standards of geographic access to care. VA should compare the 'one-size-fits-all' approach of driving distance to alternative standards that are more sensitive to differences between Veteran subgroups, clinical populations, geographic regions, and individual facilities. This

- Live more than 40 miles from the closest VHA facility with a full-time primary care provider
- Cannot be seen within 30 days of the date veterans' providers indicate they need to be seen.
- Cannot be seen within 30 days of veterans' preferred appointment date if providers have not provided a specific appointment date.

This standard is difficult to reconcile with other statutory priorities for VA care.²⁵ For example, under the *Choice Program*, a veteran with severe service-incurred health conditions may have no access to providers outside VHA, yet a veteran with no service-related disabilities does have such a choice.²⁶ Implementing the *Choice Program* has posed challenges, including difficulties arising from overlapping, but fundamentally different, care-purchasing authorities. Veterans, VHA staff, and community providers²⁷ have been confused because of conflicting requirements and processes in eligibility rules, referrals and authorizations, provider credentialing and network development, care coordination, and claims management.²⁸

Adding to the confusion is the fact that VHA, facing a 90-day deadline for implementing the program, outsourced the creation and management of its provider networks to two private contractors, thus blurring lines of responsibility and leaving both patients and providers confused about who exactly holds responsibility for what. In execution, the program has aggravated wait times and frustrated veterans, private-sector health care providers participating in networks, and VHA alike.²⁹

In October 2015, VA submitted a report to Congress that proposed legislation to harmonize the different purchased-care authorities into a single approach.³⁰ VA's report also set out a plan for establishing high-performing networks. The report acknowledged that "[n]o organization can excel at every capability," and that "[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers."³¹ As further articulated by Dr. David Shulkin, USH:

assessment highlighted the importance of time spent driving, mode of transportation, traffic, and availability of needed services as key considerations in assessing geographic access to care."

²⁵ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705.

²⁶ Ibid.

²⁷ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, 43, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf. Pete Henry, retired VA medical center director, response to questions about the challenges facing field officials, email to Commission on Care staff, January 18, 2016.

²⁸ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

²⁹ "Despite \$10B 'Fix,' Veterans are Waiting Even Longer to See Doctors," Quil Lawrence, Eric Whitney, and Michael Tomsic, accessed May 16, 2016, <http://www.npr.org/sections/health-shots/2016/05/16/477814218/attempted-fix-for-va-health-delays-creates-new-bureaucracy>.

³⁰ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

³¹ Ibid., 18.

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It's become apparent that the VA alone cannot meet all the health care needs of U.S. veterans. The VA's mission and scope are not comparable to those of other U.S. health systems. Few other systems enroll patients in areas where they have no facilities for delivering care. Fewer still provide comprehensive medical, behavioral, and social services to a defined population of patients, establishing lifelong relationships with them. These realities, combined with the wait-time crisis, have led the VA to reexamine its approach to care delivery . . . [A]ddressing veterans' needs requires a new model of care: rather than remaining primarily a direct care provider, the VA should become an integrated payer and provider. This new vision would compel the VA to strengthen its current components that are uniquely positioned to meet veterans' needs, while working with the private sector to address critical access issues.³²

Analysis

VHA needs systemic transformation, and merely clarifying and simplifying the rules for purchased care, as proposed in the *Independent Assessment Report*, is not sufficient to achieve that goal. VHA must replace the arbitrary eligibility requirements and unworkable clinical and administrative restrictions of current purchased programs with the new VHA Care System, available to all enrolled veterans.

The VHA Care System is defined as VHA employed providers and facilities; Department of Defense (DoD) and other federally-funded providers and facilities; and community-based, VHA-credentialed community providers and facilities, forming integrated networks to deliver high-quality and high-access care to enrolled veterans across the United States. VHA may establish the networks with the use of national contractors or with internal resources, but networks should be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.

This new delivery model must preserve critical VHA programs and competencies that are unique to VHA or that are of higher quality or greater scope than is available in the private sector, either locally or nationally³³ They include specialized behavioral health care programs, integrated behavioral health and primary care (in patient-aligned care teams), specialized rehabilitation services, spinal cord injury centers, and services for homeless veterans.³⁴ These and similar programs and services are core competencies and special capabilities that serve the needs of combat veterans, veterans with conditions incurred or aggravated in service, and veterans reliant on safety-net services and supports.³⁵ Because of its unique capabilities and competencies, VHA should play an important role in expanding and enhancing the care of veterans across the United States by collaborating with local network providers to improve the

³² David J. Shulkin, "Beyond the VA Crisis — Becoming a High-Performance Network," *New England Journal of Medicine*, 374, (2016): 1003-1005, accessed June 15, 2016, <http://doi.org/10.1056/NEJMp1600307>.

³³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

³⁴ Special capabilities like spinal cord injury care, which draw from specialty care available in the full-service hospitals in which they are currently provided, merit continued support and investment. Thus, in instances where VHA might no longer operate a full-service hospital that had once housed a spinal cord injury center, it would need to establish community partnerships to assure veterans would continue to receive the same high quality care.

³⁵ David J. Shulkin, "Why VA Health Care Is Different," *Federal Practitioner*, 33, no. 5 (2016): 9-11, <http://www.fedprac.com/home/article/why-va-health-care-is-different/c8da5ba1261bdb726bdddcbceea81f27.html>.

availability and quality of care in areas especially needed by veterans, such as mental health and rehabilitation.

Management and Oversight

VHA Care System networks will be built out in a well-planned, phased approach overseen by the new governing board, which will determine the criteria and sequencing for the phases, to ensure effective execution of the strategy. The timing and phasing criteria may include veteran service needs, access issues, quality issues, facility issues, and IT capabilities.

The networks within the VHA Care System will require ongoing management and evaluation of their performance. This process will be the responsibility of VHA management and board, with board oversight of network performance.

The governing board will oversee the budget for the VHA Care System. Local leadership will provide input on funding, and the local networks will determine their funding needs and submit their respective requests to the chief of VHA Care System (CVCS), formerly the undersecretary of health for VHA. The governing board will recommend to Congress the budget required to implement the VHA Care System, with multiyear appropriations. The local network leaders will have the flexibility to manage their respective network budgets based upon local needs. A key element of the new system will be combining a national strategy and local flexibility for managing the budget to allow for effective decision making to ensure veterans' needs are met.

Provider Payment

Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS). MACRA is intended to move the health care industry away from a fee-for-service model to value-based payments.³⁶ Such a system is expected to drive improved quality and lower costs.³⁷

Care Administration

From a strategic perspective, service-connected disabled veterans should receive the highest priority access to the VHA Care System. This principle should guide access to all types and points of care. Veterans with limited financial means should also have high priority. If needed, cost sharing (applicable only to those who are non-service-connected disabled and not financially needy) can provide a means for offering broader choice. The current time and distance criteria for community care access (30 days and 40 miles) should be eliminated. VISN geography should also be eliminated as a factor in determining where veterans can access care. Eligible veterans should be permitted to receive care at any facility and by any provider in the VHA Care System, whether in a veteran's home VISN or not.

Choice and Care Coordination

The topic of choice was the most contentious issue considered by the Commission. Some Commissioners advocated complete choice of providers for veterans, with no requirement for

³⁶ "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, <http://www.nationalpartnership.org/issues/health/macra.html>.

³⁷ Ibid.

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care coordination by primary care physicians. Others advocated for a tightly managed model with VHA controlling access to community providers, as is done today. After considering the costs of various design options, the importance of care coordination, and the need for greater veteran access to both primary care and specialty care services, the Commission agreed to the following design principles:

- VHA will establish and credential community networks with a focus on quality of providers, access to comprehensive services, and utilization of VHA resources.
- Veterans will have complete choice of primary care providers within the VHA Care System.
- All primary care providers in the VHA Care System (including VHA providers, DoD and other federally funded providers, and community providers) will coordinate veterans' care.
- Specialty care will require a referral from a primary care provider.
- VHA will assume overall responsibility for care coordination and navigation for all enrolled veterans.

Quality of care must be a core element of network design and consistently monitored with metrics that are routinely used by the private sector. Accordingly, VHA must adopt standards that both ensure networks are composed of high-quality providers and set appropriate expectations of those providers. Critically, all providers in the networks must have fully interoperable IT platforms to allow for complete data exchange. Providers must work together to maximize patients' well-being using evidence-based protocols of care.

Lack of coordination among providers is a major quality and patient-safety issue throughout the U.S. health care system. It is important for VHA to coordinate the care it provides because it serves an especially vulnerable population that has more chronic medical conditions, behavioral health conditions, and individuals of lower socioeconomic status than the general medical population.³⁸ Veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers.³⁹

³⁸ Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, <http://doi.org/10.1001/jama.2012.196>.

³⁹ "The Impact of the Affordable Care Act on VA's Dual Eligible Population," Patricia Vandenberg et al., Department of Veterans Affairs, accessed June 2, 2016, <http://www.hsrd.research.va.gov/publications/forum/apr13/apr13-1.cfm>. Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, <http://doi.org/10.1001/jama.2012.196>. Brigham R. Frandsen et al., "Care Fragmentation, Quality, and Costs Among Chronically Ill Patients," *American Journal of Managed Care*, 21, no. 5, (2015): 355-362, accessed June 20, 2016, <http://www.ajmc.com/journals/issue/2015/2015-vol21-n5/care-fragmentation-quality-costs-among-chronically-ill-patients>. Chuan-Fen Liu et al., "Use of Outpatient Care in Veterans Health Administration and Medicare among Veterans Receiving Primary Care in Community-Based and Hospital Outpatient Clinics," *Health Services Research*, 45, no. 5 part 1, (2010): 1268-1286, accessed June 20, 2016, <http://doi.org/10.1111/j.1475-6773.2010.01123.x>.

VHA Care System will operate as outlined in Table 2 below.

Table 2. VHA Care System Operations

Key Component	Expectations
Choice	<ul style="list-style-type: none"> ▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	<ul style="list-style-type: none"> ▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Scope of Provider Networks

In setting up networks within the VHA Care System, VHA must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans' choice, yet would also consume far more financial resources (i.e., taxpayer dollars) due to increased utilization or cost shifting. Currently, money VHA spends on expanding choice is not available to spend on other programs and services vital to its mission.⁴⁰

Health plans commonly limit the size and scope of networks as a cost-management tool, offering insurance products with narrow networks (managed care plans) or more open networks (preferred provider plans). Well-managed, narrow networks can maximize clinical quality by requiring participating clinicians to adhere to evidence-based protocols of care.⁴¹ Achieving high quality and cost effectiveness may constrain consumer choice. A patient's preferred doctor, clinic, or hospital may not be part of that smaller network or the narrow network may not offer sufficient geographic access for some patients.⁴²

VHA must balance these competing considerations. In doing so, it faces a variety of options. In addition to the scope of networks, for example, is the question of whether and how VHA will play a role in steering patients to different providers within the networks. This is another area involving tradeoffs among competing values and considerations. Private-sector health plans

⁴⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 23 accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴¹ "What Tier Networks Will Mean to You," Ken Terry, accessed June 2, 2016, <http://medicaleconomics.modernmedicine.com/medical-economics/content/what-tiered-networks-will-mean-you>.

⁴² Ibid. U.S. Congress, House of Representatives, Committee on Ways and Means, Subcommittee on Health, *Hearing on "Health Care Consolidation"*, 112th Congress, 1st Session, (2011), (Statement of Paul B. Ginsburg, President, Center for Studying Health System Change, Research Director, National Institute for Health Care Reform), accessed June 2, 2016, http://waysandmeans.house.gov/UploadedFiles/Ginsburg_Testimony_9-9-11_Final.pdf.

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often require all specialty care to be preapproved through a referral from a primary care physician. Managed care plans may also use prospective and concurrent utilization review and care management for hospitalization. For prospective reviews, patients must receive approval from their health plan before being admitted to the hospital to ensure the admission is clinically appropriate. Plans may also use concurrent utilization or case management for inpatient care to ensure the care and tests ordered and the length of stay in the hospital are appropriate.⁴³

The Commission carefully weighed these issues in recommending an approach. The Commission considered the effect of cost using various configurations of VHA services and community delivered services (CDS). Options considered by the commission include the following:

- **Recommended Option:** This option provides an integrated network of VHA, DoD and other federally funded providers, and community providers, credentialed by VHA. It requires veterans to attain a referral from their primary care provider to access specialty care.
- **CDS Alternative 1:** The main difference between this option and the *Recommended Option* is primary care, inpatient medical and surgical care, and some standard specialty care would not be eligible for CDS networks and would be accessed within VHA unless the *Choice Program* distance exception applies.
- **CDS Alternative 2:** The division of care between VHA providers and CDS network providers would be the same as for *CDS Alternative 1*; however, veterans would only need to consult their primary care provider before seeking specialty care, rather than obtaining a referral.
- **CDS Alternative 3:** This option would combine the broad network in the *Recommended Option*, but would have no referral or consultation requirement; thus, it would be an extremely generous benefits package.
- **Premium Support:** Under this scenario, enrollees who are younger than 65 would choose a subsidized insurance premium with cost sharing. Access to VA services, including special services, would be eliminated.
- **Eligibility Expansion:** Under this scenario the VA health care system would expand to allow all veterans, regardless of priority group.
- **Other-Than-Honorable Discharges:** A policy change for which individuals with other-than-honorable (OTH) discharge is outlined in Recommendation #17. This option would allow temporary eligibility for VA health care to those with an OTH discharge until the adjudication process to determine long-term eligibility took place.

⁴³ Paul B. Ginsburg, "Achieving Health Care Cost Containment Through Provider Payment Reform that Engages Patients and Providers," *Health Affairs*, 32, no. 5, (2013): 929-934, accessed June 20, 2016, <http://doi.org/10.1377/hlthaff.2012.1007>. While these approaches can help keep costs down, patients, doctors and hospitals can experience the process as bureaucratic interference in clinical care. To implement utilization management, health plans usually include a strong clinical appeals process that both doctors and patients can access to question the decisions made by administrators.

Below is a more detailed summary of the Commission's *Recommended Option*. Additional information, including cost projections for all of the options above, can be found in Appendix A.

Cost Model for Commission Recommended Option

This option would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VHA. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in a substantially different way than by VHA).⁴⁴ In 2014, 68 percent of care would have been eligible for CDS networks at current VHA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network (i.e., from any provider in the VHA Care System). In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

Both CDS networks and traditional Care in the Community (CITC) are priced at Medicare allowable rates by matching Medicare fee schedule data to VA Health Service Categories.⁴⁵ A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities. For care shifting into the CDS networks, we assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance; those costs are not modeled.

We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a provider in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and

⁴⁴ Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health, and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

⁴⁵ Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

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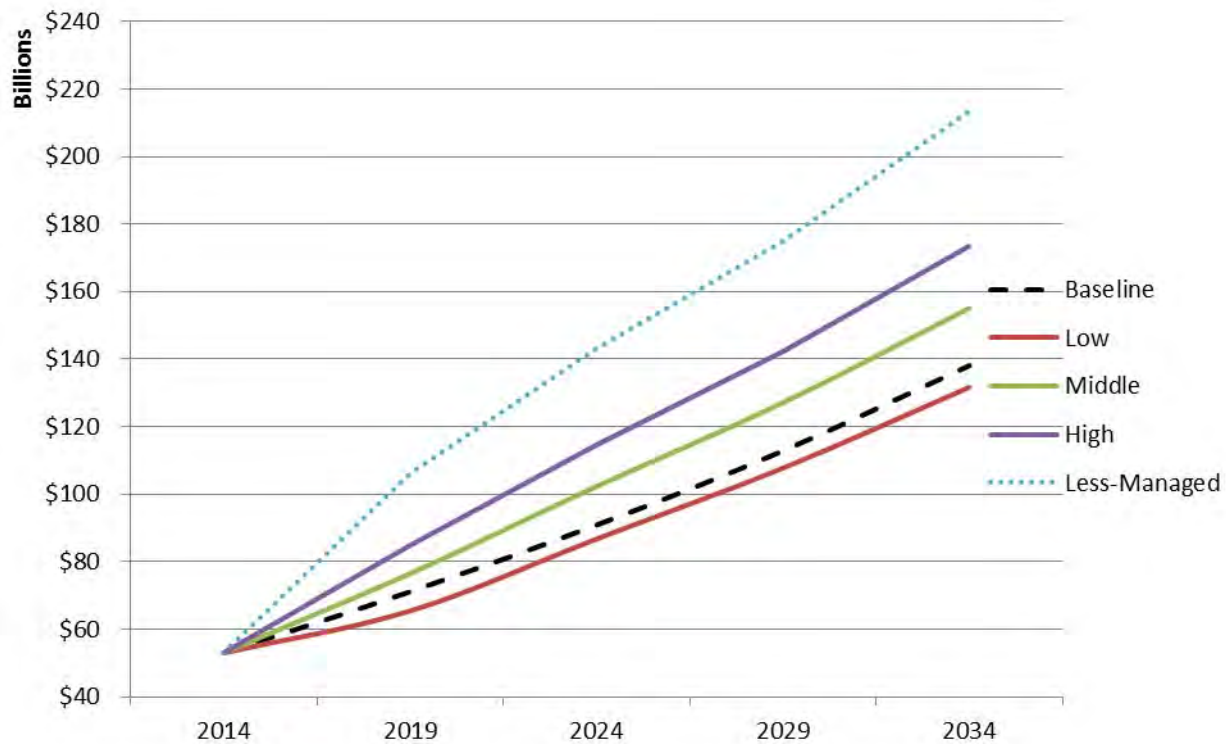
20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was formerly subject to sizable cost sharing with private insurance or Medicare and now would be subject to little, if any, cost sharing associated with VA-financed care.

There are a number of caveats associated with our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects on quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. Finally, estimates do not include administrative costs associated with CDS networks; these costs could be substantial.

Figure 1 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from \$65 billion to \$85 billion in 2019, with a middle estimate of \$76 billion. The middle estimate is moderately above the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is \$106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

This model is described more fully in Appendix A, along with models for a range of other options, some of which are previously described in this section. Consult Appendix A for more details on the technical assumptions necessary to understand the results presented here. The assumptions and caveats detailed in Appendix A play a critical role in our estimates, and any deviation from these assumptions could substantially affect the estimates.

Figure 1. Projected Costs of Recommended Option



Mitigating Risks

Choice involves tradeoffs. Reducing drive times to see a doctor may lead to longer wait times, for example, if it induces substantially more veterans to seek more care.⁴⁶ VHA reliance on contracting could also have unintended consequences for already underserved communities. Providers in such communities who join the local VHA network may decide to limit the number of Medicare and Medicaid patients they accept into their practices. In other, highly concentrated health care markets, which are increasingly common throughout the United States, VHA may not be able to contract for care in the community except at higher prices.⁴⁷ Such circumstances underscore the importance of VHA retaining the option of building its own capacity.

Policymakers must also carefully weigh concerns that leaders of seven major veterans organizations expressed in a recent joint letter in which they warned “choice should never be the ultimate goal of a health care system designed to meet the unique needs of veterans.”⁴⁸ These organizations do not support providing unfettered choice, and the VSO leaders stated that “any health care reform proposal that elevates the principle of ‘choice’ above all other clinical considerations would have severe consequences for veterans who rely on VA, resulting

⁴⁶ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 284, accessed May 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁴⁷ David M. Cutler and Fiona Scott Morton, “Hospitals, Market Share, and Consolidation,” *Journal of the American Medical Association*, 310, no. 18, (2013): 1964-1970, accessed June 20, 2016, <http://doi.org/10.1001/jama.2013.281675>.

⁴⁸ Garry J. Augustine, Disabled American Veterans et al., letter sent to Commission on Care, April 29, 2016.

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in less ‘choice’ rather than the intended desire for more health care options for many disabled veterans.”⁴⁹

The Commission has addressed this concern in several ways, including the following:

- recommendations to substantially improve VHA operations, thereby enhancing the attractiveness of using VHA providers and facilities by enrolled veterans
- VHA control of network design
- VHA Care System governing board oversight of network execution and phasing
- high standards for community provider participation, including credentialing, military competence, and quality and utilization performance
- VHA oversight of care coordination and navigation
- requirement of primary care referral for specialty care

The Commission recognizes that greater choice of provider can result in higher utilization of health care services, which increases costs. This risk can be mitigated by recommendations in this report that will produce cost savings. To incentivize cost mitigation, all cost savings associated with improved efficiency and operations should be reinvested into the VHA Care System. Examples of cost mitigation strategies include the following:

- recovering third-party payments owed to VHA more effectively
- maintaining VHA as a secondary payer when veterans have other health insurance and treatment is for non-service-connected care
- increasing cost-sharing or changes in eligibility and/or benefit design could also substantially contain the projected costs of increasing provider-choice
- reducing fixed costs of underutilized facilities and services
- managing the supply chain to produce cost savings
- improving facilities to increase provider productivity (e.g., increase in outpatient exam rooms)
- adopting information technology that improves the quality and efficiency of care

Effectively implementing and managing integrated networks will require extensive changes in the governance and leadership of VHA, as well as flexible and smart procurement policies and

⁴⁹ Ibid.

contracting authorities, as discussed elsewhere in this report. The highest priority for standing up networks should be locations where VHA quality of care is deficient or capacity is strained.⁵⁰

Where capacity constraints exist within networks, first priority for care should go to those veterans with greatest medical need, followed by service-connected disabled veterans and indigent veterans.⁵¹ VHA should develop processes and procedures for insuring that veterans have the knowledge and assistance they need to make informed health care decision and to navigate effectively through the expanding health care networks. By employing strategies proven by other managed care plans, VHA will find administrative means to guard against inappropriate treatment, wasteful spending, and fraud.

As many surgical and medical procedures that previously required inpatient hospital stays have routinely become outpatient procedures, there continues to be a substantial shift from inpatient to outpatient care.⁵² Consequently, to ensure improved access to care for veterans, the VHA Care System and long-term plans for facilities should focus on creating a robust ambulatory network and reshaping inpatient resources to match expected demand. Additionally, to inform veterans' and providers' decisions and create increased accountability for performance, all VHA and community network providers and facilities must provide transparent information on inpatient and outpatient quality, service, and access using the same performance metrics, including those used by Medicare.

Implementation

Legislative Changes

- Enact legislation amending 38 U.S. Code, Chapter 17 to consolidate existing purchased-care authorities and authorize the SECVA to furnish enrolled veterans needed hospital care and medical services through agreements with providers the SECVA deems meet quality standards the SECVA will establish. Veterans would be eligible for community care on the same basis as for VHA-furnished care, and current wait time and geographic distance criteria should no longer be applicable.

VA Administrative Changes

- Develop national policy to govern local establishment of networks, and in doing so, focus its design and long-term planning on creating a robust ambulatory capability and reshaping inpatient resources to match expected demand.
- Establish standards that community providers must meet to qualify for participation in community networks, to include becoming fully credentialed, meeting patient-access criteria, demonstrating high-quality clinical outcomes and appropriate use decisions, demonstrating military cultural competency, and having capability for interoperable data exchange.

⁵⁰ Information on what medical centers are deficient in their care is available, for example, from the VHA's own Strategic Analytics for Improvement and Learning (SAIL) data.

⁵¹ It would seem prudent to begin such phased development by piloting that effort, and limiting the scope of unfettered choice to service-connected veterans.

⁵² Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/21183845>.

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- Establish systems to ensure that all primary care providers in the VHA Care System can effectively coordinate veterans' care.
- Provide veterans navigation services for complex care needs, including information needed by patients and their families for informed decision making about treatments and providers. Navigation services should assist veterans and their families with eligibility, cost-sharing, and other administrative issues.
- Establish policies and procedures to ensure that VHA provider as well as community providers within each network, provide transparent information (using the same metrics) on care-quality, service, and access.
- Eliminate the practice of cross-country referrals if quality care is available locally.
- Employ the most current payment approaches that incentivize quality and appropriate use of health care services.

Other Department and Agency Administrative Changes

- None required.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

Problem

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.⁵³

The Commission Recommends That . . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.⁵⁴ For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified “not working to top of provider licensure” as a barrier in health care provision.⁵⁵

VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

Background

A large part of the VHA’s problem with inadequate clinical support staff derives from its difficulties in hiring, retaining, and training medical support assistants (MSAs). These individuals answer phones, schedule care, and verify health care eligibility, among other duties.

⁵³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016,

http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁵⁴ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016,

http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵⁵ *Ibid.*, 95.

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Congress has recently given VHA the flexibility to offer MSAs market-based pay rates.⁵⁶ VHA is changing cumbersome rules that have made hiring new MSAs exceptionally time-consuming.⁵⁷

VHA is working to resolve its problems with resource allocation in clinics. For example, the agency has committed to increasing use of clinical managers to help medical centers better match resources to patient demand. Widely used by other health care systems, clinic managers enhance operations by ensuring that telephone protocols, scheduling, and clinic workflow are operating at peak efficiency. They also ensure that staff members are assigned appropriate caseloads and are meeting productivity standards and wait time targets and that administrative staff has appropriate training in scheduling, coding, and/or documentation.

Many states have already taken the steps to ensure APRNs have full practice authority. VHA is working to do the same, which will allow a vast increase in the number of VHA clinicians available to treat patients independently.⁵⁸

To effectively manage clinician supply for the inpatient setting, administrators require accurate bed count data. Currently in VHA, data integrity of bed counts is compromised as a consequence of disclosure requirements of Congress. VHA is required by statute to complete a complicated reporting, approval, and notification process when it closes hospital beds.⁵⁹ To avoid the reporting requirements some VA medical centers count beds as unavailable indefinitely. This action can skew occupancy rates and thwart planning activities. VHA developed its guidance in part to satisfy the Millennium Act⁶⁰ and other requirements that essentially froze beds at FY 1998 levels.⁶¹

Analysis

VHA has taken a number of measures to address data integrity issues. VHA has started hiring clinical managers to assist in managing resources for effective performance. VHA has made efforts to address problems affecting supply and training of MSAs. Additionally, VHA has recently proposed a rule that would authorize full practice for APRNs working within the agency.⁶²

These measures by themselves, however, will not be sufficient to solve the current problems. VHA must ensure all facilities have enough support positions—both clerical and clinical—to

⁵⁶ Sloan D. Gibson, Deputy Secretary, Department of Veterans Affairs, presentation to Commission on Care, April 18, 2016.

⁵⁷ 38 U.S.C. § 7401(3)(A)(iii).

⁵⁸ Establishing Medication Prescribing Authority for Advanced Practice Nurses, VHA Directive 2008-049, (2008).

⁵⁹ Inpatient Bed Change Program and Procedures, VHA Handbook 1000.01, (2010).

⁶⁰ The Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545, Sec. 301. Title III of the Millennium Act prohibits the secretary from closing in any fiscal year more than 50 percent of the beds within a department medical center unless the secretary first submits to the veterans' committees a justification for such closure and waits to take action on a closure until 21 days after the submission of the report. It also requires the secretary to report annually to the veterans committees on bed closures during the preceding fiscal year.

⁶¹ Extended Care Services, 38 U.S.C. § 1710B(b) requires staffing for extended care to remain at FY 1998 levels.

⁶² "VA Proposes to Grant Full Practice Authority to Advanced Practice Registered Nurses," Department of Veterans Affairs, accessed June 3, 2016, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2793>.

enable all clinicians to work at the top of their licenses and to avoid problems with turnover, unexpected staff absences, and surges in patient demand.⁶³

VHA must have authority to pay competitive rates for the personnel it needs. This goal would be accomplished in part by adopting Recommendation #15 of this report for creating a new personnel system under Title 38 for all VHA employees. Currently, for example, clinical managers and practitioners earn far more in the private sector.⁶⁴

As VHA develops improved clinic management tools such as the Health Operations Dashboard, these tools draw from clinical data, patient data, and other sources to allow managers to make decisions using real-time data.⁶⁵ To be effective tools, the data fed into them must be accurate. Relieving VHA from some of the reporting requirements of the Millennium Act will help accomplish effective use of the dashboard for inpatient management.

Implementation

Legislative Changes

- Create a new alternative personnel system under Title 38 authority as mentioned in Recommendation #15.
- Eliminate bed reporting requirements under the Millennium Bill, and require VHA to report new beds as closed, authorized, operating, staffed, or temporarily inactive within 90 days of enactment.

VA Administrative Changes

- Develop policy to allow full practice authority for APRNs.
- Develop leadership tracks, including clinical and group practice managers, for ambulatory settings.
- Develop training programs for medical support assistants (MSAs).
- Modify policy in VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, as appropriate.

Other Department and Agency Administrative Changes

- None required.

⁶³ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 17-18, accessed June 3 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

⁶⁴ For example, Salaries.com listed a median salary for Clinic Manager III (a manager of a clinic with more than 50 physicians) in Dallas, TX, as \$94,000.⁶⁴ The pay grade assigned for this position is GS-13, which pays about \$73,800 in the first step and increases up to \$96,000. Office of Personnel Management, *Schedule 1 General Schedule*, accessed March 31, 2016, <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/pay-executive-order-2016-adjustments-of-certain-rates-of-pay.pdf>.

⁶⁵ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, presentation to Commission on Care, April 18, 2016.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-supported programs.

Problem

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.⁶⁶ Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).⁶⁷

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a national revised clinical-appeals process.

As part of the MyVA initiative, the SECVA has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.⁶⁸ The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.⁶⁹

Background

VHA policy has long required medical centers to operate a patient advocate program to address patient complaints.⁷⁰ In 1996, Congress enacted an eligibility reform statute that, for the first time, gave enrolled veterans access to a uniform benefits package.⁷¹ In implementing that law, VHA conducted a systemwide review of how clinical disputes were handled and consequently instituted an external appeal system in FY 2000. The policy, as outlined in a subsequent directive, allowed VISNs to request external professional boards to conduct impartial reviews of clinical determinations.⁷² That directive also addressed a process for internal clinical appeals. It stated as policy that patients or their representatives who have disputes regarding clinical determinations or services pertaining to provision or denial of care that are not resolved at the facility level must have access to a fair and impartial review of those disputes that could result in a different and/or improved clinical outcome. That policy requires VISN directors to have written policy and procedures in place for how internal appeals are to be handled. Under this policy, VISNs still have authority to request an external review at any time during the clinical

⁶⁶ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

⁶⁷ VHA Clinical Appeals, VHA Directive 2006-057, (2006).

⁶⁸ "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, <http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx>.

⁶⁹ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷⁰ VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁷² VHA Clinical Appeals, VHA Directive 2006-057 (2006).

appeals process.⁷³ Although the directive itself expired in 2011, it continues to serve as guidance because it has not been renewed or replaced.

VHA policy directs that all facilities have a patient advocate office to manage and attempt to resolve complaints. That office, which can serve as the liaison between patients and clinicians, is generally the first stop for veterans who are dissatisfied with a clinical decision.⁷⁴ If a clinical issue is not resolved at the point of the service, it generally goes to the facility director, who is to provide veterans written notification of the facility's decision and inform veterans about the VISN's appeals process. Under the same policy directive, veterans may appeal the facility decision to the VISN director. That official, or a clinical review panel that he or she establishes, is to render a decision within 30 days (or 45 days if the director requests an external clinical review).⁷⁵ Should the VISN director agree with the facility, he or she must notify the veteran that the decision is final or may refer the matter to a VACO office to arrange for an external review.⁷⁶

The VHA process does not appear fully comparable to procedures required under other federal and federally-supported health care programs. For example, under the Affordable Care Act, health care plans are required to provide external reviews to beneficiaries whose internal appeals have been denied.⁷⁷ Unlike those and other appeals processes, veterans have no right to external review; such review is at the discretion of the VISN director. Medicare has an extensive review process for clinical disputes between its managed care organizations and beneficiaries. Beneficiaries have the right to an internal appeal with an option for an expedited review, an internal reconsideration of the initial review, an independent review, a hearing with an administrative law judge, a review by the Medicare Appeals Council and, finally, a federal district court review.⁷⁸ Medicaid has requirements for localities to review appeals from its beneficiaries and for states to offer timely access to fair hearings to determine whether managed care organizations have denied or terminated medically necessary care.⁷⁹ Although VHA's timeframe for decision making seems reasonable, the national policy makes no provision for an expedited review, unlike Medicare managed care organizations and plans providing health benefits to federal employees. VHA's policy is also silent on meeting with veterans to hear their cases much less hold hearings during any point of the appeal. Unlike Medicaid, VHA also lacks any provision for service-continuity while the matter is being appealed. The Commission recommends that VHA develop a revised clinical-appeals process that provides veterans protections at least comparable to those afforded patients under other federal and federally-supported programs, including, at a minimum, a right to an external review at the veteran's discretion.

⁷³ Ibid.

⁷⁴ VHA Patient Advocacy Program, VHA Handbook 1003.4, (2005).

⁷⁵ VHA Clinical Appeals, VHA Directive 2006-057, (2006).

⁷⁶ Ibid.

⁷⁷ "Appealing Health Plan Decisions," Department of Health & Human Services, accessed June 1, 2016, <http://www.hhs.gov/healthcare/about-the-law/cancellations-and-appeals/appealing-health-plan-decisions/index.html>.

⁷⁸ Centers for Medicare & Medicaid Services, *Managed Care Appeals Flowchart CY2016*, accessed May 26, 2016, <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Managed-Care-Appeals-Flow-Chart.pdf>.

⁷⁹ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

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Implementation***Legislative Changes***

- None required.

VA Administrative Changes

- Convene an interdisciplinary panel to assist in developing a revised clinical-appeals process and policy that includes all care provided within the VHA Care System, to include representation from Patient Care Services, MyVA's Patient Advocates and Veterans Experience Program, the Office of Equity, the National Center for Ethics in Health Care, and the Office of Access and Clinical Administration. VHA should have that panel examine and offer recommendations regarding the following:
 - Each level of review in the clinical-appeals process – from the facility's initial reconsideration to a final decision by the VISN director to assess the fairness and impartiality in those processes compared to Medicare Managed Care and Medicaid appeals processes and private-sector managed care providers' best practices.
 - Whether VHA should establish a uniform national clinical appeals process.
 - The advisability of requiring review panels consisting of individuals such as attorneys, clinicians, case managers, patient advocates, and administrators to review clinical appeals.
 - Whether hearings or judicial reviews are appropriate at any level of the appeals process.
 - Whether resolutions of clinical appeals are equitable for all types of veterans (service-connected or non-service-connected, by racial or ethnic group, by age, or gender).
 - Options for increasing veterans' awareness of the clinical-appeals process.
- Publish the new clinical appeals policy and process for comment and input by veterans, VHA business partners, and other stakeholders.
- Once the new policy is finalized, VHA must train staff on the new process.

Other Department and Agency Administrative Changes

- None required.

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

Problem

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.⁸⁰

VHA has a program of systems engineering — the Veterans Engineering Resource Center (VERC) — that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to proactively identify problem areas within the system and offer assistance.

Background

To become a truly veteran-centric care provider, VHA is working to become a learning organization.⁸¹ Learning organizations focus on worker competency rather than on rules compliance. Instead of using results to identify high- and low-performers, VHA will use this information to identify opportunities to intervene with training or other resources to improve employees' performance universally. Employees and patients should benefit from this approach because it values listening and encourages risk taking and innovation.

VA and VHA have adopted the tenets of LEAN Six Sigma as a systemic change approach to move the system forward. This methodology employs a rigorous define, measure, analyze, improve, and control approach to systemic change. LEAN, initially used by manufacturers, has been used successfully by many health care organizations.⁸² The goal of implementing LEAN practices is to eliminate waste, ensuring that any work done adds value. The MyVA plan calls for MyVA districts and the Office of Policy and Planning to ensure the transmission of best practices and the adopting of LEAN throughout the enterprise to provide a more comprehensive view of quality that balances a results-oriented approach with more process-

⁸⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow—Clinical)*, 14 and A-2 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁸¹ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.

⁸² MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 12, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

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oriented practice.⁸³ So far these efforts have been guided by trial and error, rather than directives and adopting a LEAN, process-driven model.⁸⁴ VHA must sustain its commitment to LEAN Six Sigma as a continuous improvement methodology.

VHA will have to use VERC staff and other trained staff members to ensure that principles of LEAN Six Sigma are applied at every level of the system. VERC has the mission to propose, develop, and facilitate innovative solutions to challenges within VHA health care delivery through the integration of systems engineering principles.

With VERC's reach already extending into access to care, health policy, population health, LEAN management, business systems, clinical systems, safety systems, and innovation, all other programs and initiatives become redundant or ancillary. VHA must assess its new system for best practice diffusion to ensure that selected practices are being appropriately scaled. This goal can best be achieved by collapsing all related efforts into VERC.

There are a number of emerging best practices within the health care sector that apply to all aspects of VHA – health care capabilities, staffing, access, supplies, and facilities – and involve the testing, dissemination, and application of procedures or systems that have been shown to improve approaches, processes, or systems.⁸⁵ VHA needs to have the opportunity to fully leverage and build on institutional strengths by implementing best practices.

VHA has recently developed the Diffusion of Excellence Initiative, which is designed to serve as the mechanism for improving practice through a combination of targeted national guidance and nationally-supported local best practice sharing and innovation.⁸⁶ Its organizational structure includes a governance board chaired by the USH, a Diffusion Council, and action teams responsible for implementing promising practices.

VHA also has many business lines charged with disseminating best practices information, including VERC, Systems Redesign SharePoint – Center for Improvement Education, VA Center for Innovation, MyVA – Best Practices in LEAN, MyVA Blog, MyVA Performance Improvement Hub, Knowledge Management System–Improvement in Action (I-ACT), VA Idea House, VA Pulse: Promising Practices Consortium, Evidence-based Synthesis Program (ESP), Quality Enhancement Research Initiative (QUERI), the Annual Conference on the Science of Dissemination and Implementation, and the Diffusion of Excellence Initiative.

Analysis

LEAN Six Sigma offers VHA a methodology to effect change and VERC offers VHA the agents to lead its implementation. VHA must consolidate its transformational tools, including its best

⁸³ MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 21, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

⁸⁴ The MITRE Corporation, Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow—Clinical), viii accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁸⁵ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 41, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁸⁶ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.

practice repositories within VERC. The VERC uses a systemic change process to streamline workflow and procedures by eliminating waste and redundancy to ensure that every step in the process adds value. The VERC offers services to VHA health care facilities upon request, but VHA would substantially benefit if the service was authorized to perform outreach to ensure awareness across the VHA Care System.⁸⁷

Until developing the Diffusion of Excellence Initiative, VHA lacked a uniform way to scale and optimize best practices throughout the enterprise. Although the Diffusion Initiative is initially targeting best practices from within VHA, to be successful, a long-term plan should also allow for the adoption of best practices from the private sector and other government sectors (e.g., the Medicare program related to pricing, contracting, privatization, value-based purchasing, management, and oversight). Plans should also allow for adaptation at the local and regional levels to reflect respective differences in provider supply, veteran needs, and marketplace characteristics.⁸⁸

VHA has multiple offices and sites invested in system reengineering, continuous process improvement, and best practices implementation. Repositories of best practices do not get information to the intended person or group that could benefit from the information and are dependent upon VHA employees knowing they exist.⁸⁹

VHA's National Leadership Council has proposed consolidating these best practice repositories under the VERC, which now serves within the Office of Organizational Excellence. Until recently, VERC has been underutilized because it is not known throughout the enterprise.⁹⁰

QUERI is a system that identifies evidence-based care practices that may be scaled for systemwide implementation. QUERI was integrally involved in the transformation of VHA from a largely hospital-based system to one centered on primary care⁹¹ and is now integral to the collaborative endeavor to transform VHA into a learning organization. QUERI recently released a policy brief that indicated veterans' reliance on VHA was strongly correlated to economic factors such as unemployment rates and availability of other health care coverage.⁹²

VA should use a systematic, continuous performance improvement process to improve access to care. Although many VA facilities achieve very high-performance ratings on key access and quality measures, a systematic effort is needed to improve performance. These efforts need to

⁸⁷ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

⁸⁸ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, 28, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf

⁸⁹ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

⁹⁰ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 27, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁹¹ "HSR&D Perspectives Blog, QUERI Corner: Surviving and Thriving," Amy Kilbourne, QUERI Program Director, January 20, 2015, accessed from VA Intranet, April 4, 2016, <http://vaww.blog.va.gov/hsrd/category/queri-corner/>.

⁹² Christine Yee, Austin Frakt, and Steven Pizer, U.S. Department of Veterans Affairs, "Economic and Policy Effects on Demand for VA Care," Partnered Evidence-based Policy Resource Center, Policy Brief, March 2016, accessed June 21, 2016, http://www.queri.research.va.gov/partnered_evaluation/YeeFraktPizer.pdf.

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be embedded into routine use across the VA system. The best solutions should be adjusted to reflect local needs and designed to respond to veterans' preferences, needs, and values.⁹³

A systems approach to health care is “one that applies scientific insights to understand the elements that influence health outcomes, models the relationships between those elements, and alters design, processes, or policies based on the resultant knowledge in order to produce better health at lower cost”⁹⁴ and would benefit VA greatly, especially with resources like VERC to serve as a guide.

Emerging best practices have improved health care access and scheduling in various locations and serve as promising bases for research, validation, and implementation.⁹⁵ A variety of quality improvement organizations are involved in establishing and maintaining standards in health care as well as developing measures for the monitoring and assessment of these standards, including The Centers for Medicare & Medicaid Services, the Joint Commission, the National Committee for Quality Assurance, and the National Quality Forum.⁹⁶

The tools of operations management, industrial engineering, and systems approaches are successful in increasing process gains and efficiencies. In particular, a wide range of industries have employed systems-based engineering approaches to address scheduling issues, among other logistical challenges.⁹⁷

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Consolidate all best practices and continuous improvement portals under VERC to provide a more accessible and comprehensive approach to best practice sharing and adoption.

Other Department and Agency Administrative Changes

- None required.

⁹³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 110 and 297 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁹⁴ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 27 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁹⁵ Ibid., 15.

⁹⁶ Ibid., 60.

⁹⁷ Ibid., 27-28.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

Problem

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.⁹⁸

A systematic review of VHA in 2015 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.⁹⁹ VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues—the Health Equity Action Plan (HEAP)—but it has not been fully implemented.

Background

It is time to refocus, reinforce, and repeat the message that health disparities exist and that health equity benefits everyone.¹⁰⁰

Across the nation, health care systems are raising awareness about health care equity, inequality, and disparities.¹⁰¹ The growing incidence of health care disparities and inequities is said to be ascribed to individual and collective cultural indifference on the part of health care

⁹⁸ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

⁹⁹ Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, accessed May 19, 2016, <http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf>.

¹⁰⁰ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

¹⁰¹ Centers for Disease Control and Prevention, *CDC Health Disparities and Inequalities Report – United States, 2013*, accessed April 5, 2016, <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>.

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providers and the health care system as a whole.¹⁰² A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on racial or ethnic group, gender, age, sexual orientation, military era, geographic location, religion, socioeconomic status, mental health, cognitive/sensory/physical disability, and other characteristics historically linked to discrimination or exclusion.¹⁰³

The United States is becoming increasingly diverse, with racial and ethnic minorities making up more than 36 percent of the population.¹⁰⁴ Indicators of overall health, such as life expectancy and infant mortality, have improved for most Americans; however, some minorities still face comparatively greater likelihood of preventable disease, death, and disability.¹⁰⁵

Although the country's veteran population is projected to decline from 22 million to 14.5 million by 2040, the percentage of minority veterans will increase from 20 percent to 34 percent during the same period.¹⁰⁶ Currently, African Americans make up 11 percent of the veteran population, and Hispanics, 6 percent.¹⁰⁷

Survey data show that minority veterans use VA health care more than White veterans, as shown below:¹⁰⁸

- African American: 38 percent
- Hispanic: 34 percent
- American Indian/Alaska Native: 38 percent
- White: 32 percent

¹⁰² G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," *JHSA* (2011), 146.

¹⁰³ "Office of Health Equity," U.S. Department of Veterans Affairs, accessed June 12, 2016, <http://www.va.gov/HEALTHY/index.asp>.

¹⁰⁴ "Minority Health and Health Equity – CDC," Centers for Disease Control and Prevention (CDC), accessed March 28, 2016, <http://www.cdc.gov/minorityhealth/index.html>.

¹⁰⁵ *Ibid.*

¹⁰⁶ National Center of Veterans Analysis and Statistics, *Minority Veterans 2011 Report*, May 2013, accessed April 6, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf.

¹⁰⁷ U.S. Census Bureau, *American Community Survey, Public Use Microdata Sample (PUMS)*, 2011. Department of Defense, *Population Representation in the Military Services Fiscal Year 2011 Report*, accessed April 5, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf

¹⁰⁸ Reliance projections here are based on ambulatory care utilization. Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 82, accessed May 19, 2016,

http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

Survey data on racial and ethnic minority veterans' use of VHA health care offer revealing insights on current equity issues:¹⁰⁹

- Fifty-seven percent of African Americans indicated they are more likely to use VA as their primary source of health care as compared to 45 percent of Whites.¹¹⁰
- The percentage of African Americans who reported they use VA for all or most of their care needs is 18 percent higher than the percentage of Whites who do so.¹¹¹
- A higher percentage of Whites assessed their health to be good or excellent than did African Americans.¹¹²

Analysis

VHA Office of Health Equity

VA created the OHE in 2012 to identify health care inequities, understand the cause of them, and bring to clinical practice interventions intended to reduce disparity drivers within VA. OHE partners with other VA offices, federal government offices, and nongovernment institutions with missions aimed at promoting health equity.¹¹³ OHE has substantial stakeholder involvement from minority veterans groups, including the Advisory Committee on Minority Veterans (ACMV), rural veterans groups, women veterans, and the Office of Diversity and Inclusion (ODI).¹¹⁴ A staunch internal partner and stakeholder of OHE, ODI's mission is to foster a diverse workforce and an inclusive work environment. The OHE and ODI missions intersect with ODI's special emphasis programs, intended to engage affinity groups and agencies to raise the awareness of the importance of diversity and demonstrate VA's commitment to a diversity model.¹¹⁵

OHE's foundational work included updated systematic reviews and data analyses that not only revalidated VA's previous findings on health care inequities, but also identified more areas of health care disparity among veterans. For instance, hepatitis C virus (HCV) was noted to have disparate effect on racial/ethnic minority veterans and Vietnam-era veterans. Additionally, OHE convened stakeholders and worked with the Health Equity Coalition to develop the VHA Health Equity Action Plan (HEAP), which aligns with the VHA Strategic Plan Objective 1e: Quality & Equity, which states, "Veterans will receive timely, high quality, personalized, safe effective and equitable health care irrespective of geography, gender, race, age, culture or sexual

¹⁰⁹ Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.

¹¹⁰ Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, 85, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.

¹¹¹ Ibid.

¹¹² Ibid.

¹¹³ Department of Veterans Affairs, Office of Health Equity, *US Department of Veterans Affairs Office of Health Equity Mission and Accomplishments*, accessed March 30, 2016, http://www.va.gov/HEALTHEQUITY/docs/OHE_Mission_and_Accomplishments_November_2015.pdf.

¹¹⁴ "Office of Diversity and Inclusion (ODI)," Department of Veterans Affairs, accessed May 13, 2016, <http://www.diversity.va.gov/>.

¹¹⁵ "Office of Diversity and Inclusion (ODI), Special Emphasis Programs," Department of Veterans Affairs, accessed May 17, 2016, <http://www.diversity.va.gov/programs/default.aspx>.

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orientation.”¹¹⁶ HEAP aims to address five strategic areas: awareness, leadership, health system and life experience, cultural and linguistic competency, and data that are vital for effectively implementing its mission. HEAP implementation strategies are conceptually modeled after the goals and strategies of the National Partnership for Action to End Health Disparities’ National Stakeholder Strategy for Achieving Health Equity sponsored by the U.S. Department of Health and Human Services.¹¹⁷

Despite OHE’s best efforts, HEAP was not fully implemented because VHA leadership failed to establish it as a strategic priority with adequate staffing, resources, and support, and the departure of the then USH, a champion for health equity. These factors led to the reduction of OHE staffing from 8 to 2 FTEs in FY 2013 and a realignment of OHE to several layers down in the organization. As a result of an FY 2015 budget reduction, OHE continues to operate with a two-person staff.¹¹⁸ The reduced staffing level is inadequate to meet the requirements and mission of the office.

OHE has a broad and challenging mission, particularly given the number of minority veterans who rely on VA health care, the health risks in those populations, and the health care disparities those populations experience.¹¹⁹ OHE faces serious challenges in its efforts to carry out its action plan and to realize its broad and critical mission, challenges intensified by its limited staffing and the downgrade of this office within VHA’s organization structure. These include the following:¹²⁰

- lack of quality data on vulnerable populations and disparate health outcomes
- health equity projects that have been delayed or halted due to staff and resource limitations
- lack of data on the overall impact of existing health equity initiatives at facilities
- lack of common definitions on vulnerable populations and health equity concepts

Notwithstanding its limited staffing, OHE has compiled a substantial record of accomplishments. Among its initiatives, OHE embarked in 2015 on a strategy of working collaboratively with the Quality Enhancement Research Initiative (QUERI) to advance health equity. The two collaborative efforts focus on using a population health approach to examine the distribution of diagnosed health conditions, mortality, and health care quality across the VA health care system. A fully staffed OHE would have the capability of creating additional

¹¹⁶ Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018*, accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.

¹¹⁷ “National Partnership For Action (NPA), National Stakeholder Strategy for Achieving Health Equity,” U.S. Department of Health & Human Services, accessed May 16, 2016, <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286>

¹¹⁸ Uche S. Uchendu, Executive Director, OHE, briefing to Commission on Care, December 14, 2015.

¹¹⁹ “Management Brief no. 99,” Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=eBrief-no99. Somnath Saha et al., “Racial and Ethnic Disparities in the VA Health Care System: A Systematic Review,” *Journal of General Internal Medicine*, 23, no. 5, (2008): 654-671.

¹²⁰ Uche S. Uchendu, Executive Director, Office of Health Equity, briefing to Commission on Care, December 14, 2015.

analytical tools to manage the daily health care equity program and provide needed services to advance health equity.¹²¹

Health Care Disparities Among Minority Veterans

Minority groups are at increased risk of major, life-threatening health conditions, as documented in a substantial body of research¹²² and illustrated in the table below:¹²³

Table 3. Major Health Conditions in Racial/Ethnic Minority Groups

Major Health Conditions Identified and Examined in Racial/Ethnic Minority Groups		
African Americans	Hispanics	American Indian or Alaska Natives
<ul style="list-style-type: none"> ▪ Colon Cancer ▪ HIV ▪ Chronic Kidney Disease ▪ Diabetes ▪ Stroke ▪ Venous Thromboembolism (VTE) ▪ Cancer ▪ Heart Disease 	<ul style="list-style-type: none"> ▪ Hepatitis C ▪ Cancer ▪ Heart disease 	<ul style="list-style-type: none"> ▪ Major Non-cardiac Surgery ▪ Pregnant Women with PTSD

HCV is more prominent among some racial and ethnic minority veterans and they are less likely to receive treatment for HCV. In VHA, some racial and ethnic minorities diagnosed with HCV are disproportionately more at risk for having associated liver disease (ALD). Disparities among veterans in the incidence of HCV, illustrated in the graphs below, show the important policy and resource implications for VA.¹²⁴

¹²¹ Ibid.

¹²² Andy I. Choi et al., “White/Black Racial Differences in Risk of End-Stage Renal Disease and Death,” *The American Journal of Medicine*, 122, no. 7, (2009): 672-678. Andy I. Choi et al., “Racial Differences in End-Stage Renal Disease Rates in HIV Infection with Diabetes,” *Journal of the American Society of Nephrology*, 18, no. 11 (2007): 2968-2974. Hashem B. El-Serag et al., “Racial Differences in the Progression to Cirrhosis and Hepatocellular Carcinoma in HCV-Infected Veterans,” *The American Journal of Gastroenterology*, 109, no. 9, (2014): 1427-1435. Cleo A. Samuel et al., “Racial Disparities in Cancer Care in the Veterans Affairs Health Care System and the Role of Site of Care,” *American Journal of Public Health*, 104, Supplement 4, (2014): S562-571.

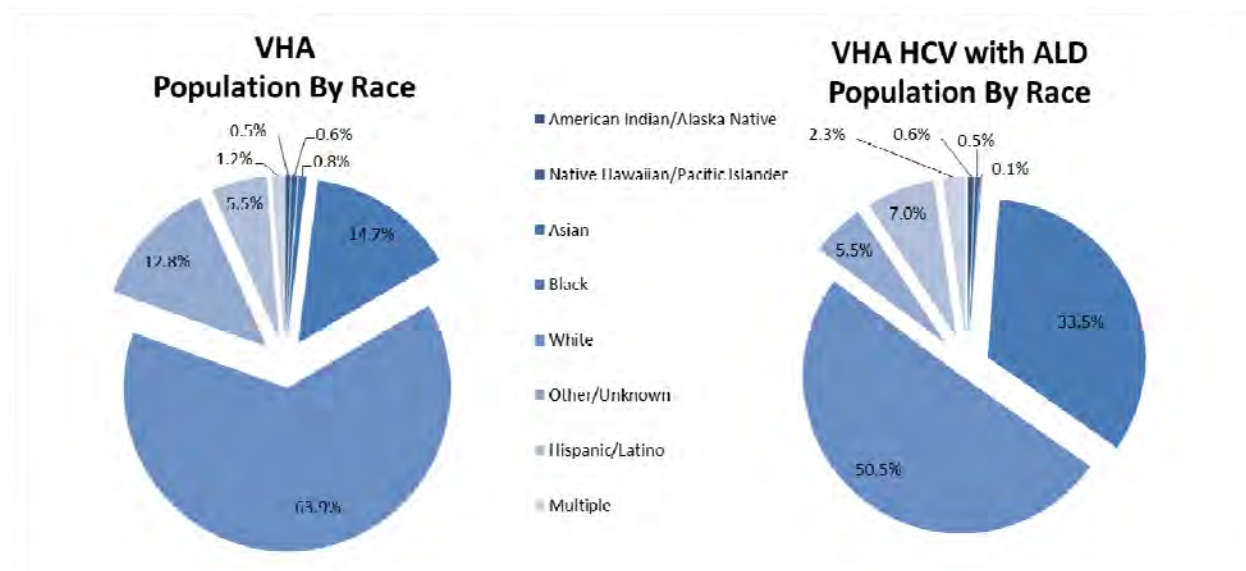
¹²³ Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, accessed May 19, 2016,

<http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf>.

¹²⁴ Department of Veterans Affairs, Office of Health Equity, *Hepatitis C Factsheet, Hepatitis C, Advanced Liver Disease & Health Care Disparities*, accessed May 25, 2016, <https://github.com/departement-of-veterans-affairs/VHA-Asset/raw/master/Hep%20C%20FACT%20SHEET%20FINAL%2010162015.pdf>.

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Figure 2. Disparities Among Veterans in the Incidence of Hepatitis C Virus



A recent review of evidence related to racial and ethnic differences in outcomes for VA patients showed moderate- and low-strength evidence suggestive of gaps in morbidity and mortality outcomes among vulnerable veteran populations with major health conditions. These data, presented in the table below, highlight targets for further research.¹²⁵

Table 4. Comparison of Health Outcomes by Race

Comparison		Worse Health Outcomes For Racial Minority Group Relative to Reference Population (usually White)
Moderate-Strength Evidence		
(based on VA data from the early 2000s)		
African American v. White	Increased end-stage renal disease among chronic kidney disease patients	
	Increased end-stage renal disease among HIV patients (with or without diabetes)	
	Decreased colon cancer survival 3 years after diagnosis	
Hispanic v. White	Increased cirrhosis and hepatocellular carcinoma among hepatitis C patients	
Low-Strength Evidence		
(each finding supported by only a single retrospective study with important methodological limitations)		
African American v. White	Increased mortality among diabetes patients	
	Increased risk of preterm birth among PTSD patients	
	Increased mortality at 2 years post-hospitalization among stroke patients	
	Decreased survival 3 years after diagnosis of rectal cancer	
American Indian or Alaskan Native v. White	Increased risk of 30-day post-op mortality after major noncardiac surgery	
	Increased risk of preterm birth among PTSD patients	
Combined other racial/ethnic minority groups v. African American	Increased injury-related death among alcohol use disorder patients	

¹²⁵ "Management Brief no. 99," Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=ebrief-no99.
VA-18-0457-A-002764

OHE's focus, health equity, is intended to combat health care disparities, namely, the differences in the preventive, diagnostic, or treatment services offered to veterans with similar health conditions. Health care disparities stem from a combination of complex factors occurring at the level of the health system, provider, and patient.¹²⁶ Health care disparities can result from biological differences among various racial/ethnic groups as well as from social disparities,¹²⁷ also termed social determinants, which stem from such factors as socioeconomic status, discrimination, education levels, housing, transportation, and crime and violence, and are causally linked to subsequent adult disease.¹²⁸ For example, poor-quality housing poses a risk of exposure to many conditions that can contribute to poor health, such as indoor allergens that can lead to and exacerbate asthma, injuries, and exposure to lead and other toxic substances.¹²⁹ Social determinants that drive health disparities among African Americans, Hispanics, American Indians, and Alaska Natives include race/ethnicity; gender; age; geographic location; religion; socio-economic status; sexual orientation; military era; disabilities, including cognitive, sensory, or physical; and other characteristics historically linked to discrimination or exclusion. Positioned in a department that also provides benefits that fall within the social determinants of health, OHE is in a unique position to improve veterans' health.

The Henry Ford Health System (HFHS) is an example of a health system that is committed to health equity and one VHA can emulate as it works to improve health equity. HFHS is a nonprofit, vertically integrated health care organization that serves the primary and specialty health care needs of residents in southeastern Michigan, including Detroit and its surrounding metropolitan area.¹³⁰ HFHS's comprehensive health equity staff has a health care equity campaign with a goal of increasing knowledge, awareness, and opportunities to ensure health care equity is understood and practiced by HFHS providers and other staff, the research community, and the community-at-large.¹³¹ The campaign is also intended to make health care equity a key, measurable aspect of clinical quality.¹³² A similar effort by VHA would create a system for tracking improvement of health equity over time and holding the organization accountable for ongoing efforts in this regard.

The VHA strategic plan for FY 2013–2018 states that veterans will receive timely, high quality, personalized, safe, effective, and *equitable* health care, irrespective of geography, gender, race, age, culture, or sexual orientation.¹³³ Although that statement signals a sensitivity to health equity, the level of funding support for the VHA office with the lead role in promoting health equity and reducing disparity calls into serious question the leadership priority and commitment to that strategic goal. VHA leadership must make health care equity a strategic

¹²⁶ Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, <http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf>.

¹²⁷ James H. Price, Molly A. McKinney, and Robert E. Braun, *Social Determinants of Racial/Ethnic Health Disparities in Children and Adolescents*, accessed April 1, 2016, <http://www.sophe.org/Sophe/PDF/Webinars/20120416151902.pdf>.

¹²⁸ Ibid.

¹²⁹ "What Drives Health," Robert Wood Johnson Foundation, Commission to Build a Healthier America, accessed April 1, 2016, <http://www.commissiononhealth.org/WhatDrivesHealth.aspx>.

¹³⁰ Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, <http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf>.

¹³¹ Ibid.

¹³² Ibid.

¹³³ Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018*, accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.

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priority by directing and funding the implementation of VHA HEAP nationwide and designating a leader and clinical champions within each VISN and VAMC, as a designated full-time equivalent (FTE), providing OHE budgetary support in FY 2017 and beyond to fully staff the office so that it can successfully achieve its mission and goals, to include providing additional needed funding to support implementation of the VHA HEAP; and ensuring OHE reports to the chief of VHA Care System (CVCS).

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Make health equity a strategic priority by directing the implementation of the VHA HEAP nationwide and designating a leader and health equity clinical champion within each VISN and VAMC for whom part of their respective FTE position descriptions includes focusing on health equity issues.
- Reestablish OHE staffing based on the 2011 VHA Health Care Equality Workgroup recommendations to enable OHE to fulfill VHA's vision to provide appropriate individualized health care to each veteran in a method that eliminates disparate health outcomes and assures health equity. Action required includes, but is not limited to, funding FTE staffing levels commensurate with the scope and size of other federal offices of health equity.
- Reinstate OHE within the office of the CVCS to underscore health equity as a priority and to position the office to champion successfully the advancement of health equity for all veterans.¹³⁴
- Monitor and evaluate the department's success in implementing HEAP.

Other Department and Agency Administrative Changes

- None required.

¹³⁴ Department of Veteran Affairs, Health Equity Coalition Request for VHA Commitment, February 2016. Principal Deputy Under Secretary of Health Memorandum, Health Equity Coalition, March 21, 2013.

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

Problem

Veterans who turn to VHA to meet their health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern ambulatory health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of these barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks, as proposed in

Recommendation #1 holds the promise of markedly improving veterans' access to care.

That promise cannot be realized without transformative changes to VHA's capital

structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of the build out of the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as much control as possible to drive the process so that all facility plans are fully integrated with the strategic vision for the VHA Care System.

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meet its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission process to be implemented as soon as practicable. The Commission recommends that the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

Background

Most VHA health care centers were designed when care was focused on inpatient hospital treatment. VA acquired some of these facilities nearly a century ago from the Public Health Service; many others were transferred from the War Department shortly after World War II.¹³⁵ The average VHA building is 50 years old – five times older than the average building age of not-for-profit hospital systems in the United States.¹³⁶ Most of its facilities were designed to meet markedly different needs than today's health care facilities. Some were tuberculosis

¹³⁵ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

¹³⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, vi, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

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sanatoriums, others for years primarily housed patients with mental health conditions.¹³⁷ Although many have been extensively renovated, the renovations themselves are now outdated, and the condition of buildings shows this strain. Independent assessments of infrastructure and facilities showed that VHA facilities average a *C minus* score,¹³⁸ meaning much of the total facilities portfolio is nearing the end of its useful life, and 70 percent of facility correction repairs are being made on Grade D facilities.¹³⁹

During the past 8 years, veteran inpatient bed days of care have declined nearly 10 percent as outpatient clinic workload has increased more than 40 percent.¹⁴⁰ Current facilities, whether they have been maintained adequately or not, often do not support contemporary ambulatory care needs, with outpatient care often housed in converted inpatient spaces.

Through its capital planning methodology, VA has identified more than \$51 billion in total capital needs during the next 10 years.¹⁴¹ Capital funding during the past 4 years has averaged just \$2 billion annually.¹⁴² If funding levels remain consistent during the next 10 years, anticipated funding would be \$25 billion to \$35 billion less than the \$51 billion capital requirement.¹⁴³ VA planning must also take account of demographic changes and population migration that have led to underutilized medical centers in some areas of the country, and a need for new capacity in others.¹⁴⁴

Analysis

New Planning Paradigm

As the department acknowledged, “VA’s health care delivery model must . . . change.”¹⁴⁵ Importantly, it recognizes that “No organization can excel at every capability,” and stated “[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers.”¹⁴⁶ The acknowledgement that VHA can best serve veterans by focusing on its core competencies and unique capabilities, while relying more heavily on purchased care holds important implications for VHA’s capital needs and capital asset management. Rather than assessing VHA’s capital needs by reference to an expectation that each VA medical center, or constellation of medical centers, must provide virtually all needed hospital and medical services, capital needs must be redefined within the framework of the VHA Care System’s high-performing integrated community health care networks. VHA must determine what services it will continue to provide directly in a given community before it can determine its respective infrastructure needs. In identifying its core competencies, unique

¹³⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

¹³⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 27, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹³⁹ *Ibid.*

¹⁴⁰ *Ibid.*, 46.

¹⁴¹ *Ibid.*, 17.

¹⁴² *Ibid.*, 18.

¹⁴³ *Ibid.*, 18.

¹⁴⁴ *Ibid.*, 59-61.

¹⁴⁵ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 18, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

¹⁴⁶ *Ibid.*

capabilities, and needed ancillary services, VHA would be setting at least a general framework through which network and local planners could assess where and how needed services would be delivered, including which would be provided directly by VHA and which through purchased care. Such a mapping exercise would be a first step in developing the integrated community health care networks.

The shape of an integrated delivery network will take different forms in each service-area, and planning and developing those local networks will necessarily require assessing VHA's physical plant and capacity in a new light. That reassessment process would inform capital planning, and must take account of at least three distinct needs: capital needs associated with buildings VA would retain; meeting new or replacement space needs; and the disposal of unused, unneeded property.

Property Divestiture

VHA's principal mission is to provide health care to veterans, yet over time it has acquired an ancillary mission: caretaker of an extensive portfolio of vacant buildings. As recently as October 2015, VA reported that its inventory includes 336 buildings that are vacant or less than 50 percent occupied, requiring it to expend patient-care funds to maintain more than 10,500,000 square feet of unneeded space.¹⁴⁷ The SECVA recently testified that it costs VA an estimated \$26 million annually to maintain and operate vacant and underutilized buildings.¹⁴⁸

VA's authority to carry out property-management is circumscribed in law,¹⁴⁹ and the department at times faces insurmountable challenges in either attempting to repurpose or divest itself of underutilized or vacant property.¹⁵⁰ In contrast to more rigid property-divestiture provisions, VA has had success in using a flexible authority to enter into long-term leases of VA property for *enhanced use*.¹⁵¹ This authority allows VA to lease underutilized capital

¹⁴⁷ Ibid., 92.

¹⁴⁸ "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, <https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2>.

¹⁴⁹ Authority for Transfer of Real Property; Department of Veterans Affairs Capital Asset Fund, 38 U.S.C. § 8118 Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122. For example, under section 8118, VA must receive at least full market value in transferring property, unless the property is transferred to an entity that provides services to homeless veterans, and any proposed transfer is subject to the requirement in section 8122 that VA first hold hearings, notify Congress in advance, and not proceed for a specified period. VA property can be determined to be "excess," though under 38 U.S.C. § 8122(d)(1), VA may not make such a declaration unless the property is not suitable for use for provision of services to homeless veterans and reviewed for possible disposal under the Property Act Disposal, administered by the General Services Administration (GSA) (40 U.S.C., subchapter III). GSA employs a rigorous, multistep process to assure that the asset is not needed by any other Federal agency. Under the Act, the agency disposing of the asset is responsible for funding disposal costs, including environmental remediation. GAO has testified that properties remain in an agency's possession for years and continue to accumulate maintenance and operations costs because of the legal requirements agencies must meet and the length of the process. (U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain*, GAO-11-520T (Washington, DC, 2011), 5, <http://www.gao.gov/products/GAO-11-520T>).

¹⁵⁰ With many properties under the protection of the National Historic Preservation Act (16 U.S.C. § 470h-3), VA faces obstacles and delays in efforts to divest itself of these properties; VACO staff report that stakeholder concerns have been obstacles.

¹⁵¹ Enhanced-Use Leases of Real Property, 38 U.S.C. §§ 8161-8169, as amended by Veterans Millennium Health Care and Benefits Act, Section 208, Pub. L. No. 106-117, 113 Stat. 1545 (1999), as in effect when GAO testified on this successful program (U.S. Government Accountability Office, *VA Real Property: VA Emphasizes Enhanced-Use Leases to*

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assets to private-sector entities for up to 75 years to develop housing for homeless and at-risk veterans and their families. Most recently, however, Congress imposed severe limits on that leasing authority.¹⁵²

Ongoing Capital Needs

Establishing a transformative new health care delivery model that relies more on purchased care will not eliminate the need for new clinics, facility renovations, and remedying VHA space deficiencies. The scope of those needs must still be determined in light of a proposed new delivery system, but they cannot be ignored. The *Independent Assessment Report* catalogued the challenges of managing and operating VA's capital program and the need to deploy best practices to improve total performance, and clearly address the importance of more modern facilities for delivering high quality care.¹⁵³

Of particular concern is an apparent breakdown in the process of bringing new clinics online and renewing the leases of existing clinics. With current law requiring congressional approval of any lease with an average annual rental of more than \$1 million,¹⁵⁴ a Congressional Budget Office (CBO) ruling¹⁵⁵ has upended the approval process and halted the leasing program.¹⁵⁶ Indicative of the scope of the problem, VHA's then USH testified in 2013 that VA, since 2008, had opened 180 leased medical facilities, 50 of which required authorization as major leases.¹⁵⁷ Currently, 24 major VA leases are in limbo.¹⁵⁸

Manage its Real Property Portfolio, GAO-09-776T (Washington, DC, 2009), <http://www.gao.gov/assets/130/122697.pdf>. For example, VA has authority to outlease its facilities for up to 3 years, but may not retain the proceeds of any such leasing (Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122(a)(1)). U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain*, GAO-11-520T (Washington, DC, 2011), 5, <http://www.gao.gov/products/GAO-11-520T>.

¹⁵² Before the sunset of that authority in 2011, VA could enter into such a long-term lease if (1) at least part of the property's use would contribute to VA's mission, (2) the lease would not be inconsistent with that mission; and (3) the lease would enhance the use of the property (Enhanced-Use Leases, 38 U.S.C. § 8162(a)(2)). Congress reauthorized enhanced-use leasing, but limited it to a single use: the development of supportive-housing for veterans who are homeless or at risk of homelessness (Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Sec. 211, Pub. L. No. 112-154, 126 Stat. 1165 (2012).)

¹⁵³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁵⁴ Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104.

¹⁵⁵ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., 42 (June 27, 2013) (Statement of Robert A. Sunshine, Deputy Director, Congressional Budget Office), accessed June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

¹⁵⁶ *Ibid.* CBO maintains that the structure of VHA's lease transactions—the lease of a facility, designed by and built for VHA, and for which payments retire most or all of the debt over the life of the lease—is in the nature of a governmental purchase, and, as such, the full cost of acquiring the facility should be budgeted up front, rather than spread over the duration of the lease. As budget rules generally require that Congress offset that aggregate cost, CBO's position has had the effect of blocking what had previously been a manageable funding process.

¹⁵⁷ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., 44 (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

¹⁵⁸ "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, <https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2>.

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One of the primary benefits of leasing is that it can provide flexibility and speed.¹⁵⁹ But the time VHA has required to execute a lease, from planning through to activation, has taken almost 9 years in the case of a major lease,¹⁶⁰ in contrast with private-sector expectations of build-to-suit leases that often take fewer than 3 years.¹⁶¹

In acknowledging the magnitude of the challenges associated with VA's capital program and the budget constraints within which VA is operating, the *Independent Assessment Report* includes a suggestion that transformative options be considered, to include alternative vehicles for capital delivery such as public-private partnerships.¹⁶²

Capital Asset Management

Capital asset management itself requires reengineering. Facilities-related functions are dispersed through VA, resulting in a lack of accountability for outcomes, a mismatch between planning efforts and funding decisions, and separation of project execution and facilities management,¹⁶³ suggesting a need for transformative changes in operations.¹⁶⁴

In its work to foster transformation, department officials have recognized many organizational and process challenges that require priority attention, including the need to realign its infrastructure, identify new (private) sources of financing, streamline investment decision making and contracting, and improve the management of capital projects.¹⁶⁵ Organizational change aimed at streamlining and better aligning core processes is vital to effective operation of VA's facilities programs.

Capital-Asset Imperatives

The planning and development of a new delivery model centered on establishing integrated networks of care has major implications for identifying, planning for, and realizing VHA's capital needs. Greater reliance on community care, inherent in that model, establishes a new set of imperatives, specifically, a need for

- facility realignment
- more effective means of repurposing or other divestiture of unneeded buildings and land
- new, more effective tools to meet VHA's need for new clinic capacity and major construction
- more effective management of VHA's capital needs

¹⁵⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 159, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁶⁰ Ibid., 159-160.

¹⁶¹ Ibid., 160.

¹⁶² Ibid., vii-ix, 34.

¹⁶³ Ibid., vi, 20.

¹⁶⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, K-5, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁶⁵ Interviews of VA staff by Commission on Care staff, April 2016.

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Facility Realignment

VA planning must closely examine the role of, and future for, individual facilities, in light of a transformative new delivery model. For more than a quarter century, VHA leaders have cited the need for medical center mission changes, realignments, disposal of unneeded buildings, and where indicated, hospital closures.¹⁶⁶ The critical importance of transforming VA health care delivery gives new urgency to providing tools to realign VHA's care-delivery infrastructure. The Commission recognizes that the SECVA does have authority to "consolidate, eliminate, abolish, or redistribute the functions of . . . [VA] facilities, and to carry out an administrative reorganization" of a field facility.¹⁶⁷ But that authority may generally not be unilaterally exercised.¹⁶⁸ In addition, despite VA's having established two previous commissions to address the need for facility realignment, leaders have had only limited success in achieving that objective. The exercise of SECVA's broad authority to reorganize is tempered by the prerogatives and fiscal authority held by Congress. Congress has rejected legislation that proposed a process to reassess the future of individual VA facilities,¹⁶⁹ reflecting concerns over veterans losing access to care and the potential of constituents losing employment. Such concerns can be addressed. To be successful, a capital asset realignment process must be conducted on a systemwide basis within a framework that provides for sound planning; the exercise of objective, independent expertise; and a reliable mechanism for implementation. Congress can look to and adapt a proven model¹⁷⁰ — the military base realignment and closure (BRAC) process — to meet those objectives and achieve marked improvements in access to care.

Congress should enact legislation, based on DoD's BRAC model, to establish a VHA capital asset realignment process to more effectively align VHA facilities and improve veteran's access to care. Creating a robust capital asset realignment process is vital because previous capital divestiture efforts have failed.¹⁷¹ This process should offer a level of rigor far beyond what currently exists for repurposing and selling capital assets. It should require VHA to employ criteria set by the VHA Care System governing board (see Recommendation #9) to conduct locally-based analyses of capital assets, based on national process criteria. Information generated would be used to assist an independent commission, established under the

¹⁶⁶ "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com*, accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578>.

¹⁶⁷ Authority to Reorganize Offices, 38 U.S.C. § 510.

¹⁶⁸ Authority to Reorganize Offices, 38 U.S.C. § 510(c). In instances where a reorganization would reduce employment by 15 percent or more at a facility, VA must provide Congress a detailed plan and justification, and must defer implementation for at least 45 days.

¹⁶⁹ Veterans Millennium Health Care and Benefits Act, H.R. 2116, 106th Cong. (1999). Section 107 of House-passed H.R. 2116 would have established a mechanism for VA to cease providing hospital care at medical centers which were no longer providing high quality, efficient hospital care because of factors such as aging physical plant, functional obsolescence, and low utilization, and to redirect funds instead toward establishment of enhanced-service programs. In taking up H.R. 2116, the Senate did not adopt that provision, and it was not included in the Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545 (1999), accessed January 12, 2016, <https://www.gpo.gov/fdsys/pkg/PLAW-106publ117/html/PLAW-106publ117.htm>

¹⁷⁰ Defense Base Closure and Realignment Commission, *Defense Base Closure and Realignment Act of 1990 (as amended through FY 05 Authorization Act)*, accessed June 23, 2016, <http://www.brac.gov/docs/BRAC05Legislation.pdf>.

¹⁷¹ "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com*, accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578>.

legislation, in making recommendations regarding realignment and capital asset needs.¹⁷² The independent commission would conduct a thorough, one-time process, to include making site visits and holding hearings to inform recommendations that would constitute a proposed national realignment plan. The VHA Care System governing board would review, and adopt or make recommendations to revise, the independent commission's recommended realignment plan. The commission would then empower the VHA Care System governing board to implement the recommendations unless, within a specified timeframe, Congress disapproves the entire plan on an up or down vote. The Commission on Care envisions that after the completion of a realignment carried out under such proposed legislation and in the course of ongoing VHA transformation, the VHA Care System governing board would make all additional facility alignment decisions, to meet veterans' needs and to fully integrate with the strategic vision for the VHA Care System.

Repurposing and Divestiture of Unneeded Buildings and Land

Maintaining health care facilities to provide state-of-the-art care requires ongoing financial support. Bearing the additional cost of maintaining outdated, vacant, and unused buildings diminishes operating funds needed for patient care, and yields no benefit. Even taking unused buildings offline and placing them in *mothball status*, requires tens of millions of dollars in basic building maintenance.¹⁷³ If VA could sell, repurpose, or otherwise divest itself of unused or underutilized buildings in a timely, cost-effective manner, it would free funds for the purposes for which they are appropriated.¹⁷⁴

Enhanced-use leasing authority has in the past provided VHA a viable tool that prevents the need for such unnecessary spending, while permitting development of vacant property for uses compatible with VHA's mission, and effective use of the proceeds, whether in cash or in kind.¹⁷⁵ This leasing mechanism has been put to particularly effective use in leveraging an asset that VHA can no longer use, but which has development potential, as consideration for an asset it may need, such as clinic space. But limiting enhanced-use leasing to a single use that may not be feasible in many locations precludes effective use of a valuable capital-alignment tool.

In many instances, however, the condition or remote location of VHA buildings does not lend itself to enhanced-use leasing. Given the need to dispose of a large inventory of vacant

¹⁷² The process should take into account the community health needs assessments (CHNA) that not-for-profit hospitals are required to carry out under current law, (Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat.119, sec. 9007(a) (2010)) and opportunities to engage community providers in collaborative partnerships. This provision requires tax-exempt hospitals to create a hospital community health needs assessment every three years. This hospital CHNA is developed alongside community stakeholders. The community health needs assessment requirements include: demographic assessment identifying the community the hospital serves; a community health needs assessment survey of perceived healthcare issues; quantitative analysis of actual health care issues; appraisal of current efforts to address the healthcare issues; and formulation of a 3-year plan under which the community comes together to address those remaining issues collectively.

¹⁷³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 49, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁷⁴ *Ibid.*, B-13.

¹⁷⁵ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), accessed June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

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buildings for which there is no realistic prospect of their being repurposed, a streamlined divestiture process is needed.

Meeting Clinic Capacity and Other Infrastructure Needs

Developing a new delivery model and establishing a thorough realignment process may shrink VHA's future capital needs but will not eliminate them. As congressional budget rules have frustrated VHA efforts to lease needed clinic space, it is critical that VHA and Congress find models or remedies to establish new ambulatory care space and renew leases of existing clinics. Congress and VHA should work together to find the means to meet VHA's need for new clinic capacity. Given an impasse in congressional authorization of VA clinic leasing based on build-to-lease contracts, VA should explore the feasibility of restructuring those arrangements. VA should explore an arrangement that remedies the concern that it is entering into capital leases. Such an approach, for which VA provides the builder with space needs rather than a complete design, would have the additional benefit of bringing projects on line much sooner. Absent an effective solution to meeting VA's ongoing need for clinic space, Congress must be willing, as it was in passing VACAA, to take extraordinary steps¹⁷⁶ to overcome a funding challenge, and, in this instance to waive, or suspend for at least 5 years, the operation of current congressional authorization and scorekeeping requirements governing major medical leases.

In addition to severe leasing challenges, current statutory spending limits make it difficult for VHA to modernize and renovate its aging facilities.¹⁷⁷ Notably, minor construction funds, available for "constructing, altering, extending, and improving"¹⁷⁸ any VA facility, are limited to \$10 million,¹⁷⁹ yet such projects may require substantially more given the age and condition of many VA buildings. Congress last lifted the threshold of what constitutes a major medical facility project – the amount above which a project requires specific authorization – more than a decade ago.¹⁸⁰ The Commission believes that with the tight controls a governing board would exercise, that threshold should be lifted substantially, providing needed flexibility to carry out minor construction projects.

As VHA works more closely with community providers and participates in discussions regarding community health needs, it should be open to opportunities to discuss and potentially work toward joint efforts at meeting infrastructure needs.¹⁸¹

¹⁷⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 stat. 1754, sec. 803 (2014).

¹⁷⁷ VA Office of Inspector General, *Veterans Health Administration: Review of Minor Construction Program*, 8, accessed June 3, 2016, <http://www.va.gov/oig/pubs/VAOIG-12-03346-69.pdf>.

¹⁷⁸ Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242 Div. J., Title II, Department of Veterans Affairs (2015).

¹⁷⁹ A major medical facility project is one involving a total expenditure of more than \$10 million. Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(a)(3)(A).

¹⁸⁰ Sec. 812 of the Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. No. 109-461, 120 Stat. 3403 (2006), raised the threshold as to what constitutes a major medical facility project from more than \$7 million to more than \$10 million.

¹⁸¹ One such public-private model, such as under discussion in Omaha, NE, where talks have centered on private donors' partially funding construction of a replacement medical center, necessarily poses challenges, but merits exploration and support. ("VA Exploring Public-Private Plan for New Facility," Lincoln Journal Star, accessed June 3, 2016, http://journalstar.com/news/state-and-regional/nebraska/va-exploring-public-private-plan-for-new-facility/article_6a90778e-6962-545f-a86a-3f27930bd84e.html.) Although Congress must ultimately provide apt facilities for VA care-delivery, the law has long authorized the SECVA to accept gifts or donations, for purposes of facility

Capital Asset Management

The Commission fully recognizes that VHA has much to do on its own to more effectively meet its capital asset needs. At the core, leaders must strengthen and streamline the capital asset programs' management and operation, to include better aligning the component elements; streamlining the leasing program, contracting, and investment decisions; managing and streamlining project delivery for construction and renovation; and adopting a facility (or building) life-cycle-model planning tool. These are all important elements of needed system transformation.

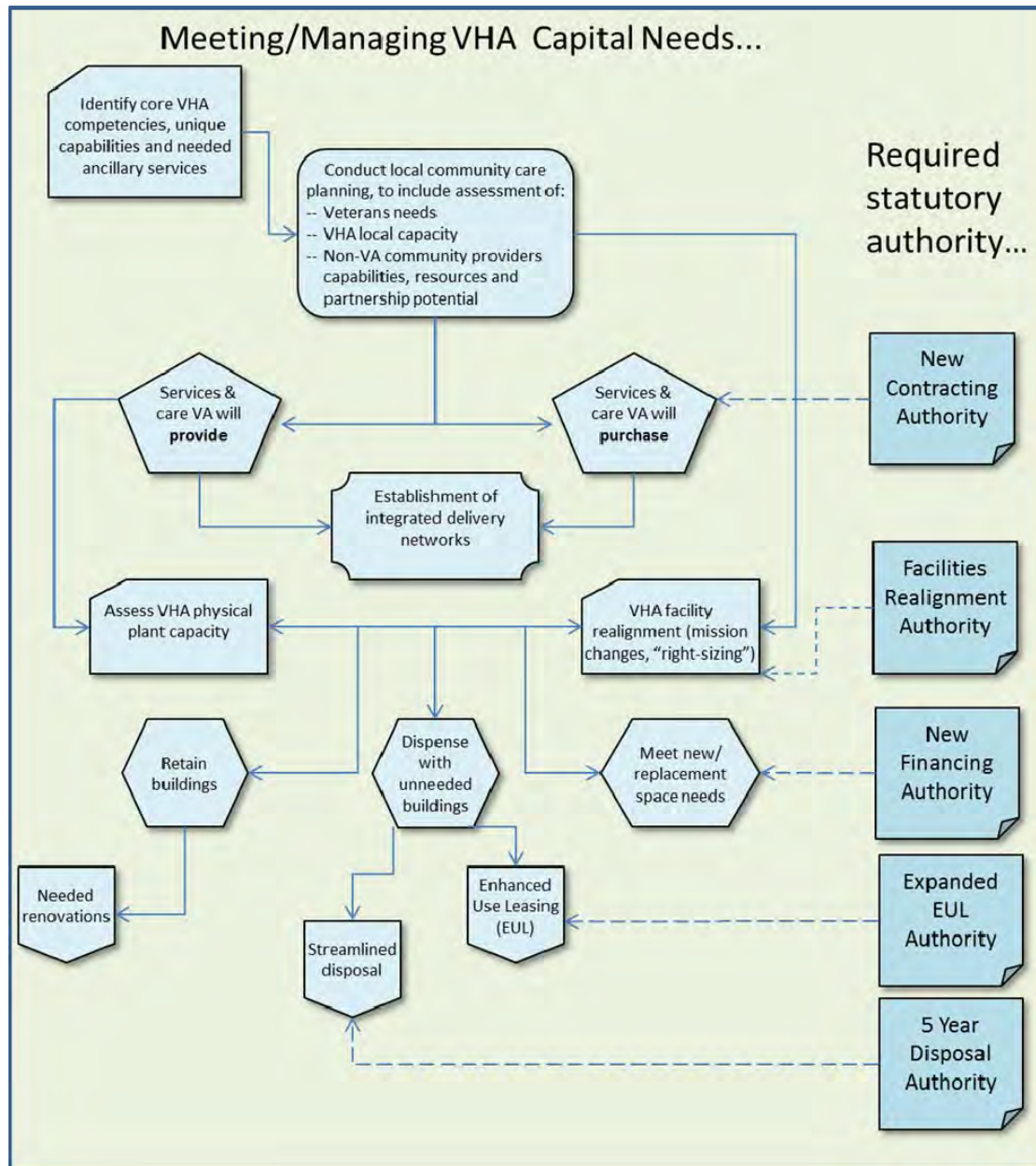
As depicted in Figure 3, meeting and managing VHA's capital-asset needs require an integrated approach that requires congressional support to tackle the multiple capital-asset challenges facing VHA. The Commission's recommendations for meeting and managing those interrelated capital-asset needs are set forth in the *Implementation* section following Figure 3.

construction. (Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(e)) Nevertheless, new legislative authority would almost assuredly be needed to permit development of public-private partnerships that provide new platforms for the construction of new or replacement medical facilities. For example, H.R. 5099 would establish a pilot program permitting VA to enter into public-private partnership agreements to plan, design, and construct new VA facilities using private donations. To Establish a Pilot Program on Partnership Agreements to Construct New Facilities for the Department of Veterans Affairs, H.R. 5099, 114th Cong. (2016), <https://www.congress.gov/bill/114th-congress/house-bill/5099>.

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Figure 3. The Complicated Process of Meeting and Managing VHA's Capital-Needs

**Implementation****Legislative Changes**

- Provide VA new, more flexible authorities to realign facilities, meet capital-asset needs, and divest itself of unneeded buildings.
- Establishing a VHA capital asset realignment process that provides (notwithstanding any other law) for more effectively aligning VHA facilities with the objective of improving the access, quality, and cost-effectiveness of VA care, and provides for:

- Establishing an independent commission (empowered to hold public hearings, make site visits, and have full access to VHA analyses and data) charged with developing a national capital asset realignment plan that would include recommendations to the VHA Care System governing board (see Recommendation #9) for systemwide facility realignment (to include changes in facility mission, facility downsizing, integration of facilities, and closures), with the rationale for each recommended change.
- The proposed plan would identify (a) the criteria used in developing realignment recommendations, (b) proposals for reinvestment and savings/cost avoidance resulting from the realignment, (c) the projected care improvements that would result, and (d) mechanisms to minimize the adverse effects on displaced employees, to include assuring that, to the extent feasible, VA retrain and reemploys displaced employees.
- The VHA Care System governing board would be empowered to adopt or alter the proposed realignment plan, and to implement the final plan unless, within a specified timeframe, Congress disapproves the plan as a whole on an up-or-down vote.
- Waive or suspend for at least 5 years current authorization and scorekeeping requirements governing major medical facility leases under 38 U.S.C. § 8104.
- Amend 38 U.S.C. § 8104 to lift the threshold of what constitutes a major medical facility project from \$10 million to \$50 million.
- Amend pertinent provisions of 38 U.S.C. § 8161, and what follows, to reinstate and extend for 10 years the authority in prior law (as in effect on December 30, 2011) for VHA to enter into enhanced-use leases for any use that is not incompatible with VA's mission.
- Provide the VHA Care System governing board authority to promulgate regulations that for a period of not more than 5 years, and notwithstanding any other law, would ease the divestiture of unneeded vacant VHA buildings, to include (a) shifting to a third party the cost of meeting environmental requirements, (b) allowing VHA to retain the proceeds of any property sale, and (c) creating a streamlined process to address historic preservation considerations.

VA Administrative Changes

- None required.

Other Department and Agency Administrative Changes

- None required.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

Problem

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems and other health care providers; enables scheduling, billing, claims, and payment; and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.¹⁸²

VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, currently within VHA, there is no experienced senior health care IT leader focusing on the strategic health care IT needs of veterans and VHA staff.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing and implementing a comprehensive health IT strategy and developing and managing the health IT budget.
- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Background

A fully functional electronic health record (EHR) can improve the quality of patient care, help avert medical errors, and improve communication among providers and with patients.¹⁸³ Starting in the 1970s, VHA became a leader in the development of EHR technology with VistA and a computerized patient record system (CPRS).¹⁸⁴ Full implementation of the EHR, together with other reforms, helped improve the quality of care at VHA.¹⁸⁵ During the last decade, VHA has not been able to maintain an IT advantage.¹⁸⁶ Although in the past most VHA clinicians

¹⁸² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁸³ "Does health information technology improve quality of care?" Robert Wood Johnson Foundation, accessed May 20, 2016, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71333.

¹⁸⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 29-30, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

¹⁸⁵ Phillip Longman, *Best Care Anywhere: Why VA Care Is Better Than Yours* (3rd ed., Berrett-Koehler Publishers, Inc., 2012). Jonathan B. Perlin, Robert M. Kolodner, and Robert H. Roswell, "The Veterans Health Administration: Quality, Value, Accountability, and Information as Transforming Strategies for Patient-Centered Care," *The American Journal of Managed Care* (November 2004), 828-836, accessed June 3, 2016, <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.476.450&rep=rep1&type=pdf>.

¹⁸⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, vi, accessed April 5, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

have had a high opinion of the clinical applications and databases enabled by VistA and CPRS, a lack of upgrades has put VHA's EHR at risk of becoming obsolete.¹⁸⁷ Many large U.S. health care systems that were early adopters of homegrown EHR systems found themselves in similar circumstances and have since purchased and migrated to commercial off-the-shelf (COTS) products.¹⁸⁸ DoD recently made the same choice.¹⁸⁹

To achieve the Commission's vision of a health care system that delivers quality, access, choice, and veteran well-being, VHA requires effective, robust, and modern information technology systems. A robust EHR system would allow veterans and clinical providers to send, receive, find, and use electronic health information in a manner that is appropriate, secure, timely, and reliable. It would be seamlessly interoperable with other systems including DoD, private-sector providers, and with other VA enterprise systems such as those in the Veterans Benefits Administration (VBA). It would support VHA clinical workflow, evidence-based practice, and patient safety. It would provide clinicians, patients, and administrators the data, analytic power, and user interfaces required to monitor the effectiveness of care and improve it over time. A robust IT system for VHA should include more than just the EHR, however, extending to all the systems and tools required to facilitate and automate business processes that support access and veterans' care. These capabilities include an effective scheduling system, telephone systems, mobile applications, telehealth, financial management systems, human resources systems, and other systems that enable community care.

To realize such a transformation of IT in a system as complex as VHA requires exceptional leadership and staff, sufficient budget, a robust change management plan, effective systems for accountability and quality control, and efficient and agile contracting.¹⁹⁰ Presently, VHA appears to lack a majority of these factors required for success.¹⁹¹

Analysis

Leadership and Staff

Prior to 2006, VHA had a chief health informatics officer responsible for the VHA electronic record system and for coordinating with VA on IT systems. The programmers in VHA worked closely with the clinicians who used the tool to create a system that met their needs.¹⁹² VHA was able to prioritize clinical needs and patient safety requirements within its overall budget and plan for IT spending; however, there was no specific budget line item for the electronic health

¹⁸⁷ Ibid., 29-30.

¹⁸⁸ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

¹⁸⁹ "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

¹⁹⁰ LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

¹⁹¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 41, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁹² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

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record system or related technology, and there was limited central oversight or accountability for information technology infrastructure.

VA's IT budget was centralized in 2006, and the Office of Information and Technology (OIT) was assigned to deliver, operate, and manage IT and its budget, across the department. With this change, VHA's needs became only one of the priorities that OIT has had to accommodate and VHA's priorities have not always prevailed.¹⁹³

To ensure that clinical needs and patient safety are a priority, many large health care systems, such as DoD, Cleveland Clinic, Geisinger, and Kaiser Permanente, have a medical CIO (i.e., CMIO) who manages and advocates for the clinical IT needs of the organization. A CMIO ensures that clinicians are involved in the selection of any IT systems they use to perform their job functions and provide patient care, including EHRs. Clinicians involved in the selection and deployment of an IT system are more likely to feel ownership of it and fully adopt its use. The CMIO usually reports to the health system's CEO or CMO, and working in concert with these individuals and the organization's CIO, makes sure that health information needs are prioritized and funded.¹⁹⁴

VA does not have staff with the necessary expertise to execute large-scale IT projects. Previous system implementations have failed because VA did not have individuals with adequate experience to effectively plan and manage system development and deployment. If VA had an adequate system and skilled staff to monitor and identify program and contracting problems affecting the progress of prior IT implementations, effective and timely decisions could have been made to either redirect or terminate VA IT projects that ultimately failed. To avoid repeating these previous IT implementation failures, VA needs to develop effective oversight systems and develop in-house staff with the expertise to oversee, fully support, manage, and execute complex integrated IT programs.¹⁹⁵

Given all of these critical needs, the Commission believes that it is essential for VHA to have a CIO with health care expertise and substantial experience, reporting to the chief of VHA Care System. The VHA CIO will be responsible for managing the complex implementation of a state-of-the-art comprehensive information system platform to support the new integrated VHA Care System, with the functionality, interoperability, and data management capabilities to support the delivery and coordination of high-quality health care for veterans. The CIO will need to work closely with clinical and operational leaders on the effective execution of the new system, and will also need to collaborate with the VA CIO to ensure the integration and coordination of the health care information system and the Veterans Benefit Administration system.

¹⁹³ Ibid., 10.

¹⁹⁴ "CMIOs Help Hospitals Make Tech Transitions," Naseem S. Miller, accessed May 13, 2016, <https://www.acep.org/content.aspx?id=79744>.

¹⁹⁵ Department of Veterans Affairs Office of the Inspector General, *Review of the Awards and Administration of Task Orders Issues by the Department of Veterans Affairs for the Replacement Scheduling Application Development Program*, accessed May 25, 2016, <http://www.va.gov/oig/52/reports/2009/VAOIG-09-01926-207.pdf>.

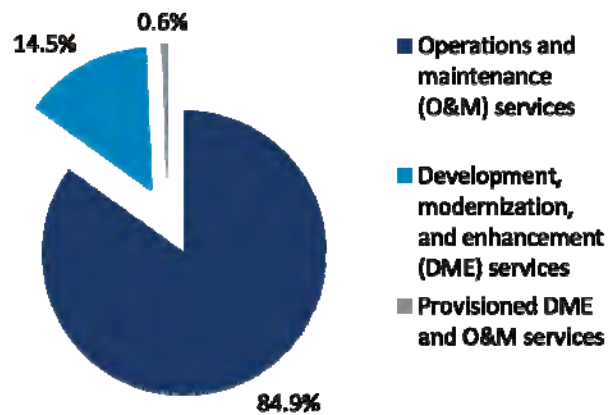
Budget

The 1-year budget appropriations cycle makes it difficult to secure multiyear funding for long-term development and important IT projects.¹⁹⁶ The budget process is disconnected from total lifecycle IT costs.¹⁹⁷ That disconnect has grown wider with a change in law¹⁹⁸ under which Congress provides VHA advanced medical care appropriations—in effect a 2-year budget—while health IT funding remains 1-year money.¹⁹⁹ As the Congressional Research Service (CRS) testified,

*providing an advance appropriation for some VHA accounts and funding IT accounts under a regular appropriation act could create a situation whereby, for example, VHA could not purchase computer software although it has procured medical equipment that needs software. Another example would be the difficulty of procuring IT infrastructure to support opening of a new community-based outpatient clinic (CBOC).*²⁰⁰

Spending on new systems and upgrades to existing systems now represents only 15 percent of VA's total IT budget (see Figure 4),²⁰¹ meaning that essential upgrades like a new scheduling package and EHR modernization have not had the funding or focus required to succeed. Clinical users have become increasingly frustrated by the lack of any clear advances with VistA during the past decade. Numerous VHA clinicians have experience with commercial EHR systems and want the same level of features, modern clinical capabilities, integration, and mobility they see emerging in the commercial marketplace.²⁰²

Figure 4. VA IT Spending



In July 2015, DoD awarded a \$4.3 billion, 10-year contract to overhaul the Pentagon's electronic health records for millions of active-duty military members and retirees. Officials estimate that

¹⁹⁶ "Coming in 2016: Cloud Legislation," Aisha Chowdhry and Adam Mazmanian, accessed January 12, 2016, <https://fcw.com/articles/2015/12/22/cloud-bill-2016.aspx>.

¹⁹⁷ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.

¹⁹⁸ Veterans Health Care Budget Reform and Transparency Act of 2009, Pub. L. No. 111-81, 123 Stat. 2137 (2009).

¹⁹⁹ With the Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235 (December 16, 2014), Congress expanded advanced appropriations to additional VA program accounts.

²⁰⁰ U.S. Congress, House of Representatives, Committee on Veterans Affairs, *Funding the U.S. Department of Veterans Affairs of the Future: Hearing before the Committee on Veterans Affairs U.S. House of Representatives*, 111th Congress, 1st Sess., April 29, 2009, 60, accessed June 3, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-111hhrg49914/pdf/CHRG-111hhrg49914.pdf>.

²⁰¹ Department of Veterans Affairs, *Information Technology Agency Summary*, accessed May 25, 2016, <https://itdashboard.gov/drupal/summary/029>.

²⁰² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

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during its potential 18-year life, the contract could be worth just less than \$9 billion.²⁰³ The recent Senate appropriations bill for VA OIT allots \$63 million toward development and modernization of VA's existing EHR (i.e., VistA Evolution).²⁰⁴ Assuming that VA's implementation of a new COTS EHR would be similar in size and scope to DoD's EHR implementation, VA would be short \$3.67 billion in funding for a new COTS EHR, given the current funding amount of \$63 million per year. VA will require a substantial increase in IT funding to support the successful implementation of a new comprehensive COTS EHR.

Robust Change Plan

Because VistA has been customized at each medical center, there are few standard data elements. The varied algorithms lead to a complex, heterogeneous mix of hardware and software that impedes system changes and new capabilities and raises operations and maintenance costs.²⁰⁵ Due to excessive project management overhead, a complex legacy IT infrastructure that is difficult to modernize, and more than 130 variations of the primary software system deployed across VHA medical facilities, the implementation of improved IT capabilities in the last 10 years has been extremely limited.²⁰⁶ VA is currently weighing whether to continue to modernize VistA or purchase a COTS health information technology platform. The Commission recommends moving to a COTS program.

Whether VHA moves forward with the purchase of a COTS product, as recommended by the Commission, or continues attempting to modernize VistA, VHA must effectively manage the change process. At present, a lack of standard clinical documentation has made it harder to develop effective clinical decision-support systems and hinders EHR information exchange among VA Medical Centers (VAMC), between VA and non-VA facilities (including those of DoD), and between VA and individual veterans. Shared data must be well labeled in a way that the receiving system can identify and properly ingest such data. An electronic medical record can contain as many as 100,000 different data fields. The lack of data standards presents challenges to using comparable data for analysis and disparities among the 130 tailored local instances of VistA, complicating information sharing, data aggregation, and analytics.²⁰⁷ VHA has not established comprehensive semantic definitions for data elements through the use of standard nomenclatures, terminologies, and code sets. Doing so is required to ensure consistency and integration across multiple systems, leverage follow-on IT products, and facilitate analytics for clinical decision making.²⁰⁸

The Office of the National Coordinator (ONC) for Health IT, under HHS, is responsible for advancing national connectivity and interoperability of health information technology. The

²⁰³ "Cerner wins \$4.3 billion DoD contract to overhaul electronic health records," Amy Brittain, *The Washington Post*, accessed May 25, 2016, https://www.washingtonpost.com/national/health-science/cerner-wins-dod-contract-to-overhaul-electronic-health-records/2015/07/29/7fbfccfa-35f5-11e5-b673-1df005a0fb28_story.html.

²⁰⁴ S. Rept. 114-237 – Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, 2017, accessed May 25, 2016, <https://www.congress.gov/congressional-report/114th-congress/senate-report/237/1>.

²⁰⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²⁰⁶ *Ibid.*, 41.

²⁰⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, vi, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁰⁸ *Ibid.*, viii.

ONC developed the National Interoperability Roadmap with the goal of being able to use electronic health information exchange, so information can follow a patient where and when it is needed, across organizational, health IT developer, and geographic boundaries. The roadmap lays out a clear path to catalyze the collaboration of stakeholders who are going to build and use the health IT infrastructure.²⁰⁹ VA's intent to expand veteran care to more community providers through the creation of locally-integrated health care networks will mean that it is important for VHA to follow the ONC roadmap and standards. Following this roadmap includes using the continuity of care document to exchange data, which was established by ONC and is followed by community health care providers. VA OIT is currently collaborating with the ONC on VA's plans for interoperability and has committed VA to following the roadmap.²¹⁰

VHA does not yet have a robust, detailed strategy and roadmap for IT initiatives across VHA that integrates veteran access to scheduling via phone, telehealth, and mobile apps.²¹¹ National deployment of the VistA Scheduling Enhancement and the veteran mobile scheduling Veteran Appointment Request app, are initial steps to prepare for the implementation of new COTS electronic medical system with a scheduling package.

To resolve the underlying systemic issues with VistA scheduling, VA awarded a contract for the implementation of VA's new COTS medical appointment scheduling system in August 2015.²¹² This system is a COTS scheduling solution that, when implemented, is expected to move VHA from primarily a face-to-face appointment model to a coherent, resource-based system with broad opportunities for improved services for VA stakeholders.²¹³ Deployment is awaiting the final decision on whether VHA will continue with VistA or purchase a full COTS product.

COTS Solution

The current VistA/computerized patient records systems are based on a tightly integrated, monolithic architecture and design with numerous and diverse functional components and associated interdependencies. These characteristics impose barriers to modernizing the respective systems. In addition, the high cost of infrastructure operation and maintenance (85 percent of the total IT budget) reduces funding available for new development efforts.²¹⁴ Maintenance and data sharing are further complicated because most VAMCs have customized their local versions of VistA, leading to approximately 130 different versions of VistA across the country.²¹⁵

²⁰⁹ "A Shared Nationwide Interoperability Roadmap Version 1.0," HealthIT.gov, accessed March 29, 2016, <https://www.healthit.gov/policy-researchers-implementers/interoperability>.

²¹⁰ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²¹¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 44, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²¹² "\$623M Medical Appointment Scheduling System (MASS) Contract," G2Xchange, accessed May 3, 2016, <https://www.g2xchange.com/statics/623m-medical-appointment-scheduling-system-mass-contract>.

²¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 40, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²¹⁴ *Ibid.*, vi.

²¹⁵ *Ibid.*, vi.

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VHA relies on a VistA scheduling package to provide veterans with access to health care. The system is antiquated, highly inefficient, does not optimally support processes or allow for efficient scheduling of appointments. A report on scheduling published by the Northern Virginia Technology Council (NVTC) in October 2014, showed that VA's exam-scheduling processes are not enabled by state-of-the-art technologies or consistently applied standard operating procedures.²¹⁶ To improve this situation, VHA has developed, and is in the process of a national roll out of, VistA scheduling enhancements, which provides an improved user interface (i.e., graphic user interface or GUI). Although the new GUI will help veterans gain access to care by implementing better scheduling procedures, it does not address the need that managers, planners, and administrators have for accurate and timely data on clinic use.²¹⁷ For instance, VHA's new health care operations dashboard shows that more than 55 percent of clinic slots in VHA go unused each day.²¹⁸ However when questioned about this data, VHA notes that it is not correct.²¹⁹ The underlying VistA scheduling software does not allow accurate representation of clinician time toward each clinic stop. As a result, whether data is presented in a dashboard or a new GUI tool, as long as the underlying data cannot be captured accurately, then VHA will not have the information it needs to effectively manage the supply of clinic slots.²²⁰

VA's financial management information technology system is woefully outdated and VA has previously wasted approximately \$500 million in two failed attempts to replace it. Given VA's lack of an integrated finance and logistics IT system, VA has no method to perform commitment accounting.²²¹ VA's current financial management system does not support streamlining and automation of VA's revenue cycle.²²²

Community care processes currently include eligibility determinations, referrals and authorizations, care coordination, network management, claims, and customer service.²²³ VA's information technology systems limitations often demand manual processes to support community care that can reduce the timeliness and accuracy of data and obscure the true state of VHA's activities. Relying on manual processes slows collections and payment activities and introduces errors and waste into the process.²²⁴ Barriers to automation are multifactorial,

²¹⁶ Ibid., 39-40.

²¹⁷ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

²¹⁸ Crystal Wilson, Office of Analytics and Business Intelligence, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.

²¹⁹ Joe Francis, Director of Clinical Analytics and Reporting, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.

²²⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

²²¹ Jan R. Frye, *Letter to Secretary McDonald, March 19, 2015*, accessed May 17, 2016, http://extras.mnginteractive.com/live/media/site36/2015/0522/20150522_025126_WhistleblowerMemo.pdf.

²²² Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, 24, accessed May 24, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf.

²²³ Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.

²²⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 42, accessed March 28, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

including confusing eligibility rules governing which veterans may receive care outside VHA and for what conditions, in what circumstances, and which services may be billed to third-party insurers.²²⁵ In addition, there are multiple authorities for purchasing community care—all with different business rules²²⁶ and reimbursement rates, as well as antiquated financial management information systems that are not standardized to private-sector processes. All of these impediments are exacerbated by workers throughout the revenue cycle who are poorly compensated and marginally trained, experience high turnover, and work in environments with a continuous 20 percent vacancy rate;²²⁷ thus, they cannot effectively manage certain business practices such as insurance verification and ensuring clinicians complete necessary coding documentation.²²⁸

Many large U.S. health care systems that originally developed in-house EHRs have since purchased and migrated to COTS EHRs.²²⁹ DoD recently made the same choice, deciding to replace its homegrown EHR with a COTS product to take advantage of private-sector innovation and have an EHR that communicates with private-sector systems. For a system in which 60 to 70 percent of military health care takes place outside the DoD,²³⁰ this was an important business consideration that is also consistent with VHA's long term direction. Very large IT programs with purpose-built systems and labor-driven business models are shifting rapidly toward more open source, COTS systems. Large proprietary IT solutions are increasingly being replaced by less risky, agile, and open-source solutions or IT as-a-service models, and getting away from client-server models.²³¹

Interoperability

VHA's EHR issues stymie interoperability among VHA facilities as well as between VHA and DoD and other non-VHA providers. Multiple assessments noted the lack of interoperability resulted in incomplete patient records with potentially substantial implications for veterans and VHA. Incomplete records introduce unnecessary clinical risk, complicate the transition from

²²⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I (Business Processes)*, 19-20, accessed April 26, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²²⁶ Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.

²²⁷ Healthcare Talent Management, Veterans Health Administration, email to Commission on Care, April 11, 2016. Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America's Veterans*, accessed April 25, 2016, <http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf>.

²²⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I, Business Processes*, I3-I4, accessed November 24, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²²⁹ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

²³⁰ "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

²³¹ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

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DoD to VHA care, and inhibit VHA's ability to bill and collect revenue in an accurate and timely manner.²³²

As GAO reported in August 2015, VA and DoD have taken initial steps to increase interoperability between their existing electronic health record systems.²³³ They have deployed the Joint Legacy Viewer (JLV), which provides a patient-centric, integrated view of a patient's health data from VA, DoD, and community health partners on one screen. It has been available at all VA medical centers since October 2014 and currently has more than 70,000 users.²³⁴ The JLV is a positive step in supporting coordination of care among VA, DoD, and community partners, but it only allows for providers to view veterans'/service members' medical records and does not yet allow for the other agencies' medical records to be updated by providers.²³⁵

VA's next evolution in interoperability with DoD and community partners is the deployment of their Enterprise Health Management Platform (eHMP). eHMP is intended to provide VA streamlined access to complete patient history from VA, DoD, and community health partners in a single, reliable, customizable, and secure interface that is easy to use. It is reported to deliver a modern, web-based user interface and supporting infrastructure and is intended to replace the Computerized Patient Record System (CPRS) as VA's primary point-of-care application. The national rollout of eHMP is expected to be completed by December 2017.²³⁶

VHA does not have everything that is needed in an IT system to manage the business and clinical aspects of care in the community and support the overall veteran experience in an expanded community network. To address these gaps and provide health care well into the future, VA intends to develop in house a comprehensive and interoperable digital health platform (DHP). The DHP is intended to seamlessly integrate all of VHA's core processes, including scheduling, supply chain management, billing, and claims. Through consolidation of more than 40 contact center systems and more than 130 versions of the VistA EHR and clinical procurement/inventory systems, the DHP is designed to enable VHA's operation as a holistic, platform business and greatly reduce the cost of system maintenance across the IT enterprise.²³⁷

Because there is no unique patient identifier, problems exist with "1) accessing and integrating information from different providers and provider computer systems, 2) aggregating and providing a lifelong view of a patient's information, and 3) supporting population-based research and development."²³⁸ To accurately match veteran patient data that is exchanged between VA and non-VA providers, both organizations need to use the same unique patient

²³² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 44, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²³³ "Electronic Health Records: VA and DOD Need to Establish Goals and Metrics for Their Interoperability Efforts," U.S. Government Accountability Office, accessed April 1, 2016, <http://www.gao.gov/products/GAO-16-184T>.

²³⁴ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²³⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, A-35, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²³⁶ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²³⁷ LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²³⁸ "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPVU-508.pdf>.

identifier. This practice is currently not used.²³⁹ Each health care system uses a unique patient identifier number, but it is specific to that system.²⁴⁰ VA uses patients' social security numbers as unique identifiers; whereas, due to stricter security standards required by HIPPA privacy laws that community providers must adhere to, many non-VA providers use other personally identifiable information (e.g., first name, last name, date of birth, and phone number) to match patient identities between record systems. Studies have shown that patient identification error rates range from 7-20 percent.²⁴¹ For VA to accurately identify patients and their records, a unique national patient identifier is essential.

The security of electronic records is an ongoing concern. One in three Americans had health care records breached in 2015.²⁴² Recent hacks of U.S. hospital health care systems through the use of ransomware, viruses that hold systems hostage until victims pay for a key to regain access, further highlight the need for enhanced VA cybersecurity.²⁴³ VA's OIG has repeatedly identified the same weaknesses and deficiencies in VA's information security program in its annual FISMA audit reports.²⁴⁴ Although VA has recently made some progress in developing policies and procedures to address current security gaps, OIG's FY 2015 audit concluded that information security is still a *material weakness* for VA and that VA must take comprehensive measures to mitigate security vulnerabilities affecting VA's mission-critical systems.²⁴⁵ For sharing of veteran data to be secure, only the designated correct parties can have access to patients' data.²⁴⁶ Interoperability increases the risk to veterans' health records.²⁴⁷ Cybersecurity guidelines and best practices are being developed by HHS in response to the requirements in the recently enacted Cybersecurity Information Sharing Act;²⁴⁸ however, security protocols also cannot impede health information exchange with VA community providers and health systems. VA OIT needs to be involved in the health information exchange planning discussions, which

²³⁹ "Interoperability 2015: Current State and Next Steps", Kent Gale, KLAS Research, accessed March 9, 2016, <http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0>.

²⁴⁰ "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPVU-508.pdf>.

²⁴¹ "The Right Fit: How We Solve the Puzzle of Interoperability," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, <http://www.futureofhealthcarenews.com/telemedicine/the-right-fit-how-we-solve-the-puzzle-of-interoperability>.

²⁴² "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, <http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records>.

²⁴³ "Virus Infects Medstar Health System's Computers, Forcing an Online Shutdown," John Woodrow Cox, Karen Turner and Matt Zapotosky, accessed March 28, 2016, https://www.washingtonpost.com/local/virus-infects-medstar-health-systems-computers-hospital-officials-say/2016/03/28/480f7d66-f515-11e5-a3ce-f06b5ba21f33_story.html?hpid=hp_local-news_medstar-health-virus-345pm%2Fstory.

²⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, A-24, accessed May 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁴⁵ Department of Veterans Affairs, Office of the Inspector General, *Federal Information Security Modernization Act Audit for Fiscal Year 2015*, accessed May 25, 2016, <http://www.va.gov/oig/pubs/VAOIG-15-01957-100.pdf>.

²⁴⁶ "Interoperability 2015: Current State and Next Steps; Market Immaturity Highlights Opportunity," Kent Gale, KLAS Research, accessed March 9, 2016, <http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0>.

²⁴⁷ Jon White, M.D., The Office of the National Coordinator for Health Information Technology, briefing to Commission on Care, December 15, 2015.

²⁴⁸ "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 17, 2016, <http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records>.

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are currently handled solely within VHA, so that VA OIT can assist in removing impediments to health information exchange.²⁴⁹

Veterans currently have to opt in (i.e., provide consent) to allow VA to share their health information with non-VHA/community care providers. Although the technology is in place for VA to exchange patient health information with more than 100 health information exchange partners, only a fraction of data can be exchanged in these networks because, due to lack of awareness, only 3 percent of veterans have opted in to allow VA to share their health information.²⁵⁰ The standard industry policy is to have patients opt out of having their health data shared with their other health care providers. VA is prohibited from taking this approach because statutory language in 38 U.S.C. § 7332 prohibits VA from disclosing information relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia, except when required in emergencies, without written authorized consent from the patient.²⁵¹

In response to this limitation, VA approved and submitted Legislative Proposal VHA-10 (10P-07), Authority for the Department of Veterans Affairs (VA) to Release Patient Information under 38 U.S.C. § 7332 to Health Care Providers for Treatment of Shared Patients in 2013. The proposal allows veterans to opt out of sharing their data with VA community providers instead of having to opt in. The proposal was approved by OMB and was included in the president's 2015 Budget. VHA provided a briefing to a Senate Veterans Affairs Committee staff in April 2015 on this legislative proposal. A House Bill was introduced, but it limited the opt-out option to the *Choice Program*. VA's Office of Congressional and Legislative Affairs responded back to Congress that the bill should be expanded to include all external purchased care options (i.e., community providers) thus directly supporting more veterans.²⁵²

Collaboration between VA OIT and VHA is paramount to transforming VHA's health IT infrastructure. Such collaboration would be most effectively achieved by establishing an IT leader for VHA who is focused on ensuring that the strategic and operational IT needs of VHA clinicians, staff, and veterans are met. Current OIT leadership is in the process of modernizing VA's IT management processes, to include putting in place IT account managers (ITAMs) for each of the agency's departments, including VHA.²⁵³ An account manager is neither senior enough, nor has the level of expertise and experience, to manage the complexity of the VHA IT system. VHA's extensive IT needs require a VHA CIO with authority over the health IT budget and the execution of the health IT strategy. VA needs a robust process for IT investment decisions, especially those relating to VHA's health strategy. The VHA CIO would work with the CVCS and the VA CIO to define the health IT strategy and key IT acquisitions/projects and ensure that health IT funding is aligned and committed to the execution of VHA's health IT

²⁴⁹ Jamie Bennett, VLER Health Program Manager, phone call with Commission on Care Staff, March 2, 2016.

²⁵⁰ Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015

²⁵¹ 38 U.S.C. § 7332 Subchapter III - Protection of Patient Rights Sec. 7332 - Confidentiality of certain medical records.

²⁵² Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015.

²⁵³ "OI&T Enterprise Strategy: Putting Veterans First," LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.

strategy. Rolling out a new system takes multiple years, and VA must commit to funding system deployments to completion.

The modernization of VHA's IT infrastructure requires a substantial increase in and reallocation of VA's IT budget to implement it. The budget process for VA health care IT funding should be the same as the process for VHA medical care funding. That shift can be accomplished by establishing a separate line item for *health* IT within VA's IT appropriation, and providing for advanced appropriations for that account. In addition, there is also a potential supplementary role for government-wide IT legislation. For example, H.R. 4897, the Information Technology Modernization Act of April 2016, would create a \$3.1 billion revolving fund for upgrading outdated federal IT systems.²⁵⁴

The Commission strongly recommends that VA purchase a comprehensive COTS health IT platform, and implement all information systems with minimal customization. VHA leadership is in the process of assessing whether VistA is the best solution to support veterans' future health care needs or whether a new EHR, such as a COTS product or open-source EHR, should be used.²⁵⁵ The decision to choose a COTS product would be consistent the approach adopted by DoD and by other large health systems that have moved away from homegrown solutions to commercial and open-source products. It would allow VHA to focus energy on excellent patient care as a core competency and shift the IT development and maintenance risk of software products to external vendors with more expertise in this area.²⁵⁶ It is also likely to accelerate interoperability as vendors continue to offer IT solutions that meet meaningful use standards and the roadmap published by ONC.

A COTS product must be able to execute key functionalities required by VHA. These requirements include one standard version of an EHR across all VHA sites of care; interoperability within VA, such as with Veterans Benefit Administration (VBA), and between VHA and DoD, and community providers; robust security; and the ability to accommodate a national unique patient identifier. This system must also be a robust clinical management tool that supports VHA clinical workflow and has a customizable interface for clinical users, allows for evidence-based clinical order sets and patient safety features like automated medication reconciliation, has robust analytic capability for both clinical and administrative functions, and enables automated abstraction and reporting of performance measures.

The system must also seamlessly support administrative functions like scheduling, patient intake, eligibility determination, referrals, and patient out-of-pocket expense determination. The system must enable effective business operations in billing coding, automated claims processing, and all aspects of supply chain management. This COTS purchase should include a scheduling package. Improvements in scheduling should dramatically increase access and satisfaction, as well as data quality, productivity, and operational reporting capabilities.

²⁵⁴ "Two IT Modernization Bills Could See Movement in Congress," Aisha Chowdhry, accessed April 28, 2016, <https://washingtontechnology.com/articles/2016/04/22/it-bills-congress.aspx>.

⁷³ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²⁵⁶ "DoD awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

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Broadening and improving scheduling capabilities will provide more opportunities for veterans to become active partners in their own care.²⁵⁷

For VHA to transition to a COTS product, the new VHA CIO must develop and implement a strategy that will allow the current nonstandard data to effectively roll into a new system, engage clinical-end users and internal experts in the procurement and transition process, ensure effective cybersecurity, and limit spending on the current systems to fund only critical changes required for continued operations. Finally, this plan should be coordinated with ONC and DoD.

Implementation

Legislative Changes

- Provide a specific appropriation to fully fund the complete development and deployment of the comprehensive COTS electronic health platform, recognizing this will require significant resources above the current annual appropriation and funding to support VHA's IT transformation; including funds that ensure appropriate training of all staff, recognize loss of staff productivity during implementation, and provide proper maintenance and upgrades of VA IT infrastructure in preparation for new and successor technologies.
- Establish within the Department's IT appropriation a line item for health IT, and provide for advanced appropriations for that account, consistent with the overall VHA IT strategy.
- Amend section 38 U.S.C. §7332, to authorize VA to share protected health information under the same rules as all other HIPAA protected information.

VA Administrative Changes

- Hire a CIO for the VHA IT transformation. The CIO should report to the CVCS, with secondary reporting responsibility to VA CIO.
- Establish a transformation strategy that addresses all of the following needs (as directed by the VHA CIO):
 - standardizes data elements in the current IT systems through the use of standard nomenclatures, terminologies and code sets in order to promote the transition to a COTS EHR and to support interoperability²⁵⁸
 - develops a robust cybersecurity plan for VHA IT infrastructure, in coordination with VA CIO and Chief Information Security Office, which addresses both current systems and defines
 - the requirements for new systems

²⁵⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 46, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁵⁸ *Ibid.*, 55.

- collaborates with the Office of the National Coordinator for Health IT on national interoperability standards and implementation
- limits any continued VistA development and associated spending to only those upgrades required to keep VistA functioning until a new system is in place
- Plan and implement procurement of a comprehensive COTS electronic health platform that executes all of the following requirements:
 - establishes one logical version of an electronic health record platform in VHA²⁵⁹
 - standardizes evidenced-based, best practice clinical order sets across VHA
 - incorporates effective analytic capabilities to drive health and business outcomes and offers the ability to interface with other tools for data management and presentation²⁶⁰
 - modernizes appointment scheduling so that it accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veterans²⁶¹
 - accomplishes a coordinated IT infrastructure for appointment scheduling, coding, billing, claims payment, third party collections, and other core VHA business processes, including the following specific capabilities: integration across patient intake, medical records, coding, and billing systems; single sign-on capability; automated first-party claims matching; real-time estimate of out-of-pocket patient expenses; and automation to support algorithmic edits and claims correction²⁶²
 - supports the business processes required to implement integrated community care networks, including eligibility determinations, referrals and authorizations, care coordination, network management, claims and customer service
 - promotes full interoperability with IT systems across VA (including VBA and National Cemetery Administration) and between VA and DoD
 - supports the development of full interoperability with integrated community care network facilities and providers

²⁵⁹ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²⁶⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, viii, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁶¹ The Independent Budget, *The Independent Budget—Veterans Agenda for the 114th Congress: Policy Recommendations for Congress and the Administration*, accessed May 17, 2016, http://www.independentbudget.org/2016/IB_FY16.pdf.

²⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 49, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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- enables automated abstraction and reporting of quality performance measures including process and outcome measures of clinical quality, access measures, and cost effectiveness that are the same as the private sector
- includes functionality to use a national unique patient identifier
- integrates supply chain and financial systems with the electronic health records to provide accurate operational data²⁶³
- Streamline its current IT procurement processes so that IT procurement is expeditious, including lengthier contract vehicles with more options, the use of indefinite delivery indefinite quantity vehicles, blanket purchase agreements, time and material contracts, and flexible contract structures to allow for the onboarding of emerging technologies in a competitive fashion.
- Increase health IT expertise within VHA.

Other Department and Agency Administrative Changes

- CMS and federal health care providers should collaborate to develop a national unique patient identifier standard. CMS should require health care providers to use these identifiers as a condition of participation in Medicare and HHS should require federally qualified health centers to use them as a condition of participation. The President should require all federal health care providers to adopt the standard.

²⁶³ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Problem

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.²⁶⁴

Background

Health systems nationwide, under pressure from reforms driven by the Affordable Care Act, are looking at every aspect of their business to maximize cost savings, while maintaining quality services.²⁶⁵ This effort includes examining the supply chain for ways to save money.²⁶⁶

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.
- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

²⁶⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁶⁵ Bob Kehoe, "Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness," *Health Facility Management Magazine*, 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.

²⁶⁶ "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, <http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends>. "5 Ways Supply Chain Can Reduce Rising Health Care Costs," Jasmine Pennie, accessed April 28, 2016, <http://hitconsultant.net/2013/05/13/5-ways-supply-chain-can-reduce-rising-health-care-costs/>.

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Price competition achieved through technology and aggressive management of supply chain efficiencies by retailers such as Walmart and Amazon are held up as just the kind of disruption that health care requires.²⁶⁷ Health care organizations as diverse as Kaiser Permanente, Cleveland Clinic, Stanford Medicine, and Johns Hopkins Health System have taken on the challenge of transforming their supply chains, realizing savings of as much as hundreds of millions of dollars.²⁶⁸ VHA, which in FY 2014 spent approximately \$3.4 billion on clinical supplies, medical devices, and prosthetic appliances, has an opportunity to realize similar savings.²⁶⁹

Opportunities for efficiency in the supply chain include reducing pricing for purchases and lowering operating costs of procurement processes. To achieve price savings, organizations must have detailed information on what products they use, understand and reduce variability in the products purchased, and aggressively negotiate pricing, usually by consolidating purchases to a small number of preferred vendors who are willing to offer volume discounts and improve service delivery. On the operations side, cost savings are achieved by managing inventory lifecycle and restocking processes; order management; and the logistics of shipping, receiving, and transportation to drive down costs and lower waste and breakage. In health care, it also pays to ensure that clinical staff, both nurses and doctors, are treating patients rather than conducting inventory checks or ordering and collecting supplies.²⁷⁰ To be successful in managing the supply chain in health care, a partnership with clinical staff is key. Variability in device and supply purchases can be driven by clinician preferences and thus, to reduce variability, clinicians must be engaged in analyzing product options and examining data on product effectiveness to determine what products to use with patients.²⁷¹

VHA has a successful internal model of aggressive supply chain management that can serve as a model for improving the management of medical, surgical and other supplies: the VHA Pharmacy Benefits Management Service (PBM). PBM has taken a systems approach to

²⁶⁷ John Agwunobi and Paul London, "Removing Costs from the Health Care Supply Chain: Lessons from Mass Retail," *Health Affairs*, 28, no 5, (2009): 1336-1342, accessed April 26, 2016, <http://content.healthaffairs.org/content/28/5/1336>.

²⁶⁸ "In Age of Mergers, Hospitals Get Strategic with Medical Supply Purchasing," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/age-mergers-hospitals-get-strategic-medical-supply-purchasing>. "Supply Chain Management," Cleveland Clinic, accessed April 27, 2016, <http://my.clevelandclinic.org/services/supply-chain-management>. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering>.

²⁶⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 47, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁰ "EY Provider Post: Choosing Your Innovation Pathway," EY, accessed April 26, 2016, <http://www.ey.com/US/en/Industries/United-States-sectors/Health-Care/Provider-Post--Choosing-your-innovation-pathway>.

²⁷¹ "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, <http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends>. "Strategic Supply Chain Management," Lee Ann Jarrow, accessed April 28, 2016, <http://www.hhnmag.com/articles/4522-strategic-supply-chain-management>. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering>.

managing pharmaceutical supplies, logistics, and prescribing.²⁷² PBM has largely solved the internal contracting deficiencies in VA by consolidating its activities under just two contracting organizations that oversee all national-level contracts for pharmaceuticals. PBM also applies effective mechanisms to drive standardization of supplies through a national formulary, clinical guidelines for prescribers and utilization review, and feedback to help clinicians identify outlier prescribing practices.²⁷³ Vital to the success of this program is the involvement of clinicians and pharmacists in a vertically integrated model of engagement and decision making through facility-level, Veterans Integrated Service Network (VISN)-level, and national-level PBM committees that contribute to formulary and clinical guideline decisions and manage utilization review with local clinicians.²⁷⁴ PBM also has a sophisticated web of communications, education, and engagement efforts to ensure clinical leaders across the system are helping drive PBM policy and practices.²⁷⁵ As a result, 90 percent of purchases are acquired through pharmaceutical prime vendor contracts.²⁷⁶

PBM, taking advantage of standardized industry nomenclature and bar codes for pharmaceuticals, has implemented automated dispensing, distribution, and ordering processes, including VA's Consolidated Mail Outpatient Pharmacy (CMOP).²⁷⁷ The use of CMOP, a system of seven highly automated pharmacies that process more than 460,000 prescriptions every work day, results in exceptional accuracy and lower processing costs than would result if filling prescriptions at each VAMC.²⁷⁸ Eighty percent of prescriptions in VHA are filled through CMOP,²⁷⁹ which has been recognized for the last 6 years as the best or one of the best mail order pharmacies in the country meeting or exceeding customer satisfaction scores of health care systems like Kaiser Permanente and on-line pharmacies like Express Scripts and Walgreens Online Pharmacy.²⁸⁰ Customer service, veteran satisfaction, and patient safety delivered through team-based care are a hallmark of the mission of PBM,²⁸¹ and are a useful reminder of the principles that must drive any successful transformation of supply chain management in VHA.

²⁷² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 19, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷³ *Ibid.*, 20.

²⁷⁴ VHA Formulary Management Process, VHA Handbook 1108.08 (2009).

²⁷⁵ Clinical Pharmacy Services, VHA Handbook 1108.11, 28-30 (2015). The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 32-34, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁷ *Ibid.*

²⁷⁸ "VA Mail Order Pharmacy," U.S. Department of Veterans Affairs, accessed April 29, 2016, http://www.pbm.va.gov/PBM/CMOP/VA_Mail_Order_Pharmacy.asp.

²⁷⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁸⁰ "U.S. Pharmacy Study – Mail Order (2015)," J.D. Power, accessed April 29, 2016, <http://www.jdpower.com/ratings/study/U.S.-Pharmacy-Study-Mail-Order/631ENG2>.

²⁸¹ "Pharmacy Benefits Management Services," U.S. Department of Veterans Affairs, accessed April 29, 2016, <http://www.pbm.va.gov/PBM/index.asp>.

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Analysis

VHA's supply chain for clinical supplies, medical devices, and related services is inadequate compared to the agency's pharmacy organization or to best practices in leading hospital systems.

*Its contracting processes are bureaucratic and slow, which can delay veterans access to care. Purchasing processes are cumbersome which has driven VHA staff to work arounds and exacerbates the variation in prices VA pays for products. Utilization is difficult to measure or manage given a lack of data which likely leads to significant avoidable expense for VA.*²⁸²

Leadership and Organizational Structure and Function

Best-in-class supply chain organizations typically have a single group responsible for the strategy, sourcing, procurement, and logistics of clinical supplies and medical devices. The organization is typically led by an executive-level leader, such as a chief supply chain officer (CSCO), and personnel are aligned along product categories to develop and use deep expertise in the products and suppliers they manage.²⁸³ In contrast, the organizational structure for contracting, logistics, and supply management in VA and VHA is complex and duplicative.²⁸⁴ Four contracting entities are located within VA central office but report to two different management offices within VA's office of acquisition, logistics, and construction (OALC).²⁸⁵ Procurement personnel within VHA's regional contracting and VISN offices report to VHA's national office of procurement. In contrast, facility-based and VISN logistics personnel report to their local VAMC or VISN director and not to the national VHA logistics office.²⁸⁶ To further complicate the management picture, clinical supplies are managed by the logistics organization, yet medical devices are managed by the Prosthetics and Sensory Aid Service (PSAS)²⁸⁷ (see Figure 5). In most health care organizations, the supply chain chief operating officer and their integrated supply chain group manages the procurement and distribution of all clinical supplies and medical devices.²⁸⁸ This is not the case in VA. Senior leaders in VA's and VHA's supply chain organizations and field-based supply chain personnel indicate current organizational structure is too complex and should be simplified.

*National supply chain leaders expressed lack of clarity regarding the scope of responsibilities of the entities for which they are responsible, which has led to some tension and what one leader described as a 'turf war.' Others described a vacuum of ownership and accountability, and lack of clarity on roles and responsibilities.*²⁸⁹

²⁸² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, v, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁸³ Ibid., 57-58.

²⁸⁴ Ibid., ix.

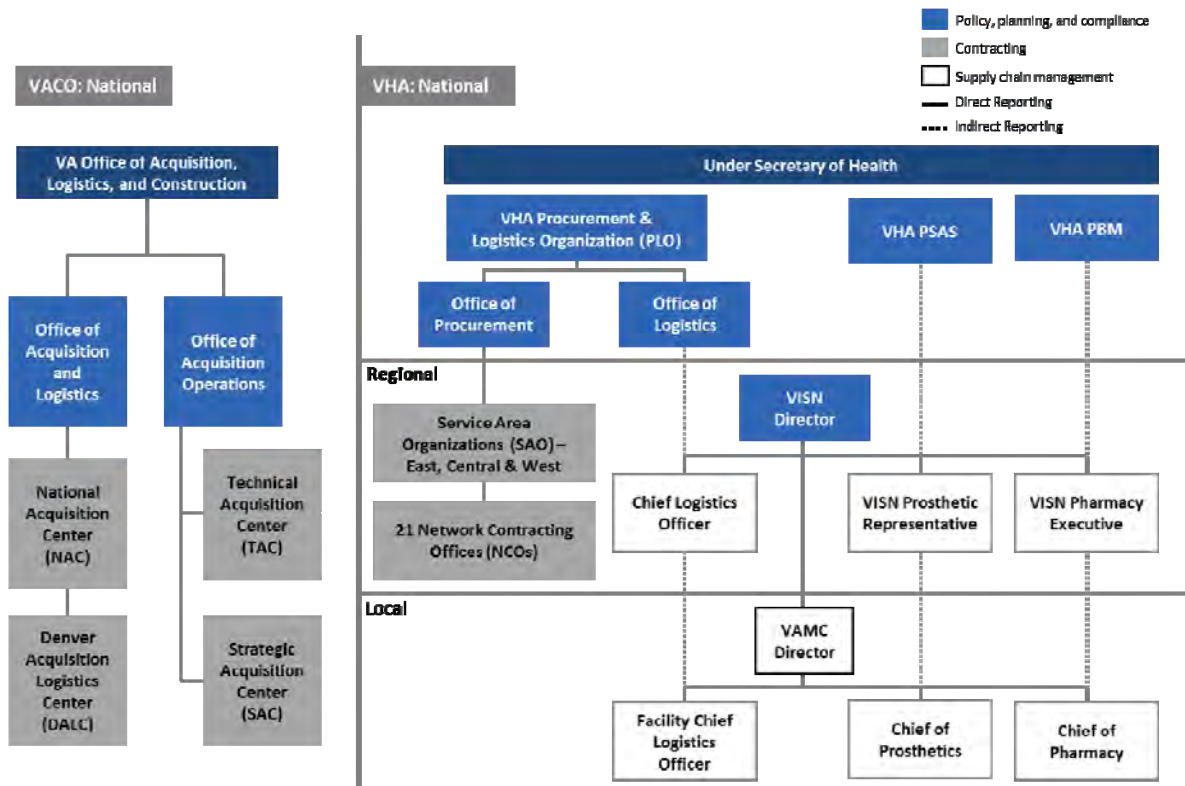
²⁸⁵ Ibid., 96-97.

²⁸⁶ Ibid., 47-50.

²⁸⁷ Ibid., 58.

²⁸⁸ Ibid.

²⁸⁹ Ibid., 55.

Figure 5. Organizations Comprising VA's Supply Chain²⁹⁰

Notes: Some VISNs may have different reporting relationships with facility prosthetics staff.

The separation of clinical supplies and prosthetics/medical devices causes issues in coordinating products needed for procedures. Frontline staff members indicate the time it takes to procure simple items through contracting (1 to 3 months) is problematic. For example, heart valve surgery may be delayed because some heart valves cost more than the micro-purchase threshold (\$3,000), thus the purchase must be made through the contracting process.²⁹¹ Medical center staff consistently expressed concern that VHA procurement offices are not responsive to the needs of a health care organization and do not communicate effectively with them,²⁹² findings borne out by low customer satisfaction scores given to these organizations.²⁹³

There is great overlap and redundancy in procurement and logistics functions in VA and VHA and the reporting structures are not aligned to ensure that the needs of veteran patients and their clinical providers are met. In an environment with limited sharing of best practices and a lack of transparent, open communications, the current complicated reporting structures impede customer-service quality and effectiveness. The original intent behind the current structure was to consolidate and strengthen purchasing power through the establishment of national contracts; however implementation of the vision has been poor and the result has been a

²⁹⁰ Ibid., 49.

²⁹¹ Ibid., 67.

²⁹² Ibid., 68.

²⁹³ Ibid., 69.

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complicated, bureaucratic system filled with redundancies.²⁹⁴ These broken processes serve as a precursor for catastrophic systems failures.²⁹⁵

There is an immediate need to consolidate and streamline procurement and logistics for medical and surgical supplies under one leader in VHA, the VHA chief supply chain officer (CSCO), who would be accountable for transforming VHA supply chain management. As identified under MyVA, medical and surgical supply chain management is the first priority but the rest of the supply chain needs to be addressed by the CSCO in a staged approach. The VERC or other experts in business process engineering must be engaged to create a vertically aligned organizational structure with clear delegated responsibilities at each level of the organization to create an efficient and responsive procurements and logistics process which the VHA CSCO would lead.

Clinical Engagement and Value Analysis

In contrast to pharmaceuticals, usage of clinical supplies and medical devices is not strictly monitored or managed in VA. In general, physicians and nurses can choose whichever products they believe are best for patients and the supply chain organization's role is to make those items available.²⁹⁶

VHA does not have a means to determine what supplies should be standardized or a feedback loop administrators and staff use to assess whether standards were being used when they did exist.²⁹⁷ As a result, limited product standardization has been achieved across VHA, despite VHA establishment of national standardization user groups in 2001 responsible for identifying items for standardization based on national procurement data.²⁹⁸ To date, national product standardization has been achieved in only a limited number of categories.²⁹⁹ Since 2011,

VHA required that medical centers establish Clinical Product Review Committees (CPRCs) to: (i) review and approve the use of new clinical items and reusable medical equipment (RME) at each medical center; (ii) maintain a list of approved expendable clinical supplies and RME by establishing and maintaining a Medical/Surgical Supply Formulary; and (iii) ensure compliance with nationally standardized contracts and blanket purchase agreements. In all sites visited, CPRCs exist and meet regularly but reviews were generally formalities.³⁰⁰

²⁹⁴ Ibid., 47-50.

²⁹⁵ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

²⁹⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 54, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁹⁷ Ibid., xii.

²⁹⁸ VHA Handbook 1761.1, Standardization of Supplies and Equipment Procedures, July 2003.

²⁹⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 81, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁰ Ibid., 82.

Under this 2011 policy, the establishment of VISN oversight committees was also required to provide accountability and feedback to the local committees, but these committees were apparently never established.³⁰¹

VHA, with the engagement of the Veterans Engineering Resource Center (VERC), is making progress on clinician alignment to accomplish value-based purchasing decisions for medical and surgical supplies. VERC has recently rolled out a national clinical product review committee (CPRC-E) e-portal to better organize this function. This portal provides a central system and standard processes for all new product requests and approvals to inform the procurement processes.³⁰²

In the area of medical and surgical supplies, clinician preference can drive variability in procurement and utilization. As has been done in VHA for pharmaceutical prescribing, a similar system to engage and align clinicians must be undertaken for medical devices and surgical supplies. VERC has started this process, but requires further funding and leadership support to fully implement a clinician-driven sourcing process. Current and future leaders of VA and VHA must ensure that VERC continues to receive the funding support and leadership engagement it needs to fully accomplish this transformation with support and direction from a VHA CSCO.

Information Technology, Data Standards, and Analytics

Information technology systems, data systems, and analytical capability for finance, inventory management, and purchasing impede VHA's ability to effectively manage its supply chain.³⁰³ VHA needs greater "end-to-end visibility into the operational and financial performance of their supply chain" and more effective means to accomplish supply chain budgeting, forecasting, inventory management and automation of at least some key supply chain functions.³⁰⁴

*VA lacks visibility into supplies and devices spending at the level of granularity usually seen in the private sector. For example, in the private sector, it is typically possible to measure clinical supply spend and utilization at the service, patient, or physician level. However, this is not possible in VHA because it does not capture such data. Therefore, supplies spend per case can only be calculated in aggregate, which is relatively meaningless and does not allow for fair comparison across hospitals, services, or physicians. This inhibits VA's ability to manage utilization and to understand fully the impact of product standardization efforts.*³⁰⁵

VERC is working to reduce the more than 130 versions of VistA in place across the country so that the same data sets can be tracked and reported.³⁰⁶ Funding was approved by OIT for the Future Transformation Tool (FTT) graphical user interface that will standardize product names

³⁰¹ Ibid., 54.

³⁰² Heather Woodward-Hagg, PhD, email to Commission on Care, March 17, 2016.

³⁰³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁴ Ibid.

³⁰⁵ Ibid., 60.

³⁰⁶ Ibid.

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and provide data integration across all of VHA. Point of Use Solution, a commercial off the shelf supply management software product, has been purchased to achieve better inventory and demand management control and has been deployed to 32 percent of facilities, as of April 2016.³⁰⁷

True sustainment of a clinician driven process cannot be achieved with fragmented information systems that do not communicate. Leaders at all levels of the organization are not able to effectively identify and manage procurement requirements or provide effective feedback to clinicians on utilization. Similarly, automated inventory control, ordering, billing, and payment cannot occur without a seamless information technology infrastructure. With a current IT system in which fiscal, supply chain, and clinical informatics systems do not interface, the hopes of moving to automated processes for supply ordering, equipment life cycle management, and vendor communications cannot be realized. A plan for the transformation of supply chain management, developed by a VHA CSCO with support from VERC, must be fully integrated with planning and procurement within OI&T and fully financed to accomplish these important goals.

Policy and Procedures

Ninety-eight percent of all clinical supplies are acquired using purchase cards³⁰⁸ and 75 percent of what VHA spends on clinical supplies is made through this purchase mechanism.³⁰⁹ This is not a surprise given that the standard contracting process can take anywhere from 150 to 180 days to complete,³¹⁰ yet use of purchase cards is inefficient as this mechanism does not take advantage of economies of scale and potential cost savings an organization the size of VHA can achieve through price negotiations and strategic sourcing.³¹¹ It can also be contrary to law, as use of purchase cards often necessitates orders be split to remain under the \$3,000 purchase card limit.³¹² An analysis of purchase records showed that 38 percent of supply orders were made through standing vendor contracts which is in stark contrast to the private sector benchmark of aiming to complete 80-90 percent of supply purchases from master contracts with negotiated price discounts.³¹³ Indeed, the private sector trend in health care has been for hospitals and health care systems to form alliances in “group purchasing organizations” to achieve the scale that VHA naturally enjoys.³¹⁴ Weaknesses in logistic management have been recognized in VHA for some time and still remain.³¹⁵ For instance, a review of logistics business

³⁰⁷ Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.

³⁰⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁹ Ibid., xii.

³¹⁰ Ibid., x.

³¹¹ U.S. Government Accountability Office, *Strategic Sourcing: Improved and Expanded Use Could Save Billions in Annual Procurement Costs*, accessed April 28, 2016, <http://www.gao.gov/assets/650/648644.pdf>.

³¹² U.S. Department of Veterans Affairs, Office of Inspector General, *Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System*, accessed April 28, 2016, <http://www.va.gov/oig/pubs/VAOIG-11-00826-261.pdf>.

³¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xii, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³¹⁴ Bob Kehoe, “Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness,” *Health Facility Management Magazine*, 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.

³¹⁵ U.S. Government Accountability Office, *Veteran’s Health Care: VHA Has Taken Steps to Address Deficiencies in Its Logistics Program, but Significant Concerns Remain*, accessed April 28, 2016, <http://www.gao.gov/assets/660/653886.pdf>.

practices at 17 VHA medical facilities in 2014 showed that none of the facilities achieved 100 percent compliance on the factors assessed, and the rate of noncompliance ranged from 53 to 88 percent, depending on the business metrics examined.³¹⁶

VA is inhibited by a failure to update its acquisition regulations to take advantage of modernization made in 2014 to the governmentwide regulations to promote simplified purchasing procedures.³¹⁷

VERC initiatives to improve VHA supply chain are intended to standardize business processes and address the great price variations for the purchasing of medical and surgical supplies. A national medical surgical prime vendor (MSPV) contract has been established. This development has several advantages to include (a) increased ability to leverage pricing negotiations; (b) standardized pricing; (c) elimination of redundant contract development, bidding, and selection; and (d) future ability to integrate with CPRC E-Portal.³¹⁸ VA has established a goal for 85 percent of all orders in FY 2016 be made under the prime vendor contract and has made 1,100 contracting officers available to meet demand against the contract.³¹⁹ As of April 2016, an estimated \$24.4 million in supply chain costs had already been avoided since January.³²⁰

The establishment of a new MSVP contract in April 2016, the assignment of 1,100 staff to support its use, and the expectation communicated to the field that 85 percent of all purchases be made from the contract are important steps in the right direction. For efficient ordering processes to take hold and be sustained across VHA, all of the policies and procedures from the bedside (or surgical suite) to the head contracting office must be reworked to align with the desired business outcomes. Reworking policies and procedures must occur together with appropriate training and communication at all levels of the organization. Each staff member involved in the procurement process must be held accountable for meeting the new requirements and expectations assigned to them. Updating the VA Acquisition Regulation (VAAR) is just one small piece of such a transformational change. The VERC or others with appropriate experience in aligning business processes within government should be assigned responsibility to finish developing and implementing plans for such a transformation under the direction of a VHA CSCO.

Contracting

Analysis of the *Independent Assessment Report* confirmed issues with the responsiveness of contracting. For example, at one facility, if a request was submitted to contracting that was incomplete or inaccurate, it took on average 21 to 39 days from the date of initial submission to

³¹⁶ U.S. Department of Veterans Affairs, *VA Supply Chain News*, Issue 13, Jan/Feb 2015.

³¹⁷ Jonathan Miller, Director of Logistics Operations, VHA Procurement & Logistics Office, phone call with Commission on Care, December 9, 2015.

³¹⁸ Heather Woodward-Hagg, PhD, Acting Director, Veterans Engineering Resource Center, phone call with Commission on Care, March 18, 2016.

³¹⁹ Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.

³²⁰ Ibid.

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receive the first response from contracting requesting, for example, additional information or paperwork.³²¹ This problem appears to be a widespread.

In another instance, interviews conducted as part of the independent assessment showed that VA vendor contracting processes to order equipment valued at less than \$3,000, for example, scalars for dentistry, can be confusing and lengthy, leading to shortages in equipment and delays in clinic as equipment is located. Delays in sterile processing were also indicated by providers as an issue pertaining to equipment availability.³²²

Communication with contracting is another substantial challenge within VHA. In surveys that assessed the effectiveness of VA's contracting organization, VHA employees' customers rated the communications received from contracting officials the lowest of all contracting dimensions that were evaluated.³²³ Several interviewees recommended that VA provide more clarity on the status of contracting requests to help them plan and schedule care.³²⁴

Individuals in contracting believed that VAMC staff members were responsible for some of the delays in the contracting process. They reported that requests submitted to them from VAMCs were often incomplete or unclear and that facilities were poor at forecasting demand for items, leading to unpredictable peaks in demand for contracting services that exceeded their capacity. The VHA Procurement and Logistics Organization (PLO) and facilities are seeking to address these challenges by placing contract liaisons in facilities to better support contracting officer representatives throughout the process.³²⁵

Contracting compliance analysis showed substantial opportunity for improvement. Analysis of purchase order data showed that 38 percent of purchases were made on a government contract, 27 percent were made at open-market prices, and 34 percent did not have a source type specified.³²⁶ Private-sector organizations typically aim to buy 80 to 90 percent of their clinical supplies and medical devices on some type of negotiated contract.³²⁷

Interviews and observations undertaken as part of the independent assessment revealed that there are two primary reasons for VHA's relatively high share of open-market purchasing. First, in contrast to pharmaceutical purchasing, VHA's supply purchasing systems are not integrated

³²¹ The consulting team based this on an IFCAP/eCMS transmission log received during a VAMC site visit (2015). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²² Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 91, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

³²³ The consulting team derived this from a VHA procurement metrics book. McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 69, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²⁴ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²⁵ Ibid.

³²⁶ Ibid., xii.

³²⁷ Ibid.

with contract or pricing catalogs. Therefore, the purchasing process relies on buyers (often clinical staff) to research whether an item is on contract and through which contract a purchase should be made. Because of that complexity, several buyers reported that they bypass this step and buy products through the channel that is most familiar and convenient, for example, by replicating previous orders to their usual supplier, despite changes that may have occurred (new contracts and pricing arrangements, for example). Second, VHA has limited ability to monitor and drive compliance with the contract hierarchy because the required data are not captured electronically. In fact, more than 60 percent of all clinical supply items do not have a contract number listed.³²⁸

VHA's fragmented inventory management systems and processes also create challenges. VHA's current inventory management does not have a feedback loop to link inventory to product use, contracting, ordering, and vice versa. This lacking information prevents optimal use of the MSPV contract program and creates missed opportunities to establish more effective volume-based national or regional contracts. It also leads to peaks and troughs in demand for contracting services, which can overwhelm contracting's capacity.³²⁹

There are pockets of good performance and innovation in VHA that could be replicated across its supply chain. The *Independent Assessment Report* notes that the Denver Acquisition and Logistics Center (DALC) is a bright spot within VHA's supply chain organization in its acquisition and distribution of select devices such as hearing aids to veterans. It has developed an integrated operating model that brings together clinicians, contracting, finance, logistics, and program management. That integrated team makes decisions around product and supplier selection based on a holistic view of what is best for veterans and for VHA.³³⁰

Talent Management

VHA is unable to hire good talent to manage its supply chain. In 2014, 20 to 30 percent of logistics positions were unfilled, and 20 percent of medical supply aide jobs were vacant.³³¹ The causes were identified as lengthy time-to-hire, nonexistent internal career progression ladders for these individuals, and inability to provide competitive pay due to position downgrades made by OPM under Title 5.³³² Examples of recent downgrades include supply technician, mail manager, administrative officer, and materials handler.³³³

*It is well known in the health care industry that there is a shortage of supply chain talent currently. The private sector organizations interviewed during this assessment stated that they are recruiting more highly trained individuals than they did in the past and, because of competition for talent, are paying them more than they used to. This may be contributing to VHA's recruitment and retention challenges.*³³⁴

In Recommendation #15, the application of the more than 60-year old standards and processes used in the Title 5 personnel system does not serve the needs of a modern health care delivery

³²⁸ Ibid.

³²⁹ Ibid.

³³⁰ Ibid., xiii.

³³¹ Ibid.

³³² Ibid.

³³³ Ibid., 87.

³³⁴ Ibid., 88.

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organization. Health care supply chain management is a recognized field of study and a valued component of leadership teams at the highest performing health care organizations. For VHA to compete for top leadership talent in this field and frontline staff, logistics and procurement personnel must be included in a new excepted personnel system for VHA under Title 38 (see Recommendation #15).

To address talent management issues, VERC has established a new VA Acquisition Academy (VAAA) Supply Chain Management School.

*The mission of the Supply Chain Management School is to provide best-in-class education, training, professional development, and certification of the VA supply chain workforce. VAAA's competency-based curriculum addresses general and technical skills, VA-specific functional areas, and core activities for VA logistics professionals. Emphasis is on translating theory, fundamentals, and concepts to practical application with realistic VA-based scenarios utilizing hands-on application of problem-solving skills.*³³⁵

The supply chain management school is organized under VAAA which has been recognized by external organizations to offer high quality training.³³⁶

Implementation

Legislative Changes

- Establish a new excepted personnel system under Title 38 to permit VHA to compete effectively with the private sector for personnel required to run a complex health care system, including staff to manage and operate a modern supply chain system.

VA Administrative Changes

- Establish an executive position for supply chain management, a VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- Transform policy and procedures for supply chain management in parallel with identification and procurement of new management software: new software should support the new processes and not the existing, poorly organized business processes and requirements.
- Establish a staged process for the transformation of all supply chain operations in VHA under the direction of a VHA CSCO, with support from VERC.
- Reconcile the VAAR with the Federal Acquisition Regulation (FAR) to ensure the VAAR aligns with recent updates to the FAR to permit streamlined acquisition processes.
- Provide consistent and standardized training to ensure those developing and administering contracts have updated information regarding FAR and VAAR

³³⁵ "Message from the Vice Chancellor," Veterans Affairs Acquisition Academy, accessed April 28, 2016, <http://www.acquisitionacademy.va.gov/schools/scm/message.asp>.

³³⁶ "VA Acquisition Academy Recognized as a 2016 Learning Elite Organization," U.S. Department of Veterans Affairs, accessed May 13, 2016, <http://www.acquisitionacademy.va.gov/rss/index.xml#20160413b>.

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regulations as well as a thorough understanding of their responsibilities under the new approach to supply chain management and how to carry out these duties.

Other Department and Agency Administrative Changes

- None required.

Governance, Leadership, and Workforce

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

Problem

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center (VAMC), and similar problems at multiple other VAMCs, had both direct and indirect causes. Weak governance was found to be among those indirect causes.³³⁷ As the authors of a root-cause analysis of the Phoenix scandal highlighted, “a governance gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed to the wait-time problems.³³⁸ The report authors observed, “Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors.”³³⁹ The governance limitations made evident in the Phoenix scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration’s expectations for short-term results,³⁴⁰ and VHA’s operating in a “dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act and be structured based on the key elements included in Table 5.
- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term to allow for continuity and to protect the CVCS from political transition. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

³³⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³³⁸ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.

³³⁹ Ibid.

³⁴⁰ Ibid.

competing demands”³⁴¹ offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

Background

VHA, as an agency within a cabinet department, is accountable to the secretary of Veterans Affairs (SECVA) and to the President. This framework, when it works well, can provide VHA access to, and support from, the President and White House staff. Like other executive branch agencies, VA and VHA undergo Office of Management and Budget (OMB) oversight; must win OMB approval of proposed rulemaking, budgets, IT development, and performance plans; and are also subject to governmentwide regulation of such areas as procurement, personnel, and property management. VHA health care and operations are subject to close congressional scrutiny.³⁴² VHA undergoes oversight from several independent bodies, including the internal Office of the Inspector General audits and external Government Accountability Office audits.

Within VA, VHA participates in the VA Executive Board (VAEB) and Senior Review Group, which are designated as the principal governance bodies of the department.³⁴³ VAEB serves as the department’s risk-governance board and determines VA’s strategic direction. VAEB oversees the department’s planning, programming, budgeting, and execution. Notwithstanding certain strengths inherent in this framework, VHA governance can be paralyzed by bureaucratic decision-making processes and competing stakeholder concerns.³⁴⁴

Among its principal recommendations, the *Independent Assessment Report* calls for “establishing a governance board to develop fundamental policy, define the strategic direction, insulate VHA leadership from direct political intervention, and ensure accountability for the achievement of established performance measures.”³⁴⁵

Analysis

In recent years, VHA leadership priorities and strategic direction have been unclear. Leaders have been consumed by crisis and by responding to congressional demands, creating a reactive, rather than proactive environment.³⁴⁶ Additionally, the leadership vision has lacked continuity.³⁴⁷ The SECVA and deputy secretary of Veterans Affairs may exercise oversight of

³⁴¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³⁴² “Legislation,” U.S. House of Representatives, House Committee on Veterans’ Affairs, accessed June 15, 2016, http://veterans.house.gov/legislation?type=hearing&tid=All&tid_1=All&page=3. Over the course of calendar year 2015, the House Veterans Affairs Committee and its subcommittees alone held 18 oversight hearings relating to the Veterans Health Administration, with VHA and/or VA officials testifying as often as three times in a month.

³⁴³ Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014).

³⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 26, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³⁴⁵ *Ibid.*, 23.

³⁴⁶ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 52-54.

³⁴⁷ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, vi-viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Linda Belton, former VHA VISN Director and Director of National Center for Organizational Development, written submission to the Commission on Care Staff, January 19, 2016.

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VHA and try to impose accountability, but incumbents do not necessarily have experience in federal health care administration or delivery.³⁴⁸ The SECVA has often lacked independent information and metrics on VHA performance, and the oversight, risk management, and compliance functions of VHA report to the undersecretary for health (USH) or to lower officials in VHA.³⁴⁹

Previous studies, dating back 20 years,³⁵⁰ have proposed fundamental change in VHA's governance and government structure, to include a proposal that it be restructured as a government corporation.³⁵¹ The earliest rationale for making VHA a government corporation was based on the view that the system needed a new service-delivery strategy,³⁵² and envisioned specific legislation to permit the corporation to operate more expansively under a wide range of reforms.³⁵³ Although the authors of the 1996 report presented a VHA government

³⁴⁸ Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Under Secretary of Health, 38 U.S.C. § 305. While statute requires the USH of VHA to be appointed “solely on the basis of demonstrated ability in the medical profession, in health-care administration and policy formulation, or in health-care fiscal management; and on the basis of substantial experience in connection with the programs of the Veterans Health Administration or programs of similar content and scope” there is no such selection criteria for the VA Secretary or VA Deputy Secretary. Of the eight men to hold the position of Secretary of Veterans Affairs, only one, James Peake would qualify to be USH (“United States Secretary of Veterans Affairs,” Wikipedia, accessed June 15, 2016, https://en.wikipedia.org/wiki/United_States_Secretary_of_Veterans_Affairs#List_of_Secretaries_of_Veterans_Affairs) and of the six men to hold the position of DEPSECVA, none would qualify to be USH.

³⁴⁹ Department of Veterans Affairs, *2014 Functional Organizational Manual v2.0: Description of Organization Structure, Missions, Functions, Tasks, and Authorities*, 57-58, accessed June 15, 2016, http://www.va.gov/ofcadmin/docs/va_functional_organization_manual_version_2.0a.pdf.

³⁵⁰ Veterans Benefits Improvement Act of 1994, Pub. L. No. 103-446, 108 Stat. 4645 (1994). In 1994, Congress in sec. 1104 of Public Law 103-446 called for an independent examination of the justifiability of establishing an alternative government structure to provide health care services for veterans, culminating in the 1996 report.

³⁵¹ Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. A government corporation has been described as “a government agency that is established by Congress to provide a market-oriented public service and to produce revenues that meet or approximate its expenditures.” Kevin R. Kosar, Congressional Research Service, *Federal Government Corporations: An Overview*, 2, accessed June 15, 2016, <https://fas.org/sgp/crs/misc/RL30365.pdf>. Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report* September 22, 2015. Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce*, accessed June 15, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>. Commission on the Future for America's Veterans, *Preparing for the Next Generation*, 3, accessed June 15, 2016, http://s3.amazonaws.com/siteninja/site-ninja1-com/1438121489/original/2014-05_Commission-Report-on-America-Veterans.pdf. That task force study, for example, called for an independent governance model and stated that “the operational structure of VHA does not lend itself to progress. Due to its size, governmental structure and geographic extension it does not readily foster innovation and faces challenges in addressing the politics of changing demographics and ancient facilities.” The study report states, “VHA provides excellence in care in spite of its operations/governance structure, not because of it.”

³⁵² Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. The strategy was premised in part on the view that VHA would be operating in a resource-constrained environment and lacked the resources it would need to invest in making significant changes.

³⁵³ Ibid. The 1996 report proposed such measures as providing VHA authority to seek additional revenue streams, to include billing and keeping funds from Medicare, Medicaid, and other government sources; authorizing it to invest nonappropriated funds; developing a trust fund for deposit of Medicare taxes by active-duty personnel; incorporating VHA as a Federal Employee Health Benefits Plan selection; allowing it to become part of health maintenance organization (HMO) networks and open HMO enrollment to veterans; changing appropriation law to create

corporation as a means of achieving specific objectives, those objectives were largely met (though ultimately not fully sustained) by reforms within existing government structures and processes set in place by former USH Kenneth W. Kizer.³⁵⁴

Nearly 20 years later, the report analyzing the root causes of delayed care at the Phoenix and other VA centers proposed creation of “governance mechanisms to bridge ‘Secretary suite’ leadership transitions and provide more stable strategy, oversight, and stewardship.”³⁵⁵ Explaining that “the study team feels that the complexity of this organization requires a more stable and professionalized governance model that more closely resembles the governance of large health care systems in the private sector,”³⁵⁶ the study authors proposed the creation of a board-of-directors-type oversight board to set the strategy for the organization, define priorities, provide operational oversight, and review budget requests. “The board would . . . create a body that would be the steward of the organizational vision, providing institutional memory and continuity as senior political appointees transition.”³⁵⁷

Frequent turnover of the USH is a critical problem. Recently, each USH has served for only a relatively short period, leaving office with a change in administration or sooner. This pattern has deprived VHA of vitally needed sustained leadership and has likely contributed to short-term decision making. VHA history shows a connection between longer tenure and transformative accomplishment.³⁵⁸ As testimony to the Commission from three former USHs would indicate, brevity of tenure tends to limit leaders’ strategic horizon and create a pattern of leadership discontinuity. Because transformative change can only be realized through many years of focused leadership, VHA and those who depend on it cannot afford the senior leadership turnover routinely associated with a change in administration.

The complex, sustainable transformation VHA needs will take years to implement. To succeed, VHA needs strong, consistent leadership and a governance framework that can assure effective development and execution of transformation plans over time. The current governance structure emphasizes operational, rather than strategic priorities; experience has shown it to be incapable of sustaining transformational change. Establishing a well-designed, overarching-governance model would provide an opportunity to achieve objectives shared by both the executive and legislative branches.

To be effective, a VHA Care System governance model should be empowered with a governing board that exercises fiduciary-like responsibilities (not subject to the Federal Advisory Committee Act) to carry out the following key functions:

multiyear/no-year appropriations; reforming human resources management practices for increased flexibility in hiring and firing, compensation, leave, and other functions; and reforming; and reforming procurement and contracting.

³⁵⁴ Ibid., 46, 48. The Klemm report saw a VHA corporation as having greater capacity to focus on strategic as well as short term goals; greater results orientation; greater flexibility; greater capacity to replicate and develop best practices; upgraded staff competence and expertise at senior levels; and greater political independence.

³⁵⁵ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 59.

³⁵⁶ Ibid.

³⁵⁷ Ibid.

³⁵⁸ See Dr. William S. Middleton, Chief Medical Director (1955-1963) and Dr. Kenneth W. Kizer, Under Secretary for Health (1994-1999).

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- select the chief of VHA Care System (CVCS) and recommend the appointment of the CVCS to the President
- provide long-term, strategic direction for VHA Care System and establish priorities, milestones, and timelines
- oversee, direct, and make critical decisions regarding the transformation process
- review and approve major operational, business, and organizational plans
- set VHA Care System performance objectives and provide annual reports to Congress and the President on VHA Care System performance
- review and make decisions regarding VHA's budget request, and independently assess and report to Congress on the adequacy of VHA budgets

New governance and changes to assure continuity of leadership are critical to meeting the needs of VHA and veterans who depend on it. At the core of this foundational recommendation, the Commission calls for establishing a VHA board of directors,³⁵⁹ referred to as the VHA Care System governing board, which is independent of department leadership to provide governance, strategic direction, decision making, and oversight of VHA Care System's operations and transformation. Table 5 provides details regarding the governing board.

Table 5. Overview of VHA Care System Governing Board

Detailed Outline for VHA Care System Governing Board	
Voting Members	The President, the majority leader of the Senate, speaker of the House, the minority leaders of the Senate and House would each appoint two members. In addition, the SECVA would serve on the Board as a voting member.
Qualifications	Members would be selected to achieve collectively broad experience, expertise, and leadership, such as experience in senior management of large, private, integrated health care systems; clinical expertise; extensive experience with federal government health care systems; extensive experience with (though not current employment in) VHA; expertise in federal medical facility construction and leasing, and commercial property transactions; expertise in government contracting; expertise in federal health care budgeting and finance; expertise in health equity and disparities; and veterans' representation. Because of the importance of veterans' representation, at least one of each congressional leader's two appointees would be a veteran; at least one of the appointees of the President would be a veteran who receives VHA care.

³⁵⁹ Michael A. Froomkin, "Reinventing the Government Corporation," *University of Illinois Law Review*, (1995): 543, accessed June 15, 2016, <http://osaka.law.miami.edu/~froomkin/articles/reinvent.htm>. Congress need not create a government corporation to meet VHA's governance needs. The Commission notes that Congress has created entities it has called government corporations that are not predominantly commercial enterprises, rely on appropriations, and do not have the potential to become self-sustaining. A principal intention behind assigning this status and title has been to provide insulation from central management oversight agencies and the application of general management laws. When the corporation relies in whole or in part on appropriations, Congress retains the power of the purse, and the means of exercising it on matters large and small, and through formal and informal means.

Detailed Outline for VHA Care System Governing Board	
Terms	Governing board members would serve staggered terms of up to 7 years, with the governing board members electing a chair and vice chair from among the membership (other than the SECVA, who would not be eligible to serve as the chair) for 3-year terms.
Personnel Matters	Compensation would be at a rate equal to the daily equivalent of annual pay prescribed for level IV of the executive level. ³⁶⁰
Funding	Congress would provide a specific budget for the operation of the governing board as a separate account within VA's appropriations.
Relationship to the CVCS	Relationship to the CVCS: The governing board would provide the President its recommendation for a chief of VHA Care System (CVCS); the President would appoint that executive to a 5-year term; the governing board would annually review the CVCS's performance and be empowered to reappoint that official to a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. The CVCS can be removed by mutual agreement of the President and the governing board.
Staff	The chairperson would determine the size and compensation of the permanent staff of the board, including an executive director responsible for governing board operations and a chief of staff. The director of the proposed transformation office within VHA would report to the chairperson through the CVCS.
Powers	<p>The board would have the power to do the following:</p> <ul style="list-style-type: none"> ▪ Select the CVCS and recommend the candidate to the President. ▪ Review the performance of the CVCS on an annual basis. ▪ Reappoint the CVCS to a second 5-year term. ▪ Remove the CVCS with the mutual agreement of the President. ▪ Direct and exercise decision-making authority regarding the transformation process and operations related to the transformation process. ▪ Establish priorities, milestones, and timelines for the transition process. ▪ Review and approve major new initiatives; major operational and organizational plans (including plans regarding capital asset and facility management); strategic and business plans; and goals and metrics for operational performance and established priorities. ▪ Oversee and manage facility and capital asset strategies and operations. ▪ Review, approve, and/or amend VHA's budget requests, and independently assess and comment on pertinent elements of the President's budget, as deemed appropriate.
Reporting	The board would report annually to the President and Congress on VHA's progress toward transformation.

Navigating transformation of one of the largest agencies in the federal government requires not only extraordinary leadership, but steady, sustained, long-range-focused governance. A governing board structured to provide continuity of membership—as the Commission proposes through staggered terms among members—is vital. A second critical step toward assuring such continuity would be to address the tenure of the CVCS and the process for selecting candidates for that position.³⁶¹ VHA, Congress, and the President would be better served by a VHA leader who holds a 5-year term of office, with the governing board empowered to reappoint that leader to a second 5-year term.

³⁶⁰ The rate of compensation provided for members of the Commission on Care.

³⁶¹ Under Secretary of Health, 38 U.S.C. § 305. Current law provides that the Under Secretary is appointed by the President with the advice and consent of the Senate. When a vacancy in that position occurs or is anticipated, the Secretary is to convene a commission (the composition of which is set forth in the statute) which is to recommend at least three individuals to the Secretary, who is to forward those names, with any comments the Secretary considers appropriate, to the President.

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It is important that that the CVCS report to the board and function as a chief executive officer of VHA. Although the Commission envisions that the President would appoint this official, it is critical that the governing board be empowered to recommend to the President an individual for appointment when the office becomes vacant. This would replace the framework in current law that requires the establishment of a new commission convened solely to carry out the task of recommending candidates to the President.³⁶²

A governing board must be tailored to the unique needs of VHA.³⁶³ It should include members of appropriate expertise and experience to provide strategic guidance and continuity of leadership and it should possess authority to exercise the powers needed to realize and sustain a VHA transformation.³⁶⁴

Although some might consider Congress to be VA or VHA's board of directors and might question the appropriateness of establishing a VHA board of directors, this governance model does not diminish Congress's role. Instead, a board that would report periodically to congressional committees would provide a level of close oversight and health care expertise that would complement, and in many ways enhance, Congress's work.

A change in governance alone will not bring about successful transformation. This recommendation must be instituted in concert with many other Commission recommendations. For example, a board will require data, and data systems, to carry out its responsibilities, and establishing these and other appropriate systems, as addressed throughout this report, is key to empowering a board to drive and sustain transformation.

Implementation

Legislative Changes

- Amend 38 U.S.C., Chapter 3 to establish a VHA Care System governing board.
 - Amend 38 U.S.C. § 305 – which currently provides in subsection (a) for the President to appoint the USH by and with the advice and consent of the Senate, and subsection (c) for the establishment of a commission to provide recommendations for appointees for USH when a vacancy is expected or has occurred – as follows:
 - Amend subsection (a) to provide for the President to appoint the CVCS to a 5-year term of office.
 - Repeal subsection (c) of that section.
 - Provide instead for the governing board to recommend a CVSC candidate.
 - Authorize the governing board to reappoint the CVSC to a second 5-year term.

VA Administrative Changes

- None required.

³⁶² Under Secretary of Health, 38 U.S.C. § 305.

³⁶³ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 60.

³⁶⁴ The Board is not an advisory body, and as such would not be subject to the Federal Advisory Committee Act.

Other Departments and Agency Administrative Changes

- None required.

Leadership

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

Problem

High-performing organizations have healthy cultures in which diverse staff members feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government.³⁶⁵ For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

The Commission Recommends That . . .

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report to the chief of the VHA Care System and the new VHA Care System governing board (also included in Recommendation #12).

Background

Healthy organizations successfully align, execute, and renew themselves through learning and innovation.³⁶⁶ They are characterized by a high level of trust, accountability, and ownership among staff; high functioning, empowered teams; and an environment that provides psychological safety and open communication, focuses on the needs of customers, and instills pride in performance.³⁶⁷ An inclusive workplace where diversity is valued, staff feel empowered and supported, are treated with fairness, and cooperation and open communication helps engage employees and drive organizational performance.³⁶⁸ Engaged

³⁶⁵ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 56, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

³⁶⁶ "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, <http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage>.

³⁶⁷ [http://organizationalhealth.vssc.med.va.gov/Resource percent20Library/Forms/AllItems.aspx](http://organizationalhealth.vssc.med.va.gov/Resource%20Library/Forms/AllItems.aspx)

³⁶⁸ "Diversity & Inclusion; Federal Workforce At-A-Glance," U.S. Office of Personnel Management, accessed May 13, 2016, <https://www.opm.gov/policy-data-oversight/diversity-and-inclusion/federal-workforce-at-a-glance/>.

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employees who are dedicated to their work and attached to the organization and its mission support a healthy organization.³⁶⁹

Companies that have a healthy organizational culture or engaged staff outperform those that do not. Companies that score in the top 25 percent of organizational health metrics outperform comparable companies in the bottom 25 percent by more than two-fold.³⁷⁰ Similarly, high employee engagement is correlated with better staff and customer experiences that include higher patient satisfaction, higher staff retention, better safety and quality, higher productivity and lower absenteeism.³⁷¹ Companies with engaged employees outperform those without by more than 200 percent.³⁷² Leaders and supervisors play a key role in establishing and sustaining employee engagement and in establishing a positive environment and culture that supports a healthy organization.³⁷³

Analysis

VHA staff and leaders are highly dedicated to the mission of VA and to serving veterans.³⁷⁴ This dedication is arguably VHA's greatest strength, and it can be leveraged to create and sustain positive change.³⁷⁵ There are substantial impediments to moving VHA forward, however, as noted in the *Independent Assessment Report*. There is a pervasive lack of trust throughout the organization.³⁷⁶ Staff perceives VHA to be bureaucratic and political and to lack a systems orientation.³⁷⁷ Employees want to work for an organization that is accountable and efficient, but instead they operate in a bureaucratic, siloed, and political organization.³⁷⁸ The culture creates risk aversion in staff, and when cultural factors are measured in VHA, none of the metrics align with the definition of a healthy organization.³⁷⁹ Staff find the work environment at VA challenging, with no connection to leadership, and feel they receive little positive

³⁶⁹ U.S. Office of Personnel Management, *Strategic Plan FY2014-2018: Recruit, Retain, and Honor*, 22, accessed January 25, 2016, <https://www.opm.gov/about-us/budget-performance/strategic-plans/2014-2018-strategic-plan.pdf>. Office of Management and Budget, *Memorandum for Heads of Executive Departments and Agencies: Strengthening Employee Engagement and Organizational Performance*, M-15-04, December 23, 2014, accessed May 16, 2016, <https://www.whitehouse.gov/sites/default/files/omb/memoranda/2015/m-15-04.pdf>.

³⁷⁰ "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, <http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage>.

³⁷¹ U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015, 4. Melissa Bottrell, *Ethics Quality Helps Build Healthy Organizations*, VHA Organizational Health, Volume 19, Summer 2013, 4-5, accessed January 25, 2016, http://www.ethics.va.gov/docs/integratedethics/art_bottrell_orghealth_v19_2013.pdf.

³⁷² U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015, 4. Dee Ramsel, Improving VHA's Culture: A Presentation Before the National Leadership Council, Veterans Health Administration, December 2015, 7-9. U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change*, 6, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.

³⁷³ Dee Ramsel, "Improving VHA's Culture. A Presentation Before the National Leadership Council, Veterans Health Administration," December 2015, 7-9.

³⁷⁴ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 43, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

³⁷⁵ *Ibid.*, 44.

³⁷⁶ *Ibid.*, 47.

³⁷⁷ *Ibid.*, 46.

³⁷⁸ *Ibid.*, 46.

³⁷⁹ *Ibid.*, 49-51.

reinforcement or clear feedback on performance.³⁸⁰ As demonstrated in the Federal Employee Viewpoint Survey for 2015, VHA staff does not believe top leaders lead (only 47 percent positive³⁸¹) and only 65 percent have a positive view of their immediate supervisor compared to 70 percent in other large federal agencies.³⁸²

Through the review of available documents and briefings from key staff, the Commission found VA and VHA have a number of activities intended to support a positive environment and culture in VHA (see Table 6), but the efforts are not systematic, integrated, or broadly deployed.³⁸³ The efforts are under-resourced to achieve success. Specifically, the effort lacks mandatory positions at the facilities to lead these efforts and has no requirements on the VHA Central Office (VHACO) program offices to participate in the efforts.³⁸⁴ At the same time, the efforts are duplicative in that multiple offices communicate similar, but distinct messages to field staff and leaders. VHA appears to lack systematic mechanisms to ensure leaders at all levels of the organization have the knowledge, skills, and ability to create an effective culture; metrics are not comprehensive or aligned with a single-change model; and leaders in VHACO and the field are not consistently held accountable for their actions in support of a positive organizational culture.³⁸⁵

*Table 6. Cultural Transformation Efforts in VA and VHA*³⁸⁶

Program/Initiative	Responsible Office
Servant Leadership	VHA National Center for Organizational Development
Leaders Developing Leaders	MyVA
Just Culture	VHA National Center for Patient Safety
Civility, Respect, and Engagement in the Workplace (CREW)	VHA National Center for Organizational Development
Organizational Transformation Pilot	MyVA
Employee Engagement Playbooks	MyVA
VHA Voices	VHA Office of Patient Centered Care and Cultural Transformation

³⁸⁰ Ibid., 53 and 60.

³⁸¹ U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change*, 47, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.

³⁸² Ibid.

³⁸³ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 29-31. Dee Ramsel, Virginia Ashby Sharpe, Veterans Health Administration, conference call with staff of the Commission on Care, November 9, 2015.

³⁸⁴ See “Ethical Leadership, Fostering an Ethical Environment and Culture,” National Center for Ethics in Health Care, U.S. Department of Veterans Affairs, accessed June 22, 2016, <http://www.ethics.va.gov/integratedethics/elc.asp>. “Stop the Line for Patient Safety Initiative,” U.S. Department of Veterans Affairs, accessed June 22, 2016, <http://www.qualityandsafety.va.gov/StoptheLine/StoptheLine.asp>. “VHA Center for Organizational Development,” U.S. Department of Veterans Affairs, accessed from VA Intranet, May 16, 2016, http://vaww.va.gov/NCOD/Organizational_Health.asp. U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015.

³⁸⁵ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 13-14. Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan, Network Director and Medical Center Director*, November 20, 2015.

³⁸⁶ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 29-31.

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VHA must rebuild a high-performing, healthy culture by cultivating greater employee collaboration, ownership, and accountability to accomplish its mission.³⁸⁷ This cultural transformation needs to occur at all levels of the organization (VA, VHACO, veterans integrated service network [VISN], VA medical center, and community-based outpatient clinic). To achieve transformation in VHA, create a healthy environment and culture, and sustain staff engagement, the solution must start with leaders. Leaders must understand and believe in the powerful effect they have on the climate and culture in their organization. Change occurs one employee at a time. Leaders at all levels must commit to this change process. They must be inspired by top executives and embrace the values and mission of VHA and then, in turn, inspire their teams, engaging with individual employees to make change. Leaders must be given the roadmap and tools to make such change and then be supported with training, coaching, and feedback to achieve success. They must also be held accountable for their personal behavior and for the actions they take to positively influence the environment and culture of their unit or facility. Leaders should not be on their own in this transformation. Fellow leaders, outside experts, national program offices, and VA and VHA top executives must provide them with incentives, support, feedback, coaching, and, when needed, admonishment to support this cultural transformation.

To align leaders at all levels with expectations for the cultural transformation, all leaders must understand the role they play in the process. VHA must create standards for the behavior and actions leaders adopt to accomplish the transformation and widely publicize the standards among leaders and staff to establish uniform expectations across the organization and a single vision of cultural transformation. The CVCS and other senior leaders must model and reinforce these behaviors to further embed expectations. These behaviors and actions should be integrated into leadership assessment tools such as a 360 evaluation, performance management frameworks, and coaching guides to ensure expected behaviors and actions are reinforced across the leadership development and advancement system. The strategy must include the development of tools, training, guidelines, and operating procedures that create a living curriculum to support leaders in developing and deploying these new skills and behaviors. Finally, to ensure leaders at all levels implement the behaviors and actions, the strategy must establish both explicit rewards and sanctions. The rewards and recognition (nonmonetary) should liberally acknowledge and publicize leaders and staff who embody the very best standards of behaviors and actions that support a positive organizational culture. At the same time, leaders and staff at all levels must clearly understand what behavior and actions are not acceptable and be held accountable through disciplinary action if they cross these boundaries. Expectations and repercussions should be clearly articulated.

VA and VHA have a number of competing models of organizational health and staff engagement. The models are not integrated with one another or with an overall leadership competency model. Some models are robust, coupling abundant resources and training, while others are not. To create a clear focus for engagement and organizational health and guide

³⁸⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 55 accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

transformation effectively, one model must be selected for use in VHA. To do so, VHA must establish a cross functional executive team to make this decision. The team should include all of the stakeholder offices involved in current efforts, but none of them should lead the effort, to avoid parochial interests driving decisions. Once a single model is selected, the executive team must then outline a clear strategy, involving and engaging the offices in VHA with relevant expertise and resources to support the execution, and put forward a single strategic plan. Consequently, each of those offices must also be required to stand down its own efforts that are not part of this new model going forward and align its work and budget behind a single focused model and strategy. Tools, training, and communication to support broad deployment must be part of the strategy, and the CVCS and the executive team must present a compelling, transparent rationale for what the model is, why it was selected, and how it is to be deployed. All leaders and staff members in the organization must understand their roles in cultural transformation and what is expected of them.

The strategy must establish and articulate a clear set of behaviors and actions expected of staff to ensure their alignment around the transformation. The standards should be incorporated into the hiring process to ensure that VHA is hiring into the new culture and avoids a poor fit from the start. These behavioral expectations must be articulated clearly in the on-boarding process and reinforced on an ongoing basis in performance evaluations, reviews, and individual development plans. Leaders at all levels of the organization must also reinforce these behavioral expectations with staff and be provided with tools, messages, and communication support to accomplish this. Leaders must also recognize and reward the positive examples of the desired behaviors and sanction the worst examples, up to and including discipline and removal.

The change strategy should also recognize that cultural transformation and staff engagement go beyond individual leader and staff behaviors. Systems and processes at both the local and national level can impede the realization of the positive organizational culture desired. As such, the transformation strategy must also anticipate changing systems and processes as an explicit component of transformation. Leaders at all levels must establish mechanisms to elicit staff concerns and have quality improvement tools in place to address them, such as LEAN Six Sigma. Line staff must be engaged as part of the solution to these system issues. Leaders should be transparent about these issues and publicly track and report on progress.

To ensure the effective execution of this strategy, specific responsibilities must be assigned to program offices. The program offices must also support the VISN and facilities in their transformation effort by developing the standards and guidance for them to use and making program office expertise available to support coordination, coaching, and sharing of best practices across the institution. The program offices must be held accountable for supporting the application of these same standards and process within VHACO.

Standards for facility implementation must include a funded, full-time equivalent employee to support each major facility director³⁸⁸ and be the point person to coordinate efforts with VHACO and other facilities. Facilities may take the opportunity to consolidate related functions that currently exist in the facility. Each facility must have a local mechanism, such as an organizational health council, to integrate and drive transformation locally. But this does not

³⁸⁸ This equates to one person at each of the approximately 141 VHA health care systems led by a facility director.

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mean the facility should create yet another committee or oversight group to accomplish the transformation. Instead, facilities must look to existing leadership structures and activities, consolidating similar efforts to create an efficient process.

Finally, the executive team must oversee the development of a consolidated and meaningful set of metrics, using community standards where available, to track cultural transformation, organizational health and staff engagement. The metrics should not only measure the desired outcomes but also provide insights to leaders on how to fix problems by providing sufficient detail and specificity to offer this insight. Once deployed, the metrics should be used by the executive team and responsible program offices to identify under-performing facilities and to provide additional expertise, resources, and support to help those facilities improve. If, after much support, the continuing behavior and actions of the leaders at the under-performing facility are identified as the cause of the long-term culture problem, these individuals must be removed from leadership positions in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Develop and implement a strategy for cultural transformation.
- Establish a cross-functional senior executive team reporting directly to the CVCS with long-term responsibility for creating, executing, and tracking the cultural transformation.
- Align frontline staff in support of the cultural transformation strategy.
- Require standards and a strategy for execution of the cultural transformation from every program office and facility and these efforts must be fully funded.
- Develop consolidated, meaningful metrics for organizational health and staff engagements with input from experts and field users.

Other Department and Agency Administrative Changes

- None required.

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

Problem

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an Office of Management and Budget management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Background

*Our Corps does two things for America: We make Marines and we win our nation's battles. Our ability to successfully accomplish the latter depends upon how well we do the former.*³⁸⁹

Effective leaders are required for organizational success. Thus, attracting, growing, and advancing leaders is a key business imperative across all sectors.³⁹⁰ The most urgent human capital management need worldwide, according to one survey, is the development of leadership talent.³⁹¹ This need is driven by a changing workforce that is motivated more by passion than by monetary incentives, a rapid advance in knowledge that quickly creates obsolescence, and technology drivers that change business practices over months instead of years.³⁹² Investing in new supervisors and emerging leaders is critically important because

³⁸⁹ U.S. Marine Corps, *Sustaining the Transformation*, Foreword, accessed June 9, 2016, [http://www.marines.mil/Portals/59/Publications/MCRP percent206-11D percent20Sustaining percent20the percent20Transformation.pdf](http://www.marines.mil/Portals/59/Publications/MCRP%20206-11D%20Sustaining%20the%20Transformation.pdf).

³⁹⁰ Jim Collins, *Good to Great: Why Some Companies Make the Leap . . . And Others Don't* (New York, NY: HarperCollins Publishers, Inc., 2001), 17-40. Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015).

³⁹¹ Deloitte Consulting LLP and Bersin by Deloitte, *Global Human Capital Trends 2014: Engaging the 21st Century Workforce*, 25, accessed June 10, 2016, http://dupress.com/wp-content/uploads/2014/04/GlobalHumanCapitalTrends_2014.pdf.

³⁹² *Ibid.*, 3.

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employees report that when they quit a job they leave their supervisors and not their organization.³⁹³ In an organization like VHA, with more than 300,000 employees but only a bit more than 200 executives, VHA's 28,000 supervisors are responsible for leading the staff.³⁹⁴

Going back to at least 1998, the federal civilian sector has had difficulty identifying and promoting individuals with leadership skills.³⁹⁵ Staff members who can produce results and meet organizational objectives are promoted into supervisory and leadership positions.³⁹⁶ Yet, the skills needed to be a successful leader are different than those needed to be a successful technical expert. Today, soft skills such as empathy, effective listening, and team coaching are valued in leaders.³⁹⁷ The most effective leaders are those who consistently display integrity, high moral character, and the ability to inspire others.³⁹⁸ An effective leadership system develops leaders at all levels, from frontline supervisor to executives, and does so in all dimensions of leadership: "knowing, doing, and being."³⁹⁹

Analysis

In a review of VHA's approach to leadership development, the *Independent Assessment Report* noted the current system was not sufficient to meet VHA's need for high-quality, prepared leaders.⁴⁰⁰ VHA lacks a comprehensive approach to leadership development that would include formal structured programs such as networking, reflection, goal setting, learning, mentoring, experiential learning, and a clear career ladder. As a result, leaders are unable to fully prepare

³⁹³ "People Leave Managers, Not Companies," Victor Lipman, accessed June 10, 2016, <http://www.forbes.com/sites/#/sites/victorlipman/2015/08/04/people-leave-managers-not-companies/#78b15df216f3>.

³⁹⁴ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 21-23, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

³⁹⁵ U.S. Merit Systems Protection Board, Office of Policy and Evaluation Perspectives, *Federal Supervisors and Strategic Human Resources Management*, accessed June 10, 2016, <http://www.mspb.gov/netsearch/viewdocs.aspx?docnumber=280538&version=280868&application=ACROBAT>.

³⁹⁶ Ibid. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

³⁹⁷ Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. "Creating and Retaining Great Leaders," Dominique Jones, accessed June 10, 2016, <http://www.hrreview.co.uk/analysis/analysis-hr-news/dominique-jones-creating-and-retaining-great-leaders/60419>. "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, <http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success>.

³⁹⁸ Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015). "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, <http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success>. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

³⁹⁹ Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. U.S. Marine Corps, *Sustaining the Transformation*, accessed June 9, 2016, http://www.marines.mil/Portals/59/Publications/MCRP_percent206-11D_percent20Sustaining_percent20the_percent20Transformation.pdf.

⁴⁰⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

for future roles.⁴⁰¹ Although VHA does have some components of a development program, the activities are not connected to a career path and not well coordinated. Comprehensive development efforts are impeded by the use of multiple competing competency models in VA that make it impossible to align assessment and development with a cohesive standard. Emerging leaders are left to navigate career progression largely on their own and may be stymied because development opportunities are cancelled due to budget restrictions. Even when promising young leaders complete the current activities, gaps remain in their experience and training because the training programs are not coordinated.⁴⁰² As a result, VHA does not have a robust pipeline of young leaders ready to take on higher-level responsibilities.⁴⁰³

Included in the *Independent Assessment Report* is a recommendation that VA stabilize, grow, and empower leaders. This recommendation includes suggestions to fill current vacancies with high-quality leaders, improve the attractiveness of the roles, ensure leaders are prepared to assume their roles, and create a comprehensive strategy that connects top performers to leadership opportunities and development plans.

There is little concrete information in the assessment to suggest how VA and VHA should accomplish these objectives. The commission examined VA's and VHA's current work to assess whether they have created plans to operationalize the leadership development recommendations articulated in the *Independent Assessment Report*.

Neither VA nor VHA has rationalized the multiple competency models within the department. A competency model is the core driver informing recruitment, development, assessment, and advancement in any comprehensive approach to leadership development and management.⁴⁰⁴ Having a cogent competency model is a prerequisite to a coherent strategy.⁴⁰⁵ Leading a health care organization requires specialized knowledge and skills not required of leaders in other fields.⁴⁰⁶ Thus, any competency model applied in VHA must include health care specific components. Health care executive competencies embrace such topics as an understanding of ethics in health care, management of self-governing professionals (e.g., physicians, nurses), the technical knowledge of health care regulation and operational management, and leading change, in addition to other leadership skills and knowledge.⁴⁰⁷

The current models used in VHA do not reference external benchmarks, and they are not health care specific. VHA plans to continue to use the High Performance Development Model (HPDM) as its competency model.⁴⁰⁸ HPDM was developed by VHA and is not benchmarked to private-sector competency models for health care executives. VHA plans to use the model to drive

⁴⁰¹ Ibid.

⁴⁰² Ibid., 38.

⁴⁰³ Ibid., 37.

⁴⁰⁴ The American College of Healthcare Executives, *ACHE Healthcare Executive: 2016 Competencies Assessment Tool*, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf.

⁴⁰⁵ Ibid.

⁴⁰⁶ Ibid.

⁴⁰⁷ Ibid. "Joint Medical Executive Skills," Joint Medical Executive Skills Program, U.S. Department of Defense, accessed May 16, 2016, http://www.au.af.mil/au/awc/awcgate/leadership/med_exec_skills.htm. "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁰⁸ "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

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position requirements, performance management, and training content.⁴⁰⁹ The plan mentions coordination with VA Learning University but provides no detail.⁴¹⁰ The plan also does not provide specific information about how the use of HPDM will link to formal recruitment, performance assessment, and advancement of leaders.⁴¹¹

VHA is working to understand the current career progression of candidates who move into field-based executive positions. VHA field leaders are cultivated from within VHA with about 98 percent advancing from lower-level field positions such as associate director, service chief, or chief of staff.⁴¹² As a result, field senior executives often lack outside experience and first-hand knowledge of alternative management methods.⁴¹³ Most companies look for a mix of internal and external hires, and the circumstances of the organization often drive the mix.⁴¹⁴ For instance, Henry Ford Health System, a successful growing company with a robust internal leadership development program has set a target of 70 percent internal promotions and 30 percent external hires.⁴¹⁵

The VHA pool of internal candidates is also deficient in racial and ethnic diversity with striking under-representation of women of color in all of the positions that constitute the pipeline for medical center director positions (see Figures 6 and 7).⁴¹⁶ VHA leadership development programs have failed to effectively recruit and advance under-represented minorities with a striking over-representation of White men in the leadership class that feeds the senior executive service (see Table 7).⁴¹⁷ Minority women shoulder the biggest burden of formal mentoring within the organization.⁴¹⁸ VHA also has the lowest representation of veterans among its staff (31 percent) compared to Veterans Benefit Administration (52 percent) and National Cemetery Administration (74 percent). The number of veterans among doctors and dentists in VHA is only about 14 percent of the employees.⁴¹⁹ Among leaders, 22 percent of senior executives are veterans and a similar number (23.8 percent) populate the leadership pipeline.⁴²⁰

⁴⁰⁹ Ibid.

⁴¹⁰ Ibid.

⁴¹¹ Ibid.

⁴¹² Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A*, November 23, 2015.

⁴¹³ Ibid.

⁴¹⁴ Eric Krell, "Staffing Management: Look Outside or Seek Within?" *HR Magazine*, January/February 2015.

⁴¹⁵ "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

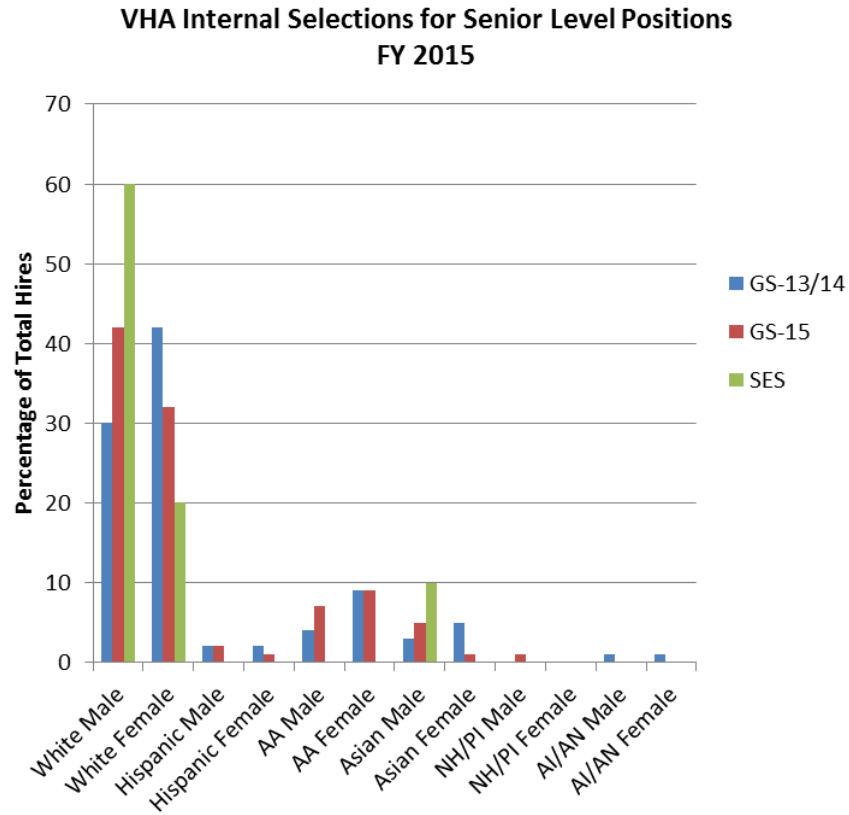
⁴¹⁶ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

⁴¹⁷ Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A*, November 23, 2015.

⁴¹⁸ Ibid.

⁴¹⁹ Health Care Talent Management Office from PAID and NOA, September 17, 2015: Path to Medical Center Director, Healthcare Leadership Talent Institute.

⁴²⁰ VHA Health Care Talent Management Office, provided to Commission on Care for employees in VHA as of September 30, 2015 by request, March 8, 2016.

Figure 6. Diversity of Senior-Level Hires in VHA

AA = African American

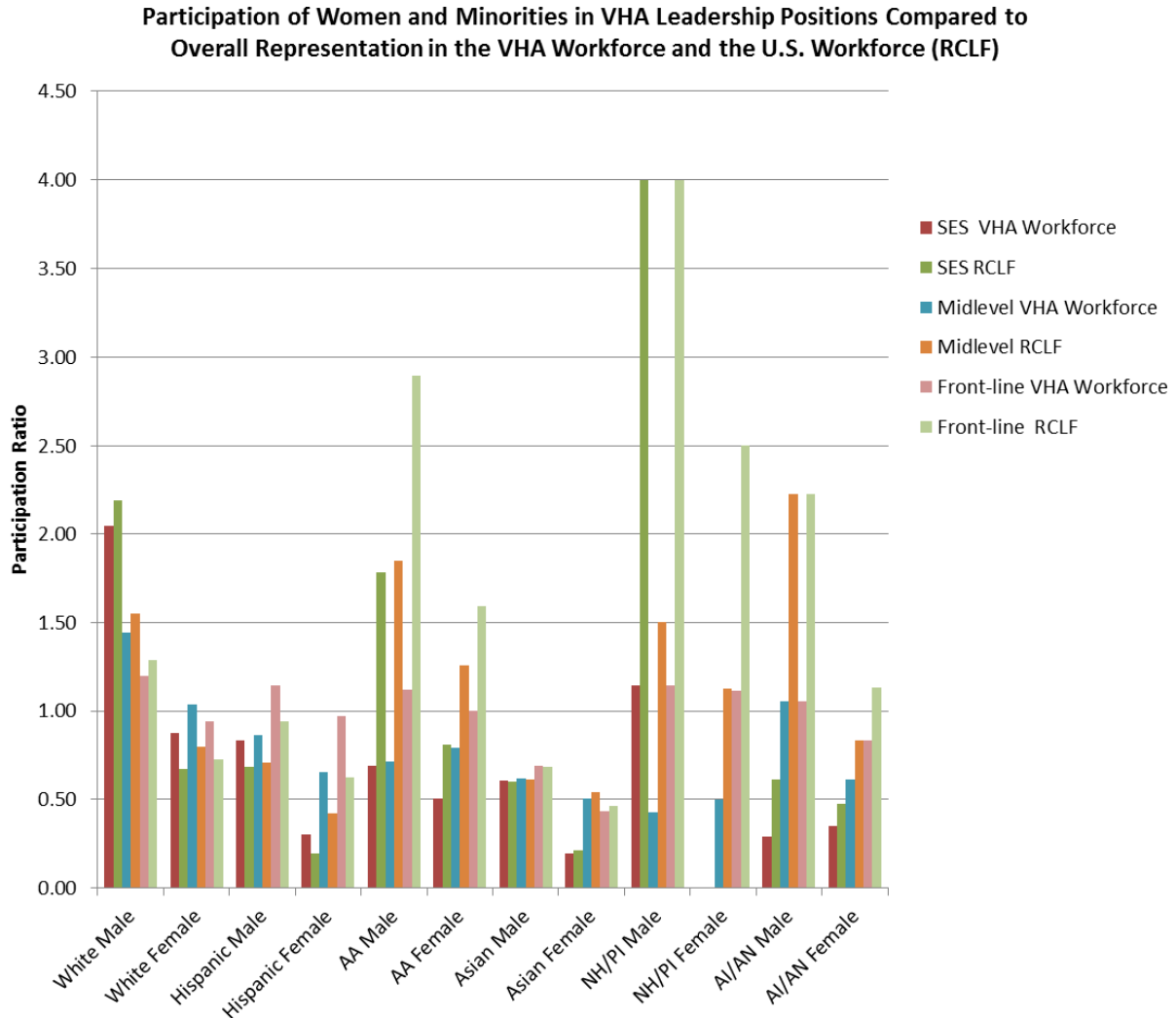
NH/PI = Native Hawaiian/Pacific Islander

AI/AN = American Indian/Alaska Native

Note: In FY 2015, VHA failed to select many candidates from diverse racial and ethnic backgrounds for senior executive positions. These data were drawn from the VHA annual equal employment opportunity (EEO) report.

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Figure 7. Minority Women are Under Represented in Higher-Level Positions in VHA



AA = African American

NH/PI = Native Hawaiian/Pacific Islander

AI/AN = American Indian/Alaska Native

Note: Women and particularly minority women are under-represented in comparison to their participation in the U.S. workforce (relevant civilian labor force [RCLF]) and their participation in the VHA workforce at higher levels in the organization. Some minority men are also under-represented in high-level positions. These data were derived from the VHA annual EEO report.

Table 7. White Males are Over Represented in VHA SES Development Program, HCLDP

	TCF 2015 (N)	GHATP 2014 (N)	Facility LEAD 2015 (N)	VISN/CO LEAD 2015 (N)	HCLDP 2015 (N)	VHA Workforce
White Male	35% (78)	30% (14)	19% (160)	22% (69)	41% (151)	23%
White Female	16% (35)	28% (13)	41% (342)	41% (127)	39% (144)	36%
African American Male	15% (33)	9% (4)	8% (66)	8% (24)	4% (14)	9%
African American Female	19% (42)	15% (7)	22% (180)	16% (50)	6% (23)	15%
Hispanic/Latino Male	4% (10)	4% (2)	3% (23)	4% (11)	1% (5)	3%
Hispanic/Latina Female	3% (7)	2% (1)	3% (29)	3% (10)	1% (4)	4%
Asian Male	4% (9)	2% (1)	1% (9)	>1% (2)	2% (7)	3%
Asian Female	2% (5)	9% (4)	2% (16)	4% (13)	3% (12)	5%
Native Hawaiian/Pacific Islander Male	0% (0)	0% (0)	>1% (3)	0% (0)	0% (0)	>1%
Native Hawaiian/Pacific Islander Female	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	>1%
American Indian/Alaska Native Male	2% (4)	0% (0)	>1% (1)	>1% (2)	1% (3)	1%
American Indian/Alaska Native Female	0% (0)	0% (0)	1% (7)	1% (4)	1% (3)	1%

Note: VHA offers career development opportunities from entry-level programs (TCF and GHATP) to an SES preparatory curriculum (HCLDP). Overall, White men make up about 23% of VHA employees but are over-represented in the HCLDP program at 41%. African American and Hispanic men and women are under-represented in the same program.

TCF= Technical Career Field; GHATP=Graduate Healthcare Administration Training Program; LEAD=Leadership, Effectiveness, Accountability, and Development; HCLDP=Health Care Leadership Development Program.

No evidence was presented to indicate that career progression mapping is occurring for positions within VHA central office, where high-quality leaders are also required.⁴²¹

⁴²¹ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

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VHA has much work to do to produce an effective leadership management system. Recruitment, retention, development and advancement are key processes that require immediate and sustained attention from VHA leaders. Without substantial changes, high-potential staff will continue to struggle to understand their career trajectory. Without a driving competency model and coordinated training to guide advancement, hiring decisions will continue to be made without uniform standards against which to measure applicants and new executive hires will continue to struggle to understand VHA and their role in leading it. Without the committed engagement and support of the chief of VHA Care System (CVCS) and the other top VHA executives for the leadership management system and their direct communications about and modeling of the leadership competencies, VHA will continue to flounder. As a result, veterans will be denied the high-performing health system they deserve.

Executive Commitment

The long-term success of any enterprise rests on having excellent leaders in key positions and sustaining them over time. To accomplish this goal, leadership management, development, and recruitment must be a core responsibility and a priority for VHA senior executives. To start, VA must include the goal of achieving an effective leadership management system in VHA as a component of the department's management agenda in the annual budget. The goal is a robust, high-quality, diverse leadership team in VHA. VA needs to establish a credible operational plan and accountability mechanisms for meeting this goal. Executive leaders are then held accountable for attaining the leadership management goals, including personally investing time in meeting diversity targets, recruitment plans, and succession planning objectives. These targets are to be reviewed in the individual performance of top leaders as well as in the Office of Management and Budget's ongoing review of the department's management objectives. Executive leaders need to also set and communicate clear expectations for the behavior of leaders and staff and to invest their own time in mentoring, coaching, and developing subordinate leaders and promising staff, including under-represented populations. They must be visible and role-model leadership competencies in meetings, training, and new-hire orientations. They must take an interest in developing leaders and help create opportunities for them to gain leadership experience and competencies. The CVCS and senior executives must keep in mind that their sole role is not to manage crises or to oversee a process or to manage up. Rather, their primary role is to lead their people. Their time and attention must reflect that priority.

Leadership Model

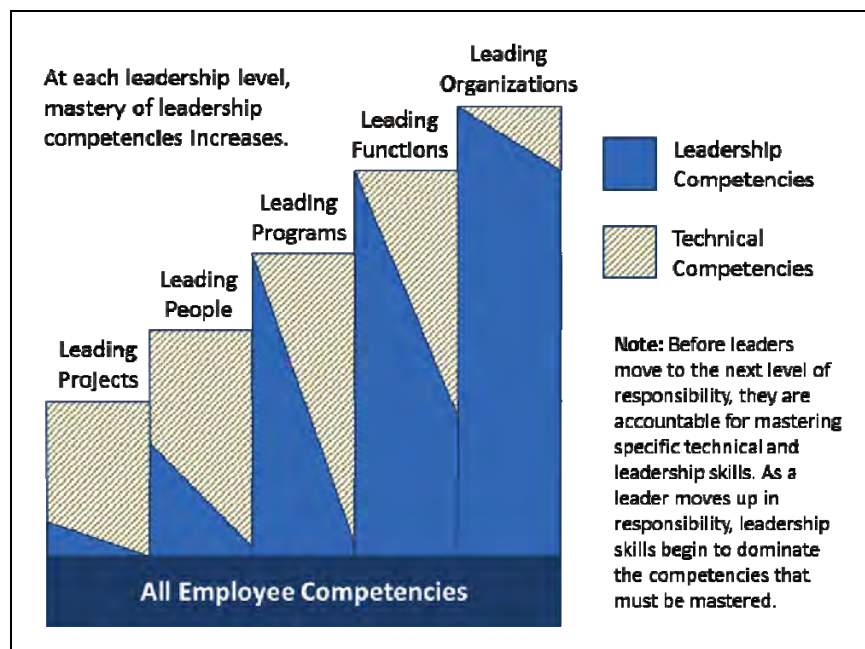
To establish clear leadership standards to guide hiring, development, and the advancement of leaders, VHA needs to adopt one benchmarked health care competency model. Currently, VHA is subject to the Office of Personnel Management executive core qualifications, HPDM, and standards for servant leadership. Although all of the models have value, none provide a clear trajectory for high-potential staff to follow, and they do not provide opportunities for VHA to intersect with leaders in the private sector. VHA must stop using these varied competency models and instead adopt a single model that is benchmarked to private-sector standards. The Commission is not making a recommendation about which model VHA should choose. Rather VHA should apply the criteria below to select a model around which to base its leadership development program:

- The standard must embrace leading through ethics and values, demonstrating character and concern for others, and creating a strong organizational culture.
- The standard must be health care based and describe the knowledge, skills, ability, and leadership bearing and behaviors that health care leaders must master to be effective.
- The standard must be a robust competency model including aligned training and tools to permit quick implementation.
- The model must describe different career tracks and the mastery requirements for key points in each career track. Key career tracks such as VISN director, facility director, and VHA Central Office (VHACO) program executive should fit into the competency model.
- A career path must specify the competencies that require mastery before moving to a higher position.
- VHA may need to enhance the model with competencies in care and services to Veterans and knowledge of military occupational health.

Training and Assessment

VHA needs to develop assessment tools based on the competency model, including 360, 180, self-assessment, and supervisory review processes. Leaders and developing leaders should be required to use at least one of the assessments each year and to apply the results to identifying their training and development needs. Findings from the assessments should be rolled into an individual development plan (IDP) for each leader or developing leader and enrollment in a leadership course should require a documented need from one of these assessments.

Figure 8. At Each Leadership Level, Mastery of Leadership Competencies Increases



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Training must be mapped against the competency model career track. All current leadership training should be mapped against the model. Gaps should be identified and filled with commercially available, or where needed, internally developed training. This training should include leadership competencies for the care of veterans, including an understanding of military occupational health, combat injuries and exposure, combat readjustments, and military sexual trauma. (See Appendix H for descriptions of such training material.) VHA should look for opportunities to partner with Department of Defense and the private sector to provide joint training and development opportunities to fill some of the identified gaps. VHA must develop one or more face-to-face training series that allow high-potential candidates to complete all the competencies required to move to the next career stage. As VHA strengthens its partnership with community providers and health systems, executive and high-potential training resources from VHA should be made available to community health care leaders and VHA should join training offered by these private-sector partners.

Based on the benchmarked competency model, VHA should collaborate with Academic Affiliates to establish two new programs. The first is to create opportunities for VHA physicians to gain masters-level training in health care management to prepare them to lead a medical facility. Second, VHA should work to create rotations in VHA for external physicians who are completing graduate health care management programs. Like academic affiliate residency training programs, VHA should collaborate with academic medicine to establish, fund, and run these programs with the goal that all participants rotate in management positions in VHA or VHA-partnered private-sector systems for six or more months during their training. Graduates of such programs would be candidates for recruitment into the VHA leadership pipeline and would encumber a pay-back commitment to VHA for any direct funding provided.

All training should include formal assessment to assure that learners have mastered the material and this mastery should be noted in their IDPs and training record.

As part of the leadership development model, experiential learning opportunities and formal coaching are critical to executive learning. Individual and group coaching standards and programs must be established for all developing and new leaders. A program for senior leaders to pair them with private-sector health care leaders must also be supported. VHA must establish rotation opportunities for developing leaders to rotate for substantial periods (e.g., 3 to 18 months) in not-for-profit hospital systems. This program could be structured as a certificate program that the employee and VHA jointly fund and include a payback commitment on the part of the trainee. Similar rotations from the private sector into VHA should be developed with health care system partners to help develop private-sector competencies in care for veterans and inject private-sector approaches into VHA.

Apply the Leadership Model

VHA is required to apply the competency model in all hiring decisions for executive career field positions. Thus all functional statements must be based on the model, all interview protocols must incorporate the competencies, and all candidates who are not internally certified to the standard of the job must undergo an assessment by a board to ensure they meet the position requirements. Conversely, internal candidates must be required to demonstrate mastery of the competencies before qualifying to apply for a position. VHA must adopt the strategies of executive recruiters to identify and recruit needed experts outside of government with the

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competencies VHA seeks. Recruiters can look to the pipelines the Commission has recommended building to bring military treatment facility commanders and other senior leaders and private sector experts into VHA as a network for identifying additional recruits. Executive recruiters can particularly help ensure diverse candidates are identified for open positions.

VHA will require competency assessments and IDPs for all existing executives, potential executives, and new hires. Current leaders and new hires who have an identified gap in any competency must have it included in their IDP and be required to fill these deficiencies by a specific deadline or face demotion or dismissal. Completion of IDP development opportunities is required for advancement in grade or promotion to higher position within the leadership pipeline.

VHA will aggressively manage its leadership candidate pool by identifying and tracking all high-potential individuals. Diversity statistics should be tracked and diversity in this pool actively managed. This pool of candidates derives from annual ratings as well as leadership development program graduates. Supervisors and executive leaders must provide ongoing coaching for higher positions to this pool of developing leaders. VHA must identify anticipated succession needs and offer development opportunities that would help prepare candidates for these anticipated openings. Once the positions are open, individuals in the high-potential pool must receive notices of new job postings and detail opportunities that provide experience into higher positions. Candidates who agree to be in this pool should be required to enter into formal mentoring relationships with leaders outside their chain of command to further advance their career development. For highest-level positions (VISN director, facility director, VHACO chief officer) a formal pool of approved or precertified candidates should be established.

To expand the perspectives and management experience in its leadership pipeline, VHA must develop explicit strategies to on-ramp diverse candidates at critical midcareer transition points. This process includes creating pathways for retiring commanders and other senior officers of military treatment facilities to compete effectively for leadership positions in VHA. To increase VHA understanding of private-sector health care, VHA must develop midcareer entry points for private-sector candidates. This could be accomplished through the use of temporary hiring authority and the ability to convert these positions to permanent staff positions if leadership competencies standards have been met by the candidates. Such opportunities can be modeled on efforts recently announced by DoD and, wherever practicable, should be developed collaboratively with DoD to establish the legal and policy requirements for implementing these programs. Finally, the current graduate health administration training program (GHATP) program should be expanded to include more schools and programs with diverse trainees. This expansion must allow high-performing residents to continue to convert to full time positions.

On-boarding

A formal on-boarding process should be instituted for all new executive hires. In addition to the transactional knowledge the individual will need, on boarding should establish the expectations for what it means for that executive to be successful in VHA. The values of the organization and the expectations for ethical practice must be conveyed by the CVCS and the top leadership team. A formal assessment of knowledge and skills should be made during on-boarding and an IDP established to cover the probationary period of new hires if any deficiencies are identified.

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Completion of the IDP is required for continued employment. All new leadership hires should be assigned a coach based on their individual needs. Within their first 6 months of employment, the undersecretary for health and Secretary should meet with these new executives to build a relationship with them and hear their fresh perspectives on the performance of VHA.

Stabilize Leadership

VHA should immediately stabilize its leadership ranks by authorizing VA medical center and veterans integrated services network (VISN) director details to last up to a year with no restrictions on an acting leader competing for the permanent position. VHA should also create flexible capacity by creating more assistant-level positions (e.g., assistant director, assistant VISN chief medical officer, assistant nurse executive, deputy chief officer). These individuals would comprise the pool of potential leaders and also allow for cross filling positions that are empty due to development assignments, training, or other leadership development opportunities.

Implementation

Legislative Changes

- Establish direct-hire authority from the graduate health care administration training program, military treatment facility, and private-sector fellow pools, clarifying application of merit-system principles, including approaches to managing veterans' preference in these programs.
- Establish Intergovernmental Personnel Act authority for VHA to include the for-profit private sector; this could be done as a pilot program with a report to Congress before considering whether to make the authority permanent.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.
- Aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: All hires and promotions are required to demonstrate these competencies.
- Require a formal on-boarding process for HPDM 3 and 4 leaders at all levels that reinforces the leadership competency model.
- Take immediate steps to stabilize the continuity of leadership by extending the length of authorized details to extend the continuity of leadership at medical centers and allow leaders detailed to a position to compete for a permanent appointment to the position by removing the non-compete requirements.

COMMISSION RECOMMENDATIONS

- Establish the competency model in regulation and include requirements for its use in hiring, promotion and dismissal and clarify the application of veterans' preference in executive development.

Other Department and Agency Administrative Changes

- None required.

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Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Problem

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and their functions overlap or are duplicative. The role of the Veterans Integrated Service Network (VISN) is not clear, and the delegated responsibilities of the medical center director are not defined.

Background

A prerequisite of a successful, high-performing system is having strong leaders and a strong leadership system.⁴²² An organization's leadership system is "the way leadership is exercised, formally and informally, throughout the organization; the basis for key decisions and the way they are made, communicated, and carried out."⁴²³ It includes "structures and mechanisms for making decisions; ensuring two-way communication; selecting and developing leaders and managers; and reinforcing values, ethical behavior, directions, and performance expectations."⁴²⁴ In an organization the size of VHA, with a budget of \$69 billion,⁴²⁵ more than 300,000 employees, and more than 1,000 sites of care,⁴²⁶ strong leadership systems are essential.

The Commission Recommends That . . .

- VHA redesign VHA Central Office (VHACO) to create high-performing support functions that serve Veterans Integrated Service Networks (VISNs) and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the chief of VHA Care System with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report (also included in Recommendation #10).

⁴²² Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 50.

James Collins, *Good to Great: Why Some Companies Make the Leap and Others Don't*, (New York, NY: HarperCollins, 2001), 17-64.

⁴²³ Ibid.

⁴²⁴ Ibid.

⁴²⁵ Department of Veterans Affairs, *VA 2017 Budget Request: Fast Facts*, accessed March 10, 2016, <http://www.va.gov/budget/docs/summary/FY2017-FastFactsVAsBudgetHighlights.pdf>.

⁴²⁶ "About VHA," Department of Veterans Affairs, accessed February 5, 2016, <http://www.va.gov/health/aboutVHA.asp>.

In the last successful reorganization of VHA in 1995,⁴²⁷ the organizational design and functional roles of the leadership system were organized into clear structures with clear functions. The VISNs were responsible for operations⁴²⁸ and VHACO program offices were responsible for policy, guidelines, and outcomes.⁴²⁹ The National Leadership Board (made up of VISN directors and all program office leaders) was responsible for collective, fact-based decision making and the Friday Hotline call was used to communicate leadership priorities and decisions directly to VA medical center (VAMC) leadership. A negotiated performance measurement system based on consistent, benchmarked, outcome-focused metrics⁴³⁰ was also established that was supported by centralized functions that benefit from economies of scale.⁴³¹ As part of the reorganization, VHA experienced a reduction in staff and consolidation of VHACO offices to create a flat, agile leadership system.⁴³² Because this functional matrix was not sustained, VHA now faces the challenge of reinstituting an effective leadership system.

Analysis

Twenty years after the Kizer reorganization, VHA has a very different leadership system, under which it “is intensely, unnecessarily complex due to a lack of clear operating model, limited role clarity, fragmentation of authority, and overlapping responsibilities.”⁴³³ The *Independent Assessment Report* included the following findings about the VHA operating model:⁴³⁴

- VHACO has grown rapidly since 2009 from 753 in FY 2009 to 1,990 in FY 2014.
- The VISNs’ ability to manage and support their regions is heavily hampered by resourcing restrictions and direct VHACO control over VAMC operations.
- The VAMCs’ operating model suffers from powerful silos, which prevent an effective end-to-end mission focus.
- VA’s increasingly top-down management style, coupled with poor prioritization and the external political environment, result in a lack of clarity around strategic direction, reactivity to external headwinds, and flawed efforts to standardize.

VHACO has grown rapidly in the past few years.⁴³⁵ The growth in central office was driven in part by new ideas, new priorities, and new crises being addressed through the creation of new

⁴²⁷ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco, CA: Berrett-Koehler Publishers, Inc., 2012), 54.

⁴²⁸ Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 35. Kizer, Kenneth W and Ashish Jha, “Restoring Trust in VA Health Care,” *New England Journal of Medicine*, 371, (2014): 295-297.

⁴²⁹ Ibid.

⁴³⁰ Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 61-72.

⁴³¹ Ibid., 33.

⁴³² Ibid., 60. Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation of the Veterans Healthcare System*, Objective 3 and 17, 1996.

⁴³³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 95, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁴³⁴ Ibid.

⁴³⁵ Ibid., 98.

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offices and new staff infrastructure to support it.⁴³⁶ A portion of the growth came from the centralization of functions that were previously managed in the field such as business office functions. The final component has come from the duplication in VHA of offices in which decision-making authority rests with VA, such as communications and regulatory management. VHA has also duplicated functions and responsibilities between two or more offices in VHA, such as primary care, surgery, mental health, and geriatrics and extended care. This increased growth in staff and offices has resulted in more complex and lengthy decision processes, often with little clarity as to whom ultimate responsibility for decisions or follow up falls.⁴³⁷

One symptom of the top-down management is VHACO control of budgeting and resource management. “Support funding is outside local control” and the “increasing share of Specific Purpose funding hinders” local leaders in their ability to use resources effectively.⁴³⁸ In FY 2015, specific-purpose funds were spread across more than 450 line items,⁴³⁹ taking money away from general purpose funding and restricting how this money can be used. Both VHACO and Congress have been complicit in taking control away from medical center directors through these budget controls.⁴⁴⁰ For instance, the congressional appropriation to fund VHA for 1998 included only five appropriation line items; medical care, medical administration, construction major, construction minor, and medical and prosthetic research.⁴⁴¹ In contrast, the budget request to Congress for FY 2016 included 12 budget categories relevant to VHA with some of those accounts having four or five subcategories.⁴⁴² In his testimony before the Commission and Congress, Secretary McDonald made the point that such fragmentation of the VHA budget and the prohibition to reallocate across budget categories without first receiving Congressional approval was an impediment to effective and agile management of the department.⁴⁴³ Greater Congressional control of VHA spending is understandable in light of VA’s lack of adequate management systems and data analytic capabilities to track expenditures in real time⁴⁴⁴ and report them to Congress and central office. The only means available to hold the medical centers

⁴³⁶ Ibid., 96-99.

⁴³⁷ Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health*, (Washington, DC, Veterans Health Administration, February 2015), 7-9.

⁴³⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership)*, 102, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴³⁹ Ibid., 107.

⁴⁴⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership)*, 102-108, accessed June 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴⁴¹ PL 105-65, October 27, 1997.

⁴⁴² Department of Veterans Affairs Fiscal Year 2016 Budget Submission, Volume II Medical Programs and Information Technology, Accessed June 10, 2016, <http://www.va.gov/budget/products.asp>.

⁴⁴³ On January 21, 2016, Secretary of Veterans Affairs, Robert A. McDonald, provided the following testimony before the U.S. Senate Committee on Veteran’s Affairs “Flexible Budget Authority: We need flexible budget authority to avoid artificial restrictions that impede our delivery of care and benefits to Veterans. Currently, there are over 70 line items in VA’s budget that dedicate funds to a specific purpose without adequate flexibility to provide the best service to Veterans. These include limitations within the same general areas, such as health care funds that cannot be spent on health care needs and funding that can be used for only one type of Care in the Community program, but not others. These restrictions limit the ability of VA to deliver Veterans with care and benefits based on demand, rather than specific funding lines.” accessed June 10, 2016,

<http://www.veterans.senate.gov/imo/media/doc/VA%20Sec%20Testimony%2001.21.2016.pdf>

⁴⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 105, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

accountable was to fund the priority initiatives as separate budget lines or indicate allocations to be made under the specific-purpose process.

To fix the overly complex and bureaucratic structure of VHA, the *Independent Assessment Report* suggests that VHA “redesign (its) operating model to create clarity for decision-making authority, prioritization, and long-term support.”⁴⁴⁵ VHA must take a systems approach to reorient its leadership operations, restructuring and re-orienting VHACO program offices to ensure all of the following:⁴⁴⁶

- fact based, innovative decision making that is responsive to the field, other offices, and external stakeholder requirements
- feedback mechanisms to incorporate system learning into policy development and operational guidance
- communication mechanisms to effectively share information across offices and reach VISN and facilities to explain expectations and tie decisions to organizational values and goals
- effective execution of policy decisions through expert coaching, deployment of resources, and guidance based on external benchmarks and sharing of internal best practices
- analytic capability and infrastructure to effectively monitor progress and outcomes of all organizational priorities

Such a reorientation will involve a different skill set and expertise than currently required in VHACO. Transformation will call for recruiting new expertise, making advancement decisions based on these new competencies, reinforcing them through recognition and performance assessment, and developing new skills in current staff through training and coaching. This skill set includes a high level of technical expertise relevant to the program office; the ability to build relationships with external stakeholders; demonstrated skills in coaching, staff development, and training; certification in quality improvement methodologies; analytic capabilities to develop and track metrics; and the ability to lead transformational change. VHA must fully fund the retraining and the hiring of skilled staff in VHACO to accomplish this transformation.

For the VHACO program offices to work effectively with one another and with the field, the specific authority of each office must also be defined. Where overlap and confusion exists between offices, programs must be combined and streamlined or eliminated with a corresponding reduction in force. In changing the structure and orientation of VHACO program offices, VHA leadership can take the opportunity to align functions to achieve its stated priority of patient-centered care. In a fully aligned operating structure, business processes from the VAMC front line to central office must be organized to deliver important

⁴⁴⁵ Ibid., ix.

⁴⁴⁶ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 7, 34, and 50.

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patient outcomes rather than aligned in professional silos. For instance, instead of having an office of nursing, one for social work, and a lead for physician assistants, business offices should be aligned around the work they do together, like patient aligned care teams, to deliver positive outcomes for veterans.

The administrative operations of VHACO should also be flattened. Senior staff should be speaking directly to other senior staff to discuss and make decisions rather than relying on bureaucratic, paper-based processes as a means of negotiation: It is neither a healthy culture nor an efficient process. At the same time, VHACO needs to take full advantage of being a large-scale enterprise by centralizing functions such as acquisition package development, recruitment package development, and account reconciliation so that staff is not required in each program office to take on these occasional but complex activities. The net savings resulting from this reorganization and delayering of the bureaucracy must be reinvested in the transformation process.

VISNs must also examine the skills needed to take on an expanded role as facilitators, coaches, and guides in improving services and sharing best practices across facilities. VISNs are critical players in the feedback loop between service delivery and VHACO to identify ineffective processes, problems, and emerging issues that need to be raised to VHACO for help in clearing away barriers to effective operations. Similar to VHACO, VISNs must define the new skill set required by their staffs and establish these requirements in hiring, promotion, and performance evaluation as well as training and coaching staff to develop these competencies. Finally, the chief of VHA Care System (CVCS) should establish a required staffing ratio for the VISN office and reduce the staffing in VISNs that exceed this standard.

A new operating model also means that medical center directors must control the budget, staff, supplies, and infrastructure required to deliver needed health care. This model includes consolidation of budget lines and new authority and expanded authority to reallocate funds across the remaining budget categories. To manage the new VHA Care System and ensure that facility and network directors have the local control needed to make decisions about how to deliver services, fewer restrictions should be placed on the VHA budget. To start, specific-purpose funds must no longer be used to direct obligations at facilities. Congress should also work with the administration to reduce the number of budget lines and specific spending authorities back to a simpler system like that used in 1998. To support these changes and create transparency, medical centers should be accountable for their expenditure of funds by ensuring accurate, complete, and timely cost accounting. This last requirement, however, can only be met if it is supported by effective financial management data systems and fully trained staff and leadership who understand how to use such systems.

To support the leaders, program offices, and the field in this transformation, the CVCS must establish a transformation office that has appropriate expertise in business process reengineering and is fully funded to conduct this work. Existing offices with the requisite expertise, including the Office of Strategic Integration and the Veterans Engineering Resource Center (VERC), should be rolled into the transformation office. This office would oversee transformation and incubate new initiatives with the goal of incorporating them into regular work of other program offices once the new initiative is established. This mechanism, if used consistently, would prevent VHA from growing new offices as new priorities arise.

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Finally, as part of cultural change within the leadership system, the CVCS, VISN directors, and program office leaders must promote open and productive dialogue among themselves about problems and solutions. To accomplish this goal, leaders must address both the culture within the leadership ranks, as well as establish systems and processes that support identification and discussion of problems. The CVCS must model this behavior by inviting input on problems and rewarding leaders when they bring issues forward, including rewarding them with access to expertise, staff, and money; removing barriers; and aligning other leaders in support of solutions.

In its work to oversee change in VHA, the transformation office will create an implementation plan for transformation, identifying key strategies and milestones. This plan will drive data collection, development of strategic goals and supporting objectives to encourage effective planning, accountability, and the ability to unearth critical gaps that need to be addressed. The transformation office will require each new initiative to establish a project plan and provide periodic reports that include all of the following components: tactic/action, initiative owner, cost (i.e., operational, equipment, contracts), number of FTEs, start and completion dates, outcome measures, strategic drivers, and milestone.⁴⁴⁷ The President's Management Agenda Scorecard will serve as the evaluation model. The Office of Management and Budget created this tool to evaluate new initiatives and track progress on outcomes over time with regular spotlight reports (red, yellow, green) to leadership.⁴⁴⁸

Implementation

Legislative Changes

- Simplify the VHA budget to include fewer accounts while at the same time requiring more transparent and detailed accounting of VHA expenditures.

VA Administrative Changes

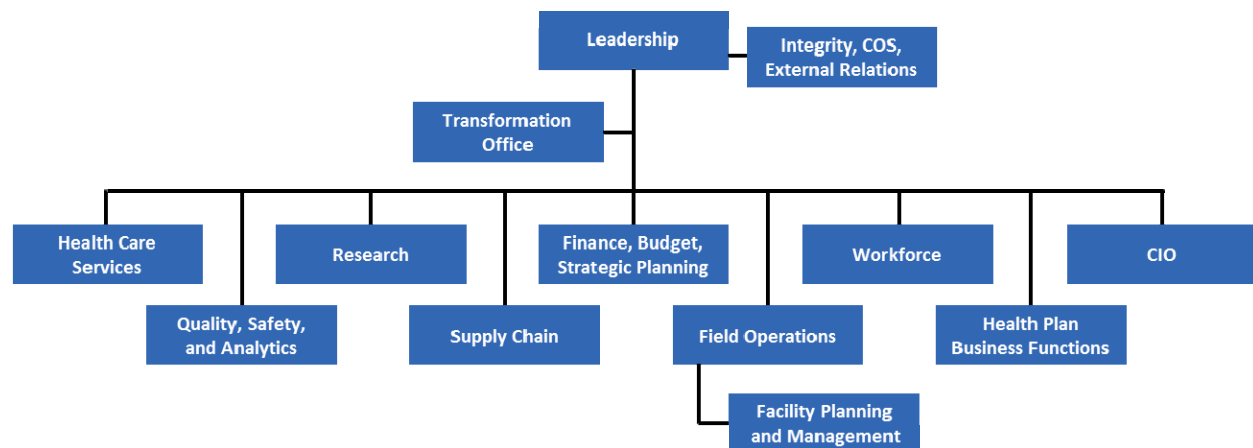
The following administrative changes are a priority during the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B. Responsibility for establishing a transformation plan with milestones, timelines, and evaluation of outcomes is assigned to the transformation office that the Commission recommends be established in VHA.

- Eliminate duplication within VHA and consolidate program offices to create a flat structure. Figure 9 is one model of an organizational chart for accomplishing this goal. This organizational chart shows how VHA can be streamlined to mirror the structure of large private-sector hospital systems. Figure 10 is the current VHA organizational chart, provided as a point of comparison and to emphasize the cumbersome nature of the current structure.

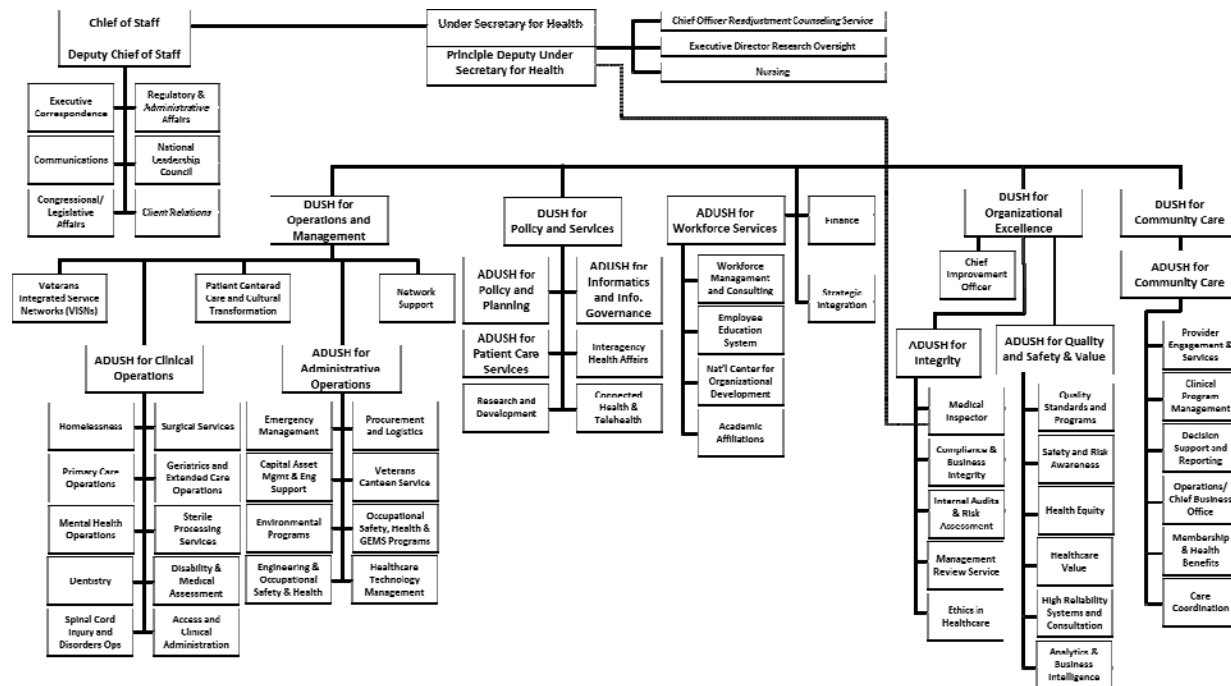
⁴⁴⁷ For example, see "VA Faith-based and Community Initiative President Management Agenda Scorecard," September 30, 2008,

⁴⁴⁸ "Office of Federal Financial Management President's Management Agenda," Office of Management and Budget, accessed June 15, 2016, https://www.whitehouse.gov/omb/financial_fia_pma/.

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Figure 9. Proposed VHA Organizational Chart⁴⁴⁹

Note: This organizational chart is an example of how to align VHA functions to create a flatter organization, remove duplication, and streamline decision making as discussed throughout this section of the report. Of note, the placement of the Transformation Office, CIO, and supply chain in this diagram is consistent with recommendations made by the Commission elsewhere in this report. In this chart, COS is chief of staff.

Figure 10. Current VHA Organizational Chart⁴⁵⁰

⁴⁴⁹ Modified from Appendix C, Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health*, (Washington, DC, Veterans Health Administration, February 2015), 41.

⁴⁵⁰ Ibid.

COMMISSION RECOMMENDATIONS

- Eliminate the duplication of functions between VHA and VA by closing VHA offices as needed.
- Create innovative organizational structures that are aligned to patient's needs rather than professional silos, to support clinical care.
- Undertake a reduction-in-force in VHACO that facilitates layering and efficiency in communication and decision making.
- Establish a transformation office implementation plan to ensure effective and comprehensive implementation of the transformation across VHA. The transformation plan is to capture all of the transformation activities recommended in the Commission report, establish specific timelines and milestones for accomplishing each objective, and report on both progress and outcomes at least quarterly to VHA leadership and the governing board. Periodic evaluation of the effect of these change initiatives on internal and external stakeholders would also be appropriate.
- Clarify the roles and responsibilities of VISNs and facilities and implement a change strategy to orient staff and leaders to these new expectations. Establish effective leadership communication mechanisms to promote transparency, dialogue, and collaboration among VHACO offices and with the field.

Other Department and Agency Administrative Changes

- None required.

Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

Problem

To achieve the Commission's vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set, identical to private-sector standards, will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes for veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders' performance not just on *what* they achieve but *how* they achieve it.

Background

One of the criteria for performance excellence in health care is the measurement, analysis, and improvement of organizational performance.⁴⁵¹ Performance measurement is used to track daily operations, overall organizational performance, and progress in achieving organizational objectives and action plans. Performance measurement is also used to benchmark organizational performance against internal and external standards.

Organizational performance measurement is not the same as workforce performance management.⁴⁵² Workforce performance management is intended to reinforce intelligent risk taking, help focus the workforce on the needs of patients and other customers, and support

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Workforce and Leadership Performance Management System

- VHA create a new performance management system appropriate for health care leaders, tied to health care leadership competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

⁴⁵¹ Baldrige Performance Excellence Program, 2015-2016 *Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.

⁴⁵² *Ibid.*, 20.

health care delivery and the achievement of action plans.⁴⁵³ Although there is a relationship between organizational performance measurement and workforce performance management, they are not synonymous processes.

Workforce performance management is made up of much more than just clinical outcome measures. As noted by the American College of Healthcare Executives (ACHE), performance evaluations of hospital CEOs must also evaluate leadership traits such as judgment, communication, and diplomacy.⁴⁵⁴ Furthermore, ACHE emphasizes the inclusion of individual professional objectives in performance plans, such as promoting ethical behavior, supporting diversity and inclusion within the organization, or fostering effective medical staff relationships.⁴⁵⁵ ACHE and other leading practitioners⁴⁵⁶ emphasize that performance management is not a plan or an event, but rather a continuous, ongoing process and conversation among the leaders and their reviewers. A workforce performance management system must also make meaningful distinctions among individuals⁴⁵⁷ and promote high performance through rewards, recognition, and incentive practices.⁴⁵⁸ Ideally, when coupled with a leadership competency model and development program, workforce performance management should also help to identify high-performing potential leaders and provide guidance to the workforce on how to move up in the leadership ranks.⁴⁵⁹ As deployed in FY 2015 and evaluated by the *Independent Assessment Report*, VHA's performance management system failed to effectively achieve any of these objectives.⁴⁶⁰

Analysis

One of the findings in the *Independent Assessment Report* was that “hundreds of operational performance measures overwhelm leaders and this, combined with limited transparency and inconsistent data availability, makes it difficult to focus on what is most important.” More than 300 measures spanned everything from critical clinical metrics to political priorities introduced to address the most recent crisis. VHA reports that it was tracking approximately 500 measures,

⁴⁵³ Ibid.

⁴⁵⁴ “Policy Statement: Evaluating the Performance of Hospital or Health System CEO,” November 2013 (revised), American College of Healthcare Executives, accessed February 18, 2016, <https://www.ache.org/policy/ceo-perf.cfm>.

⁴⁵⁵ Ibid.

⁴⁵⁶ Ibid. NeuroLeadership Institute’s “Reengineering Performance Management: How Companies are Evolving Beyond Ratings” webinar, scheduled on January 14, 12-1.

⁴⁵⁷ “Implementing FCAT-M Performance Management Competencies: Differentiating Performance,” Office of Personnel Management, Performance Management: Performance Management Cycle, accessed June 10, 2016, <https://www.opm.gov/policy-data-oversight/performance-management/performance-management-cycle/developing/differentiating-performance/>.

⁴⁵⁸ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization’s Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.

⁴⁵⁹ Office of Personnel Management. Proficiency Levels for Leadership Competencies. <https://www.opm.gov/policy-data-oversight/proficiencylevelsforleadershipcompetencies/>. “Joint Medical Executive Skills Institute,” Health.mil: The official website of the Military Health System and the Defense Health Agency, accessed June 13, 2016, <https://www.jmesi.army.mil/documents.asp>, National Center for Healthcare Leadership. NCHL Healthcare Leadership Competency Model. <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁶⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 78-79, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

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including 156 related to access, 29 measuring employee engagement, 18 on high-performing networks, 250 best practice measures, and seven related to trust.⁴⁶¹

Distinct from performance measurement, the performance management process⁴⁶² is a cycle that begins with clear input from top leadership on the priorities of the organization, followed by clear targets, performance tracking, reviews, and rewards. The *Independent Assessment Report* noted that, “Individual performance management processes are hindered by targets inconsistent with the VHA mission, delayed implementation, lack of meaningful performance dialogue, and limited rewards.”⁴⁶³ Many of the same system flaws that impede effective organizational performance also impede individual success. Performance plans are released late in the performance cycle,⁴⁶⁴ metrics are hard to track in real time and lack the detail required for individual performance assessment,⁴⁶⁵ and few plans are written to support shared accountability and team-based solutions. In addition, participants observed that the current senior executive performance agreements and rating process (a) do not result in meaningful distinctions in performance between individuals, (b) do not drive meaningful conversations about individual performance, (c) and do not consistently focus on key health care metrics of quality, safety, patient experience, operational efficiency, finance, and human resources.⁴⁶⁶ The *Independent Assessment Report* notes that the rewards currently offered to employees do not motivate them to work toward exceptional performance.⁴⁶⁷

Information provided to the Commission indicates that VHA has taken action to address some of these findings. First, the USH has reestablished a performance accountability workgroup (absent for a number of years) comprising leaders from the field and VHACO to provide oversight and direction to the performance measurement process.⁴⁶⁸ The workgroup has been charged with aligning metrics to each level of VHA, dramatically simplifying metrics, and increasing the capacity of the organization to focus on measures that truly matter.⁴⁶⁹ The group has created an aspirational vision of a performance measurement system that describes cascading accountability from the top of the organization with health system outcomes (reported annually) through strategic measures (reported quarterly), to tactical measures (reported monthly) to transactional measures (reported in real time).⁴⁷⁰ It is critical that these aspirations become policy.

⁴⁶¹ Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.

⁴⁶² McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 78, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁴⁶³ Ibid., 82.

⁴⁶⁴ Ibid., 82.

⁴⁶⁵ Ibid., 84.

⁴⁶⁶ Ibid., 84.

⁴⁶⁷ Ibid., 87.

⁴⁶⁸ David Shulkin, *Charter of the Performance Accountability Workgroup*, (Washington, DC, Veterans Health Administration, September 22, 2015).

⁴⁶⁹ Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.

⁴⁷⁰ Ibid.

Starting in the 1990s, VHA has used performance measurement, benchmarking, and reporting internally to motivate higher clinical quality performance by individuals and teams.⁴⁷¹ As a large, national health care system, internal benchmarking can be a valid method to drive change, yet both internal and external audiences may ask how well VHA performance compares to that of private-sector providers. VHA currently posts some patient quality, safety, and outcome measures on both its website and on the Department of Health and Human Services (HHS) Hospital Compare website.⁴⁷² These measures allow patients to evaluate the quality of care they receive from VA and make informed health care decisions. They include measures of timely and effective health care; measures of readmissions; complications of death, surgical complication measures and health-care related infection measures; survey data of patient experiences; and other measures required of hospitals participating in Medicare.⁴⁷³ Former USH Kizer believes this reporting is insufficient, noting

*the VA health care system has become increasingly insular and inward-looking. It now has little engagement with private-sector health care, and too often it has declined to make its performance data public. For example, it contributes only a small proportion of its data to Hospital Compare and has declined to participate in other public performance reporting forums such as the Leapfrog Group's efforts to assess patient safety.*⁴⁷⁴

The Commission has reviewed VHA's principal measurement approach, Strategic Analytics for Improvement and Learning Value Model (SAIL) and has determined that although it is modelled on private-sector approaches to measurement and rating, measures are not exactly the same as those reported in the private sector and consequently impede direct benchmark comparisons of VHA to the private sector. Updating these measures so they are consistent with the private sector will be especially important as integrated delivery networks are established and more care is received in the community, as they will allow for making objective comparisons.

Measurement, analysis, and improvement of organizational performance work together as a key system.⁴⁷⁵ The USH has signed a new organizational chart for VHA that acknowledges the interconnection of these elements by establishing an office for organizational excellence that encompasses all of these functions.⁴⁷⁶ To be effective, not only must all of the various units within this office work together but also they must work with personnel in the field to coach and develop their ability to effectively apply performance measurement and improve organizational performance.

⁴⁷¹ "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation?" Ashish K. Jha, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, September 2006, accessed April 21, 2016, <https://psnet.ahrq.gov/perspectives/perspective/31/what-can-the-rest-of-the-health-care-system-learn-from-the-vas-quality-and-safety-transformation>.

⁴⁷² "Quality of Care: How Does Your Medical Center Perform?" Medical Center Performance Search (MCPS), U.S. Department of Veterans Affairs, accessed May 16, 2016, <http://www.va.gov/qualityofcare/apps/mcps-app.asp>.

⁴⁷³ Title XVIII of the Social Security Act 42 U.S.C. § 1395 et seq.

⁴⁷⁴ Kenneth Kizer and Ashish Jha, *Restoring Trust in VA Health Care*, N Engl J Med 2014; 371:295-297, July 24, 2014

⁴⁷⁵ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.

⁴⁷⁶ See the proposed organizational chart at end of Recommendation #12.

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These improvements in performance measurement do not appear to be mirrored on the performance management side of the equation. The draft FY 2016 performance plan template for network directors and medical center directors,⁴⁷⁷ although more streamlined than in previous years, continues to reflect confusion of performance measurement and performance management. It also continues to distribute all of the organization's key (and not so key) priorities under OPM executive core qualifications of leading change, leading people, business acumen, building coalitions, and results driven. The new, streamlined performance measures described above could be considered results-driven; however, the rest of the plan continues to be a confusing presentation of instructions to field leaders, restatements of policy, and performance objectives for action plans. Only the last category is appropriate for workforce performance management.⁴⁷⁸ The Corporate Senior Executive Management Office has implemented a new online performance management data tool that allows for tracking and assessment of the performance management process for senior executive service and equivalent leaders in VA.⁴⁷⁹

To improve performance measurement and organizational performance, the *Independent Assessment Report* recommends that VHA focus and simplify organizational performance measurement to clarify accountability, actively support the mission, and promote continuous improvement. Specifically, VHA must create a simplified, focused, balanced scorecard that reduces the total number of metrics to about 20; establish metrics that support cross-functional collaboration; cascade metrics down the organizational hierarchy; and make data tracking transparent, timely, broadly available, credible, reliable, and meaningful down to the lowest level of the organization. Furthermore, leaders should support continuous improvement, problem-solving, and the exchange of best practices across the organization rather than focusing on only correcting poor performance.⁴⁸⁰ The Commission broadly agrees with this approach to performance measurement. In addition, the Commission emphasizes that VHA customers and stakeholders require public reporting of clinical quality measures that are the same as, and therefore directly comparable to, measures used by the private sector. Although VHA may require an enhanced set of measures that reflects services not broadly deployed in the private sector, or for which measures do not yet exist, a minimum set that are the same as private-sector measures must be used by VHA. As VHA expands integration of care with the community, the use of the same measures as the private sector will be important so that direct comparisons can be made of care delivered inside VHA and that delivered under contract or partnership agreement by the VHA community care network.

VHA also requires a cohesive, integrated personnel performance management system that is specific to the knowledge, skills, and abilities required of health care leaders; includes

⁴⁷⁷ Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan Template*, Network Directors and Medical Center Director, November 20, 2015.

⁴⁷⁸ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.

⁴⁷⁹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁴⁸⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 81, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

accountability to key organizational outcomes; but also assesses organizational and professional objectives. A new personnel performance management system must be free of OPM requirements for executive core qualification and certification process and instead be benchmarked to the private sector⁴⁸¹ and consistent with the new leadership competency model. Congress required DoD to establish independent competency standards for the Commanders of Military Treatment Facilities (MTFs) and should consider doing the same for VHA.⁴⁸² This new performance management model must be based on both evaluation of leadership competencies and demonstrated success in delivering on strategic priorities. To break with current perceptions of the rating scales, it would be helpful to establish a new rating scale for the performance management system. Once the new system is developed, VHA must conduct training to describe the system, rating process, and expectations for both participants and raters.

A performance management system must also address the responsibilities of the rater. This includes clearly establishing written performance requirements for subordinates that are both timely (i.e., prior to the start of the rating period) and meaningful. Raters must be required to provide continuous feedback and assessment throughout the year to recognize and reward progress and outstanding achievements as well as to coach and trouble shoot when needed. The CVCS must establish this expectation by clearly communicating what is required of raters, and most importantly, by modeling the behavior. Finally, raters must provide meaningful ratings that distinguish achievement based on objective performance and demonstrated leadership skills. For instance, the Cleveland Clinic has moved to a system of forced rankings for which the top 10 percent of performers are celebrated and the bottom 10 percent are given intensive coaching or, if justified, sanctioned.⁴⁸³ To accomplish the last point, raters themselves must be given feedback and oversight to understand how their approach to rating compares to other leaders in the organization. If raters' assessments are not consistent with rating standards, their supervisor must bring this issue to their attention and include it in the performance assessment they receive.

The newly established performance management data tool can be used to support the performance management process. The submission of written performance plans (or failure to do so) can be tracked and reported; and the quality of those plans can be audited to provide feedback to raters. Final ratings and a comparison of raters can be conducted and provided to all of the executive raters in the organization. Finally, such a tool can also be used to identify and track high performers who deserve further investment and development as leaders from VHA.

⁴⁸¹ The American College of Healthcare Executives, *2016 Competencies Assessment Tool*, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf. "NCHL Health Leadership Competency Model™," National Center for Healthcare Leadership, accessed May 16, 2016 <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁸² Department of Defense Appropriations Act of 1999, Pub. L. No 105-262, Section 8052 (1998): "None of the funds appropriated in this Act may be used to fill the commander's position at any military medical facility with a health care professional unless the prospective candidate can demonstrate professional administrative skills."

⁴⁸³ Delos M. (Toby) Cosgrove, MD, CEO, Cleveland Clinic, statement during Commission on Care public meeting, March 22, 2016.

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Implementation***Legislative Change***

- Obtain legislative relief from the requirement to use the OPM executive core qualifications system of competencies and ratings and tied to new Title 38 pay authority for health care leaders (see Recommendation #15).

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Establish a workgroup and engage outside experts to create a new performance management system for VHA leaders that is appropriate for health care executives.
- Establish standards and processes to hold raters accountable for creating meaningful distinctions in performance between subordinate leaders.
- The new Office for Organizational Excellence should work with experts to reorganize their internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Other Department and Agency Administrative Changes

- None required.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

Problem

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans, and must become a strategic priority throughout the organization, because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veteran's care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Background

Cultural competence is the ability of health care organizations and their providers to understand and respond effectively to the cultural, language, and in VA's case, military service experience brought by the patient to the health care encounter. It has been endorsed as a viable skill set to reduce, if not eliminate, the rate at which health care disparities occur. VHA has recognized the problem of health disparities among its patient population and has taken steps to address it by tasking certain internal offices with building cultural and military competence throughout the organization. For example, VHA established the Office of Health Equity (OHE) and charged it with championing the efforts to identify, understand, and address health care disparities among veterans.

Analysis

There are seven essential strategies for promoting and sustaining organizational and systemic cultural competence. These strategies include the following:⁴⁸⁴

- Provide executive-level support and accountability.
- Foster patient, community, and stakeholder participation and partnerships.
- Conduct organizational cultural competence assessments.
- Develop incremental and realistic cultural competence action plans.

⁴⁸⁴ Miriam E. Delphin-Rittmon et al., "Seven Essential Strategies for Promoting and Sustaining Systemic Cultural Competence," *Psychiatric Quarterly*, 84, (2013), 53-64.

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- Ensure linguistic competence.
- Diversify, develop, and retain a culturally competent workforce.
- Develop an agency strategy for managing staff and patient grievances.

VA has taken some steps to address cultural and military competence strategies, but these programs are not sufficient to address the breadth and depth of the problem. These strategies will not take hold and become fully ingrained in VHA's culture unless VHA leadership makes them a key priority and commits the resources and on-going, comprehensive training required to build cultural competencies across the entire VHA workforce.

Military Competency

In addition to addressing the needs of minority veterans and vulnerable veterans populations, VA must address military-specific needs and ensure that all providers in the VHA Care System have sufficient military competency (i.e., knowledge of specific issues and health care needs of those who served in the military). VHA's Office of Academic Affiliations developed a *Clinician Pocket Card* for providers that includes questions for clinicians to ask veterans about their military health history.⁴⁸⁵ The *Pocket Card* and similar resources should be given to all VHA and community providers to leverage during veteran patient medical assessments and appointments. In addition, VA's Office of Public Health (OPH) provides information on VA health care programs for veterans who were exposed to environmental and occupational hazards during military service, such as Agent Orange, chemicals leading to Gulf War veterans' illnesses, and Camp Lejeune water contamination.⁴⁸⁶ This military exposure information should be leveraged in VA's cultural competency strategy.

Health care disparities often result from patients' lack of trust in their health care provider; therefore, enhancing the patient-provider relationship is paramount in overcoming these disparities. Stereotypical thinking on the part of providers about certain patient groups, including veterans, may unwittingly influence their prognosis.⁴⁸⁷ Specific reasons for the increase of health care disparities in the military population include the following:

- the cultural norms of the military are such that to admit or display any signs of perceived weakness, especially related to mental health issues, discourages military personnel and veterans from seeking medical care and treatment
- changes in the demographical makeup of the civilian population result in similar changes to the military population
- a small but gradual increase in the number of foreign born personnel who have joined the ranks of the military

⁴⁸⁵ Department of Veterans Affairs, Office of Academic Affiliations, *Military Health History: Pocket Card for Health Professions Trainees and Clinicians*, accessed June 12, 2016, <http://www.va.gov/oaa/archive/Military-Health-History-Card-for-print.pdf>.

⁴⁸⁶ "Public Health: Military Exposures," U.S. Department of Veterans Affairs Intranet, accessed June 12, 2016, <http://vaww.publichealth.va.gov/exposures/index.asp>

⁴⁸⁷ G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," JHHSA (2011), 148.

- a disengaged provider culture that may have become more immersed in the medical culture than the military culture

VA must make cultural and military competence a strategic priority, provide the resources needed to execute the strategy, and hold leadership and providers, both within VHA and community partners, accountable for strategy implementation and integration into VA's culture.

Women

Women are the fastest growing group within the veteran population.⁴⁸⁸ As of 2011, approximately 1.8 million (8 percent) of the 22.2 million veterans were women. Data indicate that by 2020 women veterans will comprise nearly 11 percent of the total veteran population. As the number of women veterans increases, VHA continues to prepare for an increasing demand for women veterans' health care needs.⁴⁸⁹ To address the health disparities affecting women veterans, VHA must provide high-quality, equitable care on par with that of men, deliver that care in a safe and healing environment, provide seamless coordination of services, and actively recognize women as veterans.⁴⁹⁰

In the past, VHA found gaps in its ability to provide comprehensive primary care for women veterans because many primary care providers had little or no exposure to women patients and women were often referred outside of primary care for gender-specific care. To close these gaps, VHA has implemented women's health comprehensive primary care clinic models with the goal of providing complete primary care from one designated women's health provider (DWHP) at one site. An analysis of FY 2012 data revealed that women assigned to DWHPs had more positive overall experiences with care and were more satisfied on six composite scores including access, communication, shared decision making, self-management support, comprehensiveness, and office staff.⁴⁹¹ VA has substantially reduced gender gaps in care,⁴⁹² but women veterans still encounter challenges when accessing care. VHA leadership must support the future planning of women's services and programming so that women veterans receive the highest quality health.⁴⁹³

LGBT Equity

In its systemwide implementation of cultural competency, VHA should leverage best practices from an area in which the agency is already an equity leader: treatment of LGBT patients. Every year since 2007, the Human Rights Campaign has published a Health Equality Index (HEI) report that aims to measure the quality of health care for LGBT patients based on core criteria

⁴⁸⁸ "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, <http://www.womenshealth.va.gov/>.

⁴⁸⁹ U.S. Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care*, April 2015, accessed June 12, 2016, http://www.womenshealth.va.gov/WOMENSHEALTH/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf.

⁴⁹⁰ Patricia M. Hayes, Chief Consultant Women's Health Services, VHA Office of Patient Services, briefing to the Commission on Care, October 19, 2015.

⁴⁹¹ Ibid.

⁴⁹² Ibid.

⁴⁹³ "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, <http://www.womenshealth.va.gov/>.

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that require health care systems to couple strong policies with appropriate training.⁴⁹⁴ In 2016, VAMCs made up 20 percent of all HEI participants. Among participating VAMCs, 84 percent were designated with *Leader* status.⁴⁹⁵ VHA hospitals publicize that discrimination against LGBT patients and employees is prohibited. Senior managers are registered for HEI training. And equal visitation rights are granted to families and friends of LGBT patients. VHA hospitals play a critical role in promoting patient care equality in states where VHA is the only Equality Leader.⁴⁹⁶ VHA should create strong policies and mandatory training, like that used to promote health equity for LGBT patients, to address equity issues for racial and ethnic minorities and women.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- VHA Care System providers should be required to ask patients about their military health history and incorporate veterans' responses into patients' treatment plans.
- VHA leadership should support the future planning of women's services and programming so that women veterans receive the highest quality health care.
- VHA should leverage the best practices developed in support of LGBT equity and implement them across VHA.
- VHA Care System providers should be required to attend comprehensive, on-going cultural and military competency training.

Other Department and Agency Administrative Changes

- None required.

⁴⁹⁴ "How the VA is leading the way on LGBT patient care," Andrew Park, The Week, February 25, 2014, accessed June 12, 2016, <http://theweek.com/articles/450361/how-v-a-leading-way-lgbt-patient-care>.

⁴⁹⁵ "Office of Health Equity: Healthcare Equality Index," U.S. Department of Veterans Affairs, accessed June 15, 2016, http://www.va.gov/HEALTHYEQUITY/Healthcare_Equality_Index.asp

⁴⁹⁶ "How the VA is leading the way on LGBT patient care," Andrew Park, The Week, February 25, 2014, accessed June 12, 2016, <http://theweek.com/articles/450361/how-v-a-leading-way-lgbt-patient-care>.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

Problem

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

Background

During the 1990s, Congress passed the Government Performance and Results Act⁴⁹⁷ to correct shortcomings in the way government was managed and assessed in an effort to bring modern business management practices into the federal government. The law was updated in 2011,⁴⁹⁸ yet one essential

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does all of the following:
 - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
 - Promotes veteran preferences and hiring.
 - Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, due process) through simplified, sensible processes that work for managers and employees.
 - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
 - Provides due process and appeals standards to adverse personnel actions.
 - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
 - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
 - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
 - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
 - Grandfathers current employees with respect to pay and benefits.
- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

⁴⁹⁷ Government Performance and Results Act of 1993, Pub. L. No. 103-62, 107 Stat. 285 (1993).

⁴⁹⁸ GPRA Modernization Act of 2010, Pub. L. No. 111-352, 124 Stat. 3866 (2011).

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component of modernizing the management of federal programs is still missing: reform of human capital management.⁴⁹⁹

The Civil Service Act was initially passed in 1883 and revised in 1978.⁵⁰⁰ The *general schedule*, which governs the pay and job classification process, was codified by regulation in 1949. The U.S. workforce, including the federal workforce, has changed dramatically since these laws and regulations were implemented. As noted in a recent report from the Partnership for Public Service, “the personnel system, designed more than 60 years ago, now governs more than 2 million workers and is a relic of a bygone era, reflecting a time when most federal jobs were clerical and required few specialized skills.”⁵⁰¹ As of 2013, nearly two-thirds of federal employees work in professional or administrative positions focused on knowledge-based work, with the Department of Veterans Affairs accounting for the largest percentage of such workers.⁵⁰²

The Partnership for Public Service calls for broad reform of the civil service system, noting that the

*the federal workforce has become an island disconnected from the larger talent market for knowledge-based professional and administrative occupations that are mission critical. . . . Federal employee pay . . . is not tied to the broader labor market, making it harder to compete with the private sector for talent. That disconnect is exacerbated by a job classification system that describes a workplace from the last century.*⁵⁰³

This system lacks mechanisms for rewarding top performers, demoting or firing poor performers, and holding managers accountable.⁵⁰⁴ The unnecessarily complex hiring system is difficult for applicants to navigate and makes it challenging for hiring managers to identify the most qualified candidates, hindering the ability to bring in experienced candidates from the private sector.⁵⁰⁵

*The civil service system has become a maze of rules and procedures that are not perceived as rational by the people who serve in government or by the general public. . . . Rigid policies . . . are now a burden on a government that needs to encourage flexibility and innovation to meet rapidly changing and difficult challenges.*⁵⁰⁶

⁴⁹⁹ U.S. General Accountability Office, Office of the Comptroller General, *Human Capital – A Self-Assessment Checklist for Agency Leaders*, accessed April 11, 2016, <http://www.gao.gov/assets/80/76520.pdf>. U.S. General Accountability Office, *Transforming the Civil Service: Building the Workforce of the Future – Results of a GAO Sponsored Symposium*, accessed April 11, 2016, <http://www.gao.gov/assets/200/197256.pdf>.

⁵⁰⁰ The Pendleton Civil Service Reform Act of 1883, Pub. L. No. 16, 22 Stat. 403 (1883).

⁵⁰¹ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵⁰² Ibid. The Department of Defense in total has more knowledge workers but the numbers for each service are reported independently and are below the total for the VA workforce.

⁵⁰³ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵⁰⁴ Ibid.

⁵⁰⁵ Ibid.

⁵⁰⁶ Ibid.

The General Accounting Office (GAO) also continues to point to human capital management as a high-risk area across government.⁵⁰⁷ DoD has proposed walking away from the Title 5 civil service system to support modernization of human capital management,⁵⁰⁸ President Barack Obama has repeatedly called for a commission to overhaul and modernize the civil service,⁵⁰⁹ and Congress is considering whether the time is right for civil service reform.⁵¹⁰

VHA currently uses three different personnel systems: Title 5 (the civil service/general schedule system) for senior executive service (SES) and other, mostly nonclinical, employees; Title 38 for physicians, dentists, and other specified health care professionals;⁵⁰⁹ and Title 38 Hybrid for allied health professionals such as pharmacists and licensed physical therapists.⁵¹⁰ Each system has its own set of requirements, procedures, and rules for the employees under its respective authority.⁵¹³ Currently, about two-thirds of VHA employees serve in the Title 38 Hybrid occupations.⁵¹⁴

VHA is not alone in having an excepted service system. More than a dozen agencies have special legislative authority to create a personnel system to fit their particular needs, including the Federal Bureau of Investigation, National Institutes of Health, National Security Agency, U.S. Public Health Service, Defense Intelligence Agency, U.S. Nuclear Regulatory Commission, and National Aeronautics and Space Administration.⁵¹¹ In an acknowledgement of the failure of the general schedule process to meet the needs of certain professions, OPM has also instituted governmentwide direct hiring authority for difficult-to-recruit positions, including medical officer, nurse, pharmacist, radiologic technician, and information technologist – all positions critically important to VHA’s mission success.

Modernizing human capital management is a global imperative for the private sector as well, with 92 percent of participants in one assessment of 7,000 businesses noting that a new approach to human resources is a critical organizational priority in 2016.⁵¹² According to a report from Deloitte, which examined broad human resource (HR) trends, “HR is redesigning almost everything it does – from recruiting to performance management to onboarding to reward systems” to learning and development.⁵¹³ Younger workers are driving many of these

⁵⁰⁷ U.S. GAO, *Federal Workforce—Human Capital Management Challenges and the Path to Reform, Testimony Before the Subcommittee on Federal Workforce U.S. Postal Service and the Census, Committee on Oversight and Government Reform, House of Representatives, Statement of Robert Goldenkoff*, GAO-14-723T, July 15, 2014, Washington, DC, 2014, accessed June 12, 2016, <http://www.gao.gov/assets/670/664772.pdf>.

⁵⁰⁸ “Draft Proposal Calls for Major Revamp of DoD Civilian Personnel System,” Jared Serbu, Federal News Radio, accessed April 8, 2016, <http://federalnewsradio.com/defense/2015/09/draft-proposal-calls-major-revamp-dod-civilian-personnel-system/>.

⁵⁰⁹ “Obama’s Budget Touts Progress Within Federal Workforce, but Offers It Nothing New,” Eric Katz, Government Executive, accessed April 8, 2016, <http://www.govexec.com/management/2016/02/obamas-budget-touts-progress-within-federal-workforce-offers-it-nothing-new/125815/>. The Office of Management and Budget, *Fiscal Year 2016 Budget of the U.S. Government*, accessed May 13, 2016, <https://www.whitehouse.gov/sites/default/files/omb/budget/fy2016/assets/budget.pdf>.

⁵⁰⁹ “Brace Yourselves: Congress Preps Civil Service Reform,” Andy Medici, Federal Times, accessed April 8, 2016, <http://www.federaltimes.com/story/government/management/oversight/2015/01/19/congress-civil-service-reform/21458717/>.

⁵¹⁰ Ibid.

⁵¹¹ See, e.g., 38 U.S.C. § 7401(1).

⁵¹² See, e.g., 38 U.S.C. § 7401(3).

⁵¹³ Joleen Clark, Jack Hetrick, and Donna Schroeder, “Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers,” Alternative Personnel System (2014).

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changes with expectations for meaningful work, learning opportunities, and career progression.⁵¹⁴ These workers have been choosing the federal government in diminishing numbers, with only 6 percent of federal employees currently younger than 30 years of age (compared to 23 percent of the civilian workforce).⁵¹⁵ In VHA, millennials (those 34 and younger) make up only 15 percent of the workforce, but are disproportionately over-represented among staff that quit VHA, at 20 percent.⁵¹⁶

As of January 2016, VHA had a vacancy rate of 16 percent for all positions, despite filling more than 40,000 positions in FY 2015.⁵¹⁷ VHA faces the additional challenge that 40 percent of its overall workforce is eligible for retirement in the next few years.⁵¹⁸ This problem occurs in the face of acknowledged national shortages of physicians⁵¹⁹ and geographic misalignment of the current health care workforce that leaves many localities short of needed providers.⁵²⁰ Taken together, this information makes clear that excellence in human capital management continues to be a business imperative for VHA.

Analysis

The human resource function within VHA needs a fundamental overhaul to increase responsiveness, efficiency, and customer service, as well as to align its orientation to the business needs of VHA.⁵²¹ Medical center directors do not receive the support they need from HR to accomplish hiring, disciplining, and planning for succession of employees.⁵²² During exit interviews, staff members who leave VHA cite barriers to career growth, insufficient professional development, a lack of promotions, and poor on-boarding and training as reasons for departing.⁵²³ In a recent national survey of VA employees, improving end-to-end hiring, recognizing stellar job performance, and providing professional development and career

⁵¹⁴ U.S. GAO, *The Excepted Service: A Research Profile*, GAO/GGD-97-92, accessed April 12, 2016, <http://www.gao.gov/assets/80/79968.pdf>.

⁵¹⁵ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 12, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵¹⁶ Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.

⁵¹⁷ “VA Struggles to Fill Medical Center Positions in Arizona, Across Nation,” Danika Worthington, Arizona Daily Sun, accessed April 5, 2016, http://azdailysun.com/news/local/va-struggles-to-fill-medical-center-positions-in-arizona-across/article_a14e6937-ecc1-5415-9391-7a6d759e5025.html.

⁵¹⁸ Joleen Clark, Jack Hetrick, and Donna Schroeder, *Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers, Alternative Personnel System* (2014).

⁵¹⁹ IHS Inc., *The Complexities of Physician Supply and Demand: Projections from 2013-2025*, accessed April 12, 2016, <https://www.aamc.org/download/426242/data/ihsreportdownload.pdf>.

⁵²⁰ “Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations,” U.S. Department of Health and Human Services, Health Resources and Services Administration, accessed April 12, 2016, <http://www.hrsa.gov/shortage/>.

⁵²¹ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, x, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵²² Ibid., vii.

⁵²³ Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.

planning ranked, numbers one, six, and nine respectively as top priorities for improving the employee experience at VA.⁵²⁴

The Civil Service System Does Not Support a High-Performing Health System.

Recruitment in VHA operates in an incredibly complex environment. Federal rules and regulations make HR more challenging than it is in the private sector.⁵²⁵ For example, interviews in 2014 with more than 500 VHA hiring managers and HR staff members pointed to the top problems with Title 5 recruitments as OPM classification standards, grading of position descriptions, position characterization, and the ranking and rating process.⁵²⁶ The group specifically noted that there are many staff positions required in a health care delivery system that do not translate into a general schedule occupational series; therefore, when the positions are graded, the grade and salary is too low to compete with the private sector. Examples of such positions are custodial workers (hospital employees need to apply antiseptic cleaning techniques, but general custodians do not) and general facilities and equipment maintenance (hospital employees need to understand the maintenance of such items as specialized medical equipment, positive pressure rooms, and sterile plumbing systems that are not requirements for general plant maintenance at an office building).⁵²⁷ In another example, VHA managers noted that the OPM classification standard for supply chain positions rendered VHA unable to compete for local talent because the assigned grade was too low.⁵²⁸

The general schedule system also has been identified as a barrier to career advancement.⁵²⁹ Clerical staff members in particular often cannot advance in pay and responsibility without leaving their positions and moving into a different job series.⁵³⁰ Similarly, frontline customer service staff under the general schedule cannot receive advanced steps within the grade for better performance or completing job-related certifications or degrees, unlike nurses and allied health professionals who can receive advances in pay for these accomplishments.⁵³¹

The hiring process in VHA is acknowledged to take too long.⁵³² “HR is expected to fill a position within 60 calendar days . . . but process requirements, even if perfectly executed, take about 49

⁵²⁴ “MyVA, Putting Veterans First,” MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.

⁵²⁵ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵²⁶ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People. Powerpoint of findings, July 29, 2014.

⁵²⁷ Veterans Health Administration, “Leading Access Scheduling Initiative – People, Assessment of Hiring Barriers,” VHA Classification Workgroup, 2014.

⁵²⁸ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xiii, accessed December 28, 2015, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

⁵²⁹ Ibid.

⁵³⁰ “Classification and Qualification: Classifying General Schedule Positions,” U.S. Office of Personnel Management, accessed November 24, 2015, <https://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/>.

⁵³¹ Pay Administration, VA Directive 5007 (2002). Staffing, VA Directive 5005 (2002).

⁵³² McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 109, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

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to 62 days.” Hiring timelines can span 4-8 months compared to private-sector hiring that takes between 0.5 and 2 months.⁵³³

This finding was echoed in a Northern Virginia Technology Council report on information technology challenges in VA that indicated across the board hiring of needed staff proceeds too slowly. “The causes are complex, but much of the delay can be traced to redundant, inconsistent, and inefficient hiring processes.”⁵³⁴ One driver of extended VHA hiring times is the government background checks and the licensing and credential review for clinical staff that is managed through VetPro, an internet-enabled data bank for credentialing VHA personnel.⁵³⁵

Although addressing recruiting and hiring problems will not be easy, doing so is essential to maintaining VHA’s workforce.⁵³⁶ An internal VHA workgroup that examined HR concluded that a complete break with Title 5 and a reworking of current Title 38 hiring authority is required, stating:

*The existing Personnel system does not meet today’s market or demand. With VHA’s tremendous volume of occupations to hire and significant turn-over rate in critical positions, it is necessary to promote an efficient organizational system to be able to hire qualified candidates as quickly as possible. The current classification system led to disparity across the systems and only looks at the duties of the position versus the qualifications of the person. The VHA hiring system must be agile and attractive to recruit those that just graduated or are entering the workforce... An agency specific excepted employment system would allow VHA to meet the unique staffing demands that are required of a complex health care organization.*⁵³⁷

VHA is Not Competitive in Pay for Many Positions

Many VHA staff have substantially lower earning potential than their private-sector counterparts. Despite a generous benefits package and the possible opportunities for greater work-life balance, and for research and teaching in a system that serves the important role of caring for the nation’s veterans, lower salaries reduce VHA’s competitive edge in the marketplace when trying to attract top talent.⁵³⁸ For example, although VHA is often able to provide physicians an entry salary that is comparable or better than industry standards, physicians’ long-term earning potential is dramatically less in VHA than that of their private-sector peers. “At the top of the salary ranges, VHA providers made less than their counter parts

⁵³³ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow-Clinical)*, 45-49, accessed May 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁵³⁴ Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America’s Veterans*, 12, accessed April 25, 2016, <http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf>.

⁵³⁵ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 37, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵³⁶ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵³⁷ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report*, August 2014.

⁵³⁸ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 39, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

by up to \$310,000 and on average, \$74,631. The only specialties for which VHA physicians made equal to or more than industry averages were anesthesiology, nephrology, ophthalmology, and psychiatry.”⁵³⁹ In another example of barriers to competitive pay, current provisions in law limit VA to a 60 percent level of market pay compensation for allied health professionals, even when recruitment failures demonstrate the need to offer higher salaries.⁵⁴⁰ As noted above in the discussion on classification, failure to appropriately classify positions also leads to a salary that is not competitive with private-sector health care organizations for positions such as customer service personnel.

In the area of educational debt repayment relief, VHA lags behind other federal and state agencies that use such programs to fill critical physician shortages in medically under-served areas.⁵⁴¹ VHA can offer up to a maximum of \$60,000 for 2 years (\$30,000 per year). HRSA National Health Service Corps (NHSC) runs three programs: the NHSC loan repayment program that provides up to \$50,000 in loan payments, the Student-to-Student Loan Repayment Program for up to \$120,000, and the State Loan Repayment Program with each state establishing loan amounts that are administered by HRSA.⁵⁴² These amounts range broadly from \$80,000 in Arizona and Arkansas, \$90,000 in Colorado, \$100,000 in Georgia and Alabama, and \$190,000 in California.⁵⁴³

Clinic Staffing Is Impaired by Current Law, Regulation, and Policy

Successfully reallocating staff to meet veterans’ needs in a rapidly evolving health care environment is difficult in VHA. The *Independent Assessment* recommended that VHA use extended clinic hours and weekend clinics to better optimize space and increase access to care for veterans.⁵⁴⁴ VA policy currently prohibits full-time VA physicians from receiving fee-basis compensation from the same VA facility in which they are salaried, although they can, under certain circumstances, receive fee-basis appointments at other VA facilities.⁵⁴⁵

These restrictions can make it hard to meet policy requirements for night and weekend schedules⁵⁴⁶ without reducing staffing on inpatient units or under-resourced primary care clinics. Use of alternative work schedules and overtime pay for physicians to meet local patient demands should be under control of local medical center directors.

⁵³⁹ Ibid., 40.

⁵⁴⁰ Increases in Rates of Basic Pay, 38 U.S.C. § 7455.

⁵⁴¹ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report*, August 2014.

⁵⁴² “Loan Repayment Program,” U.S. Department of Health and Human Services, National Health Service Corps, accessed June 9, 2016, <http://nhsc.hrsa.gov/loanrepayment/>.

⁵⁴³ “Physician Loan Repayment Guide,” Jimmy Karnezis, accessed April 13, 2016, <https://www.credible.com/blog/physician-loan-repayment-guide/>.

⁵⁴⁴ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 136, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵⁴⁵ VA Handbook 5005, pt. II, ch. 3, § A, para. 3b.

⁵⁴⁶ Extended Hours Access for Veterans Requiring Primary Care Including Women’s Health and Mental Health Services at Department of Veterans Affairs Medical Centers and Selected Community Based Outpatient Clinics, VHA Directive 2013-001 (2013).

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VHA Staff Receive Inadequate Training Including at Initial Hire

Leading practices include providing mandatory onboarding training that introduces policies, procedures, and necessary skills. Onboarding programs include various activities that expose new hires to the culture of the organization and expectations based on roles and responsibilities. A report released by the Society for Human Resources Management suggests, “Formal orientation programs help new employees understand many important aspects of their jobs and organizations, including the company’s culture and values, its goals and history and its power structure.”⁵⁴⁷ To make up for inadequate on-boarding and to fill current staff’s understanding of VA, VHA is providing VA 101 training for current employees, with 60 facilities having completed the training in FY 2015.⁵⁴⁸ Employees in VA continue to desire a wide array of training, including customer service training, professional development, peer-to-peer training, hands-on training, and role-specific training.⁵⁴⁹

HR Professionals Must Focus on People and Business Priorities Not Compliance

VHA job candidates indicate they have unsatisfactory recruiting experiences, noting failures in timely follow-up and communication.⁵⁵⁰ VA human resources management and administration indicate that VA HR professionals do not exhibit a uniform level of competency, frequently do not understand the employee recruitment process end-to-end, and fail to provide high quality consultative support to managers with respect to all HR functions, but particularly in the area of progressive discipline and firing of employees.⁵⁵¹ Currently HR professionals in VA are largely focused on compliance with a complex set of rules,⁵⁵² rather than adding true value to the organization and being able to be full partners in accomplishing VHA business objectives. Resolving these staffing issues would render the overall HR function more effective.

VHA must become the employer of choice to attract and retain the very best health care workforce. To help it accomplish this goal, VHA requires competitive pay and flexible hiring and talent management processes. VHA cannot achieve that goal within its current personnel systems. A uniform alternative personnel system under Title 38 for all VHA human capital management would accomplish all of the following:

- Meet the unique staffing demands of a health care delivery organization.
- Allow market-based compensation and pay-setting latitude using broad pay bands to support staff growth and progression within their job. VHA must consider total compensation (with benefits), as compared to market rates because the government provides many more benefits than private-sector organizations. Consequently, VA may

⁵⁴⁷Talya Bauer, Society for Human Resource Management, *Onboarding New Employees: Maximizing Success*, 2010, 9-10, accessed May 13, 2016, <https://www.shrm.org/about/foundation/products/documents/onboarding-percent20epg-percent20final.pdf>.

⁵⁴⁸ Veterans Health Administration, *Blueprint for Excellence: Fiscal Year 2015 Results: Communicating Accomplishments*, presented to the National Leadership Committee, March 22, 2016.

⁵⁴⁹ “MyVA, Putting Veterans First,” MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.

⁵⁵⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁵¹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁵² Ibid.

pay less than private-sector employers for a position, but the total compensation (with benefits) may end up being equivalent to private-sector total compensation.

- Allow flexibility in the processes used to hire staff including direct hiring when needed.
- Support career planning and professional development through the application of competency models and training specific for health care as part of position management.
- Simplify the management tasks for supervisors and hiring managers who will only need to know one set of rules and processes instead of four.
- Simplify the job of HR professionals who will only need to know one set of rules and processes instead of four.
- Allow development and training of the HR workforce in VHA to focus on only one personnel system to create true end-to-end hiring expertise.
- Reduce competition within government where shortages of HR professionals create competition for Title 5 trained HR professionals.
- Create streamlined and uniform standards and approach to discipline and dismissal.
- Create fairness among staff in sick leave, vacation pay, salary, awards and bonuses, and compensatory time off.
- Support flow of staff between the field and VHA Central Office (VHACO) under a single personnel system.

Establishing a new human capital management system in VHA will neither be easy nor quick, nor will it be a panacea that alone will fix all that is wrong with recruitment, retention, development, and advancement. In designing and implementing a new system, VHA must take full advantage of private-sector resources and expertise in human resource management and ensure that the new system is built to be compatible with the private-sector. As VHA moves toward greater integration of care delivery, with networks of community providers, compatibility in personnel systems and a resulting greater flow of employees between VHA and community sites can help create closer linkages between the two parts of the care delivery system.

Implementation

Legislative Changes

- Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.
- Update student loan reimbursement limits to be competitive with other federally administered programs and market conditions.

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- Establish an appeals process that provides staff appropriate due process that is based on the regulatory standards for the new alternative personnel system.

VA Administrative Changes

- Eliminate barriers to creating hiring pools for positions with frequent turnover (e.g., extend the length of time over which candidates can continue to be hired from a completed certification until all of the qualified candidates are hired or have declined offers).
- Eliminate barriers to initiating a recruitment process when vacancies are anticipated; positions need not be empty before recruitment ensues. In some cases, hires should also be made before the departure of key personnel to allow for on-the-job training and mentoring of the replacement.
- Benchmark credentialing to private-sector processes and consider outsourcing the process as much as practicable through centralized mechanisms.
- Release market pay and total compensation information to the field for all job categories using commercially available data and information, at least every 2 years.

Other Department and Agency Administrative Changes

- OPM should continue to oversee and administer benefits for VHA but not impose any of the other existing conditions or requirements on the management of the new alternative personnel system. The new personnel system should be governed by the new legislative requirements and those established during the anticipated rulemaking process in VA. These requirements include market-based pay, performance awards, or performance and disciplinary processes other than those imposed under Title 38.

Recommendation #16: Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Problem

Effective planning for and management of human capital are core enabling requirements for any organization. If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

Background

As recognized by GAO, “to attain the highest level of performance and accountability, federal agencies depend on three enablers: people, process, and technology. The most important of these is people, because an agency’s people define its character and its capacity to perform.”⁵⁵³ Human capital management, although often viewed as a cost, must be viewed as an investment in business success.⁵⁵⁴ For too long, VA human capital management has been undervalued and under resourced. A 1993 report from GAO outlined many of the same deficiencies found in 2016: a focus on compliance instead of outcomes, a lack of proactive human capital planning and management, and a weak system of rewards and incentives to attract and retain qualified personnel.⁵⁵⁵

Today, VA Human Resources and Administration (HRA) shares responsibility for human capital management with VHA. Neither organization has been able to establish a high-performing, effective, human capital management system. For VHA to transform to a high-performing organization, human capital management must do the same.

Analysis

VA “needs a fundamental overhaul of the core support functions (including human resources) . . . to increase responsiveness and efficiency and improve customer service. These functions should be aligned with the needs of the VHA organizations delivering care to

The Commission Recommends That . . .

- VHA hire a chief talent leader who holds responsibility for the operation’s entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the CVCS.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.
- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

⁵⁵³ U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders*, GAO/OCG-00-14G, version 1, September 2000, 3, accessed June 10, 2016, <http://www.gao.gov/assets/80/76520.pdf>.

⁵⁵⁴ Ibid.

⁵⁵⁵ U.S. General Accountability Office, *Management of VA: Improved Human Resource Planning Needed to Achieve Strategic Goals*, GAO/HRD-93-10, March 1993, accessed June 10, 2016, <http://www.gao.gov/assets/220/217512.pdf>.

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Veterans.”⁵⁵⁶ Governance and responsibility for human capital management is fragmented and complicated.⁵⁵⁷ Medical center directors appear to be largely on their own in addressing human capital management needs, without competent and timely assistance to support hiring employees, planning for succession, and taking disciplinary actions.⁵⁵⁸ Recruiting takes too long and is cumbersome because information is not shared freely among the various organizational components.⁵⁵⁹ Candidates are not treated with respect, experience lengthy intervals between contacts from VA, fail to receive timely follow-up once candidates are selected, and experience a lengthy on-boarding process.⁵⁶⁰ Human capital management also fails to effectively support the disciplinary process, which is perceived as too long and too difficult.⁵⁶¹ Insufficient resources are devoted to training,⁵⁶² leaving VHA vulnerable to failure.

VA requires a comprehensive redesign of the human resources function to be more responsive, more efficient, and more focused on customer service.⁵⁶³ Transforming HR will require “redesigning key processes, shifting the mindset of [human resources] staff from compliance to effectiveness, training [human resources] and its customers on key roles and responsibilities, and rationalizing its technology systems.”⁵⁶⁴

Some progress has been made in updating human capital management functions. VA is in the process of implementing new talent management software to provide better process management and analytics.⁵⁶⁵ HRA has also started a new HR Academy.⁵⁶⁶ The academy is intended to demonstrate alignment between training resources and competency requirements⁵⁶⁷ and to describe the experience needed to advance to the next position level in human resources.⁵⁶⁸ VA instituted a new online senior executive service performance management system that permits real-time tracking of the performance management process and analysis of

⁵⁵⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁵⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁵⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, L3, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁵⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 109, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁶⁰ *Ibid.*, 110.

⁵⁶¹ *Ibid.*, 61.

⁵⁶² *Ibid.*, 67.

⁵⁶³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, L5, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁶⁴ *Ibid.*

⁵⁶⁵ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁶⁶ *Ibid.*

⁵⁶⁷ Department of Veterans Affairs, HR Academy, *TMS User eIDP Checklist*, accessed January 25, 2016, www.vahracademy.va.gov/docs/TMSUserIDPChecklist.pdf.

⁵⁶⁸ “VA HR Academy: Resources,” Department of Veterans Affairs, accessed January 25, 2016, www.vahracademy.va.gov/resources.asp. Department of Veterans Affairs, *VA HR Competency Model Reference Guide*, accessed January 25, 2016, www.vahracademy.va.gov/docs/VAHRCompetencyModelReferenceGuide.pdf.

performance outcomes;⁵⁶⁹ however, HR specialists must still use as many as 30 different IT systems that do not communicate with each other to do their work.⁵⁷⁰ Although some new systems have been purchased, life cycle funding for them is not guaranteed by the Office of Information and Technology and no concrete plan has been approved to replace and consolidate the many current systems that are not interoperable. In addition, funding support for HRA initiatives overall are not planned, allocated, and maintained at consistent levels year-to-year in the departmental budget, impeding long term transformation.⁵⁷¹

A VHA workgroup was formed with HR subject matter experts and leadership to identify hiring barriers and develop recommendations for improvements. The workgroup fielded a survey in July 2014 to gather broad input from VHA on the deficiencies in the management of human capital in VHA. These experts concluded that VHA should move to a new alternative personnel system under Title 38.⁵⁷² (See Recommendation #15.)

Substantial deficiencies in human capital management still remain in VA. The funding mechanism to support the departments' human capital management does not support long-range planning and effective program implementation. The lines of authority and management for human capital management professionals do not permit consistency in the quality and skill of the human capital management professionals hired and promoted, nor does the reporting structure allow HRA to hold human capital management staff accountable for effective service delivery. The investment in human capital management information technology systems has been inadequate for decades.⁵⁷³

Top leadership, including the SECVA, DEPSECVA, and CVCS, must make the transformation of human resources a top priority as demonstrated by investing their personal time in human capital management transformation; reviewing and endorsing a transformation plan including the funding required to accomplish it; receiving regular progress updates; and engaging in problem-solving sessions with human capital management leaders to refine and advance transformation efforts. Top leadership must demonstrate to other leaders that human capital management transformation is an organizational priority by disseminating clear goals for transformation in planning documents, communicating expectations for change that are clear to all key employees, and sharing successes with subordinate leaders and employees. The CVCS must ensure that the executive who leads the human capital management function has the demonstrated knowledge, skills, and experience in human capital management to competently lead the function and make this individual part of the executive leadership team on par with other key functions like finance and clinical operations. (See suggested organization chart in Recommendation #12.)

⁵⁶⁹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁷⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 24, 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁷¹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁷² Ibid.

⁵⁷³ Ibid.

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The SECVA, DEPSECVA, and CVCS must engage subordinate leaders in the transformation process by ensuring the needs of these leaders have informed the transformation solutions; that subordinate leaders are assigned specific responsibilities under the transformation plan; and they are held accountable by the CVCS for outcomes. They must also ensure that the HR transformation and ongoing HR function is adequately resourced to be successful.

The VA HRA and VHA Workforce Management Office must engage change management experts to undertake a review of human resource business processes, management structures, funding, and technology needs to create a transformation agenda and human capital management plan. As VHA is shifting to a new alternative personnel system under Title 38, the human capital management plan should consolidate in VHA the HR functions, responsibility, and authority required to hire, manage, develop, reward, and discipline staff and consider whether functions such as benefit management remain with HRA or move to VHA. Furthermore, the plan should address all of the following issues:

- need for a chief of talent management
- consistency with benchmark standards of private-sector health care systems
- key organizational structures and roles and responsibilities of VA and VHA in human capital management that are clearly defined and consistent with benchmark organizations
- the full life cycle of human capital management (i.e., planning, recruitment, hiring, retention, development, performance management, and discipline), which should be supported effectively by human capital management and fully meet the needs of managers and staff
- federal sharing authority and the ability to outsource human capital management functions to the private sector are addressed
- IT investments and analytical capability to provide meaningful, timely data to managing staffing, performance tracking, and accountability
- meaningful performance metrics and risk management indicators that are established for human capital management⁵⁷⁴
- funding and full-time equivalent employee staffing for human capital functions that meet private-sector benchmark standards for health care
- knowledge, skills, and ability required of human capital management professionals at each grade and within each series, which should be clearly defined, and a requirement to assess current staff, new hires, and promotions against this standard, which should include procedures for dismissal

⁵⁷⁴ U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders*, GAO/OCG-00-14G, version 1, September 2000, 34, accessed June 10, 2016, <http://www.gao.gov/assets/80/76520.pdf>.

Once completed, this analysis and draft plan must be shared widely within the department to gain feedback and input, and it must be shared with OPM, OMB, and Congress. After incorporating feedback and finalizing the plan, HRA should engage change management experts to fully implement the transformation agenda and new human capital management plan. Implementation will require funding contributions from VA and VHA that the SECVA must mandate.

HRA must develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 Hybrid, Title 38 7306, and SES). This process must include clear standards, guidelines, and training for supervisors and managers on how to implement the new progressive discipline process. All managers and supervisors and human capital management professionals must complete the training, and VA must establish a process for ensuring that new supervisors and managers complete the training on an ongoing basis. HRA must develop HR staff to be effective coaches so they can provide the coaching and support that managers need as they embark on disciplinary procedures to ensure timely and effective interventions.

VHA supervisors and managers must be held accountable for applying these procedures when poor performance or conduct occurs. To enable accountability, VHA must have a technology infrastructure to actively track and manage poor performance (annual ratings and disciplinary actions) that both human capital managers and supervisors can use to keep track of issues.

The Commission notes GAO is launching a comprehensive audit of human capital management functions in VA to be delivered to Congress in September 2016.⁵⁷⁵ The review and resulting recommendations will provide further insights to promote meaningful transformation of human capital management in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Employ HR and change management experts to undertake a review of its business processes, management structures, funding, technology, and the legal authority needed in HR to create a transformation agenda and human capital management plan.
- Require VHA to allocate budget to fully support the change plan and ongoing HR operations.

⁵⁷⁵ Ms. Frieda Stenzel, lead investigator, U.S. Government Accountability Office, during an initial meeting with VACO HR&A about a new study being undertaken by GAO, December 18, 2015. The study is intended to 1) assess VHAs capacity to perform its workforce planning and talent management, and 2) evaluate the effectiveness of VHAs human capital functions.

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- Develop and implement an effective progressive discipline process for all staffing authorities.

Other Department and Agency Administrative Changes

- None required.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

Problem

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

The Commission Recommends That . . .

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an other-than-honorable discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

In some cases, individuals have been dismissed from military service with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury, posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

Background

Veteran status is the basis for eligibility for all VA benefits,⁵⁷⁶ and under law a veteran is a person who has met three criteria: active-duty military service (subject to specified exceptions), 2 years of continuous service, and discharge or separation from the military under conditions other than dishonorable.⁵⁷⁷ The military characterizes discharges into one of five categories: honorable, general (under honorable conditions), OTH, bad conduct (adjudicated by a general court or special court-martial), and dishonorable.⁵⁷⁸

Congress has established specific bars to VA benefits. Those barred by statute include deserters, individuals sentenced by a general court-martial, and conscientious objectors who refused to perform military duty.⁵⁷⁹ VA regulations interpret the phrase "discharged or released . . . under conditions other than dishonorable" to mean that a discharge or release because of one of the following offenses is considered to have been issued under dishonorable conditions:

(1) acceptance of an OTH discharge to escape trial by general court-martial, (2) mutiny or

⁵⁷⁶ Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁷⁷ Veterans Benefits, 38 U.S.C. § 101(2).

⁵⁷⁸ Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁷⁹ Certain Bars to Benefits, 38 U.S.C. § 5303(a).

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spying, (3) an offense involving moral turpitude, (4) willful and persistent misconduct, and (5) certain homosexual acts involving aggravating circumstances.⁵⁸⁰

Limited exceptions to those statutory and regulatory bars permit VA to award of benefits. A claimant may be granted benefits if VA determines that the claimant was insane at the time of the offense leading up to discharge.⁵⁸¹ Benefits may be granted based on a prior period of other-than-dishonorable service for individuals with two or more periods of service.⁵⁸²

Former service members with an OTH discharge as a result of a regulatory (rather than a statutory) bar are eligible for VA care for service-incurred conditions.⁵⁸³ Former service members with OTH discharges are not recognized as veterans, so they will be routinely denied treatment unless they initiate, and prevail in, an adjudication conducted by the Veterans Benefits Administration as to the character of their discharge. No routine mechanism exists to trigger adjudication to determine if such a discharge is not dishonorable. In many instances, the character of an individual's discharge is predicated on behaviors that resulted from, or are linked to, behavioral health conditions that had their origin in service, yet VA regulation bars the individual from receiving benefits.⁵⁸⁴

Analysis

Veterans' benefits are understood to be earned. The principle has been described as follows: In harsh environments in which lives may be on the line, serious breaches of conduct that interfere with the military mission should rightfully brand the offender for life and should likewise prohibit them from being eligible for the special military benefits and entitlements reserved for honorable and meritorious service.⁵⁸⁵

Some argue the offender's mental state at the time of the misconduct must be taken into account when considering veteran status.⁵⁸⁶ For example, many service members have experienced combat and sustained psychological wounds of war that manifest behaviors that lead to military discipline.⁵⁸⁷ VA regulations not only fail to account for the role of those psychic wounds, but are themselves overbroad, weak discriminators as to what is truly dishonorable service. To illustrate, commentators have identified two regulatory bars as particularly problematic: those based on moral turpitude,⁵⁸⁸ and willful and persistent misconduct.⁵⁸⁹ Neither of those two regulatory terms, which originated in 1944,⁵⁹⁰ are defined; neither provides

⁵⁸⁰ Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸¹ Certain Bars to Benefits, 38 U.S.C. § 5303(b).

⁵⁸² Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁸³ Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).

⁵⁸⁴ Certain Bars to Benefits, 38 U.S.C. § 5303(a). Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸⁵ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 12-13, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁸⁶ *Ibid.*, 13.

⁵⁸⁷ *Ibid.*

⁵⁸⁸ Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸⁹ *Ibid.*

⁵⁹⁰ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the

criteria or examples of what is or is not covered. Both are ambiguous and susceptible to subjective judgment,⁵⁹¹ with great potential for different VA regional offices reaching different outcomes on the same facts.⁵⁹² VA officials have acknowledged that these terms are broad and imprecise,⁵⁹³ and advocates have documented the resultant disparities in VA adjudicative decisions.⁵⁹⁴

The only specific mental-health exception to the bar-to-benefits rules — that the person was insane at the time of the commission of offense⁵⁹⁵ — is very limited. VA regulations define the term *insane*, as follows:

*An insane person is one who, while not mentally defective or constitutionally psychopathic, except when a psychosis has been engrafted upon such basis condition, exhibits, due to disease, a more or less prolonged deviation from his normal method of behavior; or who interferes with the peace of society; or who has so departed (become antisocial) from the accepted standards of the community to which by birth and education he belongs as to lack the adaptability to make further adjustments to the social customs of the community in which he resides.*⁵⁹⁶

VA's Office of General Counsel (OGC), in a now almost 20-year old precedential opinion, has construed that regulation narrowly. Responding to a request for an opinion regarding the parameters for behavior that would constitute insanity under the regulation, the General Counsel advised, as follows:

*The question of insanity arises in numerous legal proceedings, and its meaning may vary according to the jurisdiction and the object or purpose of the proceeding. However, in all contexts, the term indicates a condition involving conduct which deviates severely from the social norm. Black's Law Dictionary, at 794, states that '[t]he term is more or less synonymous with . . . psychosis, which itself has been defined as "a mental disorder characterized by gross impairment in reality testing' or, in a more general sense, as a mental disorder in which 'mental functioning is sufficiently impaired as to interfere grossly with the . . . capacity to meet the ordinary demands of life.'*⁵⁹⁷

Armed Forces," *Military Law Review*, 214, Winter, (2012): 160-192, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁹¹ Ibid., 164, 186.

⁵⁹² Ibid., 10, 172. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable*, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁵⁹³ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 67, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁹⁴ Ibid., 68-70.

⁵⁹⁵ Characters of Discharge, 38 C.F.R. 3.12(b).

⁵⁹⁶ Determinations of Insanity, 38 C.F.R. 3.354(a).

⁵⁹⁷ "Office of General Counsel: Opinions Year 1997," U.S. Department of Veterans Affairs, accessed June 15, 2016, <http://www.va.gov/ogc/opinions/1997precedentopinions.asp>. Vet. Aff. Op. Gen Couns. Prec. 20-97, VAOPGCPREC 20-97, 1997, accessed June 15, 2016, <http://www.va.gov/ogc/docs/1997/Prc20-97.doc>.

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As understood by VA OGC at the time, *insanity*, with its emphasis on gross impairment, and as reflected in practice,⁵⁹⁸ is a highly restrictive standard. That narrow standard is also limiting with respect to the range of symptoms that could be considered under the *insanity* exception: gross cognitive impairment or gross impairment in capacity to function in daily life. That limited range effectively excludes behaviors associated with a widely prevalent service-related condition, PTSD. Those behaviors, which often lead to disciplinary actions, include aggressive behavior, substance-abuse,⁵⁹⁹ impulsivity, and risk-taking (including sensation seeking, aggressive driving, interpersonal violence, and self-injurious or suicide-related behavior).⁶⁰⁰ Research has shown that combat veterans with PTSD and other psychiatric diagnoses have a heightened risk of misconduct outcomes.⁶⁰¹ Other than its *insanity* rule, the regulations provide no specific opportunity to consider mental health as a likely cause of, or mitigating factor in, disciplinary issues leading to an individual's discharge.

The following are illustrative examples of how these regulations have worked in practice:

- John, a service member with multiple deployments to Iraq and Afghanistan and 7 years of service, received an OTH discharge after self-medicating with marijuana. He was denied VA treatment for PTSD.⁶⁰²
- Tim, a rifleman with two purple hearts and four campaign ribbons for service in Vietnam, was sent to combat while still 17 years old, and had a nervous breakdown and suicide attempt before his 18th birthday. He was sent back to Vietnam involuntarily for a second tour, and had a third nervous breakdown that led to an AWOL and OTH discharge. He was denied service connection for PTSD because the nature of his discharge.
- Tom, a combat infantryman in the first Gulf War, on his return, started experiencing symptoms of PTSD and attempted suicide. He was denied leave to be with his family,

⁵⁹⁸ Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable,"* accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁵⁹⁹ Deirdre MacManus et al., "Aggressive and Violent Behavior Among Military Personnel Deployed to Iraq and Afghanistan: Prevalence and Link with Deployment and Combat Exposure," *Epidemiologic Reviews*, 37, no. 1, (2015): 196-212, <http://doi.org/10.1093/epirev/mxu006>.

Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, <http://dx.doi.org/10.1186%2F1471-244X-10-88>.

⁶⁰⁰ Lisa M. James, Thad Q. Strom, and Jennie Leskela, "Risk-Taking Behaviors and Impulsivity Among Veterans With and Without PTSD and Mild TBI," *Military Medicine*, 179, no. 4, (2014): 357 – 363, <http://publications.amsus.org/doi/pdf/10.7205/MILMED-D-13-00241>.

⁶⁰¹ Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, <http://dx.doi.org/10.1186%2F1471-244X-10-88>.

⁶⁰² Swords to Plowshares, presentation to Commission on Care, January 21, 2016, accessed June 25, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former service members.

but left anyway. After a 60-day absence, he returned and was given an OTH discharge. He was denied services for 20 years.⁶⁰³

In short, the VA regulation used to determine whether the character of a veteran's OTH discharge is disqualifying does not take into account behavioral health problems associated with military service. As a result, former service members who were discharged for disciplinary problems that cannot be disassociated from PTSD or other behavioral health disorders are routinely barred from VA treatment for those disorders.

Individuals with PTSD and traumatic exposure are at heightened risk of substance abuse,⁶⁰⁴ depression,⁶⁰⁵ homelessness,⁶⁰⁶ premature mortality,⁶⁰⁷ and suicide.⁶⁰⁸ Access to VA health care is vital to successful reintegration of combat-traumatized veterans into society because it provides "the only reservoir of combat PTSD expertise."⁶⁰⁹

The importance of early access to needed treatment for behavioral health conditions like PTSD cannot be overstated,⁶¹⁰ yet many former service members are reluctant to seek treatment for behavioral health problems.⁶¹¹ Those with unfavorable discharge records who finally come forward to seek medical care must not only initiate a request for a character of discharge adjudication, but be prepared to confront a lengthy process if they elect to do so.⁶¹²

⁶⁰³ Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁶⁰⁴ Kipling M. Bohnert et al., "The Association Between Substance Use Disorders and Mortality among a Cohort of Veterans with Posttraumatic Stress Disorder: Variation by Age, Cohort, and Mortality Type," *Drug and Alcohol Dependence*, 128, no. 1-2, (2013): 98-103, <http://www.sciencedirect.com/science/article/pii/S0376871612003328>.

⁶⁰⁵ Leo Sher, Maria Dolores Braquehais, and Miquel Casas, "Posttraumatic Stress Disorder, Depression, and Suicide in Veterans" *Cleveland Clinic Journal of Medicine*, 79, no. 2 (2012): 92-97, <http://doi.org/10.3949/ccjm.79a.11069>.

⁶⁰⁶ Eve B. Carlson et al., "Traumatic Stressor Exposure and Post-Traumatic Symptoms in Homeless Veterans," *Military Medicine*, 178, no. 9, (2013): 970-973, <http://doi.org/10.7205/MILMED-D-13-00080>.

⁶⁰⁷ Joseph A. Boscarino, "Posttraumatic Stress Disorder and Mortality Among U.S. Army Veterans 30 Years After Military Service," *Annals of Epidemiology*, 16, no. 4 (2005): 248-256, <http://www.sciencedirect.com/science/article/pii/S1047279705001109>.

⁶⁰⁸ Holly J. Ramsawh et al., "Risk for Suicidal Behaviors Associated with PTSD, Depression, and their Comorbidity in the U.S. Army," *Journal of Affective Disorders*, 161, no. 1, (2014): 116-122, <http://www.sciencedirect.com/science/article/pii/S0165032714001189>.

⁶⁰⁹ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 14, accessed June 20, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁶¹⁰ Ronald C. Kessler, "Posttraumatic Stress Disorder: The Burden to the Individual and to Society," *Journal of Clinical Psychology*, 5, Suppl. 5, (2000): 4-12, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/10761674>.

⁶¹¹ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶¹² Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable*, 74-78, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

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Several generations of former service members were exposed to combat trauma and continue to live with the psychological wounds of war. Lack of access to treatment for those who sustained psychological wounds that went untreated and were manifest in undesirable behavior in service is concerning. Although Congress could address this concern, VA has the means to remedy the problem without congressional action by amending its own regulations. VA could afford former service members needed treatment for their conditions when they are able to establish that their health problems were incurred in service.⁶¹³ In other circumstances, when it is likely an individual could establish eligibility for VA care, current regulation permits the individual to receive the care on the basis of a tentative eligibility determination.⁶¹⁴ This regulation permits VA to provide treatment without prior adjudication of the character of discharge.

VA should revise its regulations to lift the immediate bar to health care for former service members who have an OTH discharge. VA should award tentative eligibility for health care to at least some former service members who have an OTH discharge. The criteria for awarding tentative eligibility for care could include service in a combat theater, more than a single enlistment, duration of service, or some combination thereof. This approach would allow VA to provide meaningful access to treatment without delay for those likely to be granted eligibility. For health care purposes, VA should also revise its regulations by recognizing that the severe punishment of characterizing a person's service as OTH is not justified when extenuating circumstances (to include behavioral health issues at the time) explain or mitigate that misconduct that resulted in the OTH discharge.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Amend 38 C.F.R. 17.34 to provide for tentative eligibility determinations applicable to individuals with OTH discharges who have had substantial honorable service, including service in a combat theater.
- Amend of 38 C.F.R. 3.12(d) to provide for recognition of extenuating circumstances that show, for purposes of health care eligibility, that service was not OTH.

Other Departments and Agency Administrative Changes

- None required.

⁶¹³ Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).

⁶¹⁴ Tentative Eligibility Determinations, 38 C.F.R. 17.34.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Problem

Although VHA continues to offer the promise of health care to all veterans, its capacity to meet that promise is constrained by appropriated funding.⁶¹⁵ Congress and VA leadership must work to identify who VHA will serve, and what services it will provide, yet eligibility criteria have not been examined in 20 years.⁶¹⁶

Background

VHA's core mission is to care for veterans who has borne the battle. But its secondary mission of caring for veterans' non-service-connected health care needs is longstanding, dating back to Civil War origins. Congress has included veterans without service-connected needs among those eligible as highlighted below:

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use underutilized VHA providers and facilities, providing payment through private insurance.
- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

- In March 1865, Congress incorporated the National Home for Disabled Volunteer Soldiers and Sailors, originally intended for Union veterans who suffered economic distress from disabilities incurred during the Civil War. The National Home constructed the first hospitals for Civil War veterans in 1866, and after a series of acts of Congress, those hospitals were opened in 1887 to veterans suffering economic distress from disabilities not incurred in military service.⁶¹⁷
- The World War Veterans Act of 1924, which established the Veterans Bureau⁶¹⁸ (the predecessor to the Department of Veterans Affairs), authorized its director to provide hospitalization and related travel expenses to veterans whose services dated back as far as 1897, regardless of the type or cause of their disabilities, as long as those veterans who were unable to pay received preferential admission.⁶¹⁹
- Public Law 85-56 (1957), which codified prior VA laws and regulations, effectively expanded eligibility to veterans of future wars, providing needed hospital care for veterans with service-connected disability incurred or aggravated during war, or for any other disability if the veteran is unable to pay for hospital care.⁶²⁰

⁶¹⁵ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶¹⁶ *Ibid.*, 25.

⁶¹⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

⁶¹⁸ The Veterans Bureau consolidated the National Home and other veterans-related functions housed in different government bureaucracies.

⁶¹⁹ World War Veterans Act, 1924, Pub. L. No. 68-242, (1924).

⁶²⁰ Veterans Benefits Act of 1957, Pub. L. No. 85-56, 71 Stat. 83 (1957). That law provided separate authority in section 512 for outpatient medical treatment, which was limited to treatment for a service-connected disability.

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- In 1966, Congress expanded eligibility for hospital care to *peacetime* veterans (of service after January 1955).⁶²¹
- In 1970, Congress extended eligibility for hospital care to veterans 65 and older for a non-service-connected disability,⁶²² exempting that group of veterans from taking the then-required oath affirming their inability to defray the expense of care for non-service-connect ailments.⁶²³
- With the Veterans Health Care Expansion Act of 1973, Congress eliminated the distinction between wartime and peacetime veterans for purposes of eligibility for outpatient care, and further expanded eligibility to outpatient care. It granted veterans who are 80 percent or more service-connected disabled eligibility for treatment of any condition, and authorized others eligible for hospital care to receive outpatient care to prepare for or preclude a need for hospitalization or to complete treatment initiated during hospitalization.⁶²⁴
- Congress expanded eligibility again in 1976, authorizing hospital care for treating a non-service-connected condition of any veteran 65 or older (without regard to ability to pay), authorizing outpatient care for any disability to any veteran 50 percent or more service-connected disabled, and directing VA to ensure, by regulation, special treatment priority to service-connected veterans and others receiving benefits because of a need for aid and attendance, or being permanently housebound.⁶²⁵

Eligibility laws for veterans' health care have changed substantially during the past century, yet the commitment to serving service-connected veterans and veterans in financial need has remained constant.

Prior to enactment of the Veterans' Health Care Eligibility Reform Act of 1996,⁶²⁶ VHA was a hospital-based model with entirely different eligibility rules for hospital care than for outpatient care. The eligibility reform law was aimed at transforming access to VA care from a 1950s hospital-based model to one that erased distinctions between eligibility for hospital and outpatient care.⁶²⁷ It essentially provided that all veterans are eligible for VA hospital care and *medical services*.⁶²⁸

⁶²¹ Veterans Readjustment Benefits Act of 1966, Pub. L. No. 89-358, 80 Stat. 12 (1966).

⁶²² Pub. L. No. 91-500.

⁶²³ S. Rep. No. 91-481.

⁶²⁴ Veterans Health Care Expansion Act of 1973, Pub. L. No. 93-82, 87 Stat. (1973).

⁶²⁵ Veterans Omnibus Health Care Act of 1976, Pub. L. No. 94-581, 90 Stat. 2842 (1976). The patchwork of eligibility provisions resulting from a succession of incremental changes set the stage for development and enactment of the Veterans' Health Care Eligibility Reform Act of 1996, Pub. Law 104-262.

⁶²⁶ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁶²⁷ *Ibid.*

⁶²⁸ The term "medical services" was broadly defined to include in addition to medical examination and treatment, preventive health services; surgical services; wheelchairs, artificial limbs, and similar appliances; optometric and podiatric services; noninstitutional extended care services; and rehabilitative services (including services to restore physical, mental, and psychological functioning. Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C.

§ 1701(6),(8). VA regulations more fully set out the "medical benefits package" that VA is to provide patients, as needed; VA regulations detail that the benefits package includes services ranging from emergency care and prescription drugs to

Recognizing there could be circumstances in which VHA might lack capacity to provide timely care, Congress noted in the reform act that the requirement to provide care would be in effect only to the degree to which there were appropriated funds to pay for such care.⁶²⁹ This qualified availability of care clearly indicated veterans' health care is not an entitlement. Congress went further, though, and established a statutory patient enrollment mechanism for VA to manage access.⁶³⁰ The law specifically requires VA to establish and operate a patient enrollment system managed in accordance with statutory priorities and within any additional priority classifications established by VA. The eligibility reform act gave VA tools both to limit demand consistent with available funding and to discourage veterans from seeking VA care simply to fill an occasional need not met by a private health plan.⁶³¹ The act also requires the SECVA to manage the enrollment system such that care is timely and of acceptable quality.⁶³²

The enrollment system the department established is not being used today to calibrate supply and demand as envisioned.⁶³³ Although law and VA regulation require a system of annual patient enrollment,⁶³⁴ VHA last curtailed enrollment in 2003, and then only for veterans who were deemed eligible based on the category 8 criteria (see Table 8) that include those with higher-level incomes who lack any higher priority. In 2009, the Obama administration eased access for higher income veterans. Under that policy, veterans whose gross household income exceeds VA's current geographic income limit by 10 percent or less may enroll for VA care, subject to cost-sharing requirements.⁶³⁵ In 2014, Congress established the *Choice Program* to expand availability of care through contracts with community providers. Veterans' choice was limited by reference to distance and wait-time issues, but was otherwise broadly open to any enrolled veterans.⁶³⁶

comprehensive rehabilitative services, home health services, noninstitutional extended care services, hospice care, and pregnancy and delivery services and newborn care. Medical Benefits Package, 38 C.F.R. 17.38.

⁶²⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General 38 U.S.C. § 1710(a)(4).

⁶³⁰ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705. As explained in the report of the House Committee on Veterans Affairs which developed the legislation, "[T]he Act would...provide the VA with an important tool, the authority to design and manage access to care through a system of patient enrollment...Enrollment...would help the VA plan more effectively, so that facilities can better calculate and dedicate the resources needed to provide the care its enrollees require. The Act would direct the Secretary...to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment (or registration) system would operate. For example, the VA would be able to establish a system which simply registers patients throughout all or part of a fiscal year, or could employ a time-limited registration period. Significantly, the Act would permit the Secretary to set priorities within the specified priority classifications established in the Act. The Secretary could, for example, establish a policy which, within any priority classification, gives veterans who have previously been "enrolled" as VA patients priority over new applicants. However, the Committee expects any enrollment system to be designed and administered to assure that any veteran with a service-connected condition would receive priority treatment for that condition whether or not that veteran had enrolled for VA care." H. Rep. No.104-690, 6-7.

⁶³¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262; 110 Stat. 3177 (1996).

⁶³² Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705(b).

⁶³³ H. Rep. No. 104-690, 16.

⁶³⁴ Enrollment, 38 C.F.R. sec. 17.36(c). VA regulations state that "[i]t is anticipated that that each year the Secretary will consider whether to change the categories and subcategories of veterans eligible to be enrolled."

⁶³⁵ Enrollment, 38 C.F.R. 17.36(b)(8)(ii),(iv).

⁶³⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014). Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, Pub. L. No. 114-41 (2015).

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Table 8. Priority Groups

Priority Group	Definition
1	<ul style="list-style-type: none"> Veterans with VA-rated service-connected disabilities 50% or more disabling Veterans determined by VA to be unemployable due to service-connected conditions
2	<ul style="list-style-type: none"> Veterans with VA-rated service-connected disabilities 30% or 40% disabling
3	<ul style="list-style-type: none"> Veterans who are former prisoners of war Veterans awarded a Purple Heart medal Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty Veterans with VA-rated service-connected disabilities 10% or 20% disabling Veterans awarded special eligibility classification under Title 38, U.S.C. § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation" Veterans awarded the Medal of Honor
4	<ul style="list-style-type: none"> Veterans who are receiving aid and attendance or housebound benefits from VA Veterans who have been determined by VA to be catastrophically disabled
5	<ul style="list-style-type: none"> Non-service-connected veterans and noncompensable service-connected veterans rated 0% disabled by VA with annual income below VA's and geographically (based on resident zip code) adjusted income limits Veterans receiving VA pension benefits Veterans eligible for Medicaid programs
6	<ul style="list-style-type: none"> Compensable 0% service-connected veterans Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki Project 112/SHAD (shipboard hazard and defense) participants Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975 Veterans of the Persian Gulf War who served between August 2, 1990 and November 11, 1998 *Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987 Veterans who served in a theater of combat operations after November 11, 1998 as follows: <ul style="list-style-type: none"> Currently enrolled veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge. **Combat veterans who were discharged between January 2009 and January 2011, and did not enroll in the VA health care during their five-year period of eligibility have an additional one year to enroll and receive care. The additional one-year eligibility period began February 12, 2015 with the signing of the Clay Hunt Suicide Prevention for America Veterans Act. <p>Note: At the end of this enhanced enrollment priority group placement time period veterans will be assigned to the highest Priority Group (PG) their unique eligibility status at that time qualifies for.</p> <p>*Note: While eligible for PG 6; until system changes are implemented you would be assigned to PG 7 or 8 depending on your income.</p> <p>*Note: While eligible for PG 6; due to system limitations, veterans will be manually assigned to PG 8c, yet eligible for the enhanced benefits</p>
7	<ul style="list-style-type: none"> Veterans with gross household income below the geographically-adjusted income limits for their resident location and who agree to pay copays

Priority Group	Definition
8	<ul style="list-style-type: none"> ▪ Veterans with gross household income above VA and the geographically-adjusted income limits for their resident location and who agrees to pay copays <p>Veterans eligible for enrollment:</p> <p>Noncompensable 0% service-connected:</p> <ul style="list-style-type: none"> – Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA or geographic income limits by 10% or less <p>Non-service-connected and:</p> <ul style="list-style-type: none"> – Subpriority c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority d: Enrolled on or after June 15, 2009, whose income exceeds the current VA or geographic income limits by 10% or less <p>Veterans not eligible for enrollment:</p> <p>Veterans not meeting the criteria above:</p> <ul style="list-style-type: none"> – Subpriority e: Noncompensable 0% service-connected (eligible for care of their service-connected condition only) – Subpriority g: Non service-connected

Analysis

Two decades have passed since Congress last reexamined VHA eligibility and benefits, and many far-reaching changes that affect veterans' health care have occurred in that time. In more than a decade of war, 2.75 million troops have deployed to Iraq and Afghanistan⁶³⁷ where many have faced long and repeated deployments; constant risk of injury and death; and high levels of psychological disorders, substance abuse issues, and physical health problems.⁶³⁸ Post-9/11-era veterans are enrolling for VA care at historically high levels.⁶³⁹

Under current law and VA policy, enrollment is open to a relatively broad spectrum of veterans, though some veterans with higher incomes are not eligible to enroll.⁶⁴⁰ As discussed above, the law draws distinctions between those whose health problems have been adjudicated as service-connected and those whose problems are deemed non-service-connected. If Congress substantially reduced funding for VA medical care, the distinction would be important because those with service-connected issues have higher priority for enrollment. Under VA's current enrollment policy, which bars only veterans with higher incomes from receiving care, the

⁶³⁷ Defense Manpower Data Center, *Contingency Tracking System (CTS) Deployment File*, (Dec. 31, 2015).

⁶³⁸ Institute of Medicine of the National Academies, *Returning Home from Iraq and Afghanistan: Readjustment Needs of Veterans, Service Members, and Their Families*, (Washington, DC: The National Academies Press, 2013), accessed June 25, 2016, <http://www.nationalacademies.org/hmd/Reports/2013/Returning-Home-from-Iraq-and-Afghanistan.aspx>.

⁶³⁹ Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *Profile of Post-9/11 Veterans: 2014*, accessed May 27, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Post_911_Veterans_Profile_2014.pdf.

⁶⁴⁰ Veterans Health Administration, *Enrollment Determinations*, VHA Handbook 1601A.03, 9-10 (2015). Veterans with gross household income that do not exceed VA's means test threshold and a geographic means test by more than 10 percent may enroll for care, while those with higher income and no other special eligibility may not.

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statutory service-connected enrollment priority has little practical significance.⁶⁴¹ Future budget constraints could result in more restrictive enrollment criteria⁶⁴² or recurrence of lengthy wait times that hinder service-connected, disabled veterans' ability to receive timely care.

Current eligibility law does afford special status to veterans who deployed to a combat theater. It grants a 5-year window of eligibility for care to those veterans who are not otherwise eligible.⁶⁴³ All combat veterans are also eligible for readjustment counseling services at VHA Vet Centers without needing to enroll in VHA care and without time limitation.⁶⁴⁴ It is questionable, however, if the 5-year time limit takes sufficient account of continued reluctance of some veterans to seek care for behavioral health problems⁶⁴⁵ or of the difficulties of establishing service-connection years later for conditions that may be linked to wartime exposures to toxic substances.⁶⁴⁶ It is challenging for veterans to establish service-connection for health conditions that may have been caused by or associated with a long-distant exposure for which there may be no documentation. Given emerging evidence that combat exposure should be considered a risk factor for coronary heart disease,⁶⁴⁷ it has been suggested that combat exposure may not only take a toll on psychological health, but may exert a physiologic toll as well.⁶⁴⁸

Congress has attempted to remedy the challenge of documenting toxic exposures and establishing that particular illnesses are linked to wartime or other service exposure. It has, for example, enacted statutes that provide certain veterans eligibility for health care on the presumption that they were exposed to particular toxic substances.⁶⁴⁹ Congress went a step further in the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 which provided eligibility for care for several types of cancer and other specified conditions for family members of veterans who had been exposed to drinking water contaminated with industrial solvents and other toxic chemicals at the Marine Corp base.⁶⁵⁰

Congress has made only limited provision for VA to cover care for family members of certain veterans,⁶⁵¹ but with research suggesting that long combat deployments can take a

⁶⁴¹ Prior to 1996, provisions of law required VA to ensure special priority to service-connected veterans in furnishing outpatient care. 38 U.S.C. § 1712(i), repealed by § 101(c), Pub. L. No. 104-262.

⁶⁴² Enrollment, 38 C.F.R. 17.36(c)(1).

⁶⁴³ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(3), as amended by Sec. 7, Pub. L. No. 114-2 (2015), accessed June 20, 2016, <https://www.govtrack.us/congress/bills/114/hr203/text>.

⁶⁴⁴ Readjustment Counseling Service, 38 U.S.C. § 7309.

⁶⁴⁵ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶⁴⁶ Matthew S. King et al., "Constrictive Bronchiolitis in Soldiers Returning from Iraq and Afghanistan," *New England Journal of Medicine*, 365, no. 10 (2011): 222-230, accessed June 20, 2016, <http://doi.org/10.1056/NEJMoa1101388>.

⁶⁴⁷ Nancy F. Crum-Cianflone et. al., "Impact of Combat Deployment and Posttraumatic Stress Disorder on Newly Reported Coronary Heart Disease Among US Active Duty and Reserve Forces," *Circulation*, 129, (2014), accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.113.005407>.

⁶⁴⁸ Rachel Lampert, "Veterans of Combat: Still at Risk When the Battle is Over," *Circulation*, 129, (2014): 1797-1798, accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.114.009286>.

⁶⁴⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(10).

⁶⁵⁰ Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Pub. L. No. 112-154, 126 Stat. 1165 (2012).

⁶⁵¹ Health Care of Persons Other Than Veterans, 38 U.S.C. §§ 1781-1787.

psychological toll on family members,⁶⁵² there may be circumstances under which it might be argued that VA should afford such family members behavioral health services. Studies indicate that longer deployments, deployment extensions, and posttraumatic stress disorder in military personnel are associated with psychological problems for the spouse.⁶⁵³ Long-term effects are unknown, yet studies suggest children may have heightened risk for psychosocial issues during a parent's deployment.⁶⁵⁴

The experience of the nation's longest war and increased options available under the Affordable Care Act (ACA), particularly to previously uninsured non-service-connected veterans, may raise new questions for policymakers.⁶⁵⁵ VHA's most recent survey of enrollees showed that 20 percent of enrollees reported that they were uninsured, down from 22 percent in 2014.⁶⁵⁶ Enrollment in VHA-provided care meets the ACA requirement for health care coverage, creating pressure to continue to provide care to those enrolled.⁶⁵⁷ Given that VHA serves large numbers who are poor or near poor and have chronic medical conditions and behavioral health problems,⁶⁵⁸ it is important to note that receiving care under an ACA plan would not necessarily be a substitute for the rich benefits afforded through VHA. In addition, adults in this population are only eligible for coverage under ACA through state expansion of Medicaid that 19 states have elected not to accept, making this option unavailable to poor or near poor veterans in many parts of the country.⁶⁵⁹

Over time Congress has expanded VA health care eligibility to increasingly more cohorts of non-service-connected veterans. There is wide variability among different cohorts in the extent to which veterans rely on VA care. Those at the higher-income levels (priority categories 7 and 8) who were generally not eligible for ambulatory care prior to 1996, for example, rely on VA for

⁶⁵² Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, accessed June 20, 2016, <http://dx.doi.org/10.1186%2F1471-244X-10-88>. Swords to Plowshares, presentation to Commission on Care, January 21, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former servicemembers. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁶⁵³ H. Thomas De Burgh et al., "The Impact of Deployment to Iraq or Afghanistan on Partners and Wives of Military Personnel," *International Review of Psychiatry*, 23, no. 2 (2011): 192-200, <http://www.ncbi.nlm.nih.gov/pubmed/21521089>.

⁶⁵⁴ Gregory H. Gorman, Matilde Eide, and Elizabeth Hisle-Gorman, accessed June 20, 2016, "Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints," *Pediatrics*, 126, no. 6 (2010): 1058-1066, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-2856>. Anita Chandra et al., "Children on the Homefront: The Experience of Children from Military Families," *Pediatrics*, 125, no. 1 (2010): 16-25, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-1180>.

⁶⁵⁵ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁶ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁵⁷ "Affordable Care Act & Veterans," Department of Veterans Affairs, accessed May 27, 2016, <http://explore.va.gov/health-care-affordable-care-act?show=all>.

⁶⁵⁸ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁹ "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update," Rachel Garfield and Anthony Damico, Kaiser Family Foundation, accessed March 29, 2016, <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/>.

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less than 22 percent of their outpatient care-needs, based on VA's most recent survey of veteran enrollees' health and use of care.⁶⁶⁰

One consideration, as suggested by a few Commissioners, is the feasibility of allowing veterans' family members and currently ineligible veterans to purchase VHA care through their health plans in areas where VHA hospitals and other facilities might otherwise need to close. In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. A related challenge is maintaining safe volume of care when patient loads decline. As an extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁶¹ Similarly, VHA may be unable to continue offer specialty care in certain areas if it forced to close facilities. Patients in a polytrauma unit for example, require a full spectrum of routine and nonroutine health care.

Closing a low-volume hospital may be the answer in some instances. But closing VHA facilities reduces the choices available to veterans. Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. See Appendix C for a further discussion of the challenge of future VHA hospital closures and an outline of suggested pilot programs.

Substantial changes have occurred since Congress last comprehensively examined eligibility for VHA care. These changes merit a reexamination of VA health care eligibility.⁶⁶² The Commission did not, however, view its charge of examining veterans' access and how best to organize VHA, locate health care resources, and deliver care in the years ahead⁶⁶³ as calling for it to make recommendations on this fundamental policy issue, and recommends that the President or Congress consider tasking another body to develop recommendations for VA care eligibility and benefit design. The Commission's work, however, has illuminated the fact that nothing in law or regulation assures a service-connected, disabled veteran of priority for care. VA can and should amend its regulations to provide for such priority, subject to a necessarily higher priority for urgent and emergent care.

Implementation

Legislative Changes

- Task another body to examine the need for changing eligibility for VA care and benefits design, which would include simplifying eligibility criteria, and may include exploring

⁶⁶⁰ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 75, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁶¹ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

⁶⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 25, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶⁶³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

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pilots for expanding eligibility for nonveterans to use underutilized providers and facilities when paid for through private insurance.

VA Administrative Changes

- SECVA should amend 38 C.F.R., chapter 17 to establish that veterans with service-connected disabilities shall be afforded priority for access to care, subject to the priority dictated by clinical care needs.

Other Departments and Agency Administrative Changes

- None required.

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APPENDIX A: FINANCING THE VISION AND MODEL

Estimating the Cost of Alternative Policy Proposals

This chapter presents estimates of the costs of allowing veterans access to expanded community care through integrated networks, as well as a range of other options. In the *Recommended Option*, the one chosen by the Commission and described in Recommendation #1, veterans would be eligible to receive community care for primary and standard specialty care with a referral from any primary care doctor in the VHA Care System. Special emphasis care, care provided in a distinctive fashion by VHA, is not included in community networks.

In addition to the *Recommended Option*, we considered three alternatives that are based on a similar concept of integrated networks, but which have potential costs that could vary dramatically due to differences in the openness of access to community care and the breadth of services eligible. We also estimated the costs of three options that differ in focus from the integrated network options, including options that move selected services entirely to the community, set up a premium support model, and expand access to all Priority 8 veterans. Finally, we estimated costs for two additional policies: expanding nurse navigator/care coordinator staff to help guide and coordinate veterans' care in the integrated networks of expanded community care and granting temporary eligibility for VA health care to those with other-than-honorable discharges.

Baseline Projections

We used projections from the Enrollee Health Care Projection Model (EHCPM) produced by VHA and Milliman as the baseline upon which to build our estimates. However, with the exception of the options involving premium support and an expansion of Priority 8 enrollment, we use separate analyses and not the EHCPM to derive the estimates. Costs of VA care are modeled as the product of utilization and cost per unit of care (unit cost). Utilization is dependent on both enrollment in, and reliance on, the VA health care system, total demand for health care, and other factors. Enrollment measures how many people enroll to receive VA health care, and reliance is the percentage of their medical care that enrollees receive through VA or VA-financed community care. Unit costs measure the cost of each health care service. Unit costs can be calculated for care in VA facilities, for care outside of VA facilities, or for both, depending on the scenario being estimated.

Utilization

Utilization depends on enrollment, reliance, total demand for health care, and characteristics of the health care system, such as medical technology and practice patterns. We discuss enrollment and reliance in further detail below, but overall demand for health care is similarly important. Enrollment, reliance, and overall demand each have a multiplicative effect on

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utilization and total costs. For example, if enrollment increases by 10 percent, costs will increase by 10 percent (assuming new enrollees have the same characteristics as existing enrollees). Thus, it is important to consider carefully the effect of any policy change on enrollment, reliance, and overall demand for health care. Each of these factors is subject to effects by policies that make care more convenient, less expensive, or less restricted.

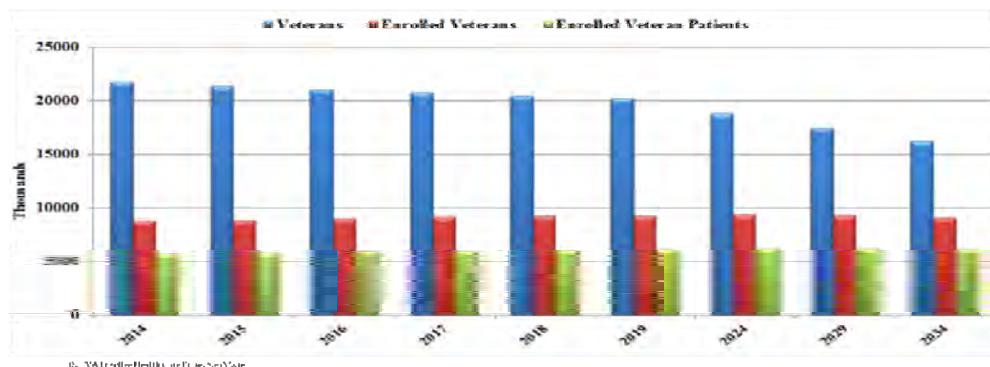
Enrollment

Currently there are 22 million veterans, 9 million of whom have enrolled and 7 million of whom are eligible to enroll but have not done so. Even though the number of veterans is decreasing, projected numbers of enrollees and patients should remain relatively stable during the next 20 years. Younger veterans enroll at particularly high rates, and once enrolled, they remain continuously enrolled until death.

This enrollment trend is subject to change based on various inputs. Enrollment rates are projected based on current policy, and if policy changes, the number of enrollees and patients will change. For example, an increase in cost sharing would likely decrease enrollment and the number of patients, yet easing access to care would likely increase enrollment and the number of patients. Changes to other health insurance policies outside of VA can also affect enrollment and the number of patients (for example, changes to the Affordable Care Act).

Figure A-1. Changes in Number of Veterans, Enrollees over a 20-year Period

Veterans, Enrollees, and Patients FY 2014-2034



Reliance

On average, enrolled veterans receive 34 percent of their health care through VHA, and approximately 80 percent of enrollees have other health insurance in addition to VA health care. Many factors affect reliance rates including, age, income, service-connected disabilities, distance from VA facilities, cost-sharing levels, and characteristics of other insurance options. Any policy that affects the cost of receiving VA care, the convenience of receiving VA care, the cost or convenience of other health insurance held by enrollees, or demographic or health characteristics of enrollees, is likely to change reliance. Any increase in reliance will increase

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costs to VHA, and the effect can be very large. In the absence of a policy change, VHA predicts that reliance will decline slightly from 34 percent to 32 percent during the next 20 years.

Unit Cost

Unit cost measures how much a particular service, procedure, or drug costs to provide. Unit costs can measure the cost of the unit of care in the VHA system or in the community, depending on where veterans receive care. We used unit cost projections from the EHCPM for 78 Health Care Service Categories (HSCs). The unit of measurement depends on the service. Examples include office visits, pathology procedures, vision exams, and inpatient surgical days. Unit cost projections reflect anticipated changes in price inflation and health care practice patterns, as well as historical trends. EHCPM projects separate unit costs, depending on whether veterans receive a service in a VA facility, in the community at historic Care in the Community (CITC) rates, or in the community at Medicare allowable rates. Any policy that affects the quantity of care provided in VA facilities, as opposed to the community, will have an effect on the total cost of care. If veterans receive care in the community, the rate of provider reimbursement will also affect costs.

Baseline Cost Projections

The baseline cost projections, produced by the EHCPM, show how cost will change in the future. They incorporate projected changes in enrollment, reliance, unit costs, and other factors. The projections reflect current policy with regard to enrollment eligibility and VA health care benefits, with the exception of the *Choice Program*, which is assumed to continue for veterans living more than 40 miles away from a VA medical care facility.⁶⁶⁴

We based the projections on assumptions about inflation and anticipated effects of changes in health care practice on the cost of VA health care in the next 20 years. New military conflicts, policies, legislation, regulations, and external factors, such as economic recession, can occur and change projected demand for VA health care during this period. The projections do not include requirements for several activities/programs not projected by the VA EHCPM, including nonrecurring maintenance; readjustment counseling; state-based, long-term services and support programs; and some components of the CHAMPVA program.

In the absence of any policy changes, costs increase from \$53 billion in 2014 to \$125 billion in 2032. This growth is largely due to inflation and how health care practices are expected to change over time, which reflects factors that affect the cost of both VA and non-VA health care. These trends increase the cost of VA health care regardless of changes in enrollment growth and demographics. Within enrollment, the increasing number of enrollees adjudicated for service-connected disabilities by the Veterans Benefit Administration (VBA) is the most significant driver of cost increases. Enrollees will likely increase their reliance to reflect the substantially higher reliance of enrollees in the service-connected Priorities 1-3.

These baseline estimates, along with our scenario estimates presented below, carry some key limitations. First, the EHCPM does not track capacity at VA facilities. We assume health care

⁶⁶⁴ Veterans qualifying based on wait times or excessive travel burdens are not included.

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utilization will increase or decrease at the average unit cost, when in fact it is the marginal cost that would be relevant for cost estimates. This marginal cost could be smaller or larger than the average cost, depending on existing capacity. Although we did make some assumptions about fixed and variable unit costs when care leaves VA facilities in our policy estimates below, precise estimates are not possible given data availability. Second, the EHCPM does not consider health care capacity in local communities. For these and other reasons, the EHCPM is best for the near future and for policy scenarios that do not stray dramatically from current policy. A 2008 RAND review of the EHCPM highlighted these limitations, which are particularly important for analyzing policy changes such as expanded community care.⁶⁶⁵ In light of the types of policy choices VHA is likely to consider in the future, it would be particularly beneficial for VHA to collect and incorporate the data necessary to mitigate these limitations. Due both to these limitations and to the general uncertainty regarding any long-term changes in the health care system, we suggest focusing attention on the 2019 estimates of the scenarios below, as 2019 is the first year to incorporate the fully phased-in effects of the scenarios.

Policy Estimates

In this section, we present results for the *Recommended Option* and three alternative options for expanding access to providers outside of VA through integrated networks. These options expand community care for different categories of care and vary by whether referrals are required to receive specialty care. We present estimates for several other scenarios we examined, each with a design or focus that differs from the integrated network options. Finally, we estimate costs for two other policies discussed in this report: (1) expanding the use of nurse navigators to help patients coordinate their care in VA and in the community, and (2) expanding eligibility to all veterans with an other-than-honorable (OTH) discharge until the adjudication process is complete to determine whether they will remain eligible.

Community-Delivered Services Networks

This section describes the *Recommended Option* and the first three alternative options. At least initially, all care currently provided by VA would continue to be provided by VA. In addition, expanded community care, also called Community-Delivered Services (CDS), will be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA. CDS will focus on tertiary and quaternary care, and may include primary care and all standard specialty care, depending on the scenario considered. CDS will not include special-emphasis care and some types of specialty care provided in a distinctive fashion by VHA. The network of CDS providers that VA will coordinate varies by community. To make the flow of service both appropriate and smooth in operation, there will be navigators who will help guide veterans to the best and most appropriate providers inside and outside VA.

The Commission's recommendation to create the VHA Care System (see p. X) considers the ways in which health plans can vary the size and scope of networks as a means of managing costs. It highlights that broad, open networks offer greater choice, but narrow, well-managed

⁶⁶⁵ Katherine M. Harris, James P. Galasso, and Christine Eibner, "Review and Evaluation of the Enrollee Health Care Projection Model," RAND Corporation, Santa Monica, CA, 2008.

networks potentially result in lower costs. It discusses ways in which, after networks are designed, VHA could exercise additional cost controls by steering patients to different providers within the networks. Finally, the recommendation regarding the VHA Care System emphasizes that access and local needs are important considerations in setting up the integrated networks, and that governance of the networks should be a process of ongoing management and evaluation.

In the estimates that follow, we assume that networks are designed and governed in a way that gives major consideration to cost, choice, and access. We assume that management of the integrated networks would be an iterative process that involves continual evaluation of resulting outcomes, including cost outcomes, and that networks would be adjusted in light of those outcomes. We also assume that local communities and services with poor access would require more community providers and/or expanded capacity within VHA than those that already have adequate access. Finally, we assume that the networks will be integrated, relatively narrow, and well-managed with the aim of controlling costs effectively. One exception is that for the *Recommended Option*, we added an estimate that assumes less-managed, broader networks to illustrate that costs are sensitive to network size and management.

Technical Assumptions for Community-Delivered Services Options

We based our estimates on utilization and unit cost data and projections for 78 HSCs that we obtained from the VHA Office of Policy and Planning. Starting from a base year of 2014, we projected utilization and unit costs through 2034. For HSCs that are eligible for CDS networks, we assume a certain fraction of care, depending on the option, shifts from VA facilities to the networks. We assume traditional CITC will be offered and used at baseline levels.⁶⁶⁶ We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks. All effects are phased in during the first 5 years.

Both CDS networks and CITC are priced at Medicare allowable rates by matching Medicare fee schedule data to VA HSCs.⁶⁶⁷ A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities.

For care shifting into the CDS networks, we use data on the components of HSC unit costs that we obtained from the VA Allocation Resource Center. We assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. These portions, which together averaged approximately 10 percent of care in 2014, form our proxy for the portion of unit costs that VA will not be able to shed in scenarios for which, on net, care leaves VA facilities for CDS networks. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance. These costs are not part of the EHCPM, and costs and/or savings associated with changes to facilities and nonrecurring maintenance are not included in our estimates.

⁶⁶⁶ CITC accounted for approximately 11 percent of modeled expenditures in the base year 2014.

⁶⁶⁷ Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

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Improving access, choice, and/or quality of services is likely to induce greater reliance and enrollment in the VA system. Although reliance and enrollment increases result in greater budgetary costs for VA, it is important to note that these increases do not represent societal costs or costs to the government. The VA budgetary cost increases may be associated with reductions in out-of-pocket expenses and improved health care benefits for patients, as well as savings to Medicare, Medicaid, and other government programs. Our cost estimates are confined solely to the VA budget.

Approximately 52 percent of eligible veterans have enrolled in VA health care, and enrolled veterans receive 34 percent of health care through VA. There is little data from which to anticipate how reliance and enrollment might change under the scenarios, and our estimates use wide ranges of assumptions for these parameters. In forming our assumptions, we consider a variety of factors, such as insurance coverage and other characteristics of eligible veterans (both enrolled and unenrolled), survey responses of veterans (both enrolled and unenrolled) on use and reasons for lack of use of VA health care, and research on take-up of health insurance coverage.⁶⁶⁸ We are confident that enrollment and reliance would increase more with greater patient choice and access. For all options, we present low, middle, and high estimates.

In addition to increases in reliance and enrollment, reduced cost sharing, increased convenience of receiving community care, and the removal of a requirement to get a referral for specialty care can increase the total amount of medical care that a patient receives. Depending on the option considered, some health care is subject to reduced cost sharing from levels typical of private insurance coverage and Medicare to the very small levels of cost sharing found in the VA system. We assume utilization increases for health care subject to lower cost sharing and/or removal of a requirement to get a referral, with our estimates based in part on the literature examining how cost sharing affects health care demand.⁶⁶⁹

Caveats

There are a number of caveats associated with all of our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. New enrollees are assumed to cost slightly less than existing enrollees for *CDS Alternative 3* and the

⁶⁶⁸ Examples of sources include: the 2014 American Community Survey; the 2010 National Survey of Veterans; the 2015 Survey of Veteran Enrollees' Health and Use of Health Care; Katherine Baicker, William J. Congdon and Sendhil Mullainathan, "Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics," *The Milbank Quarterly*, 90(1) (2012), 107-134.

⁶⁶⁹ Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," Washington, DC, 2008. Willard G. Manning, Joseph P. Newhouse, Naihua Duan, Emmett B. Keeler, Arleen Leibowitz, and M. Susan Marquis, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review* 77(3) (1987), 251-77.

same as existing enrollees in the *Recommended Option* and *CDS Alternatives 1 and 2*.⁶⁷⁰ Finally, we do not estimate any administrative costs associated with CDS networks other than the additional RN care managers hired to handle the increased clinical and administrative burden of expanded community care. These additional, nonmodeled administrative costs could be substantial.

Commission Recommended Option

The *Recommended Option* would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA or a third-party administrator. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in VA in a distinct fashion).⁶⁷¹ In 2014, 68 percent of care would have been eligible for CDS networks at current VA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network. In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a doctor in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and 20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was

⁶⁷⁰ Assumptions based on previous analysis by VHA and Milliman.

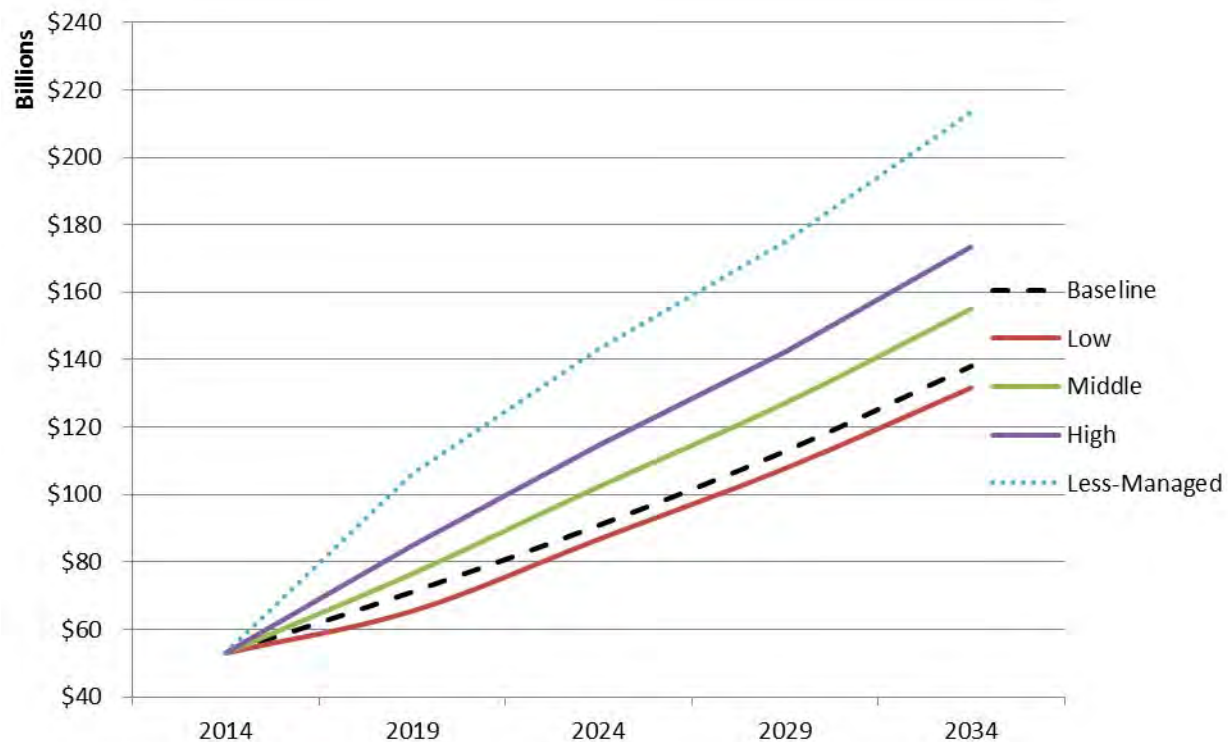
⁶⁷¹ Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

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formerly subject to sizable cost sharing with private insurance or Medicare, and now it would be subject to little if any cost sharing associated with VA-financed care.

Figure A-2 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from \$65 billion to \$85 billion in 2019, with a middle estimate of \$76 billion. The middle estimate is moderately above the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is \$106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

Figure A-2. Projected Costs of Recommended Option



APPENDIX A

FINANCING THE VISION AND MODEL

COST ESTIMATES Commission on Care Scenarios							
	Brief Description	Utilization Increase	Enrollment Increase (low, middle, high)	Reliance (low, middle, high)	Cost FY 2014 Actual (billions)	Cost FY 2019 Projected (billions)	Cost FY 2034 Projected (billions)
Baseline	2014 Actual		9,078,615	34%	\$53	\$ 71	\$ 138
Recommended (low)	Referral Based Care in VHCS (68% of current VHA care eligible as CDS)	+20% of new demand in CDS Care	5%	40%	\$	65	\$ 132
Recommended (middle)	same	same	15%	50%	\$	76	\$ 155
Recommended (high)	same	same	20%	60%	\$	85	\$ 173
Recommended (less-managed)	same	same	50%	60%	\$	106	\$ 213
Alternative 1 (low)	Similar to Recommended but primary care, inpatient med and surg and some standard specialty care not eligible for CDS remain in VHA (47% of care eligible for CDS)	+20% of new demand in CDS Care	0%	10%	\$	66	\$ 128
Alternative 1 (middle)	same	same	5%	35%	\$	73	\$ 140
Alternative 1 (high)	same	same	10%	50%	\$	78	\$ 151
Alternative 2 (low)	Similar to Alternative 1 but primary care coordinator must only be consulted; no referral required (47% of care eligible for CDS)	+20% CDS eligible Care	5%	60%	\$	97	\$ 191
Alternative 2 (middle)	same	same	10%	80%	\$	123	\$ 243
Alternative 2 (high)	same	same	20%	100%	\$	154	\$ 307
Alternative 3 (low)	Similar to Alternative 2 but primary care, inpatient med/surg and specialty care eligible for CDS and no consult required	+20% CDS eligible Care	75% (level)	80%	\$	167	\$ 320
Alternative 3 (middle)	same	same	85% (level)	90%	\$	206	\$ 395
Alternative 3 (high)	same	same	95% (level)	100%	\$	250	\$ 479
Keep Selected Services (low)	Move most standard ambulatory specialty care to community	+20% of new demand in CDS Care	0%	10%	\$	64	\$ 128
Keep Selected Services (middle)	same	same	4%	25%	\$	70	\$ 136
Keep Selected Services (high)	same	same	8%	40%	\$	75	\$ 145
Premium Support	Enrollees under age 65 can choose a subsidized insurance premium with cost sharing in lieu of VHA care	42% of enrollees <65 choose premium support	6%		\$	82	\$ 158
Eligibility Expansion	Allow all eligible veterans to enroll	increase to 30% market share among priority 8	5%		\$	72	\$ 140
Initiatives	Nurse navigators for CDS care				\$	71	\$ 138
	Make veterans with Other than Honorable Discharges Temporarily Eligible for VA Health Care While Claims are Adjudicated				\$	72	\$ 139

Additional Sample Cost Models

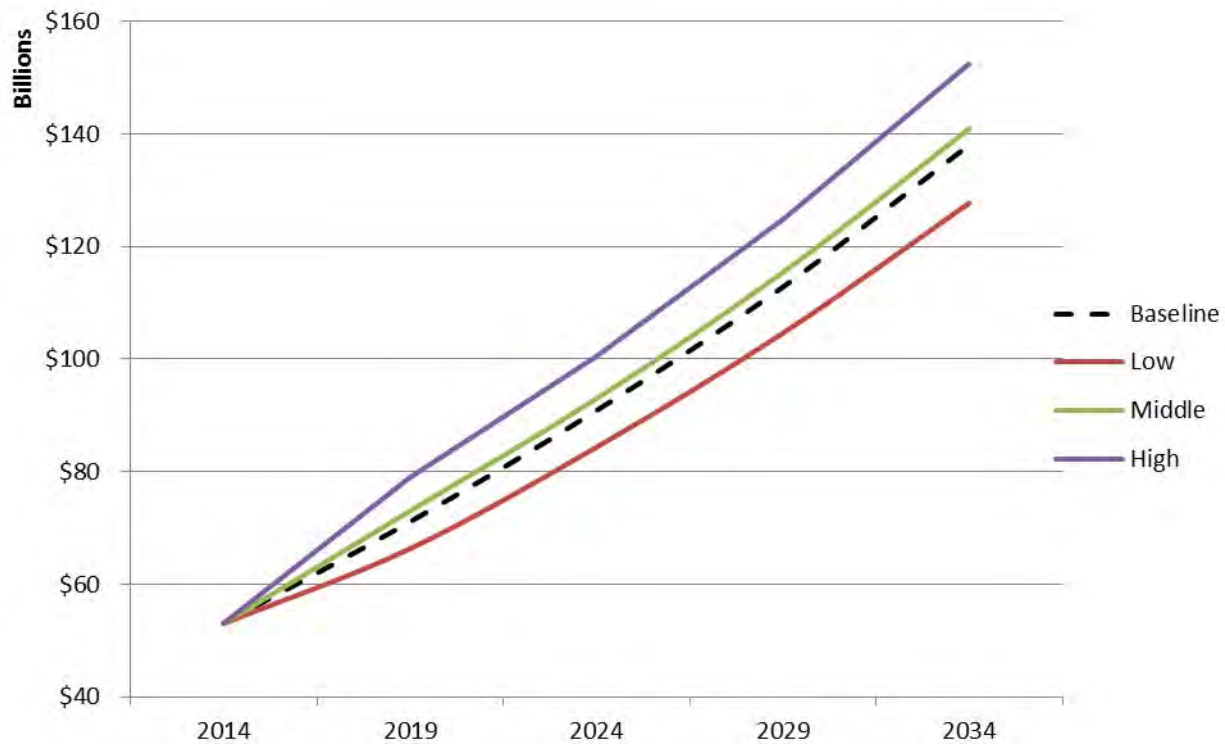
CDS Alternative 1

CDS Alternative 1 is similar to the Commission's *Recommended Option* above. The main difference is that a narrower subset of services is available in the CDS networks. Primary care, inpatient medical and surgical care, and some standard specialty care are not eligible for CDS networks and must be accessed within VA. The CDS network for *CDS Alternative 1* would focus on tertiary and quaternary care; it would not include primary care, some specialty care, inpatient medical and surgical care, and special-emphasis care (care that is provided in VA in a distinct fashion). In 2014, 47 percent of care would have been eligible for CDS networks.

Because less care is eligible for CDS networks than in the *Recommended Option*, less care will shift to CDS networks, reliance increases will be smaller, and enrollment increases will be smaller. We assumed that 50 percent of eligible care shifts from VA facilities to CDS networks. We modeled increases in reliance of 10, 35, and 50 percent, which correspond to reliance rates of approximately 37, 46, and 51 percent. These reliance increases pertain only to CDS care, not CDS-eligible care provided in VA facilities. We modeled enrollment increases of 0, 5, and 10 percent. As in the *Recommended Option*, we assume newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks.

Figure A-3 displays estimates for CDS Alternative 1. Estimates range from \$66 billion to \$78 billion in 2019, with a middle estimate of \$73 billion. As in the *Recommended Option*, the middle estimate is close to the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to Medicare allowable rates for CDS networks and CITC offsets these effects.

Figure A-3. Projected Costs of CDS Alternative 1



CDS Alternative 2

Like *CDS Alternative 1*, CDS care in *Alternative 2* would focus on tertiary and quaternary care. CDS networks would not include primary care, special-emphasis care, inpatient medical and surgical care, and some types of specialty care.

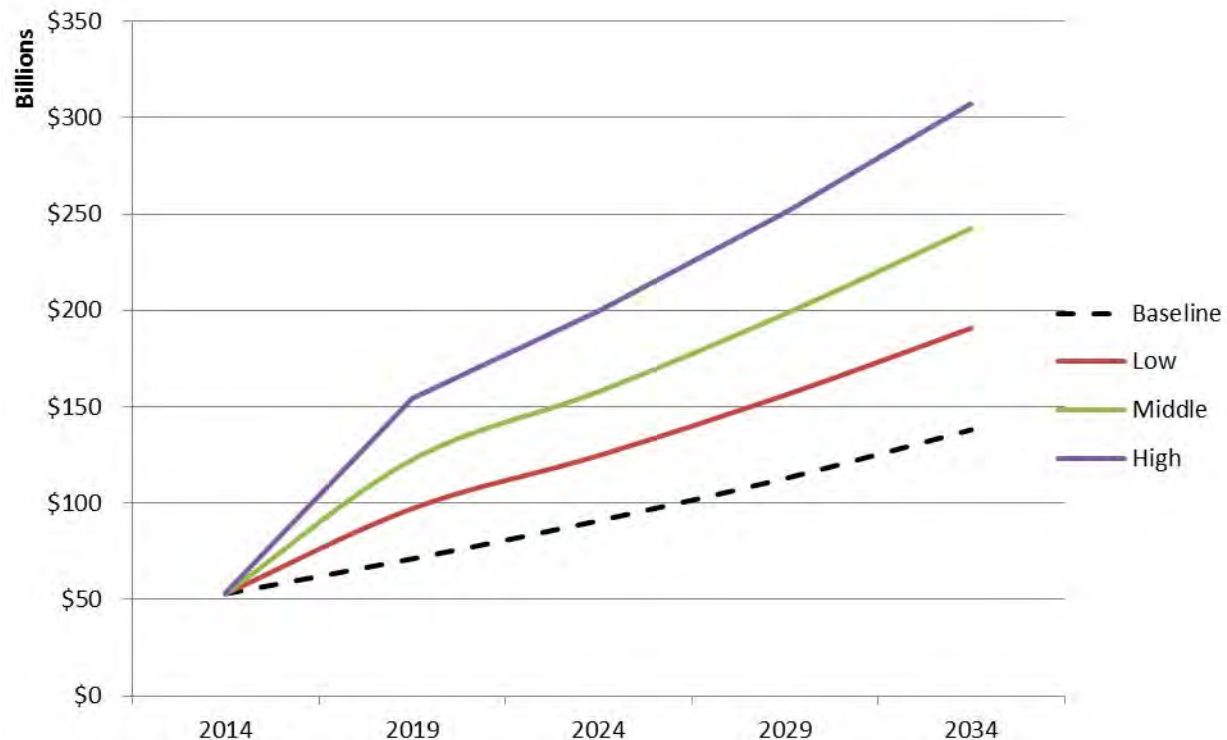
This option differs from the *Recommended Option* and *CDS Alternative 1* in that veterans must consult their VHA primary care provider in some way before seeking specialty care, but they *do not* need a referral to receive CDS eligible care whether they receive it in or out of VA. Some specialty care, all primary care, and all special-emphasis care are only provided in VA unless the veteran is eligible for traditional CITC. However, after the primary care consultation, the choice of whether to seek eligible care in CDS networks is entirely up to the veteran. As in *CDS Alternative 2*, the care eligible for CDS networks comprised 47 percent of total modeled expenditures in 2014.

We expect reliance increases to be relatively high, and we apply these reliance increases to CDS eligible care regardless of where veterans receive it because referrals are not required for any CDS eligible care. Further, we expect enrollment increases to be higher than the *Recommended Option* and *CDS Alternative 1* because the absence of a referral requirement makes this a more attractive policy for potential enrollees. We model reliance rates of 60, 80, and 100 percent for care eligible for CDS networks; enrollment increases of 5, 10, and 20 percent; 70 percent of VA facility care shifting into CDS networks; and a 20 percent utilization increase for CDS eligible care.

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Estimates are displayed in Figure A-4. In 2019, the baseline projection is \$71 billion. *CDS Alternative 2* estimates range from \$97 billion to \$154 billion, with a middle estimate of \$123 billion. The potential for considerable reliance and enrollment increases could push costs substantially higher than the baseline.

Figure A-4. Projected Costs of CDS Alternative 2



CDS Alternative 3

CDS Alternative 3 differs from *Alternative 2* in two main ways. First, a broader array of care is eligible for CDS networks. CDS would include primary and standard specialty care, including inpatient medical and surgical care. It would not include special-emphasis care (care that is provided in VA in a distinct fashion). This array of eligible care is the same as that for the *Recommended Option*, and comprised 68 percent of total modeled expenditures in 2014. Second, enrollees do not need to consult with a primary care doctor in order to access CDS eligible care.

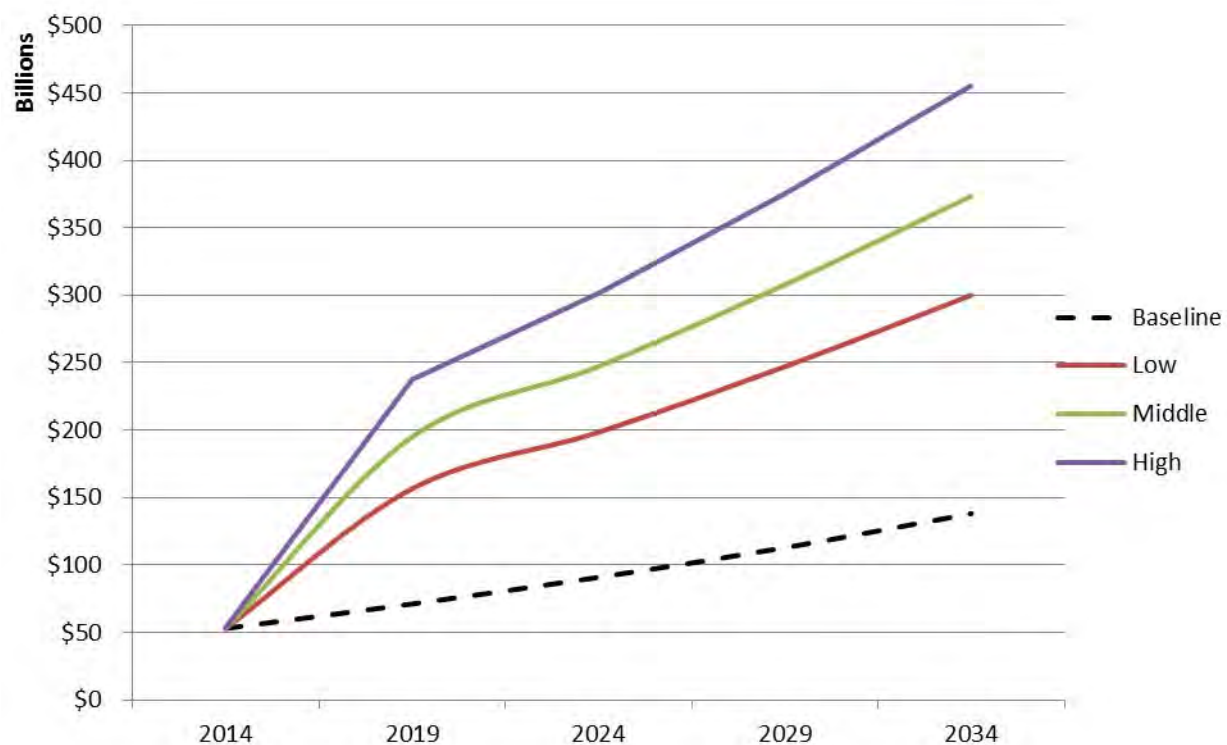
CDS Alternative 3 would offer an extremely generous benefits package for patients. With no referral or consultation, no premiums, and little if any copayments, patients would have access to a robust network of high-quality providers in their area. Although care within VA facilities would be available, no clinical contact would be necessary for those seeking care in CDS networks. Even within VA facilities, care is more attractive because patients would no longer need to consult their primary care doctors to receive specialty care. The benefits of this option contrast with the 10 to 30 percent cost sharing typical in Medicare and private coverage, the low

provider reimbursements, stigma and access barriers often associated with Medicaid,⁶⁷² and the requirements for referrals and/or prior authorizations that are widespread among health insurance plans. Few veterans would have reason to turn down such an attractive option.

Consequently, we model high ranges for reliance, enrollment, and care shifting into CDS networks. We model reliance rates of 80, 90, and 100 percent for all CDS eligible care; enrollment shares of 75, 85, and 95 percent; and a 70-percent rate of eligible care shifting from VA facilities to CDS networks. We apply the reliance increases to all care eligible for CDS networks, even if the care is provided in VA facilities or traditional CITC, because this option eliminates the need for consultations with primary care doctors for all CDS eligible care. Additionally, we assume that the total amount of CDS eligible care received by veterans from any provider and payer increases by 20 percent due to the lack of a referral requirement and/or reduced cost sharing.

Estimates are displayed in Figure A-5. In 2019, when effects are fully phased-in, estimated costs range from \$156 billion to \$237 billion, with a middle estimate of \$195 billion. This compares to a baseline projection of \$71 billion. Although estimates are highly uncertain, a key takeaway is that this option could result in very large cost increases relative to the baseline scenario, *Recommended Option*, and *CDS Alternatives 1 and 2*.

Figure A-5. Projected Costs of CDS Alternative 3



⁶⁷² Yu-Chu Shen and Stephen Zuckerman, "The Effect of Medicaid Payment Generosity on Access and Use among Beneficiaries," *Health Services Research* 40, no. 3 (2005), 723-44. Jennifer Stuber and Karl Kronebusch, "Stigma and Other Determinants of Participation in TANF and Medicaid," *Journal of Policy Analysis and Management* 23, no. 3 (2004), 509-530.

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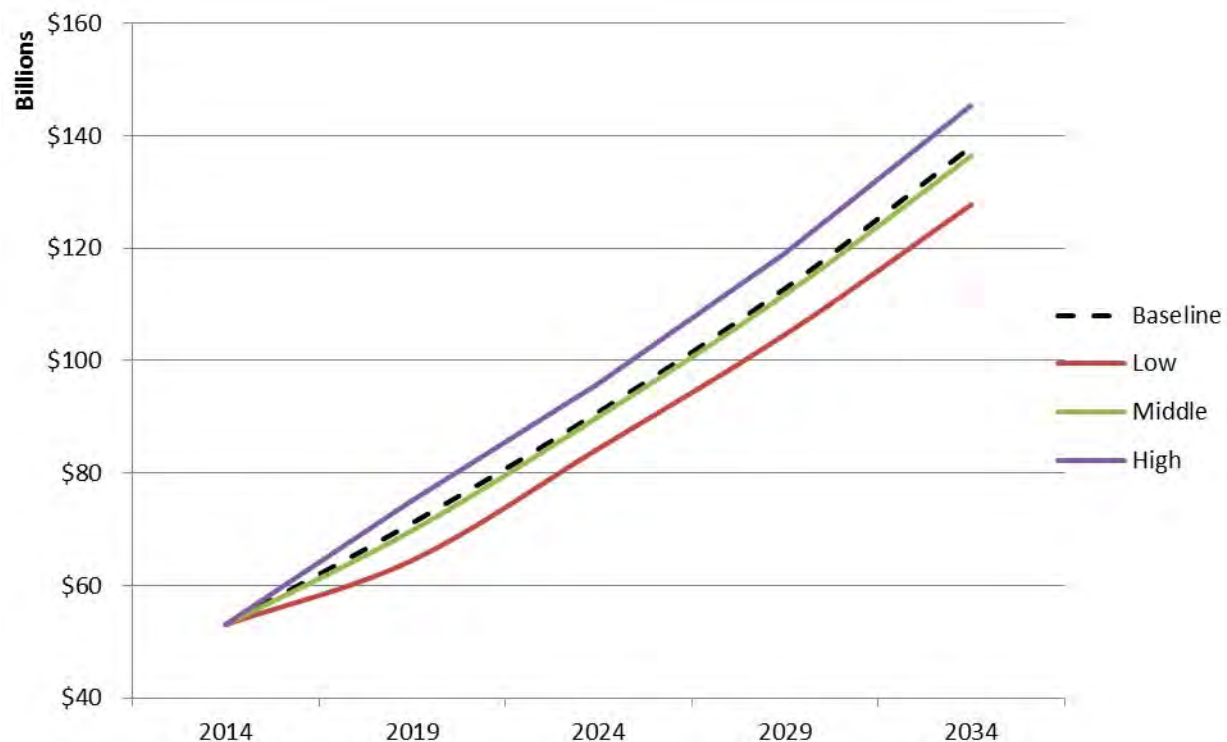
Keep Selected Services

The *Keep Selected Services (KSS)* scenario would move most standard ambulatory specialty care entirely into the community, yet keep the remainder of care entirely within VA facilities or traditional CITC. Although VA would no longer provide most standard ambulatory specialty care in VA facilities, it would continue to provide primary care, inpatient care, and special-emphasis care in VA facilities, including long term services and supports, prosthetics and orthotics services, inpatient and outpatient mental health and substance abuse, inpatient medical and surgical care, prescription drugs, medication management, recreational therapy, and immunizations. Under this scenario, approximately 35 percent of the cost of care currently provided in VA would be provided solely in the community. Providers in the community would receive Medicare rates.

We modeled increases in reliance of 10, 25, and 40 percent, which correspond to reliance rates of approximately 37, 43, and 48 percent. These reliance increases pertain only to care that moves into the community. We modeled enrollment increases of 0, 4, and 8 percent.

Estimates are displayed in Figure A-6. In 2019, when effects are fully phased-in, estimated costs range from \$64 billion to \$75 billion, with a middle estimate of \$70 billion. This estimate compares to a baseline projection of \$71 billion. Although estimates are highly uncertain, a key takeaway is that even with expanded community care, cost increases are constrained when veterans cannot choose whether they receive care in VA facilities or in the community.

Figure A-6. Projected Costs of Keep Selected Services Scenario



Premium Support⁶⁷³

Under the *Premium Support* (PS) scenario, all current and future enrollees younger than age 65 can choose a subsidized insurance premium with cost sharing (for some priorities) in lieu of their current VHA benefit. Enrollees electing the premium and cost sharing subsidy no longer have access to any VA services, including the special services VA offers. Under this scenario, there is an annual election period, and VA actively engages with enrollees to make a decision. Enrollees ages 65 and older receive no additional benefit options.

For those enrollees choosing the subsidized insurance program, the cost sharing varies by priority level: 10 percent for priorities 1 and 2; 20 percent for priorities 3 and 4; 30 percent for priorities 5 and 6; and 40 percent for priorities 7 and 8. Veterans would buy *Silver* policies on the state individual insurance exchanges, and VA would provide additional cost sharing assistance to meet the target subsidy. If enrollees purchased plans offered with lower cost sharing, such as *Gold* (20 percent cost sharing) or *Platinum* plans (10 percent cost sharing), the additional premium costs would likely exceed the cost of purchasing a Silver plan and subsidizing the cost sharing. The cost estimates did not consider the potential effect of adding a large number of veterans on exchange plans. Were VA to do this, considerations for veteran morbidity as well as the proposed cost sharing subsidies would need to be accounted for within the purchase of state exchange plans from commercial insurers.

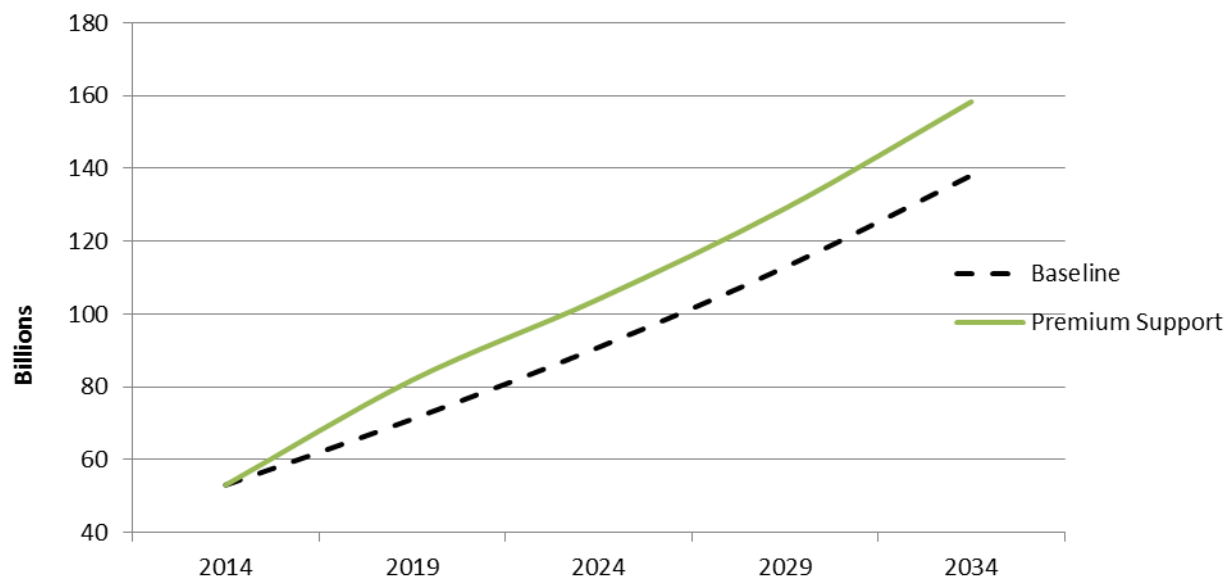
To determine participation rates in the subsidized premium program, we summarized enrollees' FY 2014 baseline data into cost brackets by attaching 2015 EHCPM unit costs to workload and then summarizing the total cost of workload provided to each enrollee. Overall, 42 percent of enrollees younger than age 65 were assumed to select the subsidized premium option, but the model assigned different rates of participation depending on enrollees' priority level and historical VA utilization. Enrollees with little to no costs were assumed to participate in the program at a higher rate as compared to those who had larger levels of VA costs. Participation rates for priority 5 veterans were assumed to be half the rates set for other priority levels. This assumption was made because many of these lower-income enrollees already have the option of participating in a highly subsidized state exchange plan with low cost sharing. It is also assumed that offering this option will motivate additional nonenrolled veterans to enroll to receive the subsidized premium plan. To estimate this effect, we analyzed the proportion of veterans by priority level with either no insurance or individual insurance plans, as reported in recent years of data captured by the American Community Survey (ACS). We estimated that this potential subsidy would lead to an additional 577,000 enrollees over the projection period.

Finally, it is assumed that the subsidized premium plan serves as a primary payer and does not supplement other coverage available to the enrollee, such as Medicare or employer sponsored insurance.

⁶⁷³ Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.

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Figure A-7. Projected Costs of Premium Support Scenario



Eligibility Expansion⁶⁷⁴

Under the *Eligibility Expansion* (EE) scenario, the VA health care system expands to allow all veterans to enroll in VA health care. In 2014, half of veterans eligible under priorities 1-7, 8b,⁶⁷⁵ and 8d were enrolled, representing a 50 percent *market share*,⁶⁷⁶ with the highest market share among those with service-connected priorities. The market share among Priorities 8a and 8c was an estimated 21 percent, reflecting enrollment from before suspension began in January 2003 and from enrollees who initially enrolled in another priority and later transitioned to Priorities 8a and 8c. If the suspension of new priority 8 enrollment had never occurred, we estimate that the market share would be 28 percent in 2014 and 30 percent in 2021 under natural growth and priority transition rates.

Under a scenario of lifting priority 8 enrollment suspension beginning in FY 2017, we estimate that the market share would climb steadily during a 5-year phase-in period to reach 30 percent in 2021, which equates to 464,000 new priority 8 enrollees. The market share is not expected to reach the level observed among other priorities because Priority 8 veterans have higher incomes, are not service-connected disabled, are more likely to have employer-sponsored coverage and individually purchased health plans, and are less likely to be uninsured relative to other priorities. Further, regression analysis of market shares among veterans in census data demonstrated that higher income veterans, nondisabled veterans and veterans with employer-sponsored health insurance are all less likely to enroll. To develop the cost estimates, newly

⁶⁷⁴ Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.

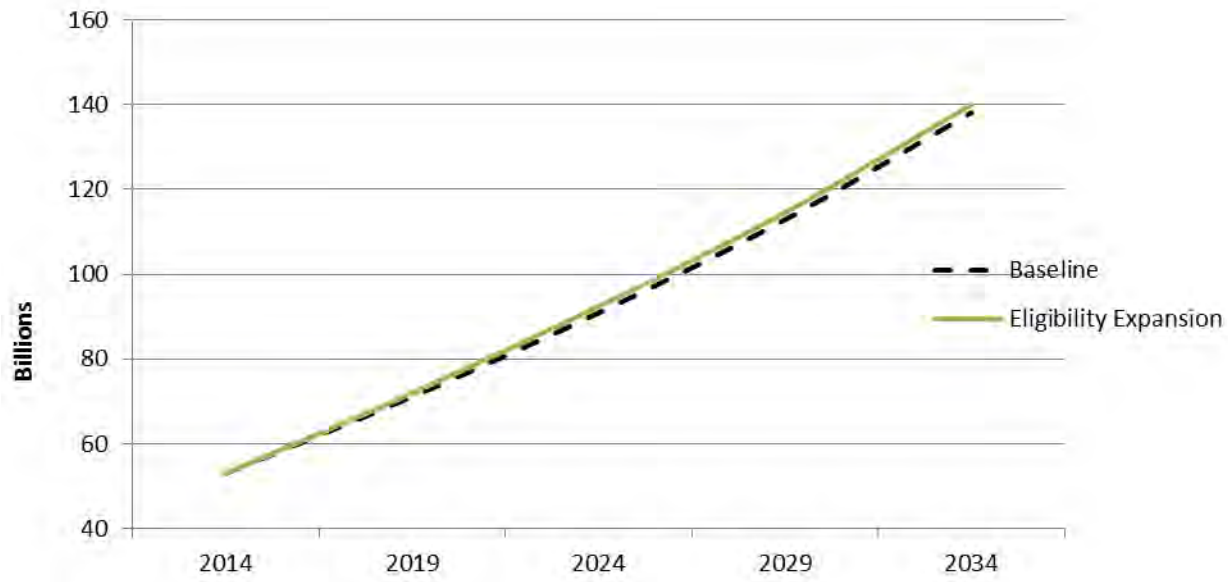
⁶⁷⁵ Priority 8b and 8d were enrolled on or after June 15, 2009 and have incomes that exceed the current VA or geographic income limits by 10 percent or less.

⁶⁷⁶ Market share is the percentage of veterans who are enrolled in VHA out of all veterans. This differs from the enrollment share, which is the percentage of eligible enrollees who are enrolled.

eligible priority 8 veterans are assumed to have the same morbidity and reliance as current priority 8 enrollees.

By 2032, based on the estimated market share, we project an additional 368,000 priority 8 enrollees with an additional \$1.8 billion in costs.

Figure A-8. Projected Costs of Eligibility Expansion Scenario



Additional Cost Factors

Nurse Navigators

VHA already has a robust care manager program that largely overlaps with the proposed nurse navigators in the CDS scenarios. VHA patient aligned care teams (PACTs) were created to coordinate care and maintain long-term relationships with patients. Most PACTs exist in a primary care setting, but there are also special-emphasis PACTs, such as those for spinal cord injury and disorders, geriatrics, and HIV care. All patients may choose to be assigned to a primary care PACT, and the vast majority do so: There are approximately 5.3 million unique patients in primary care PACTs out of a total of 5.8 million.

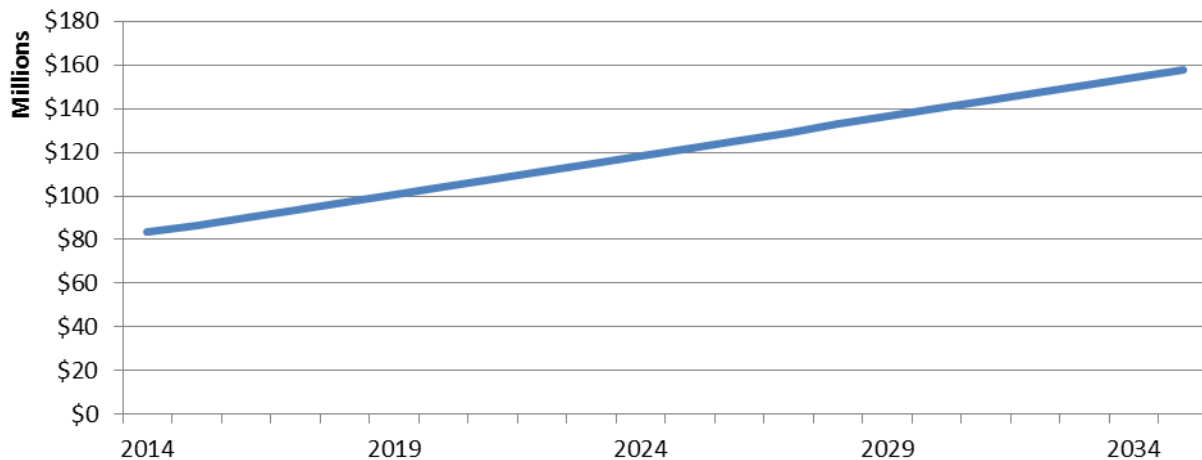
The primary care PACT typically consists of a provider, an RN care manager, a clinical associate, and a clerk. This team is assigned to a panel of approximately 1,200 patients. There are also expanded team members who are assigned to multiple panels, such as clinical pharmacy specialists, nutritionists, and behavioral health professionals. The RN care manager is the lynchpin of the primary care PACT.

One of the tasks of the care manager is to coordinate care received in VHA facilities with care received in the community. Because this coordination role would increase with the CDS scenarios, we provide a notional estimate for expanding the number of care managers to account for the additional administrative and clinical burden of an increase in community care.

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Based on discussions with VHA primary care operations and policy staff, we assume that one additional RN care manager per five panels would be necessary to handle a substantial increase in community care such as that associated with the CDS scenarios.⁶⁷⁷ Based on 2014 data on the number of patients in PACTs and the recommended panel size, we estimate that 882 RN care managers would need to be hired if the CDS scenarios were fully phased in. Incorporating the average total compensation of RN care managers (\$94.4 thousand in FY 2014) and inflating costs using the projected patient population and personnel inflation trend from the EHCPM, we generate the following cost estimates. These estimates are assumed to be fully phased in. The cost of this policy is \$100 million in 2019 and rises to \$158 million in 2034.

Figure A-9. Cost of Hiring Additional RN Care Managers



Other-than-Honorable Discharges

We also consider a policy for which those with an OTH discharge are made temporarily eligible for VA health care while their claims are adjudicated. The adjudication process would determine whether these individuals would remain eligible for care or would lose eligibility. Adjudication would be based on the reason for the discharge. For example, if the discharge were due to behavior associated with a mental health condition caused by serving in the military, that person would likely be positively adjudicated. However, the specific criteria for adjudicating cases still needs to be determined.

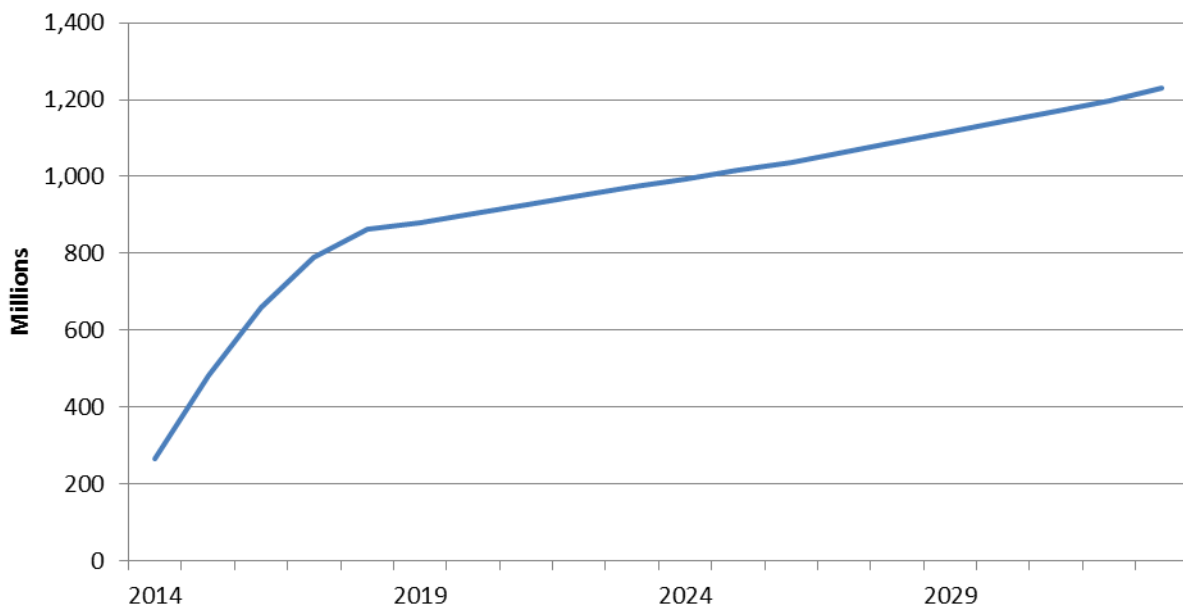
To model the cost of this proposal, we assume all people with an OTH discharge who would otherwise be eligible for VHA care are initially eligible. We assume that, consistent with the rest of the population, 73 percent of veterans with an OTH discharge are eligible for VA health care based on income and disability criteria. During a period of 5 years, their cases are examined, and 50 percent are positively adjudicated. Whether this number is actually higher or lower than 50 percent will depend on the exact details of the policy as well as the specific circumstances of veterans with an OTH discharge. In our model, the number of eligible veterans with an OTH discharge who enroll increases during the first 5 years as they become aware of the new rules. It

⁶⁷⁷ These estimates would differ depending on the CDS option pursued, but we provide a single notional estimate to give a sense of the magnitude of costs involved.

increases to 52 percent, which is the enrollment share of veterans who are currently eligible. In reality, this rate could be higher or lower for those with an OTH discharge if they are different from those who are already eligible. We assume costs per patient are similar to other veterans of the same age.

The cost of this policy increases from \$264 million in 2014 to \$1.23 billion in 2033. Fully phased-in, the cost is \$864 million in 2019. The shape of the cost curve reflects increasing enrollment during the first 5 years as veterans learn about the new rule and sign up. It also reflects adjudications as all enrolled veterans are initially eligible and then their eligibility is adjudicated during the 5 years. These calculations reflect estimates that the number of veterans with an OTH discharge for active duty military has fallen from a high of 8.8 percent in 2002 to 2.1 percent in 2015. We assume that the rate continues at 2.1 percent of discharges throughout the projection window.

Figure A-10. Projected Costs of Temporarily Covering Veterans with OTH Discharges



Conclusion

The estimated cost of allowing veterans to receive expanded community care through integrated networks varies dramatically depending on the specifics of the policy, including which categories of care are eligible for the community and whether referrals are required to access specialty care. We estimate that the *Recommended Option*, which provides increased community care that is reimbursed at Medicare allowable rates but maintains referrals for specialty care, increases costs modestly, assuming that networks are narrow and well-managed with cost as a major consideration. *CDS Alternative 1*, which offers a more restricted array of services eligible for CDS care, yet maintains a referral requirement, does not substantially increase costs. However, *CDS Alternative 3* and to a lesser degree *Alternative 2*, which eliminate the need for referrals for standard specialty care, potentially lead to very high costs. The estimated costs of the other scenarios range from small to substantial, though these costs would

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ultimately depend on the details of the proposals (e.g., the premium support schedule). Finally, we find that the costs of introducing expanded nurse navigators/care coordinators and making those with OTH discharge temporarily eligible are comparatively modest.

APPENDIX B: LEADERSHIP IMPLEMENTATION

Table B-1. Organizational Health and Cultural Transformation

Action	Responsible	Timeline
That VHA create a comprehensive, coordinated, sustainable cultural transformation effort by aligning programs and activities around a single, benchmarked concept.		
Establish the charter for the cross-functional SE team responsible for cultural transformation.	SECVA/DEPSECVA or CVCS depending on level	Now (0-6 mos)
Assess cultural transformation models and decide on a single model.	Chartered SE team	Now (0-6 mos)
Create an execution strategy for cultural transformation.	Chartered SE team	Now (0-6 mos)
Develop communication strategy and materials and release.	Chartered SE team	Near (18 mos)
That VHA aligns leaders at all levels in support of the cultural transformation strategy.		
Establish a subcommittee under the SE team to drive leadership transformation.	Chartered SE team	Near (6 mos)
Establish leadership standards for behaviors and actions.	Chartered SE team Subcommittee	Near (6-9 mos)
Publicize the standard.	Chartered SE team Subcommittee/CVCS/HTM	Near (12 mos)
Develop assessment tools.	SE Subcommittee/NCOD, NCEHC, HTM	Near (12-24 mos)
Establish expectations (in policy) for use of leadership standards in IDPs, performance review, hiring, promotions.	HTM/CVCS	Near (12-36 mos)
Provide coaching to the standard.	(Current HCM office responsible)	Near (24 mos)
Collect standards, training, support materials into a living curriculum for leaders.	EES/HTM	Near (24 mos)
Modify VA Directive 5021 (Employee/Management Relations) to include unacceptable behavior and unacceptable performance standards related to organizational transformation responsibilities of leaders and update table of penalties to correspond.	HRA/HTM	Future (36 mos)
That VHA align frontline staff in support of the cultural transformation strategy.		
Establish subcommittee to support staff transformation.	Chartered SE team	Near (9 mos)
Establish behavioral expectations/requirements for staff.	Subcommittee	Near (9-18 mos)
Develop hiring tools against the staff standard.	Subcommittee	Near (18-36 mos)
Establish requirements (in policy) for use of the standard for IDP, performance reviews, advancement in grade/promotions.	HTM/HRA/nursing and similar/unions	Near (18-36 mos)

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Action	Responsible	Timeline
Support leaders and supervisors at all levels of the organization to communicate and reinforce these standards with staff (see align leaders, above).	(Policy owner)	Near (18 mos)
Establish program office and VAMC standards and strategy for execution.		
Establish subcommittee to develop VAMC and PO execution standards.	Chartered SE team	Near (18 mos)
Establish execution strategy and policy requirements.	Chartered SE team Subcommittee/NCEHC/ NCOD	Near (18-36 mos)
Develop consolidated, meaningful metrics with input from experts and field users.		
Assign responsibility for metric development.	Chartered SE team/CVCS	Near (6 mos)
Develop and test metrics.	Organizational Excellence	Near (6-18 mos)
Deploy metrics.	Chartered SE team/CVCS/ (policy owner)	Near (18 mos)
Identify outliers and intervene.	SE team/CVCS/(policy owner)	Near (24 mos)

APPENDIX B
LEADERSHIP IMPLEMENTATION

Table B-2. Recruitment, Retention, Development, and Advancement

Action	Responsible	Timeline
VHA executives are required to make the leadership system a top priority for funding, strategic planning, and investment of their own time and attention.		
Establish a VHA leadership management goal for inclusion in the 2018 budget with specific targets, including diversity targets.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (3 mos)
Submit the leadership management goal to VA for inclusion in the budget submission for 2018.	VHA OPP and CVCS	Now (3 mos)
Adopt VHA leadership management goal and submit to OMB/White House.	VA OPP and SECVA	Now (3 mos)
Establish an operational plan and accountability mechanisms for meeting these goals.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (4 mos)
Include yearly targets in the performance plan of the CVCS and SES members.	VHA NLC subcommittee on performance planning	Now (4 mos)
Schedule regular communication (at least quarterly) to the field that speaks to mission, vision, values, and expectations for ethical behavior.	CVCS	Now – ongoing
Schedule regular meetings with VHACO and field senior staff that allows for a discussion of mission, vision, values and expectations for ethical behavior.	CVCS	Now – ongoing
Develop opportunities for developing leaders to participate in the leadership and management decisions and processes of VHA.	CVCS /ask NLC executive committee to develop and implement a plan	Now (6 mos)
Adopt and implement a comprehensive system for leadership development and management.		
Convene a group to review ACHE and the National Center for Health Care Executives and devise a benchmarked model that meets the needs of health care executives in VHA as well as the private sector.	NCEHC with NCOD, & Human Capital Management; report to the NLC subcommittee for leadership development	Now (6 mos)
Create career tracks for key positions based on this new competency model.	HTM	Near (within 12 mos)
Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.		
Develop assessment tools (360, 180, self-assessment, supervisory) to support the competency model.	HTM with support as required from other offices, e.g., NCOD, EES	Near (within 18 mos)
Assess existing training against the model and identify gaps.	EES	Near (18 mos)
Develop and implement a plan to fill these gaps.	EES/reporting to NLC to ensure funding	Near (plan 20 mos – fill gaps 36 mos depending on \$)

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Action	Responsible	Timeline
Assess opportunities to share additional leadership training with DoD and create a plan to implement it.	HEC/JEC	Near (9 mos)
Develop and fund a face-to-face training to fulfill competencies for critical career positions.	EES	Near (24 mos)
Develop a masters level training program for clinical leaders in partnership with academic medicine.	EES/Academic Affiliations	Near (36 mos)
Establish sharing agreements with non-profit institutions to permit the exchange of executives for extended rotations.	EES/Academic Affiliations	Near (18 mos)
Create an experiential learning program to parallel the competency model.	EES, HTM reporting to the leadership development subcommittee of the NLC	Near (24 mos)
Establish a coaching program.	HTM/EES	Near (18 mos)
Incorporate tracking of competency assessment, training, coaching, and IDP completion into an appropriate IT platform (e.g., TMS).	HRA/EES/Workforce Management and Consulting	Near (18 mos)
VHA is required to aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: all hires and promotions are required to demonstrate these competencies.		
Create functional statements for all key positions based on the competency model.	HTM	Near (18 mos)
Create interview questions incorporating competencies for all key positions.	HTM	Near (12 mos)
Establish a process for certifying internal candidates for advancement to the next position.	Human Capital Management	Near (18 mos)
Incorporate the tracking of competency achievement with performance ratings and create a tracking mechanisms and pool of high potential candidates.	Human Capital Management	Near (18 mos)
Create regulatory requirements for the use of the competency model in hiring, promotion, development opportunities, and discipline; and incorporate procedures for veterans preferences.	Human Capital Management in VHA	Near (36 mos)
Establish an IDIQ, PBA or similar contract for executive recruitment.	Human Capital Management	Now (6 mos)
Establish requirement in policy for all ECF, SES / SES equivalent to complete IDP.	Human Capital Management	Future (following regulatory change)
Create on-ramp for retiring MTF.	Human Capital Management / DoD Coordination	Now (6 mos)
Expand (GHATP) program.	EES	Now (6 mos)
Establish a plan for developing and managing the candidate pool.	NLC subcommittee for leadership	Now (6 mos)
Require a formal on boarding process for leaders at all levels that re-enforces the leadership competency model.		
Establish an onboarding curriculum and process.	Human Capital Management, EES, HTM	Now and Near (18 mos)

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APPENDIX B
LEADERSHIP IMPLEMENTATION

Action	Responsible	Timeline
VHA is required to take immediate steps to stabilize the continuity of leadership.		
Extend authority for length of details and ability to compete for the detail position.	Human Capital Management	Now (6 mos)
Establish and fund assistant level positions in all key career development tracks.	CVCS	Now (18 mos)

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Table B-3. Organizational Structure and Function

Action	Responsible	Timeline
Eliminate duplication within VHA and consolidate program offices to create a flat structure.		
Eliminate the duplication of functions between VHA and VA by closing VHA offices.		
Create innovative organizational structures to support clinical delivery that are aligned to patient's needs rather than professional silos.		
Undertake a reduction-in-force (RIF) in VHACO that promotes delayering and efficiency in communication and decision making.		
Publish a new organizational chart consistent with Figure 9.	CVCS	Now (1 mos)
Prepare an initial RIF for offices eliminated.	VHA Human Capital Management	Now (3 mos)
Engage VERC (or other resources with expertise in business process reengineering) to re-design the processes and structures with remaining offices to ensure end-to-end support for field function and to further reduce duplication; including clinical function re-organization.	Transformation Office/ VERC	Near (3-12 mos)
Each program office in collaboration with VERC or other transformation resources identifies areas of "stop work" with staffing and budget savings.	Transformation Office/ PO/ CVCS	Near (3-12 mos)
Publish clear roles, responsibilities and expectations that apply to all VHACO offices.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VHACO staff to the new expectations for the role of VHACO.	Transformation Office/ EES	Now (1 mos)
Develop training curriculum to support VHACO staff in developing the skills and competencies required.	Transformation Office/ EES	Near (18 mos)
Develop an engagement strategy to inspire VHACO staff to embrace their new role and tie to in-service training roll out.	Transformation Office/ CVCS	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VHACO employees.	Transformation Office/ EES	Now (6 mos)
Adopt customer service training in VHACO and roll it out; include as part of new employee on-boarding in VHACO.	Transformation Office/ EES	Near (12 mos)
Draft basic competencies for VHACO program staff (e.g., customer service, quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ Each PO	Near (18 mos)
Acquire, configure, and train PO staff on data analytics infrastructure to support program office and field tracking of key performance metrics.	Office of Organizational Excellence/OIT	Near (18 mos)

APPENDIX B
LEADERSHIP IMPLEMENTATION

Action	Responsible	Timeline
Clarify and specifically define the roles and responsibilities of the VISNs and facilities, pushing decision making down to the lowest level.		
Publish clear roles, responsibilities and expectations that apply to the VISNs.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VISN staff to the new expectations for the role of VISN.	Transformation Office/ EES	Now (1 mos)
Develop an engagement strategy to inspire VISN staff to embrace their new role and tie to in-service training roll out.	VISN directors	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VISN employees.	Transformation Office/ EES	Now (6 mos)
Draft basic competencies for VISN staff (e.g., quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ each PO	Near (18 mos)
Gain agreement from Congress to institute three appropriation lines only: medical, major construction, research.	CVCS/SECVA/OMB	Near (12 mos)
Eliminate segregation of specific-purpose funds to the VISNs and facilities.	CVCS/Office of Finance	Now (6 mos)
Modernize financial management system (FMS) to permit effective cost accounting and tracking of priority spending.	OIT/Office of Finance	Future (36 mos)
Develop training to support effective use of FMS to permit effective account tracking and reporting and roll it out.	Finance/EES	TBD post procurement
Establish quarterly spend reports covering all priority areas (e.g., NRM, IT, facility minor, purchased care, mental health, women's health, administration) by facility and release to Congress and the public.	Finance Office	TBD post procurement
Delegate decisions in recruitment, retention and advancement (e.g., hiring bonus, retention bonus, market pay) for staffing to the facility.	CVCS/HCM	Now (1 mos)
Delegate training and travel decisions.	CVCS/EES/OAA	Now (1 mos)
The USH establishes leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue and collaboration.		
Improve communication with field leadership and frontline employees through the liberal use of social media, town halls and other direct engagement channels with a dedicated champion to help the USH and senior staff in this endeavor.	CVCS	Now (3 mos)
Reestablish in-person leadership conferences, at least semi-annually, to foster communication and relationship building between VHACO, VISN and facility leadership.	CVCS/EES/NLC	Now (6 mos)
Add behavioral competencies to performance plans that promote effective communication amongst leaders.	CVCS	Near (12 mos)

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Action	Responsible	Timeline
Establish expectations and requirements for program office leaders to communicate the USH leadership messages, coordinate PO communications with the USH and with one another.	CVCS	Now (3 mos)
Establish a transformation office with broad authority and a supporting budget to accomplish the change.		
Establish the new transformation office in the organizational chart, populate with expertise in business process re-engineering, and fund initially using savings from closure and consolidation of offices in VHACO and a budget reduction to all other VHACO offices.	CVCS	Now (6 mos)
Create a Transformation Office strategic plan to educate and provide guidance to the new initiatives and support the goals of VA and VHA.	Transformation Office	Near (3-6 mos)
Create a new initiative implementation plan to include follow-on priorities, tasks and milestones. The Transformation Office will support the operation and the plan moving forward.	Transformation Office	Near (3-6mos)
The Transformation Office will be responsible for evaluating all new initiatives and programs using the President's Management Agenda Scorecard or a model that emulates its rating standards of Green represents success; yellow for mixed results; and red for unsatisfactory. These ratings are indicative of standards of success or failure.	Transformation Office	Near (3-6mos)

Table B-4. Performance Metrics and Management

Action	Responsible	Timeline
Create a new performance management system for VHA leaders appropriate for health care executives.		
Establish a workgroup and engage outside experts to create the new performance management system that is benchmarked to private-sector models, is consistent with the new leadership competency model, and recognizes both leadership competencies and success in delivering strategic priorities. The model should include a new rating scale.	Transformation Office/Human Capital Management	Now (6 mos)
Develop and conduct training on the new performance management system for all participants to describe the system, rating process, and expectations.	Human Capital Management	Near (6-12 mos)
Establish a mechanism to capture performance assessment outcomes and track and manage high-potential staff.	Human Capital Management/HRA	Now (3 mos)
Establish a project plan to deliver annual guidance on performance plans at least a month in advance of the new fiscal year (i.e., at the start of the new rating period).	Human Capital Management/CVCS/Sec/OMB	Now (3 mos)
Hold raters accountable for creating meaningful distinctions between leaders.		
Provide training to raters on the application of the new performance management system and expectations for ratings.	Human Capital Management	Future (12 mos)
Require raters to establish plans for subordinates that are timely and meaningful; track and provide feedback on meeting this goal.	Human Capital Management/HRA	Now (3 mos)
By modeling the behavior and communicating the requirement, establish expectations that raters, and secondary-level raters, engage in continuous dialogue and coaching with subordinates about performance throughout the year, not just at mid-year and at the end of the rating period.	CVCS	Now (3 mos)
Establish oversight and feedback process for raters and incorporate this into the raters performance evaluation.	Human Capital Management/CVCS	Now (12 mos)
Provide coaching to raters and focused reviews if their rating profile doesn't provide meaningful distinctions in performance.	Supervisors	Near (12 mos)

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Table B-5. Leadership Implementation: Human Capital Management

Action	Responsible	Timeline
VA re-align HR functions and processes to be consistent with best practice standards of high-performing health care systems.		
Charge HRA to undertake an HR transformation study and ensure budget and solicitation of customer requirements.	SECVA/DEPSECVA	Now (0-6 mos)
Engage HR and change management experts to develop a benchmark human capital management plan for VA.	HRA	Now (0-6 mos)
Circulate new human capital plan for feedback and finalize.	HRA with input from VHA, Congress, OPM, OMB, SECVA/DEPSECVA, CVCS	Now (6 mos)
That VA and VHA leaders make transformation of Human Capital management a priority, with adequate attention, funding and continuity of vision.		
Endorse human capital management plan and ensure alignment of budget, IT system funding, training resources, and accountability mechanisms to support it.	SECVA/DEPSECVA and CVCS, as applicable	Near (9 mos)
Employ HR and change management experts to fully implement the transformation agenda and the new human capital management plan.	HRA	Near (12-30 mos)
Create an HR IT technology plan.	HRA & OIT	Near (9 mos)
Establish meaningful measures and risk indicators for VA human capital management.	HRA	Future (24 mos)
Incorporate HR measures into systematic reporting to leadership; and as appropriate into performance plans for key subordinate leaders.	HRA, DEPSECVA, CVCS as appropriate	Near (18 mos)
VA develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 Hybrid, Title 38 7306, and SES).		
Develop clear standards, guidelines, and training on progressive discipline.	HRA (with support from OPM)	Now (6 mos)
Managers, supervisors and HR professionals complete training.	SECVA/ DEPSECVA and CVCS (HTM office)	Near (12 mos)
Train HR staff to be coaches in progressive discipline.	HRA	Now (6-12 mos)
Establish performance metrics for HR professionals and client feedback mechanisms to ensure effective coaching and support for progressive discipline process.	HRA	Near (12 mos)
Establish performance expectations for VA supervisors and managers to apply the progress discipline process.	SECVA/ DEPSECVA, CVCS	Near (12 mos)

APPENDIX C: PILOT PROJECTS FOR EVALUATING EXPANDED CARE

As discussed in Recommendation #18, some Commissioners support the idea of developing pilot programs to test the feasibility of avoiding VA hospital closures by allowing veterans' spouses and currently ineligible veterans to purchase VA care in selected areas.

Problem

In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. This trend is driven by four main factors: (a) the overall decline in the size of veterans population, (b) the migration of veterans away from some parts of the country, such as New England and the Upper-Midwest, (c) the general trend in health care toward less intensive use of acute-care hospital beds, and (d) increased use of purchased care, which now accounts for 27 percent of all appointments.

A related challenge is maintaining safe volume of care when patient loads decline. As extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁷⁸

Simply closing a low-volume hospital is sometimes the answer. But closing a local VA hospital may mean that area veterans will have reduced access not only to routine, but also to specialty care related to their military service, such as for spinal cord or traumatic brain injuries. In many areas, such care is not available or is in short supply outside VHA.

At the same time, it may not be clinically feasible for VHA to engage in highly specialized care if it lacks the ability to offer other forms of care in the same setting. Patients in a polytrauma unit for example, require a full-spectrum of routine and nonroutine health care.

Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. Toward that end, VHA could develop pilot programs to test the feasibility of enabling veterans' spouses and currently ineligible veterans in these areas to purchase VHA care through their health plans. These pilots could be tested in conjunction with the growth of the high-performance, integrated VHA networks recommended elsewhere in this report. These networks will allow VHA far more flexibility than in the past to expand or contract its local capacity in different markets as appropriate.

⁶⁷⁸ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

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Background***Current Nonveteran Access to VHA Care***

VHA already treats many nonveterans. VHA estimates it treated 694,120 unique nonveteran patients at a total cost of \$1.9 billion in 2015,⁶⁷⁹ or 3.6 percent of total VHA obligations.⁶⁸⁰

By far the largest subgroup within the nonveteran patient population are participants in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA beneficiaries are the dependents of permanently and totally disabled veterans, survivors of veterans who died from service-connected conditions or while on active duty, or spouses of veterans who at the time of death were rated permanently and totally disabled from a service-connected condition.

Congress authorized CHAMPVA in 1973. The authorization specifies that VHA is the secondary payer for those with Medicare Part A and B coverage. In cases for which VA medical facilities are equipped to provide the care, VA may use facilities not being used for the care of veterans to provide services to the dependent or survivor.

Congress has also directed VHA to offer specific health care services to many other classes of nonveterans. These include mental health and counseling services for family caregivers of seriously injured veterans of post-9/11 service. Several provisions of law also authorize VA care for certain family members of veterans who were exposed to toxic substances. In the case of veterans with 50 percent or more service-connected disability, VHA must provide by law “consultation, professional counseling, marriage and family counseling, training and mental health services as are necessary in connection with” the veteran’s treatment.⁶⁸¹

Analysis

Others who have developed strategic plans for the long-term future of VA health care have recommended expanding upon these precedents, specifically by allowing currently ineligible veterans and the spouses of veterans to purchase VHA care.⁶⁸² In effect, providing such care would allow VHA to operate as an accountable care organization, capable of receiving reimbursement from patients covered by Medicare, Medicaid, as well as by private insurance plans. Among the potential benefits envisioned are the following:

- optimizing patient safety, productivity, and cost-effectiveness by ensuring sufficient patient volumes in currently under-utilized facilities
- preserving mission critical veterans’ programs that would otherwise need to be terminated in many parts of the country
- optimizing the integration of VHA and non-VHA care within communities

⁶⁷⁹ Allocation Resource Center, information provided to Commission on Care, December 8, 2015.

⁶⁸⁰ Department of Veterans Affairs, “Volume II: Medical Programs and Information Technology Programs, Congressional Submission, FY 2016 Funding and FY 2017 Advance Appropriations,” accessed May 27, 2016, <http://www.va.gov/budget/products.asp>.

⁶⁸¹ Counseling, Training, and Mental Health Services for Immediate Family Members and Caregivers, 38 U.S.C. § 1782.

⁶⁸² Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce*, accessed May 27, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>.

APPENDIX C
PILOT PROJECTS FOR EVALUATING EXPANDED CARE

- providing a *public option* for health care to a wider range of veterans as well as nonveterans in communities where health care choices are currently limited
- bringing in new sources of revenue to contribute to the funding for veterans' healthcare

The pilot projects described below would specifically evaluate whether such a strategy will allow VHA to optimize the quality and cost-effectiveness of its health care system by avoiding low volumes of routine and specialty care in certain sections of the country. These pilot projects would also allow VHA to evaluate whether such a strategy could provide new revenues for sustaining the VA health system while providing other benefits to veterans and the public at large.

The chart below sketches six possible pilot projects designed to test different specific policy configurations. The configurations include projects in which VA care is marketed to health care plans on fee-for-service (FFS) basis, and plans in which VA facilities are markets to health care plans as Accountable Care Organizations that provide integrated health services to a fixed population of insured patients for a fixed cost.

*Demonstration Projects to Assess VHA's Capability to Treat
Nonveteran Spouses and Ineligible Priority 8 Veterans*

	Eligibility	Capitation/Fee For Service	Timing
Demonstration 1: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) With Private Insurance	FFS	Years 2-7
Demonstration 2: FFS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance	FFS	Years 2-7
Demonstration 3: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) with private insurance	FFS	Years 3-8
Demonstration 4: FSS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance and/or Medicare	FFS	Years 3-8
Demonstrations 5 and 6: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses	Enrollment: May choose higher cost plan with more coverage and less copayment; lower cost option with less coverage and higher copayments.	Years 4-9

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	Eligibility	Capitation/Fee For Service	Timing
Demonstrations 7 and 8: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses with private insurance and/or Medicare	Enrollment: May choose higher cost plan with more coverage and less copayment; or lower cost option with less coverage and higher copayments. Pilot sites would be deemed Accountable Health Care Organizations for Medicare Advantage plans.	Years 5-10

Certification of Access: Any participating VHA facility must certify that its waiting times for primary care, specialty care and behavioral health are less than 30 days.

Site selection: Sites should include facilities in different regions with various population densities (urban, suburban, rural) and levels of service complexity. VHA may also consider such factors as stability of medical center leadership, and whether local markets are underserved or subject to high degrees of market concentration among either providers or payers.

Assumptions

- Many provisions are subject to Congressional authorization.
- Participating VHA facilities will be able to retain any “profit” associated with treatment of new users without offset;
- Congress will (preferably) waive the current prohibition on Medicare funding federal health care programs,
- VHA will not be subject to proving “level of effort” in order to receive Medicare funds

Assessment

After the first year of operations, VHA will assess these projects according the following criteria:

- Was access to care or patient satisfaction among veterans already enrolled in the system affected by the demonstration?
- What was the level of patient satisfaction among new users purchasing VA care?
- Did VHA cover the costs of delivering care to its patients purchasing care? If so, what were its net revenues and how were they used?
- If VHA collected Medicare funds, did funding cover costs of delivering care?

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APPENDIX C
PILOT PROJECTS FOR EVALUATING EXPANDED CARE

- Were there administrative challenges in opening the VHA to new users? If so, what lessons were learned?
- How did VHA promote the demonstration project to those eligible?
- What are the recommended strategies for further implementation?
- Were there non-financial benefits to treatment of new users, such as diversifying case mix, providing sufficient volume to allow certain VHA services to remain available, or keeping scarce health professionals employed in an area that is medically underserved?
- How did the demonstrations affect the overall quality of care, market structure, pricing, and range of health care options available to both veterans and nonveterans in the surrounding community?

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APPENDIX D:

HISTORY AS A CONTEXT FOR SYSTEMIC TRANSFORMATION

History provides opportunities to see the problems and challenges facing VHA today through the lens of recurring themes from the past. Veterans' health care has, over the course of its history, been marked by periods of both progress and problems. Understanding the challenges of the past and the solutions used to address them provides context for building a plan for reforming veterans' health care in a manner that is flexible and sustainable.

Challenges and Growth

The federal government's role as a care provider for veterans has evolved, paralleling, to some extent, medicine's evolution. Prior to World War I, the only benefits afforded then-eligible veterans were pensions and domiciliary care (which involved only incidental medical treatment), provided under the National Home for Disabled Volunteer Soldiers and Sailors established after the Civil War.⁶⁸³

World War I brought real change. At the time, no single agency was responsible for the anticipated deluge of sick and wounded soldiers. The more than 200,000 wounded who returned home from battle quickly exceeded capacity of the U.S. Public Health Service (PHS), the National Home, and other agencies. According to one account of the period, "[c]haos and confusion reigned for more than two years . . . [n]ew hospital construction languished," and "[b]y 1921, veterans' care had become a national embarrassment."⁶⁸⁴ At the recommendation of a presidential committee, Congress passed legislation in 1921 to consolidate the several veterans-related bureaucracies into a single Veterans Bureau, to which the President Warren Harding transferred 57 PHS hospitals. A new administrator, Frank T. Hines, proposed care and treatment of veterans' non-service-connected ailments when facilities and bed space were available. Congress adopted the proposal in the World War Veterans Act of 1924.⁶⁸⁵

Under Hines' tenure, VA grew from 64 to 91 hospitals, nearly doubling bed capacity. Civil Service Commission personnel rules and low pay led to generally poor quality VA physicians, yet Congress rebuffed VA proposals to set up a VA Medical Corps.⁶⁸⁶ With many physicians having left VA to serve in World War II or for more lucrative practice, the VA health care system was left critically understaffed.⁶⁸⁷

⁶⁸³ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 4.

⁶⁸⁴ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 13-14.

⁶⁸⁵ *Ibid.*, 19.

⁶⁸⁶ *Ibid.*, 21.

⁶⁸⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 149.

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World War II and the need to care for millions of service members, including 671,000 wounded, highlighted the problems facing VA. Scathing reports of shoddy veterans' care, including an exposé characterizing veterans' hospitals as backwaters of medicine, magnified the problems.⁶⁸⁸

Congressional hearings led to a shakeup in leadership and General Omar Bradley was appointed to head the agency, with its network of 97 hospitals, and a need for more.⁶⁸⁹ Dr. Paul Magnuson, who served as VA's chief medical director (CMD) from 1948 to 1951, later described the conditions at the time:

The majority of Veterans Administration hospitals were stuck in far off places, some of them on Indian reservations, others as much as fifty miles from the nearest through-line railway stop. The doctors were all full-time Civil Service employees, hemmed in by regulations and practically forbidden to do any research, attend any medical meetings or otherwise keep in touch with scientific progress. Operating rooms closed at noon so everybody could spend the afternoon happily doing required paperwork, while patients waited days and weeks for surgery.⁶⁹⁰

With President Harry Truman's statement that "the Veterans Administration will be modernized," new VA leadership worked with Congress to pass far-reaching legislation, Public Law 293, which created a VA Department of Medicine and Surgery (DM&S), and freed VA physicians, dentists, and nurses from the Civil Service Commission and its rules.⁶⁹¹ Within weeks, the chief medical director of the new DM&S issued a policy memorandum that outlined a cooperative affiliation agreement between VA and medical schools under which deans' committees would recommend consultants and attending physicians for appointment to VA, and residency-training programs would be established at VA hospitals. The law, and Policy Memorandum #2, broke a recruitment logjam and enabled the short-staffed department to hire medical professionals needed for the dozens of new VA hospitals being built. Soon after, medical students and residents began working in 32 VA hospitals. The reforms instituted under Bradley and his team were palpable,⁶⁹² with the physician staff at VA hospitals increasing from 2,300 (1,700 of whom were detailed by the military) in June 1945 to 4,000 full-time staff a year later.⁶⁹³ By 1948, VA had 125 hospitals in operation with 60 medical school affiliations and 2,000 residents.⁶⁹⁴

After this turn-around, Bradley left to become Army Chief of Staff, and under his successor, "who did not enjoy the same level of prestige and support that Bradley did . . . VA quickly

⁶⁸⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 22.

⁶⁸⁹ *Ibid.*, 23-25.

⁶⁹⁰ *Ibid.*, 22.

⁶⁹¹ "31: The President's News Conference," Harry S. Truman Library & Museum, accessed June 3, 2016, <http://trumanlibrary.org/publicpapers/viewpapers.php?pid=38>.

⁶⁹² James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 27.

⁶⁹³ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 214.

⁶⁹⁴ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 28.

reverted to its pre-Bradley ways and remained that way for the next forty years,”⁶⁹⁵ according to one account.

By the early 1950s, the veteran population had grown to more than 20 million.⁶⁹⁶ VA was operating 162 hospitals, with an average census of more than 104,000 patients.⁶⁹⁷ A VA historian observed that “waiting lists contained 22,613 applicants awaiting admission, none of whom were service-connected, although some of the latter were hospitalized in other than VA hospitals.”⁶⁹⁸ At the time, non-service-connected veterans seeking care had to state under oath that they could not afford to pay for hospitalization, and admission was granted only when beds were available in VA or other federal hospitals.⁶⁹⁹ Critics called for reducing free medical care of non-service-connected veterans, and questioned whether some were getting care that they could afford. This issue led VA to institute a policy of formal counseling under which hospitals would supply the veterans with an estimated cost of care to assist them in determining their ability to pay.⁷⁰⁰

In contrast to the generous Bradley-era funding, the 1950s funding cuts necessitated layoffs, bed-closures, and moth-balling of newly constructed hospital wards.⁷⁰¹ During this period, annual debates over the DM&S budget centered on the number of beds VA should operate. VA leaders contended that the number should be 125,000, yet the director of the Bureau of the Budget (the predecessor to the Office of Management and Budget [OMB]) asserted 87,000 was sufficient.⁷⁰²

The expiration of the incumbent CMD’s term led to the appointment in 1955 of medical educator Dr. William Middleton, dean of the Wisconsin Medical School, and a long-time member of a VA special medical advisory group. One of his first acts as CMD was to champion medical research in VA and broaden its scope to include geriatric research. Soon after, Congress began earmarking funds for VA research, and expanded DM&S’ statutory role to include medical research.⁷⁰³ During Middleton’s tenure, from 1955 to 1963, VA research funding grew from some \$6 million to more than \$30 million.⁷⁰⁴ Middleton’s work laid the foundation for a research program long recognized for pioneering important medical technologies, including medical use of radioisotopes, dialysis, cardiac pacemakers, liver transplantation, as well as seminal studies that documented the benefits of coronary artery bypass surgery and drug treatment of hypertension.⁷⁰⁵ The program also stood out for its capacity to design and rapidly implement large-scale cooperative trials, first mounted in the 1950s with successful evaluation

⁶⁹⁵ Ibid., 29.

⁶⁹⁶ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 254.

⁶⁹⁷ Ibid.

⁶⁹⁸ Ibid.

⁶⁹⁹ Ibid., 253.

⁷⁰⁰ Ibid., 253-254.

⁷⁰¹ Ibid., 256.

⁷⁰² Ibid., 258.

⁷⁰³ Ibid., 262-263.

⁷⁰⁴ Ibid., 263-264.

⁷⁰⁵ Stanley Zucker et al., “Veterans Administration Support for Medical Research: Opinions of the Endangered Species of Physician-Scientists,” *The FASEB Journal*, 18, no. 13, (2004): 1481-1486, <http://doi.org/10.1096/fj.04-1573lfe>.

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of chemotherapy for tuberculosis.⁷⁰⁶ Working on issues relevant to veterans, VA researchers developed functional electrical stimulation systems to allow patients to move paralyzed limbs, helped develop the first ankle-foot prosthesis, and launched the largest-ever trial of psychotherapy to treat posttraumatic stress disorder.⁷⁰⁷

Middleton expanded the VA educational program. In addition to growing the number of medical residents it helped train, VA provided training to a large share of clinical psychologists, graduate dentists, student nurses, occupational and physical therapists, social work students, and dietetic interns. Middleton instituted numerous advances in VA care such as introducing outpatient care for preadmission workups and post-hospital treatment that allowed earlier release from inpatient stays. He moved VA away from operating hospitals for specific diseases (as had been done for tuberculosis and mental illness).⁷⁰⁸

The enactment of Medicare in 1965 raised questions about the effect that program would have on the VA health care system. The House Veterans Affairs Committee sent a questionnaire to a group of 10,000 veterans explaining the new program and asking the veteran to if they preferred VA care or treatment in a community hospital under Medicare.⁷⁰⁹ Some 59 percent responded, and nearly two-thirds of respondents preferred VA.⁷¹⁰ At the time, the policy governing those eligible for VA care based on financial need was that Medicare benefits were to be considered in determining an individual's ability to pay for needed care.⁷¹¹

The enactment of Medicare and other changes in health care in 1977, led to a commission being established by the National Academy of Sciences (NAS) which issued a report pursuant to a congressional directive to evaluate the VA health care system. Among its findings, the commission reported that VA had a surplus of acute beds and recommended that new facilities be constructed only after examining bed availability in the community. It also recommended that underutilized VA hospitals be closed or converted to long-term care facilities, and resources redistributed to permit a shift from inpatient to outpatient care. The NAS commission also recommended that VA experiment with models for community-based integrated care.⁷¹² The commission's recommendation for integrating the VA system into the nation's civilian health care program⁷¹³ provoked objection, particularly in Congress.⁷¹⁴ Hearings produced sharp rejections of the NAS commission findings and its call to end VA's role in providing health care to veterans.

⁷⁰⁶ Ibid.

⁷⁰⁷ Veterans Health Administration, *History of VA Research Accomplishments*, accessed June 3, 2016, http://www.research.va.gov/researchweek/press_packet/Accomplishments.pdf.

⁷⁰⁸ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 265-267.

⁷⁰⁹ Ibid., 390.

⁷¹⁰ Ibid.

⁷¹¹ Ibid.

⁷¹² *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs*, 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.

⁷¹³ J. William Hollingsworth and Philip K. Bondy, "The Role of Veterans Affairs Hospitals in the Health Care System," *New England Journal of Medicine*, 322, no. 10, (1990): 1851-1857, <http://doi.org/10.1056/NEJM199006283222605>.

⁷¹⁴ *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs*, 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.

The VA of the 1970s and 1980s is remembered as bureaucratic, reliant on paper health care records, and driven by patient admissions (on which budgets were based).⁷¹⁵ The quality of VA care was also an issue. Complaints from Vietnam veterans and critical media accounts fueled outrage, and led to the view that the system was broken. The question, how to fix it, reopened an earlier dialogue around making VA a cabinet-level department, a view strongly supported by veterans service organizations (VSOs) and veterans' leaders in the House of Representatives. In 1988, after years of debate, and opposition from administration offices and advisors, President Reagan signed legislation creating a Department of Veterans Affairs.⁷¹⁶ The new department, with DM&S now renamed the Veterans Health Services and Research Administration (to emphasize its research legacy in such fields as infectious disease, pacemaker technology, and prosthetics), employed some 194,000 people with a \$12 billion budget.⁷¹⁷

Facing an aging veteran population⁷¹⁸ expected to overwhelm the system by 2010, the new secretary, Edward Derwinski, in 1989 requested Congress establish an independent commission to review the alignment and mission structure of VA's hospitals. Congress rebuffed the request after VSOs, suspecting a plan to close hospitals, lobbied against it.⁷¹⁹ Derwinski created his own "Commission on the Future Structure of Veterans Health Care" that was to review all VA hospitals and recommend needed mission changes. Instead, the so-called Mission Commission called for expanding eligibility law to enable veterans to obtain the full continuum of VA health care services. Although the commission identified the need for fundamental restructuring of the VA health care system, the subject was soon overtaken by national health reform proposals, and what role VA might have under a universal coverage system.⁷²⁰

Dr. James Holsinger, a new under secretary for health (USH), made care quality a top goal and issued a Blueprint for Quality tool in 1992, setting the stage for more far-reaching changes instituted by his successor, Dr. Kenneth Kizer. Care quality, a perennial topic, had led to the previous under secretary's resignation following reports of multiple veterans' deaths under questionable circumstances at VA's North Chicago medical center.⁷²¹ Two years later, Derwinski lost his job after creating ire among veterans' organizations in response to his proposed pilot program to open two VA hospitals to poor, rural nonveterans.⁷²²

⁷¹⁵ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 30-31.

⁷¹⁶ *Ibid.*, 33-40.

⁷¹⁷ *Ibid.*, 50.

⁷¹⁸ As the General Accounting Office reported in 1990, "The Department of Veterans Affairs (VA) faces a major challenge: planning how to meet the long-term care needs of a rapidly aging veteran population. The number of veterans 65 years old and over is projected to grow to 9 million by 2000—a 50percent increase over the 1988 level.

U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), accessed June 20, 2016, <http://www.gao.gov/assets/150/149139.pdf>.

⁷¹⁹ U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), 51, accessed June 20, 2016, <http://www.gao.gov/assets/150/149139.pdf>.

⁷²⁰ U.S. Government Accountability Office, *Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Care Reform*, GAO/HEHS-95-14 (Washington, DC, 1994), accessed June 20, 2016, <http://archive.gao.gov/f0902a/153054.pdf>.

⁷²¹ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 53.

⁷²² "Angry Veterans Groups Say They Made Bush Oust Agency's Head," Eric Schmitt, accessed June 3, 2016, <http://www.nytimes.com/1992/09/29/us/angry-veterans-groups-say-they-made-bush-oust-agency-s-head.html>.

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Transformational Leadership

VA's second secretary, Jesse Brown, brought his passion as a veterans advocate to the department's leadership.⁷²³ Among Brown's most important early acts was selecting Dr. Kenneth Kizer, a prominent California physician-administrator and educator, from among 90 candidates identified by a search committee for the USH post.⁷²⁴ With experience heading the California department of public health, Kizer saw health care as a system, and data as a tool to improve it.⁷²⁵

Kizer, in essence, launched a major reengineering of the VA health care system through better use of information technology, measurement and reporting of performance, integration of services, and realigned payment policies.⁷²⁶ His vision was large and bold, underscored by his belief that "we have to be able to demonstrate that we have an equal or better value than the private sector, or frankly we should not exist."⁷²⁷ At VA, Kizer found a workforce trapped in a micro-managerial, command-and-control system in which there was little accountability.⁷²⁸ He set the tone for what was to come at a meeting with senior managers at which he stated,

*The old culture must give way to a new culture . . . that is based on innovation and creativity; a culture based on personal initiative and individual and collective accountability; a culture that is based on outcomes and heightened productivity; and a culture that is committed to change.*⁷²⁹

Among his first steps was the development of what was to become a Vision for Change, a new organizational model to restructure both field operations and central office management. At its core was the creation of 22 veterans integrated service networks, or VISNs, (replacing four regions which had been responsible for overseeing 40 to 45 hospitals each), with decision making shifted away from VA Central Office (VACO) to the new VISN directors. VISNs were to be the basic budgetary and planning unit, and to have staffs of no more than 7 to 10 employees.⁷³⁰ Each VISN was in charge of all the care provided to veterans in that network, and each was funded on a capitated basis rather than based on historical costs.⁷³¹ The VACO structure would be marked by its *flatness*, foregoing a tiered hierarchy.⁷³²

⁷²³ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 89.

⁷²⁴ *Ibid.*, 92.

⁷²⁵ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 50-51.

⁷²⁶ Ashish K. Jha et al., "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care," *New England Journal of Medicine*, 348, no. 22, (2003): 2218-2227, accessed June 20, 2016, <http://doi.org/10.1056/NEJMsa021899>.

⁷²⁷ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 51.

⁷²⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 97-8.

⁷²⁹ *Ibid.*, 105.

⁷³⁰ *Ibid.*, 110.

⁷³¹ "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation," Ashish K. Jha, accessed June 3, 2016, <https://psnet.ahrq.gov/perspectives/perspective/31>.

⁷³² James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 111.

The system Kizer and his team inherited was characterized by a multitude of problems.⁷³³ Kizer and his team literally reengineered the veterans' health care system based on a set of transformation strategies: to create management accountability, integrate and coordinate services, improve the quality of care, align system finances with desired outcomes, and modernize information management.⁷³⁴

Kizer also launched a technological revolution in VHA with deployment of a powerful electronic medical record,⁷³⁵ and development of systems such as medication bar-coding to tackle medical errors and ensure patient safety.⁷³⁶

Some of Kizer's successes involved winning support within the administration and from Congress for bold initiatives. He won a critical concession from OMB that VA savings could be reinvested into VA, permitting his transformation efforts to be funded through internal cost-savings rather than new funding,⁷³⁷ and garnered support from Congress for a dramatic reduction of acute care beds and for closing massive regional offices.⁷³⁸ These steps and congressional passage of legislation to reform health care eligibility laws paved the way for establishing universal primary care in VA and developing community-based clinics across the country.⁷³⁹

Sweeping Reform

During a 5-year period, Kizer dramatically changed almost every major VHA management system and improved operational performance through the use of performance measures and contracts. He closed nearly 29,000 acute care beds, merged 52 medical centers into 25 multi-campus facilities, reduced staffing by almost 26,000, opened more than 300 community-based outpatient clinics, and treated 24 percent more patients. In addition to bringing measurable quality into VA health care, Kizer achieved marked reductions in waiting times and medical errors.⁷⁴⁰

Kizer's tenure brought dramatically improved quality, service, and operational efficiency to VHA yet threatened powerful interests. As he noted, "...places like Florida, Arizona, and the

⁷³³ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 316, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷³⁴ Ibid., 318-323.

⁷³⁵ VA in 2006 won the Harvard Innovations in Government Award for its VistA system. James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 211.

⁷³⁶ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 157-165.

⁷³⁷ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 323, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷³⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 128-129.

⁷³⁹ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 319-320, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷⁴⁰ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 170.

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Sun Belt States were not getting their fair share [of funds] and their elected officials were unhappy about it. People from Pennsylvania and Illinois and New York were not about to give their money away, so there was this big disconnect.”⁷⁴¹ Kizer’s team developed a capitation system to more equitably allocate funds across the system. Aware of the political ramifications, he implemented incremental changes during a 2- to 3-year period to make them as painless as possible. But the congressional goodwill he had enjoyed unraveled when Kizer and his VISN directors began cutting and consolidating facilities to accommodate VISN funding cuts. The threat of hospital mergers and consolidations ultimately led several senators to block his confirmation to a second term.⁷⁴²

Under new eligibility reform law, all veterans became *eligible* for VA health care, though its authors did not envision that the system could or would serve all eligible individuals, or even all who might someday seek VA care. The law’s priority-based enrollment system was intended to give VA a tool to align demand for care with its funding level.⁷⁴³ The law instead unleashed political pressure to expand enrollment, opening the door to an influx of veterans who historically had not been VA health care users and many of whom were already covered under military retirement benefits, private insurance, or Medicare.⁷⁴⁴ That expansion led to a tremendous demand for prescription drug benefits by new enrollees and in 2003, Secretary Tony Principi ended enrollment for higher income (category 8) veterans “to keep the system solvent.”⁷⁴⁵ At about the same time, other related pressures led Principi to establish an advisory body, the Capital Asset Realignment for Enhanced Services (CARES) Commission, to develop a comprehensive capital asset plan. Principi cited the age of VA facilities and the changes in medical practice, but also reminded a congressional oversight committee of a 1999 Government Accountability Office finding that “maintaining obsolete or duplicative structures diverts \$1 million a day, every day, every year, away from the care of veterans.” Principi did not want to repeat Kizer’s experience and hoped to avoid political backlash.⁷⁴⁶

The CARES Commission released a final report in February 2004 that recommended relatively few actual facility closures, though it proposed substantial facility mission changes at a number of facilities.⁷⁴⁷ As the then USH later recounted, “CARES, like so many things in Washington, was well-intended, but it was derailed politically once it began moving toward actual targeted action within specific congressional districts.”⁷⁴⁸

Despite such defeats, Principi and VA under secretaries following Kizer met formidable challenges, left legacies, and saw the veterans’ health care system continue to be heralded for several years.⁷⁴⁹ A cascade of other events muddled, and even blackened, VHA’s reputation:

⁷⁴¹ Ibid., 133-134.

⁷⁴² Ibid., 168-169.

⁷⁴³ Veterans Affairs Comm., Veterans’ Health Care Eligibility Reform Act of 1996, H. R. Rep. No. 104-690 (1996), accessed June 3, 2016, <https://www.congress.gov/congressional-report/104th-congress/house-report/690/1>.

⁷⁴⁴ James Rife, *Not Your Father’s VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 193.

⁷⁴⁵ Ibid., 194.

⁷⁴⁶ Ibid., 195.

⁷⁴⁷ Ibid., 196.

⁷⁴⁸ Ibid.

⁷⁴⁹ “The Best Care Anywhere,” Phillip Longman, *Washington Monthly*, accessed June 3, 2016,

accounts of veterans' suicides (and an alleged cover-up); incompetent surgeries and patient deaths at a high-visibility VA medical center (VAMC); failed software acquisitions;⁷⁵⁰ hard-hitting inspector general audit reports on issues such as system flaws, quality of care issues, and lack of timely care that fueled congressional oversight and other constraints. The 2014 scandal that erupted at the Phoenix VAMC represented a decisive turning point and set the stage once again for transforming veterans' health care.

Among initial steps on that long road to transforming the system, the Senate in July 2014 unanimously confirmed Robert A. McDonald, former chief executive officer of Proctor & Gamble, as secretary of veterans affairs. With a business career of delivering better results, McDonald, along with DEPSECVA Sloan Gibson and USH Dr. David Shulkin, has been working to improve VA's health care system and service delivery, and to set a framework for long-term reform. Days after McDonald's confirmation, Congress passed the Veterans Access, Choice, and Accountability Act of 2014, omnibus legislation to improve veterans' access to care. This legislation established the *Choice Program*, mandated an independent assessment of VHA, and established the Commission on Care.

<http://www.washingtonmonthly.com/features/2005/0501.longman.html>. "Revamped Veterans Health Care Now a Model," Gilbert Gaul, accessed June 3, 2016, <http://www.washingtonpost.com/wp-dyn/content/article/2005/08/21/AR2005082101073.html>. "The Best Medical Care in the U.S.: How Veterans Affairs Transformed Itself—and What it Means for the Rest of Us," Catherine Arnst, accessed June 3, 2016, <http://www.bloomberg.com/bw/stories/2006-07-16/the-best-medical-care-in-the-u-dot-s-dot>.

⁷⁵⁰ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 216-217.

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APPENDIX E: THE EVOLVING HEALTH CARE INDUSTRY

Health care has evolved in major ways since the federal government began providing care to veterans after the Civil War, and it will continue to evolve substantially in the future. There are a number of factors that drive evolution in health care, such as population and lifestyle changes, changes within the various health care professions, medical and information systems technology, and systems changes in management and operations.⁷⁵¹ IBM Center for Applied Insight reports that there are 18 trends to watch in health care.⁷⁵² These trends closely encompass those highlighted below. The categories in which the trends fall mirror key topic addressed in the Commission's report to include data system interoperability (10 trends), consumer technology (two trends), health care providers (two trends), government regulations (two trends), and human resources and leadership (two trends). With health care changing so rapidly, and in so many different ways, it is imperative that veterans' health care continually evolve to remain aligned with current and future trends. This section highlights key trends that, based on past experience and current practice, will likely shape health care in the future, were considerations in formulating the Commission's recommendations, and will likely affect transformation of veterans' health care.

Emergence of Large Health Care Systems

The health care industry is moving away from stand-alone community hospitals that serve the needs of a local constituency to large, multiple-campus health care systems.⁷⁵³ The industry will see more high profile mergers and acquisitions in the second half of 2016.⁷⁵⁴ The December 2015 Health Research Institute's report indicates that well-known health care systems may have a market advantage as Americans are willing to travel further for care from a well-known system. This may explain the development and affiliation for Mayo Clinic in Arizona and Florida, and Cleveland Clinic opening in Florida. The report also states that although people are willing to drive for care they are not willing to pay prices higher than the local market. Because of increasing use of outpatient services and same-day surgery, facilities within these health care systems require fewer inpatient beds.⁷⁵⁵ With the advancement of psychotropic drugs, the perceived need for large mental hospitals has declined.⁷⁵⁶ Because of shorter recovery stays, increased outpatient services, telemetry and other monitoring programs, and new medical inventions, hospitals are now built as smaller facilities with parts or sections that can be quickly

⁷⁵¹ Lynn Etheredge, Stanley B. Jones, and Lawrence Lewin, "What is Driving Health System Change?" *Health Affairs*, 15, 4, (1996): 93-104.

⁷⁵² "Healthcare Internet of Things 18 Trends to watch in 2016," Bill Chamberlain, IMB Center for Applied Insights, March 1, 2016, accessed June 20, 2016, <https://ibmcai.com/2016/03/01/healthcare-internet-of-things-18-trends-to-watch-in-2016>.

⁷⁵³ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed April 29, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

⁷⁵⁴ Ibid.

⁷⁵⁵ Ibid.

⁷⁵⁶ "How Release of Mental Patients Began," Richard Lyons, accessed May 1, 2016, <http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all>.

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modified for future changes and medical advances.⁷⁵⁷ VHA will need to consider this trend in evaluating its current physical plant and planning for future facility needs.

Management Changes

As health care systems become increasingly complex, there is a need to manage these institutions using current management theories and models.⁷⁵⁸ During the past few decades, hospital and health care management changed from being managed by a traditional top-down model to continuous quality improvement models that respond to issues such as staff satisfaction, medication errors, safety matters, and wasteful use of supplies. To address errors, hospitals have implemented Six Sigma principles. To address waste, hospitals have implemented LEAN principles. Embracing these changes in management approach and implementing Six Sigma and LEAN principles will support VHA's transformational process.

Health Care Payment

The health care industry is in the midst of transforming its payment model away from a fee-for-service model to value-based payments, a system that drives improved health outcomes.⁷⁵⁹ This transformation is tied to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which health care experts expect to shape care delivery and payment reform across the U.S. health care system over the coming decades. Congress created MACRA as a transformative law to fast track the health care system's transition from a traditional fee-for-service payment model to new risk-bearing, coordinated care models.⁷⁶⁰ Because this legislation is still in rulemaking, it is premature for the Commission to weigh in on its potential effect on VA. The MACRA legislation expands the trend toward creation of accountable care organizations (ACOs) and bundled payments for care. ACO models have been reported to drive reduced hospitalization and generate cost savings.⁷⁶¹

Specialty Care Facilities

With changes in the federal payment for hospitals, some high-cost and longer-stay care treatments have been moving out of community hospitals to specialty hospitals. For example, long-term acute care hospitals primarily treat patients on ventilators; rehabilitation facilities treat short-term, post-acute patients who need primarily physical and occupational therapy services for orthopedic or stroke incidences; and cancer hospitals provide innovative treatments for Stage 4 cancer. As a result, community hospitals may no longer need beds to take care of these special patients. VHA will need to consider this trend in planning integrated care networks and evaluating its facility needs in conjunction with these networks.

⁷⁵⁷ "The Small Hospital of the Future," Shati Matambanadzo, accessed May 3, 2016, <http://www.healthcaredesignmagazine.com/article/small-hospital-future>.

⁷⁵⁸ "How to Solve the Cost Crisis in Health Care," Robert S. Kaplan and Michael E. Porter, accessed May 2, 2016, <https://hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care>.

⁷⁵⁹ "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, <http://www.nationalpartnership.org/issues/health/macra.html>.

⁷⁶⁰ "MACRA: Disrupting the health care system at every level," Deloitte, accessed June 23, 2016, <http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/macra.html>.

⁷⁶¹ "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, Inquisitr: Medicine, accessed May 2, 2016, <http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/>.

Outpatient Care and Lifestyle-oriented Venues for Care

With improvements in surgical procedures, many surgeries that required post-surgery hospital stays are now routinely performed in outpatient settings.⁷⁶² Many nonsurgical procedures are being performed in outpatient clinics as well, such as medical imaging, cardiac catheterization, substance abuse treatment, gastrointestinal screening and cancer treatment.⁷⁶³ As care that was once provided only in hospitals is now provided in specialized medical clinics, care that was once provided only in physicians' offices is now being provided in alternative settings. As reported in Health Affairs, "another health care trend consumers are using to save both time and money is that rather than making appointments with their doctors, they are choosing to use walk-in clinics."⁷⁶⁴ Many of these clinics are located in pharmacies, retail chains, or supermarkets, allowing consumers quick, convenient, less-costly care.⁷⁶⁵ Do-it-yourself health care is also a trend, with increasingly more people taking responsibility for their health care. Consumers are using smart phone apps to monitor vital signs, medication adherence, and even urinalysis.⁷⁶⁶ As part of a commitment to continuous improvement, VHA will need to consider alternative venues as it creates integrated health care networks.

Medical Technology

Medical technology companies create life-changing innovation, and "advanced medical devices and diagnostics allow people to live longer, healthier and more productive lives."⁷⁶⁷ In fact, during the past 30 years, medical advancements helped add five years to U.S. life expectancy and reduce fatalities from heart disease, stroke, and breast cancer by more than half.⁷⁶⁸ These advancements also yield savings across the health care system by replacing more expensive procedures, reducing hospital stays, and allowing people to return to work more quickly.⁷⁶⁹ Ensuring veterans receive care that employs cutting-edge technology will be an important part of establishing integrated care networks.

Telemedicine

According to the American Telemedicine Association, "telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status."⁷⁷⁰ Telemedicine includes a growing variety of applications and

⁷⁶² Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/21183845>.

⁷⁶³ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

⁷⁶⁴ "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, accessed May 2, 2016, <http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/>.

⁷⁶⁵ Ibid.

⁷⁶⁶ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

⁷⁶⁷ "Value of Medical Technology," Advanced Medical Technology Association, accessed May 2, 2016, <http://advamed.org/page/74/value-in-medical-technology>.

⁷⁶⁸ "Value of Medical Innovation," HealthCare Institute of New Jersey, accessed May 2, 2016, <http://hinj.org/value-of-medical-innovation/>.

⁷⁶⁹ Ibid.

⁷⁷⁰ "What is Telemedicine," American Telemedicine Association, accessed May 2, 2016, <http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VwFrqfkrJaQ>.

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services using two-way video, email, smart phones, wireless tools, and other forms of telecommunications technology. The use of telemedicine has spread rapidly and is now becoming integrated into hospitals, specialty departments, home health agencies, private physician offices, as well as consumers' homes and workplaces. The following are examples of how telehealth is being used:

- A specialist assisting the primary care physician in rendering a diagnosis might use interactive video or store-and-forward transmission of diagnostic images or information.
- Home-use devices might be used to remotely collect information such as vital signs, blood glucose, or heart electrocardiogram data and transfer it in real time to a home health agency or a remote diagnostic testing facility for interpretation.
- Consumers' internet and wireless devices might be used to obtain specialized health information or participate in online peer-to-peer support groups.

VHA already excels in the use of telehealth and should expand upon its work in this area.

Midlevel Practitioners

During the past few decades, new categories of health care professionals have become increasingly commonplace in hospital settings. For example, hospitalists, physicians who specialize in the practice of hospital medicine, take over when the community-based physician admits his/her patient to the hospital.⁷⁷¹ The hospitalist does not perform the surgery but rather takes on the monitoring of the hospital services needed by the patient. Another example is medical technicians, who monitor the specialized medical equipment and devices that previously were under the purview of nurses in specialty units such as intensive care units. The growing physician shortage has led to reliance on mid-level health care providers. According to the Centers for Medicare and Medicaid Services' National Provider Identifier dataset, there were approximately 106,000 practicing nurse practitioners and 70,000 practicing physician assistants in 2010.⁷⁷² Provider trends may play into ways VHA can address its current staffing shortage.

Electronic Patient Health Information

Health records have undergone transformation from free-form physician notes of the 17th century to electronic health records (EHRs) of the 21st century. Today, providers are using clinical applications such as computerized physician order entry systems; EHRs; and radiology, pharmacy, and laboratory systems to track patient care and progress. Health plans are providing access to claims and care management, as well as member self-service applications.⁷⁷³ These advances allow the medical workforce to be more mobile and efficient (i.e., physicians can check patient records and test results from wherever they are). Though their use comes with

⁷⁷¹ "Definition of a Hospitalist and Hospital Medicine," Society of Hospital Medicine, accessed May 2, 2016, http://www.hospitalmedicine.org/Web/About_SHM/Hospitalist_Definition/Web/About_SHM/Industry/Hospital_Medicine_Hospital_Definition.aspx.

⁷⁷² "The Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the United States," Agency for Healthcare Research and Quality, accessed May 2, 2016, <http://www.ahrq.gov/research/findings/factsheets/primary/pcwork2/index.html>.

⁷⁷³ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

inherent potential security and privacy risks, they will surely play a substantial role in shaping future health care.⁷⁷⁴ Interoperability of these sources of patient information will be a continuing key issue in private-sector, military, and veterans' healthcare organizations.

Population Health

Population health refers to considering incidence and prevalence of diseases in a given area to determine if the area or the environment is contributing to the illness. Physicians and other health care providers may look at a region's demographics to determine what types of care are needed within the population. For example, if 65 percent of the region is older than age 65, then a series of wellness programs that address the chronic care concerns of this population may be needed. From a population health perspective, communities and their respective populations are as important as the individual patients who comprise them when it comes to keeping residents healthy. For VHA, population health issues may revolve around populations of veterans who served in particular wars and operations and the respective injuries and illnesses associated with them.

Geriatric Care

In the United States and Western Europe the birth rate has slowed⁷⁷⁵ and people are living longer.⁷⁷⁶ Demographic researchers report that if an American makes it to age 65, he/she should have about 17 to 20 additional years of life.⁷⁷⁷ Nursing homes and assisted living facilities are now seeing increasingly more of residents' first-time admissions occurring at age 80 or older. Some congregate care retirement facilities report that even with admission in the 80s, the average life expectancy is another 12 or 13 years.⁷⁷⁸ The aging population accounts for increasingly more hospital admissions, and as a result, hospitals rely on more revenue from Medicare.⁷⁷⁹ The VHA beneficiary population mirrors the general U.S. population, and older veterans receiving care through VHA may be sicker than their private-sector counterparts.

Chronic Disease Care

Chronic conditions now account for more than 50 percent of the death rate. Acute problems had previously been the primary causes of death.⁷⁸⁰ Even HIV/AIDS has moved away from being considered an immediate death sentence, and now, with proper treatment, is considered by

⁷⁷⁴ "Summary of the HIPAA Privacy Rule," U.S. Department of Health and Human Services, accessed May 2, 2016, <http://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/>.

⁷⁷⁵ "Fact Sheet: The Decline in U.S. Fertility," Mark Mather, accessed May 2, 2016, <http://www.prb.org/publications/datasheets/2012/world-population-data-sheet/fact-sheet-us-population.aspx>.

⁷⁷⁶ National Center for Health Statistics, *Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities*, accessed May 2, 2016, <http://www.cdc.gov/nchs/data/abus/abus15.pdf>.

⁷⁷⁷ National Center for Health Statistics, *Life Expectancy at Birth, at Age 65, and at Age 75, by Sex, Race, and Hispanic Origin: United States, Selected Years 1900-2010*, accessed May 2, 2016, <http://www.cdc.gov/nchs/data/abus/2011/022.pdf>.

⁷⁷⁸ Kathleen Harris, *CCRC Resident Demographics and Health Care Utilization: An Analysis*, accessed May 3, 2016, <http://www.avpowell.com/docs/Fall1997.pdf>.

⁷⁷⁹ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

⁷⁸⁰ "Chronic Disease Overview," Centers for Disease Control and Prevention, accessed May 2, 2016, <http://www.cdc.gov/chronicdisease/overview/>.

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most to be a chronic disease.⁷⁸¹ The Centers for Disease Control reports that since 2014, more Americans are dying as a result of chronic conditions and diseases than from acute diseases. Most chronic diseases result from lifestyle choices. Lifestyle diseases result from choices that individuals make.⁷⁸² Health care systems invest resources in addressing lifestyle-related issues caused by behaviors such as smoking, using opiates, and overeating.⁷⁸³ Lifestyle diseases such as cancer caused by smoking, addiction caused by drug use, and diabetes caused by obesity, are costly to treat.⁷⁸⁴ Because lifestyle diseases change over time, they are important to consider in thinking about the future of veterans' healthcare. Treating chronic diseases can be costly because care is ongoing, and assuming this trend continues to become more prominent, it will affect the cost of care and how it is provided.⁷⁸⁵

Needs-based Health Care

The Affordable Care Act requires all not-for-profit hospitals to complete a survey of the community (community health needs assessment, or CHNA) to show what entities in the community will address identified needs (asset mapping) and then report on how the hospital will address these needs in a community health care implementation program (CHIP).⁷⁸⁶ Starting in 2016, hospitals must post these reports on their websites and conduct these evaluations every 3 years thereafter. Monitoring community health needs can lead to preventing or stopping the spread of disease. For example, scarcity of quality food has been documented to result in poor school attendance and increased illness.⁷⁸⁷ Some Americans simply have not been exposed to how to prepare vegetables and fruits because they live in areas that are called *food deserts*, where healthy foods are not readily available. Identifying such needs and how they will be addressed can help improve health for specific populations.⁷⁸⁸ In Washington, DC, such a health assessment led to new treatments and protocols for addressing the appearance of a rare strain of tuberculosis brought in by a group of legal immigrants.⁷⁸⁹ Using CHNA and CHIP could be part of VHA's ongoing planning process.

⁷⁸¹ Steven G. Deeks, Sharon R. Lewin, and Diane V. Havlir, "The End of AIDS: HIV Infection as a Chronic Disease," *Lancet*, 382, 9903, (2013): 1525-1533.

⁷⁸² "Lifestyle Choices: Root Causes of Chronic Diseases," Cleveland Clinic, accessed May 2, 2016, https://my.clevelandclinic.org/health/transcripts/1444_lifestyle-choices-root-causes-of-chronic-diseases.

⁷⁸³ D. B. Resnik, "Responsibility for Health: Personal, Social, and Environmental," *Journal of Medical Ethics*, 33, 8, (2007): 444-445.

⁷⁸⁴ "How to Save a Trillion Dollars," Mark Bittman, accessed May 2, 2016, <http://opinionator.blogs.nytimes.com/2011/04/12/how-to-save-a-trillion-dollars/>.

⁷⁸⁵ "Why We Need Public Health to Improve Healthcare," National Association of Chronic Disease Directors, accessed May 2, 2016, <http://www.chronicdisease.org/?page=WhyWeNeedPH2impHC>.

⁷⁸⁶ "New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act," Internal Revenue Service, accessed May 2, 2016, <https://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501%28c%29%283%29-Hospitals-Under-the-Affordable-Care-Act>.

⁷⁸⁷ "Hunger In Our Schools: Breakfast Is A Crucial 'School Supply' For Kids In Need," Tom Nelson, accessed May 2, 2016, <http://blogs.usda.gov/2015/03/03/hunger-in-our-schools-breakfast-is-a-crucial-school-supply-for-kids-in-need/>.

⁷⁸⁸ "The Capital's Food Deserts," Jeremy Moorhead, accessed May 3, 2016, <http://eatocracy.cnn.com/2012/03/14/the-capitals-food-deserts/>.

⁷⁸⁹ District of Columbia Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration, *District of Columbia HIV/AIDS, Hepatitis, STD, and TB (HAHSTA) Annual Report: 2010*, accessed May 3, 2016, http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2010_Annual_Report_FINAL_0_0.pdf.

Behavioral Health

Treatment for mental health, now more commonly referred to as behavioral health, has changed dramatically since a 1968 federal law required individuals be cared for in the least restrictive environment.⁷⁹⁰ This law led to an expectation that most patients would receive care in out-patient facilities. Recently legislation was passed that requires insurance companies to increase the amount of payment for behavioral health, which could add more patients to the health care system.⁷⁹¹ VHA is a leader in mental health treatment and should continue to be a trendsetter in this regard.

Preventive Medicine

Traditionally, physicians were trained to cure illness and to restore the sick to health. The trend, however, is changing, and physicians are now trained in prevention and are more active participants in the prevention of illness.⁷⁹² Additionally, insurance and Medicare now cover preventive care and annual physicals, further supporting prevention.⁷⁹³ Preventive medicine is a key component of integrated health care and will need to be considered as VHA works to transform veterans' healthcare.

Pharmacy Changes

Health Affairs reports that "in 2015 . . . an alarming trend of new high-cost specialty pharmaceuticals entered the market. . . . Overall drug spending increased 12.2 percent last year, the highest rate of increase in more than a decade."⁷⁹⁴ Escalating drug prices account for some of this increase, including more than 3,500 generic drugs that at least doubled in price from 2008–2015 and about 400 drugs that increased in cost 1000 percent.⁷⁹⁵ Newly emerging and very expensive developments in the area of genomic medication also contribute to the increase. "One way to combat skyrocketing prices will be biosimilar drugs. These drugs are near substitutes for original brand drugs and could bring significant price discounts."⁷⁹⁶ Because many of VHA's beneficiaries seek only prescription benefits, prescription drug trends will be important to consider in the transformation process.

⁷⁹⁰ "How Release of Mental Patients Began," Richard Lyons, accessed May 2, 2016,

<http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all>.

⁷⁹¹ "Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)," Substance Abuse and Mental Health Services Administration, accessed May 2, 2016, <http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>.

⁷⁹² "Opinion 8.075 – Health Promotion and Preventive Care," American Medical Association, accessed May 2, 2016, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8075.page>.

⁷⁹³ "Preventive Services Covered Under the Affordable Care Act," U.S. Department of Health and Human Services, accessed May 2, 2016, <http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/>.

⁷⁹⁴ Anne Martin et al., "National Health Spending In 2014: Faster Growth Driven By Coverage Expansion And Prescription Drug Spending," *Health Affairs*, 35, 1, (2016): 150-160.

⁷⁹⁵ "Generic Drug Prices Quickly on the Rise," Anthony L. Komaroff, accessed May 2, 2016, <http://www.spokesman.com/stories/2016/feb/18/generic-drug-prices-quickly-on-the-rise/>.

⁷⁹⁶ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

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APPENDIX F:

THE COMMISSION'S PROCESS

Commission Meetings

From September 2015 to June 2016, the Commission held convened 12 sessions of public meetings (26 days). The content addressed at each meeting is listed in the following table.

September 21-22, 2015

Assessment A: Demographics	RAND Corporation <ul style="list-style-type: none"> Christine Eibner
Assessment B: Health Care Capabilities	RAND Corporation <ul style="list-style-type: none"> Peter Hussey, PhD
VA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> Bob McDonald, Secretary Sloan Gibson, Deputy Secretary David Shulkin, MD, Under Secretary for Health
Assessment C: Care Authorities	RAND Corporation <ul style="list-style-type: none"> Michael D. Greenberg
Assessment I: Business Processes	Grant Thornton LLP <ul style="list-style-type: none"> Lane Jackson Aamir Syed Sharif Ambrose
Assessment E: Scheduling Workflow	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Alex Harris Pooja Kumar
Assessment F: Clinical Workflow	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Gretchen Berlin
Assessment G: Staffing/Productivity/Time Allocation	Grant Thornton LLP <ul style="list-style-type: none"> Peter Erwin, PhD Hillary Peabody Erik Shannon
Assessment J: Supplies	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Robin Roark, MD
Assessment K: Facilities	McKinsey & Company <ul style="list-style-type: none"> Vivian Riefberg John Means

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September 21-22, 2015 (continued)

VHA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning
Assessment Leadership	CMS Alliance to Modernize Health care <ul style="list-style-type: none"> Stephen Kirin Jay Schnitzer, PhD, MD McKinsey & Company <ul style="list-style-type: none"> Vivian Riefberg
Assessment H: Health IT	MITRE Corporation <ul style="list-style-type: none"> Aparna Durvasula Glenn Himes McKinsey & Company <ul style="list-style-type: none"> Celia Huber Vivian Riefberg

October 6, 2015

Eligibility	Veterans Health Administration <ul style="list-style-type: none"> Stephanie Mardon, Chief Business Officer Kristin Cunningham, Director, Business Policy Affairs
2014 Choice Act/2015 Enhancement to Choice/Care in the Community, Current State	Veterans Health Administration <ul style="list-style-type: none"> Stephanie Mardon, Chief Business Officer Kristin Cunningham, Director, Business Policy Affairs
Future State of VA Community Care/ Care in the Community	Veterans Health Administration <ul style="list-style-type: none"> Joe Dalpiaz, Director, VISN 17 Baligh Yehia, MD, Senior Health Advisor to the Secretary of Veterans Affairs Gene Migliaccio, Deputy Chief Business Officer, Managed Care
Academic Affiliations	Veterans Health Administration <ul style="list-style-type: none"> Robert Jesse, MD, Chief, Office of Academic Affiliations Karen Sanders, MD, Deputy Chief, Office of Academic Affiliation Long-Term Care Richard Allman, MD, Chief Consultant, Geriatrics and Extended Care Services

October 19–20, 2015

Independent Assessment, Perspective on VA Health Care, and Q&A/Panel Discussion	<ul style="list-style-type: none"> ▪ Brett Giroir, MD, Senior Fellow, Health Policy Institute, Texas Medical Center ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE ▪ Jonathan Perlin, MD, Chief Medical Officer and President, Clinical Services at Hospital Corporation of America
Women's Health	Veterans Health Administration <ul style="list-style-type: none"> ▪ Patricia Hayes, PhD, Chief Consultant, VA Women's Health Services
Mental Health	Veterans Health Administration <ul style="list-style-type: none"> ▪ David Carroll, Executive Director, Mental Health Operations ▪ Harold Kudler, MD, Chief Mental Health Consultant
Homelessness	Veterans Health Administration <ul style="list-style-type: none"> ▪ Anne Dunn, Deputy Director, VHA Homeless Program Office
Assessment D: Access	Institute of Medicine <ul style="list-style-type: none"> ▪ Michael McGinnis, MD ▪ Marianne Hamilton Lopez
VACAA Section 203	Northern Virginia Technology Council <ul style="list-style-type: none"> ▪ Ken Mullins
Scheduling	Veterans Health Administration <ul style="list-style-type: none"> ▪ Michael Davies, MD, Executive Director of Access and Clinic Administration Program
MyVA Support Services Excellence Overview	Department of Veterans Affairs <ul style="list-style-type: none"> ▪ Bob Snyder, Executive Director, MyVA Task Force ▪ Tom Muir, Director, Support Services

November 16–17, 2015

Health Care Economics/Finance	<ul style="list-style-type: none"> ▪ Mark Yow, Acting Chief Financial Officer, VHA ▪ Paul Mango, McKinsey & Company ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE
Academic Affiliations	Association of American Medical Colleges <ul style="list-style-type: none"> ▪ Atul Grover, PhD, MD, Chief Public Policy Officer ▪ John E. Prescott, MD, Chief Affiliations Officer ▪ Matthew Schick, JD, Director, Government Regulations & Regulatory Counsel
VHA Clinical Matters	Veterans Health Administration <ul style="list-style-type: none"> ▪ Lucille Beck, PhD, Deputy Chief Patient Care Services Officer, Rehab and Prosthetic Services ▪ Donna Gage, PhD, RN, Chief Nursing Officer

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December 14-16, 2015

Minority Affairs and Health Equity	<p>Department of Veterans Affairs</p> <ul style="list-style-type: none"> Barbara Ward, Director, Center for Minority Affairs <p>Veterans Health Administration</p> <ul style="list-style-type: none"> Uchenna S. Uchendu, MD, Executive Director, Office of Health Equity
Framework for the Future of Veterans Health	<ul style="list-style-type: none"> Garry Augustine, Disabled American Veterans Carl Blake, Paralyzed Veterans of America Carlos Fuentes, Veterans of Foreign Wars Ray Kelley, Veterans of Foreign Wars
Veteran Service Organizations	<ul style="list-style-type: none"> Louis Celli, The American Legion Renee Campos, Military Officers Association of America
National Health Information Operability	<ul style="list-style-type: none"> Dr. Jon White, Deputy National Coordinator, Department of Health and Human Services
DoD I Procurement: Lesson Learned/Interagency Program Office	<ul style="list-style-type: none"> Chris Miller, Program Executive Officer, Defense Health Care Management Systems, Department of Defense
Health Information Exchange	<ul style="list-style-type: none"> Elaine Hunolt, Do-Director Interoperability Office, Veterans Health Administration Dr. Harry Leider, Chief Medical Officer, Walgreens James Wood, VP-Federal, Walgreens Mariann Yeager, Chief Executive Officer, The Sequoia Project
Vision for OI&T/Collaboration with VHA	<ul style="list-style-type: none"> LaVerne Council, Chief Information Officer, Department of Veterans Affairs
Leadership and Transformation	<ul style="list-style-type: none"> Charles Rossotti, Former Commissioner, Internal Revenue Service

January 19 and 21, 2016

VHA Leadership	<ul style="list-style-type: none"> Dr. Michael Kussman, former Undersecretary for Health, Veterans Health Administration Dr. Kenneth Kizer, former Undersecretary for Health, Veterans Health Administration
Labor Perspectives	<p>American Federal of Government Employees</p> <ul style="list-style-type: none"> Marilyn Park <p>National Association of Veterans Affairs Physicians and Dentists</p> <ul style="list-style-type: none"> Samuel Spagnolo <p>Nurses Organization of Veterans Affairs</p> <ul style="list-style-type: none"> Joan Clifford Sharon Johnson

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January 19 and 21, 2016 (continued)

Behavioral Health	<ul style="list-style-type: none"> Association of Veterans Affairs Psychologist Leaders <ul style="list-style-type: none"> Thomas Kirchberg Russell Lemle Edgardo Padin-Rivera Antonette Zeiss American Psychiatric Association <ul style="list-style-type: none"> Jenny L. Boyer Association of Veterans Affairs Social Workers <ul style="list-style-type: none"> LeAnn Bruce Jerry Satterwhite
Homeless Veterans	<ul style="list-style-type: none"> Keith Armstrong, San Francisco Veterans Affairs Health care System
Other-Than-Honorable Discharges	<ul style="list-style-type: none"> Branford Adams

February 8-9, 2016

Construction Management	<ul style="list-style-type: none"> Lisa Freeman, Medical Center Director, Palo Alto Health care System
VISN and Field Leadership Perspectives	<ul style="list-style-type: none"> Joleen Clark, Former Network Director, VISN 8 Jon Gardner, Former Medical Center Director, Tucson VA Medical Center Lisa Freeman, Medical Center Director, Palo Alto Health care System
Implementation of the <i>Choice Program</i>	<ul style="list-style-type: none"> Billy Maynard, President HealthNet Federal Service David J. McIntyre, Jr., President and Chief Executive Officer, TriWest Healthcare Alliance
Update on VHA	<ul style="list-style-type: none"> Dr. David Shulkin, Undersecretary for Health, Veterans Health Administration
Determining Feasibility	<ul style="list-style-type: none"> Patrick Ryan, Former Staff Director and Chief Counsel, House Veterans Affairs Committee

February 29 – March 1, 2016

Economist Briefing	<ul style="list-style-type: none"> Gideon Lukens, PhD, Staff Economist Jamie Taber, PhD, Staff Economist
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March 21-23, 2016

Conversation with HVAC Chairman	<ul style="list-style-type: none"> Rep. Jeff Miller (R-FL)
Conversation with HVAC Member	<ul style="list-style-type: none"> Rep. Beto O'Rourke (D-TX)
Veterans Health Administration	<ul style="list-style-type: none"> Dr. David Shulkin, Undersecretary for Health Barbara Manning, Office of Policy and Planning Lyn Stoesen, Office of Policy and Planning

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March 21-23, 2016 (continued)

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Merideth Randles, FSA, MAAA, Milliman, Inc.
- Jamie Taber, PhD, Staff Economist

April 18-19, 2016

Veterans Service Organizations

- Garry Augustine, Disabled American Veterans
- Peter Dickinson, Disabled American Veterans
- Verna Jones, American Legion
- Rick Weidman, Vietnam Veterans of America
- Bill Rausch, Got Your 6
- Ray Kelley, Veterans of Foreign Wars
- Rene Campos, Military Officers Association of America

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Jamie Taber, PhD, Staff Economist

VA Leadership

Department of Veterans Affairs

- Bob McDonald, Secretary
- Sloan Gibson, Deputy Secretary

Community Care

- Baligh Yehia, MD, Assistant Deputy Under Secretary for Community Care, VHA

May 9-11, 2016

VA Office of General Counsel

- Leigh Bradley, General Counsel
- Jessica Tanner, Staff Attorney

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Jamie Taber, PhD, Staff Economist

June 7-8, 2016

No speakers

Commission Workgroups

The Commission on Care organized itself into workgroups in order to complete an analysis of relevant issues, consider options, and suggest recommendations to the full Commission for debate. The Commission formed five workgroups with each responsible for sections of the Independent Assessment or other topics taken on by the group. In establishing each workgroup an effort was made to balance perspectives and expertise, although Commissioners expressed interests were also taken into account in forming the membership of each group. The membership of each workgroup and the topics taken on by each is summarized in Table F-1.

Table F-1. Workgroup Structure and Topics

WORKGROUP NAME	TOPICS	MEMBERSHIP	
Health Care Alignment	<ul style="list-style-type: none"> ▪ Demographics ▪ Health care Capabilities ▪ Care Authorities ▪ Access Standards ▪ Governance 	<ul style="list-style-type: none"> ▪ Blecker ▪ Johnson ▪ Longman ▪ Selnick 	<ul style="list-style-type: none"> ▪ Gorman ▪ Khan ▪ McClenney
Health Care Operations	<ul style="list-style-type: none"> ▪ Access Standards ▪ Workflow Scheduling ▪ Workflow Clinical ▪ Staffing Productivity 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Harvey ▪ Longman ▪ Webster 	<ul style="list-style-type: none"> ▪ Gorman ▪ Hickey ▪ Taylor
Health Care Data, Tools & Infrastructure	<ul style="list-style-type: none"> ▪ Health IT ▪ Business Processes ▪ Supplies ▪ Facilities 	<ul style="list-style-type: none"> ▪ Blom ▪ Harvey ▪ Steele 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Johnson ▪ Taylor
Health Care Leadership	<ul style="list-style-type: none"> ▪ Organizational Health ▪ Leadership Systems 	<ul style="list-style-type: none"> ▪ Blecker ▪ Hickey ▪ Selnick ▪ Steele 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ McClenney ▪ Schlichting
Health Care Trends	<ul style="list-style-type: none"> ▪ Market Trends ▪ Technology ▪ Financing ▪ Vision 	<ul style="list-style-type: none"> ▪ Blom ▪ Johnson ▪ Schlichting 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Khan ▪ Webster

Each workgroup, together with any staff assigned to it, reviewed the findings and recommendations of the Independent Assessment and the Integrated Report; investigated external benchmarks and best practice models; heard testimony in public meetings (with the full Commission); met in workgroup session with VA employees, leaders, former staff and external experts to gather additional insights and explore relevant questions. Commissioners reviewed white papers and strawman proposals prepared by staff and by one another. Based on the assessments and group deliberations, each workgroup developed recommendations for consideration by the full Commission. Details of the process and outputs from each workgroup are described in the following sections.

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Health Care Alignment Workgroup

The alignment workgroup organized its work around six main topics: governance, realignment of facilities and services, medical sharing, eligibility, other than honorable discharges, and the organization of provider networks. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic was introduced through a summary paper or summary points which then were used as the basis for a conference call or a face-to-face discussion. For most topics, subsequent calls were held to discuss more detailed papers or to re-visit outstanding issues not yet resolved.

Commissioners also reviewed draft papers and provided additional feedback, revisions, and comments through written comments. The papers were finalized for inclusion in the draft Commission report for discussion on April 19. A summary of the work completed on each topic is provided in the table below.

Table F-2. Alignment Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E=email review M=face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Governance	11/17/2015	M	Vivian Riefberg	9/22/2015	F
	1/7/2016	C	Stephen Kirin	9/22/2015	F
	1/28/2016	C	Jay Schnitzer	9/22/2015	F
	2/18/2016	C	Paul Light	10/30/2015	S
	3/3/2016	C	Charles Rossotti	12/16/2015	F
	3/10/2016	C	Michael Kussman	1/19/2016	F
	3/17/2016	C	Ken Kizer	1/19/2016	F
	4/7/2016	C	Jeff Miller	3/21/2016	F
Realignment of Facilities and Services	1/7/2016	C	Vivian Riefberg	9/22/2015	F
	1/28/2016	C	John Means	9/22/2015	F
	3/10/2016	C			
	3/17/2016	C			
	4/7/2016	C			
Medical Sharing	1/28/2016	C	Atul Gover	11/16/2015	F
	3/3/2016	C	John Prescott	11/16/2015	F
	3/10/2016	C	Mathew Schick	11/16/2015	F
	3/17/2016	C			
	4/7/2016	C			
Eligibility	11/17/2015	M	Christine Eibner	9/21/2015	F
	12/10/2015	C	Michael Greenberg	9/21/2015	F
	1/28/2016	C	Pat Vandenberg	9/21/2015	F
	2/25/2016	C	Stephenie Mardon	10/6/2015	F
	3/10/2016	C	Kristin Cunningham	10/6/2015	F
	3/17/2016	C	Gail Wilensky	10/19/2015	F
	4/7/2016	C	Michael McGinnis	10/20/2015	F
			Marianne Hamilton Lopez	10/20/2015	F
			Michael Kussman	1/19/2016	F
			Jeff Miller	3/21/2106	F

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THE COMMISSION'S PROCESS

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E=email review M=face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Other-Than-Honorable Discharge	1/28/2016	C	Bradford Adams	1/20/2016	F
	2/18/2016	C			
	3/10/2016	C			
	3/17/2016	C			
	4/7/2016	C			
Organization of Provider Networks	1/28/2016	C	Peter Hussey	9/21/2015	F
	2/25/2016	C	Joe Dalpiaz	10/6/2015	F
	3/10/2016	C	Baligh Yehia	10/6/2015	F
	3/17/2016	C	Gene Migliaccio	10/6/2015	F
	4/7/2016	C	Michael Kussman	1/19/2016	F
			Jon Gardner	2/8/2016	F
			Billy Maynard	2/8/2016	F
			David McIntrye	2/8/2016	F
			Jeff Miller	3/21/2016	F
			Beto O'Rourke	3/22/2016	F

Health Care Operations Workgroup

The health care operations workgroup was organized around five main topics: access standards, scheduling, clinical workflow, staffing (HR), and productivity. The workgroup (select Commissioners and support staff) first met face-to-face on October 7, 2015 to: introduce the staff, review guiding principles and business rules, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics was discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research on the four main topics; and cover other issues that may have come up during sessions (i.e., Best Practices) or from questions posed by Commissioners. To supplement the Commission conferences, the workgroup held teleconferences to cover additional research or present information from subject matter experts or emailed informational briefs and write-ups for review before a workgroup teleconference. Feedback from the Commissioners was addressed and the potential recommendations were refined. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

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Table F-3. Health Care Operations Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Access Standards	10/20/2015	M	Stephanie Mardon	10/6/2015	F
	12/3/2015	C	Kristin Cunningham	10/6/2015	F
	2/25/2016	C	Institute of Medicine	10/13/2015	S
	4/27/2016	C	Institute of Medicine	10/20/2015	F
Scheduling	10/7/2015	M	McKinsey Co	9/22/2015	F
			Stephanie Mardon	10/6/2015	F
			Kristin Cunningham	10/6/2015	F
			Dr. Michael Davies	10/14/2015	S
			Gary Monder	10/14/2015	S
			Steve Green	10/14/2015	S
			Michael McGinnis	10/14/2015	S
			Ken Mullins	10/14/2015	S
			Marianne Hamilton Lopez	10/14/2015	S
			Institute of Medicine	10/20/2015	F
			Dr. Michael Davies	10/20/2015	F
			Dr. Michael Davies	11/18/2015	W
Clinical Workflow	10/27/2015	C	McKinsey & Co.	9/22/2015	F
	2/18/2016	C	Nora Socci	12/29/2015	S
	4/6/2016	C	Diane Pulphus	2/3/2016	S
			Hugh Scott	2/26/2016	S
Staffing	11/4/2015	C	McKinsey Co	9/22/2015	F
	12/3/2015	C	Dr. Jonathan Perlin	10/19/2015	F
	1/20/2016	M	Barbara Ward	12/7/2015	S
	2/18/2016	C			
	2/25/2016	C			
	4/6/2016	C			
Productivity	12/15/2015	M	McKinsey Co	9/22/2015	F
			Gene Migliaccio	10/6/2015	F
			Boston VAMC	12/7/2015:	S
			Dr. Michael Charness		
			Melanie Gilhern		
			Meredith Walker		
Best Practices	1/6/2016	C	Dr. Melanie Vielhauer		
			Rosemary Conlon		
	1/20/2016	M	McKinsey Co	9/22/2015	F
	2/25/2016	C	Dr. Theresa Cullen	12/2/2015	W
	3/14/2016	E	Dr. Daniel Bochicchio	12/3/2015	S
			David Atkins	1/5/2016	S
			Linda Lipson	1/5/2016	S
			Amy Kilbourne	1/5/2016	S
			Bob Monte	1/5/2016	S
			Rachel Goffman	1/5/2016	S
			Dr. Daniel Bochicchio	1/20/2016	S
			Barbara Meadows	2/25/2016	W
			Barbara Meadows	3/17/2016	W

Health Care Data, Tools & Infrastructure Workgroup

The Health Care Data, Tools & Infrastructure (DTI) workgroup organized its work around four main topics: Health Information Technology, Business Processes, Supplies and Facilities. DTI first met face to face on October 7, 2015 to: introduce the staff, review the charge of DTI, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics were discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research via white papers on the four main topics; and cover other issues that may have come up during sessions or from questions posed by Commissioners. To supplement the Commission face-to-face meetings, the workgroup held teleconferences to cover additional research or present information from subject matter experts. Feedback from the Commissioners was incorporated into the white papers and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

Table F-4. Data, Tools & Infrastructure Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call		S=met with staff		
	E= email review		W=met with workgroup		
	M= face-to-face meeting		F=full Commission testimony		
	Date	Type	Expert	Date	Type
Health IT	10/7/2015	M	MITRE Co	9/22/2015	F
	11/18/2015	C	Dr. Brett Giroir	10/19/2015	S
	12/2/2015	C	LaVerne Council,	10/27/15	HVAC
	3/7/2016	C	Chris Miller, Brian Burns		Hearing
	3/14/2016	C	Brookings Institution	11/6/2015	S
	3/21/2016	M	LaVerne Council	11/25/2015	S
	4/4/2016	C & E	Dr. Theresa Cullen	12/2/2015	W
			Chris Miller	12/15/2015	F
			Chuck Hume	12/15/2015	F
			Elaine Hunolt	12/15/2015	F
			Jim Wood	12/15/2015	F
			Mariam Yeager	12/15/2015	F
			LaVerne Council	12/15/2015	F
			Jamie Bennett	3/2/2016	S
			Margaret Donahue	3/11/2016	S
			Kai Miller	4/12/2016	S
Business Processes	10/20/2015	M	SecVA Bob McDonald	9/21/2015	F
	10/26/2015	M			
	3/14/2016	C			
	3/21/2016	M			
	4/4/2016	C			

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WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting	Date	Expert	Date	Type
Supplies (Pharmaceutical & Medical Devices)	10/7/2015	M	McKinsey Co	9/21/2015	F
	10/26/2015	M	Jonathan Miller	12/4/2015	S
	2/23/2016	E	Tucker Taylor	12/4/2015	S
	2/24/2016	C			
	3/7/2016	C			
	3/14/2016	C			
	3/21/2016	M			
Facilities	10/7/2015	M	Bob McDonald	9/21/2015	F
	11/18/2015	M	Jim Sullivan	11/11/2015	S
	12/2/2015	C	Mark W. Johnson	12/21/2015	S
	12/22/2015	M	Kyle Reinhardt	12/22/2015	S
	2/16/2016	E	Thom Kurmel	12/22/2015	S
	2/17/2016	C	Rick Bond	12/22/2015	S
	2/24/2016	C & E	John Bulick	12/22/2015	S
	3/7/2016	C	John Kay	12/22/2015	S
	3/14/2016	C	Jim Sullivan	2/16/2016	S
	3/21/2016	M	Ed Bradley	2/16/2016	S
	4/4/2016	C	Jim Sullivan	2/17/2016	W
	4/11/2016	C	Jim Sullivan	3/15/2016	S
	4/27/2016	C			
Other	11/5/2015	E			
	11/6/2015	E			
	3/11/2016	E			

Health Care Leadership Workgroup

The leadership workgroup organized its work around five main topics: organizational health and cultural transformation and four leadership system issues: recruitment, retention, development and advancement; organizational structure and function; performance management and performance measurement; and human capital management. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic received an evidence review and summary which was the basis for a conference call or a face-to-face discussion. On a few topics, Commissioners or staff heard directly from VA staff or outside experts to inform the deliberation. Then, in a second meeting on the topic, the Commissioners debated a strawman proposal and alternative recommendations based on the evidence review and the prior Commission discussion. Feedback from the Commissioners was incorporated into the strawman and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. The papers were finalized and presented to the full Commission for deliberation and feedback on March 22, 2016. A summary of the work completed on each topic is provided in the table below.

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Table F-5. Leadership Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Organizational Health and Cultural Transformation	12/2/2015	C	Stephen Kirin	9/23/2015	F
	12/9/2015	C	Jay Schnitzer	9/23/2015	F
	2/9/2016	M	Vivian Riefberg	9/23/2015	F
	2/17/2016	C	Dee Ramsel	11/9/2015	S
	3/11/2016	E	Ashby Sharpe	11/9/2015	S
			Ken Berkowitz	11/9/2015	S
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
Recruitment, Retention, Development, and Advancement	11/17/2015	M	Stephen Kirin	9/23/2015	F
	11/25/2015	C	Jay Schnitzer	9/23/2015	F
	2/17/2016	C	Vivian Riefberg	9/23/2015	F
	2/24/2016	C	Volney Warner	11/9/2015	S
	3/9/2016	C	Lisa Red	11/17/2015	W
	3/11/2016	E	Payton Rica-Lewis	11/17/2015	W
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Georgia Coffey	2/22/2016	S
			David Perry	2/24/2016	S
			Audrey Oatis-Newsome	2/24/2016	S
Organizational Structure and Function	10/27/2015	C	Stephen Kirin	9/23/2015	F
	2/9/2016	M	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Charles Rossotti	12/16/2015	F
			Michael Kussman	1/19/2016	F
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Robin Hemphill	3/4/2016	S
Performance Management and Performance Measurement	11/4/2015	C	Stephen Kirin	9/23/2015	F
	11/12/2015	C	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Peter Almenoff	10/30/2015	S
			Joe Francis	1/8/2016	S
			Carolyn Clancy	1/8/2016	S
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Noel Baril	3/9/2016	S

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WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Human Capital Management	12/15/2015	M	Stephen Kirin	9/23/2015	F
	12/23/2015	C	Jay Schnitzer	9/23/2015	F
	3/11/2016	E	Vivian Riefberg	9/23/2015	F
			Sam Retherford	12/15/2015	W
			Joleen Clark	2/8/2016	F
Leadership Vision	1/6/2016	C			
	1/21/2016	M			
	2/3/2016	C			
	2/4/2016	E			
Leadership Pre-amble	3/14/2016	E			

Site Visits

Background

In the coming decades there will be increased demand for accountability in health care and increased emphasis on health care outcomes and measurements, and VHA will need to rise to meet these expectations to survive and remain competitive in the demanding and turbulent health care environment.⁷⁹⁷ The changing nature of health care organizations, including pressure to reduce costs, improve the quality of care, and meet stringent guidelines, has forced health care professionals to reexamine how they evaluate performance.⁷⁹⁸ Although many health care organizations have long recognized the need to look beyond financial measures when evaluating performance, many still struggle with what measures to select and how to use the results of those measures.⁷⁹⁹

As the nation's largest health care system in 2016, VHA employs more than 305,000 health care professionals and support staff at more than 1,000 sites of care, including hospitals, community-based outpatient clinics (CBOCs), nursing homes, domiciliaries, and 300 Vet Centers.⁸⁰⁰ Given the scope of this health care system, the Commission recognized the importance of direct lines of communication and interaction with VHA leaders, staff, and patients, to include conducting facility site visits. Commissioners conducted facility site visits to their local VA facilities to assist in the evaluation of the findings identified by the *Independent Assessment Report*, to contribute to an environmental scan of the VHA, and to inform the development of recommendations.⁸⁰¹

Scope of Site Visits

In January and February 2016, most of the 15 Commissioners conducted site visits to the VA medical centers (VAMCs) and CBOCs proximal to their respective residences. The Commissioners approached these site visits with a collaborative and information-seeking tone with the purpose of having open discussions with VAMC leadership, staff, and patients.

Individual Commissioners visited 12 VAMC facilities or CBOCs in 7 out of 19 Veteran Integrated Service Networks (VISNs). Additionally, all the Commissioners who attended the February 29, 2016, meeting in Dallas, TX, toured the Dallas VAMC.

⁷⁹⁷ Kenneth W. Kizer, M.D., M.P.H./Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation for the Veterans Healthcare System*, accessed March 1, 2016, <http://www.va.gov/healthpolicyplanning/rxweb.pdf>.

⁷⁹⁸ Kicab Castaneda-Mendez/Quality Digest, Performance Measurement in Health Care, accessed, March 1, 2016, <http://www.qualitydigest.com/magazine/1999/may/article/performance-measurement-health-care.html#>.

⁷⁹⁹ Ibid.

⁸⁰⁰ Department of Veterans Affairs, Undersecretary for Health, accessed March 1, 2016, <http://vaww.ush.va.gov/>.

⁸⁰¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, v, accessed March 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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Table F-6. VA Facility Site Visit Locations

VISN	VISN Name	VA Facility
2	VISN 2	VA Hudson Valley Health Care System (Montrose, NY)
6	VA Mid-Atlantic Health Care Network	Fredericksburg Community-based Outpatient Center, (Fredericksburg, VA)- part of Hunter Holmes McGuire VA Medical Center, Richmond, VA
7	VA Southeast Network	Ralph H. Johnson VA Medical Center (Charleston, NC) Wm. Jennings Bryan Dorn VA Medical Center (Columbia, SC)
10	VA Health Care System	VA Ann Arbor Health care System (Ann Arbor, MI) John D. Dingell VA Medical Center (Detroit, MI)
17	VA Heart of Texas Health Care System	Dallas VA Medical Center (Dallas, TX)
21	Sierra Pacific Network	Southern Nevada Health care System (Las Vegas, NV) VA Northern California Health Care System (Mather, CA) VA Palo Alto Health Care System (Palo Alto, CA)
22	Desert Pacific Health Care Network	Greater Los Angeles Health care System (Los Angeles, CA) VA San Diego Health care System (San Diego, CA)

The Commissioners were provided with a generic basic agenda as guidance, though they had the latitude to determine their own agendas as appropriate for the locations they visited. The model agenda included the following activities: a welcome and overview of the VA health care facility; tour of the facility; veteran discussion session (informal or formal); VHA employee session (e.g., informal or small group discussion); a discussion with the facility leadership, and were provided the recommended questions listed below:

- What does the medical center do well?
- What unique resources can the medical center draw on?
- What do others see as the strengths of the medical center?
- What could the medical center improve?
- Where does the medical center have fewer resources than others?
- What are others likely to see as weaknesses of medical center?
- What opportunities are open to the medical center?
- What trends could the medical center take advantage of?
- How can the medical center turn its strengths into opportunities?
- What threats could harm the medical center?
- What obstacles does the medical center face?
- What threats do the medical center's weaknesses expose it to?

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- What is the impact of MyVA?
- How do employees view working at VA compared to two or three years ago? If there is a change, what is driving it?
- In your view, what is the most important factor affecting patient satisfaction with the care you provide?
- In your view, has there been a change in the perception of the quality of care provided by the medical center? If so, what might be driving this different perception?

Once the Commissioners completed their visits, they provided the data they gathered to Commission staff to be organized in a strengths-weaknesses-opportunities-threats (SWOT) analysis framework. A SWOT analysis is a simple but useful framework for analyzing the four factors as they are faced by an organization. It helps organizations develop strengths, minimize threats, and take the greatest advantage of available opportunities.⁸⁰²

Findings

VHA leadership and staff enthusiastically shared their time, insights, perspective, and data on organizational and operational processes with the Commissioners. The site visits provided insight and reinforced the findings of the *Independent Assessment Report*.

Confirming what the *Independent Assessment Report* stated, the Commissioners found VHA facilities' staff members exhibit a deep commitment to serving veterans, but that VHA's health care facilities deliver strikingly different patient experiences, apply inconsistent business processes, and differ widely on key measures of performance and efficiency.⁸⁰³ Based on Commissioners' observations of weaknesses, challenges, and threats related to daily operations, VAMC staff members appear to be searching for suitable solutions. Anecdotal responses provided to the Commissioners illuminated the following systemic problem areas at the VAMCs:

- Care authorities: health care capabilities (i.e., purchased care)
- Staffing: productivity (i.e., human resources), health care capabilities, access standards, clinical workflow
- Leadership: staffing, productivity (i.e., human resources)
- Facilities: health care authorities (i.e., patient-centered community care)

Data from Commissioners' observation notes were organized into a SWOT analysis chart based on the common themes of the Commissioners' facility site visits. The purpose of this exercise was to gather information to inform the Commission's recommendations and to confirm or

⁸⁰² "SWOT Analysis," Mind Tools, accessed March 15, 2016, https://www.mindtools.com/pages/article/newTMC_05.htm.

⁸⁰³ "Veterans Integrated Service Networks (VISN)," Department of Veterans Affairs, VHA, accessed March 14, 2016 <http://www.va.gov/directory/guide/division.asp?dnum=1>.

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dispute the findings of the *Independent Assessment Report*. The Commissioner site visit inputs are summarized in the table below.

Table F-7. SWOT Analysis of Commissioner Site Visit Observations

Strengths	Weaknesses	Opportunities	Threats
<ul style="list-style-type: none"> ▪ VA medical center workforce customer service and dedication ▪ Research and national databases ▪ Veterans service – connected services and programs ▪ Partnerships with medical schools and training programs 	<ul style="list-style-type: none"> ▪ Inefficient/ineffective HR policies ▪ High levels of staffing vacancies ▪ Lack of clinical space; inefficient configurations of clinical space ▪ Poor access to VA care for rural veterans ▪ Lack of an effective financial system to provide real-time payment process to veterans Choice and Purchased Care Programs ▪ Lack of effective VHA leadership workforce ▪ Lack of capacity/access to appointments in VHA ▪ Insufficient federal government health care appropriation rules 	<ul style="list-style-type: none"> ▪ Modernization of VA IT ▪ Customer service training/standards ▪ Strategic focus on VHA core mission ▪ Local funding flexibility from Congress ▪ New vision and mission for VHA health care ▪ Process/systems reengineering ▪ Recruitment of outside leader candidates and retention of high-performing VHA leaders 	<ul style="list-style-type: none"> ▪ Misalignment between Congress's health care operational plans for veterans and VHA strategic health care plans ▪ Competing stakeholders health care interests ▪ Office of Personnel Management outdated standards/policies ▪ Insufficient VHA leadership development ▪ Insufficient IT funding ▪ The physician shortages around the nation has severely impacted the care of patients

Conclusions

Fundamental transformation of VHA is needed to ensure optimal delivery of veteran-centered, high-quality care. Essential to laying the path to excellence and strategic planning is a comprehensive understanding of the current state as well as the opportunities and threats facing the system. A robust connection between leaders in VHA Central Office and leaders in the field is critical to meet the needs of the veteran population served.

As part of the strategic planning process, VA/VHA leadership should make recurring site visits to VHA facilities, including VAMCs, VISN headquarters, and CBOCs to obtain current insight of the following critical areas: health care trends, health care operations, facility management and renovation/replacement, business processes and contracting, and other trends or issues affecting VAMCs. VA/VHA leaders should use performance management tools and activities to ensure the strategic goals are being met in an effective and efficient manner. It is a constant challenge to continuously and reliably measure the pulse of the organization. Site visits promote a healthy culture of sharing and building an understanding of organizational mission.

APPENDIX G: VETERAN FEEDBACK

In addition to the more than 4,000-page *Independent Assessment Report*, the Commission examined dozens of other reports, studies, and presentations as cited in the hundreds of footnotes dispersed throughout this Final Report. Collectively, these many sources provide a wealth of information on the challenges VHA confronts in realizing a vision for veterans' healthcare that leverages the strengths of VA and capitalizes on the potential non-VA providers offer.

A key source the Commission considered was the views of veterans themselves. Given the Commission's brief tenure, it was not possible to conduct a survey representative of the views of millions of veterans receiving health care from VHA. Instead, the Commission encouraged veterans to offer feedback on their health care experiences and the work of the Commission through its website. Many veterans service organizations (VSOs) also provided views representing their members in open sessions with the Commission and in formal letters and position statements directly to the Commission.

The feedback offered by veterans through the Commission's web site covered a range of health care topics, such as whether and to what extent care should be privatized, how much choice veterans should have in deciding on their care, and their assessment of the quality of care received. Not surprisingly, veterans (including a few who were also VA employees) are quite passionate about their views on health care. For the most part, veterans' feedback from the web site expressed opposition to efforts to *privatize* VHA, although a few did want more access to non-VA providers. The *Choice Program* was frequently criticized for long delays in appointments, convoluted or misapplied eligibility criteria, and issues with how providers should be reimbursed for treatment and how much the veteran should pay. When the quality of care was noted, on balance veterans praised the care received from VHA, with a few disappointed, especially when care was outsourced to non-VA providers. Because the feedback was unstructured, veterans could offer any observations they found pertinent.

The Disabled American Veterans (DAV) shared with the Commission a compendium of more than 4,000 verbatim comments on veterans' health care experiences gathered from their members during April 2016. The DAV reviewed the comments and categorized 82 percent of the comments as "overall positive experiences."⁸⁰⁴ The Commission staff reviewed the comments from DAV, with findings consistent to DAV's.

⁸⁰⁴ Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.

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VA Efforts to Gather Input on Veterans Views on Health Care

Like most institutions that provide products and services to customers, VA/VHA solicits input from veterans on their health care needs and their views on specific services VA/VHA provides. Surveys, focus groups, and in-depth interviews are the more typical means for gathering input from veterans. On occasion, VA, like most agencies, encourages veterans and others to submit comments on a particular aspect of VA services and benefits.⁸⁰⁵

The following sections describe the more typical methods employed by VA/VHA to gather input from veterans.

VHA Survey of Veterans' Health and Use of VHA

Conducted by the assistant deputy undersecretary for policy and planning, the survey of veteran enrollees' health and use of health care (Survey of Enrollees) is an annual survey of more than 40,000 veterans who are enrolled in VA's health care system. The Survey of Enrollees was initially designed to give VHA the information it needed to predict the demand for services in the future. The data are used to develop health care budgets and to assist VA with its annual enrollment decisions. Over the years, the data have also been used to analyze policy decisions, provide insights into specific populations and their perspectives, and inform management decisions affecting delivery of care. In addition to collecting basic demographic information, the survey explores insurance coverage, use of health care inside and outside of VA, pharmaceutical use, attitudes and perceptions about VHA services, perceived health status, and trends in smoking among veterans enrolled in the VHA system.⁸⁰⁶

Survey of Healthcare Experiences of Patients⁸⁰⁷

The Survey of Healthcare Experiences of Patients (SHEP) program was initiated in 2002 in an effort to create standardized survey instruments administered monthly to assess ambulatory and inpatient care. In an effort to standardize its survey instruments with other health care providers, SHEP now employs the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey methodology for VHA's primary care and inpatient medical and surgical services. These surveys are supported in the public domain by the CAHPS Consortium, Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, and National Committee for Quality Assurance. Although SHEP deployed the standardized CAHPS surveys,

⁸⁰⁵ "Quality of Care Feedback Form," Department of Veterans Affairs, accessed June 20, 2016, <http://www.va.gov/QUALITYOFCARE/apps/contact.asp>. As an example, the VA web site provides a Quality of Care feedback page for veterans and others to enter comments on the care a veteran received.

⁸⁰⁶ Westat, 2015 Survey of Veteran Enrollees' Health and Use of Health Care, accessed June 6, 2016, http://www.va.gov/healthpolicyplanning/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁸⁰⁷ For more details on SHEP and VHA's recent initiatives to expand the scope of the program, see "Health Services Research & Development, Commentary: Listening to Veterans about Access to Care," Steven M. Wright, VHA Office of Analytics and Business Intelligence, U.S. Department of Veterans Affairs, accessed June 20, 2016, <http://www.hsrd.research.va.gov/publications/forum/nov15/default.cfm?ForumMenu=nov15-1>.

the access questions were limited and did not evaluate the full scope of services used by veterans.

VHA intends to expand the SHEP program with additional surveys in 2016 and beyond. These surveys will focus on satisfaction with various specialty care services and experience with community care available through the Veterans Access, Choice, and Accountability Act of 2014. VHA has also launched a survey that focuses on new veteran enrollments and their experience with first clinic appointments.

Veteran Insights Panel

VHA also established a Veteran Insights Panel, comprising more than 3,200 veterans that are representative of users of VA health care.⁸⁰⁸ VHA interacts with the panel through email notification and a special access website (mobile device enabled). This approach provides VHA an opportunity to engage panel members in direct discussions, including real time feedback via live chat, about important themes and issues, and survey development and testing. The panel can be engaged collaboratively with operational program offices and researchers to prompt direct discussions with our veterans.

Voices of Veterans: On-going Research

Initiated in the spring of 2014, the VA Center for Innovation (VACI) sponsors an on-going effort to employ human-centered design (HCD)⁸⁰⁹ concepts in a pilot to explore veterans' experience with VA through the eyes of 40 veterans across a range of demographics and locations.⁸¹⁰ The pilot had two goals:

- To test the usefulness and application of an HCD methodology within the context of VA.
- To better understand veterans' experiences interacting with VA, identify pain points in the present day service delivery model, and explore opportunities to transform these interactions into a more veteran-centered experience.

Developing Veteran Personas

As a part of this pilot, VACI set out to identify high-level trends in ways veterans seek out assistance, use technology, take advantage of services, and react to challenging interactions. Based on these patterns, VACI created a set of four profiles, or personas, that represent the

⁸⁰⁸ Ibid.

⁸⁰⁹ Human-centered design (HCD) is a discipline in which the needs, behaviors and experiences of an organization's customers (or users) drive product, service, or technology design processes. It is a practice used heavily across the private sector to build a strong understanding of users, generate ideas for new products and services, test concepts with real people, and ultimately deliver easy-to-use products and positive customer experiences. HCD is a multi-disciplinary methodology which draws from the practices of ethnography, cognitive psychology, interaction and user experience design, service design, and design thinking. It is closely tied to "user-centered design," which applies parallel processes to technology projects, and "service design" which address the service specific experiences.

⁸¹⁰ U.S. Department of Veterans Affairs, Center for Innovation, *Toward a Veteran-Centered VA: Piloting Tools of Human-Centered Design for America's Vets, Findings Report, July 2014*, accessed June 20, 2016, http://www.innovation.va.gov/docs/Toward_A_Veteran_Centered_VA_JULY2014.pdf.

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kinds of users within the set of 40 veterans engaged in the pilot (see Table G-1). Each persona is an archetype based on commonalities observed among veterans who exhibited similar behaviors and approaches to accessing VA services. They are not categorized by positive or negative experiences, but by shared expectations and needs. These personas were designed to help VHA begin to understand that it is serving users who are seeking not just different services, but also varied degrees of contact, support, information, and so forth. For this exercise, VACI assessed veterans' modes of communication, channels, frequency, stated and observed needs, reactions to service experiences, military service, and analyzed observed behavior and service experiences.

*Table G-1. Veteran Profiles Developed by the VA Center for Innovation*⁸¹¹

THE LIFER	THE TRANSACTIONAL
<p>Frequently use VA services and plans to continue doing so. Look to VA to play a supporting, community-building role in life. Grateful for VA benefits, but get frustrated when problems arise which break up the continuity of care—like when doctors change too frequently and when they cannot get transportation to VA facilities. Generally, try to speak highly of VA and wants to contribute to making it work better for fellow veterans.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA cares and takes the time to understand veteran's needs and story ▪ That cost of VA services won't rise ▪ That veteran can reach someone at VA anytime <p>Needs</p> <ul style="list-style-type: none"> ▪ Does not want to tell story over and over, especially after using VA for so long ▪ Wants to know what is going on with services and especially benefits ▪ Likes patient, nurturing health care 	<p>Joined the military largely based on the promise of the opportunities it would provide in life. Plan to use VA services to "get life on track" post-service. Tend to be in the younger generation of veterans (OEF, OIF, OND). Often engaged in the veteran community, see other veterans as allies, and advocates in helping folks understand and use their benefits. Will share frustrations if feels like VA is not helping as promised.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA will deliver on its promises and help veteran access the benefits earned ▪ That VA has benefits available to veterans families ▪ That it will be a headache, and veterans will have to figure it out on their own with the help of network <p>Needs</p> <ul style="list-style-type: none"> ▪ Accurate expectations ▪ Financial support at times, especially for family ▪ To feel a part of a community

⁸¹¹ Ibid.

THE JUST-IN-CASE	THE INFREQUENT
<p>Proud of service, but does not need VA and plans on using it only as a backup. Mature and organized by nature, has all papers in order with VA and have a good idea of services for which they are eligible. Grateful for the benefits available, but see working with VA as a tradeoff for time and will likely only lean on VA as a backup plan.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That will likely never need VA benefits ▪ That VA will be there if needed ▪ That there are benefits available to family ▪ That private benefits are of higher quality and greater ease <p>Needs</p> <ul style="list-style-type: none"> ▪ Peace of mind ▪ To be assured that all documents are in order ▪ To easily get in touch with one person about one question 	<p>Does not think very much about VA. Have used VA benefits in lifetime, yet often years will go by between those interactions. This might be because these veterans live in places where it is difficult to access VA services, because veterans are financially comfortable, or because it seems like too much hassle. Tend to prefer quick interaction—a short phone call or a few clicks on a website.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA is slow—like any bureaucracy ▪ That VA is for “other, injured veterans who need it more” ▪ That someone will tell veterans when and if they are eligible for something <p>Needs</p> <ul style="list-style-type: none"> ▪ To be able to quickly navigate processes ▪ To be reminded every few years of how VA might be able to help

Vantage Point: VA’s Official Blog

In addition to surveys, focus groups, and town-hall sessions, VA instituted a blog on its website and invites veterans and others interested in veterans matters to submit guest posts of potential interest to others in the community. Like most blogs, the content offered is vetted by the VA. Since 2010, Vantage Point includes hundreds of contributors with articles on various health care topics.⁸¹²

Veterans’ Views Gathered by VSOs

Like VHA, the VSOs solicit input from their membership and other stakeholders on a variety of topics and issues relevant to veterans. Occasionally surveys and polls are undertaken, but most VSO efforts to gather input take place at the grassroots level during town halls, chapter meetings and other gatherings. While these venues often suffer from self-selection bias and non- or under-represented participant samples, these are nevertheless an important source of timely information on topics of interest and concern to veterans. What follows is a selection of VSO efforts to gather input on issues important to veterans.

⁸¹² “Vantage Point: Official Blog of the U.S. Department of Veterans Affairs,” Department of Veterans Affairs, accessed June 20, 2016, <http://www.blogs.va.gov/VAntage/>.

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The DAV Veterans Pulse Survey (2015)

In mid-2015 the DAV surveyed a nationally representative sample of veterans to solicit their views on issues important to veterans.⁸¹³ The survey includes questions on various aspects of veterans' healthcare. The survey consists of a national probability sample of 1,701 veterans intended to represent the veteran population in the United States. Oversampling occurred in certain subgroups, such as female veterans and veterans age 18-40 to allow for more precision in the response estimates for these subgroups.

Veterans of Foreign Wars Our Care Veterans Survey (2015)

In the fall of 2015, the Veterans of Foreign Wars of the U.S. (VFW) published a report on its veterans 2015 Health Care Options, Preferences and Expectations Survey.⁸¹⁴ In response to the intensified debate over reform of veterans' healthcare, the VFW launched a survey in the summer of 2015 designed to evaluate veterans' options, expectations, and preferences when seeking health care. The survey did not just focus on VA services, but sought to paint a picture of how the veterans' community at large interacts within the American health care infrastructure, and the choices they make in today's health care marketplace. According to the VFW report, 1,847 veterans responded to the survey, with 92 percent eligible for care and 83 percent of those eligible reporting that they utilize VA health care.⁸¹⁵ Respondents' average age was 65, with about two-thirds Vietnam War veterans.

VFW Survey of Women Veterans (2016)

In an effort to identify barriers women veterans face when accessing their earned veterans' benefits and services, the VFW has commissioned a survey of women veterans that will guide the VFW's policy priority goals for women veterans.⁸¹⁶ Though the survey data collection phase is completed, results have not been published prior to release of the Commission's Final Report.

⁸¹³ Disabled American Veterans (DAV), *The DAV Veterans Pulse Survey: A landmark study of the attitudes and perceptions of America's veterans*, accessed June 20, 2016, <https://www.dav.org/wp-content/uploads/DAV-Pulse-Report-Final.pdf>. The survey was conducted on behalf of DAV by GfK Knowledge Networks, Inc. using their KnowledgePanel® survey participants in November 2015.

⁸¹⁴ Veterans of Foreign Wars, *Our Care: A Report on Veterans' Options, Preferences and Expectations in Health Care*, September 22, 2015, accessed June 20, 2016, http://www.vfw.org/uploadedFiles/VFW.org/VFW_in_DC/VFWOurCareReport2015.pdf.

⁸¹⁵ Ibid., 4.

⁸¹⁶ "VFW Survey of Women Veterans: Help Hold the VA Accountable," Veterans of Foreign Wars, December 22, 2015, accessed June 20, 2016, <http://www.vfw.org/News-and-Events/Articles/2015-Articles/VFW-Survey-of-Women-Veterans/>.

The American Legion Survey of Patient Health Care Experiences (2014)

This survey of 3,116 opt-in, self-reported veterans focuses on satisfaction and levels of perceived benefits with VA's posttraumatic stress disorder/traumatic brain injury (PTSD/TBI) programs, including alternative and complementary treatments.⁸¹⁷

Survey questions include veteran status; gender; era of service; number of times deployed; diagnosis of TBI and/or PTSD; availability of appointments; time and distance to care facilities; treatment type (therapy, medication and complementary and alternative medicine); reported symptoms; efficacy of treatment; and side effects.

The American Legion Women Veterans Survey Report (2011)

This survey of 3,012 women veterans, and the resulting report, was prepared by ProSidian Consulting, LLC on behalf of The American Legion. The survey assessed the perceptions of and satisfaction with women veterans' health care and other benefits delivered to women veterans through the VA system. Additionally, the survey sought to determine the factors driving women veterans' decision to use the VA system as opposed to other private or public health care systems.⁸¹⁸

Iraq and Afghanistan Veterans of America Member Survey (2015)

During the first half of 2015, 1,501 Iraq and Afghanistan Veterans of America members completed a wide-ranging on-line survey covering such issues as employment, education, GI Bill usage, health (including mental health), VA utilization, VA benefits, reintegration and more. The survey was composed of approximately 300 questions, with respondents answering only questions relevant to their experiences. Health care topics included percent enrollment in and reliance on VA care; health insurance coverage by type; and experience rating for VA care. Usage percent and experiencing rating for the VA *Choice Program* was also covered separately.⁸¹⁹

The 2015 Wounded Warrior Project® Alumni Survey

This web-enabled, opt-in survey of 23,200 Wounded Warrior Project (WWP) members measures a series of outcome domains within the following general topics about WWP Alumni: background information (military experiences and demographic data), physical and mental well-being, and economic empowerment.⁸²⁰ This WWP membership survey has been conducted annually since 2010. As it has done in prior years, Westat conducts the survey and population-

⁸¹⁷ "Legion survey to measure effectiveness of PTSD/TBI treatment," The American Legion, July 29, 2015, accessed June 20, 2016, <http://www.legion.org/pressrelease/229354/legion-survey-measure-effectiveness-ptsdtbi-treatment>.

⁸¹⁸ ProSidian Consulting, LLC, *The American Legion Women Veterans Survey Report*, March 9, 2011, accessed June 20, 2016, http://www.legion.org/documents/legion/pdf/womens_veterans_survey_report.pdf.

⁸¹⁹ "Media Advisory: IAVA to Release Groundbreaking Veterans Survey," Iraq and Afghanistan Veterans of America (IAVA), May 23, 2016, accessed June 20, 2016, <http://iava.org/press-release/media-advisory-iava-to-release-groundbreaking-veterans-survey-2/>.

⁸²⁰ Westat, *2015 Wounded Warrior Project Survey, Report of Findings*, August 14, 2015, accessed June 20, 2016, https://www.woundedwarriorproject.org/media/2118/2015_wwp_alumni_survey_full_report.pdf.

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weights the reported results, to include adjustments for potential non-response bias, to be representative of the WWP membership base (approximately 59,000).

Right to Care: Voices of Swords to Plowshares' Veteran Community (2015)

The Swords to Plowshares, Institute for Veteran Policy interviewed in-person or by phone 22 veterans.⁸²¹ Although the topics were established in advance, Swords to Plowshares characterized these interviews as individual “conversations” with a preselected group of veterans. The veterans were chosen to represent a cross-section of combat eras and VHA usage levels. The topics covered included: navigating VA care, reliance on VA and non-VA care, comprehensiveness of care, and rating quality of care. The study includes extensive verbatim comments from veterans on these topics.

Comments from Veterans About Their Experiences as Users of VHA (DAV, 2016)

During April 2016, DAV reached out to veterans around the United States and asked them to share their experiences with the VA health care system. As a result, DAV received (as of April 2016) more than 4,000 responses from veterans sharing their own stories about the care they received from VHA.⁸²² The Commission’s review of the material showed that a majority of the veterans’ comments were positive in nature. DAV’s own analysis concluded that 82 percent of the comments could be categorized as “overall positive experiences.”

Other Surveys on Veterans Issues

In addition to efforts by VA and VSOs to gather feedback from veterans on their health care, other organizations have also addressed veterans’ health care issues.

Concerned Veterans for America Survey of Veterans' Healthcare (November, 2014)

The Concerned Veterans for America commissioned The Tarrance Group to conduct a national survey of 1,000 veterans during November 2014.⁸²³ This survey used a random, demographically representative sample of veterans. Four survey items addressed health care, including: knowledge of any problems at VA; need for reform of veterans’ healthcare; importance of more choice (or options) in health care for veterans; and importance of best possible veterans care, even if outside VA.

⁸²¹ Megan Zottarelli, *RIGHT to CARE: Voices of Swords to Plowshares' Veteran Community*, Swords to Plowshares, Institute for Veterans Policy, April 2016.

⁸²² Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.

⁸²³ Concerned Veterans for America, *Fixing Veterans Health Care*, A Bipartisan Policy Taskforce, accessed June 20, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>.

Vet Voice Foundation Survey of Veterans (October, 2015)

Chesapeake Beach Consulting and Lake Research Partners conducted 800 phone (landline and cell) interviews of veterans during October 2015. The results were population weighted by demographics. Topics included rating the job VA hospitals are doing in their area and the extent they favor/oppose privatizing some of VA's health care.

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APPENDIX H: ADDITIONAL RESOURCES

The VHA health care system is immense and complex. This report provides background for the areas for which the Commission has made recommendations, yet this information is but a glimpse at the intricacies of veterans' health care. The resources below may serve as a starting point for those who would like to develop a deeper understanding of the topic than the Commission could address in this report.

Independent Assessment Report

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow – Scheduling)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow – Clinical)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

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Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

Veteran Health Competency Resources

American Nurses Foundation

The American Nurses Foundation, the philanthropic arm of the American Nurses Association, is launching an innovative web-based PTSD Toolkit for registered nurses. The toolkit provides easy to access information and simulation based on gaming techniques on how to identify, assess and refer veterans suffering from PTSD. www.nurseptsdtoolkit.org

American Osteopathic Association

The American Osteopathic Association (AOA) represents osteopathic physicians, many of whom are in primary care practice, and essentially all of whom treat America's veterans and their families. The AOA is raising awareness in the osteopathic community about the importance of having a comprehensive understanding of the unique physical and mental health care needs of our service members, veterans, and their families. The AOA is committed to ensuring that medical students, physicians, and other health care providers understand that an individual's physical and/or mental health condition may be linked to his or her military experience.

www.osteopathic.org/inside-aoa/public-policy/Pages/federal-initiatives.aspx

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Center for Deployment Psychology

The Center for Deployment Psychology of the Uniformed Services University of the Health Sciences, Department of Medical and Clinical Psychology offer a wide variety of on-line courses and other resources to help uniformed clinical providers, VHA providers, and community clinicians provide care consistent with the needs and experience of military service members, veterans and their families.

<http://deploymentpsych.org/online-courses>

<http://deploymentpsych.org/military-culture-course-modules>

Rural Clergy Training Program

The Rural Clergy Training Program, an initiative of the VHA National Chaplain Center and the Office of Rural Health, offers training and information to clergy providing pastoral services to veterans and their families.

http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December_2015.pdf

Swords to Plowshares Combat to Community Training

Swords to Plowshares is nationally recognized for its expertise in providing comprehensive services and promoting and protecting the rights of veterans. Swords to Plowshares' *Combat to Community*® training is a series of accredited cultural competency curricula developed by its Institute for Veteran Policy team with the purpose of educating the community to address the reintegration challenges veterans face and the unique skill sets they acquire in service. The training was developed for law enforcement, first responder, mental health, and service professionals to teach:

- Commonly shared attitudes, values, goals, and practice that often characterize service in the military
- Recruitment and retention strategies for veteran employment
- How deployment, combat experience, service related injuries, and disability can impact veterans
- How veteran or military family status can inform interactions and services
- Potential resources to refer veterans and families to for supportive services

The training incorporates knowledge developed by experts in the fields of veteran culture and direct services with practical tools and resources to increase understanding and improve interactions with veterans.

<https://www.swords-to-plowshares.org/combat-to-community>

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VA Military Culture Training Courses on TMS

The resources below are available to VA employees and contractors. Versions of these courses should be made available to community providers through an alternative to TMS that allows outside providers to access the training.

- **Military Culture Training for Health Care Professionals – Organization and Roles (VA 19332)**

The first module of this online course provides an overview of the differences between the explicit and implicit features of military culture and describes the characteristics of implicit military culture. The next module identifies four sources of information about implicit military culture and describes six defining characteristics of warrior ethos. The learner is provided information about the influence of military guiding ideals and values on the lives of service members and veterans. The final module offers an overview regarding the connotations of implicit military culture on the health care professional.

- **Military Culture Training for Health Care Professionals: Self-Awareness and Military Ethos (VA 19333)**

This online course, sponsored by the Department of Veterans Affairs and Department of Defense, helps health care professionals understand the role that military culture plays in the lives of those they serve. The course is comprised of four modules: 1) Self-Assessment and Introduction to Military Ethos, 2) Military Organization and Roles, 3) Stressors and Their Impact, and 4) Treatment Resources and Tools.

- **Military Culture Training for Health Care Professionals: Stressors & Resources (VA 19334)**

This online course offers the learner an explanation of how stress can be either helpful or harmful depending on the nature of the provoking stressor and the availability of resources. The four phases of modern operational deployment cycles is presented in great detail in module 3. The next two modules describe the characteristic operational stressors and the spectrum of operational stress states and outcomes experienced by service members and their families during each deployment cycle phase.

- **Military Culture Training for Health Care Professionals: Treatment Resources, Prevention & Treatment (VA 19335)**

This online course in the military culture curriculum outlines the military culture impact on patient care and the health care professional's role and explains the range of DoD and VA psychological health services. The course also provides information on interpreting military culture knowledge into patient assessment and treatment. Finally, the learner is exposed to the military culture implications of VA/DoD clinical practice guidelines relevant to the care of service members and veterans and the strategies for identifying current military culture relevant patient and health care professional resources.

- **Military Cultural Awareness (NFED 1341520)**

This military cultural awareness online course provides a common foundation for all VA employees. This course offers an overview of common military culture and courtesies, roles and ranks within the military, differences between the branches of the armed services, some of the conflicts in which veterans have served, and why this information

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is important in helping VA employees better serve the needs of veterans and their families. After taking this course, participants will understand the perspective of the veterans they serve by having a greater awareness of the military experience, and the customs and courtesies that are common in the military environment.

- **PTSD 101: Understanding Military Culture When Treating PTSD (VA 9494)**
This online web-based course is part of the PTSD 101 education series which is presented by subject-matter experts to increase provider knowledge related to the assessment and treatment issues of PTSD. Each course specifically addresses trauma events, treatments, or special population issues, not normally addressed in general therapy protocols. This course is specifically designed to familiarize clinicians with military culture, terminology, demographics, and stressors. It also provides an overview of programs offered by DoD for managing combat or operational stress, as well as implications for assessment and treatment.
- **Why Military Culture Matters (Mobile Accessible) (VA 16353)**
This independent online study activity is designed to help the learner better connect with veterans and understand how veterans' military experiences influence their health. This course is formatted to be accessible using a VA networked mobile device.

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APPENDIX I: ENABLING DOCUMENTS

Veterans Access, Choice, and Accountability Act of 2014

TITLE II—HEALTH CARE ADMINISTRATIVE MATTERS

SEC. 201. INDEPENDENT ASSESSMENT OF THE HEALTH CARE DELIVERY SYSTEMS AND MANAGEMENT PROCESSES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) INDEPENDENT ASSESSMENT. —

(1) ASSESSMENT. — Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into one or more contracts with a private sector entity or entities described in subsection (b) to conduct an independent assessment of the hospital care, medical services, and other health care furnished in medical facilities of the Department. Such assessment shall address each of the following:

(A) Current and projected demographics and unique health care needs of the patient population served by the Department.

(B) Current and projected health care capabilities and resources of the Department, including hospital care, medical services, and other health care furnished by non-Department facilities under contract with the Department, to provide timely and accessible care to veterans.

(C) The authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Department facilities, including whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care.

(D) The appropriate system-wide access standard applicable to hospital care, medical services, and other health care furnished by and through the Department, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation.

(E) The workflow process at each medical facility of the Department for scheduling appointments for veterans to receive hospital care, medical services, or other health care from the Department.

(F) The organization, workflow processes, and tools used by the Department to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.

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(G) The staffing level at each medical facility of the Department and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics, which may include an assessment of any of the following:

(i) The case load of, and number of patients treated by, each health care provider at such medical facility during an average week.

(ii) The time spent by such health care provider on matters other than the case load of such health care provider, including time spent by such health care provider as follows:

(I) At a medical facility that is affiliated with the Department.

(II) Conducting research.

(III) Training or supervising other health care professionals of the Department.

(H) The information technology strategies of the Department with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by Department, especially those strategies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Department in Department or non-Department facilities.

(I) Business processes of the Veterans Health Administration, including processes relating to furnishing non-Department health care, insurance identification, third- party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows:

(i) To avoid the payment of penalties to vendors.

(ii) To increase the collection of amounts owed to the Department for hospital care, medical services, or other health care provided by the Department for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate.

(iii) To increase the collection of any other amounts owed to the Department with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate.

(iv) To increase the accuracy and timeliness of Department payments to vendors and providers.

(J) The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Department, including the following:

(i) The prices paid for, standardization of, and use by the Department of the following:

(I) Pharmaceuticals.

(II) Medical and surgical supplies.

(III) Medical devices.

(ii) The use by the Department of group purchasing arrangements to purchase pharmaceuticals, medical and surgical supplies, medical devices, and health care related services.

(iii) The strategy and systems used by the Department to distribute pharmaceuticals, medical and surgical supplies, medical devices, and health care related services to Veterans Integrated Service Networks and medical facilities of the Department.

(K) The process of the Department for carrying out construction and maintenance projects at medical facilities of the Department and the medical facility leasing program of the Department.

(L) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.

(2) PARTICULAR ELEMENTS OF CERTAIN ASSESSMENTS. —

(A) SCHEDULING ASSESSMENT. — In carrying out the assessment required by paragraph (1)I, the private sector entity or entities shall do the following:

(i) Review all training materials pertaining to scheduling of appointments at each medical facility of the Department.

(ii) Assess whether all employees of the Department conducting tasks related to scheduling are properly trained for conducting such tasks.

(iii) Assess whether changes in the technology or system used in scheduling appointments are necessary to limit access to the system to only those employees that have been properly trained in conducting such tasks.

(iv) Assess whether health care providers of the Department are making changes to their schedules that hinder the ability of employees conducting such tasks to perform such tasks.

(v) Assess whether the establishment of a centralized call center throughout the Department for scheduling appointments at medical facilities of the Department would improve the process of scheduling such appointments.

(vi) Assess whether booking templates for each medical facility or clinic of the Department would improve the process of scheduling such appointments.

(vii) Assess any interim technology changes or attempts by Department to internally develop a long-term scheduling solutions with respect to the feasibility and cost effectiveness of such internally developed solutions compared to commercially available solutions.

(viii) Recommend actions, if any, to be taken by the Department to improve the process for scheduling such appointments, including the following:

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(1) Changes in training materials provided to employees of the Department with respect to conducting tasks related to scheduling such appointments.

(II) Changes in monitoring and assessment conducted by the Department of wait times of veterans for such appointments.

(III) Changes in the system used to schedule such appointments, including changes to improve how the Department –

(aa) measures wait times of veterans for such appointments;

(bb) monitors the availability of health care providers of the Department; and

(cc) provides veterans the ability to schedule such appointments.

(IV) Such other actions as the private sector entity or entities considers appropriate.

(B) MEDICAL CONSTRUCTION AND MAINTENANCE PROJECT AND LEASING PROGRAM ASSESSMENT. – In carrying out the assessment required by paragraph (1)(K), the private sector entity or entities shall do the following:

(i) Review the process of the Department for identifying and designing proposals for construction and maintenance projects at medical facilities of the Department and leases for medical facilities of the Department.

(ii) Assess the process through which the Department determines the following:

(1) That a construction or maintenance project or lease is necessary with respect to a medical facility or proposed medical facility of the Department.

(II) The proper size of such medical facility or proposed medical facility with respect to treating veterans in the catchment area of such medical facility or proposed medical facility.

(iii) Assess the management processes of the Department with respect to the capital management programs of the department, including processes relating to the methodology for construction and design of medical facilities of the Department, the management of projects relating to the construction and design of such facilities, and the activation of such facilities.

(iv) Assess the medical facility leasing program of the Department.

(3) TIMING. – The private sector entity or entities carrying out the assessment required by paragraph (1) shall complete such assessment not later than 240 days after entering into the contract described in such paragraph.

(b) PRIVATE SECTOR ENTITIES DESCRIBED. – A private entity described in this subsection is a private entity that –

(1) has experience and proven outcomes in optimizing the performance of the health care delivery systems of the Veterans Health Administration and the private sector and in health care management; and

(2) specializes in implementing large-scale organizational and cultural transformations, especially with respect to health care delivery systems.

(c) PROGRAM INTEGRATOR. —

(1) IN GENERAL. — If the Secretary enters into contracts with more than one private sector entity under subsection (a), the Secretary shall designate one such entity that is predominately a health care organization as the program integrator.

(2) RESPONSIBILITIES. — The program integrator designated pursuant to paragraph (1) shall be responsible for coordinating the outcomes of the assessments conducted by the private entities pursuant to such contracts.

(d) REPORT ON ASSESSMENT. —

(1) IN GENERAL. — Not later than 60 days after completing the assessment required by subsection (a), the private sector entity or entities carrying out such assessment shall submit to the Secretary of Veterans Affairs, the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and the Commission on Care established under section 202 a report on the findings and recommendations of the private sector entity or entities with respect to such assessment.

(2) PUBLICATION. — Not later than 30 days after receiving the report under paragraph (1), the Secretary shall publish such report in the Federal Register and on an Internet website of the Department of Veterans Affairs that is accessible to the public.

(e) NON-DEPARTMENT FACILITIES DEFINED. — In this section, the term “non-Department facilities” has the meaning given that term in section 1701 of title 38, United States Code.

SEC. 202. COMMISSION ON CARE.

(a) ESTABLISHMENT OF COMMISSION. —

(1) IN GENERAL. — There is established a commission, to be known as the “Commission on Care” (in this section referred to as the “Commission”), to examine the access of veterans to health care from the Department of Veterans Affairs and strategically examine how best to organize the Veterans Health Administration, locate health care resources, and deliver health care to veterans during the 20-year period beginning on the date of the enactment of this Act.

(2) MEMBERSHIP. —

(A) VOTING MEMBERS. — The Commission shall be composed of 15 voting members who are appointed as follows:

(i) Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a veteran.

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(ii) Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a veteran.

(iii) Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a veteran.

(iv) Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a veteran.

(v) Three members appointed by the President, at least two of whom shall be veterans.

(B) QUALIFICATIONS. — Of the members appointed under subparagraph (A) —

(i) at least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code;

(ii) at least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000;

(iii) at least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)));

(iv) at least one member shall be familiar with the Veterans Health Administration but shall not be currently employed by the Veterans Health Administration; and

(v) at least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.

I DATE. — The appointments of members of the Commission shall be made not later than 1 year after the date of the enactment of this Act.

(3) PERIOD OF APPOINTMENT. —

(A) IN GENERAL. — Members shall be appointed for the life of the Commission.

(B) VACANCIES. — Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(4) INITIAL MEETING. — Not later than 15 days after the date on which eight voting members of the Commission have been appointed, the Commission shall hold its first meeting.

(5) MEETINGS. — The Commission shall meet at the call of the Chairperson.

(6) QUORUM. — A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(7) CHAIRPERSON AND VICE CHAIRPERSON. — The President shall designate a member of the commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.

(b) DUTIES OF COMMISSION. —

(1) EVALUATION AND ASSESSMENT. — The Commission shall undertake a comprehensive evaluation and assessment of access to health care at the Department of Veterans Affairs.

(2) MATTERS EVALUATED AND ASSESSED. — In undertaking the comprehensive evaluation and assessment required by paragraph (1), the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201, including any findings, data, or recommendations included in such assessment.

(3) REPORTS. — The Commission shall submit to the President, through the Secretary of Veterans Affairs, reports as follows:

(A) Not later than 90 days after the date of the initial meeting of the Commission, an interim report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(B) Not later than 180 days after the date of the initial meeting of the Commission, a final report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(c) POWERS OF THE COMMISSION. —

(1) HEARINGS. — The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

(2) INFORMATION FROM FEDERAL AGENCIES. — The Commission may secure directly from any Federal agency such information as the Commission considers necessary to carry out this section. Upon request of the Chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

(d) COMMISSION PERSONNEL MATTERS. —

(1) COMPENSATION OF MEMBERS. —

(A) IN GENERAL. — Each member of the Commission who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily

COMMISSION ON CARE FINAL REPORT

equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission.

(B) OFFICERS OR EMPLOYEES OF THE UNITED STATES. — All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES. — The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(3) STAFF. —

(A) IN GENERAL. — The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(B) COMPENSATION. — The Chairperson of the Commission may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(4) DETAIL OF GOVERNMENT EMPLOYEES. — Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES. — The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals that do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(e) TERMINATION OF THE COMMISSION. — The Commission shall terminate 30 days after the date on which the Commission submits the report under subsection (b)(3)(B).

(f) FUNDING. — The Secretary of Veterans Affairs shall make available to the Commission from amounts appropriated or otherwise made available to the Secretary such amounts as the Secretary and the Chairperson of the Commission jointly consider appropriate for the Commission to perform its duties under this section.

(g) EXECUTIVE ACTION. —

(1) ACTION ON RECOMMENDATIONS. — The President shall require the Secretary of Veterans Affairs and such other heads of relevant Federal departments and agencies to

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implement each recommendation set forth in a report submitted under subsection (b)(3) that the President —

(A) considers feasible and advisable; and

(B) determines can be implemented without further legislative action.

(2) REPORTS. — Not later than 60 days after the date on which the President receives a report under subsection (b)(3), the President shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives and such other committees of Congress as the President considers appropriate a report setting forth the following:

(A) an assessment of the feasibility and advisability of each recommendation contained in the report received by the President.

(B) For each recommendation assessed as feasible and advisable under subparagraph (A) the following:

(i) Whether such recommendation requires legislative action.

(ii) If such recommendation requires legislative action, a recommendation concerning such legislative action.

(iii) A description of any administrative action already taken to carry out such recommendation.

(iv) A description of any administrative action the President intends to be taken to carry out such recommendation and by whom.

H.R. 4437: Extension of Deadline for Submittal of Final Report by Commission on Care

[114th Congress Public Law 131]

[[Page 130 STAT. 292]]

Public Law 114-131

114th Congress

An Act

To extend the deadline for the submittal of the final report required by the Commission on Care.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. 38 USC 1701; EXTENSION OF DEADLINE FOR SUBMITTAL OF FINAL REPORT BY COMMISSION ON CARE.

COMMISSION ON CARE FINAL REPORT

Section 202(b)(3)(B) of the Veterans Access, Choice, and Accountability Act of 2014, 128 Stat. 1775 (Public Law 113-146; 128 Stat. 1773) is amended by striking “Not later than 180 days after the date of the initial meeting of the Commission” and inserting “Not later than June 30, 2016”.

Approved February 29, 2016.

DEPARTMENT OF VETERANS AFFAIRS
CHARTER OF THE
COMMISSION ON CARE

1. OFFICIAL DESIGNATION: Commission on Care
2. AUTHORITY: The Commission on Care established as required by section 202 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Public Law 113-146, and operates under the provisions of the Federal Advisory Committee Act (FACA), as amended, 5 U.S.C. App. 2.
3. OBJECTIVES AND SCOPE OF ACTIVITIES: The Commission on Care (the "Commission") is established to examine the access of Veterans to health care from the Department of Veterans Affairs (VA) and strategically examine how best to organize the Veterans Health Administration (VHA), locate health care resources, and deliver health care to Veterans during the 20-year period beginning on the date of the enactment of VACAA, August 7, 2014.
4. DUTIES OF THE COMMISSION:
 - A. Evaluation and Assessment: In accordance with section 202(b)(1), the Commission shall undertake a comprehensive evaluation and assessment of access to health care at VA.
 - B. Matters Evaluated and Assessed: In undertaking the comprehensive evaluation and assessment required by section 202(b)(1) of VACAA and paragraph (4)(A) above, the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201 of VACAA, including any findings, data, or recommendations included in such assessment.
 - C. Reports: In accordance with section 202(b)(3) of VACAA, submit an interim report not later than 90 days after the initial meeting of the Commission to the President, through the Secretary of Veterans Affairs, and a final report not later than 180 days after the initial meeting of the Commission. The reports shall include (i) the findings of the Commission with respect to the evaluation and assessment required by section 202(b)(1); and (ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through VHA.
5. OFFICIAL TO WHOM THE COMMISSION REPORTS: The Commission reports to the President, through the Secretary of Veterans Affairs.

VA is responsible for ensuring the reporting requirements of Section 6(b) of the FACA are fulfilled.

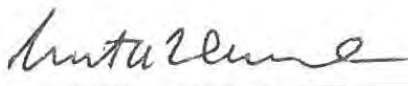
COMMISSION ON CARE FINAL REPORT

6. OFFICE RESPONSIBLE FOR PROVIDING THE NECESSARY SUPPORT FOR THE COMMISSION: VHA is responsible for providing support to the Commission.
7. ESTIMATED ANNUAL OPERATING COSTS AND STAFF-YEARS: Annual operating cost for the Commission is estimated at \$3,600,000 per year, including compensation of members and staff, in accordance with section 202(d) of VACAA. All members will receive travel expenses and a per diem allowance in accordance with the Federal Travel Regulations for any travel made in connection with their duties as members of the Commission. Approximately 15 FTE are anticipated.
8. DESIGNATED FEDERAL OFFICER: The Designated Federal Officer (DFO) or an Alternate DFO, full-time or permanent part-time VA employees, will be present at all meetings, including subcommittee meetings. The DFO will work with the Commission Chair to schedule the meetings and develop meeting agendas. The DFO is authorized to adjourn any meeting when he or she determines it is in the public interest to do so.
9. ESTIMATED NUMBER AND FREQUENCY OF MEETINGS: The Commission will meet at the call of the Chair for the duration of the Commission. The Commission may hold such hearings, sit and act at such times and places, and take such testimony, and receive such evidence as the Commission considers advisable to carry out its duties under section 202 of VACAA. A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.
10. DURATION: The Commission is subject to the termination date as specified below in section 11.
11. TERMINATION: The Commission shall terminate 30 days after the date on which the Commission submits the final report required by section 202(b)(3)(B) of VACAA.
12. MEMBERSHIP: The Commission shall be composed of 15 voting members who are appointed as Special Government Employees and described in paragraph (A) below for the life of the Commission and have the qualifications described in paragraph (B) below:
 - A. APPOINTMENT AUTHORITY:
 - i. Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a Veteran.
 - ii. Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a Veteran.

- iii. Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a Veteran.
 - iv. Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a Veteran.
 - v. Three members appointed by the President, at least two of whom shall be Veterans.
- B. QUALIFICATIONS: Of the members appointed under 12(A) –
- i. At least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of Veterans under 38 U.S.C. 5902;
 - ii. At least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000;
 - iii. At least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined by in section 1905(1)(2)(B) of the Social Security Act (42 U.S.C. 1396d(1)(2)(B));
 - iv. At least one member shall be familiar with VHA but shall not be currently employed by VHA; and
 - v. At least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.
- C. CHAIRPERSON AND VICE CHAIRPERSON: The President shall designate a member of the Commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.
- D. VACANCIES: If a vacancy occurs, it shall be filled in the same manner as the original appointment.
13. SUBCOMMITTEES: The Commission is authorized to establish subcommittees, with DFO approval, to perform specific projects or assignments as necessary and consistent with its mission. The Commission Chair shall notify the Secretary, through the DFO, of the establishment of any subcommittee, including its function, membership, and estimated duration. Subcommittees will report back to the Commission.
14. RECORDKEEPING: Records of the Committee shall be handled in accordance with General Records Schedule 26 or other approved agency records disposition schedules. Those records shall be available for public inspection and copying, subject to the Freedom of Information Act 5, U.S.C. 552.

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15. DATE CHARTER IS FILED:

Approved:  Date 7/24/15
Robert A. McDonald
Secretary of Veterans Affairs



APPENDIX J:

COMPOSITION OF THE COMMISSION

Nancy M. Schlichting, Chairperson

Appointed by President Barack Obama

Nancy M. Schlichting is Chief Executive Officer of Henry Ford Health System (HFHS), a nationally recognized \$5 billion health care organization with 27,000 employees and recipient of the 2011 Malcolm Baldrige National Quality Award, 2011 John M. Eisenberg Patient Safety Quality Award, and 2004 Foster G. McGaw Award. She is credited with leading the health system through a dramatic financial turnaround and for award-winning patient safety, customer service and diversity initiatives.

Schlichting joined HFHS in 1998 as its Senior Vice President and Chief Administrative Officer, served as Executive Vice President and Chief Operating Officer, President and CEO of Henry Ford Hospital and was named President and CEO of the System in 2003. Her career in health care administration spans over 35 years of experience in senior level executive positions.

Schlichting serves on several national and community boards including The Kresge Foundation, Walgreens Boots Alliance, the Federal Reserve Bank of Chicago – Detroit Branch, the Detroit Regional Chamber, the Detroit Economic Club, and the Downtown Detroit Partnership. Nancy is also a Fellow of the American College of Healthcare Executives.

In 2015, Schlichting was honored as one of the 100 Most Influential People in Healthcare by Modern Healthcare magazine, the eighth time she received this recognition. She was also named to the Top 25 Women in Healthcare by Modern Healthcare, the fourth time she received this recognition and the only Michigander named to the list. Her other awards include: NCHL Gail L. Warden Leadership Excellence award, ACHE Senior-Level Healthcare Executive Regent's Award, AHA/HRET 2014 TRUST Award, Becker's Hospital Review "40 of the Smartest People in Healthcare-2014," Crain's Detroit Business "2012 Newsmaker of the Year," HealthLeaders Media "20 People Who Make Healthcare Better-2012," and most recently was named one of "Crain's 100 Most Influential Women in Michigan."

Author of the acclaimed book, *Unconventional Leadership*, Schlichting is a highly regarded expert and accomplished speaker on strategic leadership, quality, patient/family-centered care, and diversity.

Schlichting received her A.B. in Public Policy Studies, Magna Cum Laude from Duke University and her M.B.A. from Cornell University. She has also been the recipient of honorary doctoral degrees from Walsh College, Eastern Michigan University and Central Michigan University.

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Delos M. (Toby) Cosgrove, MD, Vice Chairperson*Appointed by Speaker of the House John Boehner*

Toby Cosgrove, CEO of Cleveland Clinic, presides over a \$6.2 billion health care system comprising Cleveland Clinic, eight community hospitals, 16 family health and ambulatory surgery centers, Cleveland Clinic Florida, the Lou Ruvo Center for Brain Health in Las Vegas, Cleveland Clinic Toronto, and Cleveland Clinic Abu Dhabi. His leadership has emphasized patient care and patient experience, including the reorganization of clinical services into patient-centered, organ- and disease-based institutes. He launched major wellness initiatives for patients, employees, and communities. Under his leadership, Cleveland Clinic has consistently been named among America's top four hospitals by U.S. News & World Report and is one of only two hospitals named among America's 99 Most Ethical Companies by the Ethisphere Institute.

Cosgrove was a surgeon in the U.S. Air Force and served in Da Nang, Republic of Vietnam, as the chief of U.S. Air Force casualty staging flight. He received the Bronze Star and the Republic of Vietnam Commendation Medal.

He has published nearly 450 journal articles, book chapters, one book, and 17 training and continuing medical education films. He performed more than 22,000 operations and earned an international reputation for expertise in all areas of cardiac surgery, especially valve repair. As an innovator, Cosgrove has 30 patents filed for developing medical and clinical products used in surgical environments.

Cosgrove received his medical degree from the University of Virginia School of Medicine in Charlottesville, VA, and completed his clinical training at Massachusetts General Hospital, Boston Children's Hospital, and Brook General Hospital in London. He received a BA in biology from Williams College in Williamstown, MA.

Michael A. Blecker*Appointed by House Minority Leader Nancy Pelosi*

Michael Blecker has been associated with Swords to Plowshares since 1976 and has served as Executive Director since 1982. The agency was started in 1974 by returning Vietnam veterans and VISTA volunteers assigned to the VA regional office in San Francisco.

In the 1980s, when homelessness exploded, Swords to Plowshares started a transitional housing program with funding support from VA and the city and county of San Francisco. Swords to Plowshares continues to provide housing, employment, case management, and benefits advocacy for veterans from offices in San Francisco and Oakland. In 2005, the Iraq Vet Project (IVP) was established to help veterans of those wars and to shape policies affecting them. Recognizing Swords to Plowshares' long and effective history of challenging and shaping public policy with regard to veterans, in 2011, the IVP became known as the Institute for Veterans Policy.

Under Blecker's leadership, Swords to Plowshares' annual budget has grown from \$75,000 to nearly \$16 million. He has a nationwide reputation for dedicated service and as an authority on

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veterans' services and veterans' rights. He served on the Advisory Committee on Homeless Veterans (2002-2007), which advises the Secretary of Veterans Affairs. He is cofounder of both the National Coalition for Homeless Veterans and the California Association of Veterans' Service Agencies. He has served on the Congressional Commission on Service Members and Veterans Transition Assistance, the California Senate Commission on Homeless Veterans, the San Francisco Mayor's Homeless Planning Committee, the National Agent Orange Settlement Advisory Board, The Agent Orange Information Center, and the Veterans Speakers Alliance.

Blecker served in the U.S. Army as a combat infantryman in Vietnam in 1968-69 with the 101st Airborne Division, achieving the rank of E-5. He received an AB degree in criminology from University of California, Berkeley and a JD degree from New College of California Law School.

David P. Blom

Appointed by Speaker of the House John Boehner

David Blom has been instrumental in the development and growth of the OhioHealth system. He has served as president of OhioHealth's central Ohio hospitals – Grant Medical Center, Riverside Methodist Hospital, and Doctors Hospital – while also serving as executive vice president and chief operating officer of OhioHealth. He was named president and CEO of OhioHealth in March 2002. He has a track record of achievement with a solid understanding of complex issues facing health care delivery. He has expertise in leading strategic initiatives, managing and developing human capital, improving profitability, and improving quality of care and customer experience.

Blom maintains many professional and community affiliations, currently serving as a board member of the Voluntary Hospitals of America (VHA), a member and treasurer of Columbus' Downtown Development Corporation (CDDC), member of the Columbus Partnership, and member of the local World President's Organization (WPO). In 2001, he was named a Top 100 Business Leader by Smart Business and in 2012 CEO of the Year by Columbus CEO Magazine.

He received a BA from Ohio State University and an MA in health care administration from The George Washington University.

David W. Gorman

Appointed by President Barack Obama

David Gorman is a retired, combat-disabled veteran of the Vietnam War, who was appointed executive director of the Disabled American Veterans (DAV) National Service and Legislative Headquarters in Washington, DC in 1995. His responsibilities include oversight of the DAV National Service, Legislative, and Voluntary Service Programs. He is the organization's principal spokesperson before Congress, the White House, and the U.S. Department of Veterans Affairs.

Gorman entered the U.S. Army in 1969 and served with the 173rd Airborne Brigade, the famed "Sky Soldiers" of the Vietnam War. During a campaign to secure an area in Central Vietnam

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where U.S. forces suffered extremely high casualties, Mr. Gorman was severely wounded. His wounds required amputation of both legs.

Discharged from the Army in 1970, he immediately joined the DAV and is currently a life member of the DAV's National Amputation Chapter and DAV Chapter 39 in Greer, SC.

Gorman retired from his post executive director at the Washington Headquarters for Disabled American Veterans and now resides in Simpsonville, SC. Gorman attended Cape Cod Community College.

The Honorable Thomas E. Harvey, Esq.

Appointed by Senate Majority Leader Mitch McConnell

Thomas Harvey is a Vietnam combat veteran whose decorations include the Silver Star, the Purple Heart and 12 others for valor and service. In Vietnam, he spent a year as a company commander with the 173rd Airborne brigade and a year and a half as an advisor with the Vietnamese Airborne Division.

A lawyer by training, Harvey has spent much of his professional career working with veterans and issues of concern to them. He has served as Chief Counsel and Staff Director of the Senate Veterans Affairs Committee, Deputy Administrator of the Veterans Administration, and Assistant Secretary for Congressional Affairs of the Department of Veterans Affairs. Following 5 years with a major Wall Street law firm, Harvey came to Washington, DC, in 1977 as a White House fellow, serving as an assistant to ADM Stansfield Turner, then director of the Central Intelligence Agency. He has also served in the Department of Defense and as General Counsel and Congressional Liaison of the United States Information Agency. For 5 years, he was Senior Counselor of the Institute of International Education, which administers the Fulbright Program on behalf of the U.S. Department of State, as well as a number of other international educational exchange programs.

He currently serves on the boards of the Milbank Memorial Fund, the focus of which is public health policy, and of the Art Students League of New York, where he studies watercolor painting. He holds both BA and JD degrees from the University of Notre Dame and a LLM degree from the New York University School of Law.

Maj. Stewart M. Hickey, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Since 2011, Stewart Hickey has served as American Veterans (AMVETS) National Executive Director, operating the nation's fourth largest congressionally chartered veterans service organization and its subordinate organizations, and the daily advocacy of issues affecting veterans, national security, foreign affairs, and the economy.

Previously, Hickey was chief executive officer for the Hyndman (Pennsylvania) Area Health Center, a multisite community health center providing medical and dental services to several counties of Pennsylvania, West Virginia, and Maryland. His health care administration experience includes serving as chief human resources officer and chief operating officer of

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Western Maryland Hospital Center in Hagerstown, Maryland, a 123-bed Joint Commission on Accreditation of Healthcare Organizations accredited, long-term care and sub-acute hospital with rehabilitation, occupational therapy, physical therapy, and respiratory care.

Hickey enlisted in the U.S. Marine Corps Reserve in February 1977, in Cumberland, MD, as an infantryman, and transferred to platoon leaders class in the summer of 1978. He served in Operation Desert Storm and Desert Shield and was awarded a Bronze Star Medal with Combat "V" for his achievements as commanding officer, Company D, Third Tank Battalion, Task Force RIPPER, 1st Marine Division, I Marine Expeditionary Force, Saudi Arabia from September 1990 to February 1991. His military education includes the Basic School, Armor Officer Basic, Amphibious Warfare School, Armor Officer Advanced Course, and Marine Corps Command and Staff College.

Hickey resides on his family farm in Cumberland Valley Township in McConnellsburg, PA. He and his wife, Ellen, have five children: Monroe, Ali, Charles, Andrew, and Bryce. Three of his sons, Andrew, Monroe, and Charles, followed their father's path and currently serve in the U.S. military.

Hickey received a BA in history from Penn State University and an MA in management from Webster University.

Rear Adm. Joyce M. Johnson, DO, US PHS (ret.)

Appointed by President Barack Obama

Joyce Johnson is a physician with senior public health leadership experience in civilian and military sectors.

Johnson served in the U.S. Public Health Service (Rear Admiral, Upper Half). Her last active-duty assignment was with the U.S. Coast Guard as Director, Health and Safety ("surgeon general"). She managed the Coast Guard's health care system, including 150 sickbays and clinics, and coordinated both medical and behavioral health care for the beneficiary population. She also had responsibility for the Coast Guard's safety and work-life programs. She held a Top Secret security clearance.

Other government assignments included senior scientific and management positions with the Food and Drug Administration (pharmaceutical safety and post-market surveillance) and the Substance Abuse and Mental Health Services Administration. She has held clinical positions at the National Institute of Mental Health and the Department of Veterans Affairs. At the Centers for Disease Control and Prevention, she was an Epidemiologic Intelligence Service (EIS) Officer and staff epidemiologist in the Center for Infectious Disease.

In the private sector, Johnson served as vice president, health sciences and chief medical officer for a large research organization, where she managed a portfolio of government contracts, including laboratory and social sciences research, and held a top secret security clearance.

Johnson is an osteopathic physician board certified in psychiatry and public health/preventive medicine. She is also a certified clinical pharmacologist and certified addiction specialist. In

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addition to her medical degree, she earned a master's degree in hospital and health administration. She has been conferred six honorary doctoral degrees. She is a Distinguished Life Fellow of the American Psychiatric Association.

Johnson has extensive international health experience on all seven continents. She has particular interests in global mental health, health systems development, infectious disease, and disaster relief. She has led five Flag Expeditions with the Explorers Club. For more than a decade she has been a consultant to the National Science Foundation on the health care system in Antarctica.

Johnson recently coauthored the book, *Lizard Bites and Street Riots, Travel Emergencies and Your Health, Safety and Security*, and writes a monthly medical column. She is a Clinical Professor and Adjunct Professor at Georgetown University. She has served on expert committees including the Committee on Substance Abuse in the Military, National Academy of Medicine. She is active in numerous professional associations including the American Psychiatric Association, serving on the Committee on Psychiatric Dimensions of Disasters; the American Osteopathic Association, serving on the Bureau of International Osteopathic Medicine; and the Explorers Club, serving on the Medical Committee.

The Honorable Ikram U. Khan, MD

Appointed by Senate Minority Leader Harry Reid

Ikram Khan currently, he is president and 50-percent partner of Quality Care Consultants, LLC, founded in March 1992. The company provides consultant services in health care strategy and policy development for employers and other health care organizations. The company assists clients in development and implementation of wellness and disease-management programs. The company also develops quality improvement initiatives and techniques and assists in development and implementation of programs for cost-effective utilization of medical resources. Major emphasis is on clinical outcomes and data monitoring analysis.

Khan is a member the United States Institute of Peace (USIP) Board of Directors; he was nominated by President George Bush, and confirmed by the U.S. Senate on June 5, 2008. He is also currently a member of the Nevada Homeland Security Commission, having been appointed by the Governor of Nevada.

He was nominated by President Clinton and confirmed by the U.S. Senate to serve as member of The Board of Regents Uniformed Services University of Health Sciences, an advisory board to U.S. Secretary of Defense (1999-2006).

Khan also served as Special Advisor on Healthcare to Former Nevada Governor Gibbons, was a member of the Nevada Academy of Health (appointed by Nevada Governor Gibbons), and is a past member of the Nevada Academy of Health Sciences (appointed by Nevada Governor Kenny Guinn). He is past member of Nevada Governor's Commission for Medical Education, Research and Training and was a member of the Nevada State Board of Medical Examiners for eight years. Dr. Khan received "Special Congressional Recognition" for invaluable community service in 1994 and a Congressional citation—"U.S. Senate - Honoring Dr. Ikram Khan"—on April 25, 1994.

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Khan currently serves as member on the board of trustees at Sunrise Hospital Las Vegas-a 600 bed hospital. He has received recognition as “Most Influential Man in Southern Nevada” in 2000. He is also a recipient of a Las Vegas Chamber of Commerce community achievement award (October 1999), and a “Distinguished Community Service Award” from Anti-defamation League of B’nai B’rith (1994).

November 30, 1999 was declared “Dr. Ikram U. Khan Day” by the Governor of the State of Nevada, Mayor of Las Vegas, and the Board of Commissioners of Clark County.

During the course of his practice as General Surgeon, Khan has served in multiple leadership positions at various hospitals in Las Vegas.

Ikram Khan is president of quality Care Consultants LLC in Las Vegas Nevada. He received a doctor of medicine and surgery (MBBS) degree from University of Karachi, Pakistan.

Khan received a Doctor of Medicine and Surgery (MB, BS) in August 1972 from the University of Karachi, Pakistan. He completed post-graduate surgical residency in General Surgery in New York from 1974 through 1978, and practiced as a General Surgeon in Las Vegas through 2005.

Phillip J. Longman

Appointed by Senate Minority Leader Harry Reid

Phil Longman is a director at New America, a public policy institute. He is also a senior editor at the Washington Monthly and a lecturer at Johns Hopkins University, where he teaches a course in health care policy.

Longman has written extensively on issues related to health care delivery system reform, including in his book *Best Care Anywhere* (currently in its third edition). The book chronicles the quality transformation of the Veterans Health Administration during the 1990s and applies its lessons to the broader U.S. health care system.

Longman received a BA in philosophy from Oberlin College.

Col. Lucretia M. McClenney, USA (ret.)

Appointed by House Minority Leader Nancy Pelosi

Lucretia McClenney is a consultant with the Department of Defense Vietnam War Commemoration Office and Executive Coach with the Brookings Institute Executive Education Program. Previously she served as director of the Department of Veterans Affairs Center for Minority Veterans. As director, she served as the principal advisor to the Secretary of Veterans Affairs on policies and programs affecting minority veterans. Prior to her appointment, she served as special assistant to the assistant secretary for policy, planning, and preparedness, Department of Veterans Affairs (VA). She led the department’s emergency exercise planning, training, and evaluation program, and served as liaison to other government agencies. She has served on numerous working groups to include the congressionally mandated National Commission on VA Nursing, Task Force on Employment of Women at VA, and as the Secretary

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of Veterans Affairs' representative on the American Red Cross Board of Governors and Disaster and Chapter Services Committee.

Serving 30 years in the Army, McClenney retired as a colonel in November 2001. She served in various medical treatment facilities and on staffs worldwide serving as director, population health integration team, TRICARE management activity; chief nurse, European regional medical command and deputy commander for nursing, Landstuhl Regional Medical Command; deputy commander for nursing, Moncrief Army Community Hospital, Fort Jackson, South Carolina; assistant deputy for human resources, Office Of The Assistant Secretary Of The Army for Manpower and Reserve Affairs, the Pentagon; chief ambulatory nursing, Walter Reed Army Medical Center; senior policy analyst, Office of the Secretary of Defense (Health Affairs), The Pentagon; and member of the President's National Health Care Reform Task Force.

McClenney's military and civilian awards/decorations include the Legion of Merit (two oak leaf clusters), Defense Meritorious Service Medal, Meritorious Service Medal (seven oak leaf clusters), Army Commendation Medal (two oak leaf clusters), Navy Commendation Medal, Army Achievement Medal, Army Good Conduct Medal, the Army Staff Identification Badge, Office of the Secretary of Defense Staff Identification Badge, the coveted "9A" designator, in recognition of numerous achievements at the pinnacle of nursing excellence, and The Outstanding Civilian Service Medal for her significant contribution to the mission of the United States Army and Department of Defense in assisting with the production of the book, *For Children of Valor – Arlington National Cemetery*. Her professional affiliations include the Association of Military Surgeons of the United States, Sigma Theta Tau, National Nursing Honor Society, Alpha Kappa Alpha Sorority, Inc., Top Ladies of Distinction, Inc., The ROCKS, Inc., the Order of Military Medical Merit, Past President, Federal Health Care Executives Interagency Institute Alumni Association, and former Board Member of the Bon Secours Health Care System and Chair, Quality Committee.

She is a graduate of the Command and General Staff College and the United States Army War College Fellowship Program at George Washington University, Washington, DC. She is also a graduate of the Johnson & Johnson-Wharton's Fellows Program in Management for Nurse Executives, Wharton School of Business, University of Pennsylvania; Federal Health Care Executives Interagency Institute at George Washington University, Washington, DC; Leadership VA 2004; and Brookings Institute Executive Fellowship Program. She received a BSN from Murray State University and an MS in psychiatric/mental health nursing from Catholic University.

Capt. Darin S. Selnick, USAF (ret.)

Appointed by Speaker of the House John Boehner

Darin Selnick is an independent consultant who provides a variety of services to organizations in the areas of government and community relations, business development, and veterans' issues. He is currently the senior veterans affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He also volunteers his time as Chairman of the West Los Angeles Veterans Home Support Foundation and as the Vice President of Development for the GI Film Festival.

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From 2001–2009, Selnick was an appointee at the Department of Veteran Affairs. From 2004–2009 he served as the director of the center for faith-based and community initiatives. In this role he was responsible for the management and operations of the Center and was the VA liaison to the White House Office of faith-based and community initiatives. From 2001–2004 he served as Special Assistant to the Secretary and Associate Dean, VA Learning University. In this role he was responsible for providing program and operational oversight of VA Learning University.

Selnick is a retired Air Force officer who attained the rank of Captain. He has been very active in veterans' issues and joined the Jewish War Veterans in 1994. Since that time he has taken various leadership positions and is the past department commander of the Department of California. Mr. Selnick is also a member of the American Legion, AMVETS, Air Force Association, and National Association of Uniformed Services.

Darin Selnick currently serves as senior veterans' affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He lives in Oceanside, CA. Selnick is retired from the U.S. Air Force. He received a BS in health science from California State University, Northridge and an MA in political science/public management from Midwestern State University.

Lt. Gen. Martin Steele, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Martin Steele enlisted in the Marine Corps in January 1965 and rose from private to three-star general, culminating his military career in August 1999 as the deputy chief of staff for plans, policies, and operations at Headquarters, U.S. Marine Corps, in Washington, DC. A decorated combat veteran with 34½ years of service, he is a recognized expert in the integration of all elements of national power (diplomatic, economic, informational, and military) with strategic military war plans and has served as an executive strategic planner/policy director in multiple theaters across Asia. His extraordinary career was chronicled as one of three principals in the award winning military biography, *Boys of '67*, by Charles Jones.

Upon his retirement from active duty in 1999, he served as president and CEO of the Intrepid Sea-Air-Space Museum in New York City. Currently, Steele serves as The Associate Vice President for Veterans Partnerships, the Executive Director, Military Partnerships, and Co-chair of the Veterans Reintegration Steering Committee at the University of South Florida in Tampa, Florida. Additionally, Steele is the chairman and CEO of Steele Partners, Inc., a strategic advisory and leadership consulting company. He has led a philanthropic transition program assisting exiting Marines into private-sector jobs throughout the country, at no cost to the Marine participants, the Marine Corps, or the companies that provide employment opportunities.

Steele serves proudly on several boards across the country. He is currently the Chairman of the Board, Marine Corps Scholarship Foundation. He was appointed to the Board of Directors of Florida is for Veterans, Inc., a not for profit, state legislated organization designed to assist both Veterans and businesses throughout Florida in not only hiring Veterans but also developing entrepreneurship programs designed for veterans. He is a member of Fisher House Foundation;

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chairman of the advisory committee, Stability Institute; advisory committee member, Call of Duty Endowment; advisory board member, Stay in Step Foundation; advisory council member, Operation Helping Hand; member, Veterans Advantage; board member, University of Arkansas Veterans Resource and Information Center; and advisory committee member, Jesse Lewis Choose Love Movement.

Steele is a graduate of the University of Arkansas where he obtained a bachelor's degree in history and was recognized as a distinguished graduate of the Fulbright College of Arts and Sciences. He is a recipient of the 2013 Arkansas Alumni Award Citation of Distinguished Alumni, which recognizes exceptional professional and personal achievement and extraordinary distinction in a chosen field. He also holds master's degrees from Central Michigan University, Salve Regina College, and Naval War College.

Charlene M. Taylor

Appointed by House Minority Leader Nancy Pelosi

Charlene Taylor joined Kaiser Permanente in 1997 as the director of specialty services for the Permanente Medical Group at South Sacramento. In 2002 she became the service director for Kaiser Foundation Hospitals, responsible for perioperative and perinatal services at South Sacramento. In 2008, she was promoted to chief nursing officer at the Sacramento Medical Center where she was responsible for a 287-bed tertiary acute care hospital that conducted more than 11,000 operations per year. There, she oversaw 800 full-time employees and a budget of \$150 million. Taylor was promoted to chief operating officer in 2010 and retired from Kaiser Permanente in 2013.

Before working for Kaiser Permanente, Taylor served as assistant hospital administrator for Sutter Health at the Sutter Amador Hospital from 1988 to 1997. She is a member of the Veterans of Foreign Wars, Reserve Officers Association, and the Society of Air Force Nurses.

Taylor's patriotic and adventurous nature led her to join the Air Force as a reserve officer at the age of 40, rising to the rank of Lieutenant Colonel. She was commissioned as a Captain in the United States Air Force (Reserve Command) in October 1993, earning her flight nurse wings in 1994. She subsequently was selected to be a flight nurse instructor followed by a promotion to evaluator status. Her last squadron assignment was that of chief nurse at the 349 AMDS, Travis Air Force Base.

In addition to years of experience conducting aeromedical evacuation missions throughout the world, Taylor was activated in support of Operation Enduring Freedom from March 2003 to March 2004. In January 2005 she was selected to be the chief nurse of the 379th Expeditionary Aeromedical Squadron in support of Operation Iraqi Freedom. While transporting the injured out of Mosul, Iraq in a C-130, the aircraft took enemy fire, landing without casualties. Due to the demands of her civilian position, Taylor transferred to inactive status in the Air Force Reserve Command. Taylor is the recipient of two Meritorious Service medals, Expert Marksmanship (2), and multiple other medals.

Taylor currently serves on the Veterans Board. In 2012 she was appointed to the Board by Gov. Jerry Brown and approved by the Senate. She became chair in 2014 and continues to serve

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in that role. The California Veterans Board serves as an advocate for veterans affairs, identifying needs and working to ensure and enhance the rights and benefits of California veterans and their dependents.

Taylor is a diploma nurse graduate from the Kaiser Foundation School of Nursing. She continued her education receiving a BSN from the State University of New York in Albany, New York. She earned a master's degree in nursing administration from the University of California, San Francisco.

Taylor lives in Elk Grove, CA.

Marshall W. Webster, MD

Appointed by Senate Minority Leader Harry Reid

Marshall Webster is a senior vice president of the University of Pittsburgh Medical Center (UPMC), and a distinguished service professor of surgery at the University of Pittsburgh. A graduate of Penn State University and the Johns Hopkins Medical School, he trained in surgery at the University of Pittsburgh, and subsequently served 2 years as a surgeon on active duty in the U.S. Navy.

Webster returned to the University of Pittsburgh as a faculty vascular surgeon, including initially, a part-time attending staff position at the Pittsburgh VA Medical Center for 3 years. He has held the Mark M. Ravitch Chair in Surgery, and has had a long academic career of clinical practice, research, and service in varied administrative leadership roles. From 2002–2012, he was an executive vice president of UPMC, president of UPMC's physician services division, and president of the University of Pittsburgh Physicians, the clinical practice plan of the university faculty.

His current focus is primarily strategic development: building clinical relationships and care models throughout the region with a large number of community hospitals and providers. Webster has oversight of UPMC's graduate medical education program, which sponsors a substantial number of resident rotations at the Pittsburgh VA Medical Center. He recently served for 2 years as the interim chair of the Department of Anesthesiology at UPMC. He has had a long-standing interest in patient safety and quality initiatives, and recently completed a 6-year term on the board of the Pennsylvania Patient Safety Authority.

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APPENDIX K: COMMISSION STAFF

Susan M. Webman, Esq.
Executive Director

Michael Bargmann	Program Analyst
Robert Burke, PhD	Program Analyst
Donald Cicotte	Program Analyst
Pauline Cilladi-Rehrer	DFO
John Clinton	Staff Assistant
Monica Cummins	Program Analyst, ADFO
Christopher Danns	Program Analyst
Stephen Dillard	Program Analyst, ADFO
Susan Edgerton	Program Analyst
Beth Engiles	Program Analyst
Sharon Gilles	Program Analyst, DFO
Wilmya Goldsberry	Program Analyst
John Goodrich	Executive Officer/ DFO
Sherri Hans, PhD	Program Analyst
Daniel Huck	Program Analyst
Ralph Ibson, Esq.	Program Analyst
Wendy J. LaRue, PhD	Editor-in-Chief
Gideon Lukens, PhD	Program Analyst
Sonia Mastrogiuseppe	Staff Assistant
Jennifer E. McKinney	Document Specialist
Osita Osagbue	Program Analyst
Bernadette Philpot	Staff Assistant
Patrick Ryan, Esq.	Program Analyst
Jamie Taber, PhD	Program Analyst
SaKeithia Taylor	Staff Assistant
Linda (Yvonne) Williams	Staff Assistant

DFO – Designated Federal Officer

ADFO – Assistant Designated Federal Officer

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APPENDIX L: ACRONYM LIST

ACRONYM	DEFINITION
ACA	Affordable Care Act
ACHE	American College of Healthcare Executives
APRN	Advanced Practice Registered Nurse
BRAC	Base Realignment and Closure
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARES	Capital Asset Realignment for Enhanced Services
CDS	Community Delivered Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CITC	Care in the Community
CMD	Chief Medical Director
CMIO	Chief Medical Information Officer
CMOP	Consolidated Mail Outpatient Pharmacy
COTS	Commercial Off-The-Shelf
CPRC	Clinical Product Review Committee
CPRS	Computerized Patient Record System
CVA	Concerned Veterans for America
CVCS	Chief of VHA Care System
DAV	Disabled American Veterans
DEPSECVA	Deputy Secretary, Department of Veterans Affairs
DHP	Digital Health Platform
DM&S	Department of Medicine and Surgery
DoD	Department of Defense
DUSH	Deputy Under Secretary for Health
ECF	Executive Career Fields
EES	Employee Education System
EEO	Equal Employment Opportunity

COMMISSION ON CARE FINAL REPORT

ACRONYM	DEFINITION
EHCPM	Enrollee Health Care Projection Model
eHMP	Enterprise Health Management Platform
EHR	Electronic Health Record
FFS	Fee-for-Service
FY	Fiscal Year
GAO	Government Accountability Office
GHATP	Graduate Health Administration Training Program
GUI	Graphic User Interface
HCD	Human-Centered Design
HEC	Healthcare Executive Council
HPDM	High Performance Development Model
HR	Human Resources
HRA	Human Resources and Administration
HSC	Health Service Category
HTM	Healthcare Talent Management
IAVA	Iraq and Afghanistan Veterans of America
IDIQ	Indefinite Delivery/Indefinite Quantity
IDN	Integrated Delivery Network
IDP	Individual Development Plan
IT	Information Technology
JC	Joint Commission
JEC	Joint Executive Committee
JLV	Joint Legacy Viewer
MSA	Medical Support Assistant
MTF	Military Treatment Facility
NAS	National Academy of Sciences
NCEHC	National Center for Ethics in Health Care
NCOD	National Center for Organization Development
NLC	National Leadership Council
NVTC	Northern Virginia Technology Council
OAA	Office of Academic Affiliations

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APPENDIX L
ACRONYM LIST

ACRONYM	DEFINITION
OEF	Operation Enduring Freedom
OGC	Office of General Counsel
OI&T	Office of Information and Technology
OIF	Operation Iraqi Freedom
OMB	Office of Management and Budget
ONC	Office of the National Coordinator
OND	Operation New Dawn
OPM	Office of Personnel Management
OTH	Other Than Honorable (Discharge)
PACT	Patient Aligned Care Team
PC3	Patient-Centered Community Care
PG	Priority Group
PHS	U.S. Public Health Service
PO	Program Office
PTSD	Posttraumatic Stress Disorder
QUERI	Quality Enhancement Research Initiative
RCLF	Relevant Civilian Labor Force
RIF	Reduction in Force
SCI	Spinal Cord Injury
SECVA	Secretary, Department of Veterans Affairs
SE	Senior Executive
SES	Senior Executive Service
SHEP	Survey of Healthcare Experiences of Patients
TBI	Traumatic Brain Injury
TMS	Talent Management System
USH	Under Secretary for Health
VA	U.S. Department of Veterans Affairs
VACAA	Veterans Access, Choice, and Accountability Act of 2014
VACI	VA Center for Innovation
VACO	VA Central Office
VAEB	VA Executive Board

COMMISSION ON CARE FINAL REPORT

ACRONYM	DEFINITION
VAMC	VA Medical Center
VERC	Veterans Engineering Resource Center
VFW	Veterans of Foreign Wars of the U.S.
VHA	Veterans Health Administration
VHACO	VHA Central Office
VISN	Veterans Integrated Service Network
VSO	Veterans Service Organization
WWP	Wounded Warrior Project



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United States General Accounting Office

Testimony

Before the Committee on Veterans' Affairs, U.S. Senate

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VA HEALTH CARE

Approaches for Developing Budget-Neutral Eligibility Reform

Statement of David P. Baine, Director
Health Care Delivery and Quality Issues
Health, Education, and Human Services Division



VA-18-0457-A-003008

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss proposals to reform eligibility for Department of Veterans Affairs (VA) health care benefits. Eligibility reform would present a significant challenge even with unlimited resources. But with the Congress and VA facing increasing pressures to limit VA health care spending as part of governmentwide efforts to reduce the budget deficit, this challenge has become even greater.

Over the past several years, we have conducted a series of reviews that have detailed problems in the administration of VA's outpatient eligibility provisions, compared VA benefits and eligibility with those of other public and private health benefits programs, and assessed VA's role in a changing health care marketplace. My comments this morning are based primarily on the results of those reviews and ongoing work for this Committee.¹

Specifically, we will discuss

- the problems VA's current eligibility and contracting provisions create for veterans and providers,
- the relationship between inappropriate admissions to VA hospitals and VA eligibility provisions,
- legislative proposals to reform VA eligibility and contracting rules and their potential impact on the deficit, and
- options for achieving budget-neutral eligibility reform.

Summary

In summary, VA health care has gradually evolved from a system primarily providing hospital care to veterans injured during wartime service to a system increasingly focused on the treatment of low-income veterans with medical conditions unrelated to military service. For most veterans, eligibility for veterans' health benefits is still limited primarily to hospital-related care.

Budget-neutral reforms of VA eligibility provisions could enable VA to function more like a private insurer and provider. Unlike private insurance, VA does not have a well-defined, uniform benefit package and does not guarantee the availability of covered services. In addition, a VA facility is not allowed to provide a noncovered service even if it has the resources to provide the care and the veteran is willing to pay for it. This often places VA physicians in the position of having to either (1) ignore the

¹A list of related GAO products is in app. II.

law and provide noncovered services for free or (2) turn away veterans even though VA may have the space and resources to provide the needed health care services.

Generally, VA's current eligibility provisions create uneven and uncertain access to VA health care and limit VA's ability to meet veterans' health care needs. Veterans with similar medical needs, service status, and incomes may get treated or turned away depending on what type of care they seek and where and when they seek care. This frustrates veterans, who cannot understand what services they can get from VA, and VA physicians and administrative staff, who have to interpret the subjective eligibility provisions.

During the past year, four major bills were introduced to reform VA eligibility. These bills would eliminate the current restrictions on veterans' eligibility for outpatient care, essentially making all 26.4 million veterans eligible for comprehensive outpatient care, whereas fewer than 1 million are currently eligible. In addition, the bills would increase the number of veterans in the mandatory category for comprehensive outpatient care (that is, the category for which the law says VA "shall" or "must" provide covered services) from 465,000 to between 9 million and 11 million. The bills generally would not address most of the other problems with current VA eligibility provisions, such as the lack of guaranteed funding.

Although we support the need for reform, we do not believe any of the four major eligibility reform proposals achieves budget neutrality. For example, making all 26.4 million veterans eligible for comprehensive outpatient care would likely generate significant new demand for both outpatient and inpatient care. These increases are likely to come both from VA users previously unable to obtain all of their health care services from VA and from veterans seeking care from VA for the first time.

In addition, the synergistic effects of other needed changes in the VA health care system will likely heighten the effects of eligibility expansions on future demand for care. For example, VA's plans to make its health care more accessible to veterans will probably generate new demands for care. Generally, when VA opens a new outpatient clinic, a large proportion of the users are new to the VA system. In addition, current VA users living near the new clinic tend to use VA services more often. Similarly, actions taken to improve customer service, such as installation of bedside telephones, reducing waiting times, and establishing primary care teams, will likely attract new users.

Nine out of 10 veterans have other public or private insurance that they typically use to purchase care from private sector providers. As a result, changes in the VA system to expand benefits, improve accessibility, and improve customer service will put VA in more direct competition with private sector providers and insurers. Because the proposed eligibility expansions would offer 9 million to 11 million veterans comprehensive free care, VA could gain a strong competitive advantage over private sector providers.

Because the bills would not provide for major new sources of revenue to help pay for the expanded services, their enactment would place considerable pressure on the Congress to appropriate additional funds to meet the increased demand. It would be particularly problematic for the Congress not to appropriate funds to meet the health care demands of the large group of veterans who would be added to the mandatory category for comprehensive outpatient care.

VA and the Congressional Budget Office (CBO) have arrived at starkly different assessments of the potential budgetary impact of the proposal included in the House of Representatives' budget reconciliation package last year. VA concluded that the bill would be budget neutral and might save \$268 million a year.² By contrast, CBO estimated that the bill could add \$3 billion or more to the deficit.

We find CBO's arguments more compelling for two principal reasons. First, CBO's estimate predicts that significant increases in demand for outpatient care would likely result from enactment of the bill, whereas VA estimates no increase. Second, VA's cost analysis is sensitive to a series of assumptions. Changing the assumptions can quickly turn a potential savings into a potential cost increase. For example, VA assumed that it would divert 20 percent of hospital patients to outpatient care through eligibility reform and that 7 days of hospital care would be avoided for every patient diverted. One to 3 days seems a more likely length of stay for patients who do not need a hospital level of care but are admitted to VA hospitals just to provide them services they are not eligible to receive as outpatients. Avoiding an average of 3 days of hospital care, rather than 7, would turn a claimed savings of \$268 million into a cost increase of \$167 million under VA's formula.

In addition, VA has provided little evidence to support its assumption that eligibility reform would enable it to divert 20 percent of its hospital

²The eligibility reform provisions were later dropped during the House and Senate Conference.

patients to outpatient clinics. In fact, studies done by VA and others show little evidence to link nonacute admissions to problems with VA eligibility provisions. Generally, nonacute admissions result from conservative physician practices and the lack of outpatient care capabilities. Unlike the private sector, where insurers often require policyholders to obtain approval from an external reviewer before they are admitted to hospitals, VA has no preadmission certification program. While hundreds of millions of dollars may be saved by reducing inappropriate admissions to VA hospitals, we believe that such savings should not be “spent” before administrative actions, such as establishment of an external preadmission certification program, are in place to ensure that nonacute admissions are, in fact, reduced.

Although the current proposals are not budget neutral, many approaches could be used to help design budget-neutral eligibility reform. These approaches include

- increasing veterans’ cost sharing or allowing VA to sell noncovered services to veterans;
- establishing uniform, but more limited, benefit packages; and
- expanding eligibility for some veterans but reducing or eliminating eligibility for others.

Through the use of a combination of these approaches, we believe budget-neutral eligibility reform can and should be developed.

Background

For fiscal year 1996, VA sought an appropriation of about \$17 billion to maintain and operate 173 hospitals, 376 outpatient clinics, 136 nursing homes, and 39 domiciliaries. VA facilities are expected to provide inpatient hospital care to 930,000 patients, nursing home care to 35,000 patients, and domiciliary care to 18,700 patients. In addition, VA outpatient clinics are expected to handle 25.3 million outpatient visits. The Congressional Budget Resolution, however, would essentially freeze the VA medical care appropriation at the fiscal year 1995 spending level—\$16.2 billion—for the next 7 years. Final action on VA’s fiscal year 1996 appropriation is pending.

The VA health care system consists of (1) a health benefits program and (2) a health care delivery program. The two programs are closely intertwined. For example, VA outpatient clinics are not allowed to use available resources to provide services to many veterans because (1) the services, such as prosthetics, are not covered under the veterans’ health

care benefits and (2) the clinics are not permitted under the law to sell such noncovered services to veterans.

In administering the veterans' health benefits program, VA's responsibilities are similar to those of the Health Care Financing Administration (HCFA) in administering Medicare benefits and to those of private health insurance companies in administering health insurance policies. For example, VA is responsible for determining (1) which benefits veterans are eligible to receive, (2) whether and how much veterans must contribute toward the cost of their care, (3) whether the health care services veterans need are covered under their benefits, and (4) where veterans obtain covered services (that is, whether they must use VA-operated facilities or can obtain needed services from other providers at VA expense). Similarly, VA, like HCFA and private insurers, is responsible for ensuring that the health benefits provided to its "policyholders"—veterans—are (1) medically necessary and (2) provided in the most appropriate care setting (such as a hospital, nursing home, or outpatient clinic).

In operating a health care delivery program, VA's role is similar to that of the major private sector health care delivery networks, such as those operated by Columbia/Hospital Corporation of America and Humana. For example, VA strives to ensure that its facilities (1) provide care of an acceptable quality, (2) are used to their optimum capacity, (3) are located where they are accessible to its target population, (4) provide good customer service, (5) offer potential patients services and amenities comparable to competing facilities, and (6) operate effective billing and collection systems.

Significant Changes Occurring in the Veteran Population

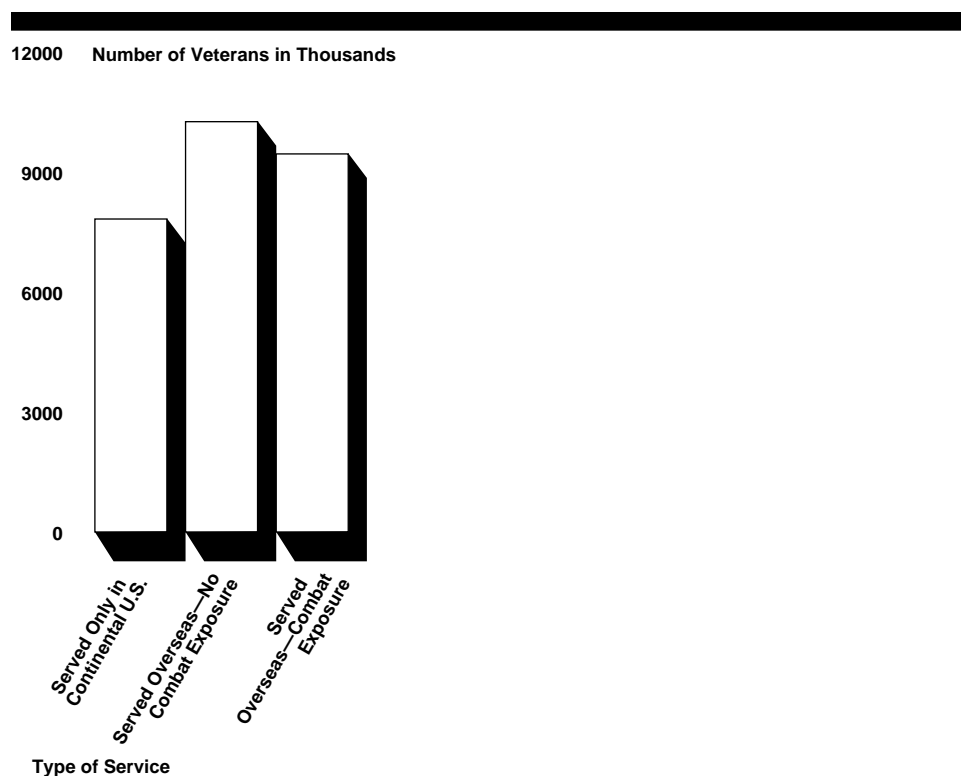
The veteran population, which totaled about 26.4 million in 1995, is both declining and aging. Between 1990 and 2010, VA projects the veteran population will decline 26 percent. The decline will be most notable among veterans under 65 years of age—from about 20.0 million to 11.5 million. By contrast, the number of veterans aged 85 and older will increase more than eight-fold. At that time, veterans aged 85 and older will make up about 6 percent of the veteran population.

Coinciding with the overall decline in the number of veterans is a decline in the percentage of veterans who served during wartime. VA projects the total number of wartime veterans to decline from 21 million in 1990 to 13.6 million in 2010. Even more dramatic is the shift in the number of wartime veterans by period of service. By 1995, deaths of World War II

veterans had accelerated to the point that Vietnam-era veterans outnumbered World War II veterans by about 826,000. By 2010, Persian Gulf veterans are expected to outnumber both Korean War and World War II veterans.

Most veterans who served during wartime had no combat exposure. About 35 percent of U.S. veterans were actually exposed to combat. (See fig. 1.)

Figure 1: Combat Exposure of Veterans, 1992

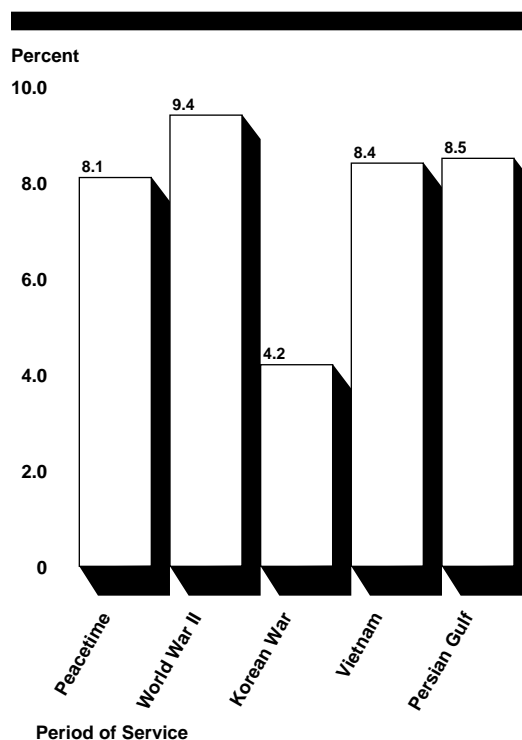


Source: Based on data from VA's National Survey of Veterans (Washington, D.C.: National Center for Veteran Analysis and Statistics, VA, 1995).

About 8.3 percent of veterans have compensable service-connected disabilities. Surprisingly, veterans who served during peacetime are almost twice as likely to have service-connected disabilities as veterans of the

Korean War and only slightly less likely to have service-connected disabilities than Vietnam-era veterans. (See fig. 2.)

Figure 2: Veterans With Service-Connected Disabilities, by Period of Service, 1994



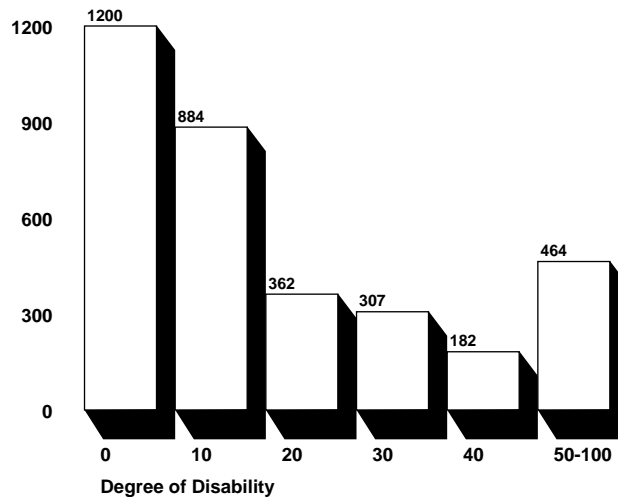
Source: Data are from the Annual Report of the Secretary of Veterans Affairs, Fiscal Year 1994 (Washington, D.C.: 1995).

Of the more than 2.2 million veterans with compensable service-connected disabilities, over half have disability ratings of 10 or 20 percent. Of the remaining veterans with service-connected disabilities, about 488,000 had disabilities rated at 30 or 40 percent.³ (See fig. 3.)

³A service-connected disability is one that results from an injury or disease or other physical or mental impairment incurred or aggravated during military service. VA determines whether veterans have service-connected disabilities and, for those with such disabilities, assigns ratings of from 0 to 100 on the basis of the severity of the disability. These ratings form the basis for determining both the amount of compensation paid to the veterans and the types of health care services for which they are eligible.

Figure 3: Veterans With Service-Connected Disability Ratings, by Degree of Disability, 1994

1500 Number of Veterans in Thousands



Note: Numbers include an estimated 1.2 million veterans with noncompensable service-connected disabilities.

Source: Data are from the Annual Report of the Secretary of Veterans Affairs, Fiscal Year 1994.

Eligibility for VA Health Care Benefits

Any person who served on active duty in the uniformed services for the minimum amount of time specified by law and who was discharged, released, or retired under other than dishonorable conditions is currently eligible for VA health care benefits. Although all veterans meeting the basic requirements are “eligible” for hospital, nursing home, and at least some outpatient care, the VA law establishes a complex priority system—based on such factors as the presence and extent of any service-connected disability, the incomes of veterans with nonservice-connected disabilities, and the type and purpose of care needed—to determine which services are covered and which veterans receive care within available resources.

The distinction between covered and noncovered services in discussing veterans’ health benefits is important because VA facilities are generally restricted to providing “covered” services to veterans. As a result, VA facilities are not allowed to provide other services directly to veterans or

others even if they have the capacity to provide the services and the patient agrees to pay for them.⁴

Certain veterans, commonly referred to as Category A, or mandatory care category, veterans, have the highest priority for hospital and nursing home care. More specifically, VA must provide hospital care, and, if space and resources are available, may provide nursing home care to veterans who

- have service-connected disabilities,
- were discharged from the military for disabilities that were incurred or aggravated in the line of duty,
- are former prisoners of war,
- were exposed to toxic substances or ionizing radiation,
- served in the Mexican Border Period or World War I,
- receive disability compensation,
- receive nonservice-connected disability pension benefits, and
- have incomes below the means test threshold (as of January 1995, \$20,469 for a single veteran or \$24,565 for a veteran with one dependent, plus \$1,368 for each additional dependent).

For higher-income veterans who do not qualify under these conditions, VA may provide hospital and nursing home care if space and resources are available. These veterans, commonly known as Category C, or discretionary care category, veterans, must pay a part of the cost of the care they receive.

VA also provides three basic levels of outpatient care benefits:

- comprehensive care, which includes all services needed to treat any medical condition;
- service-connected care, which is limited to treating conditions related to a service-connected disability; and
- hospital-related care, which provides only the outpatient services needed to (1) prepare for a hospital admission, (2) obviate the need for a hospital admission, or (3) complete treatment begun during a hospital stay.

Separate mandatory and discretionary categories apply to outpatient care. Only veterans with service-connected disabilities rated at 50 percent or higher (about 465,000 veterans) are in the mandatory category for comprehensive outpatient care. All veterans with service-connected

⁴Studies by the VA Office of Inspector General indicate that about 56 percent of the discretionary care outpatient visits VA facilities provide are for noncovered services that the veterans were not eligible to receive.

disabilities are in the mandatory care category for treatments related to their disabilities; they are also eligible for hospital-related care of nonservice-connected conditions, but, with the exception of veterans with disabilities rated at 30 or 40 percent, they are in the discretionary care category. Most veterans with no service-connected disabilities are eligible only for hospital-related outpatient care and, with few exceptions, are in the discretionary care category.

Table 1 summarizes VA eligibility provisions.

Table 1: Mandatory and Discretionary VA Health Care Benefits

Veteran category	Hospital care	Outpatient care	Nursing home care
Service-connected disabilities rated 50-100%, for any condition	Mandatory	Mandatory	Discretionary
Service-connected disabilities rated 0-40%, for a service-connected condition	Mandatory	Mandatory	Discretionary
Discharged for disability	Mandatory	Mandatory	Discretionary
Service-connected disabilities rated 30-40%, for a nonservice-connected condition	Mandatory	Mandatory, limited to hospital-related care	Discretionary
Pensioner or has income under \$12,855	Mandatory	Mandatory, limited to hospital-related care	Discretionary
Injured in VA	Mandatory	Mandatory, limited to hospital-related care	Discretionary
Prisoner of war	Mandatory	Discretionary	Discretionary
World War I or Mexican Border Period veteran	Mandatory	Discretionary	Discretionary
Pensioner receiving aid and attendance payments	Mandatory	Discretionary	Discretionary
Service-connected disabilities rated 0-20%, for a nonservice-connected condition	Mandatory	Discretionary, limited to hospital-related care	Discretionary
Nonservice-connected, with an income of \$12,855-\$20,470 (no dependents)	Mandatory	Discretionary, limited to hospital-related care	Discretionary
Exposed to Agent Orange or radiation, or Medicaid-eligible	Mandatory	Discretionary, limited to hospital-related care	Discretionary
Nonservice-connected with income over \$20,470	Discretionary, with copayment	Discretionary, with copayment, limited to hospital-related care	Discretionary, with copayment

Source: Based on data from Independent Budget for Department of Veterans Affairs, Fiscal Year 1996, prepared by the major veterans' service organizations.

Eligibility for VA Health Care Has Evolved

Eligibility for VA health care has undergone a gradual evolution since the 1930 establishment of VA. Initially, the only veterans eligible for VA health

care were those (1) with injuries incurred during wartime service or (2) incapable of earning a living because of a permanent disability, tuberculosis, or neuropsychiatric disability suffered after their wartime service.

Originally, eligibility was for hospital and domiciliary care only. Eligibility for hospital care was later expanded to include veterans injured during other than combat duty and subsequently to all veterans without service-connected disabilities.

When outpatient care was added to the VA system, eligibility was initially limited to veterans with service-connected disabilities. It was not until 1960 that VA was first authorized to treat veterans with nonservice-connected disabilities on an outpatient basis. In that year, P.L. 86-639 authorized outpatient treatment for a nonservice-connected disability in preparation for, or to complete treatment of, hospital care. So concerned was the then Administrator of Veterans Affairs about the potential implications of this change that he wrote:

“The possible adverse effects of the proposed legislation should also, I believe, be considered. This bill would for the first time mean that non-service-connected veterans would be receiving outpatient treatment even though we have endeavored to make revisions which would relate this only to hospital care. The outpatient treatment of the non-service-connected might be an opening wedge to a further extension of this type of medical treatment.”

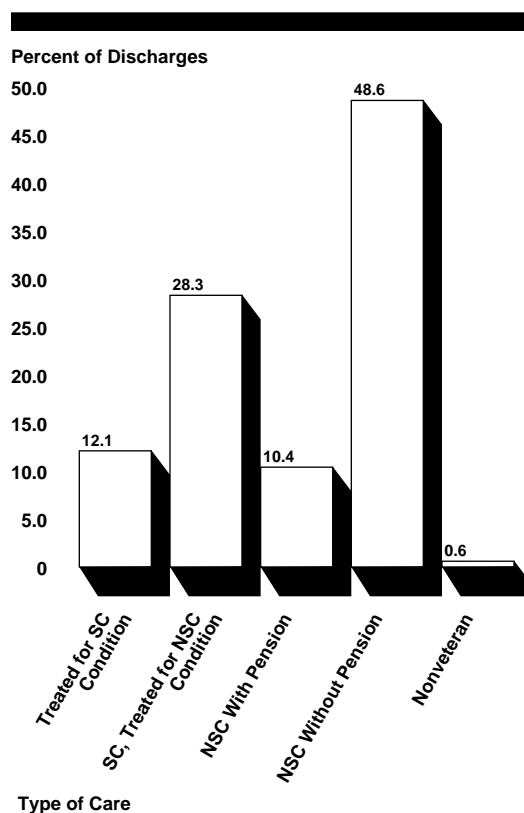
Thirteen years later, the Veterans Health Care Expansion Act of 1973 (P.L. 93-82) further extended outpatient treatment for veterans with nonservice-connected disabilities, authorizing outpatient treatment for any disability to “obviate the need of hospital admission.” Although there have been a number of further revisions to outpatient eligibility since 1973, most veterans’ eligibility for ambulatory care services continues to be restricted to hospital-related care.

VA System Increasingly Focuses on Veterans With No Service-Connected Disabilities

With the gradual evolution of VA eligibility, the VA system now provides a wide range of inpatient, outpatient, and long-term care services to veterans both with and without service-connected disabilities. VA has gradually shifted from a system primarily providing treatment for veterans with service-connected disabilities incurred in wartime to a system increasingly focused on the treatment of low-income veterans with medical conditions unrelated to military service. For example, in fiscal year 1995, only about

12 percent of VA hospital patients were treated for service-connected disabilities. By contrast, about 59 percent of the patients treated had no service-connected disabilities. (See fig. 4.)

Figure 4: VA Hospital Users by Purpose of Treatment, FY 1995



Note: SC = service connected; NSC = nonservice connected.

Source: Data are from draft tables prepared for VA's Annual Report of the Secretary of Veterans Affairs, Fiscal Year 1995, expected to be issued in April 1996.

VA Options as a Health Care Provider Are Limited

VA has limited authority to (1) buy health care services from non-VA providers and (2) sell health care services either to veterans or others. Generally, veterans can use their health benefits only in VA-operated health care facilities. There are several exceptions that allow VA to purchase care from non-VA providers:

- VA-operated nursing home and domiciliary care is augmented by contracts with community nursing homes and by per diem payments for veterans in state-operated veterans' homes.
- VA pays private sector physicians and other health care providers to provide services to certain veterans when the services needed are unavailable within the VA system or when the veterans live too far from a VA facility (commonly referred to as fee-basis care). The authorization to use fee-basis physicians is primarily limited to service-connected veterans.
- VA pays for hospitalization in non-VA facilities in medical emergencies. Patients are expected to transfer to VA hospitals when their conditions stabilize.
- Veterans treated in VA facilities can be provided scarce medical specialist services from other public and private providers through sharing agreements and contracts between VA and non-VA providers.
- VA hospitals have limited authority to contract with other providers for specialized medical resources, including equipment, personnel, or techniques, that because of costs, limited availability, or unusual nature are unique in the medical community.

Similarly, as a health care provider, VA can sell health care services only on an exception basis. Specifically, VA hospitals and outpatient clinics can sell

- health care services to the Department of Defense (DOD) and other federal health care facilities and
- specialized medical resources to nonfederal hospitals, clinics, and medical schools.⁵

VA cannot, however, sell health care services directly to either veterans or nonveterans.

VA Eligibility Provisions Frustrate Veterans and Limit VA's Ability to Meet Veterans' Health Care Needs

Unlike public and private health insurance, the VA health benefits program does not (1) have a well-defined benefit package or (2) entitle veterans to, or guarantee the availability of, covered services. Similarly, as a health care provider, VA, unlike private sector providers, is severely limited in its ability to both buy health care services from and sell health care services to individuals and other providers. These differences help make VA's eligibility provisions a source of frustration for veterans, VA physicians, and VA's administrative staff. The problems created by these provisions include the following:

⁵Medical resources can be sold to DOD and the private sector only if the sale does not adversely affect health care services available to veterans.

- Veterans are often uncertain about what services they are eligible to receive and what right they have to demand that VA provide them.
- Physicians and administrative staff find the eligibility provisions hard to administer.
- Veterans have uneven access to care because the availability of covered services is not guaranteed.
- Physicians are put in the untenable position of having to deny needed, but noncovered, health care services to veterans.

Because of these problems, veterans may be unable to consistently obtain needed health care services from VA facilities.

Veterans Are Uncertain About What Services Are Covered

Because public and private insurance policies generally have a defined benefit package, both policyholders and providers know in advance what services are covered and what, if any, limitations apply to the availability of services. Defined benefit packages also preserve insurers' flexibility in responding to funding constraints by allowing them to adjust covered benefits on the basis of funds available. An insurer might offer multiple policies with varying benefits, but individuals with the same policy have the same benefits.

Like private insurance, VA essentially offers multiple health benefit "policies" with varying benefits. Unlike private insurance, however, veterans with the same "policy" will not necessarily receive the same services. Only those veterans whose "policy" covers all medically necessary care—primarily those veterans with service-connected disabilities rated at 50 percent or more—have clearly defined, uniform benefits. Because coverage of outpatient services for most veterans varies on the basis of their medical conditions, a veteran may be eligible to receive different services at different times. For example, if a veteran with no service-connected disabilities is scheduled for admission to a VA hospital for elective surgery, he or she is eligible to receive any outpatient service needed to prepare for the hospital admission, including a physical examination with X rays and blood tests. However, if the same veteran sought a routine physical examination from a VA outpatient clinic, he or she would not be eligible for an examination, X rays, or blood tests because there is no apparent need for hospital-related care.

Because of the lack of a well-defined benefit package, veterans are often confused by VA's complex eligibility provisions. The services they can get from VA depend on such factors as the presence and extent of any

service-connected disability, income, period of service, and the seriousness of the condition. To further add to veterans' confusion about which health care services they are eligible to receive from VA, title 38 of the U.S. Code specifies the types of medical services that cannot be provided on an outpatient basis. For example, VA outpatient clinics cannot provide

- prosthetic devices, such as wheelchairs, crutches, eyeglasses, and hearing aids, to veterans not eligible for comprehensive outpatient services;
- dental care to most veterans unless they were examined and had their treatments started while in a VA hospital; and
- routine prenatal care and delivery services through the VA health care system.

Outpatient Eligibility Requirements Are Difficult to Administer

Veterans are not the only ones confused by VA eligibility provisions. Those tasked with applying and enforcing the provisions daily—VA physicians and administrative staff—express similar frustration in attempting to interpret the provisions. Although the criterion to obviate the need for hospitalization is most often cited as the primary source of frustration, VA administrative staff must also enforce a series of other requirements, which add administrative costs not typically incurred under other public or private insurance programs.

VA has broadly defined the statutory eligibility criterion relating to obviating the need for hospitalization. Guidance to medical centers says that eligibility determinations

“shall be based on the physician’s judgment that the medical services to be provided are necessary to evaluate or treat a disability that would normally require hospital admission, or which, if untreated would reasonably be expected to require hospital care in the immediate future.”

To assess medical centers’ implementation of this criterion, we used medical profiles of six veterans developed from actual medical records and presented them to 19 medical centers for eligibility determinations.⁶ At these 19 centers, interpretations of the criterion ranged from permissive (care for any medical condition) to restrictive (care only for certain medical conditions). In other words, from the veteran’s perspective, access to VA care will depend greatly on which medical center he or she

⁶VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 16, 1993).

visits. For example, if one veteran we profiled had visited all 19 medical centers, he would have been determined eligible by 10 centers but ineligible by 9 others.

Officials at VA's headquarters and medical centers agreed that the criterion to obviate the need for hospital admission is an ambiguous and inadequately defined concept. A headquarters official stated that because the term has no clinical meaning, its definition can vary among physicians or even with the same physician. A medical center official noted that the criterion

"is so vaguely worded that every doctor can come up with one or more interpretations that will suit any situation . . . Having no clear policy, we have no uniformity. The same patient with the same condition may be denied care by one physician, only to walk out of the clinic the next day with a handful of prescriptions supplied by the doctor in the next office."

With thousands of VA physicians making eligibility decisions each working day, the number of potential interpretations is, to say the least, very large.

In addition to interpreting the obviate-the-need criterion, VA physicians or administrative staff must evaluate a series of other eligibility requirements before deciding whether individual veterans are eligible for the health care services they seek. For example, they must

- determine whether the disability for which care is being sought is service connected or aggravating a service-connected disability, because different rules apply to service-connected and nonservice-connected care;
- determine the disability rating for veterans with service-connected disabilities because the outpatient services they are eligible for and their priority for care depend on their rating; and
- determine the income and assets of veterans with no service-connected disabilities because their eligibility for (and priority for receiving) care depends on a determination of their ability to pay for care.

Availability of Outpatient Care Is Uneven

Under private health insurance, Medicare, and Medicaid, the availability of covered services is guaranteed. For example, all beneficiaries who meet the basic eligibility requirements for Medicare are entitled to receive all medically necessary care covered under the Medicare part A benefit package. Similarly, those Medicare beneficiaries who enroll for part B benefits are entitled to receive all medically necessary care covered under the part B benefit package. As an entitlement program, Medicare spending

increases as utilization increases, creating guaranteed access to covered services.

Under the VA health care system, however, being in the mandatory care category does not entitle veterans to, or guarantee the availability of, needed services. The VA health care system is funded by a fixed annual appropriation; once appropriated funds have been expended, the VA health care system is not required to, and in fact is not allowed to, provide additional health care services—even to veterans in the mandatory care category. Although title 38 of the U.S. Code contains frequent references to services that “shall” or “must” be provided to mandatory care group veterans, in practical application the terms mean that services “shall” or “must” be provided if adequate resources have been appropriated to pay for them. Being in the mandatory care category essentially gives veterans a higher priority for treatment than veterans in the discretionary care category.

In effect, veterans, rather than the government, assume a significant portion of the financial risk in the VA health care system because there is no guarantee that sufficient funds will be appropriated to enable the government to provide services to all veterans seeking care. Historically, however, sufficient funds have been appropriated to meet the health care needs of all veterans in the mandatory care category and most of those in the discretionary care categories.

Because the provision of VA outpatient services is conditioned on the availability of space and resources, veterans cannot be assured that health care services are available when they need them. Even veterans in the mandatory care category are theoretically limited to health care services that can be provided with available space and resources. If demand for VA care exceeds the capacity of the system or of an individual facility to provide care, then health care services are rationed.

The Congress established general priorities for VA to use in rationing outpatient care when resources are not available to care for all veterans. VA delegated rationing decisions to its medical centers; that is, each must independently make choices about when and how to ration care.

Using a questionnaire, we obtained information from VA’s 158 medical centers on their rationing practices. In fiscal year 1991, 118 centers reported that they rationed outpatient care for nonservice-connected

conditions, and 40 reported no rationing. Rationing generally occurred because resources did not always match veterans' demands for care.⁷

When the 118 centers rationed care, they also used differing methods. Some rationed care according to economic status, others by medical service, and still others by medical condition. The method used can greatly affect who is turned away. For example, rationing by economic status will help ensure that veterans of similar financial means are served or turned away. On the other hand, rationing by medical service or medical condition helps ensure that veterans with similar medical needs are treated the same way.

The 118 medical centers' varying rationing practices resulted in significant inconsistencies in veterans' access to care both among and within centers. For example, higher-income veterans frequently received care at many medical centers, while lower-income veterans or those who also had service-connected disabilities were turned away at other centers. Some centers that rationed care by either medical service or medical condition sometimes turned away lower-income veterans who needed certain types of services while caring for higher-income veterans who needed other types of services.

Restrictions on Providing Noncovered Services Adds to Frustration

One major source of frustration for VA facilities is their inability to provide needed health care services to veterans when those services are not covered under their veterans' benefits. Unlike private sector physicians, who can generally provide any available outpatient service to any patient willing to pay, VA facilities and physicians are generally unable to provide noncovered services to veterans. In the private sector, physicians and clinics can sell their services to any person regardless of whether the service is covered by insurance. Essentially, the patient assumes the financial responsibility for any services not covered under his or her health insurance or for any charges that exceed insurance coverage.

Although VA health care facilities are primarily restricted to use by veterans, VA actually has greater authority to sell health care services to nonveterans through sharing agreements than it does to sell these same services to veterans. Specifically, VA hospitals and clinics cannot, under current law, sell veterans those services not covered under their veterans' health care benefits even if they (1) have public or private insurance that

⁷VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 16, 1993).

would pay for the care or (2) agree to pay for the services out of their own funds.

Some Veterans' Health Conditions Go Untreated

In a 1993 review, we examined veterans' efforts to obtain care from alternative sources when VA medical centers did not provide it.⁸ Through discussions with 198 veterans turned away at six medical centers, we learned that 85 percent obtained needed care after VA medical centers turned them away. Most obtained care outside the VA system, but some veterans returned to VA for care, either at the same center that turned them away or at another center.

The 198 veterans turned away needed varying levels of medical care. Some had requested medications for chronic medical conditions, such as diabetes or hypertension. Others presented new conditions that were as yet undiagnosed. In some cases, the conditions, if left untreated, could be ultimately life threatening, such as high blood pressure or cancer. In other cases, the conditions were potentially less serious, such as psoriasis.

Studies Do Not Show Strong Link Between Eligibility Provisions and Nonacute Admissions

VA hospitals too often serve patients whose care could be more efficiently provided in alternative settings, such as an outpatient clinic or nursing home. VA, the major veterans' service organizations, and the Vice President's National Performance Review attribute many of the inappropriate admissions to VA's eligibility provisions, citing (1) studies showing that over 40 percent of admissions could have been avoided through use of outpatient care and (2) anecdotes, such as the one about a patient who had to be admitted to the hospital to get a pair of crutches. Our review, however, found little basis for linking most inappropriate hospitalizations to VA eligibility provisions.

In 1985, we reported that about 43 percent of the days of care medical and surgical patients spent in the VA hospitals reviewed could have been avoided.⁹ Since then, a number of studies by VA researchers and VA's Office of Inspector General (IG) have found similar problems.

For example, a 1991 VA-funded study of admissions to VA acute medical and surgical bed sections estimated that 43 percent (+/- 3 percent) of

⁸VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (GAO/HRD-93-123, July 14, 1993).

⁹Better Patient Management Practices Could Reduce Length of Stay in VA Hospitals (GAO/HRD-85-52, Aug. 8, 1985).

admissions were nonacute. Nonacute admissions in the 50 randomly selected VA hospitals studied ranged from 25 to 72 percent. The study suggested several reasons why there is a higher rate of nonacute admissions to VA hospitals than private sector hospitals, including the following:

- VA facilities do not have the necessary financial incentives to make the transition to outpatient care.
- VA, unlike the private sector, does not have formal mechanisms to control nonacute admissions, such as mandatory preadmission review.
- VA, unlike the private sector, has a significantly expanded social mission that may influence the use of patient resources.¹⁰

A 1993 study by VA researchers reported similar findings. At the 24 VA hospitals studied, 47 percent of admissions and 45 percent of days of care in acute medical wards were nonacute; 64 percent of admissions and 34 percent of days of care in surgical wards were nonacute.

Reasons cited for nonacute admissions and days of care included nonavailability of outpatient care, conservative physician practices, inadequate discharge planning, and social factors. The authors suggested that VA establish a systemwide utilization review program. VA, however, has not established either an internal utilization review requirement or contracted for external reviews.

We recently testified that establishing preadmission certification procedures similar to those used by private health insurers could save VA hundreds of millions of dollars by reducing nonacute admissions to VA hospitals. We noted that all fee-for-service health plans participating in the Federal Employees Health Benefits Program are required to operate a preadmission certification program to help limit nonacute admissions and days of care. VA's Under Secretary for Health announced plans to implement a preadmission certification program at the same hearing.¹¹

Although the VA study also cited eligibility as contributing to some inappropriate admissions and days of care, the study identified only minor changes needed in VA eligibility provisions. Specifically, it recommended

¹⁰For example, VA facilities may admit patients who travel long distances for care or keep veterans in the hospital longer than medically necessary because they lack a social support system to assist them after they are discharged.

¹¹Testimony before the Subcommittee on VA, HUD, and Independent Agencies, Senate Committee on Appropriations, on March 8, 1996.

changes in the law to (1) allow veterans with nonservice-connected disabilities to be placed in VA-supported community nursing homes without first being admitted to a VA hospital and (2) allow prosthetic devices to be furnished to veterans on an outpatient basis.

Trying to link the studies discussed here to VA eligibility provisions is, in our view, inappropriate because the studies did not contain the types of data needed to make such a link. In other words, the studies did not determine whether the patients inappropriately admitted to VA hospitals had service-connected or nonservice-connected disabilities, whether they were in the mandatory or discretionary care category for outpatient care, or whether they would have been eligible to receive the services they needed on an outpatient basis. Had such information been included in the studies, it would be possible to determine whether a higher incidence of nonacute admissions occurred for veterans in the discretionary care category for outpatient care than for those in the mandatory care category.¹²

Similarly, while the anecdotes VA cites represent real limitations in VA eligibility provisions that need to be addressed, VA lacks data to show how many inappropriate hospital admissions resulted from the limitations. For example, how many of the approximately 7,000 patients admitted to VA hospitals in fiscal year 1994 for fractures of the arms and legs were treated on an outpatient basis and then admitted for the purpose of providing crutches? Only 765 of the 7,000 admissions were for 1 day, the most likely length of stay for patients admitted to enable VA to give them a pair of crutches or other routine outpatient care.

Studies by the VA IG show limited enforcement of outpatient eligibility provisions. VA's IG estimated that over half of the outpatient visits of veterans in the discretionary care category were to receive services that were not covered under the veterans' VA benefits. This suggests that VA physicians are more likely to "stretch" the outpatient benefit to provide crutches to veterans with broken legs than to admit the veteran to the hospital for that purpose.

¹²This is a limitation in how the study can be used, not a deficiency in how the study was conducted.

Proposed Bills Would Eliminate Restrictions on Outpatient Eligibility, but Other Problems Would Continue

Eligibility reform proposals introduced during the past year would eliminate the restrictions on veterans’ access to outpatient care. In doing so, however, the proposals would likely generate significant new demand for VA outpatient care services. In addition, the bills generally do not address the other provisions in current law that contribute to inappropriate use of VA health care resources and uneven access to health care services. (See table 2.)

Table 2: Key Provisions of VA Eligibility Reform Proposals

Key provisions	Bill/sponsor			
	S. 1345 (VA)	S. 1563 (veterans’ service organizations)	H.R. 1385 (Montgomery/ Edwards)	H.R. 2491 (House Veterans’ Affairs)
Creates an entitlement to VA care/guarantees availability of care	No	No	No	No
Expands the number of veterans in the mandatory care category	Yes	Yes	Yes	Yes
Creates a uniform benefit package/eliminates obviate-the-need provision	Yes	Yes	Yes	Yes
Reforms contracting provisions	Yes	No	No	Yes
Other provisions	— Expands the definition of covered services to include virtually any necessary inpatient or outpatient care, drugs, supplies, or appliances — Allows VA to retain a portion of third-party recoveries	— Includes nursing home care as mandatory service — Mandatory care category would include catastrophically disabled veterans — Allows adult dependents to become eligible for VA care, provided they reimburse VA — Allows VA to bill and retain collections from Medicare	— Requires VA to provide veterans similar access regardless of their home state — Allows VA to use a system of enrollment and priorities for care — Allows VA to retain a portion of third-party recoveries to expand outpatient care	— Requires VA to establish a system of annual enrollment based on priorities for care — Creates a new category of priority for catastrophically disabled veterans

Bills Would Create a Uniform Benefit Package

Each of the four major bills introduced during the past year would create a uniform benefit package by eliminating the obviate-the-need restriction on

coverage of outpatient care. The bills would make all 26 million veterans eligible for comprehensive outpatient services. In addition, the four bills would expand the number of veterans in the mandatory care category for comprehensive outpatient care from about 465,000 to 9 million to 11 million veterans.

Eliminating the obviate-the-need restriction on access to ambulatory care would simplify administration of health care benefits because VA physicians would no longer need to determine whether a patient would likely end up in the hospital if he or she was not treated. Eliminating the restriction would also promote greater equity by reducing the inconsistencies in eligibility decisions. Finally, eliminating the restriction would make benefits more understandable by essentially making veterans eligible for the full continuum of inpatient and outpatient care.

Other Major Restrictions Not Addressed in Most Bills

Most of the bills do not address the other major restrictions on VA eligibility and the ability of VA to provide noncovered services to veterans. Specifics follow:

- VA would continue to be unable to provide noncovered services directly to veterans under all of the bills. Because all veterans would become eligible for comprehensive outpatient services, there would be fewer noncovered services.
- Current restrictions on provision of dental, prenatal, and maternity care would not be changed under any of the proposals.
- S. 1345 would remove the restriction on direct admission of veterans with no service-connected disabilities to community nursing homes.
- All of the bills would retain the discretionary funding of VA health care. H.R. 1385 would, however, require VA to ensure that veterans have reasonably similar access to VA health care regardless of where they live.
- Only H.R. 1385 specifically addresses the uneven availability of VA care. That bill would require VA to expand its capacity to provide outpatient care and allocate resources to its facilities in a way that would give veterans access to care that is reasonably similar regardless of where they live. The other bills do not address the uneven availability of VA health care services caused by resource limitations, VA's limited provider network, and inconsistent VA rationing policies.

Appendix I contains a more detailed description of the major provisions of the four bills.

Eligibility Reform Bills Not Likely to Be Budget Neutral

By making all 26.4 million veterans eligible for comprehensive outpatient care, the four bills would likely generate significant new demand for both outpatient and inpatient care. The increased demand could be heightened by the synergistic effects of other changes in the VA health care system to improve access and customer service and expand contracting.

The bills would, however, provide little or no new sources of revenue to offset the costs of the new services. This would put increased pressure on the Congress to appropriate funds to meet the health care demands generated through eligibility expansions, particularly for the 9 million to 11 million additional veterans who would be placed in the mandatory care category for comprehensive outpatient benefits. Although VA and CBO arrived at strikingly different conclusions about the budgetary effects of the bills, we find CBO's arguments more compelling because they address the potential increased demand.

Bills Represent a Major Expansion of Outpatient Eligibility

Under the four bills, over 26 million veterans would become eligible to receive services that currently are available primarily to the approximately 465,000 veterans with service-connected disabilities rated at 50 percent or higher. Even many veterans who rely on other health care coverage for most of their needs are likely to attempt to take advantage of added VA benefits such as prescription drugs, which are not typically covered under other health insurance. Medicare does not cover outpatient prescription drugs, making VA an attractive alternative. Medicare-eligible veterans already make significant use of VA outpatient prescriptions even with the current eligibility limitations.¹³ Removing the restrictions on access to outpatient care would likely significantly increase demand for outpatient prescriptions.

Another area where workload would likely increase dramatically is prosthetic devices, such as eyeglasses, contact lenses, and hearing aids. In addressing the restriction in current law on provision of crutches to veterans with broken legs, the four bills would also eliminate the restriction on provision of other prosthetic devices, such as eyeglasses, contact lenses, and hearing aids. H.R. 2491 would, however, give the Secretary of Veterans Affairs the authority to restrict the provision of eyeglasses, contact lenses, and hearing aids.

¹³Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans (GAO/HEHS-95-13, Oct. 24, 1994).

Other Improvements in VA Health Care System Could Heighten Increased Demand

If concurrent changes are made in the accessibility of VA health care services, in VA customer service, and in the extent to which veterans are allowed to use private providers under contract to VA, the impact of eligibility reforms on demand for VA care will likely be heightened. As it strives to make the transition from a hospital-based system to an ambulatory-care-based system, VA is attempting to bring ambulatory care closer to veterans' homes. Because distance is one of the primary factors affecting veterans' use of VA health care, actions to give veterans access to outpatient care closer to their homes, either through expansion of VA-operated clinics or through contracts with community providers, will likely increase demand for services.

Similarly, our reports over the past 5 years have identified continuing problems in VA customer service, including long waiting times, poor staff attitudes, and lack of such amenities as bedside telephones. As part of its response to the National Performance Review, VA has developed detailed plans to improve customer service that include installing bedside telephones, reducing waiting times, and training staff. These efforts are likely to help VA retain current users and will likely attract new users as VA's reputation for customer service improves.

Finally, increased contracting with private sector providers closer to veterans' homes could attract new users. Both S. 1345 and H.R. 2491 would expand VA's authority to contract with private sector providers. Such contracting might enable veterans to use the same physicians, clinics, and hospitals they use now but have VA rather than their private insurance or Medicare pay for the care.

Bills Would Provide Few New Sources of Revenues

Three of the bills—H.R. 2491, S. 1345, and S. 1563—would provide new sources of revenue, but they would not offset the costs of eligibility expansions. The provisions in those bills, which would allow VA to retain certain third-party recoveries, would not be used to offset VA appropriations and therefore would not change the budgetary impact of these reform proposals. The bills essentially assume that eligibility reform will not require new sources of revenue because they will generate significant savings by making it possible for VA to treat on an outpatient basis 20 to 40 percent of veterans currently in VA hospitals. These savings would then be used to pay for the increased outpatient workload generated by the patients diverted to outpatient care. There is, however, little evidence to suggest that eligibility reform alone will result in significant numbers of veterans being diverted to outpatient care.

Controlling Budgetary Increases Would Be Difficult

Expanding the number of veterans in the mandatory care category while retaining current resource constraints might force rationing of care to veterans in the mandatory care group. Expanding the mandatory care category would place great pressure on the Congress to fully fund services for veterans in the mandatory care category. Historically, the Congress has fully funded both VA's mandatory and discretionary workload.

Considering the significant portion of VA resources currently used to provide services to veterans in the discretionary care category and the limited data VA provides the Congress on which to base funding decisions, it would be exceedingly difficult for the Congress to appropriate funds for the care of only a portion of the veterans in the mandatory care category. About 15 percent of veterans using VA medical centers have no service-connected disabilities and have incomes that place them in the discretionary care category for both inpatient and outpatient care. But VA does not differentiate between services provided to veterans in the mandatory and discretionary care categories in justifying its budget request. As a result, the Congress has little basis for determining which portion of VA's discretionary workload to fund.

Although two proposals (H.R. 2491 and H.R. 1385) propose establishment of an enrollment process, such a process may jeopardize VA's safety net mission. Because low-income veterans are typically the fourth highest priority for care in the proposed enrollment process, reforms that provide a richer benefit package or increase the number of higher-priority veterans, or a combination of both, could reduce funds available to treat low-income veterans.

For example, under the new definition of health care in S. 1345, veterans in the top three priority categories would be in the mandatory care category for virtually any service offered by VA. Further, VA would be required to provide comprehensive care to about 3 million veterans previously eligible for limited outpatient care. Under the VA proposal, about 1.8 million veterans currently eligible for limited outpatient care would be placed in the highest-priority group for comprehensive care. The VA proposal would also place veterans with noncompensable service-connected disabilities (estimated to number about 1.2 million) above low-income veterans with no service-connected disabilities in the priority ranking of veterans in the mandatory care category.¹⁴

¹⁴Other proposals generally would not provide a special status to such "0 percent" veterans—those with noncompensable service-connected disabilities.

Only after the needs are met for the top three priority categories could VA fund care for low-income veterans. We are concerned that sufficient funds might not be available to fulfill VA's safety net mission after meeting the expanded demands for care of higher-priority veterans. Because most of the reform proposals do not address the uneven availability of VA services, however, the increased demand for care generated by eligibility expansions would likely heighten the problems VA already faces in trying to equitably distribute available resources.

CBO's Cost Estimate Is More Compelling Than VA's

VA and CBO estimated the budgetary impact of H.R. 2491, the most modest of the reform proposals, with strikingly different results:

- VA concluded that because the bill was similar to the administration's proposal, it would be budget neutral, generating net savings of \$268 million that could be reinvested to expand outpatient care or construct new facilities.
- CBO estimated that the bill could add \$3 billion or more to the deficit annually.

A number of problems have been identified with both cost estimates that reduce their usefulness in assessing the potential impact of the bill on VA's budget. We agree with CBO's overall conclusion, however, that any broad expansion in benefits will generate significant new demand for VA health care that could potentially add billions to the budget deficit.

VA's Estimate Is Based on Questionable Assumptions

VA did not adequately consider the increased demand for outpatient care likely to be generated by the eligibility expansions, incorrectly assumed a strong link between inappropriate admissions to VA hospitals and VA eligibility provisions that would be addressed through the reform proposals, and made a number of questionable assumptions in its calculations.

VA developed a complex formula for estimating the cost effects of eligibility reform based on its overall assumption that eligibility reform would enable it to divert 20 percent of its hospital patients to outpatient care. The results, however, are sensitive to a series of assumptions about such things as how many veterans are inappropriately admitted to VA hospitals because of restrictions on outpatient eligibility; how long, on average, those veterans stay in the hospital; and how eligibility reform would affect demand for outpatient care. We have the following concerns

about VA's assumptions or how they were used in VA's calculations of savings to be realized from eligibility reforms:

Eligibility reform would enable VA to eliminate 20 percent of hospital admissions. One argument frequently used to promote the need for eligibility reform is that the obviate-the-need provision prevents VA from providing care in the most cost-effective setting. The presumed savings from removing the restrictions on access to ambulatory care services would then be used to offset the costs of expanded benefits.

We agree that significant savings can accrue from shifting a sizable portion of VA's inpatient services to other settings. But we do not believe that current eligibility provisions prevent VA from shifting much of its current inpatient services to ambulatory care settings.

The same obviate-the-need provision discussed earlier as making it difficult for VA physicians to determine whether to provide outpatient care for certain conditions makes it clear that care can be provided to any veteran, regardless of income or other factors, if it would prevent a hospital admission. The eligibility provisions, for example, allow VA to perform cataract surgery on an outpatient basis to obviate the need for inpatient care. Accordingly, we do not believe it would be appropriate to assume that the management inefficiencies that have prevented VA from effectively implementing the provision and shifting care to outpatient settings for over 20 years would be eliminated and the planned savings actually realized.

Actions such as the preadmission certification program previously discussed could, however, generate savings that could be used to offset the costs of eligibility reform.

An average of 7 days of hospital care would be saved for every patient diverted to outpatient care. This assumption is not sound given VA's argument that the patients it would be diverting were admitted in order to provide them routine outpatient care. Because the inpatients VA expects to shift to outpatient care are essentially self-care patients with no acute medical need, VA would most likely be drawing from patients with the shortest lengths of stay—such as veterans admitted to provide them crutches or as a prerequisite to placement in a community nursing home. In fiscal year 1994, about 37 percent of VA medical and surgical patients had 1- to 3-day stays. We believe it would be more reasonable to assume

the average length of stay of patients to be diverted to outpatient care to be 1 to 3 days.

Changing the assumption about average length of stay dramatically alters VA's savings estimates. Substituting 3 days for VA's assumption of a 7-day average length of stay would change VA's projected savings of \$268 million from eligibility reform into an overall increase in VA costs of almost \$167 million.

Because the less sick patients would be shifted to outpatient care, the costs of treating patients remaining in the hospital would increase by 10 percent per admission. Although VA's formula originally included this adjustment, VA did not include the calculation in its savings estimates. Including this adjustment would turn VA's projected savings of \$268 million into a cost increase of \$51 million.

An increase in demand would not occur for outpatient care other than demand generated by veterans shifted from inpatient to outpatient care. VA anticipates limited new demand because, according to headquarters officials, the administration proposal and H.R. 2491 were designed to give VA added flexibility, not to attract new users. Although headquarters officials anticipate few new users, medical centers are already aggressively pursuing new users.

CBO's Conclusions Appear Sound

CBO estimated that the eligibility reform provisions of H.R. 2491 could increase the deficit by \$3 billion or more annually if the Congress fully funds the increased demand for outpatient care that the eligibility expansions would likely generate. CBO's estimates were based in part on tables contained in what at the time was VA's newly released 1992 National Survey of Veterans. VA claimed that CBO misinterpreted one of the tables in the survey—which VA acknowledged was confusing—and raised concerns about CBO's methodology and the accuracy of its projections.

After reviewing VA's concerns, CBO determined that any problem in interpreting the survey data did not affect its overall conclusion that the bill would not be budget neutral because the expanded eligibility would generate significant new demand. CBO assumes in conducting budgetary impact analyses that if demand increases under a discretionary program, funds will be appropriated to meet that demand. CBO estimated that the cost of providing outpatient care to the 10.5 million veterans who are currently eligible only for hospital-related outpatient care would far outweigh the savings from shifting inpatients to outpatient care. Further,

CBO concluded that VA could incur significant costs under provisions that expand VA's authority to provide prosthetic devices on an outpatient basis. Finally, CBO noted that the bill could increase costs by billions more if the induced demand for outpatient care resulted in corresponding increases in demand for hospital care.

Approaches for Developing Budget-Neutral Eligibility Reforms

The cost of eligibility reform depends on a number of factors, including the benefits covered, the number of veterans offered the benefits, and the extent to which veterans are expected to pay for or contribute toward the cost of their health care benefits. The current reform proposals would essentially make all 26 million veterans eligible for comprehensive inpatient and outpatient care with little or no change in the system's sources of revenue. Three basic approaches could be used, individually or in combination, to develop budget-neutral eligibility reform. These are (1) set limits on covered benefits, (2) limit the number of veterans eligible for health care benefits, and (3) generate increased revenues to pay for expanded benefits. Another approach would be to allow VA to "reinvest" savings achieved through efficiency improvements in expanded benefits.

Set Limits on Covered Benefits

One way to control the increase in workload likely to result from eligibility expansions would be to develop one or more defined benefit packages patterned after public and private health insurance. This would narrow the range of services veterans could obtain from VA, allowing workload to be reduced by the eliminated services to offset the workload from increased demand for other services. Like private health insurers, VA could adjust the benefit package annually on the basis of the availability of resources.

Creating a defined benefit package could result in some veterans receiving a narrower range of services than they receive now, while others would receive additional benefits. This approach would essentially take some benefits away from veterans with the greatest service-connected disabilities and give additional benefits to veterans with lesser service-connected disabilities and to veterans with no service-connected disabilities.

One option for addressing this problem is to establish separate benefit packages for different types of veterans. For example, veterans with disabilities rated at 50 percent or higher might continue to be entitled to any needed outpatient service, while a narrower package of outpatient benefits—perhaps excluding such items as eyeglasses, hearing aids, and

prescription drugs—could be provided to higher-income veterans with no service-connected disabilities.

Limit the Number of Veterans Eligible for VA Health Care

Another way to develop budget-neutral eligibility reform would be to pay for expanded eligibility for some veterans by restricting or eliminating eligibility for others. Under current law, all veterans are eligible for VA hospital and nursing home care and at least some outpatient care, but there is a complex set of priorities for care based on such factors as presence and degree of service-connected disability, period of service, and income. In practical application, however, these priorities have little effect on the VA health care system. In preparation of VA budget justifications, no distinction is made between veterans in the mandatory and discretionary care categories, let alone those in different priority groups within the mandatory and discretionary care categories. Two of the reform bills (H.R. 1385 and H.R. 2491) would authorize VA to control demand for VA services through the use of priorities for care and an enrollment process.

Among the approaches that could be used to limit the number of veterans taking advantage of expanded benefits is to limit VA eligibility to those veterans who lack other public or private insurance. Exceptions could be made for treatment of service-connected disabilities and for services not covered under veterans' public or private insurance. Such an approach might help target available funds toward those veterans most in need.

The Congress would face a difficult choice, however, in determining whether VA health care is (1) a benefit of service that should be available regardless of alternate coverage or (2) a safety net available only to those who lack health care options.

Limiting eligibility of veterans with nonservice-connected disabilities to those whose income is below the current, or some new, means test limit would allow VA to retarget some resources currently used to provide services to higher-income veterans. Because about 15 percent of VA users have incomes above the means test threshold, eliminating their eligibility would make additional resources available to offset increased demand for outpatient services by veterans in higher-priority categories. Such veterans could be allowed to purchase services from VA facilities on a space-available basis.

Another way to limit the number of veterans eligible for expanded VA benefits is to restrict enrollment in VA health care to current VA users. This

approach could limit the potential “woodwork” effect and thereby reduce the costs of eligibility reforms. While current users might increase their use of VA health care in response to expanded benefits, most such veterans already obtain those services they are unable to get from VA from private sector providers through their public and private insurance. As a result, this approach might enable those higher-income veterans with nonservice-connected disabilities already using VA services to shift all of their care to VA, while veterans who had not previously used VA services but would like to start using them would essentially be shut out of the system. This would include veterans with higher priorities for care, such as those with service-connected disabilities and low incomes. Similarly, restricting enrollment to current users might prevent VA from fulfilling its safety net mission by denying care to veterans whose economic circumstances change.

Generate Increased Revenues

Several approaches could be used to generate additional revenues to pay for expanded benefits. These include increased cost sharing, authorizing recoveries from Medicare, and allowing VA to retain funds from third-party recoveries.

Increase Veteran Cost Sharing

Increased veteran cost sharing could help offset the costs of increased demand. For example, through contracting reform, VA might be authorized to sell veterans any available health care service not covered under their current veterans’ benefits without changing existing eligibility provisions. In other words, veterans could purchase, or use their private health insurance to purchase, additional health care services from VA.

Such an approach would not eliminate the problems VA physicians have in interpreting the obviate-the-need provision. But it would lessen the importance of the decision. Physicians would no longer be forced to turn away veterans needing health care services. Instead, obviate-the-need decisions would determine who would pay for needed health care services, the government or the veteran. In addition, VA could issue regulations interpreting the obviate-the-need provision. Because uninsured veterans may be unable to pay for many additional health care services, an exception could be made to help such veterans pay for additional health care services.

A second approach for offsetting the costs of eligibility expansions through cost sharing could be to impose new cost-sharing requirements for existing services. For example, VA could be authorized to increase cost

sharing for nursing home care—a discretionary benefit for all veterans—either through increased copayments or estate recoveries. Recoveries could be used to help pay for benefit expansions. Similarly, copayments and deductibles for hospital and outpatient care could be adjusted to be more comparable with other public and private sector programs.

Cost sharing could also be increased by redefining the mandatory care group. In other words, the income levels for inclusion in the mandatory care category could be lowered or copayments imposed for nonservice-connected care provided to veterans with service-connected disabilities of 0 to 20 percent.

Authorize Recoveries From Medicare

Proposals have been made in the past few years to authorize VA recoveries from Medicare either for all Medicare-eligible veterans or for those with higher incomes. For example, S. 1563 would allow VA to bill and retain recoveries from Medicare. Such proposals, though, appear to offer little promise for offsetting the costs of eligibility expansions. First, many of the services, such as hearing aids and prescription drugs, that Medicare-eligible veterans are likely to obtain from VA are not Medicare-covered services. Second, the proposals would not require VA to offset the recoveries against its appropriation. As a result, it would not affect VA's budget request. Authorizing VA recoveries from Medicare could, however, further jeopardize the solvency of the Medicare trust fund and increase overall federal health care costs. Such an action would essentially transfer funds between federal agencies while adding administrative costs.

Allowing VA to bill and retain recoveries from Medicare would create strong incentives for VA facilities to shift their priorities toward providing care to veterans with Medicare coverage. VA facilities would essentially receive duplicate payments for care provided to higher-income Medicare beneficiaries, unless recoveries were designated to fund services or programs for which VA did not receive an appropriation. For example, if VA were authorized to sell noncovered services to veterans and did not receive an appropriation for such services, then veterans should be allowed to use their Medicare benefits to help pay for the services just as they would use their private health insurance.

Allow VA to Retain a Portion of Third-Party Recoveries

Proposals, such as the ones contained in S. 1345 and H.R. 1385, that would allow VA to retain a portion of recoveries from private health insurance beyond what it needs to finance its recovery program would not reduce VA's budget request and therefore would not generate the revenues needed

to offset the costs of expanded benefits. Just as allowing VA to retain Medicare recoveries would essentially result in duplicate payments unless they were earmarked for some purpose other than to pay for care covered by an appropriation, proposals to allow VA to retain a portion of its third-party recoveries would essentially result in duplicate payments.

Reinvest Savings From Efficiency Improvements

During the past 5 to 10 years, GAO, VA's IG, the Veterans Health Administration, and others identified numerous opportunities to improve the efficiency of the VA health care system and enhance revenues from sales of services to nonveterans and care provided to veterans. Savings from such initiatives could be "reinvested" in the VA health care system to help pay for eligibility expansions.

VA has historically used savings from efficiency improvements to fund new programs. For example, VA is allowing its facilities to reinvest savings achieved by consolidating administrative and clinical management of nearby facilities into providing more clinical programs. Similarly, VA allows medical centers to use savings from efficiency improvements to fund access points.

Through establishment of a preadmission certification requirement similar to those used by many private health insurers, VA could reduce nonacute admissions and days of care in VA hospitals and save hundreds of millions of dollars. While such inappropriate admissions and days of care to a large extent are unrelated to problems with VA eligibility provisions, savings resulting from administrative actions to address the problem could nonetheless be targeted to pay for expanded benefits.

Actions to reinvest savings from efficiency improvements would, however, limit VA's ability to contribute to deficit reduction.

Conclusions

The VA health care system was neither designed nor intended to be the primary source of health care services for most veterans. It was initially established to meet the special care needs of veterans injured during wartime and those wartime veterans permanently incapacitated and incapable of earning a living. Although the system has evolved since that time, even today it focuses on meeting the comprehensive health care needs of only about 465,000 of the nation's 26.4 million veterans. In other words, its primary mission is to meet the comprehensive health care needs of veterans with service-connected disabilities rated at 50 percent or more.

For other veterans, the system is primarily intended to provide treatment for their service-connected disabilities and to serve as a safety net to provide health care to veterans with limited access to health care through other public and private programs.

Because 9 out of 10 veterans now have other public or private health insurance that meets their basic health care needs, few veterans today need to rely on VA as a safety net. Rather, most of them turn to private sector providers for all or most of their care, using VA either not at all or to supplement their use of private sector health care.

Reforms of VA eligibility that would significantly expand veterans' eligibility for comprehensive care in VA facilities would significantly alter VA's health care mission and place VA in more direct competition with the private sector. To the extent veterans are given expanded benefits that are either free or have lower cost sharing than other public and private health insurance, the VA system will gain a clear competitive advantage over its private sector competitors. Coupling eligibility reform with other changes, such as improved accessibility and customer service, could heighten the increased demand for VA services. Because most veterans currently use private sector providers, any increased demand generated by eligibility expansions would come largely at the expense of those providers.

For most veterans, VA eligibility reform might provide an additional option for health care services or additional services not covered under their public or private insurance. For those veterans who do not have public or private health insurance, however, eligibility reform is more important. It could improve their access to comprehensive health care services, including preventive health care services.

Historically, the Congress has fully funded VA's mandatory and discretionary care workload. The four eligibility reform bills that have been introduced could significantly increase demand for VA health care services, putting pressure on the Congress to increase VA appropriations to fully fund at least the demand generated by the 9 million to 11 million veterans added to the mandatory care category for comprehensive free outpatient services.

If the Congress decides not to fully fund VA's anticipated workload, VA would be faced with developing rationing policies that would ensure the funds appropriated are directed toward those veterans with the highest priorities for care. This would likely entail turning away many of the

veterans currently using VA health care. Depending on the level of funding, those turned away could include low-income uninsured veterans. The funds needed to meet the increased demand for routine health care services could also jeopardize VA's ability to provide specialized services, such as treatment of spinal cord injuries, not available through other programs.

Eligibility reforms should focus on strengthening VA's safety net mission while preserving its ability to provide specialized services veterans may be unable to obtain through their public and private insurance. Several approaches could be pursued to develop budget-neutral reforms that would also limit the extent to which the government competes with the private sector. These approaches generally involve placing limits on the number of veterans given expanded benefits, narrowing the range of benefits added, or increasing cost sharing to offset the costs of added benefits.

Mr. Chairman, this concludes my prepared statement. We will be happy to answer any questions that you or other Members of the Committee may have.

Contributors

For more information on this testimony, please call Jim Linz, Assistant Director, at (202) 512-7110. Terry Saiki, Evaluator-in-Charge, also contributed to the preparation of the statement.

Appendix I

Key Provisions of Selected Proposals to Reform Eligibility for VA Health Care

This appendix contains a synopsis of the key provisions in the four major eligibility reform bills introduced during the past year.

The Department of Veterans Affairs Improvement and Reinvention Act of 1995

The Department of Veterans Affairs Improvement and Reinvention Act of 1995 (S. 1345) was introduced at the administration's request on October 19, 1995. In addition to reforming VA health care eligibility, S. 1345 would expand VA contracting authority and amend VA housing and education benefits. The eligibility reform provisions would do the following:

- Previous provisions covering hospital care, outpatient care, respite care, pharmaceuticals, supplies, equipment, appliances, and other material and services would be combined into a new "health care" provision. Health care would be defined as "the most appropriate care and treatment for the patient furnished in the most appropriate setting."
- All veterans would be eligible for the expanded benefits offered under the new definition of health care.
- The current fixed categories of eligibility would be replaced by a priority system.
- The highest-priority groups of veterans in the mandatory category for comprehensive care would be expanded to include veterans (1) with any compensable service-connected disability, (2) who are former prisoners of war, (3) whose discharge or release was for disabilities incurred or aggravated in the line of duty, and (4) who are receiving disability compensation.
- VA would be allowed to provide, subject to available funding, comprehensive health care services to lower-priority veterans.
- The obviate-the-need-for-hospitalization criterion for outpatient care would be eliminated.
- The discretionary nature of VA funding would be retained by making the availability of services subject to annual appropriations.

The administration's proposal would also expand VA contracting authority. It would allow VA to share (purchase or sell) health care resources with health plans, insurers, organizations, institutions, or any other entity or individual who furnishes any health care resource. Under current law, such sharing agreements are limited to medical schools, health care facilities, and research centers.

Finally, S. 1345 would allow VA to retain a greater portion of its third-party collections. Currently, VA must return all third-party collections, less the

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administrative costs of collection activities, to the Treasury. Under the administration's proposal, VA would be allowed to retain an additional 25 percent of recoveries to be distributed to its health care facilities.

S. 1563

S. 1563 was introduced at the request of the veterans' service organizations (vso) on February 7, 1996. The vsos' highest priority, according to vso representatives, is eligibility reform that authorizes a full range of medical services for veterans currently in the mandatory category for hospital care, and funding to ensure the availability of those services. As a practical matter, the vsos did not attempt to include all of the eligibility reforms recommended in their 1996 Independent Budget in this year's proposal. In the scaled-back version, S. 1563 would

- add catastrophically disabled veterans to the mandatory category for comprehensive health care;¹⁵
- expand the mandatory care category (Category A) for hospital care to apply to outpatient, nursing home, domiciliary, and long-term care;
- allow VA to treat adult dependents of veterans, provided they reimburse VA for the cost of their care;
- broaden VA's authority to provide primary and preventive health care services;
- require VA to provide prosthetic appliances and aids for veterans in the mandatory care category who are blind or hearing-impaired;
- authorize VA facilities to participate as Medicare providers and retain reimbursements from Medicare;
- require VA to maintain current capacity in specialized services for mandatory care category veterans, including those with spinal cord dysfunction, blindness, and mental illness; and
- eliminate the obviate-the-need provision, making all veterans eligible for comprehensive outpatient care.

Some reforms described in their 1996 Independent Budget for VA were not included in S. 1563. vso representatives said these initiatives will be retained for future consideration. For example, the vsos also recommended that the Congress

- switch VA health care funding from a discretionary to a mandatory spending account,
- authorize VA to provide pre- and postnatal care for women veterans,

¹⁵"Catastrophically disabled" is defined in S. 1563 as any veteran whose expenditures for hospital and nursing home care exceed 7.5 percent of his or her gross adjusted income for federal income tax purposes during the preceding year.

Appendix I
Key Provisions of Selected Proposals to
Reform Eligibility for VA Health Care

- provide investment funds to improve VA's infrastructure, and
- allow VA medical centers to conduct marketing activities.

The Veterans Health Care Reform Act of 1995

Introduced April 4, 1995, by Congressmen Edwards and Montgomery, the Veterans Health Care Reform Act of 1995 (H.R. 1385) would, on a temporary basis for the period ending September 30, 1999,

- expand the mandatory care category for comprehensive outpatient medical treatment to include all veterans in the mandatory care category for hospital care (core group) other than those with noncompensable service-connected disabilities (nursing home and dental services would remain discretionary);
- require VA to expand its capacity to provide outpatient care and allocate resources to its facilities in a way that would give veterans access to care that is reasonably similar regardless of where they live;
- include preventive health services and prosthetic appliances in the definition of services that are provided to core group veterans;
- include home health services in the definition of services that may be provided to core group veterans;
- authorize the Secretary of Veterans Affairs to use systems of patient prioritization and to set up a system of enrollment of eligible veterans;
- allow VA to retain a portion of third-party recoveries to expand outpatient care; and
- require VA to ensure that any veteran with a service-connected disability is provided all benefits to which he or she is entitled.

Like the administration's proposal, H.R. 1385 would not shift VA funding from a discretionary to a mandatory account. That is, availability of benefits would still be dependent upon available funding—benefits would not be guaranteed. In addition, VA would be required to ensure that its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans is not reduced.

The Veterans Reconciliation Act of 1995

In October 1995, the House approved a budget reconciliation package (H.R. 2491) that contained a Veterans' Affairs Committee proposal—the Veterans Reconciliation Act of 1995. The bill would, among other provisions, reform eligibility for VA health care to

- subject provision of care to amounts provided in advance in appropriations, thus retaining VA's discretionary funding;

Appendix I
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- expand the mandatory care category for comprehensive outpatient care to include all veterans in the mandatory category for hospital care except those with noncompensable service-connected disabilities;
- remove the obviate-the-need criterion and other limitations on the provision of outpatient care, making all veterans eligible for comprehensive outpatient care;
- retain nursing home care as a discretionary benefit for all veterans;
- require VA to establish a system of annual patient enrollment based on priorities for enrollment contained in the bill;
- create a new category of priority for veterans who are catastrophically disabled; and
- expand VA contracting and sharing authority.

Appendix I
Key Provisions of Selected Proposals to
Reform Eligibility for VA Health Care

Appendix II

Related GAO Products

VA Health Care: Opportunities to Increase Efficiency and Reduce Resource Needs (GAO/T-HEHS-96-99, Mar. 8, 1996).

VA Health Care: Issues Affecting Eligibility Reform (GAO/T-HEHS-95-213, July 19, 1995).

VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-147, May 9, 1995).

VA Health Care: Retargeting Needed to Better Meet Veterans' Changing Needs (GAO/HEHS-95-39, Apr. 21, 1995).

VA Health Care: Barriers to VA Managed Care (GAO/HEHS-95-84R, Apr. 20, 1995).

Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Reform (GAO/HEHS-95-14, Dec. 23, 1994).

Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans (GAO/HEHS-95-13, Oct. 24, 1994).

Veterans' Health Care: Implications of Other Countries' Reforms for the United States (GAO/HEHS-94-210BR, Sept. 27, 1994).

Health Security Act: Analysis of Veterans' Health Care Provisions (GAO/HEHS-94-205FS, July 15, 1994).

Veterans' Health Care: Efforts to Make VA Competitive May Create Significant Risks (GAO/T-HEHS-94-197, June 29, 1994).

Veterans' Health Care: Most Care Provided Through Non-VA Programs (GAO/HEHS-94-104BR, Apr. 25, 1994).

VA Health Care: A Profile of Veterans Using VA Medical Centers in 1991 (GAO/HEHS-94-113FS, Mar. 29, 1994).

VA Health Care: Restructuring Ambulatory Care System Would Improve Service to Veterans (GAO/HRD-94-4, Oct. 15, 1993).

Appendix II
Related GAO Products

VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (GAO/HRD-93-94, July 29, 1993).

VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (GAO/HRD-93-123, June 30, 1993).

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Thank you.

(b) (6)



Senior Ethics Attorney/

Deputy Ethics Official

(202) 461-

From: (b) (6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6)
To: Dan Caldwell <(b) (6) cv4a.org>
Cc:
Bcc:
Subject: RE: Meeting w/Acting SecVA
Date: Mon Apr 30 2018 16:28:26 CDT
Attachments:

Sorry – 1:30pm!

From: (b) (6)
Sent: Monday, April 30, 2018 5:28 PM
To: 'Dan Caldwell'
Subject: RE: Meeting w/Acting SecVA

Yes, Sir. Friday at 4pm. A Protocol Officer will meet you on the 1st floor and escort up to our Suite. Thank you.

From: Dan Caldwell [mailto:(b) (6) cv4a.org]
Sent: Monday, April 30, 2018 5:25 PM
To: (b) (6)
Subject: [EXTERNAL] RE: Meeting w/Acting SecVA

(b) (6) – I sent an email to Peter but just wanted to confirm to you that I am good to attend this meeting.

Dan Caldwell

Executive Director

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@va.gov]
Sent: Friday, April 27, 2018 3:32 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Meeting w/Acting SecVA

Hi Dan – Let me know if you can make this meeting time. Thank you.

(b) (6)

From: O'Rourke, Peter M.
Sent: Friday, April 27, 2018 3:30 PM
To: (b) (6)@cv4a.org
Cc: (b) (6); (b) (6); Hayes-Byrd, Jacquelyn; Powers, Pamela; (b) (6)
Subject: Meeting w/Acting SecVA

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The Acting Secretary looks forward to meeting with you.

Best regards.

Peter O'Rourke

Chief of Staff

Department of Veterans Affairs

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Bcc:
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From: (b) (6) <(b) (6)@va.gov>
Date: Monday, April 30, 2018 at 2:57 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>
Cc: (b) (6) <(b) (6)@va.gov>
Subject: VSO Meetings

May 1 – 9:00am – (b) (6) DAV

May 3 – 8:00am – (b) (6) VVA

May 3 – 3:30pm – (b) (6) AMVETS

May 4 – 9:00am, (b) (6) VFW

May 4 – 1:30pm – Dan Caldwell, CVA

May 8 - 2:00pm, (b) (6) PVA

TBD – (b) (6) from AL (she is out of town until May 14.)

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May 3 – 8:00am – (b) (6) VVA

May 3 – 3:30pm – (b) (6) AMVETS

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Department of Veterans Affairs

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Cc:

Bcc:

Subject: Nearly \$700 Million in State Veterans Home Funding Leads to New Construction Projects

Date: Wed Apr 18 2018 08:42:14 CDT

Attachments: \$700 Million to go to construction projects_18APRIL2018_FINAL.pdf

Good morning. Passing this along to you...

+++++

FOR IMMEDIATE RELEASE

April 18, 2018

Nearly \$700 Million in State Veterans Home Funding Leads to New Construction Projects

Funding Represents Largest Appropriation in Program's History

WASHINGTON — Recently the Department of Veterans Affairs announced that it will use \$685 million in funding from Congress to fund several State Veterans Home construction projects through the VA State Veterans Home Construction Grant Program.

The new funding can be used where needed for repairs, renovation or new construction, and is part of an Omnibus Bill that represents the largest allocation to the more than 50-year-old State Veterans Home Construction Grant Program; funding for the program has averaged \$94 million over the last five years. The State Veterans Home Construction Grant Program provides up to 65 percent of the cost to build and renovate facilities.

“This program has been operating with a backlog of applications for construction projects,” said VA Acting Secretary Robert Wilkie. “This new allocation will let us fund projects on our priority list, many of which have been waiting for years. We thank Congress for its commitment and support of Veterans across the country.”

Plans for the new funding include at least 52 projects including bed replacement projects in Massachusetts, Michigan and Wisconsin; life safety projects in Ohio, Oklahoma and Texas; new construction projects in Arizona, Hawaii, Illinois, Montana, Nevada, North Carolina, South Carolina, Tennessee and Virginia; and general renovation projects in Alabama, Connecticut, Delaware, Florida, Georgia, Iowa, Massachusetts, Michigan, Missouri, North Carolina, North Dakota, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Vermont and Wisconsin.

“As the largest appropriation in the more-than 50-year history of this program, it demonstrates just how strongly President Donald Trump cares for and is keeping his promises to our nation’s Veterans,” Wilkie said.

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Filename: \$700 Million to go to construction projects_18APRIL2018_FINAL.pdf
Last Modified: Wed Apr 18 08:42:14 CDT 2018



U.S. Department
of Veterans Affairs

News Release

Office of Public Affairs
Media Relations

Washington, DC 20420
(202) 461-7600
www.va.gov

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To: Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
(b) (6) COS-PMO </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
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Bcc:
Subject: RE: // for approval // Q and A for Pro Publica
Date: Sat Apr 14 2018 15:02:06 CDT
Attachments:

Thanks. I will send them to the reporter.

Sent with Good (www.good.com)

From: Powers, Pamela
Sent: Saturday, April 14, 2018 12:58:28 PM
To: (b) (6) COS-PMO
Cc: Ulliyot, John; Hutton, James; (b) (6) (b) (6)
Subject: RE: // for approval // Q and A for Pro Publica

(b) (6)

These answers are good to go.

Pam

Sent with Good (www.good.com)

From: (b) (6)
Sent: Friday, April 13, 2018 4:28:21 PM
To: COS-PMO; Powers, Pamela

Cc: Ulliyot, John; Hutton, James; (b) (6) (b) (6)
Subject: RE: // for approval // Q and A for Pro Publica

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Cc: Ulliyot, John; Hutton, James; (b) (6) (b) (6)
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Cc: Ulliyot, John; Hutton, James; (b) (6) (b) (6)
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(b) (6)

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Department of Veterans Affairs

202-461-(b) (6)

(b) (6) va.gov

@(b) (6)

From: (b) (6) [mailto:(b) (6)@propublica.org]

Sent: Friday, April 13, 2018 1:37 PM

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Subject: [EXTERNAL] Re: Updated Hiring Guidance

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What is the specific angle of your piece and deadline?

Thanks,

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Department of Veterans Affairs

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(b) (6) va.gov

@ (b) (6)

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From: (b) (6) [mailto:(b) (6)@propublica.org]

Sent: Friday, April 13, 2018 11:54 AM

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Subject: [EXTERNAL] Re: Updated Hiring Guidance

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From: Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
To: [REDACTED] (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)> COS-PMO
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[REDACTED] </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
Bcc:
Subject: RE: // for approval // Q and A for Pro Publica
Date: Sat Apr 14 2018 14:58:28 CDT
Attachments:

[REDACTED] (b) (6)

These answers are good to go.

Pam

Sent with Good (www.good.com)

From: [REDACTED] (b) (6)
Sent: Friday, April 13, 2018 4:28:21 PM
To: COS-PMO; Powers, Pamela
Cc: Ulliot, John; Hutton, James; [REDACTED] (b) (6) [REDACTED] (b) (6)
Subject: RE: // for approval // Q and A for Pro Publica

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2. Who was the colonel in uniform who attended and why?

3. What is Acting Secretary Wilkie's position on merging the VA Choice with Tricare?

From: (b) (6) <(b) (6)@va.gov>
Date: Friday, April 13, 2018 at 1:10 PM
To: (b) (6) <(b) (6)@propublica.org>
Subject: RE: Updated Hiring Guidance

Please note the correction to my previous response highlighted below:

Under Secretary Shulkin during the government-wide hiring freeze, VA's then-chief of staff Vivieca Wright Simpson had to give permission to hire and approve the selection of virtually every position throughout the department. The hiring freeze was lifted in April of 2017, but confusion regarding approval levels for various hires remained.

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Thanks,

(b) (6)

(b) (6)

Department of Veterans Affairs

202-461-(b) (6)

(b) (6)@va.gov

@(b) (6)

From: (b) (6) [mailto:(b) (6)@propublica.org]
Sent: Friday, April 13, 2018 11:54 AM

To: (b) (6)
Subject: [EXTERNAL] Re: Updated Hiring Guidance

Thanks, (b) (6) The memo refers to “all other positions in the Administrations.” How is it that it only affects headquarters?

From: (b) (6) <(b) (6)@va.gov>
Date: Friday, April 13, 2018 at 11:51 AM
To: (b) (6) <(b) (6)@propublica.org>
Subject: RE: Updated Hiring Guidance

Hi, (b) (6) Please see below. Thanks – (b) (6)

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(b) (6)

(b) (6)

Department of Veterans Affairs

202-461-(b) (6)

(b) (6)@va.gov

@(b) (6)

From: (b) (6) [mailto:(b) (6)@propublica.org]
Sent: Friday, April 13, 2018 9:20 AM
To: (b) (6)
Subject: [EXTERNAL] Updated Hiring Guidance

Hi (b) (6)

I've gotten a copy of the Feb. 28 memo that Peter O'Rourke sent about Updated Hiring Guidance. My questions are:

1. How many "mission critical positions" are unrestricted?
2. How many positions are subject to the new restrictions?
3. What is the purpose of requiring such high-level approval for every job (other than to slow down hiring)?
4. Since the memo requires approval at the Under Secretary level but those positions are vacant, do the Executives in Charge have the authority to approve those hires?

Thanks,

(b) (6)

(b) (6)

ProPublica

(b) (6)

(b) (6)@propublica.org

From: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: COS-PMO </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc: Ulliyot, John </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Hutton, James </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Bcc:
Subject: RE: // for approval // Q and A for Pro Publica
Date: Fri Apr 13 2018 15:08:14 CDT
Attachments:

FYI: The reporter pinged me again. They plan to publish the story shortly.

Any update? Thanks - (b) (6)

From: (b) (6)
Sent: Friday, April 13, 2018 1:59 PM
To: COS-PMO; Powers, Pamela
Cc: Ulliyot, John; Hutton, James; (b) (6) (b) (6)
Subject: // for approval // Q and A for Pro Publica

Please see the below media inquiry from Pro-Publica. They are doing a story on Acting Secretary Wilkie's VSO breakfast last week and the VSO's White House meeting yesterday. The deadline is ASAP today.

Are you OK with the following Q and A? Thanks - (b) (6)

Q: Why was CVA invited?

A: Just like the other comparable Veterans groups that attended, CVA represents an important voice on Veterans issues.

Q: Who was the colonel in uniform who attended and why?

A: Col. (b) (6) Special Assistant to the Acting Secretary Of Veterans Affairs, and Senior Military Assistant to the Under Secretary of Defense (Personnel and Readiness)

Q: What is Acting Secretary Wilkie's position on merging the VA Choice with Tricare?

A: There is no plan to do that, and there never was one. As former Secretary Shulkin said in November of last year: "If there are efforts where we could do things better, we want to look at all those ideas and the potential synergies," he said. "But there is no plan here. There is no draft. We are simply having early discussions."

(b) (6)

(b) (6)

Department of Veterans Affairs

202-461-(b) (6)

(b) (6) va.gov

@(b) (6)

From: (b) (6) [mailto:(b) (6)@propublica.org]

Sent: Friday, April 13, 2018 1:37 PM

To: (b) (6)

Subject: [EXTERNAL] Re: Updated Hiring Guidance

It's a story about Acting Secretary Wilkie's VSO breakfast last week and the VSOs' White House meeting yesterday. We are planning to publish in the next few hours.

From: (b) (6) <(b) (6)@va.gov>

Date: Friday, April 13, 2018 at 1:31 PM

To: (b) (6) <(b) (6)@propublica.org>

Subject: RE: Updated Hiring Guidance

What is the specific angle of your piece and deadline?

Thanks,

(b) (6)

(b) (6)

Department of Veterans Affairs

202-461- (b) (6)

(b) (6) va.gov

@ (b) (6)

From: (b) (6) [mailto:(b) (6)@propublica.org]

Sent: Friday, April 13, 2018 1:24 PM

To: (b) (6)

Subject: [EXTERNAL] Re: Updated Hiring Guidance

OK, thanks.

Separately, I also have some questions about the VSO breakfast with Acting Secretary Wilkie last week:

1. Why was CVA invited?
2. Who was the colonel in uniform who attended and why?
3. What is Acting Secretary Wilkie's position on merging the VA Choice with Tricare?

From: (b) (6) <(b) (6)@va.gov>

Date: Friday, April 13, 2018 at 1:10 PM

To: (b) (6) <(b) (6)@propublica.org>

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Under Secretary Shulkin during the government-wide hiring freeze, VA's then-chief of staff Vivieca Wright Simpson had to give permission to hire and approve the selection of virtually every position throughout the department. The hiring freeze was lifted in April of 2017, but confusion regarding approval levels for various hires remained.

And please see the following response to your question:

The Feb. 28 memo is meant to clear up that confusion, while ensuring high-level approval for central office hires and allowing delegation of the approval authority for hires in the field to the lowest appropriate level. The goal is eliminating duplication and top-heavy, bureaucratic management structures within our headquarters so those resources can be redirected to the field.

Thanks,

(b) (6)

(b) (6)

Department of Veterans Affairs

202-461-(b) (6)

(b) (6)@va.gov

@(b) (6)

From: (b) (6) [mailto:(b) (6)@propublica.org]

Sent: Friday, April 13, 2018 11:54 AM

To: (b) (6)

Subject: [EXTERNAL] Re: Updated Hiring Guidance

Thanks, (b) (6) The memo refers to "all other positions in the Administrations." How is it that it only affects headquarters?

From: (b) (6) <(b) (6)@va.gov>

Date: Friday, April 13, 2018 at 11:51 AM

To: (b) (6) <(b) (6)@propublica.org>

Subject: RE: Updated Hiring Guidance

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(b) (6)

(b) (6)

Department of Veterans Affairs

202-461-

(b) (6) va.gov

@ (b) (6)

From: (b) (6) [mailto:(b) (6)@propublica.org]

Sent: Friday, April 13, 2018 9:20 AM

To: (b) (6)

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ProPublica

(b) (6)

(b) (6) propublica.org

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Bcc:
Subject: // for approval // Q and A for Pro Publica
Date: Fri Apr 13 2018 12:59:13 CDT
Attachments:

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(b) (6)

(b) (6)

Department of Veterans Affairs

202-461- (b) (6)

(b) (6) va.gov

@ (b) (6)

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ProPublica

(b) (6)

(b) (6) [propublica.org](https://www.propublica.org)

From: (b) (6) </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: VSO Breakfast Invite List
Date: Thu Apr 05 2018 09:46:18 CDT
Attachments:

Colonel (b) (6)
Pam Powers, Senior Advisor

From: (b) (6) <(b) (6)@va.gov>
Date: Wednesday, April 4, 2018 at 4:26 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>
Subject: RE: VSO Breakfast Invite List

Got it - thanks (b) (6)

(b) (6) M.B.A.
Acting Special Assistant to the Secretary for VSOs
Office of the Secretary
Department of Veterans Affairs
810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 1:12:47 PM
To: (b) (6)
Subject: Re: VSO Breakfast Invite List

One addition, (b) (6) White House, Office of Legislative Affairs.

From: Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>
Date: Wednesday, April 4, 2018 at 3:42 PM
To: (b) (6) <(b) (6)@va.gov>
Subject: Re: VSO Breakfast Invite List

Updates from CoS attached.

Inviting (b) (6) now.

From: (b) (6) <(b) (6)@va.gov>

Date: Wednesday, April 4, 2018 at 3:22 PM

To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>

Subject: RE: VSO Breakfast Invite List

(b) (6) I've attached and included the meeting invite, participant and agenda below. All of the VSOs have been invited and I was in the process of reaching out (b) (6) (b) (6) Dan Caldwell and (b) (6) per your guidance this afternoon. Please advise if you and Peter have any final edits/changes to the list of attendees prior to finalizing/preparing the seating chart.

Event/Meeting: VSO Breakfast with The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs

Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

VA Invitees:

- The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs
- The Honorable Thomas Bowman, Deputy Secretary of Veterans Affairs, Department of Veterans Affairs
- Peter O'Rourke, Chief of Staff, Office of the Secretary
- Brooks Tucker, Assistant Secretary, Office of Congressional and Legislative Affairs, VA
- John Ulyot, Assistant Secretary, Office of Public and Intergovernmental Affairs, VA
- Dr. Lynda Davis, Chief Veterans Experience Officer, VA
- (b) (6) Special Assistant to the Secretary for VSOs, VA

White House/VSO Invitees:

- (b) (6) White House, Office of Public Liaison
- (b) (6) White House, Domestic Policy Council
- (b) (6) Director of the Veterans Affairs and Rehabilitation Division, The American Legion (TAL)
- (b) (6) Executive Director, Disabled American Veterans (DAV)
- (b) (6) Executive Director, Paralyzed Veterans of America (PVA)

- (b) (6) Executive Director, American Veterans (AMVETS)
- (b) (6) Executive Director of Policy and Government Affairs, Vietnam Veterans of America (VVA)
- (b) (6) Lieutenant General, U.S. Air Force (Ret), President and CEO Military Officers Association of America (MOAA)
- (b) (6) Government and Community Relations Director, Wounded Warrior Project (WWP)
- (b) (6) Director of Government Relations, Student Veterans of America (SVA)
- Dan Caldwell, Executive Director, Concerned Veterans of America (CVA)
- (b) (6) Independence Fund

Agenda

- Welcome/Introductions – The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs
- Patient Experience/Medalia Tool/Demo – Dr. Lynda Davis, Chief Veteran Experience Officer, Veteran Experience Office, VA
- Legislation/Policy Update – Brooks Tucker, Assistant Secretary of Congressional and Legislative Affairs, VA

From: (b) (6)
 Sent: Wednesday, April 04, 2018 3:01 PM
 To: (b) (6)
 Subject: RE: VSO Breakfast Invite List

Peter wants to talk about he invites before we send.

From: (b) (6)
 Sent: Wednesday, April 04, 2018 9:25:45 AM
 To: (b) (6)
 Subject: RE: VSO Breakfast Invite List

(b) (6) I tried calling but didn't reach (b) (6)

Thanks

(b) (6)

(b) (6) M.B.A.
Acting Special Assistant to the Secretary for VSOs
Office of the Secretary
Department of Veterans Affairs
810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:21:52 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

Shoot, I wanted to (b) (5). No worries, we will adapt.

Who is the Legion sending?

Thanks,

(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:17:28 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

(b) (6) I already sent invites to DAV, Legion, VFW, PVA, AMVETS, VVA WWP, IAVA and MOAA. All have confirmed except for VFW, their principal will be on travel, and the Legion is sending their Director as their principal will be on travel.

Thanks

(b) (6)

(b) (6) M.B.A.
Acting Special Assistant to the Secretary for VSOs
Office of the Secretary
Department of Veterans Affairs
810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)

B: 202-684-(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:12:10 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

Hold on sending invites if you can, if already out that's ok.

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:08:23 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

Thanks (b) (6) - will update the list as well as provide a list of VSO RSVPs by CoB today. Do you have the contact info and/or want to invite Dan, (b) (6)

(b) (6) M.B.A.
Acting Special Assistant to the Secretary for VSOs
Office of the Secretary
Department of Veterans Affairs
810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 8:54:36 AM
To: (b) (6)
Subject: Re: VSO Breakfast Invite List

Peter is going to work on the list of VA employees in attendance so make more room for VSO's, but for the external list, let's start by adding:

Dan Caldwell, CVA

(b) (6) Independence Fund

(b) (6) White House Office of Public Liaison

I'll let you know when we are final.

Thanks!

(b) (6)

From: "(b) (6)" <(b) (6)@va.gov>
Date: Wednesday, April 4, 2018 at 10:06 AM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>
Subject: VSO Breakfast Invite List

(b) (6) per our discussion, here's the VSO breakfast invite list – please let me know if you and the team have any suggested edits/corrections.

Event/Meeting: VSO Breakfast with Acting Secretary Robert Wilkie

Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

VA Invitees:

- The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs
- The Honorable Thomas Bowman, Deputy Secretary of Veterans Affairs, Department of Veterans Affairs
- Peter O'Rourke, Chief of Staff, Office of the Secretary
- Jacquelyn Hayes-Byrd, Deputy Chief of Staff, Office of the Secretary, Office of the Secretary
- Brooks Tucker, Assistant Secretary, Office of Congressional and Legislative Affairs, VA
- John Ulliot, Assistant Secretary, Office of Public and Intergovernmental Affairs, VA
- Dr. Lynda Davis, Chief Veterans Experience Officer, VA
- Dr. Carolyn Clancy, Executive in Charge, Veterans Health Administration, VA
- Randy Reeves, Under Secretary for Memorial Affairs, VA
- (b) (6) Special Assistant to the Secretary for VSOs, VA

VSO Invitees:

- Ms. (b) (6) Executive Director, The American Legion (TAL)
- Mr. (b) (6) Executive Director, Disabled American Veterans (DAV)
- Mr. (b) (6) Executive Director, Veterans of Foreign Wars (VFW)
- Mr. (b) (6) Executive Director, Paralyzed Veterans of America (PVA)
- Mr. (b) (6) Executive Director, American Veterans (AMVETS)
- Mr. (b) (6) Executive Director of Policy and Government Affairs, Vietnam Veterans of America (VVA)
- Ms. (b) (6) Chief Policy Officer, Iraq and Afghanistan Veterans of America (IAVA)
- Mr. (b) (6) Lieutenant General, U.S. Air Force (Ret), President and CEO Military Officers Association of America (MOAA)
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To: (b) (6) </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: RE: VSO Breakfast Invite List
Date: Wed Apr 04 2018 15:26:41 CDT
Attachments:

Got it - thanks (b) (6)

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Date: Wednesday, April 4, 2018 at 3:42 PM
To: (b) (6) <(b) (6)@va.gov>
Subject: Re: VSO Breakfast Invite List

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Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

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 Acting Special Assistant to the Secretary for VSOs
 Office of the Secretary

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810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

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(b) (6) White House Domestic Policy Council

I'll let you know when we are final.

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Date: Wednesday, April 4, 2018 at 10:06 AM
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To: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: VSO Breakfast Invite List
Date: Wed Apr 04 2018 15:12:47 CDT
Attachments:

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Cc:
Bcc:
Subject: RE: VSO Breakfast Invite List
Date: Wed Apr 04 2018 14:01:16 CDT
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To: Davis, Lynda </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Tucker, Brooks </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc: COS-PMO </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Hayes-Byrd, Jacquelyn </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Bcc:
Subject: Re: Guest List - VSO Breakfast April 6, 2018
Date: Wed Apr 04 2018 13:25:59 CDT
Attachments:

CVA and IF both coming.

Peter is going to tighten up the VA group to make room for more outside attendees.

From: "Davis, Lynda" <Lynda.Davis@va.gov>
Date: Wednesday, April 4, 2018 at 2:24 PM
To: "Tucker, Brooks" <Brooks.Tucker@va.gov>, Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>
Cc: Peter O <COS-PMO@va.gov>, "Hayes-Byrd, Jacquelyn" <Jacquelyn.Hayes-Byrd@va.gov>
Subject: RE: Guest List - VSO Breakfast April 6, 2018

I understand VHA ownership of currently relevant legislation but if mtg is NOT about legislation but about moving forward then all key leadership needs to be present - it would be a notable absence not to have VBA.

I understand that CVA and IF were at last WH mtg. Their presence (and now that of AmVets) will be a statement from the new leadership.

This just needs to be thought through with intention depending on the message that is to be shared.

Lynda

Lynda C. Davis, Ph.D.
Chief Veterans Experience Officer
Department of Veterans Affairs

Sent with Good (www.good.com)

From: Tucker, Brooks
Sent: Wednesday, April 04, 2018 10:46:52 AM

To: Davis, Lynda; (b) (6)
Cc: COS-PMO; Hayes-Byrd, Jacquelyn
Subject: RE: Guest List - VSO Breakfast April 6, 2018

VHA owns Choice/Care so they are specifically relevant, if we want to nod in that direction and have the administration leader present to hear VSOs' views.

For background, IF and CVA were invited to the last VSO meeting at the WH, where Choice/Care and also Caregiver were discussed.

Sent with Good (www.good.com)

From: Davis, Lynda
Sent: Wednesday, April 04, 2018 8:44:54 AM
To: Tucker, Brooks; (b) (6)
Cc: COS-PMO; Hayes-Byrd, Jacquelyn
Subject: RE: Guest List - VSO Breakfast April 6, 2018

If VBA is not represented then VHA souls not be.

Recommend against IF being present as I'm including them other ways. There are many VSO/MSOs that should be considered in addition to IF. Glad to discuss this on the phone.

Lynda

Lynda C. Davis, Ph.D.
Chief Veterans Experience Officer
Department of Veterans Affairs

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To: (b) (6) Davis, Lynda
Cc: COS-PMO; Hayes-Byrd, Jacquelyn
Subject: RE: Guest List - VSO Breakfast April 6, 2018

(b) (6) et al, Recommend adding CVA (Dan Caldwell) and Independence Fund (b) (6) Also, (b) (6) from WH Intergovernmental and (b) (6) from WH DPC, if one or both are desired and we have seat space. They would show our unity with WH on the policy front.

I see VBA is not going to be represented, so if that isn't an oversight, would recommend VBA remain off list and that take USMA off the list.

OCLA would like to keep a sharp focus on CHOICE-CARE and, as needed, Caregivers, which are both VHA centric.

Brooks

From: (b) (6)
Sent: Wednesday, April 04, 2018 10:50 AM
To: Tucker, Brooks; Davis, Lynda
Cc: COS-PMO; Hayes-Byrd, Jacquelyn
Subject: Guest List - VSO Breakfast April 6, 2018

Brooks/Lynda,

Below is the proposed guest list (b) (6) passed to me for the Friday breakfast. I would appreciate your input on additions or subtractions to this list and any commentary you may have on any of the potential invitees (max capacity for breakfast is 22).

Thanks!

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From: Davis, Lynda </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
To: Tucker, Brooks </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)> [REDACTED] (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
Cc: COS-PMO </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)> Hayes-Byrd, Jacquelyn </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
Bcc:
Subject: RE: Guest List - VSO Breakfast April 6, 2018
Date: Wed Apr 04 2018 13:24:40 CDT
Attachments:

I understand VHA ownership of currently relevant legislation but if mtg is NOT about legislation but about moving forward then all key leadership needs to be present - it would be a notable absence not to have VBA.

I understand that CVA and IF were at last WH mtg. Their presence (and now that of AmVets) will be a statement from the new leadership.

This just needs to be thought through with intention depending on the message that is to be shared.

Lynda

Lynda C. Davis, Ph.D.
Chief Veterans Experience Officer
Department of Veterans Affairs

Sent with Good (www.good.com)

From: Tucker, Brooks
Sent: Wednesday, April 04, 2018 10:46:52 AM
To: Davis, Lynda; [REDACTED] (b) (6)
Cc: COS-PMO; Hayes-Byrd, Jacquelyn
Subject: RE: Guest List - VSO Breakfast April 6, 2018

VHA owns Choice/Care so they are specifically relevant, if we want to nod in that direction and have the administration leader present to hear VSOs' views.

For background, IF and CVA were invited to the last VSO meeting at the WH, where Choice/Care and also Caregiver were discussed.

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From: Davis, Lynda
Sent: Wednesday, April 04, 2018 8:44:54 AM
To: Tucker, Brooks; (b) (6)
Cc: COS-PMO; Hayes-Byrd, Jacquelyn
Subject: RE: Guest List - VSO Breakfast April 6, 2018

If VBA is not represented then VHA souls not be.

Recommend against IF being present as I'm including them other ways. There are many VSO/MSOs that should be considered in addition to IF. Glad to discuss this on the phone.

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Thanks!

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Cc:
Bcc:
Subject: RE: VSO Breakfast Invite List
Date: Wed Apr 04 2018 11:32:47 CDT
Attachments:

Sure thing, hope appointment goes well:)

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Washington, DC 20420
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Thanks man!

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I'll let you know when we are final.

Thanks!

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From: "(b) (6)" <(b) (6)@va.gov>

Date: Wednesday, April 4, 2018 at 10:06 AM

To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>

Subject: VSO Breakfast Invite List

(b) (6) per our discussion, here's the VSO breakfast invite list – please let me know if you and the team have any suggested edits/corrections.

Event/Meeting: VSO Breakfast with Acting Secretary Robert Wilkie

Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

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 Office of the Secretary
 Department of Veterans Affairs
 810 Vermont Avenue NW Office 1023
 Washington, DC 20420
 O: 202-461-(b) (6)
 B: 202-684-(b) (6)

From: (b) (6) </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: RE: VSO Breakfast Invite List
Date: Wed Apr 04 2018 11:21:52 CDT
Attachments:

Shoot, I wanted to (b) (5). No worries, we will adapt.

Who is the Legion sending?

Thanks,

(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:17:28 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

(b) (6) I already sent invites to DAV, Legion, VFW, PVA, AMVETS, VVA WWP, IAVA and MOAA. All have confirmed except for VFW, their principal will be on travel, and the Legion is sending their Director as their principal will be on travel.

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(b) (6) White House Domestic Policy Council

I'll let you know when we are final.

Thanks!

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From: (b) (6) <(b) (6)@va.gov>
Date: Wednesday, April 4, 2018 at 10:06 AM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>

Subject: VSO Breakfast Invite List

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Event/Meeting: VSO Breakfast with Acting Secretary Robert Wilkie

Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

VA Invitees:

- The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs
- The Honorable Thomas Bowman, Deputy Secretary of Veterans Affairs, Department of Veterans Affairs
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- Jacquelyn Hayes-Byrd, Deputy Chief of Staff, Office of the Secretary, Office of the Secretary
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(b) (6)

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From: Davis, Lynda </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
To: Tucker, Brooks </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)> [REDACTED] (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
Cc: COS-PMO </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)> Hayes-Byrd, Jacquelyn </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
Bcc:
Subject: RE: Guest List - VSO Breakfast April 6, 2018
Date: Wed Apr 04 2018 10:44:54 CDT
Attachments:

If VBA is not represented then VHA souls not be.

Recommend against IF being present as I'm including them other ways. There are many VSO/MSOs that should be considered in addition to IF. Glad to discuss this on the phone.

Lynda

Lynda C. Davis, Ph.D.
Chief Veterans Experience Officer
Department of Veterans Affairs

Sent with Good (www.good.com)

From: Tucker, Brooks
Sent: Wednesday, April 04, 2018 8:10:20 AM
To: [REDACTED] (b) (6) Davis, Lynda
Cc: COS-PMO; Hayes-Byrd, Jacquelyn
Subject: RE: Guest List - VSO Breakfast April 6, 2018

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I see VBA is not going to be represented, so if that isn't an oversight, would recommend VBA remain off list and that take USMA off the list.

OCLA would like to keep a sharp focus on CHOICE-CARE and, as needed, Caregivers, which are both VHA centric.

Brooks

From: (b) (6)
Sent: Wednesday, April 04, 2018 10:50 AM
To: Tucker, Brooks; Davis, Lynda
Cc: COS-PMO; Hayes-Byrd, Jacquelyn
Subject: Guest List - VSO Breakfast April 6, 2018

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- Jacquelyn Hayes-Byrd, Deputy Chief of Staff, Office of the Secretary, Office of the Secretary
- Brooks Tucker, Assistant Secretary, Office of Congressional and Legislative Affairs, VA
- John Ulliot, Assistant Secretary, Office of Public and Intergovernmental Affairs, VA
- Dr. Lynda Davis, Chief Veterans Experience Officer, VA
- Dr. Carolyn Clancy, Executive in Charge, Veterans Health Administration, VA
- Randy Reeves, Under Secretary for Memorial Affairs, VA
- (b) (6) Special Assistant to the Secretary for VSOs, VA

VSO Invitees:

- Ms. (b) (6) Executive Director, The American Legion (TAL)
- Mr. (b) (6) Executive Director, Disabled American Veterans (DAV)
- Mr. (b) (6) Executive Director, Veterans of Foreign Wars (VFW)
- Mr. (b) (6) Executive Director, Paralyzed Veterans of America (PVA)
- Mr. (b) (6) Executive Director, American Veterans (AMVETS)
- Mr. (b) (6) (b) (6) Executive Director of Policy and Government Affairs, Vietnam Veterans of America (VVA)
- Ms. (b) (6) Chief Policy Officer, Iraq and Afghanistan Veterans of America (IAVA)
- Mr. (b) (6) (b) (6) Lieutenant General, U.S. Air Force (Ret), President and CEO Military Officers Association of America (MOAA)
- Ms. (b) (6) Government and Community Relations Director, Wounded Warrior Project (WWP)

Mr. (b) (6) Director of Government Relations, Student Veterans of America (SVA)

From: (b) (6) aol.com>
To: (b) (6) (Miami VA)
</o=va/ou=external
(fydibohf25spdlt)/cn=recipients/cn=(b) (6)
(b) (6); (b) (6) @gmail.com>; (b) (6) (Miami
VA) </o=va/ou=visn 08/cn=recipients/cn=(b) (6) Shulkin,
David J., MD </o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
(b) (6) @gmail.com <(b) (6) @gmail.com>;
(b) (6) @yahoo.com <(b) (6) @yahoo.com>; (b) (6)
J. </o=va/ou=vba (b) (6) cn=recipients/cn=(b) (6)
(b) (6) @hotmail.com <(b) (6) @hotmail.com>; (b) (6)
(Miami VA) </o=va/ou=visn 08/cn=recipients/cn=(b) (6)
(b) (6) <(b) (6) @aol.com>; (b) (6) (Miami VA)
</o=va/ou=visn 08/cn=recipients/cn=(b) (6)
C. (Miami VA) </o=va/ou=visn 08/cn=recipients/cn=(b) (6)
(b) (6) (Ray) OAWP </o=va/ou=visn
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(b) (6) @gmail.com>; (b) (6) </o=va/ou=visn
18/cn=recipients/cn=(b) (6) @gmail.com
(b) (6) @gmail.com>

Cc:
Bcc:
Subject: [EXTERNAL] Thumb drive
Date: Mon Mar 26 2018 13:55:34 CDT
Attachments:

Although I have not worked in 11 month and I only have 7 days to respond to a removal letter and 10 to appeal my MSPB decision could you give me a little longer.

I am going to have the concern veterans of America start a whistle blower go fund me account. Also these would be all the emails from the people email accounts about me. If anyone of them is gone will it still give emails

Sent from my iPhone

From: (b) (6) <(b) (6)@cnas.org>
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Lunch next Tues 3/20
Date: Fri Mar 16 2018 06:15:30 CDT
Attachments:

Terrific. Look forward to seeing you then.

Sent from my iPhone

> On Mar 16, 2018, at 07:12, DJS <vacodjs1@va.gov> wrote:

>

> Great- 1245 pm ok?

>

>

>

> Sent with Good (www.good.com)

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>

> From: (b) (6)

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>> Sent from my iPhone

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>>> How is next Tuesday at that place I saw you last time - forget the name but it was on 16th near K?
>>>
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>>> Thanks so much (b) (6)
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>>> DC is truly crazy- so I appreciate your rational approach to things
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>>> How about catching up for lunch sometime soon?
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>>> Thought I would share this column from today. Hope you're doing as well as possible under the circumstances. Hang in there. v/r (b) (6)
>>>
>>> https://slate.com/news-and-politics/2018/03/firing-veterans-affairs-secretary-david-shulkin-is-a-bad-idea.html?wpsrc=sh_all_dt_tw_ru
>>>
>>> Firing VA Secretary David Shulkin Is a Bad Idea
>>> He's accomplishing a lot of good for America's veterans—and for Trump.
>>>
>>> By (b) (6)
>>>
>>> Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>>, "We'll never have to use those words ['You're fired'] on our David."
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>>> Eight months later, that declaration may prove ironic. Fissures have emerged and deepened between Shulkin and the president's political allies over what, exactly, the VA should be doing. On top of this, two relatively minor scandals involving Shulkin have blown up his tenure and stalled major reform. Now, Shulkin faces conflict on three overlapping fronts, leaving him at the precipice of being fired and replaced by a closer Trump ally as the administration seeks to reduce the chaos<<https://www>.

cnn.com/2018/03/13/politics/trump-departures-white-house/index.html> in its Cabinet.

>>>

>>> The first battle Shulkin is fighting has deep roots<<https://www.foreignaffairs.com/articles/2017-08-15/what-america-owes-its-veterans>> in veterans population demographics<https://www.rand.org/pubs/research_reports/RR1165z4.html> and the evolution of VA benefits over the past several decades. From the time they join up to their moment of discharge, service members<<https://www.rand.org/pubs/monographs/MG265.html>> belong to the Department of Defense. After that, they become eligible for a broad array of veterans programs that are administered by the VA's three large administrations: health, benefits, and cemeteries. These programs have evolved<<https://www.rand.org/pubs/monographs/MG1164.html>> from stingy pensions for seriously disabled veterans after the Revolution to the generous, comprehensive system of health care, disability compensation, and economic programs that exists today. All eligible veterans—meaning primarily those who serve on active duty and leave with an honorable discharge<<https://www.swords-to-plowshares.org/2016/03/30/underserved/>>—can avail themselves of these benefits, not just combat veterans or those who were wounded in the line of duty.

>>>

>>> To meet these obligations, the VA consumes a massive amount of money each year. Its 2019 budget request is \$198.6 billion<<https://www.va.gov/budget/products.asp>>—a big increase over previous years at a time when most agencies are facing cuts and totaling more than the budgets of the State Department<<https://www.state.gov/s/d/rm/c6112.htm>>, Homeland Security<<https://www.dhs.gov/dhs-budget>>, and the entire<<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program>> intelligence<<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/>> community<<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-militar/>> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

>>>

>>> Since 9/11, the VA's budget has steadily increased<<https://www.cnas.org/publications/reports/passing-the-baton-a-bipartisan-2016-agenda-for-the-veteran-and-military-community>> at a rate far greater than inflation, even as the total population of veterans has decreased. Older veterans of the Vietnam and Cold War eras rely heavily on VA services. So too does the post-9/11 generation<<https://www.publichealth.va.gov/epidemiology/reports/oeofond/>>, of whom more than 3 million have deployed to Iraq, Afghanistan, or other theaters of war. These retired service members are using the VA at much higher rates than previous generations. This demand from young and old veterans alike is putting enormous pressure on the VA—which failed to adequately predict any of this increased demand, let alone prepare and budget<<https://www.bostonglobe.com/opinion/2016/10/17/the-trillion-wars/uPVfSuDutnTZl5fIQ7YlIK/story.html>> for it.

>>>

>>> In 2014, this problem erupted in Phoenix, where veterans endlessly waited for appointments while VA employees played a shell game with veterans to deceive them and their bosses in Washington. That scandal forced the ouster<http://www.slate.com/articles/news_and_politics/politics/2014/05/shinseki_resigns_here_s_how_to_fix_the_va.html> of VA Secretary (and retired Army Gen.) Eric Shinseki and prompted the creation of a program to purchase VA care from the private sector.

>>>

>>>

>>> If the VA couldn't provide timely appointments for all veterans, Congress mused, the VA could instead purchase health care the way the Pentagon does for retirees. First as the VA's undersecretary for health, and then as secretary, Shulkin has devoted most of his energies toward implementing this new contracted-care system and making it work.

>>>

>>> All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization->

is-a-very-real-issue-right-now-american-legion-says/> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html>> Concerned Veterans for America<<https://cv4a.org/>> and many of Trump’s allies in Congress, who would like to<<https://cv4a.org/project/taskforce/>> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html>> with congressional leaders in the House and Senate.

>>>

>>> Shulkin’s second battle—political infighting with more partisan members of the administration—inflames and complicates these policy disagreements. He is the sole survivor of the Obama administration among Cabinet officials serving Trump. A practicing physician and successful health executive, Shulkin came to the Obama administration to run the VA health care system after the 2014 Phoenix scandal. His selection came after a turbulent Trump transition, during which the president interviewed several potential candidates before settling on Shulkin. Trump reportedly gave Shulkin the job because the New Jersey physician persuaded him he could continue the slow, deliberate privatization<<https://hbr.org/2016/12/a-transformation-is-underway-at-u-s-veterans-affairs-we-got-an-inside-look%20The%20case%20study%20conducted%20by%20Harvard%20Business%20School%20on%20the%20transformation%20underway%20at%20VA>> of the VA and deliver other wins to Trump on issues like employee accountability<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> (read: easier firing of civil servants).

>>>

>>> Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask Congress<https://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf> for more money<<http://www.modernhealthcare.com/article/20170927/NEWS/170929901>> to fund<<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/>> the popular program<<https://www.stripes.com/news/congress-approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>>. Shulkin made a difficult decision<<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/>> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>>). And, Shulkin has presided over the termination<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/>> problems at the VA’s Washington hospital and proposing to kill the VA’s support<<https://www.politico.com/story/2017/12/06/homeless-veterans-benefits-trump-207781>> for homeless veterans, before walking back that idea in the face of public outcry.

>>>

>>> Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>> and Trump campaign operative Cam Sandoval, began working late last year<<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html>> to engineer Shulkin’s exit<https://www.washingtonpost.com/amhtml/world/national-security/white-house-targets-vas-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html>. According to the Washington Post<https://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376>, these nominees have actively sought to sabotage Shulkin’s tenure, going so far as to call congressional leaders and lobby them to push for Shulkin’s ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more

and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

>>>

>>> It is against this backdrop that Shulkin must wage his third and most personal battle: a fight over two internal ethics investigations by the VA's inspector general. The first investigation was triggered by Washington Post reporting<https://www.washingtonpost.com/investigations/va-chief-took-in-wimbledon-river-cruise-on-european-work-trip/2017/09/29/c1f17046-a458-11e7-8c37-e1d99ad6aa22_story.html> about Shulkin's trip to meet with veterans officials in Europe—a trip that included a detour to Wimbledon, and a few days of vacation too. The VA's inspector general scorched Shulkin<https://www.washingtonpost.com/politics/veterans-affairs-chief-shulkin-staff-misled-ethics-officials-about-european-trip-report-finds/2018/02/14/f7fbc020-0c3a-11e8-8b0d-891602206fb7_story.html> in its report on this trip, finding that permission to bring his wife had been predicated on a falsified email from Shulkin's chief of staff and that Shulkin had impermissibly ordered his staff into travel concierge duty. Shulkin pushed back, retaining counsel to dissect the IG report, and he even suggested<<http://thehill.com/policy/defense/374009-va-secretary-says-he-wont-resign-doubles-down-on-allegations-aides-email-was>> that his chief of staff's email had been hacked. (It was not<<http://thehill.com/policy/defense/376045-watchdog-former-top-va-aides-email-was-not-hacked>>.) A day later, however, Shulkin's chief of staff announced<<https://www.militarytimes.com/veterans/2018/02/16/va-chief-of-staff-resigns-amid-secretarys-travel-scandal/>> her retirement, and Shulkin said<https://www.washingtonpost.com/world/national-security/va-secretary-shulkin-under-fire-for-europe-trip-to-appear-before-house-panel/2018/02/14/0c65702e-11c2-11e8-8ea1-c1d91fcec3fe_story.html?utm_term=.aa7311c9a3f1> he would repay the government for the cost of his wife's airfare.

>>>

>>> A second investigation, regarding Shulkin's use of his protective security detail, is reportedly percolating<<http://thehill.com/homenews/administration/376568-va-watchdog-preparing-report-on-shulkin-misuse-of-security-detail>> in the VA inspector general's office now. That assessment will reportedly criticize Shulkin for inappropriate use of his security detail for personal errands. On its face, the allegations aren't that damning; they show Shulkin to be an inexperienced government executive who's used to different rules in the private sector and also indicate his naïveté about how certain things will play on the proverbial front page of the Washington Post. But these errors come at a time when the Trump administration can ill afford another ethics scandal after similar abuses at HUD<https://www.washingtonpost.com/politics/using-his-position-for-private-gain-hud-lawyers-warned-ben-carson-risked-running-afoul-of-ethics-rules-by-enlisting-son/2018/01/31/bb20c48e-0532-11e8-8777-2a059f168dd2_story.html>, Interior<<http://thehill.com/homenews/administration/377497-interior-dept-spent-139k-on-construction-project-labeled-secretarys>>, and HHS<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>>, with the latter resulting in Secretary Tom Price's resignation. A Cabinet secretary aligned more closely with the White House than Shulkin, or with more political allies across the administration, could probably survive these investigations with barely a flesh wound. For Shulkin's tenure at VA, they may end up being fatal, to the extent they provide a pretext for the White House to replace Shulkin with a more trusted partisan.

>>>

>>> At this point, Shulkin's fate rests with Trump. Although Trump has largely benefited from Shulkin's service, the president must now decide whether he's better off with a competent leader like Shulkin, or a closer political ally who might march more in step with the base. The potential contenders include Energy Secretary Rick Perry (who said Wednesday<<http://abcnews.go.com/Politics/wireStory/latest-rick-perry-va-job-53748413>> he doesn't want the job), one of the 88 retired generals who endorsed<<https://www.politico.com/story/2016/09/retired-generals-admirals-endorse-trump-227755>> Trump in 2016, or veterans in Congress like Sens. Joni Ernst or Tom Cotton, whose chances are lower because of their importance to the Republicans' razor-thin Senate majority. Whether Shulkin stays or goes, the primary battle he waged, over the future of the VA, will continue. Trump is arguably better off keeping Shulkin around to keep waging this battle, and veterans are arguably better off with that outcome too.

>>>

>>>

>>> (b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\)\(6\)](https://www.cnas.org/people/(b)(6))> and adjunct professor of law at Georgetown University. The views expressed

are the author's alone and not representative of his organization.

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>> Firing VA Secretary David Shulkin Is a Bad Idea
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>> To meet these obligations, the VA consumes a massive amount of money each year. Its 2019 budget request is \$198.6 billion<<https://www.va.gov/budget/products.asp>>—a big increase over previous years at a time when most agencies are facing cuts and totaling more than the budgets of the State Department<<https://www.state.gov/s/d/rm/c6112.htm>>, Homeland Security<<https://www.dhs.gov/dhs-budget>>, and the entire<<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program>> intelligence<<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/>> community<<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-militar/>> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

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>> Since 9/11, the VA's budget has steadily increased<<https://www.cnas.org/publications/reports/passing-the-baton-a-bipartisan-2016-agenda-for-the-veteran-and-military-community>> at a rate far greater than inflation, even as the total population of veterans has decreased. Older veterans of the Vietnam and Cold War eras rely heavily on VA services. So too does the post-9/11 generation<<https://www.publichealth.va.gov/epidemiology/reports/oefoifond/>>, of whom more than 3 million have deployed to Iraq, Afghanistan, or other theaters of war. These retired service members are using the VA at much higher rates than previous generations. This demand from young and old veterans alike is putting enormous pressure on the VA—which failed to adequately predict any of this increased demand, let alone prepare and budget<<https://www.bostonglobe.com/opinion/2016/10/17/the-trillion-wars/uPVfSuDutnTZl5flQ7YllK/story.html>> for it.

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>> In 2014, this problem erupted in Phoenix, where veterans endlessly waited for appointments while VA employees played a shell game with veterans to deceive them and their bosses in Washington. That scandal forced the ouster<http://www.slate.com/articles/news_and_politics/politics/2014/05/shinseki_resigns_here_s_how_to_fix_the_va.html> of VA Secretary (and retired Army Gen.) Eric Shinseki and prompted the creation of a program to purchase VA care from the private sector.

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>> If the VA couldn't provide timely appointments for all veterans, Congress mused, the VA could instead purchase health care the way the Pentagon does for retirees. First as the VA's undersecretary for health, and then as secretary, Shulkin has devoted most of his energies toward implementing this new contracted-care system and making it work.

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>> All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization-is-a-very-real-issue-right-now-american-legion-says/>> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html>> Concerned Veterans for America<<https://cv4a.org/>> and many of Trump's allies in Congress, who would like to<<https://cv4a.org/project/taskforce/>> focus the VA on service-related care like mental health and

contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html> with congressional leaders in the House and Senate.

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>> Shulkin's second battle—political infighting with more partisan members of the administration—inflames and complicates these policy disagreements. He is the sole survivor of the Obama administration among Cabinet officials serving Trump. A practicing physician and successful health executive, Shulkin came to the Obama administration to run the VA health care system after the 2014 Phoenix scandal. His selection came after a turbulent Trump transition, during which the president interviewed several potential candidates before settling on Shulkin. Trump reportedly gave Shulkin the job because the New Jersey physician persuaded him he could continue the slow, deliberate privatization<https://hbr.org/2016/12/a-transformation-is-underway-at-u-s-veterans-affairs-we-got-an-inside-look%20The%20case%20study%20conducted%20by%20Harvard%20Business%20School%20on%20the%20transformation%20underway%20at%20VA> of the VA and deliver other wins to Trump on issues like employee accountabilityhttps://www.va.gov/accountability/Adverse_Actions_Report.pdf (read: easier firing of civil servants).

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>> Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask Congresshttps://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf for more money<http://www.modernhealthcare.com/article/20170927/NEWS/170929901> to fund<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/> the popular program<https://www.stripes.com/news/congress-approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>. Shulkin made a difficult decision<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>). And, Shulkin has presided over the terminationhttps://www.va.gov/accountability/Adverse_Actions_Report.pdf of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/> problems at the VA's Washington hospital and proposing to kill the VA's support<https://www.politico.com/story/2017/12/06/homeless-veterans-benefits-trump-207781> for homeless veterans, before walking back that idea in the face of public outcry.

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>> Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html> and Trump campaign operative Cam Sandoval, began working late last year<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html> to engineer Shulkin's exithttps://www.washingtonpost.com/amhtml/world/national-security/white-house-targets-vas-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html. According to the Washington Posthttps://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376, these nominees have actively sought to sabotage Shulkin's tenure, going so far as to call congressional leaders and lobby them to push for Shulkin's ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

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>> It is against this backdrop that Shulkin must wage his third and most personal battle: a fight over two internal ethics investigations by the VA's inspector general. The first investigation was triggered by

Washington Post reporting<https://www.washingtonpost.com/investigations/va-chief-took-in-wimbledon-river-cruise-on-european-work-trip/2017/09/29/c1f17046-a458-11e7-8c37-e1d99ad6aa22_story.html> about Shulkin's trip to meet with veterans officials in Europe—a trip that included a detour to Wimbledon, and a few days of vacation too. The VA's inspector general scorched Shulkin<https://www.washingtonpost.com/politics/veterans-affairs-chief-shulkin-staff-misled-ethics-officials-about-european-trip-report-finds/2018/02/14/f7fbc020-0c3a-11e8-8b0d-891602206fb7_story.html> in its report on this trip, finding that permission to bring his wife had been predicated on a falsified email from Shulkin's chief of staff and that Shulkin had impermissibly ordered his staff into travel concierge duty. Shulkin pushed back, retaining counsel to dissect the IG report, and he even suggested<<http://thehill.com/policy/defense/374009-va-secretary-says-he-wont-resign-doubles-down-on-allegations-aides-email-was>> that his chief of staff's email had been hacked. (It was not<<http://thehill.com/policy/defense/376045-watchdog-former-top-va-aides-email-was-not-hacked>>.) A day later, however, Shulkin's chief of staff announced<<https://www.militarytimes.com/veterans/2018/02/16/va-chief-of-staff-resigns-amid-secretarys-travel-scandal/>> her retirement, and Shulkin said<https://www.washingtonpost.com/world/national-security/va-secretary-shulkin-under-fire-for-europe-trip-to-appear-before-house-panel/2018/02/14/0c65702e-11c2-11e8-8ea1-c1d91fcec3fe_story.html?utm_term=.aa7311c9a3f1> he would repay the government for the cost of his wife's airfare.

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>> A second investigation, regarding Shulkin's use of his protective security detail, is reportedly percolating<<http://thehill.com/homenews/administration/376568-va-watchdog-preparing-report-on-shulkin-misuse-of-security-detail>> in the VA inspector general's office now. That assessment will reportedly criticize Shulkin for inappropriate use of his security detail for personal errands. On its face, the allegations aren't that damning; they show Shulkin to be an inexperienced government executive who's used to different rules in the private sector and also indicate his naïveté about how certain things will play on the proverbial front page of the Washington Post. But these errors come at a time when the Trump administration can ill afford another ethics scandal after similar abuses at HUD<https://www.washingtonpost.com/politics/using-his-position-for-private-gain-hud-lawyers-warned-ben-carson-risked-running-afoul-of-ethics-rules-by-enlisting-son/2018/01/31/bb20c48e-0532-11e8-8777-2a059f168dd2_story.html>, Interior<<http://thehill.com/homenews/administration/377497-interior-dept-spent-139k-on-construction-project-labeled-secretarys>>, and HHS<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>>, with the latter resulting in Secretary Tom Price's resignation. A Cabinet secretary aligned more closely with the White House than Shulkin, or with more political allies across the administration, could probably survive these investigations with barely a flesh wound. For Shulkin's tenure at VA, they may end up being fatal, to the extent they provide a pretext for the White House to replace Shulkin with a more trusted partisan.

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>> At this point, Shulkin's fate rests with Trump. Although Trump has largely benefited from Shulkin's service, the president must now decide whether he's better off with a competent leader like Shulkin, or a closer political ally who might march more in step with the base. The potential contenders include Energy Secretary Rick Perry (who said Wednesday<<http://abcnews.go.com/Politics/wireStory/latest-rick-perry-va-job-53748413>> he doesn't want the job), one of the 88 retired generals who endorsed<<https://www.politico.com/story/2016/09/retired-generals-admirals-endorse-trump-227755>> Trump in 2016, or veterans in Congress like Sens. Joni Ernst or Tom Cotton, whose chances are lower because of their importance to the Republicans' razor-thin Senate majority. Whether Shulkin stays or goes, the primary battle he waged, over the future of the VA, will continue. Trump is arguably better off keeping Shulkin around to keep waging this battle, and veterans are arguably better off with that outcome too.

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>> (b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\) \(6\)](https://www.cnas.org/people/(b) (6))> and adjunct professor of law at Georgetown University. The views expressed are the author's alone and not representative of his organization.

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From: (b) (6) <(b) (6)@cnas.org>
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Lunch next Tues 3/20
Date: Fri Mar 16 2018 06:07:29 CDT
Attachments:

Sounds like G Street Cafe on 15th just north of K. Perfect. I will meet you whenever works best for you.

Sent from my iPhone

> On Mar 15, 2018, at 19:59, DJS <vacodjs1@va.gov> wrote:

>

> No it was a place then on 15 th that was across from bipop rice bar and had counter service

>

>

>

> Sent with Good (www.good.com)

>

>

> From: (b) (6)

> Sent: Thursday, March 15, 2018 3:45:23 PM

> To: DJS

> Subject: [EXTERNAL] Lunch next Tues 3/20

>

> Lunch Tuesday, 3/20, sounds great. I think PJ Clarke's is the restaurant you're thinking of, but Mirabella or McCormicks or BLT also work well — whatever you prefer.

>

> Sent from my iPhone

>

>> On Mar 15, 2018, at 17:21, DJS <vacodjs1@va.gov> wrote:

>>

>> How is next Tuesday at that place I saw you last time - forget the name but it was on 16th near K?

>>

>>

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>> Sent with Good (www.good.com<http://www.good.com>)

>>

>>

>> From: (b) (6)

>> Sent: Thursday, March 15, 2018 2:01:21 PM

>> To: DJS

>> Subject: Re: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea

>>

>> Yes - would be happy to do so. Please let me know when your schedule allows.

>>

>> On 3/15/18, 3:28 PM, "DJS" <vacodjs1@va.gov> wrote:

>>

>> Thanks so much (b) (6)

>>

>> DC is truly crazy- so I appreciate your rational approach to things

>>
>> How about catching up for lunch sometime soon?
>>
>>
>>
>> Sent with Good (www.good.com<http://www.good.com<http://www.good.com<http://www.good.com>>)
>>
>>
>> From: (b) (6)
>> Sent: Thursday, March 15, 2018 11:58:56 AM
>> To: DJS
>> Subject: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea
>>
>> Thought I would share this column from today. Hope you're doing as well as possible under the circumstances. Hang in there. v/r (b) (6)
>>
>> https://slate.com/news-and-politics/2018/03/firing-veterans-affairs-secretary-david-shulkin-is-a-bad-idea.html?wpsrc=sh_all_dt_tw_ru
>>
>> Firing VA Secretary David Shulkin Is a Bad Idea
>> He's accomplishing a lot of good for America's veterans—and for Trump.
>>
>> By (b) (6)
>>
>> Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>>, "We'll never have to use those words ['You're fired'] on our David."
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>> Eight months later, that declaration may prove ironic. Fissures have emerged and deepened between Shulkin and the president's political allies over what, exactly, the VA should be doing. On top of this, two relatively minor scandals involving Shulkin have blown up his tenure and stalled major reform. Now, Shulkin faces conflict on three overlapping fronts, leaving him at the precipice of being fired and replaced by a closer Trump ally as the administration seeks to reduce the chaos<<https://www.cnn.com/2018/03/13/politics/trump-departures-white-house/index.html>> in its Cabinet.
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>> The first battle Shulkin is fighting has deep roots<<https://www.foreignaffairs.com/articles/2017-08-15/what-america-owes-its-veterans>> in veterans population demographics<https://www.rand.org/pubs/research_reports/RR1165z4.html> and the evolution of VA benefits over the past several decades. From the time they join up to their moment of discharge, service members<<https://www.rand.org/pubs/monographs/MG265.html>> belong to the Department of Defense. After that, they become eligible for a broad array of veterans programs that are administered by the VA's three large administrations: health, benefits, and cemeteries. These programs have evolved<<https://www.rand.org/pubs/monographs/MG1164.html>> from stingy pensions for seriously disabled veterans after the Revolution to the generous, comprehensive system of health care, disability compensation, and economic programs that exists today. All eligible veterans—meaning primarily those who serve on active duty and leave with an honorable discharge<<https://www.swords-to-plowshares.org/2016/03/30/underserved/>>—can avail themselves of these benefits, not just combat veterans or those who were wounded in the line of duty.
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gov/dhs-budget>, and the entire<<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program>> intelligence<<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/>> community<<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-militar/>> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

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>> All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization-is-a-very-real-issue-right-now-american-legion-says/>> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html>> Concerned Veterans for America<<https://cv4a.org/>> and many of Trump's allies in Congress, who would like to<<https://cv4a.org/project/taskforce/>> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html>> with congressional leaders in the House and Senate.

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>> It is against this backdrop that Shulkin must wage his third and most personal battle: a fight over two internal ethics investigations by the VA's inspector general. The first investigation was triggered by Washington Post reportinghttps://www.washingtonpost.com/investigations/va-chief-took-in-wimbledon-river-cruise-on-european-work-trip/2017/09/29/c1f17046-a458-11e7-8c37-e1d99ad6aa22_story.html about Shulkin's trip to meet with veterans officials in Europe—a trip that included a detour to Wimbledon, and a few days of vacation too. The VA's inspector general scorched Shulkinhttps://www.washingtonpost.com/politics/veterans-affairs-chief-shulkin-staff-misled-ethics-officials-about-european-trip-report-finds/2018/02/14/f7fbc020-0c3a-11e8-8b0d-891602206fb7_story.html in its report on this trip, finding that permission to bring his wife had been predicated on a falsified email from Shulkin's chief of staff and that Shulkin had impermissibly ordered his staff into travel concierge duty. Shulkin pushed back, retaining counsel to dissect the IG report, and he even suggested<http://thehill.com/policy/defense/374009-va-secretary-says-he-wont-resign-doubles-down-on-allegations-aides-email-was> that his chief of staff's email had been hacked. (It was not<http://thehill.com/policy/defense/376045-watchdog-former-top-va-aides-email-was-not-hacked>.) A day later, however, Shulkin's chief of staff announced<https://www.militarytimes.com/veterans/2018/02/16/va-chief-of-staff-resigns-amid-secretarys-travel-scandal/> her retirement, and Shulkin said<https://www.washingtonpost.com/world/national-security/va-secretary-shulkin-under-fire-for-europe-trip-to-appear>

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>> At this point, Shulkin's fate rests with Trump. Although Trump has largely benefited from Shulkin's service, the president must now decide whether he's better off with a competent leader like Shulkin, or a closer political ally who might march more in step with the base. The potential contenders include Energy Secretary Rick Perry (who said Wednesday<<http://abcnews.go.com/Politics/wireStory/latest-rick-perry-va-job-53748413>> he doesn't want the job), one of the 88 retired generals who endorsed<<https://www.politico.com/story/2016/09/retired-generals-admirals-endorse-trump-227755>> Trump in 2016, or veterans in Congress like Sens. Joni Ernst or Tom Cotton, whose chances are lower because of their importance to the Republicans' razor-thin Senate majority. Whether Shulkin stays or goes, the primary battle he waged, over the future of the VA, will continue. Trump is arguably better off keeping Shulkin around to keep waging this battle, and veterans are arguably better off with that outcome too.

>>

>>

>> (b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\) \(6\)](https://www.cnas.org/people/(b) (6))> and adjunct professor of law at Georgetown University. The views expressed are the author's alone and not representative of his organization.

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From: DJS </o=va/ou=exchange administrative group (fydibohf23spdl)/cn=recipients/cn=(b) (6)>
To: (b) (6) <(b) (6)@cnas.org>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Lunch next Tues 3/20
Date: Thu Mar 15 2018 18:58:59 CDT
Attachments:

No it was a place then on 15 th that was across from bipop rice bar and had counter service

Sent with Good (www.good.com)

From: (b) (6)
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> Firing VA Secretary David Shulkin Is a Bad Idea
> He's accomplishing a lot of good for America's veterans—and for Trump.
>
> By (b) (6)
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> Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>>, "We'll never have to use those words ['You're fired'] on our David."
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> Eight months later, that declaration may prove ironic. Fissures have emerged and deepened between Shulkin and the president's political allies over what, exactly, the VA should be doing. On top of this, two relatively minor scandals involving Shulkin have blown up his tenure and stalled major reform. Now, Shulkin faces conflict on three overlapping fronts, leaving him at the precipice of being fired and replaced by a closer Trump ally as the administration seeks to reduce the chaos<<https://www.cnn.com/2018/03/13/politics/trump-departures-white-house/index.html>> in its Cabinet.
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>
> To meet these obligations, the VA consumes a massive amount of money each year. Its 2019 budget request is \$198.6 billion<<https://www.va.gov/budget/products.asp>>—a big increase over previous years at a time when most agencies are facing cuts and totaling more than the budgets of the State Department<<https://www.state.gov/s/d/rm/c6112.htm>>, Homeland Security<<https://www.dhs.gov/dhs-budget>>, and the entire<<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program>> intelligence<<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/>> community<<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod->

releases-budget-figure-for-fy-2018-appropriations-requested-for-the-militar/> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

>

> Since 9/11, the VA's budget has steadily increased<<https://www.cnas.org/publications/reports/passing-the-baton-a-bipartisan-2016-agenda-for-the-veteran-and-military-community>> at a rate far greater than inflation, even as the total population of veterans has decreased. Older veterans of the Vietnam and Cold War eras rely heavily on VA services. So too does the post-9/11 generation<<https://www.publichealth.va.gov/epidemiology/reports/oefoifond/>>, of whom more than 3 million have deployed to Iraq, Afghanistan, or other theaters of war. These retired service members are using the VA at much higher rates than previous generations. This demand from young and old veterans alike is putting enormous pressure on the VA—which failed to adequately predict any of this increased demand, let alone prepare and budget<<https://www.bostonglobe.com/opinion/2016/10/17/the-trillion-wars/uPVfSuDutnTZl5fIQ7YllK/story.html>> for it.

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> In 2014, this problem erupted in Phoenix, where veterans endlessly waited for appointments while VA employees played a shell game with veterans to deceive them and their bosses in Washington. That scandal forced the ouster<http://www.slate.com/articles/news_and_politics/politics/2014/05/shinseki_resigns_here_s_how_to_fix_the_va.html> of VA Secretary (and retired Army Gen.) Eric Shinseki and prompted the creation of a program to purchase VA care from the private sector.

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> If the VA couldn't provide timely appointments for all veterans, Congress mused, the VA could instead purchase health care the way the Pentagon does for retirees. First as the VA's undersecretary for health, and then as secretary, Shulkin has devoted most of his energies toward implementing this new contracted-care system and making it work.

>

> All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization-is-a-very-real-issue-right-now-american-legion-says/>> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html>> Concerned Veterans for America<<https://cv4a.org/>> and many of Trump's allies in Congress, who would like to<<https://cv4a.org/project/taskforce/>> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html>> with congressional leaders in the House and Senate.

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> Shulkin's second battle—political infighting with more partisan members of the administration—inflames and complicates these policy disagreements. He is the sole survivor of the Obama administration among Cabinet officials serving Trump. A practicing physician and successful health executive, Shulkin came to the Obama administration to run the VA health care system after the 2014 Phoenix scandal. His selection came after a turbulent Trump transition, during which the president interviewed several potential candidates before settling on Shulkin. Trump reportedly gave Shulkin the job because the New Jersey physician persuaded him he could continue the slow, deliberate privatization<<https://hbr.org/2016/12/a-transformation-is-underway-at-u-s-veterans-affairs-we-got-an-inside-look%20The%20case%20study%20conducted%20by%20Harvard%20Business%20School%20on%20the%20transformation%20underway%20at%20VA>> of the VA and deliver other wins to Trump on issues like employee accountability<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> (read: easier firing of civil servants).

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> Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask

Congresshttps://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf for more money<http://www.modernhealthcare.com/article/20170927/NEWS/170929901> to fund<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/> the popular program<https://www.stripes.com/news/congress/approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>. Shulkin made a difficult decision<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>). And, Shulkin has presided over the terminationhttps://www.va.gov/accountability/Adverse_Actions_Report.pdf of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/> problems at the VA's Washington hospital and proposing to kill the VA's support<https://www.politico.com/story/2017/12/06/homeless-veterans-benefits-trump-207781> for homeless veterans, before walking back that idea in the face of public outcry.

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> Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html> and Trump campaign operative Cam Sandoval, began working late last year<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html> to engineer Shulkin's exithttps://www.washingtonpost.com/amphtml/world/national-security/white-house-targets-vas-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html. According to the Washington Posthttps://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376, these nominees have actively sought to sabotage Shulkin's tenure, going so far as to call congressional leaders and lobby them to push for Shulkin's ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

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> Firing VA Secretary David Shulkin Is a Bad Idea

> He's accomplishing a lot of good for America's veterans—and for Trump.

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> All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization-is-a-very-real-issue-right-now-american-legion-says/>> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html>> Concerned Veterans for America<<https://cv4a.org/>> and many of Trump's allies in Congress, who would like to<<https://cv4a.org/project/taskforce/>> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html>> with congressional leaders in the House and Senate.

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> Shulkin's second battle—political infighting with more partisan members of the administration—inflames and complicates these policy disagreements. He is the sole survivor of the Obama administration among Cabinet officials serving Trump. A practicing physician and successful health executive, Shulkin came to the Obama administration to run the VA health care system after the 2014 Phoenix scandal. His selection came after a turbulent Trump transition, during which the president interviewed several potential candidates before settling on Shulkin. Trump reportedly gave Shulkin the job because the New Jersey physician persuaded him he could continue the slow, deliberate privatization<<https://hbr.org/2016/12/a-transformation-is-underway-at-u-s-veterans-affairs-we-got-an-inside-look%20The%20case%20study%20conducted%20by%20Harvard%20Business%20School%20on%20the%20transformation%20underway%20at%20VA>> of the VA and deliver other wins to Trump on issues like employee accountability<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> (read: easier firing of civil servants).

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> Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask Congress<https://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf> for more money<<http://www.modernhealthcare.com/article/20170927/NEWS/170929901>> to fund<<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/>> the popular program<<https://www.stripes.com/news/congress/approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>>. Shulkin made a difficult decision<<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/>> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>>). And, Shulkin has presided over the termination<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/>> problems at the VA's Washington hospital and proposing to kill the VA's support<<https://www.politico.com>>.

com/story/2017/12/06/homeless-veterans-benefits-trump-207781> for homeless veterans, before walking back that idea in the face of public outcry.

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> Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>> and Trump campaign operative Cam Sandoval, began working late last year<<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html>> to engineer Shulkin's exit<https://www.washingtonpost.com/amhtml/world/national-security/white-house-targets-va-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html>. According to the Washington Post<https://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376>, these nominees have actively sought to sabotage Shulkin's tenure, going so far as to call congressional leaders and lobby them to push for Shulkin's ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

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> It is against this backdrop that Shulkin must wage his third and most personal battle: a fight over two internal ethics investigations by the VA's inspector general. The first investigation was triggered by Washington Post reporting<https://www.washingtonpost.com/investigations/va-chief-took-in-wimbledon-river-cruise-on-european-work-trip/2017/09/29/c1f17046-a458-11e7-8c37-e1d99ad6aa22_story.html> about Shulkin's trip to meet with veterans officials in Europe—a trip that included a detour to Wimbledon, and a few days of vacation too. The VA's inspector general scorched Shulkin<https://www.washingtonpost.com/politics/veterans-affairs-chief-shulkin-staff-misled-ethics-officials-about-european-trip-report-finds/2018/02/14/f7fbc020-0c3a-11e8-8b0d-891602206fb7_story.html> in its report on this trip, finding that permission to bring his wife had been predicated on a falsified email from Shulkin's chief of staff and that Shulkin had impermissibly ordered his staff into travel concierge duty. Shulkin pushed back, retaining counsel to dissect the IG report, and he even suggested<<http://thehill.com/policy/defense/374009-va-secretary-says-he-wont-resign-doubles-down-on-allegations-aides-email-was>> that his chief of staff's email had been hacked. (It was not<<http://thehill.com/policy/defense/376045-watchdog-former-top-va-aides-email-was-not-hacked>>.) A day later, however, Shulkin's chief of staff announced<<https://www.militarytimes.com/veterans/2018/02/16/va-chief-of-staff-resigns-amid-secretarys-travel-scandal/>> her retirement, and Shulkin said<https://www.washingtonpost.com/world/national-security/va-secretary-shulkin-under-fire-for-europe-trip-to-appear-before-house-panel/2018/02/14/0c65702e-11c2-11e8-8ea1-c1d91fcec3fe_story.html?utm_term=.aa7311c9a3f1> he would repay the government for the cost of his wife's airfare.

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> A second investigation, regarding Shulkin's use of his protective security detail, is reportedly percolating<<http://thehill.com/homenews/administration/376568-va-watchdog-preparing-report-on-shulkin-misuse-of-security-detail>> in the VA inspector general's office now. That assessment will reportedly criticize Shulkin for inappropriate use of his security detail for personal errands. On its face, the allegations aren't that damning; they show Shulkin to be an inexperienced government executive who's used to different rules in the private sector and also indicate his naiveté about how certain things will play on the proverbial front page of the Washington Post. But these errors come at a time when the Trump administration can ill afford another ethics scandal after similar abuses at HUD<https://www.washingtonpost.com/politics/using-his-position-for-private-gain-hud-lawyers-warned-ben-carson-risked-running-afoul-of-ethics-rules-by-enlisting-son/2018/01/31/bb20c48e-0532-11e8-8777-2a059f168dd2_story.html>, Interior<<http://thehill.com/homenews/administration/377497-interior-dept-spent-139k-on-construction-project-labeled-secretarys>>, and HHS<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>>, with the latter resulting in Secretary Tom Price's resignation. A Cabinet secretary aligned more closely with the White House than Shulkin, or with more political allies across the administration, could probably survive these investigations with barely a flesh wound. For Shulkin's tenure at VA, they may end up being fatal, to the extent they

provide a pretext for the White House to replace Shulkin with a more trusted partisan.

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> At this point, Shulkin's fate rests with Trump. Although Trump has largely benefited from Shulkin's service, the president must now decide whether he's better off with a competent leader like Shulkin, or a closer political ally who might march more in step with the base. The potential contenders include Energy Secretary Rick Perry (who said Wednesday<<http://abcnews.go.com/Politics/wireStory/latest-rick-perry-va-job-53748413>> he doesn't want the job), one of the 88 retired generals who endorsed<<https://www.politico.com/story/2016/09/retired-generals-admirals-endorse-trump-227755>> Trump in 2016, or veterans in Congress like Sens. Joni Ernst or Tom Cotton, whose chances are lower because of their importance to the Republicans' razor-thin Senate majority. Whether Shulkin stays or goes, the primary battle he waged, over the future of the VA, will continue. Trump is arguably better off keeping Shulkin around to keep waging this battle, and veterans are arguably better off with that outcome too.

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> (b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\) \(6\)](https://www.cnas.org/people/(b) (6))> and adjunct professor of law at Georgetown University. The views expressed are the author's alone and not representative of his organization.

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From: DJS </o=va/ou=exchange administrative group (fydibohf23spdl)/cn=recipients/cn=(b) (6)>
To: (b) (6) <(b) (6)@cnas.org>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea
Date: Thu Mar 15 2018 16:21:16 CDT
Attachments:

How is next Tuesday at that place I saw you last time - forget the name but it was on 16th near K?

Sent with Good (www.good.com)

From: (b) (6)
Sent: Thursday, March 15, 2018 2:01:21 PM
To: DJS
Subject: Re: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea

Yes - would be happy to do so. Please let me know when your schedule allows.

On 3/15/18, 3:28 PM, "DJS" <vacodjs1@va.gov> wrote:

Thanks so much (b) (6)

DC is truly crazy- so I appreciate your rational approach to things

How about catching up for lunch sometime soon?

Sent with Good (www.good.com)

From: (b) (6)
Sent: Thursday, March 15, 2018 11:58:56 AM
To: DJS
Subject: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea

Thought I would share this column from today. Hope you're doing as well as possible under the circumstances. Hang in there. v/r (b) (6)

https://slate.com/news-and-politics/2018/03/firing-veterans-affairs-secretary-david-shulkin-is-a-bad-idea.html?wpsrc=sh_all_dt_tw_ru

Firing VA Secretary David Shulkin Is a Bad Idea
He's accomplishing a lot of good for America's veterans—and for Trump.

Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>>, "We'll never have to use those words ['You're fired'] on our David."

Eight months later, that declaration may prove ironic. Fissures have emerged and deepened between Shulkin and the president's political allies over what, exactly, the VA should be doing. On top of this, two relatively minor scandals involving Shulkin have blown up his tenure and stalled major reform. Now, Shulkin faces conflict on three overlapping fronts, leaving him at the precipice of being fired and replaced by a closer Trump ally as the administration seeks to reduce the chaos<<https://www.cnn.com/2018/03/13/politics/trump-departures-white-house/index.html>> in its Cabinet.

The first battle Shulkin is fighting has deep roots<<https://www.foreignaffairs.com/articles/2017-08-15/what-america-owes-its-veterans>> in veterans population demographics<https://www.rand.org/pubs/research_reports/RR1165z4.html> and the evolution of VA benefits over the past several decades. From the time they join up to their moment of discharge, service members<<https://www.rand.org/pubs/monographs/MG265.html>> belong to the Department of Defense. After that, they become eligible for a broad array of veterans programs that are administered by the VA's three large administrations: health, benefits, and cemeteries. These programs have evolved<<https://www.rand.org/pubs/monographs/MG1164.html>> from stingy pensions for seriously disabled veterans after the Revolution to the generous, comprehensive system of health care, disability compensation, and economic programs that exists today. All eligible veterans—meaning primarily those who serve on active duty and leave with an honorable discharge<<https://www.swords-to-plowshares.org/2016/03/30/underserved/>>—can avail themselves of these benefits, not just combat veterans or those who were wounded in the line of duty.

To meet these obligations, the VA consumes a massive amount of money each year. Its 2019 budget request is \$198.6 billion<<https://www.va.gov/budget/products.asp>>—a big increase over previous years at a time when most agencies are facing cuts and totaling more than the budgets of the State Department<<https://www.state.gov/s/d/rm/c6112.htm>>, Homeland Security<<https://www.dhs.gov/dhs-budget>>, and the entire<<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program>> intelligence<<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/>> community<<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-military/>> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

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In 2014, this problem erupted in Phoenix, where veterans endlessly waited for appointments while VA employees played a shell game with veterans to deceive them and their bosses in Washington. That scandal forced the ouster<http://www.slate.com/articles/news_and_politics/politics/2014/05/shinseki_resigns_here_s_how_to_fix_the_va.html> of

VA Secretary (and retired Army Gen.) Eric Shinseki and prompted the creation of a program to purchase VA care from the private sector.

If the VA couldn't provide timely appointments for all veterans, Congress mused, the VA could instead purchase health care the way the Pentagon does for retirees. First as the VA's undersecretary for health, and then as secretary, Shulkin has devoted most of his energies toward implementing this new contracted-care system and making it work.

All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization-is-a-very-real-issue-right-now-american-legion-says/> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html> Concerned Veterans for America<https://cv4a.org/> and many of Trump's allies in Congress, who would like to<https://cv4a.org/project/taskforce/> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html> with congressional leaders in the House and Senate.

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Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask Congresshttps://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf for more money<http://www.modernhealthcare.com/article/20170927/NEWS/170929901> to fund<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/> the popular program<https://www.stripes.com/news/congress-approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>. Shulkin made a difficult decision<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>). And, Shulkin has presided over the terminationhttps://www.va.gov/accountability/Adverse_Actions_Report.pdf of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/> problems at the VA's Washington hospital and proposing to kill the VA's support<https://www.politico.com/story/2017/12/06/homeless-veterans-benefits-trump-207781> for homeless veterans, before walking back that idea in the face of public outcry.

Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought

in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>> and Trump campaign operative Cam Sandoval, began working late last year<<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html>> to engineer Shulkin's exit<https://www.washingtonpost.com/amphtml/world/national-security/white-house-targets-va-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html>. According to the Washington Post<https://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376>, these nominees have actively sought to sabotage Shulkin's tenure, going so far as to call congressional leaders and lobby them to push for Shulkin's ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

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A second investigation, regarding Shulkin's use of his protective security detail, is reportedly percolating<<http://thehill.com/homenews/administration/376568-va-watchdog-preparing-report-on-shulkin-misuse-of-security-detail>> in the VA inspector general's office now. That assessment will reportedly criticize Shulkin for inappropriate use of his security detail for personal errands. On its face, the allegations aren't that damning; they show Shulkin to be an inexperienced government executive who's used to different rules in the private sector and also indicate his naiveté about how certain things will play on the proverbial front page of the Washington Post. But these errors come at a time when the Trump administration can ill afford another ethics scandal after similar abuses at HUD<https://www.washingtonpost.com/politics/using-his-position-for-private-gain-hud-lawyers-warned-ben-carson-risked-running-afoul-of-ethics-rules-by-enlisting-son/2018/01/31/bb20c48e-0532-11e8-8777-2a059f168dd2_story.html>, Interior<<http://thehill.com/homenews/administration/377497-interior-dept-spent-139k-on-construction-project-labeled-secretarys>>, and HHS<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>>, with the latter resulting in Secretary Tom Price's resignation. A Cabinet secretary aligned more closely with the White House than Shulkin, or with more political allies across the administration, could probably survive these investigations with barely a flesh wound. For Shulkin's tenure at VA, they may end up being fatal, to the extent they provide a pretext for the White House to replace Shulkin with a more trusted partisan.

At this point, Shulkin's fate rests with Trump. Although Trump has largely benefited from Shulkin's service, the president must now decide whether he's better off with a competent leader like Shulkin, or

a closer political ally who might march more in step with the base. The potential contenders include Energy Secretary Rick Perry (who said Wednesday<<http://abcnews.go.com/Politics/wireStory/latest-rick-perry-va-job-53748413>> he doesn't want the job), one of the 88 retired generals who endorsed<<https://www.politico.com/story/2016/09/retired-generals-admirals-endorse-trump-227755>> Trump in 2016, or veterans in Congress like Sens. Joni Ernst or Tom Cotton, whose chances are lower because of their importance to the Republicans' razor-thin Senate majority. Whether Shulkin stays or goes, the primary battle he waged, over the future of the VA, will continue. Trump is arguably better off keeping Shulkin around to keep waging this battle, and veterans are arguably better off with that outcome too.

(b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\) \(6\)](https://www.cnas.org/people/(b) (6))> and adjunct professor of law at Georgetown University. The views expressed are the author's alone and not representative of his organization.

From: (b) (6) <(b) (6)@cnas.org>
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea
Date: Thu Mar 15 2018 16:01:21 CDT
Attachments:

Yes - would be happy to do so. Please let me know when your schedule allows.

On 3/15/18, 3:28 PM, "DJS" <vacodjs1@va.gov> wrote:

Thanks so much (b) (6)

DC is truly crazy- so I appreciate your rational approach to things

How about catching up for lunch sometime soon?

Sent with Good (www.good.com)

From: (b) (6)
Sent: Thursday, March 15, 2018 11:58:56 AM
To: DJS
Subject: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea

Thought I would share this column from today. Hope you're doing as well as possible under the circumstances. Hang in there. v/r (b) (6)

https://slate.com/news-and-politics/2018/03/firing-veterans-affairs-secretary-david-shulkin-is-a-bad-idea.html?wpsrc=sh_all_dt_tw_ru

Firing VA Secretary David Shulkin Is a Bad Idea
He's accomplishing a lot of good for America's veterans—and for Trump.

By (b) (6)

Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>>, "We'll never have to use those words ['You're fired'] on our David."

Eight months later, that declaration may prove ironic. Fissures have emerged and deepened between Shulkin and the president's political allies over what, exactly, the VA should be doing. On top of this, two relatively minor scandals involving Shulkin have blown up his tenure and stalled major reform. Now, Shulkin faces conflict on three overlapping fronts, leaving him at the precipice of being fired and replaced by a closer Trump ally as the administration seeks to reduce the chaos<<https://www.cnn.com/2018/03/13/politics/trump-departures-white-house/index.html>> in its Cabinet.

The first battle Shulkin is fighting has deep roots<<https://www.foreignaffairs.com/articles/2017-08-15/what-america-owes-its-veterans>> in veterans population demographics<https://www.rand.org/pubs/research_reports/RR1165z4.html> and the evolution of VA benefits over the past several decades. From the time they join up to their moment of discharge, service members<<https://www.rand.org/pubs/monographs/MG265.html>> belong to the Department of Defense. After that, they become eligible for a broad array of veterans programs that are administered by the VA's three large administrations: health, benefits, and cemeteries. These programs have evolved<<https://www.rand.org/pubs/monographs/MG1164.html>> from stingy pensions for seriously disabled veterans after the Revolution to the generous, comprehensive system of health care, disability compensation, and economic programs that exists today. All eligible veterans—meaning primarily those who serve on active duty and leave with an honorable discharge<<https://www.swords-to-plowshares.org/2016/03/30/underserved/>>—can avail themselves of these benefits, not just combat veterans or those who were wounded in the line of duty.

To meet these obligations, the VA consumes a massive amount of money each year. Its 2019 budget request is \$198.6 billion<<https://www.va.gov/budget/products.asp>>—a big increase over previous years at a time when most agencies are facing cuts and totaling more than the budgets of the State Department<<https://www.state.gov/s/d/rm/c6112.htm>>, Homeland Security<<https://www.dhs.gov/dhs-budget>>, and the entire<<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program>> intelligence<<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/>> community<<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-militar/>> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

Since 9/11, the VA's budget has steadily increased<<https://www.cnas.org/publications/reports/passing-the-baton-a-bipartisan-2016-agenda-for-the-veteran-and-military-community>> at a rate far greater than inflation, even as the total population of veterans has decreased. Older veterans of the Vietnam and Cold War eras rely heavily on VA services. So too does the post-9/11 generation<<https://www.publichealth.va.gov/epidemiology/reports/oefoifond/>>, of whom more than 3 million have deployed to Iraq, Afghanistan, or other theaters of war. These retired service members are using the VA at much higher rates than previous generations. This demand from young and old veterans alike is putting enormous pressure on the VA—which failed to adequately predict any of this increased demand, let alone prepare and budget<<https://www.bostonglobe.com/opinion/2016/10/17/the-trillion-wars/uPVfSuDutnTZl5fIQ7YlIK/story.html>> for it.

In 2014, this problem erupted in Phoenix, where veterans endlessly waited for appointments while VA employees played a shell game with veterans to deceive them and their bosses in Washington. That scandal forced the ouster<http://www.slate.com/articles/news_and_politics/politics/2014/05/shinseki_resigns_here_s_how_to_fix_the_va.html> of VA Secretary (and retired Army Gen.) Eric Shinseki and prompted the creation of a program to purchase VA care from the private sector.

If the VA couldn't provide timely appointments for all veterans, Congress mused, the VA could instead purchase health care the way the Pentagon does for retirees. First as the VA's undersecretary for health, and then as secretary, Shulkin has devoted most of his energies toward implementing this new contracted-care system and making it work.

All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization-is-a-very-real-issue-right-now-american-legion-says/>> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<<https://www.nytimes.com>>

[com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html](https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html)> Concerned Veterans for America<<https://cv4a.org/>> and many of Trump's allies in Congress, who would like to<<https://cv4a.org/project/taskforce/>> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html>> with congressional leaders in the House and Senate.

Shulkin's second battle—political infighting with more partisan members of the administration—inflames and complicates these policy disagreements. He is the sole survivor of the Obama administration among Cabinet officials serving Trump. A practicing physician and successful health executive, Shulkin came to the Obama administration to run the VA health care system after the 2014 Phoenix scandal. His selection came after a turbulent Trump transition, during which the president interviewed several potential candidates before settling on Shulkin. Trump reportedly gave Shulkin the job because the New Jersey physician persuaded him he could continue the slow, deliberate privatization<<https://hbr.org/2016/12/a-transformation-is-underway-at-u-s-veterans-affairs-we-got-an-inside-look%20The%20case%20study%20conducted%20by%20Harvard%20Business%20School%20on%20the%20transformation%20underway%20at%20VA>> of the VA and deliver other wins to Trump on issues like employee accountability<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> (read: easier firing of civil servants).

Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask Congress<https://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf> for more money<<http://www.modernhealthcare.com/article/20170927/NEWS/170929901>> to fund<<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/>> the popular program<<https://www.stripes.com/news/congress-approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>>. Shulkin made a difficult decision<<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/>> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>>). And, Shulkin has presided over the termination<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/>> problems at the VA's Washington hospital and proposing to kill the VA's support<<https://www.politico.com/story/2017/12/06/homeless-veterans-benefits-trump-207781>> for homeless veterans, before walking back that idea in the face of public outcry.

Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>> and Trump campaign operative Cam Sandoval, began working late last year<<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html>> to engineer Shulkin's exit<https://www.washingtonpost.com/amhtml/world/national-security/white-house-targets-vas-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html>. According to the Washington Post<https://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376>, these nominees have actively sought to sabotage Shulkin's tenure, going so far as to call congressional leaders and lobby them to push for Shulkin's ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

It is against this backdrop that Shulkin must wage his third and most personal battle: a fight over two internal ethics investigations by the VA's inspector general. The first investigation was triggered by Washington Post reporting<https://www.washingtonpost.com/investigations/va-chief-took-in-wimbledon-river-cruise-on-european-work-trip/2017/09/29/c1f17046-a458-11e7-8c37-e1d99ad6aa22_story.html> about Shulkin's trip to meet with veterans officials in Europe—a trip that included a detour to Wimbledon, and a few days of vacation too. The VA's inspector general scorched Shulkin<https://www.washingtonpost.com/politics/veterans-affairs-chief-shulkin-staff-misled-ethics-officials-about-european-trip-report-finds/2018/02/14/f7fbc020-0c3a-11e8-8b0d-891602206fb7_story.html> in its report on this trip, finding that permission to bring his wife had been predicated on a falsified email from Shulkin's chief of staff and that Shulkin had impermissibly ordered his staff into travel concierge duty. Shulkin pushed back, retaining counsel to dissect the IG report, and he even suggested<<http://thehill.com/policy/defense/374009-va-secretary-says-he-wont-resign-doubles-down-on-allegations-aides-email-was>> that his chief of staff's email had been hacked. (It was not<<http://thehill.com/policy/defense/376045-watchdog-former-top-va-aides-email-was-not-hacked>>.) A day later, however, Shulkin's chief of staff announced<<https://www.militarytimes.com/veterans/2018/02/16/va-chief-of-staff-resigns-amid-secretarys-travel-scandal/>> her retirement, and Shulkin said<https://www.washingtonpost.com/world/national-security/va-secretary-shulkin-under-fire-for-europe-trip-to-appear-before-house-panel/2018/02/14/0c65702e-11c2-11e8-8ea1-c1d91fcec3fe_story.html?utm_term=.aa7311c9a3f1> he would repay the government for the cost of his wife's airfare.

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(b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\) \(6\)](https://www.cnas.org/people/(b) (6))> and adjunct professor of law at Georgetown University. The views expressed are the author's alone and not representative of his organization.

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Date: Tue Mar 13 2018 07:05:45 CDT
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Shulkin
Daily update · March 13, 2018

NEWS

David Shulkin Makes Late Play for Most Corrupt Trump Cabinet Member

Vanity Fair

Veteran's Affairs Secretary David Shulkin's tenure got off to a promising start, at least by Trump administration standards: a former hospital administrator and renowned academic, the Obama-era appointee was the only Cabinet nominee unanimously confirmed by the Senate. Yet in recent weeks, ...

Axios: Trump now sees Shulkin as a "major problem" - Hot Air

Donald Trump Should Not Be Calling Fox & Friends Hosts For Policy Advice - SPIN

Report: Trump called a Fox & Friends host with Koch links during a meeting with the VA Secretary -

Media Matters for America (blog)

Full Coverage

Flag as irrelevant

VA Leadership on Shaky Ground after Another Damaging Report

Nonprofit Quarterly

Last week was not a great week for the VA. On Wednesday, Veterans Affairs Secretary David J. Shulkin announced that VA hospitals across the country will soon be under new leadership following the release of a 142-page investigative report that sheds light on numerous of the agency's programs' ...

Flag as irrelevant

The Trump Administration's Campaign to Weaken Civil Service Ramps Up at the VA

ProPublica

Shulkin, Trump and CVA have all touted it as a major accomplishment, as have lawmakers and veterans groups. The White House referred questions to the VA, where spokesman Cashour said the law "is one of the most significant federal civil service reforms in decades and is helping instill across the ...

Trump's VA Is Purging Civil Servants - POLITICO Magazine

Full Coverage

Flag as irrelevant

Dayton VA names new leader: What we know

Dayton Daily News

Two days before the announcement of Dietrich's appointment, U.S. Department of Veterans Affairs Secretary David Shulkin announced sweeping plans to reorganize the VA starting with the national headquarters and the consolidation of oversight of 23 hospitals. USA Today reported that if Shulkin ...

Flag as irrelevant

The problems with Trump's scandal-ridden Cabinet start right at the top
mySanAntonio.com

Veterans Affairs Secretary David Shulkin, whose chief of staff resigned after the department inspector general found she falsified an email to justify sending Shulkin's wife on a trip to Denmark and Britain at department expense, a trip on which Shulkin was also faulted for accepting free Wimbledon tickets.

Flag as irrelevant

Larry Kudlow and the Trump-TV feedback loop
GANT News

With the current secretary, David Shulkin, under increasing scrutiny, Trump “surprised Shulkin by dialing in” Hegseth on speaker phone during a meeting earlier this month. “Trump talks to Hegseth regularly and enjoys watching him on 'Fox and Friends,’” Axios reported. To date, only one prominent Fox ...

Flag as irrelevant

Wave Of Firings At VA Targets Working Staff, Not Top Officials
The National Memo (blog)

Shulkin advocated for the measure, called the VA Accountability and Whistleblower Protection Act, by highlighting a case in which the agency had to wait 30 days to fire a worker caught watching porn with a patient. “I do not see this as a tool that's going to lead to mass firings,” Shulkin said last June.

Flag as irrelevant

The American Legion Lobbies For Medical Marijuana
Weed News (blog)

So far Shulkin has been unwilling to commit the V.A. to studying medical cannabis. In a December 2017 letter to U.S. Representative Tim Walz, Shulkin stated the “VA is committed to researching and developing effective ways to help Veterans cope with post-traumatic stress disorder and chronic pain ...

Flag as irrelevant

Only Congress can end horror stories at the VA
The Hill

Now that the horrifying details of yet another scathing report from the U.S. Department of Veterans Affairs (VA) Inspector General (IG) are out, Congress must pass bold and meaningful legislation that will transform the way we deliver care to veterans. If Congress does not respond to this latest crisis with ...

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</o=va/ou=first administrative group/cn=recipients/cn=(b) (6)@vva.org
<(b) (6)@vva.org>; Thomas Bowman <(b) (6)@yahoo.com>;
Shulkin, David J., MD </o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Bcc:
Subject: [EXTERNAL] Re: Leadership Crisis in the Veterans Administration
Date: Sat Mar 10 2018 17:44:24 CST
Attachments:

(b) (6)

We're all glad you survived the Veterans Administration Healthcare!

We agree!!

Some equate choice with destroying the VA. The absence of choice could kill the Veteran. I would have been one of those Veterans. You know the sordid story.

Yes, I support Veterans Choice. No, I do not support dismantling the Veterans Administration.

Dr. (b) (6)
National Treasurer
Sent from my iPhone

On Mar 10, 2018, at 17:16, (b) (6) <(b) (6)@polarcomm.com> wrote:

I was 1 bag of whole blood away from not being here!
The VA screwed up on a routine colonoscopy and I almost didn't make it.
I believe in choice but not at the expense of destroying the VA

Sent from my iPhone

On Mar 10, 2018, at 1:57 PM, (b) (6) <(b) (6)@gmail.com> wrote:

(b) (6)

As you may have read, attached, in the Liberal Washington Post today Dr Shulkin is a major front page topic, target. Secretary Shulkin is being attacked. The Liberal Washington Post presents Dr. Shulkin in a very negative light and as desperate to hold onto his job.

You also know the Washington Post is a reflection of the positions of George Soros and the Democrats. I defend my friends Thomas Bowman and Dr. Shulkin. I also know the deep Commitment President Trump has for the VA and Veterans especially when compared to President Obama and Secretary McDonald.

I'm not certain where all of the subterfuge is coming from, but those in the VA who are carryovers from President Obama's Administration and maybe even President Bush are hurting Veterans.

I've never heard of any influence of the Cook Brothers you mentioned you. I even googled them.

I'm not aware of anyone being in favor of dismantling the VA but most want some Choice if the VA care is not adequate. You and I have both exercised choice in our Medical Care. You did when the Cardiac Team from NYU did your Aortic Valve replacement instead of VA staff cardiac surgeons. I invoked Choice did when my AML treatment was moved to University Alabama Birmingham Medical Center from the Birmingham VA Medical Center. VA paid for both choices.

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https://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html

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National Treasurer
Vietnam Veterans of America
Sent from my iPhone

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From: (b) (6)@aol.com>
Sent: Thursday, March 8, 2018 2:33 PM
To: (b) (6)
Cc: (b) (6), (b) (6), (b) (6), (b) (6), (b) (6), (b) (6), vva.org
Subject: The Policy Statements on Behalf of VVA

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<Policy Statements.pdf>

From: [REDACTED] polarcomm.com>
To: [REDACTED] gmail.com>
Cc: [REDACTED] hotmail.com>;
[REDACTED] aol.com>; [REDACTED] vva.org>;
[REDACTED] vva.org>; [REDACTED] vva.org>;
[REDACTED] vva.org>; [REDACTED] vva.org>;
[REDACTED] vva.org <[REDACTED] vva.org>;
[REDACTED] vva.org <[REDACTED] vva.org>;
</o=va/ou=first administrative
group/cn=recipients/cn=[REDACTED] vva.org
<[REDACTED] vva.org>; Thomas Bowman <[REDACTED] yahoo.com>;
Shulkin, David J., MD </o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=[REDACTED]>
Bcc:
Subject: [EXTERNAL] Re: Leadership Crisis in the Veterans Administration
Date: Sat Mar 10 2018 17:16:36 CST
Attachments:

I was 1 bag of whole blood away from not being here!
The VA screwed up on a routine colonoscopy and I almost didn't make it.
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National Treasurer
Vietnam Veterans of America

<Policy Statements.pdf>

From: (b) (6) aol.com>
To: (b) (6) (Miami VA)
</o=va/ou=external
(fydibohf25spdlt)/cn=recipients/cn=(b) (6)
>; (b) (6) @gmail.com>; (b) (6) (Miami
VA) </o=va/ou=visn 08/cn=recipients/cn=(b) (6) Shulkin,
David J., MD </o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
(b) (6) @gmail.com (b) (6) @gmail.com>;
(b) (6) @yahoo.com (b) (6) @yahoo.com>; (b) (6)
J. </o=va/ou=vba philadelphia/cn=recipients/cn=(b) (6)
(b) (6) @hotmail.com <(b) (6) @hotmail.com>; (b) (6)
(Miami VA) </o=va/ou=visn 08/cn=recipients/cn=(b) (6)
(b) (6) @aol.com>; (b) (6) (Miami VA)
</o=va/ou=visn 08/cn=recipients/cn=(b) (6)
C. (Miami VA) </o=va/ou=visn 08/cn=recipients/cn=(b) (6)
(b) (6) (Ray) OAWP </o=va/ou=visn
16/cn=recipients/cn=(b) (6) (b) (6) @gmail.com
(b) (6) @gmail.com>; (b) (6) </o=va/ou=visn
18/cn=recipients/cn=(b) (6) (b) (6) @gmail.com
(b) (6) @gmail.com>

Cc:
Bcc:
Subject: [EXTERNAL] Thumb drive
Date: Mon Mar 26 2018 13:55:34 CDT
Attachments:

Although I have not worked in 11 month and I only have 7 days to respond to a removal letter and 10 to appeal my MSPB decision could you give me a little longer.
I am going to have the concern veterans of America start a whistle blower go fund me account. Also these would be all the emails from the people email accounts about me. If anyone of them is gone will it still give emails

Sent from my iPhone

From: (b) (6) <(b) (6)@cnas.org>
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Lunch next Tues 3/20
Date: Fri Mar 16 2018 06:15:30 CDT
Attachments:

Terrific. Look forward to seeing you then.

Sent from my iPhone

> On Mar 16, 2018, at 07:12, DJS <vacodjs1@va.gov> wrote:

>

> Great- 1245 pm ok?

>

>

>

> Sent with Good (www.good.com)

>

>

> From: (b) (6)

> Sent: Friday, March 16, 2018 4:07:29 AM

> To: DJS

> Subject: Re: [EXTERNAL] Lunch next Tues 3/20

>

> Sounds like G Street Cafe on 15th just north of K. Perfect. I will meet you whenever works best for you.

>

> Sent from my iPhone

>

>> On Mar 15, 2018, at 19:59, DJS <vacodjs1@va.gov> wrote:

>>

>> No it was a place then on 15 th that was across from bipop rice bar and had counter service

>>

>>

>>

>> Sent with Good (www.good.com<http://www.good.com>)

>>

>>

>> From: (b) (6)

>> Sent: Thursday, March 15, 2018 3:45:23 PM

>> To: DJS

>> Subject: [EXTERNAL] Lunch next Tues 3/20

>>

>> Lunch Tuesday, 3/20, sounds great. I think PJ Clarke's is the restaurant you're thinking of, but Mirabella or McCormicks or BLT also work well — whatever you prefer.

>>

>> Sent from my iPhone

>>

>>> On Mar 15, 2018, at 17:21, DJS <vacodjs1@va.gov> wrote:

>>>

>>> How is next Tuesday at that place I saw you last time - forget the name but it was on 16th near K?
>>>
>>>
>>>
>>> Sent with Good (www.good.com<http://www.good.com<http://www.good.com<http://www.good.com>>)
>>>
>>> _____
>>> From: (b) (6)
>>> Sent: Thursday, March 15, 2018 2:01:21 PM
>>> To: DJS
>>> Subject: Re: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea
>>>
>>> Yes - would be happy to do so. Please let me know when your schedule allows.
>>>
>>> On 3/15/18, 3:28 PM, "DJS" <vacodjs1@va.gov> wrote:
>>>
>>> Thanks so much (b) (6)
>>>
>>> DC is truly crazy- so I appreciate your rational approach to things
>>>
>>> How about catching up for lunch sometime soon?
>>>
>>>
>>>
>>> Sent with Good (www.good.com<http://www.good.com<http://www.good.com<http://www.good.com<http://www.good.com>>>)
>>>
>>> _____
>>> From: (b) (6)
>>> Sent: Thursday, March 15, 2018 11:58:56 AM
>>> To: DJS
>>> Subject: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea
>>>
>>> Thought I would share this column from today. Hope you're doing as well as possible under the circumstances. Hang in there. v/r (b) (6)
>>>
>>> https://slate.com/news-and-politics/2018/03/firing-veterans-affairs-secretary-david-shulkin-is-a-bad-idea.html?wpsrc=sh_all_dt_tw_ru
>>>
>>> Firing VA Secretary David Shulkin Is a Bad Idea
>>> He's accomplishing a lot of good for America's veterans—and for Trump.
>>>
>>> By (b) (6)
>>>
>>> Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>>, "We'll never have to use those words ['You're fired'] on our David."
>>>
>>> Eight months later, that declaration may prove ironic. Fissures have emerged and deepened between Shulkin and the president's political allies over what, exactly, the VA should be doing. On top of this, two relatively minor scandals involving Shulkin have blown up his tenure and stalled major reform. Now, Shulkin faces conflict on three overlapping fronts, leaving him at the precipice of being fired and replaced by a closer Trump ally as the administration seeks to reduce the chaos<<https://www.>

cnn.com/2018/03/13/politics/trump-departures-white-house/index.html> in its Cabinet.

>>>

>>> The first battle Shulkin is fighting has deep roots<<https://www.foreignaffairs.com/articles/2017-08-15/what-america-owes-its-veterans>> in veterans population demographics<https://www.rand.org/pubs/research_reports/RR1165z4.html> and the evolution of VA benefits over the past several decades. From the time they join up to their moment of discharge, service members<<https://www.rand.org/pubs/monographs/MG265.html>> belong to the Department of Defense. After that, they become eligible for a broad array of veterans programs that are administered by the VA's three large administrations: health, benefits, and cemeteries. These programs have evolved<<https://www.rand.org/pubs/monographs/MG1164.html>> from stingy pensions for seriously disabled veterans after the Revolution to the generous, comprehensive system of health care, disability compensation, and economic programs that exists today. All eligible veterans—meaning primarily those who serve on active duty and leave with an honorable discharge<<https://www.swords-to-plowshares.org/2016/03/30/underserved/>>—can avail themselves of these benefits, not just combat veterans or those who were wounded in the line of duty.

>>>

>>> To meet these obligations, the VA consumes a massive amount of money each year. Its 2019 budget request is \$198.6 billion<<https://www.va.gov/budget/products.asp>>—a big increase over previous years at a time when most agencies are facing cuts and totaling more than the budgets of the State Department<<https://www.state.gov/s/d/rm/c6112.htm>>, Homeland Security<<https://www.dhs.gov/dhs-budget>>, and the entire<<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program>> intelligence<<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/>> community<<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-militar/>> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

>>>

>>> Since 9/11, the VA's budget has steadily increased<<https://www.cnas.org/publications/reports/passing-the-baton-a-bipartisan-2016-agenda-for-the-veteran-and-military-community>> at a rate far greater than inflation, even as the total population of veterans has decreased. Older veterans of the Vietnam and Cold War eras rely heavily on VA services. So too does the post-9/11 generation<<https://www.publichealth.va.gov/epidemiology/reports/oeofond/>>, of whom more than 3 million have deployed to Iraq, Afghanistan, or other theaters of war. These retired service members are using the VA at much higher rates than previous generations. This demand from young and old veterans alike is putting enormous pressure on the VA—which failed to adequately predict any of this increased demand, let alone prepare and budget<<https://www.bostonglobe.com/opinion/2016/10/17/the-trillion-wars/uPVfSuDutnTZl5fIQ7YlIK/story.html>> for it.

>>>

>>> In 2014, this problem erupted in Phoenix, where veterans endlessly waited for appointments while VA employees played a shell game with veterans to deceive them and their bosses in Washington. That scandal forced the ouster<http://www.slate.com/articles/news_and_politics/politics/2014/05/shinseki_resigns_here_s_how_to_fix_the_va.html> of VA Secretary (and retired Army Gen.) Eric Shinseki and prompted the creation of a program to purchase VA care from the private sector.

>>>

>>>

>>> If the VA couldn't provide timely appointments for all veterans, Congress mused, the VA could instead purchase health care the way the Pentagon does for retirees. First as the VA's undersecretary for health, and then as secretary, Shulkin has devoted most of his energies toward implementing this new contracted-care system and making it work.

>>>

>>> All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization->

is-a-very-real-issue-right-now-american-legion-says/> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html>> Concerned Veterans for America<<https://cv4a.org/>> and many of Trump’s allies in Congress, who would like to<<https://cv4a.org/project/taskforce/>> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html>> with congressional leaders in the House and Senate.

>>>

>>> Shulkin’s second battle—political infighting with more partisan members of the administration—inflames and complicates these policy disagreements. He is the sole survivor of the Obama administration among Cabinet officials serving Trump. A practicing physician and successful health executive, Shulkin came to the Obama administration to run the VA health care system after the 2014 Phoenix scandal. His selection came after a turbulent Trump transition, during which the president interviewed several potential candidates before settling on Shulkin. Trump reportedly gave Shulkin the job because the New Jersey physician persuaded him he could continue the slow, deliberate privatization<<https://hbr.org/2016/12/a-transformation-is-underway-at-u-s-veterans-affairs-we-got-an-inside-look%20The%20case%20study%20conducted%20by%20Harvard%20Business%20School%20on%20the%20transformation%20underway%20at%20VA>> of the VA and deliver other wins to Trump on issues like employee accountability<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> (read: easier firing of civil servants).

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>>> Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask Congress<https://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf> for more money<<http://www.modernhealthcare.com/article/20170927/NEWS/170929901>> to fund<<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/>> the popular program<<https://www.stripes.com/news/congress-approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>>. Shulkin made a difficult decision<<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/>> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>>). And, Shulkin has presided over the termination<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/>> problems at the VA’s Washington hospital and proposing to kill the VA’s support<<https://www.politico.com/story/2017/12/06/homeless-veterans-benefits-trump-207781>> for homeless veterans, before walking back that idea in the face of public outcry.

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>>> Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>> and Trump campaign operative Cam Sandoval, began working late last year<<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html>> to engineer Shulkin’s exit<https://www.washingtonpost.com/amhtml/world/national-security/white-house-targets-vas-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html>. According to the Washington Post<https://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376>, these nominees have actively sought to sabotage Shulkin’s tenure, going so far as to call congressional leaders and lobby them to push for Shulkin’s ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more

and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

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>>> It is against this backdrop that Shulkin must wage his third and most personal battle: a fight over two internal ethics investigations by the VA's inspector general. The first investigation was triggered by Washington Post reporting<https://www.washingtonpost.com/investigations/va-chief-took-in-wimbledon-river-cruise-on-european-work-trip/2017/09/29/c1f17046-a458-11e7-8c37-e1d99ad6aa22_story.html> about Shulkin's trip to meet with veterans officials in Europe—a trip that included a detour to Wimbledon, and a few days of vacation too. The VA's inspector general scorched Shulkin<https://www.washingtonpost.com/politics/veterans-affairs-chief-shulkin-staff-misled-ethics-officials-about-european-trip-report-finds/2018/02/14/f7fbc020-0c3a-11e8-8b0d-891602206fb7_story.html> in its report on this trip, finding that permission to bring his wife had been predicated on a falsified email from Shulkin's chief of staff and that Shulkin had impermissibly ordered his staff into travel concierge duty. Shulkin pushed back, retaining counsel to dissect the IG report, and he even suggested<<http://thehill.com/policy/defense/374009-va-secretary-says-he-wont-resign-doubles-down-on-allegations-aides-email-was>> that his chief of staff's email had been hacked. (It was not<<http://thehill.com/policy/defense/376045-watchdog-former-top-va-aides-email-was-not-hacked>>.) A day later, however, Shulkin's chief of staff announced<<https://www.militarytimes.com/veterans/2018/02/16/va-chief-of-staff-resigns-amid-secretarys-travel-scandal/>> her retirement, and Shulkin said<https://www.washingtonpost.com/world/national-security/va-secretary-shulkin-under-fire-for-europe-trip-to-appear-before-house-panel/2018/02/14/0c65702e-11c2-11e8-8ea1-c1d91fcec3fe_story.html?utm_term=.aa7311c9a3f1> he would repay the government for the cost of his wife's airfare.

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>>> At this point, Shulkin's fate rests with Trump. Although Trump has largely benefited from Shulkin's service, the president must now decide whether he's better off with a competent leader like Shulkin, or a closer political ally who might march more in step with the base. The potential contenders include Energy Secretary Rick Perry (who said Wednesday<<http://abcnews.go.com/Politics/wireStory/latest-rick-perry-va-job-53748413>> he doesn't want the job), one of the 88 retired generals who endorsed<<https://www.politico.com/story/2016/09/retired-generals-admirals-endorse-trump-227755>> Trump in 2016, or veterans in Congress like Sens. Joni Ernst or Tom Cotton, whose chances are lower because of their importance to the Republicans' razor-thin Senate majority. Whether Shulkin stays or goes, the primary battle he waged, over the future of the VA, will continue. Trump is arguably better off keeping Shulkin around to keep waging this battle, and veterans are arguably better off with that outcome too.

>>>

>>>

>>> (b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\)\(6\)](https://www.cnas.org/people/(b)(6))> and adjunct professor of law at Georgetown University. The views expressed

are the author's alone and not representative of his organization.

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From: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) <(b) (6)@cnas.org>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Lunch next Tues 3/20
Date: Fri Mar 16 2018 06:11:42 CDT
Attachments:

Great- 1245 pm ok?

Sent with Good (www.good.com)

From: (b) (6)
Sent: Friday, March 16, 2018 4:07:29 AM
To: DJS
Subject: Re: [EXTERNAL] Lunch next Tues 3/20

Sounds like G Street Cafe on 15th just north of K. Perfect. I will meet you whenever works best for you.

Sent from my iPhone

> On Mar 15, 2018, at 19:59, DJS <vacodjs1@va.gov> wrote:

>

> No it was a place then on 15 th that was across from bipop rice bar and had counter service

>

>

>

> Sent with Good (www.good.com)

>

>

> From: (b) (6)
> Sent: Thursday, March 15, 2018 3:45:23 PM
> To: DJS
> Subject: [EXTERNAL] Lunch next Tues 3/20

>

> Lunch Tuesday, 3/20, sounds great. I think PJ Clarke's is the restaurant you're thinking of, but Mirabella or McCormicks or BLT also work well — whatever you prefer.

>

> Sent from my iPhone

>

>> On Mar 15, 2018, at 17:21, DJS <vacodjs1@va.gov> wrote:

>>

>> How is next Tuesday at that place I saw you last time - forget the name but it was on 16th near K?

>>

>>

>>

>> Sent with Good (www.good.com<http://www.good.com>)
>>
>>
>> From: (b) (6)
>> Sent: Thursday, March 15, 2018 2:01:21 PM
>> To: DJS
>> Subject: Re: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea
>>
>> Yes - would be happy to do so. Please let me know when your schedule allows.
>>
>> On 3/15/18, 3:28 PM, "DJS" <vacodjs1@va.gov> wrote:
>>
>> Thanks so much (b) (6)
>>
>> DC is truly crazy- so I appreciate your rational approach to things
>>
>> How about catching up for lunch sometime soon?
>>
>>
>> Sent with Good (www.good.com<http://www.good.com<http://www.good.com<http://www.good.com>>))
>>
>>
>> From: (b) (6)
>> Sent: Thursday, March 15, 2018 11:58:56 AM
>> To: DJS
>> Subject: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea
>>
>> Thought I would share this column from today. Hope you're doing as well as possible under the circumstances. Hang in there. v/r (b) (6)
>>
>> https://slate.com/news-and-politics/2018/03/firing-veterans-affairs-secretary-david-shulkin-is-a-bad-idea.html?wpsrc=sh_all_dt_tw_ru
>>
>> Firing VA Secretary David Shulkin Is a Bad Idea
>> He's accomplishing a lot of good for America's veterans—and for Trump.
>>
>> By (b) (6)
>>
>> Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>>, "We'll never have to use those words ['You're fired'] on our David."
>>
>> Eight months later, that declaration may prove ironic. Fissures have emerged and deepened between Shulkin and the president's political allies over what, exactly, the VA should be doing. On top of this, two relatively minor scandals involving Shulkin have blown up his tenure and stalled major reform. Now, Shulkin faces conflict on three overlapping fronts, leaving him at the precipice of being fired and replaced by a closer Trump ally as the administration seeks to reduce the chaos<<https://www.cnn.com/2018/03/13/politics/trump-departures-white-house/index.html>> in its Cabinet.
>>
>> The first battle Shulkin is fighting has deep roots<<https://www.foreignaffairs.com/articles/2017-08-15/what-america-owes-its-veterans>> in veterans population demographics<https://www.rand.org/pubs/research_reports/RR1165z4.html> and the evolution of VA benefits over the past several

decades. From the time they join up to their moment of discharge, service members<<https://www.rand.org/pubs/monographs/MG265.html>> belong to the Department of Defense. After that, they become eligible for a broad array of veterans programs that are administered by the VA's three large administrations: health, benefits, and cemeteries. These programs have evolved<<https://www.rand.org/pubs/monographs/MG1164.html>> from stingy pensions for seriously disabled veterans after the Revolution to the generous, comprehensive system of health care, disability compensation, and economic programs that exists today. All eligible veterans—meaning primarily those who serve on active duty and leave with an honorable discharge<<https://www.swords-to-plowshares.org/2016/03/30/underserved/>>—can avail themselves of these benefits, not just combat veterans or those who were wounded in the line of duty.

>>

>> To meet these obligations, the VA consumes a massive amount of money each year. Its 2019 budget request is \$198.6 billion<<https://www.va.gov/budget/products.asp>>—a big increase over previous years at a time when most agencies are facing cuts and totaling more than the budgets of the State Department<<https://www.state.gov/s/d/rm/c6112.htm>>, Homeland Security<<https://www.dhs.gov/dhs-budget>>, and the entire<<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program>> intelligence<<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/>> community<<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-militar/>> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

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>> Since 9/11, the VA's budget has steadily increased<<https://www.cnas.org/publications/reports/passing-the-baton-a-bipartisan-2016-agenda-for-the-veteran-and-military-community>> at a rate far greater than inflation, even as the total population of veterans has decreased. Older veterans of the Vietnam and Cold War eras rely heavily on VA services. So too does the post-9/11 generation<<https://www.publichealth.va.gov/epidemiology/reports/oefoifond/>>, of whom more than 3 million have deployed to Iraq, Afghanistan, or other theaters of war. These retired service members are using the VA at much higher rates than previous generations. This demand from young and old veterans alike is putting enormous pressure on the VA—which failed to adequately predict any of this increased demand, let alone prepare and budget<<https://www.bostonglobe.com/opinion/2016/10/17/the-trillion-wars/uPVfSuDutnTZl5flQ7YllK/story.html>> for it.

>>

>> In 2014, this problem erupted in Phoenix, where veterans endlessly waited for appointments while VA employees played a shell game with veterans to deceive them and their bosses in Washington. That scandal forced the ouster<http://www.slate.com/articles/news_and_politics/politics/2014/05/shinseki_resigns_here_s_how_to_fix_the_va.html> of VA Secretary (and retired Army Gen.) Eric Shinseki and prompted the creation of a program to purchase VA care from the private sector.

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>> If the VA couldn't provide timely appointments for all veterans, Congress mused, the VA could instead purchase health care the way the Pentagon does for retirees. First as the VA's undersecretary for health, and then as secretary, Shulkin has devoted most of his energies toward implementing this new contracted-care system and making it work.

>>

>> All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization-is-a-very-real-issue-right-now-american-legion-says/>> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html>> Concerned Veterans for America<<https://cv4a.org/>> and many of Trump's allies in Congress, who would like to<<https://cv4a.org/project/taskforce/>> focus the VA on service-related care like mental health and

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Cc:
Bcc:
Subject: Re: [EXTERNAL] Lunch next Tues 3/20
Date: Fri Mar 16 2018 06:07:29 CDT
Attachments:

Sounds like G Street Cafe on 15th just north of K. Perfect. I will meet you whenever works best for you.

Sent from my iPhone

> On Mar 15, 2018, at 19:59, DJS <vacodjs1@va.gov> wrote:

>
> No it was a place then on 15 th that was across from bipop rice bar and had counter service
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> Sent with Good (www.good.com)

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>> DC is truly crazy- so I appreciate your rational approach to things

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>>
>> Firing VA Secretary David Shulkin Is a Bad Idea
>> He's accomplishing a lot of good for America's veterans—and for Trump.
>>
>> By (b) (6)
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>> Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>>, "We'll never have to use those words ['You're fired'] on our David."
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>> Eight months later, that declaration may prove ironic. Fissures have emerged and deepened between Shulkin and the president's political allies over what, exactly, the VA should be doing. On top of this, two relatively minor scandals involving Shulkin have blown up his tenure and stalled major reform. Now, Shulkin faces conflict on three overlapping fronts, leaving him at the precipice of being fired and replaced by a closer Trump ally as the administration seeks to reduce the chaos<<https://www.cnn.com/2018/03/13/politics/trump-departures-white-house/index.html>> in its Cabinet.
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>> The first battle Shulkin is fighting has deep roots<<https://www.foreignaffairs.com/articles/2017-08-15/what-america-owes-its-veterans>> in veterans population demographics<https://www.rand.org/pubs/research_reports/RR1165z4.html> and the evolution of VA benefits over the past several decades. From the time they join up to their moment of discharge, service members<<https://www.rand.org/pubs/monographs/MG265.html>> belong to the Department of Defense. After that, they become eligible for a broad array of veterans programs that are administered by the VA's three large administrations: health, benefits, and cemeteries. These programs have evolved<<https://www.rand.org/pubs/monographs/MG1164.html>> from stingy pensions for seriously disabled veterans after the Revolution to the generous, comprehensive system of health care, disability compensation, and economic programs that exists today. All eligible veterans—meaning primarily those who serve on active duty and leave with an honorable discharge<<https://www.swords-to-plowshares.org/2016/03/30/underserved/>>—can avail themselves of these benefits, not just combat veterans or those who were wounded in the line of duty.
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>> To meet these obligations, the VA consumes a massive amount of money each year. Its 2019 budget request is \$198.6 billion<<https://www.va.gov/budget/products.asp>>—a big increase over previous years at a time when most agencies are facing cuts and totaling more than the budgets of the State Department<<https://www.state.gov/s/d/rm/c6112.htm>>, Homeland Security<<https://www.dhs.gov>>.

gov/dhs-budget>, and the entire<<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program>> intelligence<<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/>> community<<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-militar/>> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

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>> Since 9/11, the VA's budget has steadily increased<<https://www.cnas.org/publications/reports/passing-the-baton-a-bipartisan-2016-agenda-for-the-veteran-and-military-community>> at a rate far greater than inflation, even as the total population of veterans has decreased. Older veterans of the Vietnam and Cold War eras rely heavily on VA services. So too does the post-9/11 generation<<https://www.publichealth.va.gov/epidemiology/reports/oefoifond/>>, of whom more than 3 million have deployed to Iraq, Afghanistan, or other theaters of war. These retired service members are using the VA at much higher rates than previous generations. This demand from young and old veterans alike is putting enormous pressure on the VA—which failed to adequately predict any of this increased demand, let alone prepare and budget<<https://www.bostonglobe.com/opinion/2016/10/17/the-trillion-wars/uPVfSuDutnTZl5fIQ7YlIK/story.html>> for it.

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>> If the VA couldn't provide timely appointments for all veterans, Congress mused, the VA could instead purchase health care the way the Pentagon does for retirees. First as the VA's undersecretary for health, and then as secretary, Shulkin has devoted most of his energies toward implementing this new contracted-care system and making it work.

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>> All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization-is-a-very-real-issue-right-now-american-legion-says/>> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html>> Concerned Veterans for America<<https://cv4a.org/>> and many of Trump's allies in Congress, who would like to<<https://cv4a.org/project/taskforce/>> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html>> with congressional leaders in the House and Senate.

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>> Shulkin's second battle—political infighting with more partisan members of the administration—inflames and complicates these policy disagreements. He is the sole survivor of the Obama administration among Cabinet officials serving Trump. A practicing physician and successful health executive, Shulkin came to the Obama administration to run the VA health care system after the 2014 Phoenix scandal. His selection came after a turbulent Trump transition, during which the president interviewed several potential candidates before settling on Shulkin. Trump reportedly gave Shulkin the job because the New Jersey physician persuaded him he could continue the slow, deliberate privatization<<https://hbr.org/2016/12/a-transformation-is-underway-at-u-s-veterans-affairs-we-got-an-inside-look%20The%20case%20study%20conducted%20by%20Harvard%20Business%20School%20on%20the%20transformation%20underway%20at%20VA>> of the VA and deliver other wins to Trump on issues like employee accountability<https://www.va.gov/accountability/Adverse_Actions_Report.pdf>

(read: easier firing of civil servants).

>>

>> Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask Congresshttps://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf for more money<http://www.modernhealthcare.com/article/20170927/NEWS/170929901> to fund<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/> the popular program<https://www.stripes.com/news/congress/approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>. Shulkin made a difficult decision<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>). And, Shulkin has presided over the terminationhttps://www.va.gov/accountability/Adverse_Actions_Report.pdf of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/> problems at the VA's Washington hospital and proposing to kill the VA's support<https://www.politico.com/story/2017/12/06/homeless-veterans-benefits-trump-207781> for homeless veterans, before walking back that idea in the face of public outcry.

>>

>> Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html> and Trump campaign operative Cam Sandoval, began working late last year<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html> to engineer Shulkin's exithttps://www.washingtonpost.com/amhtml/world/national-security/white-house-targets-vas-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html. According to the Washington Posthttps://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376, these nominees have actively sought to sabotage Shulkin's tenure, going so far as to call congressional leaders and lobby them to push for Shulkin's ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

>>

>> It is against this backdrop that Shulkin must wage his third and most personal battle: a fight over two internal ethics investigations by the VA's inspector general. The first investigation was triggered by Washington Post reportinghttps://www.washingtonpost.com/investigations/va-chief-took-in-wimbledon-river-cruise-on-european-work-trip/2017/09/29/c1f17046-a458-11e7-8c37-e1d99ad6aa22_story.html about Shulkin's trip to meet with veterans officials in Europe—a trip that included a detour to Wimbledon, and a few days of vacation too. The VA's inspector general scorched Shulkinhttps://www.washingtonpost.com/politics/veterans-affairs-chief-shulkin-staff-misled-ethics-officials-about-european-trip-report-finds/2018/02/14/f7fbc020-0c3a-11e8-8b0d-891602206fb7_story.html in its report on this trip, finding that permission to bring his wife had been predicated on a falsified email from Shulkin's chief of staff and that Shulkin had impermissibly ordered his staff into travel concierge duty. Shulkin pushed back, retaining counsel to dissect the IG report, and he even suggested<http://thehill.com/policy/defense/374009-va-secretary-says-he-wont-resign-doubles-down-on-allegations-aides-email-was> that his chief of staff's email had been hacked. (It was not<http://thehill.com/policy/defense/376045-watchdog-former-top-va-aides-email-was-not-hacked>.) A day later, however, Shulkin's chief of staff announced<https://www.militarytimes.com/veterans/2018/02/16/va-chief-of-staff-resigns-amid-secretarys-travel-scandal/> her retirement, and Shulkin said<https://www.washingtonpost.com/world/national-security/va-secretary-shulkin-under-fire-for-europe-trip-to-appear>

before-house-panel/2018/02/14/0c65702e-11c2-11e8-8ea1-c1d91fcec3fe_story.html?utm_term=.aa7311c9a3f1> he would repay the government for the cost of his wife's airfare.

>>

>> A second investigation, regarding Shulkin's use of his protective security detail, is reportedly percolating<<http://thehill.com/homenews/administration/376568-va-watchdog-preparing-report-on-shulkin-misuse-of-security-detail>> in the VA inspector general's office now. That assessment will reportedly criticize Shulkin for inappropriate use of his security detail for personal errands. On its face, the allegations aren't that damning; they show Shulkin to be an inexperienced government executive who's used to different rules in the private sector and also indicate his naïveté about how certain things will play on the proverbial front page of the Washington Post. But these errors come at a time when the Trump administration can ill afford another ethics scandal after similar abuses at HUD<https://www.washingtonpost.com/politics/using-his-position-for-private-gain-hud-lawyers-warned-ben-carson-risked-running-afoul-of-ethics-rules-by-enlisting-son/2018/01/31/bb20c48e-0532-11e8-8777-2a059f168dd2_story.html>, Interior<<http://thehill.com/homenews/administration/377497-interior-dept-spent-139k-on-construction-project-labeled-secretarys>>, and HHS<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>>, with the latter resulting in Secretary Tom Price's resignation. A Cabinet secretary aligned more closely with the White House than Shulkin, or with more political allies across the administration, could probably survive these investigations with barely a flesh wound. For Shulkin's tenure at VA, they may end up being fatal, to the extent they provide a pretext for the White House to replace Shulkin with a more trusted partisan.

>>

>> At this point, Shulkin's fate rests with Trump. Although Trump has largely benefited from Shulkin's service, the president must now decide whether he's better off with a competent leader like Shulkin, or a closer political ally who might march more in step with the base. The potential contenders include Energy Secretary Rick Perry (who said Wednesday<<http://abcnews.go.com/Politics/wireStory/latest-rick-perry-va-job-53748413>> he doesn't want the job), one of the 88 retired generals who endorsed<<https://www.politico.com/story/2016/09/retired-generals-admirals-endorse-trump-227755>> Trump in 2016, or veterans in Congress like Sens. Joni Ernst or Tom Cotton, whose chances are lower because of their importance to the Republicans' razor-thin Senate majority. Whether Shulkin stays or goes, the primary battle he waged, over the future of the VA, will continue. Trump is arguably better off keeping Shulkin around to keep waging this battle, and veterans are arguably better off with that outcome too.

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>> (b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\) \(6\)](https://www.cnas.org/people/(b) (6))> and adjunct professor of law at Georgetown University. The views expressed are the author's alone and not representative of his organization.

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Congresshttps://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf for more money<http://www.modernhealthcare.com/article/20170927/NEWS/170929901> to fund<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/> the popular program<https://www.stripes.com/news/congress/approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>. Shulkin made a difficult decision<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>). And, Shulkin has presided over the terminationhttps://www.va.gov/accountability/Adverse_Actions_Report.pdf of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/> problems at the VA's Washington hospital and proposing to kill the VA's support<https://www.politico.com/story/2017/12/06/homeless-veterans-benefits-trump-207781> for homeless veterans, before walking back that idea in the face of public outcry.

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> Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html> and Trump campaign operative Cam Sandoval, began working late last year<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html> to engineer Shulkin's exithttps://www.washingtonpost.com/amhtml/world/national-security/white-house-targets-vas-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html. According to the Washington Posthttps://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376, these nominees have actively sought to sabotage Shulkin's tenure, going so far as to call congressional leaders and lobby them to push for Shulkin's ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

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> It is against this backdrop that Shulkin must wage his third and most personal battle: a fight over two internal ethics investigations by the VA's inspector general. The first investigation was triggered by Washington Post reportinghttps://www.washingtonpost.com/investigations/va-chief-took-in-wimbledon-river-cruise-on-european-work-trip/2017/09/29/c1f17046-a458-11e7-8c37-e1d99ad6aa22_story.html about Shulkin's trip to meet with veterans officials in Europe—a trip that included a detour to Wimbledon, and a few days of vacation too. The VA's inspector general scorched Shulkinhttps://www.washingtonpost.com/politics/veterans-affairs-chief-shulkin-staff-misled-ethics-officials-about-european-trip-report-finds/2018/02/14/f7fbc020-0c3a-11e8-8b0d-891602206fb7_story.html in its report on this trip, finding that permission to bring his wife had been predicated on a falsified email from Shulkin's chief of staff and that Shulkin had impermissibly ordered his staff into travel concierge duty. Shulkin pushed back, retaining counsel to dissect the IG report, and he even suggested<http://thehill.com/policy/defense/374009-va-secretary-says-he-wont-resign-doubles-down-on-allegations-aides-email-was> that his chief of staff's email had been hacked. (It was not<http://thehill.com/policy/defense/376045-watchdog-former-top-va-aides-email-was-not-hacked>.) A day later, however, Shulkin's chief of staff announced<https://www.militarytimes.com/veterans/2018/02/16/va-chief-of-staff-resigns-amid-secretarys-travel-scandal/> her retirement, and Shulkin saidhttps://www.washingtonpost.com/world/national-security/va-secretary-shulkin-under-fire-for-europe-trip-to-appear-before-house-panel/2018/02/14/0c65702e-11c2-11e8-8ea1-c1d91fcec3fe_story.html?utm_term=.aa7311c9a3f1 he would repay the government for the cost of his wife's airfare.

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> At this point, Shulkin's fate rests with Trump. Although Trump has largely benefited from Shulkin's service, the president must now decide whether he's better off with a competent leader like Shulkin, or a closer political ally who might march more in step with the base. The potential contenders include Energy Secretary Rick Perry (who said Wednesday<<http://abcnews.go.com/Politics/wireStory/latest-rick-perry-va-job-53748413>> he doesn't want the job), one of the 88 retired generals who endorsed<<https://www.politico.com/story/2016/09/retired-generals-admirals-endorse-trump-227755>> Trump in 2016, or veterans in Congress like Sens. Joni Ernst or Tom Cotton, whose chances are lower because of their importance to the Republicans' razor-thin Senate majority. Whether Shulkin stays or goes, the primary battle he waged, over the future of the VA, will continue. Trump is arguably better off keeping Shulkin around to keep waging this battle, and veterans are arguably better off with that outcome too.

>

>

> (b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\)\(6\)](https://www.cnas.org/people/(b)(6))> and adjunct professor of law at Georgetown University. The views expressed are the author's alone and not representative of his organization.

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From: (b) (6) <(b) (6)@cnas.org>
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdl)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: [EXTERNAL] Lunch next Tues 3/20
Date: Thu Mar 15 2018 17:45:23 CDT
Attachments:

Lunch Tuesday, 3/20, sounds great. I think PJ Clarke's is the restaurant you're thinking of, but Mirabella or McCormicks or BLT also work well — whatever you prefer.

Sent from my iPhone

> On Mar 15, 2018, at 17:21, DJS <vacodjs1@va.gov> wrote:

>

> How is next Tuesday at that place I saw you last time - forget the name but it was on 16th near K?

>

>

>

> Sent with Good (www.good.com)

>

>

> From: (b) (6)

> Sent: Thursday, March 15, 2018 2:01:21 PM

> To: DJS

> Subject: Re: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea

>

> Yes - would be happy to do so. Please let me know when your schedule allows.

>

> On 3/15/18, 3:28 PM, "DJS" <vacodjs1@va.gov> wrote:

>

> Thanks so much (b) (6)

>

> DC is truly crazy- so I appreciate your rational approach to things

>

> How about catching up for lunch sometime soon?

>

>

>

> Sent with Good (www.good.com<http://www.good.com>)

>

>

> From: (b) (6)

> Sent: Thursday, March 15, 2018 11:58:56 AM

> To: DJS

> Subject: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea

>

> Thought I would share this column from today. Hope you're doing as well as possible under the circumstances. Hang in there. v/r (b) (6)

>

> https://slate.com/news-and-politics/2018/03/firing-veterans-affairs-secretary-david-shulkin-is-a-bad-idea.html?wpsrc=sh_all_dt_tw_ru

>

> Firing VA Secretary David Shulkin Is a Bad Idea

> He's accomplishing a lot of good for America's veterans—and for Trump.

>

> By (b) (6)

>

> Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>>, "We'll never have to use those words ['You're fired'] on our David."

>

> Eight months later, that declaration may prove ironic. Fissures have emerged and deepened between Shulkin and the president's political allies over what, exactly, the VA should be doing. On top of this, two relatively minor scandals involving Shulkin have blown up his tenure and stalled major reform. Now, Shulkin faces conflict on three overlapping fronts, leaving him at the precipice of being fired and replaced by a closer Trump ally as the administration seeks to reduce the chaos<<https://www.cnn.com/2018/03/13/politics/trump-departures-white-house/index.html>> in its Cabinet.

>

> The first battle Shulkin is fighting has deep roots<<https://www.foreignaffairs.com/articles/2017-08-15/what-america-owes-its-veterans>> in veterans population demographics<https://www.rand.org/pubs/research_reports/RR1165z4.html> and the evolution of VA benefits over the past several decades. From the time they join up to their moment of discharge, service members<<https://www.rand.org/pubs/monographs/MG265.html>> belong to the Department of Defense. After that, they become eligible for a broad array of veterans programs that are administered by the VA's three large administrations: health, benefits, and cemeteries. These programs have evolved<<https://www.rand.org/pubs/monographs/MG1164.html>> from stingy pensions for seriously disabled veterans after the Revolution to the generous, comprehensive system of health care, disability compensation, and economic programs that exists today. All eligible veterans—meaning primarily those who serve on active duty and leave with an honorable discharge<<https://www.swords-to-plowshares.org/2016/03/30/underserved/>>—can avail themselves of these benefits, not just combat veterans or those who were wounded in the line of duty.

>

> To meet these obligations, the VA consumes a massive amount of money each year. Its 2019 budget request is \$198.6 billion<<https://www.va.gov/budget/products.asp>>—a big increase over previous years at a time when most agencies are facing cuts and totaling more than the budgets of the State Department<<https://www.state.gov/s/d/rm/c6112.htm>>, Homeland Security<<https://www.dhs.gov/dhs-budget>>, and the entire<<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program>> intelligence<<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/>> community<<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-militar/>> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

>

> Since 9/11, the VA's budget has steadily increased<<https://www.cnas.org/publications/reports/passing-the-baton-a-bipartisan-2016-agenda-for-the-veteran-and-military-community>> at a rate far greater than inflation, even as the total population of veterans has decreased. Older veterans of the Vietnam and Cold War eras rely heavily on VA services. So too does the post-9/11 generation<<https://www.publichealth.va.gov/epidemiology/reports/oeofond/>>, of whom more than 3 million have deployed to Iraq, Afghanistan, or other theaters of war. These retired service members are using the VA at much higher rates than previous generations. This demand from young and old veterans alike is putting enormous pressure on the VA—which failed to adequately predict any of this increased demand, let alone prepare and budget<<https://www.bostonglobe.com/opinion/2016/10/17/the-trillion-wars/uPvfSuDutnTZl5flQ7YlIK/story.html>> for it.

>

> In 2014, this problem erupted in Phoenix, where veterans endlessly waited for appointments while VA employees played a shell game with veterans to deceive them and their bosses in Washington. That scandal forced the ouster<http://www.slate.com/articles/news_and_politics/politics/2014/05/shinseki_resigns_here_s_how_to_fix_the_va.html> of VA Secretary (and retired Army Gen.) Eric Shinseki and prompted the creation of a program to purchase VA care from the private sector.

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> If the VA couldn't provide timely appointments for all veterans, Congress mused, the VA could instead purchase health care the way the Pentagon does for retirees. First as the VA's undersecretary for health, and then as secretary, Shulkin has devoted most of his energies toward implementing this new contracted-care system and making it work.

>

> All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization-is-a-very-real-issue-right-now-american-legion-says/>> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html>> Concerned Veterans for America<<https://cv4a.org/>> and many of Trump's allies in Congress, who would like to<<https://cv4a.org/project/taskforce/>> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html>> with congressional leaders in the House and Senate.

>

> Shulkin's second battle—political infighting with more partisan members of the administration—inflames and complicates these policy disagreements. He is the sole survivor of the Obama administration among Cabinet officials serving Trump. A practicing physician and successful health executive, Shulkin came to the Obama administration to run the VA health care system after the 2014 Phoenix scandal. His selection came after a turbulent Trump transition, during which the president interviewed several potential candidates before settling on Shulkin. Trump reportedly gave Shulkin the job because the New Jersey physician persuaded him he could continue the slow, deliberate privatization<<https://hbr.org/2016/12/a-transformation-is-underway-at-u-s-veterans-affairs-we-got-an-inside-look%20The%20case%20study%20conducted%20by%20Harvard%20Business%20School%20on%20the%20transformation%20underway%20at%20VA>> of the VA and deliver other wins to Trump on issues like employee accountability<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> (read: easier firing of civil servants).

>

> Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask Congress<https://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf> for more money<<http://www.modernhealthcare.com/article/20170927/NEWS/170929901>> to fund<<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/>> the popular program<<https://www.stripes.com/news/congress-approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>>. Shulkin made a difficult decision<<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/>> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>>). And, Shulkin has presided over the termination<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/>> problems at the VA's Washington hospital and proposing to kill the VA's support<<https://www.politico.com>>.

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From: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) <(b) (6)@cnas.org>
Cc:
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Subject: RE: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea
Date: Thu Mar 15 2018 16:21:16 CDT
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Firing VA Secretary David Shulkin Is a Bad Idea
He's accomplishing a lot of good for America's veterans—and for Trump.

Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>>, "We'll never have to use those words ['You're fired'] on our David."

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To meet these obligations, the VA consumes a massive amount of money each year. Its 2019 budget request is \$198.6 billion<<https://www.va.gov/budget/products.asp>>—a big increase over previous years at a time when most agencies are facing cuts and totaling more than the budgets of the State Department<<https://www.state.gov/s/d/rm/c6112.htm>>, Homeland Security<<https://www.dhs.gov/dhs-budget>>, and the entire<<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program>> intelligence<<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/>> community<<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-military/>> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

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In 2014, this problem erupted in Phoenix, where veterans endlessly waited for appointments while VA employees played a shell game with veterans to deceive them and their bosses in Washington. That scandal forced the ouster<http://www.slate.com/articles/news_and_politics/politics/2014/05/shinseki_resigns_here_s_how_to_fix_the_va.html> of

VA Secretary (and retired Army Gen.) Eric Shinseki and prompted the creation of a program to purchase VA care from the private sector.

If the VA couldn't provide timely appointments for all veterans, Congress mused, the VA could instead purchase health care the way the Pentagon does for retirees. First as the VA's undersecretary for health, and then as secretary, Shulkin has devoted most of his energies toward implementing this new contracted-care system and making it work.

All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization-is-a-very-real-issue-right-now-american-legion-says/> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html> Concerned Veterans for America<https://cv4a.org/> and many of Trump's allies in Congress, who would like to<https://cv4a.org/project/taskforce/> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html> with congressional leaders in the House and Senate.

Shulkin's second battle—political infighting with more partisan members of the administration—inflames and complicates these policy disagreements. He is the sole survivor of the Obama administration among Cabinet officials serving Trump. A practicing physician and successful health executive, Shulkin came to the Obama administration to run the VA health care system after the 2014 Phoenix scandal. His selection came after a turbulent Trump transition, during which the president interviewed several potential candidates before settling on Shulkin. Trump reportedly gave Shulkin the job because the New Jersey physician persuaded him he could continue the slow, deliberate privatization<https://hbr.org/2016/12/a-transformation-is-underway-at-u-s-veterans-affairs-we-got-an-inside-look%20The%20case%20study%20conducted%20by%20Harvard%20Business%20School%20on%20the%20transformation%20underway%20at%20VA> of the VA and deliver other wins to Trump on issues like employee accountabilityhttps://www.va.gov/accountability/Adverse_Actions_Report.pdf (read: easier firing of civil servants).

Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask Congresshttps://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf for more money<http://www.modernhealthcare.com/article/20170927/NEWS/170929901> to fund<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/> the popular program<https://www.stripes.com/news/congress-approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>. Shulkin made a difficult decision<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>). And, Shulkin has presided over the terminationhttps://www.va.gov/accountability/Adverse_Actions_Report.pdf of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/> problems at the VA's Washington hospital and proposing to kill the VA's support<https://www.politico.com/story/2017/12/06/homeless-veterans-benefits-trump-207781> for homeless veterans, before walking back that idea in the face of public outcry.

Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought

in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>> and Trump campaign operative Cam Sandoval, began working late last year<<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html>> to engineer Shulkin's exit<https://www.washingtonpost.com/amphtml/world/national-security/white-house-targets-va-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html>. According to the Washington Post<https://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376>, these nominees have actively sought to sabotage Shulkin's tenure, going so far as to call congressional leaders and lobby them to push for Shulkin's ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

It is against this backdrop that Shulkin must wage his third and most personal battle: a fight over two internal ethics investigations by the VA's inspector general. The first investigation was triggered by Washington Post reporting<https://www.washingtonpost.com/investigations/va-chief-took-in-wimbledon-river-cruise-on-european-work-trip/2017/09/29/c1f17046-a458-11e7-8c37-e1d99ad6aa22_story.html> about Shulkin's trip to meet with veterans officials in Europe—a trip that included a detour to Wimbledon, and a few days of vacation too. The VA's inspector general scorched Shulkin<https://www.washingtonpost.com/politics/veterans-affairs-chief-shulkin-staff-misled-ethics-officials-about-european-trip-report-finds/2018/02/14/f7fbc020-0c3a-11e8-8b0d-891602206fb7_story.html> in its report on this trip, finding that permission to bring his wife had been predicated on a falsified email from Shulkin's chief of staff and that Shulkin had impermissibly ordered his staff into travel concierge duty. Shulkin pushed back, retaining counsel to dissect the IG report, and he even suggested<<http://thehill.com/policy/defense/374009-va-secretary-says-he-wont-resign-doubles-down-on-allegations-aides-email-was>> that his chief of staff's email had been hacked. (It was not<<http://thehill.com/policy/defense/376045-watchdog-former-top-va-aides-email-was-not-hacked>>.) A day later, however, Shulkin's chief of staff announced<<https://www.militarytimes.com/veterans/2018/02/16/va-chief-of-staff-resigns-amid-secretarys-travel-scandal/>> her retirement, and Shulkin said<https://www.washingtonpost.com/world/national-security/va-secretary-shulkin-under-fire-for-europe-trip-to-appear-before-house-panel/2018/02/14/0c65702e-11c2-11e8-8ea1-c1d91fcec3fe_story.html?utm_term=.aa7311c9a3f1> he would repay the government for the cost of his wife's airfare.

A second investigation, regarding Shulkin's use of his protective security detail, is reportedly percolating<<http://thehill.com/homenews/administration/376568-va-watchdog-preparing-report-on-shulkin-misuse-of-security-detail>> in the VA inspector general's office now. That assessment will reportedly criticize Shulkin for inappropriate use of his security detail for personal errands. On its face, the allegations aren't that damning; they show Shulkin to be an inexperienced government executive who's used to different rules in the private sector and also indicate his naïveté about how certain things will play on the proverbial front page of the Washington Post. But these errors come at a time when the Trump administration can ill afford another ethics scandal after similar abuses at HUD<https://www.washingtonpost.com/politics/using-his-position-for-private-gain-hud-lawyers-warned-ben-carson-risked-running-afoul-of-ethics-rules-by-enlisting-son/2018/01/31/bb20c48e-0532-11e8-8777-2a059f168dd2_story.html>, Interior<<http://thehill.com/homenews/administration/377497-interior-dept-spent-139k-on-construction-project-labeled-secretarys>>, and HHS<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>>, with the latter resulting in Secretary Tom Price's resignation. A Cabinet secretary aligned more closely with the White House than Shulkin, or with more political allies across the administration, could probably survive these investigations with barely a flesh wound. For Shulkin's tenure at VA, they may end up being fatal, to the extent they provide a pretext for the White House to replace Shulkin with a more trusted partisan.

At this point, Shulkin's fate rests with Trump. Although Trump has largely benefited from Shulkin's service, the president must now decide whether he's better off with a competent leader like Shulkin, or

a closer political ally who might march more in step with the base. The potential contenders include Energy Secretary Rick Perry (who said Wednesday<<http://abcnews.go.com/Politics/wireStory/latest-rick-perry-va-job-53748413>> he doesn't want the job), one of the 88 retired generals who endorsed<<https://www.politico.com/story/2016/09/retired-generals-admirals-endorse-trump-227755>> Trump in 2016, or veterans in Congress like Sens. Joni Ernst or Tom Cotton, whose chances are lower because of their importance to the Republicans' razor-thin Senate majority. Whether Shulkin stays or goes, the primary battle he waged, over the future of the VA, will continue. Trump is arguably better off keeping Shulkin around to keep waging this battle, and veterans are arguably better off with that outcome too.

(b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\) \(6\)](https://www.cnas.org/people/(b) (6))> and adjunct professor of law at Georgetown University. The views expressed are the author's alone and not representative of his organization.

From: (b) (6) <(b) (6)@cnas.org>
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea
Date: Thu Mar 15 2018 16:01:21 CDT
Attachments:

Yes - would be happy to do so. Please let me know when your schedule allows.

On 3/15/18, 3:28 PM, "DJS" <vacodjs1@va.gov> wrote:

Thanks so much (b) (6)

DC is truly crazy- so I appreciate your rational approach to things

How about catching up for lunch sometime soon?

Sent with Good (www.good.com)

From: (b) (6)
Sent: Thursday, March 15, 2018 11:58:56 AM
To: DJS
Subject: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea

Thought I would share this column from today. Hope you're doing as well as possible under the circumstances. Hang in there. v/r (b) (6)

https://slate.com/news-and-politics/2018/03/firing-veterans-affairs-secretary-david-shulkin-is-a-bad-idea.html?wpsrc=sh_all_dt_tw_ru

Firing VA Secretary David Shulkin Is a Bad Idea
He's accomplishing a lot of good for America's veterans—and for Trump.

By (b) (6)

Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>>, "We'll never have to use those words ['You're fired'] on our David."

Eight months later, that declaration may prove ironic. Fissures have emerged and deepened between Shulkin and the president's political allies over what, exactly, the VA should be doing. On top of this, two relatively minor scandals involving Shulkin have blown up his tenure and stalled major reform. Now, Shulkin faces conflict on three overlapping fronts, leaving him at the precipice of being fired and replaced by a closer Trump ally as the administration seeks to reduce the chaos<<https://www.cnn.com/2018/03/13/politics/trump-departures-white-house/index.html>> in its Cabinet.

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Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask Congress<https://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf> for more money<<http://www.modernhealthcare.com/article/20170927/NEWS/170929901>> to fund<<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/>> the popular program<<https://www.stripes.com/news/congress-approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>>. Shulkin made a difficult decision<<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/>> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>>). And, Shulkin has presided over the termination<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/>> problems at the VA's Washington hospital and proposing to kill the VA's support<<https://www.politico.com/story/2017/12/06/homeless-veterans-benefits-trump-207781>> for homeless veterans, before walking back that idea in the face of public outcry.

Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>> and Trump campaign operative Cam Sandoval, began working late last year<<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html>> to engineer Shulkin's exit<https://www.washingtonpost.com/amhtml/world/national-security/white-house-targets-vas-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html>. According to the Washington Post<https://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376>, these nominees have actively sought to sabotage Shulkin's tenure, going so far as to call congressional leaders and lobby them to push for Shulkin's ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

It is against this backdrop that Shulkin must wage his third and most personal battle: a fight over two internal ethics investigations by the VA's inspector general. The first investigation was triggered by Washington Post reporting<https://www.washingtonpost.com/investigations/va-chief-took-in-wimbledon-river-cruise-on-european-work-trip/2017/09/29/c1f17046-a458-11e7-8c37-e1d99ad6aa22_story.html> about Shulkin's trip to meet with veterans officials in Europe—a trip that included a detour to Wimbledon, and a few days of vacation too. The VA's inspector general scorched Shulkin<https://www.washingtonpost.com/politics/veterans-affairs-chief-shulkin-staff-misled-ethics-officials-about-european-trip-report-finds/2018/02/14/f7fbc020-0c3a-11e8-8b0d-891602206fb7_story.html> in its report on this trip, finding that permission to bring his wife had been predicated on a falsified email from Shulkin's chief of staff and that Shulkin had impermissibly ordered his staff into travel concierge duty. Shulkin pushed back, retaining counsel to dissect the IG report, and he even suggested<<http://thehill.com/policy/defense/374009-va-secretary-says-he-wont-resign-doubles-down-on-allegations-aides-email-was>> that his chief of staff's email had been hacked. (It was not<<http://thehill.com/policy/defense/376045-watchdog-former-top-va-aides-email-was-not-hacked>>.) A day later, however, Shulkin's chief of staff announced<<https://www.militarytimes.com/veterans/2018/02/16/va-chief-of-staff-resigns-amid-secretarys-travel-scandal/>> her retirement, and Shulkin said<https://www.washingtonpost.com/world/national-security/va-secretary-shulkin-under-fire-for-europe-trip-to-appear-before-house-panel/2018/02/14/0c65702e-11c2-11e8-8ea1-c1d91fcec3fe_story.html?utm_term=.aa7311c9a3f1> he would repay the government for the cost of his wife's airfare.

A second investigation, regarding Shulkin's use of his protective security detail, is reportedly percolating<<http://thehill.com/homenews/administration/376568-va-watchdog-preparing-report-on-shulkin-misuse-of-security-detail>> in the VA inspector general's office now. That assessment will reportedly criticize Shulkin for inappropriate use of his security detail for personal errands. On its face, the allegations aren't that damning; they show Shulkin to be an inexperienced government executive who's used to different rules in the private sector and also indicate his naïveté about how certain things will play on the proverbial front page of the Washington Post. But these errors come at a time when the Trump administration can ill afford another ethics scandal after similar abuses at HUD<https://www.washingtonpost.com/politics/using-his-position-for-private-gain-hud-lawyers-warned-ben-carson-risked-running-afoul-of-ethics-rules-by-enlisting-son/2018/01/31/bb20c48e-0532-11e8-8777-2a059f168dd2_story.html>, Interior<<http://thehill.com/homenews/administration/377497-interior-dept-spent-139k-on-construction-project-labeled-secretarys>>, and HHS<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>>, with the latter resulting in Secretary Tom Price's resignation. A Cabinet secretary aligned more closely with the White House than Shulkin, or with more political allies across the administration, could probably survive these investigations with barely a flesh wound. For Shulkin's tenure at VA, they may end up being fatal, to the extent they provide a pretext for the White House to replace Shulkin with a more trusted partisan.

At this point, Shulkin's fate rests with Trump. Although Trump has largely benefited from Shulkin's service, the president must now decide whether he's better off with a competent leader like Shulkin, or a closer political ally who might march more in step with the base. The potential contenders include Energy Secretary Rick Perry (who said Wednesday<<http://abcnews.go.com/Politics/wireStory/latest-rick-perry-va-job-53748413>> he doesn't want the job), one of the 88 retired generals who endorsed<<https://www.politico.com/story/2016/09/retired-generals-admirals-endorse-trump-227755>> Trump in 2016, or veterans in Congress like Sens. Joni Ernst or Tom Cotton, whose chances are lower because of their importance to the Republicans' razor-thin Senate majority. Whether Shulkin stays or goes, the primary battle he waged, over the future of the VA, will continue. Trump is arguably better off keeping Shulkin around to keep waging this battle, and veterans are arguably better off with that outcome too.

(b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\) \(6\)](https://www.cnas.org/people/(b) (6))> and adjunct professor of law at Georgetown University. The views expressed are the author's alone and not representative of his organization.

From: Google Alerts
<googlealerts-noreply@google.com>
To: (b) (6) </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: [EXTERNAL] Google Alert - Shulkin
Date: Tue Mar 13 2018 07:05:45 CDT
Attachments:

Shulkin
Daily update · March 13, 2018

NEWS

David Shulkin Makes Late Play for Most Corrupt Trump Cabinet Member

Vanity Fair

Veteran's Affairs Secretary David Shulkin's tenure got off to a promising start, at least by Trump administration standards: a former hospital administrator and renowned academic, the Obama-era appointee was the only Cabinet nominee unanimously confirmed by the Senate. Yet in recent weeks, ...

Axios: Trump now sees Shulkin as a "major problem" - Hot Air

Donald Trump Should Not Be Calling Fox & Friends Hosts For Policy Advice - SPIN

Report: Trump called a Fox & Friends host with Koch links during a meeting with the VA Secretary -

Media Matters for America (blog)

Full Coverage

Flag as irrelevant

VA Leadership on Shaky Ground after Another Damaging Report

Nonprofit Quarterly

Last week was not a great week for the VA. On Wednesday, Veterans Affairs Secretary David J. Shulkin announced that VA hospitals across the country will soon be under new leadership following the release of a 142-page investigative report that sheds light on numerous of the agency's programs' ...

Flag as irrelevant

The Trump Administration's Campaign to Weaken Civil Service Ramps Up at the VA

ProPublica

Shulkin, Trump and CVA have all touted it as a major accomplishment, as have lawmakers and veterans groups. The White House referred questions to the VA, where spokesman Cashour said the law "is one of the most significant federal civil service reforms in decades and is helping instill across the ...

Trump's VA Is Purging Civil Servants - POLITICO Magazine

Full Coverage

Flag as irrelevant

Dayton VA names new leader: What we know

Dayton Daily News

Two days before the announcement of Dietrich's appointment, U.S. Department of Veterans Affairs Secretary David Shulkin announced sweeping plans to reorganize the VA starting with the national headquarters and the consolidation of oversight of 23 hospitals. USA Today reported that if Shulkin ...

Flag as irrelevant

The problems with Trump's scandal-ridden Cabinet start right at the top
mySanAntonio.com

Veterans Affairs Secretary David Shulkin, whose chief of staff resigned after the department inspector general found she falsified an email to justify sending Shulkin's wife on a trip to Denmark and Britain at department expense, a trip on which Shulkin was also faulted for accepting free Wimbledon tickets.

Flag as irrelevant

Larry Kudlow and the Trump-TV feedback loop
GANT News

With the current secretary, David Shulkin, under increasing scrutiny, Trump "surprised Shulkin by dialing in" Hegseth on speaker phone during a meeting earlier this month. "Trump talks to Hegseth regularly and enjoys watching him on 'Fox and Friends,'" Axios reported. To date, only one prominent Fox ...

Flag as irrelevant

Wave Of Firings At VA Targets Working Staff, Not Top Officials
The National Memo (blog)

Shulkin advocated for the measure, called the VA Accountability and Whistleblower Protection Act, by highlighting a case in which the agency had to wait 30 days to fire a worker caught watching porn with a patient. "I do not see this as a tool that's going to lead to mass firings," Shulkin said last June.

Flag as irrelevant

The American Legion Lobbies For Medical Marijuana
Weed News (blog)

So far Shulkin has been unwilling to commit the V.A. to studying medical cannabis. In a December 2017 letter to U.S. Representative Tim Walz, Shulkin stated the "VA is committed to researching and developing effective ways to help Veterans cope with post-traumatic stress disorder and chronic pain ...

Flag as irrelevant

Only Congress can end horror stories at the VA
The Hill

Now that the horrifying details of yet another scathing report from the U.S. Department of Veterans Affairs (VA) Inspector General (IG) are out, Congress must pass bold and meaningful legislation that will transform the way we deliver care to veterans. If Congress does not respond to this latest crisis with ...

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(b) (6) <(b) (6)@aol.com>; (b) (6) <(b) (6)@vva.org>;
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</o=va/ou=first administrative group/cn=recipients/cn=(b) (6)@vva.org
<(b) (6)@vva.org>; Thomas Bowman <(b) (6)@yahoo.com>;
Shulkin, David J., MD </o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Bcc:
Subject: [EXTERNAL] Re: Leadership Crisis in the Veterans Administration
Date: Sat Mar 10 2018 17:44:24 CST
Attachments:

Dan,

We're all glad you survived the Veterans Administration Healthcare!

We agree!!

Some equate choice with destroying the VA. The absence of choice could kill the Veteran. I would have been one of those Veterans. You know the sordid story.

Yes, I support Veterans Choice. No, I do not support dismantling the Veterans Administration.

Dr. (b) (6)
National Treasurer
Sent from my iPhone

On Mar 10, 2018, at 17:16, (b) (6) <(b) (6)@polarcomm.com> wrote:

I was 1 bag of whole blood away from not being here!
The VA screwed up on a routine colonoscopy and I almost didn't make it.
I believe in choice but not at the expense of destroying the VA

Sent from my iPhone

On Mar 10, 2018, at 1:57 PM, (b) (6) <(b) (6)@gmail.com> wrote:

(b) (6)

As you may have read, attached, in the Liberal Washington Post today Dr Shulkin is a major front page topic, target. Secretary Shulkin is being attacked. The Liberal Washington Post presents Dr. Shulkin in a very negative light and as desperate to hold onto his job.

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Dr. (b) (6)
National Treasurer
Vietnam Veterans of America
Sent from my iPhone

On Mar 9, 2018, at 21: (b) (6)@hotmail.com> wrote:

Dear (b) (6) These messages from the Executive Directors of the various VSOs are common and I very rarely sign them, although I do approve them. Often they are quick messages on specific issues.

I don't understand how George Soros or the DNC can be mentioned in the same sentence as the Trump White House. The "rogue" forces are the Cooke Brothers/Concerned Veterans of America who are trying to dismantle the VA because they hate government. This has nothing to do with the Obama Administration which is now over a year old. Interestingly, when (b) (6) and his colleagues met with Gen. Kelly he did not know the individuals who seemed to be undermining Secty. Shulkin.

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As for the recent IG report on the problems at the DC VAMC, this has been a long time in the development and Secty. Shulkin had already fired the hospital administrator several months ago.

VVA has always been supportive of "Choice" but not as subterfuge for dismantling the VA. The costs would be astronomical and the private sector is not ready for us. Congress needs to deal with the doctor shortage or actually the small classes in our Medical Schools.

(b) (6)

From: (b) (6) aol.com>
Sent: Thursday, March 8, 2018 2:33 PM
To: (b) (6)
Cc: (b) (6); (b) (6); (b) (6); (b) (6); (b) (6); (b) (6) vva.org
Subject: The Policy Statements on Behalf of VVA

(b) (6)

Why didn't you sign the document, attached, or share it with the other officers or BOD. Mr. (b) (6) is not on the same level as the Executive Directors of the other organizations and was just granted permission to use his title so the Executive Directors would include him. (b) (6) you make it clear you are the CEO of VVA.

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credible evidence to support Choice is a conspiracy to dissolve VA Healthcare.

General Kelly is certainly cognizant of the lack of credibility of rumors and hearsay. He's been a victim of rumors about rogue elements himself. Much of the threat to the credibility of Dr Shulkin comes from his association with the Obama Administration. Those details were included in the VA Inspector General's report.

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National Treasurer
Sent from my iPhone

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Sent from my iPad

On Mar 8, 2018, at 11:39 AM, (b) (6) <(b) (6)@aol.com> wrote:

(b) (6)

The VVA BOD recently adopted a requirement that all legal positions taken by VVA such as "Amicus" briefs be approved by the BOD.

I recently was presented the attached letter sent to President Trump on February 26, 2018 signed by (b) (6) (b) (6) I had no prior knowledge of the document which represents a position of VVA.

What is your position of such representations as this being sent to the BOD or the National Officers? I don;t know why President (b) (6) was not the signatory to the letter and certainly don't support a Department Head of VVA representing our organization in such communication.

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National Treasurer
Vietnam Veterans of America

<Policy Statements.pdf>

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National Treasurer
Vietnam Veterans of America

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Cc: (b) (6) aol.com>; (b) (6)
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Shulkin, David J., MD </o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
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Subject: [EXTERNAL] Leadership Crisis in the Veterans Administration
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Sent from my iPhone

On Mar 8, 2018, at 12:30, (b) (6) vva.org> wrote:

Dear (b) (6) This statement was prepared and sent by the EDs of the included organizations in order to prepare for an appointment with Gen. Kelly, President Trumps Chief of Staff. This is not the least bit similar to supporting a lawsuit. We do not go to the BOD before taking positions on issues we support. Thanks, (b) (6)

Sent from my iPad

On Mar 8, 2018, at 11:39 AM, (b) (6) <(b) (6) aol.com> wrote:

(b) (6)

The VVA BOD recently adopted a requirement that all legal positions taken by VVA such as "Amicus" briefs be approved by the BOD.

I recently was presented the attached letter sent to President Trump on February 26, 2018 signed by

(b) (6) (b) (6)

I had no prior knowledge of the document which represents a position of VVA.

What is your position of such representations as this being sent to the BOD or the National Officers? I don;t know why President (b) (6) was not the signatory to the letter and certainly don't support a Department Head of VVA representing our organization in such communication.

(b) (6)

National Treasurer
Vietnam Veterans of America

<Policy Statements.pdf>

From: (b) (6) moaa.org>
To: Bowman, Thomas </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: [EXTERNAL] Re: White House Meeting
Date: Thu Feb 22 2018 20:00:01 CST
Attachments:

Tom - Thank you for your intervention and discussing this with Sec Shulkin. I received a separate e-mail from the Secretary which is much appreciated. He indicated he would convey to the WH a request to have MOAA join the meeting. Quite frankly, I don't know the specifics of the meeting (date/time) and have had no contact from the White House staff (I assume (b) (6))

If the meeting is tomorrow I'll need to adjust my calendar as I have a luncheon with Association of Military Banks of America. I don't mean this to be a big issue - just knowing that both you and the Secretary were understanding of my request is much appreciated.

Respectfully, (b) (6)

(b) (6) Lt Gen (Ret)
MOAA

On Feb 22, 2018, at 6:12 PM, Bowman, Thomas <Thomas.Bowman@va.gov> wrote:

(b) (6) I spoke with the Secretary. It was always his intention that MOAA/you be invited and feel it was an oversight. He indicated it has been corrected....MOAA should be invited....let me know if there is a problem....thanks.

tom

From: (b) (6) [mailto:(b) (6) moaa.org]
Sent: Thursday, February 22, 2018 2:33 PM
To: Bowman, Thomas
Subject: [EXTERNAL] White House Meeting

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I would appreciate the opportunity to be a part of this meeting and future discussions. I greatly appreciate your assistance and I look forward to assisting you and the Secretary in any way possible.

Vr, (b) (6)

(b) (6) (b) (6)

Lieutenant General, U.S. Air Force (Ret)

President and CEO

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Washington Post — Feb. 21, 2018

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White House officials have told Shulkin his job is safe despite the allegations, which were outlined in a report released last week by VA's inspector general.

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To: (b) (6) moaa.org>
Cc:
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Subject: RE: White House Meeting
Date: Thu Feb 22 2018 17:12:01 CST
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To: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED]>
Cc:
Bcc:
Subject: RE: White House Meeting
Date: Thu Feb 22 2018 17:09:10 CST
Attachments:

Thanks... [REDACTED] will be very Happy!!

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Subject: RE: White House Meeting

Done

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Cc:
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Subject: RE: White House Meeting
Date: Thu Feb 22 2018 17:08:11 CST
Attachments:

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Cc:
Bcc:
Subject: RE: White House Meeting
Date: Thu Feb 22 2018 16:58:54 CST
Attachments:

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From: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
To: Bowman, Thomas </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
Cc:
Bcc:
Subject: RE: White House Meeting
Date: Thu Feb 22 2018 16:58:54 CST
Attachments:

I will try to get them added- just an oversight I'm sure

Sent with Good (www.good.com)

From: Bowman, Thomas
Sent: Thursday, February 22, 2018 2:55:16 PM
To: DJS
Subject: FW: White House Meeting

Sir: was the request to only have Big 6??.....as you know General [REDACTED] (b) (6) and MOAA are ardent supporters of VA and your vision. Also, General Kelly has good history with MOAA....it would be very helpful to have them in the room.....

From: [REDACTED] (b) (6) [mailto:[REDACTED] (b) (6)@moaa.org]
Sent: Thursday, February 22, 2018 2:33 PM
To: Bowman, Thomas
Subject: [EXTERNAL] White House Meeting

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I would appreciate the opportunity to be a part of this meeting and future discussions. I greatly appreciate your assistance and I look forward to assisting you and the Secretary in any way possible.

Vr, (b) (6)

(b) (6)

Lieutenant General, U.S. Air Force (Ret)

President and CEO

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White House intends to meet with leading veterans groups amid drama at VA

Washington Post — Feb. 21, 2018

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The impending White House meeting follows a private gathering Tuesday of the top officials from 12 veterans service organizations (VSOs), including the American Legion, VFW and Disabled Veterans of America. These groups represent millions of former service members and their families, forming one of Trump's core constituencies.

"At one point ... cellphones started ringing and the directors of AMVETS, Legion, VFW and DAV politely excused themselves almost simultaneously to take the calls," said one person familiar with the gathering. "Each of these calls came from White House meeting schedulers to establish an appointment for VSOs to meet together" with Kelly.

Kelly, a retired Marine Corps general, has told Shulkin to stop the drama and infighting at VA. The White House did not respond to messages seeking details about his objectives for next week's meeting.

Kelly's offer to host the meeting comes as the troubled agency has weathered weeks of negative publicity.

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To: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED]>
Cc:
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To: Bowman, Thomas </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)
<[REDACTED]>
Cc:
Bcc:
Subject: [EXTERNAL] White House Meeting
Date: Thu Feb 22 2018 13:32:48 CST
Attachments:

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From: (b) (6) </o=va/ou=vha office of
information/cn=recipients/cn=(b) (6)
To: (b) (6) amvets.org>; (b) (6)
(b) (6) bva.org>; (b) (6) bva.org>; (b) (6)
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(b) (6) @coausphs.org>; Dan Caldwell <(b) (6) @cv4a.org>; (b) (6)
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Cc:

Bcc:

Subject: Nearly \$700 Million in State Veterans Home Funding Leads to New Construction Projects

Date: Wed Apr 18 2018 08:42:14 CDT

Attachments: \$700 Million to go to construction projects_18APRIL2018_FINAL.pdf

Good morning. Passing this along to you...

+++++

FOR IMMEDIATE RELEASE

April 18, 2018

Nearly \$700 Million in State Veterans Home Funding Leads to New Construction Projects

Funding Represents Largest Appropriation in Program's History

WASHINGTON — Recently the Department of Veterans Affairs announced that it will use \$685 million in funding from Congress to fund several State Veterans Home construction projects through the VA State Veterans Home Construction Grant Program.

The new funding can be used where needed for repairs, renovation or new construction, and is part of an Omnibus Bill that represents the largest allocation to the more than 50-year-old State Veterans Home Construction Grant Program; funding for the program has averaged \$94 million over the last five years. The State Veterans Home Construction Grant Program provides up to 65 percent of the cost to build and renovate facilities.

“This program has been operating with a backlog of applications for construction projects,” said VA Acting Secretary Robert Wilkie. “This new allocation will let us fund projects on our priority list, many of which have been waiting for years. We thank Congress for its commitment and support of Veterans across the country.”

Plans for the new funding include at least 52 projects including bed replacement projects in Massachusetts, Michigan and Wisconsin; life safety projects in Ohio, Oklahoma and Texas; new construction projects in Arizona, Hawaii, Illinois, Montana, Nevada, North Carolina, South Carolina, Tennessee and Virginia; and general renovation projects in Alabama, Connecticut, Delaware, Florida, Georgia, Iowa, Massachusetts, Michigan, Missouri, North Carolina, North Dakota, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Vermont and Wisconsin.

“As the largest appropriation in the more-than 50-year history of this program, it demonstrates just how strongly President Donald Trump cares for and is keeping his promises to our nation’s Veterans,” Wilkie said.

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information/cn=recipients/cn=(b) (6)
Filename: \$700 Million to go to construction projects_18APRIL2018_FINAL.pdf
Last Modified: Wed Apr 18 08:42:14 CDT 2018



U.S. Department
of Veterans Affairs

News Release

Office of Public Affairs
Media Relations

Washington, DC 20420
(202) 461-7600
www.va.gov

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To: Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
(b) (6) COS-PMO </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
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Date: Sat Apr 14 2018 15:02:06 CDT
Attachments:

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Sent: Saturday, April 14, 2018 12:58:28 PM
To: (b) (6) COS-PMO
Cc: Ulliot, John; Hutton, James; (b) (6) (b) (6)
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To: (b) (6) <(b) (6)@propublica.org>

Subject: RE: Updated Hiring Guidance

Please note the correction to my previous response highlighted below:

Under Secretary Shulkin during the government-wide hiring freeze, VA's then-chief of staff Vivieca Wright Simpson had to give permission to hire and approve the selection of virtually every position throughout the department. The hiring freeze was lifted in April of 2017, but confusion regarding approval levels for various hires remained.

And please see the following response to your question:

The Feb. 28 memo is meant to clear up that confusion, while ensuring high-level approval for central office hires and allowing delegation of the approval authority for hires in the field to the lowest appropriate level. The goal is eliminating duplication and top-heavy, bureaucratic management structures within our headquarters so those resources can be redirected to the field.

Thanks,

(b) (6)

Press Secretary

Department of Veterans Affairs

202-461-(b) (6)

(b) (6) va.gov

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Sent: Friday, April 13, 2018 11:54 AM

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Subject: [EXTERNAL] Re: Updated Hiring Guidance

Thanks, (b) (6) The memo refers to "all other positions in the Administrations." How is it that it only affects headquarters?

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Date: Friday, April 13, 2018 at 11:51 AM

To: (b) (6) <(b) (6)@propublica.org>

Subject: RE: Updated Hiring Guidance

Hi, (b) (6) Please see below. Thanks – (b) (6)

The premise of your inquiry is false and hinges on a misunderstanding of the memo in question.

Under President Trump, VA is committed to ensuring local offices and facilities throughout the department have all of the staff they need. This includes eliminating duplication and top-heavy, bureaucratic management structures within our headquarters so those resources can be redirected to the field. That's what this memo does.

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Sent: Friday, April 13, 2018 9:20 AM

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ProPublica

203.464 (b) (6)

(b) (6) propublica.org

From: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: COS-PMO </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc: Ulliyot, John </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Hutton, James </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Bcc:
Subject: // for approval // Q and A for Pro Publica
Date: Fri Apr 13 2018 12:59:13 CDT
Attachments:

Please see the below media inquiry from Pro-Publica. They are doing a story on Acting Secretary Wilkie's VSO breakfast last week and the VSO's White House meeting yesterday. The deadline is ASAP today.

Are you OK with the following Q and A? Thanks - (b) (6)

Q: Why was CVA invited?

A: Just like the other comparable Veterans groups that attended, CVA represents an important voice on Veterans issues.

Q: Who was the colonel in uniform who attended and why?

A: Col. (b) (6) Special Assistant to the Acting Secretary Of Veterans Affairs, and Senior Military Assistant to the Under Secretary of Defense (Personnel and Readiness)

Q: What is Acting Secretary Wilkie's position on merging the VA Choice with Tricare?

A: There is no plan to do that, and there never was one. As former Secretary Shulkin said in November of last year: "If there are efforts where we could do things better, we want to look at all those ideas and the potential synergies," he said. "But there is no plan here. There is no draft. We are simply having early discussions."

(b) (6)

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Sent: Friday, April 13, 2018 1:37 PM

To: (b) (6)

Subject: [EXTERNAL] Re: Updated Hiring Guidance

It's a story about Acting Secretary Wilkie's VSO breakfast last week and the VSOs' White House meeting yesterday. We are planning to publish in the next few hours.

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Date: Friday, April 13, 2018 at 1:31 PM

To: (b) (6) <(b) (6)@propublica.org>

Subject: RE: Updated Hiring Guidance

What is the specific angle of your piece and deadline?

Thanks,

(b) (6)

Press Secretary

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Sent: Friday, April 13, 2018 1:24 PM
To: (b) (6)
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OK, thanks.

Separately, I also have some questions about the VSO breakfast with Acting Secretary Wilkie last week:

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To: (b) (6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6)
Cc:
Bcc:
Subject: OPA Regional Summary
Date: Thu Apr 12 2018 13:59:45 CDT
Attachments: Daily Summary 04-12.docx

Regional Office Daily Summary

Thursday, April 12, 2018

Office of Public Affairs, Field Operations Service

North Atlantic OPA

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- Syracuse VAMC: PAO contacted by a local NPR reporter seeking comment on discussion Sen. Chuck Schumer (D-N.Y.), had yesterday with NY-based reporters on funding infrastructure projects, including repairs and upgrades at VAMCs and clinics. Schumer told reporters that there are more than \$500 million in projects that are ready to proceed in New York. Reviewed PAO's draft response and recommended some edits to reflect known projects already funded, and how they will improve services for Central NY veterans. (JB)

- National Veterans Outreach, OPIA: Participated in another conference call with Director to discuss the PGA's "Birdies for the Brave," program that honors and shows appreciation to military, Veterans and their families during PGA golf events. Representatives from VA New Jersey HCS, Newark VARO and the National veterans Sports Program and Sports Events participated in the discussion and offered logistics and outreach support. (b) (6) and (b) (6), of Birdies for the Brave, provided an overview of the program, which was originally created in 2004 by PGA Tour player, (b) (6) Mickelson, and his wife, Amy, to support combat-wounded veterans. (JB)

- VA Capitol Health Care Network (VISN 5): Congratulated Chief Communications Officer for being accepted into the Harvard Kennedy Senior Leader Fellowship program. The VA Maryland HCS PAO will be handling VISN 5 PA issues during her four week absence. (JB)

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Southeast OPA

Facility Developments:

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- Lexington (Ky.) VAMC; Tennessee Valley VA HS (Nashville); VISN 9 (Nashville); IGA: Worked with facility PAOs at Lexington and Tennessee Valley on obtaining the proper documentation for upcoming visits by foreign guests from Korea and Ukraine, respectively. Shared pertinent details with IGA on both visits. The Lexington visit has been approved. Awaiting a decision on the guests from Ukraine. (CH)

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- VHA Mentor Program: We co-instructed a photography/video class with a member of the VACO Digital Media Team. The class was designed for VHA Mentor program participants, and was held April 12. (ER)

- Barrancas National Cemetery (Fla.): OPA field ops director shared a notice with us concerning an executive visit in our catchment. The deputy secretary of IT operations and services will visit Barrancas National Cemetery mid-April as part of an IT inventory transfer, inspection, and tour. (JN/CH/ER)

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- Midwest OPA: RD completing work on agenda in support of Milwaukee VAMC/VISN 12 PAC scheduled for June 20-21. (CL)

Continental (North) OPA

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Continental (South) OPA

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- San Antonio / Phoenix: Working on event memos and clips for COSVA's trip to San Antonio/Phoenix. (LS and JJ)

- Phoenix VAMC: COS will participate in a healthcare journalist panel discussion, moderated by Arizona Republic Reporter (b) (6), alongside CVA executive director on Saturday to discuss VA health care. VA press secretary conducted a prep session with COS on Wednesday morning, PAO also participated. (JJ)

Pacific OPA

Facility Developments:

- Greater Los Angeles HCS: Coordinated engagement plan with PAO and director for a KPCC query regarding the relocation of a PTSD clinic within the GLA campus. The reporter also wants to observe a group therapy session. Recommended engagement with both written statements and an interview, but decline the request to sit in on a group session. Forwarded to OPA and VHA comms for approval. (JB)

- Central California HCS and Oakland VARO: Coordinated with both PAOs on the OTGR event taking place next month regarding presumptive conditions and benefits that are offered. Provided both PAOs with the final media advisory to publicize to media and stakeholders. (JB)

- Pacific Islands HCS: PAO provided us with the comms plan and draft release they plan to use in response to a GAO report coming out today. Participated in a conference call to discuss response to media on the issue. (JB)
- San Diego HCS: A local TV station reached out to the SD PAO to request a live interview with the facility director focused on privatization of VA. Recommended they decline the and provide last week's VA press release. Advised that any future interview request be worked up through OPA and VHA comms for approval. (JB)
- Loma Linda, Greater Los Angeles and San Diego: Working on event memos and media clips for the COSVA's trip to Southern California VA facilities in late April. (JB)

Owner: (b) (6) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6)
Filename: Daily Summary 04-12.docx
Last Modified: Thu Apr 12 13:59:45 CDT 2018

Regional Office Daily Summary Thursday, April 12, 2018

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North Atlantic OPA

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Pacific OPA

Facility Developments:

- Greater Los Angeles HCS: Coordinated engagement plan with PAO and director for a KPCC query regarding the relocation of a PTSD clinic within the GLA campus. The reporter also wants to observe a group therapy session. Recommended engagement with both written statements and an interview, but decline the request to sit in on a group session. Forwarded to OPA and VHA comms for approval. (JB)

- Central California HCS and Oakland VARO: Coordinated with both PAOs on the OTGR event taking place next month regarding presumptive conditions and benefits that are offered. Provided both PAOs with the final media advisory to publicize to media and stakeholders. (JB)

- Pacific Islands HCS: PAO provided us with the comms plan and draft release they plan to use in response to a GAO report coming out today. Participated in a conference call to discuss response to media on the issue. (JB)

- San Diego HCS: A local TV station reached out to the SD PAO to request a live interview with the facility director focused on privatization of VA. Recommended they decline the and provide last week's VA press release. Advised that any future interview request be worked up through OPA and VHA comms for approval. (JB)

- Loma Linda, Greater Los Angeles and San Diego: Working on event memos and media clips for the COSVA's trip to Southern California VA facilities in late April. (JB)

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Subject: VSO Communicators Meeting - follow up

Date: Thu Apr 12 2018 08:29:27 CDT

Attachments: 2018_0322 Vets CARE PFS Overview for VSOs SENT.pdf

Office of Connected Care VSO briefing - April 2018-revised vFINAL.pptx

Good morning:

Thanks to everyone who attended Wednesday's VSO Communicators Meeting. A special thanks also to Dr. (b) (6) (Office of Connected Care) and (b) (6) (Social Finance) for briefing the group. As promised, I have attached the PPTs from the meeting.

Several of you expressed interest in communications materials and/or newsletter articles from the Office of Connected Care. I expect to receive their latest toolkit later today or tomorrow and will forward it directly on to you. After you have looked it over, if you have any questions or additional needs please feel free to reach out to myself and (b) (6) – (b) (6) va.gov. (b) (6) was at the meeting yesterday, seated next to Dr. (b) (6). If you have questions about the Vets CARE program or information on materials they could provide you to promote the program, please e-mail me here.

As I said in the meeting, I'd really appreciate any feedback on how the meeting went, as well as suggestions on future briefing topics that would be of interest to you.

Best,

(b) (6)

Public Affairs Specialist

National Veterans Outreach Office

Department of Veterans Affairs

Phone: 202.461. (b) (6)

Cell: 202.746. (b) (6)

E-mail: (b) (6) va.gov

Explore VA today! <http://explore.va.gov/>

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VETERANS COORDINATED APPROACH TO RECOVERY AND EMPLOYMENT (VETS CARE) PAY FOR SUCCESS PROJECT

Confidential

10 Milk Street, Suite 1010, Boston, MA 02108

▶ THE VETERANS CARE PAY FOR SUCCESS PROJECT

Social Finance is partnering with the Federal Department of Veterans Affairs (VA), New York City, Commonwealth of Massachusetts, and the City of Boston to improve outcomes for Veterans with PTSD

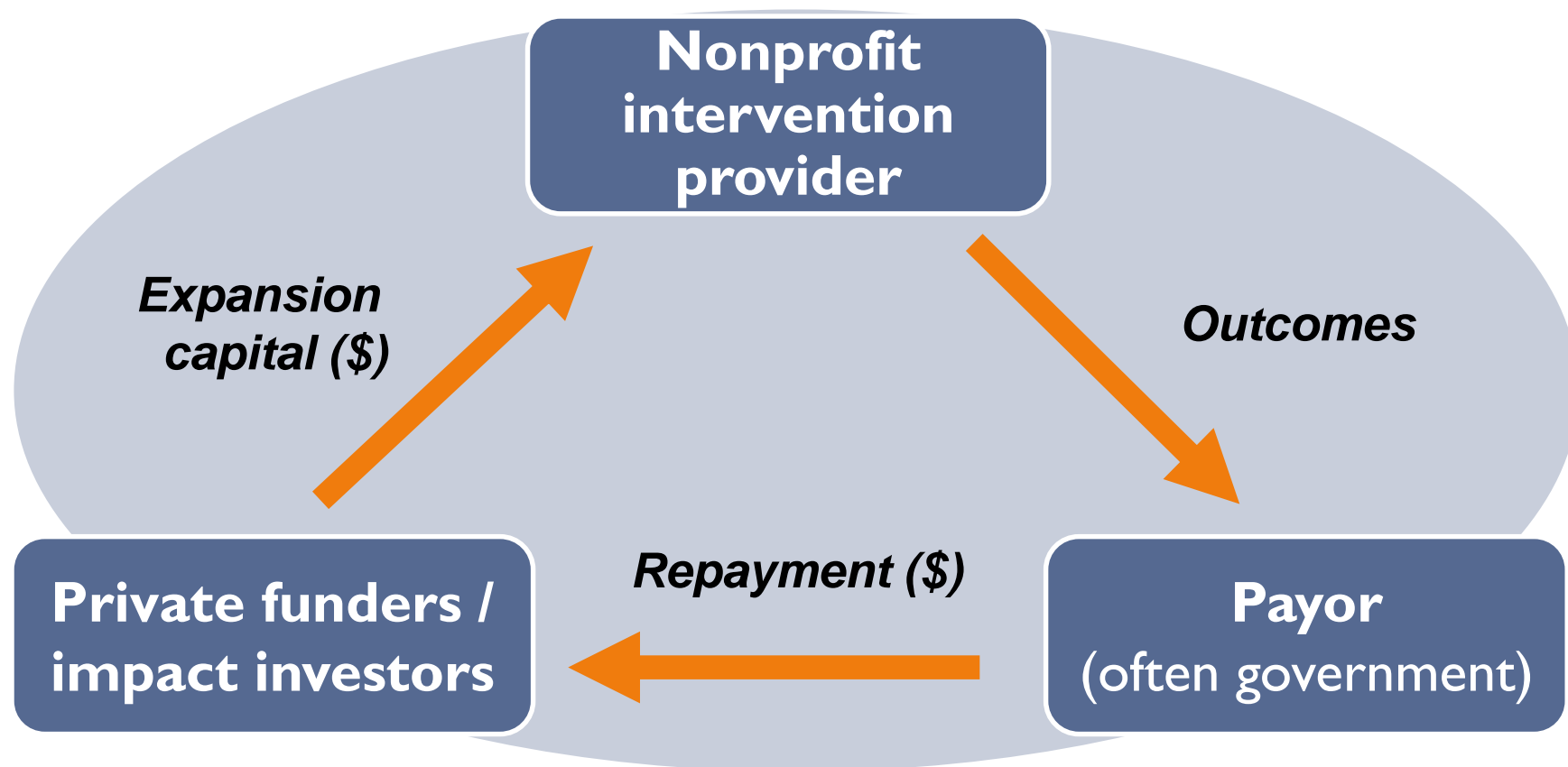


- The ***Veterans Coordinated Approach to Recovery and Employment (CARE) PFS Project*** will support unemployed or underemployed Veterans with Post-Traumatic Stress Disorder (PTSD) in attaining competitive, compatible employment
- The project **will serve 480 Veterans with Service-Connected PTSD**
 - Veterans will be served via VA Non-Profit Corporations across the country
 - Each IPS Team⁽¹⁾ will serve two cohorts of 60 Veterans over three years
- The **project will employ Individual Placement and Support (IPS)**, an evidence-based approach to supported employment that emphasizes rapid job search for employment that matches an individual's needs and preferences, and integrated mental health care
- The **outcomes** to be measured include: **earnings, sustained competitive employment, job satisfaction, and fidelity to the IPS model**

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1) An IPS Team is defined as two IPS Specialists and an IPS Program Coordinator

▶ WHAT IS PAY FOR SUCCESS?



Pay for Success is about **measurably improving** the lives of **people most in need** by driving government resources toward **more effective programs**

▶ VETERANS CARE OVERVIEW



IMPACT INVESTORS
Socially motivated investors



POPULATION IN NEED
Unemployed or underemployed
Veterans with service-connected
PTSD



OUTCOMES PAYOR
VA Center for Innovation
+ Local jurisdictions
1:1 match

1

*Impact investors
provide ~\$5M to fund
IPS service delivery
for 4 project teams*

2

*IPS services result
in positive
outcomes for
Veterans*

3

*VA & local govt.
repay investors up
to \$6M ONLY IF
positive outcomes
were achieved*

**Project-wide Service delivery
budget:**

- ~\$5.1M funds personnel costs to deliver IPS services, evaluation costs to measure impact, and PFS project costs

Payment-contingent outcomes:

- Fidelity to the IPS model
- Average days worked
- Average dollars earned
- Level of job satisfaction

Maximum project obligation:

- Up to \$6M (\$3M VA; \$3M local jurisdictions), paid for outcomes achieved (fidelity to the IPS model, average days worked, average dollars earned, level of job satisfaction)

► OVERVIEW OF INDIVIDUAL PLACEMENT & SUPPORT

IPS is an evidence-based approach to supportive employment for individuals with mental health diagnoses who want to work in competitive jobs

The Intervention

Individual Placement & Support is an evidence-based approach to supportive employment that emphasizes rapid job search for employment that matches an individual's needs and preferences, and integrated mental health care

Principles of IPS

- (1) Focus on competitive employment
- (2) Eligibility based on client choice
- (3) Integration of rehabilitation and mental health services
- (4) Attention to worker preferences
- (5) Personalized benefits counseling
- (6) Rapid job search
- (7) Systematic job development
- (8) Time-unlimited, individualized support

Evidence of IPS

- 25 published randomized controlled trials spanning multiple countries, diagnoses, and contexts show positive outcomes, including 2 studies focused on unemployed Veterans with PTSD diagnosis (12-site study was published March 2018)

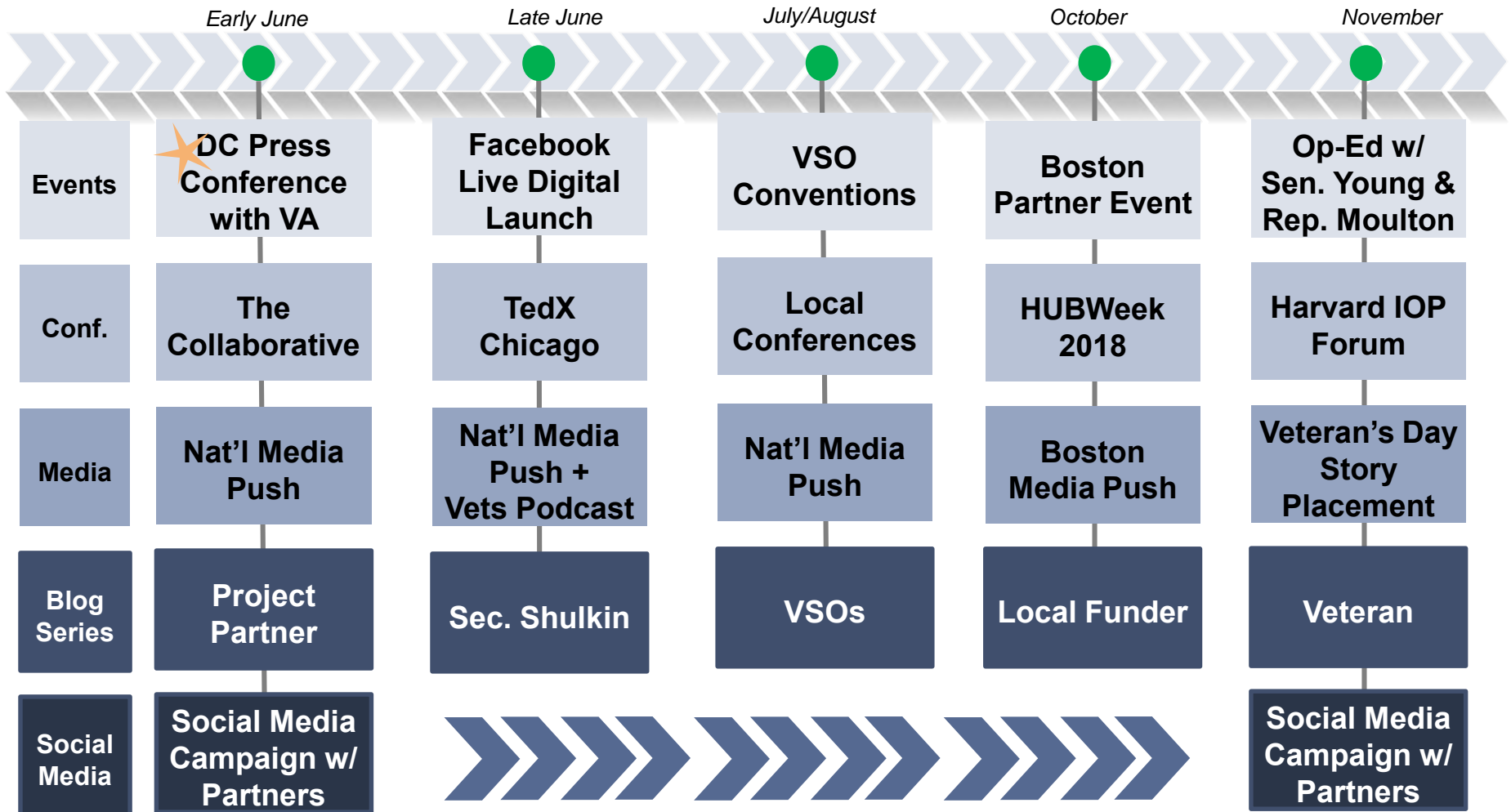
TREAC

- The Tuscaloosa Research and Education Advancement Corporation (TREAC) is a non-profit corporation that facilitates research and education activities in support of the Tuscaloosa VA Medical Center
- Dr. Lori Davis, MD is a clinical psychiatrist at TVAMC, affiliated with TREAC, who has conducted research on the efficacy of IPS for Veterans with PTSD for the past decade

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▶ VETS CARE ANNOUNCEMENT STRATEGY

Goal: Drumbeat between June Launch and Veterans Month 2018



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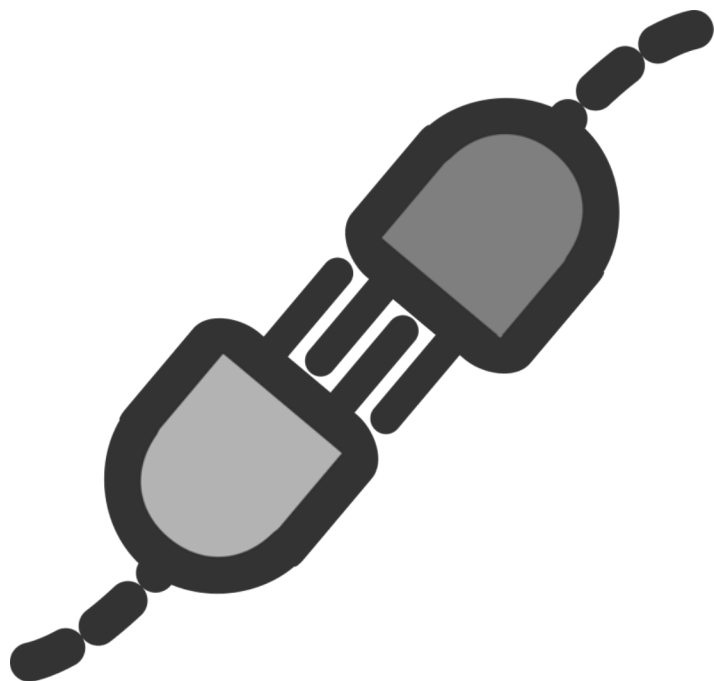
VA Connected Care

April 2018

What is Connected Care?

The Big Picture

Connections?



What Does Connection Look Like For Me as a VA Physician?

Command Sergeant Major George W. Howell, Jr., USA (Ret.)

- 30-year U.S. Army Veteran
- Rose to Command Sergeant Major of the U.S. Army Intelligence and Security Command
- Served in Germany, Thailand, Vietnam, Hawaii, and the continental United States
- Began receiving care at the Washington DC VA Medical Center in 1985
- Hypertensive, widower, lives alone.



What Does Connection Look Like in VA?

Veterans

- **~20,000,000 (9% female)** Estimated US Veteran Population
- **~623,000** Estimated Number of Living WWII Veterans
- **404** Estimated Number of WWII Veterans Passing Away Daily
- **47.1%** Percent of Veteran Population >64

Veterans in VA

- **9.05 million** Total Enrollees in VA Health Care System (FY16)
- **6.26 million** Total Unique Patients Treated in FY16
- **4.55 million** Number of Veterans receiving VA Disability Compensation
- **959,703** Number of Veterans Compensated for PTSD as of 9/30/17

What Does Connection Look Like in VA?

VA Staff

- **351,540** Full-time VA Employees
- **127,211** Health Care Professionals Rotating Through VA in FY16
- **25,769** Full-time Physicians
- **97,102** Nurses

VA Footprint

- **145** VA Hospitals
- **1,231** VA Outpatient Sites
- **300** VA Vet Centers
- **56** VBA Regional Offices
- **135** VA National Cemeteries

What Does Connection Look Like in VA?



What Does Connection Look Like in VA?



What Does Connection Look Like in VA?



Connected Care

also known as:

Consumer Health

mHealth

Connected Health

Virtual Care

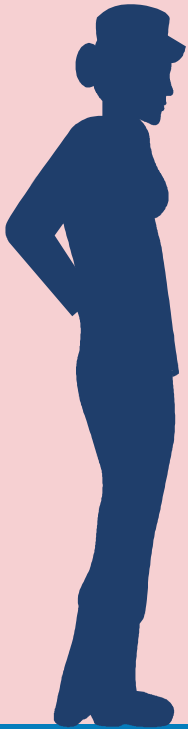
Telehealth

VA's Connected Care Vision

Access and the **Veteran Experience** will be enhanced through information and communication technologies that are effectively **integrated** into the daily lives of Veterans and VA Staff.



Veteran at the Center of Connected Care



ACCESS

- Trusted Health Information
- Simplified Transactions
- Open Communication Channels
- Self Management and Monitoring
- Clinically Supported Remote Monitoring
- Asynchronous Virtual Care
- Synchronous Virtual Care

PATIENT EXPERIENCE

- Efficient
- Effective
- Easy to Use
- Consistent
- Continuity
- Coordinated
- Delightful

REAL LIFE

HEALTH CARE

The Grand Challenge

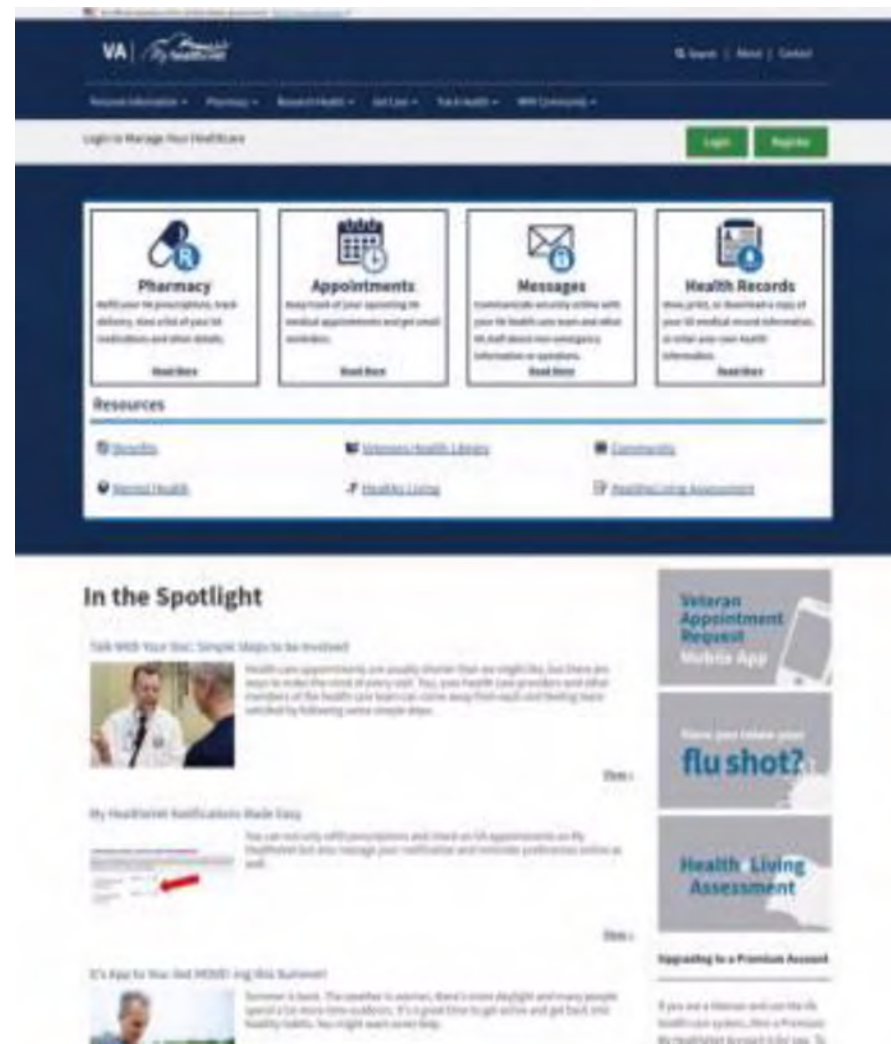
How do we meaningfully integrate Connected Care into care delivery in a way that

- preserves rich relationships,
- improves health care system efficiency,
- improves quality, and
- improves the experiences of both the consumer and deliverer of health care?

My HealtheVet

4th Quarter 2017

- **1.55 million** active users (32% mobile)
- **3.54 million** Secure Messages sent/received
- **1.39 million** Blue Button downloads
- **5.22 million** Prescription refills
- **~100K** new registrations
- Record-breaking User Satisfaction
Jan 2018 CXA survey reported user satisfaction score of **80**, the highest ever seen for My HealtheVet
- **30%** of users are 65 - 69



FY 17 Secure Messaging Workload

Secure Messaging – FY17	
Inbound messages	6.79 million
Outbound messages	6.91 million
Average Business Days to Complete	1
Completed by Providers	1.6 million
Completed by Clinical Members	3.79 million
Completed by Triage Members	1.39 million

VA Online Scheduling (MHV)

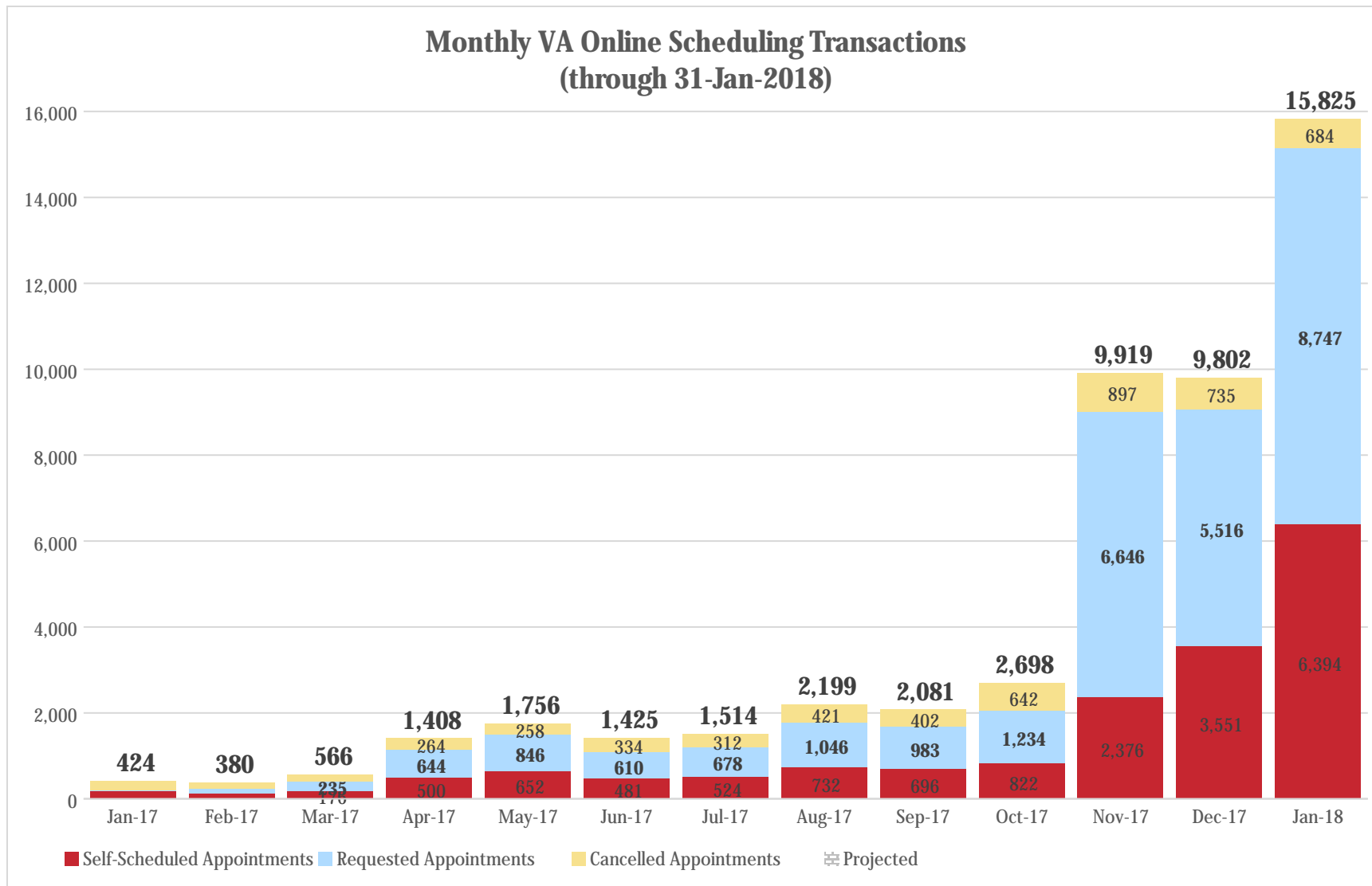
The screenshot displays the VA My HealtheVet website interface. At the top, the VA logo and 'My HealtheVet' branding are visible, along with search and navigation links. Below the header, a navigation bar includes links for Home, Personal Information, Pharmacy, Research Health, Get Care, Track Health, MHV Community, and Secure Messaging. A user is logged in as 'Test (Premium)' with a 'Log Out' button. The main content area features several service tiles: Pharmacy (Refill VA Prescriptions, Track Delivery, Medications Lists), Appointments (View My VA Appointments, Schedule a VA Appointment, VA Facility Locator), Messages (Secure Messaging), Medical Reports, Labs and Tests, and Track Health. A red callout box labeled '1' points to the 'Schedule a VA Appointment' link in the Appointments tile, stating 'Clear call to action in an obvious location'. Another red callout box labeled '2' points to the 'Log Out' button, stating 'Logged in My HealtheVet users access online scheduling directly'. A third red callout box labeled '3' points to a 'Schedule a VA Appointment' button in the 'In the Spotlight' section, stating 'Another clear call to action.' The 'In the Spotlight' section also includes a banner for the improved My HealtheVet Website and a news item about the website's redesign.

1 Clear call to action in an obvious location

2 Logged in My HealtheVet users access online scheduling directly

3 Another clear call to action.

VA Online Scheduling - Significant Growth

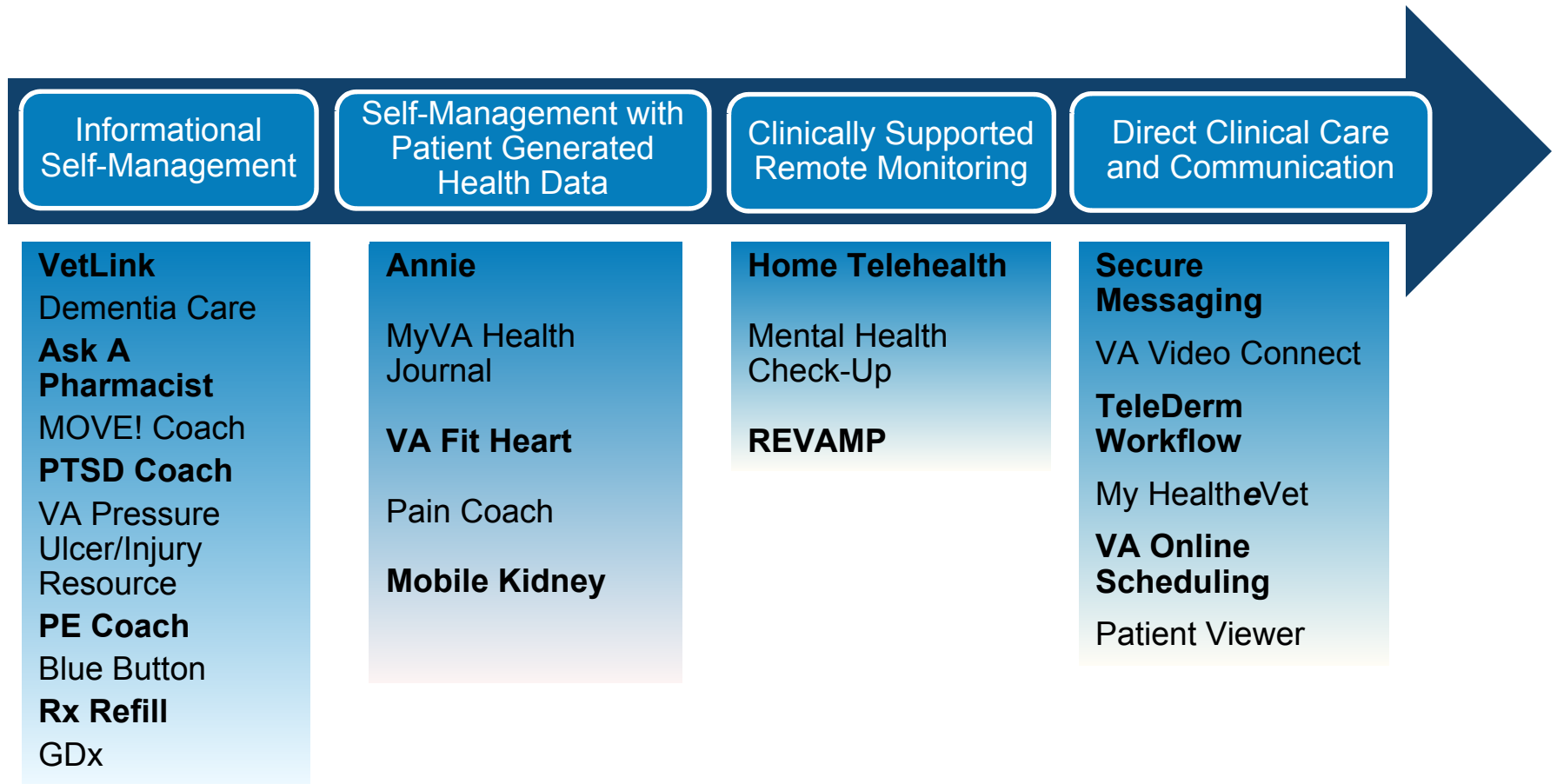


VA App Store (mobile.va.gov/appstore)

- Provides access to VA-developed apps for Veterans and VA care teams. Apps increase access, communication and coordination of care for Veterans.
- 43 apps featured on the VA App Store
 - 28 health apps
 - 18 mental health apps
 - 30 Veteran-facing apps
 - 19 care-team facing apps
 - 20 web apps
 - 23 iOS apps
 - 11 Android apps
- 25+ suites of training materials: User Manual, Quick Start Guide, FAQs, Slideshow



Spectrum of Mobile Health Applications

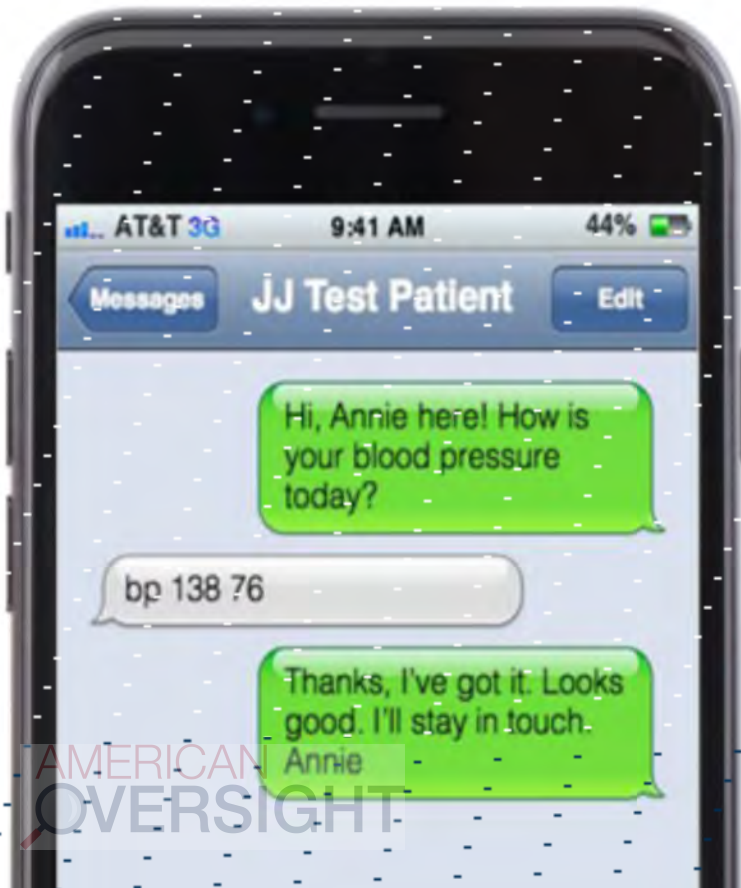


Annie

A mobile messaging system that promotes self-care for Veterans.

Annie sends regular, automated text message reminders to Veterans to help them track health information requested by their VA care teams.

Annie can also send Veterans reminders and messages from their local VA facility



Named after Lt. Annie G. Fox

First woman to receive Purple Heart for combat

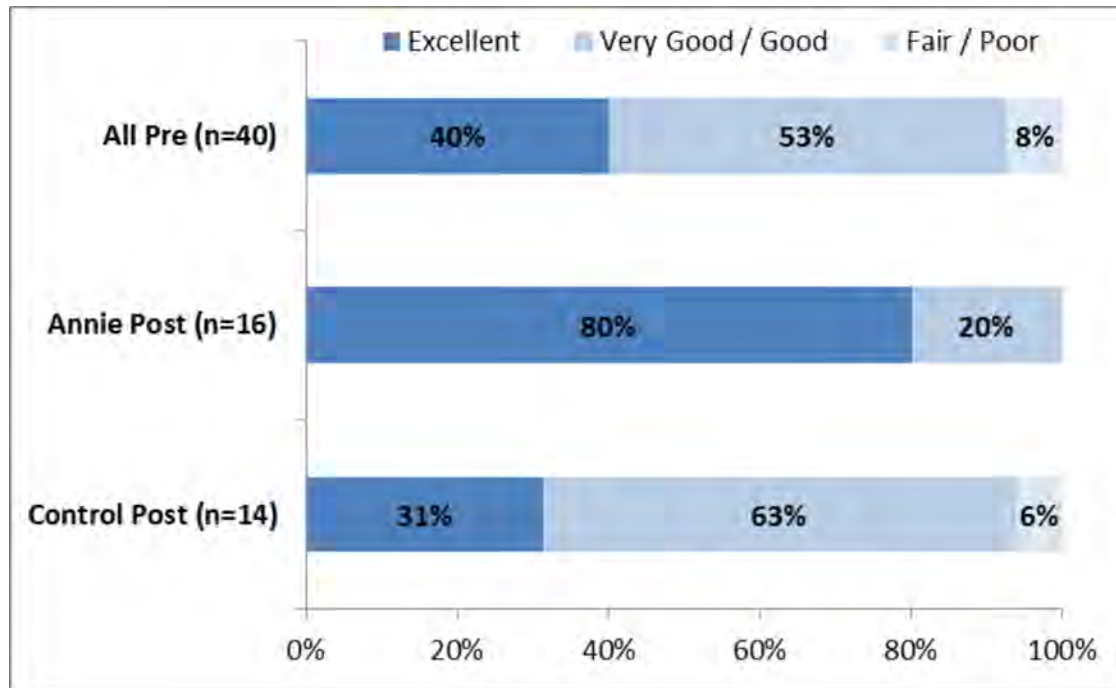
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VA



U.S. Department
of Veterans Affairs

Annie: Example of Early Clinical Outcomes



Patient Self-Reported Adherence for Hepatitis C (HCV) Medications

- Data collected at 9 HepC clinics from across the US, before treatment and after at least 6 weeks of treatment
- All Veterans trusted Annie (100%) and nearly all (94%) would recommend it to other Veterans.

VA Telehealth

VA Telehealth – Where We Started

1959

Two-Way Television
Group Therapy between
the *University of
Nebraska Medical Center*
and the *Omaha VA,*
Lincoln VA, and *Grand
Island VA*

*Image from Wittson, Cecil L.;
Affleck, D. Craig; Johnson, Van
Mental Hospitals, Vol 12(10),
1961, 22-23.*



Telehealth – By the Numbers

VHA Telehealth: FY2017

>**2.18 million** episodes of care

> **727,000 Veterans** served
900 VA Sites of care
88-93 percent Satisfaction
>50 specialty areas

~**12 percent** of Veterans received an element of their care through a Telehealth modality

<**1 percent** of Veteran received care in their home or non-VA location

Modality

- More than **336,000 Veterans** used Clinical Video Telehealth
- More than **306,000 Veterans** used Store and Forward Telehealth
- More than **145,000 Veterans** were enrolled in Home Telehealth

Improved patient outcomes resulting in reduced use of inpatient care in FY2017

- Veterans enrolled in Home Telehealth for non-institutional care needs and chronic care management had a **57 percent decrease** in VA bed days of care, and a **31 percent decrease** in VA hospital admissions.
- Mental Health services provided to Veterans via Clinical Video Telehealth (TeleMental Health) reduced Acute Psychiatric VA bed days of care by **34 percent**, and VA hospital admissions by **31 percent**.

VA Telehealth Services

Where VA Telehealth Occurs

Home



- Home Telehealth (Remote Monitoring)
- VA Video Connect
- Secure Messaging
- Telephone Visits
- Contact Center s
- mHealth - Apps, Annie

Clinic



- Video Telehealth
 - Primary Care
 - Mental Health
 - 50+ specialties
- Store and Forward Telehealth

Hospital



- TeleICU
- TeleStroke

How VA Implements Telehealth

Facility



Goal:
Telehealth
Integration
into all routine
operations



Regional

Telehealth Resource Hubs

- TeleDermatology
- TeleMental Health
- TelePrimary Care
- TeleRehabilitation
- TeleSleep

National



Expert TeleConsultation

- National TeleMental Health Center
- Provider to Provider Consultation (ECHO)
- TeleGenomics

VHA Telehealth – Why It Matters

Accessibility

- Convenience
- Expanded access
- Care available at home or preferred location

Capacity

- Helps match supply and demand across the enterprise
- Fills clinical service gaps in rural and underserved areas

Quality

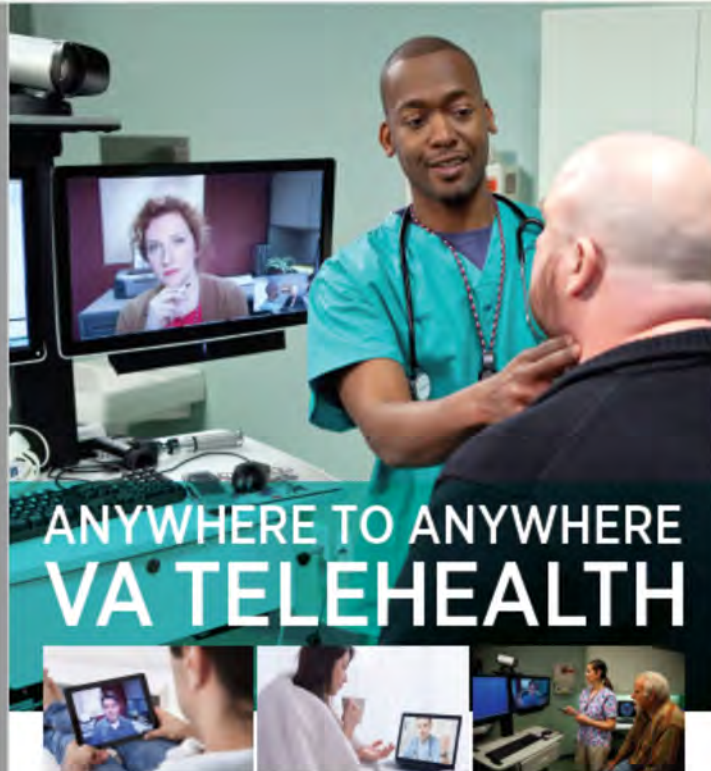
- Connects Veterans with rare conditions to specialized expertise
- Enhances provider networking (“curbside” consults) across the enterprise
- Supports standardization of best practices

VA Telehealth Regional/National Hubs

- *Enables VA to hire providers in urban areas to serve areas with fewer providers:*
 - **Ten TeleMental hubs** provide video mental health appointments. (Locations: Pittsburgh, PA; Charleston, SC; Salt Lake City, UT; the Pacific Northwest, New York, NY; West Haven CT; Honolulu, HI; Sioux Falls, SD; Battle Creek, MI; and Harlingen, TX)
 - **Eight VA TelePrimary Care Hubs** support delivery of primary care. (Locations: Boise, ID; Little Rock, AR; San Francisco, CA; Honolulu, HI; Prescott, AZ; Atlanta, GA; Minneapolis, MN; and Richmond, VA)
 - **Two VA TeleICU centers** in Minneapolis, MN and Cincinnati, OH provide additional support to intensive care unit staff in approximately 300 out of about 1,700 VA ICU beds across the nation.
 - **VA's TeleGenomic Medicine Services**, based in Utah, provides genomic medicine and counseling service to more than 80 VA medical centers.
 - **VA's National TeleMental Health Center**, based in Connecticut, provides national clinical experts in affective, psychotic, anxiety, and substance use disorders, as well as neurology treatment and has provided services to more than 5,600 Veterans in the last seven years.

Anywhere to Anywhere Telehealth


- On August 3, 2017, the President discussed plans to **expand VA telehealth services**.
- VA announced a proposed rule allows for **VA providers to deliver telehealth services from anywhere in the country to Veterans anywhere in the country**, whether it's in their homes or any location. (Rule expected to be final this spring.)
- VA launched **VA Video Connect**, an app that allows Veterans receiving VA care to access those health care services on their smartphones, tablets and personal computers.



**ANYWHERE TO ANYWHERE
VA TELEHEALTH**

VA delivers Telehealth care in more than 50 specialties

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VA Video Connect



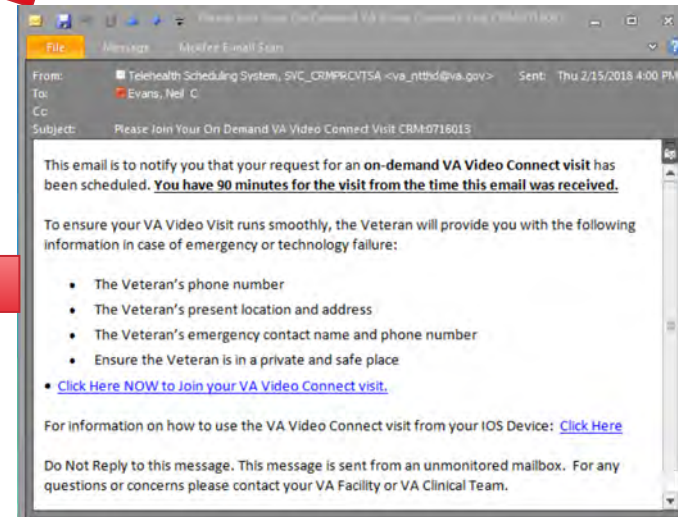
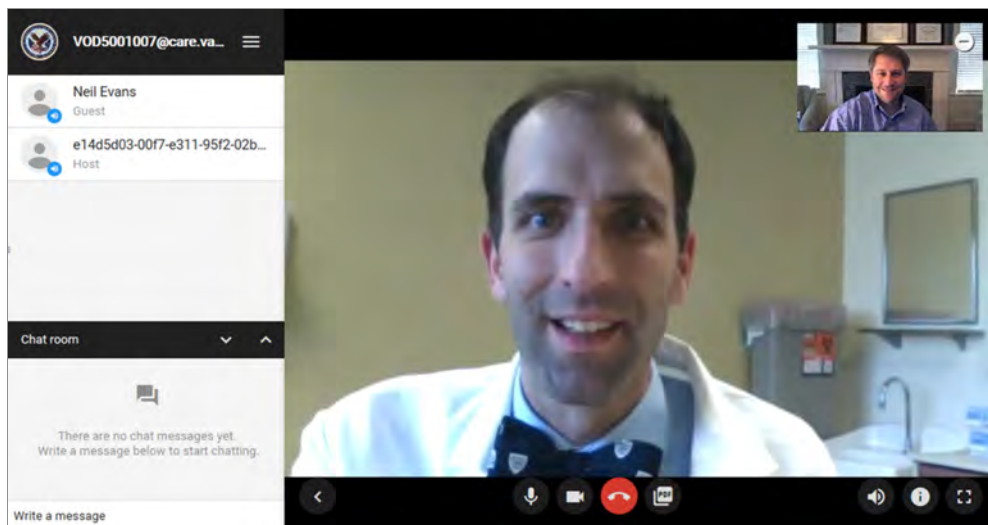
https://internalcrm....

internalcrm.crm15.xrm.va....

Request an On Demand VA Video Connect

Provider E-mail Address *

Patient E-mail Address *



A Home Telehealth Success Story:

Command Sergeant Major George W. Howell, Jr. USA (Ret.)

“I love the VA’s Home Telehealth program...it’s like having a doctor and a nurse right over your shoulder. It’s the best program in the VA.”

“I take my numbers everyday. I send over my numbers and if something is off I get a call from my nurse asking what I ate or what is wrong. I’ve lost 40 pounds on that Home Telehealth program.”

“Every time I go the VA, I talk [the Home Telehealth program] up to other Veterans...and tell them to talk to their doctors about it. It’s a life-changer.”



Questions?

From: (b) (6) </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: VSO Breakfast Invite List
Date: Thu Apr 05 2018 09:46:18 CDT
Attachments:

Colonel (b) (6)
Pam Powers, Senior Advisor

From: (b) (6) <(b) (6)@va.gov>
Date: Wednesday, April 4, 2018 at 4:26 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>
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Date/Time: Friday, April 6th – 8:00 – 9:00 AM

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Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

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(b) (6), (b) (7)(C) White House Office of Public Liaison

(b) (6), (b) (7)(C) White House Domestic Policy Council
(b) (6), (b) (7)(C)

I'll let you know when we are final.

Thanks!

(b) (6)

From: "(b) (6) <(b) (6)@va.gov>
Date: Wednesday, April 4, 2018 at 10:06 AM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>
Subject: VSO Breakfast Invite List

(b) (6) per our discussion, here's the VSO breakfast invite list – please let me know if you and the team have any suggested edits/corrections.

Event/Meeting: VSO Breakfast with Acting Secretary Robert Wilkie

Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

VA Invitees:

- The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs
- The Honorable Thomas Bowman, Deputy Secretary of Veterans Affairs, Department of Veterans Affairs
- Peter O'Rourke, Chief of Staff, Office of the Secretary
- Jacquelyn Hayes-Byrd, Deputy Chief of Staff, Office of the Secretary, Office of the Secretary
- Brooks Tucker, Assistant Secretary, Office of Congressional and Legislative Affairs, VA
- John Ulyot, Assistant Secretary, Office of Public and Intergovernmental Affairs, VA
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- Dr. Carolyn Clancy, Executive in Charge, Veterans Health Administration, VA
- Randy Reeves, Under Secretary for Memorial Affairs, VA
- (b) (6) Special Assistant to the Secretary for VSOs, VA

VSO Invitees:

- Ms. (b) (6) Executive Director, The American Legion (TAL)
- Mr. (b) (6) Executive Director, Disabled American Veterans (DAV)
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(b) (6) M.B.A.

Acting Special Assistant to the Secretary for VSOs
Office of the Secretary
Department of Veterans Affairs
810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

From: (b) (6) </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: RE: VSO Breakfast Invite List
Date: Wed Apr 04 2018 14:01:16 CDT
Attachments:

Peter wants to talk about he invites before we send.

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:25:45 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

(b) (6) I tried calling but didn't reach (b) (5)

Thanks
(b) (6)

(b) (6) M.B.A.
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To: (b) (6)
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Who is the Legion sending?

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(b) (6) I already sent invites to DAV, Legion, VFW, PVA, AMVETS, VVA WWP, IAVA and MOAA. All have confirmed except for VFW, their principal will be on travel, and the Legion is sending their Director as their principal will be on travel.

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To: (b) (6)
Subject: RE: VSO Breakfast Invite List

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Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 8:54:36 AM
To: (b) (6)
Subject: Re: VSO Breakfast Invite List

Peter is going to work on the list of VA employees in attendance so make more room for VSO's, but for the external list, lets start by adding:

Dan Caldwell, CVA
(b) (5) Independence Fund
(b) (6), (b) (7)(C) White House Office of Public Liaison
(b) (6), (b) (7)(C) White House Domestic Policy Council
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Washington, DC 20420

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B: 202-684-(b) (6)

From: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: Davis, Lynda </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Tucker, Brooks </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc: COS-PMO </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Hayes-Byrd, Jacquelyn </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Bcc:
Subject: Re: Guest List - VSO Breakfast April 6, 2018
Date: Wed Apr 04 2018 13:25:59 CDT
Attachments:

CVA and IF both coming.

Peter is going to tighten up the VA group to make room for more outside attendees.

From: "Davis, Lynda" <Lynda.Davis@va.gov>
Date: Wednesday, April 4, 2018 at 2:24 PM
To: "Tucker, Brooks" <Brooks.Tucker@va.gov>, Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>
Cc: Peter O <COS-PMO@va.gov>, "Hayes-Byrd, Jacquelyn" <Jacquelyn.Hayes-Byrd@va.gov>
Subject: RE: Guest List - VSO Breakfast April 6, 2018

I understand VHA ownership of currently relevant legislation but if mtg is NOT about legislation but about moving forward then all key leadership needs to be present - it would be a notable absence not to have VBA.

I understand that CVA and IF were at last WH mtg. Their presence (and now that of AmVets) will be a statement from the new leadership.

This just needs to be thought through with intention depending on the message that is to be shared.

Lynda

Lynda C. Davis, Ph.D.
Chief Veterans Experience Officer
Department of Veterans Affairs

Sent with Good (www.good.com)

From: Tucker, Brooks
Sent: Wednesday, April 04, 2018 10:46:52 AM

To: Davis, Lynda; (b) (6)
Cc: COS-PMO; Hayes-Byrd, Jacquelyn
Subject: RE: Guest List - VSO Breakfast April 6, 2018

VHA owns Choice/Care so they are specifically relevant, if we want to nod in that direction and have the administration leader present to hear VSOs' views.

For background, IF and CVA were invited to the last VSO meeting at the WH, where Choice/Care and also Caregiver were discussed.

Sent with Good (www.good.com)

From: Davis, Lynda
Sent: Wednesday, April 04, 2018 8:44:54 AM
To: Tucker, Brooks; (b) (6)
Cc: COS-PMO; Hayes-Byrd, Jacquelyn
Subject: RE: Guest List - VSO Breakfast April 6, 2018

If VBA is not represented then VHA souls not be.

Recommend against IF being present as I'm including them other ways. There are many VSO/MSOs that should be considered in addition to IF. Glad to discuss this on the phone.

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I see VBA is not going to be represented, so if that isn't an oversight, would recommend VBA remain off list and that take USMA off the list.

OCLA would like to keep a sharp focus on CHOICE-CARE and, as needed, Caregivers, which are both VHA centric.

Brooks

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Sent: Wednesday, April 04, 2018 10:50 AM
To: Tucker, Brooks; Davis, Lynda
Cc: COS-PMO; Hayes-Byrd, Jacquelyn
Subject: Guest List - VSO Breakfast April 6, 2018

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Thanks!

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Bcc:
Subject: RE: Guest List - VSO Breakfast April 6, 2018
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Bcc:
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Date: Wed Apr 04 2018 12:46:52 CDT
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To: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: RE: VSO Breakfast Invite List
Date: Wed Apr 04 2018 11:32:47 CDT
Attachments:

Sure thing, hope appointment goes well:)

(b) (6) M.B.A.
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810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 9:27:19 AM
To: (b) (6)
Subject: RE: VSO Breakfast Invite List

Ok, it was being tossed around. I'm getting a chipped tooth looked at by my dentist here in a minute, I'll follow up when I get back!

Thanks man!

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Sent: Wednesday, April 04, 2018 9:25:45 AM
To: (b) (6)
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(b) (6) I tried calling but didn't reach (b) (5)

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Washington, DC 20420
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Sent: Wednesday, April 04, 2018 8:54:36 AM
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(u) (v), (u) (f)(u) White House Domestic Policy Council
(b) (7)(C)

I'll let you know when we are final.

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Date: Wednesday, April 4, 2018 at 10:06 AM

To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>

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Event/Meeting: VSO Breakfast with Acting Secretary Robert Wilkie

Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

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Subject: RE: VSO Breakfast Invite List
Date: Wed Apr 04 2018 11:27:19 CDT
Attachments:

Ok, it was being tossed around. I'm getting a chipped tooth looked at by my dentist here in a minute, I'll follow up when I get back!

Thanks man!

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(b) (6) M.B.A.
 Acting Special Assistant to the Secretary for VSOs
 Office of the Secretary
 Department of Veterans Affairs
 810 Vermont Avenue NW Office 1023
 Washington, DC 20420
 O: 202-461-(b) (6)
 B: 202-684-(b) (6)

From: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: RE: VSO Breakfast Invite List
Date: Wed Apr 04 2018 11:08:23 CDT
Attachments:

Thanks (b) (6) - will update the list as well as provide a list of VSO RSVPs by CoB today. Do you have the contact info and/or want to invite Dan, (b) (6), (b) (7) (C) and (b) (6), (b) (7) (C)

(b) (6) M.B.A.
Acting Special Assistant to the Secretary for VSOs
Office of the Secretary
Department of Veterans Affairs
810 Vermont Avenue NW Office 1023
Washington, DC 20420
O: 202-461-(b) (6)
B: 202-684-(b) (6)

From: (b) (6)
Sent: Wednesday, April 04, 2018 8:54:36 AM
To: (b) (6)
Subject: Re: VSO Breakfast Invite List

Peter is going to work on the list of VA employees in attendance so make more room for VSO's, but for the external list, lets start by adding:

Dan Caldwell, CVA
(b) (5) Independence Fund
(b) (6), (b) (7)(C) White House Office of Public Liaison
(u) (o), (u) (r) (C) White House Domestic Policy Council
(b) (6), (b) (7)(C)
(C)

I'll let you know when we are final.

Thanks!
(b) (6)

From: (b) (6) <(b) (6)@va.gov>
Date: Wednesday, April 4, 2018 at 10:06 AM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>

Subject: VSO Breakfast Invite List

(b) (6) per our discussion, here's the VSO breakfast invite list – please let me know if you and the team have any suggested edits/corrections.

Event/Meeting: VSO Breakfast with Acting Secretary Robert Wilkie

Date/Time: Friday, April 6th – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

VA Invitees:

- The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs
- The Honorable Thomas Bowman, Deputy Secretary of Veterans Affairs, Department of Veterans Affairs
- Peter O'Rourke, Chief of Staff, Office of the Secretary
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O: 202-461-(b) (6)
B: 202-684-(b) (6)

From: (b) (6) </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: VSO Breakfast Invite List
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(b) (6), (b) (7)(C) White House Domestic Policy Council
(b) (6)
(C)

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Thanks!

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From: (b) (6) <(b) (6)@va.gov>
Date: Wednesday, April 4, 2018 at 10:06 AM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6)@va.gov>
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From: Davis, Lynda </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: Tucker, Brooks </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> (b) (6)
</o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc: COS-PMO </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Hayes-Byrd, Jacquelyn </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Bcc:
Subject: RE: Guest List - VSO Breakfast April 6, 2018
Date: Wed Apr 04 2018 10:44:54 CDT
Attachments:

If VBA is not represented then VHA souls not be.

Recommend against IF being present as I'm including them other ways. There are many VSO/MSOs that should be considered in addition to IF. Glad to discuss this on the phone.

Lynda

Lynda C. Davis, Ph.D.
Chief Veterans Experience Officer
Department of Veterans Affairs

Sent with Good (www.good.com)

From: Tucker, Brooks
Sent: Wednesday, April 04, 2018 8:10:20 AM
To: (b) (6) Davis, Lynda
Cc: COS-PMO; Hayes-Byrd, Jacquelyn
Subject: RE: Guest List - VSO Breakfast April 6, 2018

(b) (6) et al, Recommend adding CVA (Dan Caldwell) and Independence Fund (b) (5) Also, (b) (6), (b) (7) from WH Intergovernmental and (b) (6), (b) (7)(C) from WH DPC, if one or both are desired and we have seat space. They would show our unity with WH on the policy front. (c)

I see VBA is not going to be represented, so if that isn't an oversight, would recommend VBA remain off list and that take USMA off the list.

OCLA would like to keep a sharp focus on CHOICE-CARE and, as needed, Caregivers, which are both VHA centric.

Brooks

From: (b) (6)
Sent: Wednesday, April 04, 2018 10:50 AM
To: Tucker, Brooks; Davis, Lynda
Cc: COS-PMO; Hayes-Byrd, Jacquelyn
Subject: Guest List - VSO Breakfast April 6, 2018

Brooks/Lynda,

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Thanks!

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From: Tucker, Brooks </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Davis, Lynda </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc: COS-PMO </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Hayes-Byrd, Jacquelyn </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Bcc:
Subject: RE: Guest List - VSO Breakfast April 6, 2018
Date: Wed Apr 04 2018 10:10:20 CDT
Attachments:

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Sent: Wednesday, April 04, 2018 10:50 AM
To: Tucker, Brooks; Davis, Lynda
Cc: COS-PMO; Hayes-Byrd, Jacquelyn
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From: Aerolib Healthcare Solutions LLC
<ceo@aerolib.com>
To: DJS </o=va/ou=exchange administrative
group (fydibohf23spdlt)/cn=recipients (b) (6)>
Cc:
Bcc:
Subject: [MARKETING] [EXTERNAL] EPAS Show April 5 at 12 noon Central / What Lies
Beneath: Documentation regarding TIA vs CVA
Date: Thu Mar 29 2018 10:24:49 CDT
Attachments:

A Show By & For Physician Advisors

Empowering Physician Advisors Show
Thursday April 5 at 12 pm Central / 1pm Eastern

Next week`s topic:

What Lies Beneath:

Documentation regarding TIA vs CVA

GET THE DETAILS !

Our goal is to empower Physician Advisors and those who work with them to support provider facilities with the best ability to meet billing & revenue compliance, by providing the best possible environment for appropriate revenue integrity.

We choose to do this by discussing and presenting known solutions and possible methods to make clinical records and documentation survive payor audits of all kinds.

Our chosen vehicle to deliver results is a series of free weekly online meetings or webinars, done by physician advisors, for physician advisors.

Agenda for Empowering Physician Advisors Show!

Discussion of TIA/CVA Cases, Coding, Documentation, Medical Necessity & 360 Analysis

Do you know how the clinical indicators help show the severity of illness?

Do you know specifically what's different about the NEW definition of TIA?

Do you know the difference in medical necessity for TIA versus CVA?

All shows are archived in the Aerolib Learning Management System

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[Unsubscribe](#) [vacodjs1@va.gov](#)

[Update Profile](#) | [About our service provider](#)

Sent by ceo@aerolib.com in collaboration with

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From: (b) (6) @aol.com>
To: (b) (6) (Miami VA)
</o=va/ou=external
(fydibohf25spdlt)/cn=recipients/cn=(b) (6)
(b) (6) @gmail.com>; (b) (6) (Miami
VA) </o=va/ou=visn 08/cn=recipients/cn=(b) (6)
>; Shulkin,
David J., MD </o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
(b) (6) @gmail.com (b) (6) @gmail.com>;
(b) (6) @yahoo.com <(b) (6) @yahoo.com>; (b) (6)
</o=va/ou=vba (b) (6) cn=recipients/cn=(b) (6)
(b) (6) @hotmail.com <(b) (6) @hotmail.com>; (b) (6)
(Miami VA) </o=va/ou=visn 08/cn=recipients/cn=(b) (6)
Kevin Caldwell <(b) (6) @aol.com>; (b) (6) (Miami VA)
</o=va/ou=visn 08/cn=recipients/cn=(b) (6) (b) (6)
C. (Miami VA) </o=va/ou=visn 08/cn=recipients/cn=(b) (6)
(b) (6) (Ray) OAWP </o=va/ou=visn
16/cn=recipients/cn=(b) (6) (b) (6) @gmail.com
(b) (6) @gmail.com>; (b) (6) </o=va/ou=visn
18/cn=recipients/cn=(b) (6) (b) (6) @gmail.com
(b) (6) @gmail.com>

Cc:
Bcc:
Subject: [EXTERNAL] Thumb drive
Date: Mon Mar 26 2018 13:55:34 CDT
Attachments:

Although I have not worked in 11 month and I only have 7 days to respond to a removal letter and 10 to appeal my MSPB decision could you give me a little longer.
I am going to have the concern veterans of America start a whistle blower go fund me account. Also these would be all the emails from the people email accounts about me. If anyone of them is gone will it still give emails

Sent from my iPhone

From: (b) (6) <(b) (6)@cnas.org>
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Lunch next Tues 3/20
Date: Fri Mar 16 2018 06:15:30 CDT
Attachments:

Terrific. Look forward to seeing you then.

Sent from my iPhone

> On Mar 16, 2018, at 07:12, DJS <vacodjs1@va.gov> wrote:

>

> Great- 1245 pm ok?

>

>

>

> Sent with Good (www.good.com)

>

>

> From: (b) (6)

> Sent: Friday, March 16, 2018 4:07:29 AM

> To: DJS

> Subject: Re: [EXTERNAL] Lunch next Tues 3/20

>

> Sounds like G Street Cafe on 15th just north of K. Perfect. I will meet you whenever works best for you.

>

> Sent from my iPhone

>

>> On Mar 15, 2018, at 19:59, DJS <vacodjs1@va.gov> wrote:

>>

>> No it was a place then on 15 th that was across from bipop rice bar and had counter service

>>

>>

>>

>> Sent with Good (www.good.com<http://www.good.com>)

>>

>>

>> From: (b) (6)

>> Sent: Thursday, March 15, 2018 3:45:23 PM

>> To: DJS

>> Subject: [EXTERNAL] Lunch next Tues 3/20

>>

>> Lunch Tuesday, 3/20, sounds great. I think PJ Clarke's is the restaurant you're thinking of, but Mirabella or McCormicks or BLT also work well — whatever you prefer.

>>

>> Sent from my iPhone

>>

>>> On Mar 15, 2018, at 17:21, DJS <vacodjs1@va.gov> wrote:

>>>

>>> How is next Tuesday at that place I saw you last time - forget the name but it was on 16th near K?
>>>
>>>
>>>
>>> Sent with Good (www.good.com<http://www.good.com<http://www.good.com<http://www.good.com>>)
>>>
>>>
>>> From: (b) (6)
>>> Sent: Thursday, March 15, 2018 2:01:21 PM
>>> To: DJS
>>> Subject: Re: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea
>>>
>>> Yes - would be happy to do so. Please let me know when your schedule allows.
>>>
>>> On 3/15/18, 3:28 PM, "DJS" <vacodjs1@va.gov> wrote:
>>>
>>> Thanks so much (b) (6)
>>>
>>> DC is truly crazy- so I appreciate your rational approach to things
>>>
>>> How about catching up for lunch sometime soon?
>>>
>>>
>>>
>>> Sent with Good (www.good.com<http://www.good.com<http://www.good.com<http://www.good.com<http://www.good.com>>>)
>>>
>>>
>>> From: (b) (6)
>>> Sent: Thursday, March 15, 2018 11:58:56 AM
>>> To: DJS
>>> Subject: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea
>>>
>>> Thought I would share this column from today. Hope you're doing as well as possible under the circumstances. Hang in there. v/r (b) (6)
>>>
>>> https://slate.com/news-and-politics/2018/03/firing-veterans-affairs-secretary-david-shulkin-is-a-bad-idea.html?wpsrc=sh_all_dt_tw_ru
>>>
>>> Firing VA Secretary David Shulkin Is a Bad Idea
>>> He's accomplishing a lot of good for America's veterans—and for Trump.
>>>
>>> By (b) (6)
>>>
>>> Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>>, "We'll never have to use those words ['You're fired'] on our David."
>>>
>>> Eight months later, that declaration may prove ironic. Fissures have emerged and deepened between Shulkin and the president's political allies over what, exactly, the VA should be doing. On top of this, two relatively minor scandals involving Shulkin have blown up his tenure and stalled major reform. Now, Shulkin faces conflict on three overlapping fronts, leaving him at the precipice of being fired and replaced by a closer Trump ally as the administration seeks to reduce the chaos<<https://www.>

cnn.com/2018/03/13/politics/trump-departures-white-house/index.html> in its Cabinet.

>>>

>>> The first battle Shulkin is fighting has deep roots<<https://www.foreignaffairs.com/articles/2017-08-15/what-america-owes-its-veterans>> in veterans population demographics<https://www.rand.org/pubs/research_reports/RR1165z4.html> and the evolution of VA benefits over the past several decades. From the time they join up to their moment of discharge, service members<<https://www.rand.org/pubs/monographs/MG265.html>> belong to the Department of Defense. After that, they become eligible for a broad array of veterans programs that are administered by the VA's three large administrations: health, benefits, and cemeteries. These programs have evolved<<https://www.rand.org/pubs/monographs/MG1164.html>> from stingy pensions for seriously disabled veterans after the Revolution to the generous, comprehensive system of health care, disability compensation, and economic programs that exists today. All eligible veterans—meaning primarily those who serve on active duty and leave with an honorable discharge<<https://www.swords-to-plowshares.org/2016/03/30/underserved/>>—can avail themselves of these benefits, not just combat veterans or those who were wounded in the line of duty.

>>>

>>> To meet these obligations, the VA consumes a massive amount of money each year. Its 2019 budget request is \$198.6 billion<<https://www.va.gov/budget/products.asp>>—a big increase over previous years at a time when most agencies are facing cuts and totaling more than the budgets of the State Department<<https://www.state.gov/s/d/rm/c6112.htm>>, Homeland Security<<https://www.dhs.gov/dhs-budget>>, and the entire<<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program>> intelligence<<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/>> community<<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-militar/>> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

>>>

>>> Since 9/11, the VA's budget has steadily increased<<https://www.cnas.org/publications/reports/passing-the-baton-a-bipartisan-2016-agenda-for-the-veteran-and-military-community>> at a rate far greater than inflation, even as the total population of veterans has decreased. Older veterans of the Vietnam and Cold War eras rely heavily on VA services. So too does the post-9/11 generation<<https://www.publichealth.va.gov/epidemiology/reports/oeofond/>>, of whom more than 3 million have deployed to Iraq, Afghanistan, or other theaters of war. These retired service members are using the VA at much higher rates than previous generations. This demand from young and old veterans alike is putting enormous pressure on the VA—which failed to adequately predict any of this increased demand, let alone prepare and budget<<https://www.bostonglobe.com/opinion/2016/10/17/the-trillion-wars/uPVfSuDutnTZl5fIQ7YlIK/story.html>> for it.

>>>

>>> In 2014, this problem erupted in Phoenix, where veterans endlessly waited for appointments while VA employees played a shell game with veterans to deceive them and their bosses in Washington. That scandal forced the ouster<http://www.slate.com/articles/news_and_politics/politics/2014/05/shinseki_resigns_here_s_how_to_fix_the_va.html> of VA Secretary (and retired Army Gen.) Eric Shinseki and prompted the creation of a program to purchase VA care from the private sector.

>>>

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is-a-very-real-issue-right-now-american-legion-says/> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html>> Concerned Veterans for America<<https://cv4a.org/>> and many of Trump’s allies in Congress, who would like to<<https://cv4a.org/project/taskforce/>> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html>> with congressional leaders in the House and Senate.

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>>> Shulkin’s second battle—political infighting with more partisan members of the administration—inflames and complicates these policy disagreements. He is the sole survivor of the Obama administration among Cabinet officials serving Trump. A practicing physician and successful health executive, Shulkin came to the Obama administration to run the VA health care system after the 2014 Phoenix scandal. His selection came after a turbulent Trump transition, during which the president interviewed several potential candidates before settling on Shulkin. Trump reportedly gave Shulkin the job because the New Jersey physician persuaded him he could continue the slow, deliberate privatization<<https://hbr.org/2016/12/a-transformation-is-underway-at-u-s-veterans-affairs-we-got-an-inside-look%20The%20case%20study%20conducted%20by%20Harvard%20Business%20School%20on%20the%20transformation%20underway%20at%20VA>> of the VA and deliver other wins to Trump on issues like employee accountability<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> (read: easier firing of civil servants).

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>>> Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask Congress<https://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf> for more money<<http://www.modernhealthcare.com/article/20170927/NEWS/170929901>> to fund<<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/>> the popular program<<https://www.stripes.com/news/congress-approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>>. Shulkin made a difficult decision<<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/>> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>>). And, Shulkin has presided over the termination<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/>> problems at the VA’s Washington hospital and proposing to kill the VA’s support<<https://www.politico.com/story/2017/12/06/homeless-veterans-benefits-trump-207781>> for homeless veterans, before walking back that idea in the face of public outcry.

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>>> Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>> and Trump campaign operative Cam Sandoval, began working late last year<<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html>> to engineer Shulkin’s exit<https://www.washingtonpost.com/amhtml/world/national-security/white-house-targets-vas-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html>. According to the Washington Post<https://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376>, these nominees have actively sought to sabotage Shulkin’s tenure, going so far as to call congressional leaders and lobby them to push for Shulkin’s ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more

and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

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>>> It is against this backdrop that Shulkin must wage his third and most personal battle: a fight over two internal ethics investigations by the VA's inspector general. The first investigation was triggered by Washington Post reporting<https://www.washingtonpost.com/investigations/va-chief-took-in-wimbledon-river-cruise-on-european-work-trip/2017/09/29/c1f17046-a458-11e7-8c37-e1d99ad6aa22_story.html> about Shulkin's trip to meet with veterans officials in Europe—a trip that included a detour to Wimbledon, and a few days of vacation too. The VA's inspector general scorched Shulkin<https://www.washingtonpost.com/politics/veterans-affairs-chief-shulkin-staff-misled-ethics-officials-about-european-trip-report-finds/2018/02/14/f7fbc020-0c3a-11e8-8b0d-891602206fb7_story.html> in its report on this trip, finding that permission to bring his wife had been predicated on a falsified email from Shulkin's chief of staff and that Shulkin had impermissibly ordered his staff into travel concierge duty. Shulkin pushed back, retaining counsel to dissect the IG report, and he even suggested<<http://thehill.com/policy/defense/374009-va-secretary-says-he-wont-resign-doubles-down-on-allegations-aides-email-was>> that his chief of staff's email had been hacked. (It was not<<http://thehill.com/policy/defense/376045-watchdog-former-top-va-aides-email-was-not-hacked>>.) A day later, however, Shulkin's chief of staff announced<<https://www.militarytimes.com/veterans/2018/02/16/va-chief-of-staff-resigns-amid-secretarys-travel-scandal/>> her retirement, and Shulkin said<https://www.washingtonpost.com/world/national-security/va-secretary-shulkin-under-fire-for-europe-trip-to-appear-before-house-panel/2018/02/14/0c65702e-11c2-11e8-8ea1-c1d91fcec3fe_story.html?utm_term=.aa7311c9a3f1> he would repay the government for the cost of his wife's airfare.

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>>>

>>> At this point, Shulkin's fate rests with Trump. Although Trump has largely benefited from Shulkin's service, the president must now decide whether he's better off with a competent leader like Shulkin, or a closer political ally who might march more in step with the base. The potential contenders include Energy Secretary Rick Perry (who said Wednesday<<http://abcnews.go.com/Politics/wireStory/latest-rick-perry-va-job-53748413>> he doesn't want the job), one of the 88 retired generals who endorsed<<https://www.politico.com/story/2016/09/retired-generals-admirals-endorse-trump-227755>> Trump in 2016, or veterans in Congress like Sens. Joni Ernst or Tom Cotton, whose chances are lower because of their importance to the Republicans' razor-thin Senate majority. Whether Shulkin stays or goes, the primary battle he waged, over the future of the VA, will continue. Trump is arguably better off keeping Shulkin around to keep waging this battle, and veterans are arguably better off with that outcome too.

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>>> (b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\) \(6\)](https://www.cnas.org/people/(b) (6))> and adjunct professor of law at Georgetown University. The views expressed

are the author's alone and not representative of his organization.

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From: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/(b) (6)>
To: (b) (6) <(b) (6)@cnas.org>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Lunch next Tues 3/20
Date: Fri Mar 16 2018 06:11:42 CDT
Attachments:

Great- 1245 pm ok?

Sent with Good (www.good.com)

From: (b) (6)
Sent: Friday, March 16, 2018 4:07:29 AM
To: DJS
Subject: Re: [EXTERNAL] Lunch next Tues 3/20

Sounds like G Street Cafe on 15th just north of K. Perfect. I will meet you whenever works best for you.

Sent from my iPhone

> On Mar 15, 2018, at 19:59, DJS <vacodjs1@va.gov> wrote:

>

> No it was a place then on 15 th that was across from bipop rice bar and had counter service

>

>

>

> Sent with Good (www.good.com)

>

>

> From: (b) (6)
> Sent: Thursday, March 15, 2018 3:45:23 PM
> To: DJS
> Subject: [EXTERNAL] Lunch next Tues 3/20

>

> Lunch Tuesday, 3/20, sounds great. I think PJ Clarke's is the restaurant you're thinking of, but Mirabella or McCormicks or BLT also work well — whatever you prefer.

>

> Sent from my iPhone

>

>> On Mar 15, 2018, at 17:21, DJS <vacodjs1@va.gov> wrote:

>>

>> How is next Tuesday at that place I saw you last time - forget the name but it was on 16th near K?

>>

>>

>>

>> Sent with Good (www.good.com<http://www.good.com>)
>>
>>
>> From: (b) (6)
>> Sent: Thursday, March 15, 2018 2:01:21 PM
>> To: DJS
>> Subject: Re: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea
>>
>> Yes - would be happy to do so. Please let me know when your schedule allows.
>>
>> On 3/15/18, 3:28 PM, "DJS" <vacodjs1@va.gov> wrote:
>>
>> Thanks so much (b) (6)
>>
>> DC is truly crazy- so I appreciate your rational approach to things
>>
>> How about catching up for lunch sometime soon?
>>
>>
>> Sent with Good (www.good.com<http://www.good.com<http://www.good.com<http://www.good.com>>)
>>
>>
>> From: (b) (6)
>> Sent: Thursday, March 15, 2018 11:58:56 AM
>> To: DJS
>> Subject: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea
>>
>> Thought I would share this column from today. Hope you're doing as well as possible under the circumstances. Hang in there. v/r (b) (6)
>>
>> https://slate.com/news-and-politics/2018/03/firing-veterans-affairs-secretary-david-shulkin-is-a-bad-idea.html?wpsrc=sh_all_dt_tw_ru
>>
>> Firing VA Secretary David Shulkin Is a Bad Idea
>> He's accomplishing a lot of good for America's veterans—and for Trump.
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>> By (b) (6)
>>
>> Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>>, "We'll never have to use those words ['You're fired'] on our David."
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>> Eight months later, that declaration may prove ironic. Fissures have emerged and deepened between Shulkin and the president's political allies over what, exactly, the VA should be doing. On top of this, two relatively minor scandals involving Shulkin have blown up his tenure and stalled major reform. Now, Shulkin faces conflict on three overlapping fronts, leaving him at the precipice of being fired and replaced by a closer Trump ally as the administration seeks to reduce the chaos<<https://www.cnn.com/2018/03/13/politics/trump-departures-white-house/index.html>> in its Cabinet.
>>
>> The first battle Shulkin is fighting has deep roots<<https://www.foreignaffairs.com/articles/2017-08-15/what-america-owes-its-veterans>> in veterans population demographics<https://www.rand.org/pubs/research_reports/RR1165z4.html> and the evolution of VA benefits over the past several

decades. From the time they join up to their moment of discharge, service members<<https://www.rand.org/pubs/monographs/MG265.html>> belong to the Department of Defense. After that, they become eligible for a broad array of veterans programs that are administered by the VA's three large administrations: health, benefits, and cemeteries. These programs have evolved<<https://www.rand.org/pubs/monographs/MG1164.html>> from stingy pensions for seriously disabled veterans after the Revolution to the generous, comprehensive system of health care, disability compensation, and economic programs that exists today. All eligible veterans—meaning primarily those who serve on active duty and leave with an honorable discharge<<https://www.swords-to-plowshares.org/2016/03/30/underserved/>>—can avail themselves of these benefits, not just combat veterans or those who were wounded in the line of duty.

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>> To meet these obligations, the VA consumes a massive amount of money each year. Its 2019 budget request is \$198.6 billion<<https://www.va.gov/budget/products.asp>>—a big increase over previous years at a time when most agencies are facing cuts and totaling more than the budgets of the State Department<<https://www.state.gov/s/d/rm/c6112.htm>>, Homeland Security<<https://www.dhs.gov/dhs-budget>>, and the entire<<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program>> intelligence<<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/>> community<<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-militar/>> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

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>> Since 9/11, the VA's budget has steadily increased<<https://www.cnas.org/publications/reports/passing-the-baton-a-bipartisan-2016-agenda-for-the-veteran-and-military-community>> at a rate far greater than inflation, even as the total population of veterans has decreased. Older veterans of the Vietnam and Cold War eras rely heavily on VA services. So too does the post-9/11 generation<<https://www.publichealth.va.gov/epidemiology/reports/oefoifond/>>, of whom more than 3 million have deployed to Iraq, Afghanistan, or other theaters of war. These retired service members are using the VA at much higher rates than previous generations. This demand from young and old veterans alike is putting enormous pressure on the VA—which failed to adequately predict any of this increased demand, let alone prepare and budget<<https://www.bostonglobe.com/opinion/2016/10/17/the-trillion-wars/uPVfSuDutnTZl5fIQ7YllK/story.html>> for it.

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>> In 2014, this problem erupted in Phoenix, where veterans endlessly waited for appointments while VA employees played a shell game with veterans to deceive them and their bosses in Washington. That scandal forced the ouster<http://www.slate.com/articles/news_and_politics/politics/2014/05/shinseki_resigns_here_s_how_to_fix_the_va.html> of VA Secretary (and retired Army Gen.) Eric Shinseki and prompted the creation of a program to purchase VA care from the private sector.

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>> At this point, Shulkin's fate rests with Trump. Although Trump has largely benefited from Shulkin's service, the president must now decide whether he's better off with a competent leader like Shulkin, or a closer political ally who might march more in step with the base. The potential contenders include Energy Secretary Rick Perry (who said Wednesday<<http://abcnews.go.com/Politics/wireStory/latest-rick-perry-va-job-53748413>> he doesn't want the job), one of the 88 retired generals who endorsed<<https://www.politico.com/story/2016/09/retired-generals-admirals-endorse-trump-227755>> Trump in 2016, or veterans in Congress like Sens. Joni Ernst or Tom Cotton, whose chances are lower because of their importance to the Republicans' razor-thin Senate majority. Whether Shulkin stays or goes, the primary battle he waged, over the future of the VA, will continue. Trump is arguably better off keeping Shulkin around to keep waging this battle, and veterans are arguably better off with that outcome too.

>>

>>

>> (b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\)\(6\)](https://www.cnas.org/people/(b)(6))> and adjunct professor of law at Georgetown University. The views expressed are the author's alone and not representative of his organization.

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From: (b) (6) <(b) (6)@cnas.org>
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Lunch next Tues 3/20
Date: Fri Mar 16 2018 06:07:29 CDT
Attachments:

Sounds like G Street Cafe on 15th just north of K. Perfect. I will meet you whenever works best for you.

Sent from my iPhone

> On Mar 15, 2018, at 19:59, DJS <vacodjs1@va.gov> wrote:

>

> No it was a place then on 15 th that was across from bipop rice bar and had counter service

>

>

>

> Sent with Good (www.good.com)

>

>

> From: (b) (6)

> Sent: Thursday, March 15, 2018 3:45:23 PM

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> Subject: [EXTERNAL] Lunch next Tues 3/20

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> Lunch Tuesday, 3/20, sounds great. I think PJ Clarke's is the restaurant you're thinking of, but Mirabella or McCormicks or BLT also work well — whatever you prefer.

>

> Sent from my iPhone

>

>> On Mar 15, 2018, at 17:21, DJS <vacodjs1@va.gov> wrote:

>>

>> How is next Tuesday at that place I saw you last time - forget the name but it was on 16th near K?

>>

>>

>>

>> Sent with Good (www.good.com<http://www.good.com>)

>>

>>

>> From: (b) (6)

>> Sent: Thursday, March 15, 2018 2:01:21 PM

>> To: DJS

>> Subject: Re: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea

>>

>> Yes - would be happy to do so. Please let me know when your schedule allows.

>>

>> On 3/15/18, 3:28 PM, "DJS" <vacodjs1@va.gov> wrote:

>>

>> Thanks so much (b) (6)

>>

>> DC is truly crazy- so I appreciate your rational approach to things

>>
>> How about catching up for lunch sometime soon?
>>
>>
>>
>> Sent with Good (www.good.com<http://www.good.com<http://www.good.com<http://www.good.com>>)
>>
>>
>> From: (b) (6)
>> Sent: Thursday, March 15, 2018 11:58:56 AM
>> To: DJS
>> Subject: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea
>>
>> Thought I would share this column from today. Hope you're doing as well as possible under the circumstances. Hang in there. v/r (b) (6)
>>
>> https://slate.com/news-and-politics/2018/03/firing-veterans-affairs-secretary-david-shulkin-is-a-bad-idea.html?wpsrc=sh_all_dt_tw_ru
>>
>> Firing VA Secretary David Shulkin Is a Bad Idea
>> He's accomplishing a lot of good for America's veterans—and for Trump.
>>
>> By (b) (6)
>>
>> Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>>, "We'll never have to use those words ['You're fired'] on our David."
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>> Eight months later, that declaration may prove ironic. Fissures have emerged and deepened between Shulkin and the president's political allies over what, exactly, the VA should be doing. On top of this, two relatively minor scandals involving Shulkin have blown up his tenure and stalled major reform. Now, Shulkin faces conflict on three overlapping fronts, leaving him at the precipice of being fired and replaced by a closer Trump ally as the administration seeks to reduce the chaos<<https://www.cnn.com/2018/03/13/politics/trump-departures-white-house/index.html>> in its Cabinet.
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>> The first battle Shulkin is fighting has deep roots<<https://www.foreignaffairs.com/articles/2017-08-15/what-america-owes-its-veterans>> in veterans population demographics<https://www.rand.org/pubs/research_reports/RR1165z4.html> and the evolution of VA benefits over the past several decades. From the time they join up to their moment of discharge, service members<<https://www.rand.org/pubs/monographs/MG265.html>> belong to the Department of Defense. After that, they become eligible for a broad array of veterans programs that are administered by the VA's three large administrations: health, benefits, and cemeteries. These programs have evolved<<https://www.rand.org/pubs/monographs/MG1164.html>> from stingy pensions for seriously disabled veterans after the Revolution to the generous, comprehensive system of health care, disability compensation, and economic programs that exists today. All eligible veterans—meaning primarily those who serve on active duty and leave with an honorable discharge<<https://www.swords-to-plowshares.org/2016/03/30/underserved/>>—can avail themselves of these benefits, not just combat veterans or those who were wounded in the line of duty.
>>
>> To meet these obligations, the VA consumes a massive amount of money each year. Its 2019 budget request is \$198.6 billion<<https://www.va.gov/budget/products.asp>>—a big increase over previous years at a time when most agencies are facing cuts and totaling more than the budgets of the State Department<<https://www.state.gov/s/d/rm/c6112.htm>>, Homeland Security<<https://www.dhs>

gov/dhs-budget>, and the entire<<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program>> intelligence<<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/>> community<<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-militar/>> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

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>> Since 9/11, the VA's budget has steadily increased<<https://www.cnas.org/publications/reports/passing-the-baton-a-bipartisan-2016-agenda-for-the-veteran-and-military-community>> at a rate far greater than inflation, even as the total population of veterans has decreased. Older veterans of the Vietnam and Cold War eras rely heavily on VA services. So too does the post-9/11 generation<<https://www.publichealth.va.gov/epidemiology/reports/oefoifond/>>, of whom more than 3 million have deployed to Iraq, Afghanistan, or other theaters of war. These retired service members are using the VA at much higher rates than previous generations. This demand from young and old veterans alike is putting enormous pressure on the VA—which failed to adequately predict any of this increased demand, let alone prepare and budget<<https://www.bostonglobe.com/opinion/2016/10/17/the-trillion-wars/uPVfSuDutnTZl5fIQ7YlIK/story.html>> for it.

>>

>> In 2014, this problem erupted in Phoenix, where veterans endlessly waited for appointments while VA employees played a shell game with veterans to deceive them and their bosses in Washington. That scandal forced the ouster<http://www.slate.com/articles/news_and_politics/politics/2014/05/shinseki_resigns_here_s_how_to_fix_the_va.html> of VA Secretary (and retired Army Gen.) Eric Shinseki and prompted the creation of a program to purchase VA care from the private sector.

>>

>>

>> If the VA couldn't provide timely appointments for all veterans, Congress mused, the VA could instead purchase health care the way the Pentagon does for retirees. First as the VA's undersecretary for health, and then as secretary, Shulkin has devoted most of his energies toward implementing this new contracted-care system and making it work.

>>

>> All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization-is-a-very-real-issue-right-now-american-legion-says/>> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html>> Concerned Veterans for America<<https://cv4a.org/>> and many of Trump's allies in Congress, who would like to<<https://cv4a.org/project/taskforce/>> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html>> with congressional leaders in the House and Senate.

>>

>> Shulkin's second battle—political infighting with more partisan members of the administration—inflames and complicates these policy disagreements. He is the sole survivor of the Obama administration among Cabinet officials serving Trump. A practicing physician and successful health executive, Shulkin came to the Obama administration to run the VA health care system after the 2014 Phoenix scandal. His selection came after a turbulent Trump transition, during which the president interviewed several potential candidates before settling on Shulkin. Trump reportedly gave Shulkin the job because the New Jersey physician persuaded him he could continue the slow, deliberate privatization<<https://hbr.org/2016/12/a-transformation-is-underway-at-u-s-veterans-affairs-we-got-an-inside-look%20The%20case%20study%20conducted%20by%20Harvard%20Business%20School%20on%20the%20transformation%20underway%20at%20VA>> of the VA and deliver other wins to Trump on issues like employee accountability<https://www.va.gov/accountability/Adverse_Actions_Report.pdf>

(read: easier firing of civil servants).

>>

>> Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask Congresshttps://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf for more money<http://www.modernhealthcare.com/article/20170927/NEWS/170929901> to fund<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/> the popular program<https://www.stripes.com/news/congress/approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>. Shulkin made a difficult decision<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>). And, Shulkin has presided over the terminationhttps://www.va.gov/accountability/Adverse_Actions_Report.pdf of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/> problems at the VA's Washington hospital and proposing to kill the VA's support<https://www.politico.com/story/2017/12/06/homeless-veterans-benefits-trump-207781> for homeless veterans, before walking back that idea in the face of public outcry.

>>

>> Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html> and Trump campaign operative Cam Sandoval, began working late last year<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html> to engineer Shulkin's exithttps://www.washingtonpost.com/amhtml/world/national-security/white-house-targets-vas-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html. According to the Washington Posthttps://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376, these nominees have actively sought to sabotage Shulkin's tenure, going so far as to call congressional leaders and lobby them to push for Shulkin's ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

>>

>> It is against this backdrop that Shulkin must wage his third and most personal battle: a fight over two internal ethics investigations by the VA's inspector general. The first investigation was triggered by Washington Post reportinghttps://www.washingtonpost.com/investigations/va-chief-took-in-wimbledon-river-cruise-on-european-work-trip/2017/09/29/c1f17046-a458-11e7-8c37-e1d99ad6aa22_story.html about Shulkin's trip to meet with veterans officials in Europe—a trip that included a detour to Wimbledon, and a few days of vacation too. The VA's inspector general scorched Shulkinhttps://www.washingtonpost.com/politics/veterans-affairs-chief-shulkin-staff-misled-ethics-officials-about-european-trip-report-finds/2018/02/14/f7fbc020-0c3a-11e8-8b0d-891602206fb7_story.html in its report on this trip, finding that permission to bring his wife had been predicated on a falsified email from Shulkin's chief of staff and that Shulkin had impermissibly ordered his staff into travel concierge duty. Shulkin pushed back, retaining counsel to dissect the IG report, and he even suggested<http://thehill.com/policy/defense/374009-va-secretary-says-he-wont-resign-doubles-down-on-allegations-aides-email-was> that his chief of staff's email had been hacked. (It was not<http://thehill.com/policy/defense/376045-watchdog-former-top-va-aides-email-was-not-hacked>.) A day later, however, Shulkin's chief of staff announced<https://www.militarytimes.com/veterans/2018/02/16/va-chief-of-staff-resigns-amid-secretarys-travel-scandal/> her retirement, and Shulkin said<https://www.washingtonpost.com/world/national-security/va-secretary-shulkin-under-fire-for-europe-trip-to-appear>

before-house-panel/2018/02/14/0c65702e-11c2-11e8-8ea1-c1d91fcec3fe_story.html?utm_term=.aa7311c9a3f1> he would repay the government for the cost of his wife's airfare.

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> All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization-is-a-very-real-issue-right-now-american-legion-says/>> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html>> Concerned Veterans for America<<https://cv4a.org/>> and many of Trump's allies in Congress, who would like to<<https://cv4a.org/project/taskforce/>> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html>> with congressional leaders in the House and Senate.

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> Shulkin's second battle—political infighting with more partisan members of the administration—inflames and complicates these policy disagreements. He is the sole survivor of the Obama administration among Cabinet officials serving Trump. A practicing physician and successful health executive, Shulkin came to the Obama administration to run the VA health care system after the 2014 Phoenix scandal. His selection came after a turbulent Trump transition, during which the president interviewed several potential candidates before settling on Shulkin. Trump reportedly gave Shulkin the job because the New Jersey physician persuaded him he could continue the slow, deliberate privatization<<https://hbr.org/2016/12/a-transformation-is-underway-at-u-s-veterans-affairs-we-got-an-inside-look%20The%20case%20study%20conducted%20by%20Harvard%20Business%20School%20on%20the%20transformation%20underway%20at%20VA>> of the VA and deliver other wins to Trump on issues like employee accountability<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> (read: easier firing of civil servants).

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> Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask

Congresshttps://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf for more money<http://www.modernhealthcare.com/article/20170927/NEWS/170929901> to fund<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/> the popular program<https://www.stripes.com/news/congress/approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>. Shulkin made a difficult decision<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>). And, Shulkin has presided over the terminationhttps://www.va.gov/accountability/Adverse_Actions_Report.pdf of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/> problems at the VA's Washington hospital and proposing to kill the VA's support<https://www.politico.com/story/2017/12/06/homeless-veterans-benefits-trump-207781> for homeless veterans, before walking back that idea in the face of public outcry.

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> Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html> and Trump campaign operative Cam Sandoval, began working late last year<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html> to engineer Shulkin's exithttps://www.washingtonpost.com/amphtml/world/national-security/white-house-targets-vas-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html. According to the Washington Posthttps://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376, these nominees have actively sought to sabotage Shulkin's tenure, going so far as to call congressional leaders and lobby them to push for Shulkin's ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

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> It is against this backdrop that Shulkin must wage his third and most personal battle: a fight over two internal ethics investigations by the VA's inspector general. The first investigation was triggered by Washington Post reportinghttps://www.washingtonpost.com/investigations/va-chief-took-in-wimbledon-river-cruise-on-european-work-trip/2017/09/29/c1f17046-a458-11e7-8c37-e1d99ad6aa22_story.html about Shulkin's trip to meet with veterans officials in Europe—a trip that included a detour to Wimbledon, and a few days of vacation too. The VA's inspector general scorched Shulkinhttps://www.washingtonpost.com/politics/veterans-affairs-chief-shulkin-staff-misled-ethics-officials-about-european-trip-report-finds/2018/02/14/f7fbc020-0c3a-11e8-8b0d-891602206fb7_story.html in its report on this trip, finding that permission to bring his wife had been predicated on a falsified email from Shulkin's chief of staff and that Shulkin had impermissibly ordered his staff into travel concierge duty. Shulkin pushed back, retaining counsel to dissect the IG report, and he even suggested<http://thehill.com/policy/defense/374009-va-secretary-says-he-wont-resign-doubles-down-on-allegations-aides-email-was> that his chief of staff's email had been hacked. (It was not<http://thehill.com/policy/defense/376045-watchdog-former-top-va-aides-email-was-not-hacked>.) A day later, however, Shulkin's chief of staff announced<https://www.militarytimes.com/veterans/2018/02/16/va-chief-of-staff-resigns-amid-secretarys-travel-scandal/> her retirement, and Shulkin saidhttps://www.washingtonpost.com/world/national-security/va-secretary-shulkin-under-fire-for-europe-trip-to-appear-before-house-panel/2018/02/14/0c65702e-11c2-11e8-8ea1-c1d91fcec3fe_story.html?utm_term=.aa7311c9a3f1 he would repay the government for the cost of his wife's airfare.

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percolating<<http://thehill.com/homenews/administration/376568-va-watchdog-preparing-report-on-shulkin-misuse-of-security-detail>> in the VA inspector general's office now. That assessment will reportedly criticize Shulkin for inappropriate use of his security detail for personal errands. On its face, the allegations aren't that damning; they show Shulkin to be an inexperienced government executive who's used to different rules in the private sector and also indicate his naïveté about how certain things will play on the proverbial front page of the Washington Post. But these errors come at a time when the Trump administration can ill afford another ethics scandal after similar abuses at HUD<https://www.washingtonpost.com/politics/using-his-position-for-private-gain-hud-lawyers-warned-ben-carson-risked-running-afoul-of-ethics-rules-by-enlisting-son/2018/01/31/bb20c48e-0532-11e8-8777-2a059f168dd2_story.html>, Interior<<http://thehill.com/homenews/administration/377497-interior-dept-spent-139k-on-construction-project-labeled-secretarys>>, and HHS<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>>, with the latter resulting in Secretary Tom Price's resignation. A Cabinet secretary aligned more closely with the White House than Shulkin, or with more political allies across the administration, could probably survive these investigations with barely a flesh wound. For Shulkin's tenure at VA, they may end up being fatal, to the extent they provide a pretext for the White House to replace Shulkin with a more trusted partisan.

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> At this point, Shulkin's fate rests with Trump. Although Trump has largely benefited from Shulkin's service, the president must now decide whether he's better off with a competent leader like Shulkin, or a closer political ally who might march more in step with the base. The potential contenders include Energy Secretary Rick Perry (who said Wednesday<<http://abcnews.go.com/Politics/wireStory/latest-rick-perry-va-job-53748413>> he doesn't want the job), one of the 88 retired generals who endorsed<<https://www.politico.com/story/2016/09/retired-generals-admirals-endorse-trump-227755>> Trump in 2016, or veterans in Congress like Sens. Joni Ernst or Tom Cotton, whose chances are lower because of their importance to the Republicans' razor-thin Senate majority. Whether Shulkin stays or goes, the primary battle he waged, over the future of the VA, will continue. Trump is arguably better off keeping Shulkin around to keep waging this battle, and veterans are arguably better off with that outcome too.

>

>

> (b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\) \(6\)](https://www.cnas.org/people/(b) (6))> and adjunct professor of law at Georgetown University. The views expressed are the author's alone and not representative of his organization.

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From: (b) (6) <(b) (6)@cnas.org>
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdl)/cn=recipients/(b) (6)>
Cc:
Bcc:
Subject: [EXTERNAL] Lunch next Tues 3/20
Date: Thu Mar 15 2018 17:45:23 CDT
Attachments:

Lunch Tuesday, 3/20, sounds great. I think PJ Clarke's is the restaurant you're thinking of, but Mirabella or McCormicks or BLT also work well — whatever you prefer.

Sent from my iPhone

> On Mar 15, 2018, at 17:21, DJS <vacodjs1@va.gov> wrote:

>

> How is next Tuesday at that place I saw you last time - forget the name but it was on 16th near K?

>

>

>

> Sent with Good (www.good.com)

>

>

> From: (b) (6)

> Sent: Thursday, March 15, 2018 2:01:21 PM

> To: DJS

> Subject: Re: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea

>

> Yes - would be happy to do so. Please let me know when your schedule allows.

>

> On 3/15/18, 3:28 PM, "DJS" <vacodjs1@va.gov> wrote:

>

> Thanks so much (b) (6)

>

> DC is truly crazy- so I appreciate your rational approach to things

>

> How about catching up for lunch sometime soon?

>

>

>

> Sent with Good (www.good.com<http://www.good.com>)

>

>

> From: (b) (6)

> Sent: Thursday, March 15, 2018 11:58:56 AM

> To: DJS

> Subject: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea

>

> Thought I would share this column from today. Hope you're doing as well as possible under the circumstances. Hang in there. v/r (b) (6)

>

> https://slate.com/news-and-politics/2018/03/firing-veterans-affairs-secretary-david-shulkin-is-a-bad-idea.html?wpsrc=sh_all_dt_tw_ru

>

> Firing VA Secretary David Shulkin Is a Bad Idea

> He's accomplishing a lot of good for America's veterans—and for Trump.

>

> By (b) (6)

>

> Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>>, "We'll never have to use those words ['You're fired'] on our David."

>

> Eight months later, that declaration may prove ironic. Fissures have emerged and deepened between Shulkin and the president's political allies over what, exactly, the VA should be doing. On top of this, two relatively minor scandals involving Shulkin have blown up his tenure and stalled major reform. Now, Shulkin faces conflict on three overlapping fronts, leaving him at the precipice of being fired and replaced by a closer Trump ally as the administration seeks to reduce the chaos<<https://www.cnn.com/2018/03/13/politics/trump-departures-white-house/index.html>> in its Cabinet.

>

> The first battle Shulkin is fighting has deep roots<<https://www.foreignaffairs.com/articles/2017-08-15/what-america-owes-its-veterans>> in veterans population demographics<https://www.rand.org/pubs/research_reports/RR1165z4.html> and the evolution of VA benefits over the past several decades. From the time they join up to their moment of discharge, service members<<https://www.rand.org/pubs/monographs/MG265.html>> belong to the Department of Defense. After that, they become eligible for a broad array of veterans programs that are administered by the VA's three large administrations: health, benefits, and cemeteries. These programs have evolved<<https://www.rand.org/pubs/monographs/MG1164.html>> from stingy pensions for seriously disabled veterans after the Revolution to the generous, comprehensive system of health care, disability compensation, and economic programs that exists today. All eligible veterans—meaning primarily those who serve on active duty and leave with an honorable discharge<<https://www.swords-to-plowshares.org/2016/03/30/underserved/>>—can avail themselves of these benefits, not just combat veterans or those who were wounded in the line of duty.

>

> To meet these obligations, the VA consumes a massive amount of money each year. Its 2019 budget request is \$198.6 billion<<https://www.va.gov/budget/products.asp>>—a big increase over previous years at a time when most agencies are facing cuts and totaling more than the budgets of the State Department<<https://www.state.gov/s/d/rm/c6112.htm>>, Homeland Security<<https://www.dhs.gov/dhs-budget>>, and the entire<<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program>> intelligence<<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/>> community<<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-militar/>> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

>

> Since 9/11, the VA's budget has steadily increased<<https://www.cnas.org/publications/reports/passing-the-baton-a-bipartisan-2016-agenda-for-the-veteran-and-military-community>> at a rate far greater than inflation, even as the total population of veterans has decreased. Older veterans of the Vietnam and Cold War eras rely heavily on VA services. So too does the post-9/11 generation<<https://www.publichealth.va.gov/epidemiology/reports/oeofond/>>, of whom more than 3 million have deployed to Iraq, Afghanistan, or other theaters of war. These retired service members are using the VA at much higher rates than previous generations. This demand from young and old veterans alike is putting enormous pressure on the VA—which failed to adequately predict any of this increased demand, let alone prepare and budget<<https://www.bostonglobe.com/opinion/2016/10/17/the-trillion-wars/uPvfSuDutnTZl5flQ7YlIK/story.html>> for it.

>

> In 2014, this problem erupted in Phoenix, where veterans endlessly waited for appointments while VA employees played a shell game with veterans to deceive them and their bosses in Washington. That scandal forced the ouster<http://www.slate.com/articles/news_and_politics/politics/2014/05/shinseki_resigns_here_s_how_to_fix_the_va.html> of VA Secretary (and retired Army Gen.) Eric Shinseki and prompted the creation of a program to purchase VA care from the private sector.

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>

> If the VA couldn't provide timely appointments for all veterans, Congress mused, the VA could instead purchase health care the way the Pentagon does for retirees. First as the VA's undersecretary for health, and then as secretary, Shulkin has devoted most of his energies toward implementing this new contracted-care system and making it work.

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> All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization-is-a-very-real-issue-right-now-american-legion-says/>> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html>> Concerned Veterans for America<<https://cv4a.org/>> and many of Trump's allies in Congress, who would like to<<https://cv4a.org/project/taskforce/>> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html>> with congressional leaders in the House and Senate.

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> Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask Congress<https://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf> for more money<<http://www.modernhealthcare.com/article/20170927/NEWS/170929901>> to fund<<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/>> the popular program<<https://www.stripes.com/news/congress/approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>>. Shulkin made a difficult decision<<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/>> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>>). And, Shulkin has presided over the termination<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/>> problems at the VA's Washington hospital and proposing to kill the VA's support<<https://www.politico>

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Subject: Re: [EXTERNAL] Slate: Firing VA Secretary David Shulkin Is a Bad Idea

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https://slate.com/news-and-politics/2018/03/firing-veterans-affairs-secretary-david-shulkin-is-a-bad-idea.html?wpsrc=sh_all_dt_tw_ru

Firing VA Secretary David Shulkin Is a Bad Idea
He's accomplishing a lot of good for America's veterans—and for Trump.

Dr. David Shulkin, the current secretary of veterans affairs and the only Democrat in President Donald Trump's Cabinet, has done fairly well running the VA. At a signing ceremony for veterans legislation in June, Trump said of Shulkin<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-veterans-accountability-whistleblower-protection-act/>, "We'll never have to use those words ['You're fired'] on our David."

Eight months later, that declaration may prove ironic. Fissures have emerged and deepened between Shulkin and the president's political allies over what, exactly, the VA should be doing. On top of this, two relatively minor scandals involving Shulkin have blown up his tenure and stalled major reform. Now, Shulkin faces conflict on three overlapping fronts, leaving him at the precipice of being fired and replaced by a closer Trump ally as the administration seeks to reduce the chaos<https://www.cnn.com/2018/03/13/politics/trump-departures-white-house/index.html> in its Cabinet.

The first battle Shulkin is fighting has deep roots<https://www.foreignaffairs.com/articles/2017-08-15/what-america-owes-its-veterans> in veterans population demographicshttps://www.rand.org/pubs/research_reports/RR1165z4.html and the evolution of VA benefits over the past several decades. From the time they join up to their moment of discharge, service members<https://www.rand.org/pubs/monographs/MG265.html> belong to the Department of Defense. After that, they become eligible for a broad array of veterans programs that are administered by the VA's three large administrations: health, benefits, and cemeteries. These programs have evolved<https://www.rand.org/pubs/monographs/MG1164.html> from stingy pensions for seriously disabled veterans after the Revolution to the generous, comprehensive system of health care, disability compensation, and economic programs that exists today. All eligible veterans—meaning primarily those who serve on active duty and leave with an honorable discharge<https://www.swords-to-plowshares.org/2016/03/30/underserved/>—can avail themselves of these benefits, not just combat veterans or those who were wounded in the line of duty.

To meet these obligations, the VA consumes a massive amount of money each year. Its 2019 budget request is \$198.6 billion<https://www.va.gov/budget/products.asp>—a big increase over previous years at a time when most agencies are facing cuts and totaling more than the budgets of the State Department<https://www.state.gov/s/d/rm/c6112.htm>, Homeland Security<https://www.dhs.gov/dhs-budget>, and the entire<https://www.dni.gov/index.php/newsroom/press-releases/press-releases-2017/item/1767-dni-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-national-intelligence-program> intelligence<https://fas.org/blogs/secrecy/2017/06/fy18-intelbud/> community<https://www.defense.gov/News/News-Releases/News-Release-View/Article/1211989/dod-releases-budget-figure-for-fy-2018-appropriations-requested-for-the-military/> combined. Roughly half of these funds go to disability compensation for 4.4 million veterans; the next biggest chunk goes to fund VA's huge health care network comprising more than 1,000 facilities nationwide.

Since 9/11, the VA's budget has steadily increased<https://www.cnas.org/publications/reports/passing-the-baton-a-bipartisan-2016-agenda-for-the-veteran-and-military-community> at a rate far greater than inflation, even as the total population of veterans has decreased. Older veterans of the Vietnam and Cold War eras rely heavily on VA services. So too does the post-9/11 generation<https://www.publichealth.va.gov/epidemiology/reports/oefoifond/>, of whom more than 3 million have deployed to Iraq, Afghanistan, or other theaters of war. These retired service members are using the VA at much higher rates than previous generations. This demand from young and old veterans alike is putting enormous pressure on the VA—which failed to adequately predict any of this increased demand, let alone prepare and budget<https://www.bostonglobe.com/opinion/2016/10/17/the-trillion-wars/uPVfSuDutnTZl5fIQ7YllK/story.html> for it.

In 2014, this problem erupted in Phoenix, where veterans endlessly waited for appointments while VA employees played a shell game with veterans to deceive them and their bosses in Washington. That scandal forced the ousterhttp://www.slate.com/articles/news_and_politics/politics/2014/05/shinseki_resigns_here_s_how_to_fix_the_va.html of

VA Secretary (and retired Army Gen.) Eric Shinseki and prompted the creation of a program to purchase VA care from the private sector.

If the VA couldn't provide timely appointments for all veterans, Congress mused, the VA could instead purchase health care the way the Pentagon does for retirees. First as the VA's undersecretary for health, and then as secretary, Shulkin has devoted most of his energies toward implementing this new contracted-care system and making it work.

All of this distills down into a policy question that is at the heart of Shulkin's first battle: What, exactly, does the nation owe to those who have served in uniform? And how should the VA deliver on that promise? On one side is the VA establishment, and major veterans organizations, who have taken a "mend it, don't end it" stance<https://federalnewsradio.com/veterans-affairs/2018/03/va-privatization-is-a-very-real-issue-right-now-american-legion-says/> toward VA health care. On the other side are political conservatives including the Koch brothers—funded<https://www.nytimes.com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html> Concerned Veterans for America<https://cv4a.org/> and many of Trump's allies in Congress, who would like to<https://cv4a.org/project/taskforce/> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html> with congressional leaders in the House and Senate.

Shulkin's second battle—political infighting with more partisan members of the administration—inflames and complicates these policy disagreements. He is the sole survivor of the Obama administration among Cabinet officials serving Trump. A practicing physician and successful health executive, Shulkin came to the Obama administration to run the VA health care system after the 2014 Phoenix scandal. His selection came after a turbulent Trump transition, during which the president interviewed several potential candidates before settling on Shulkin. Trump reportedly gave Shulkin the job because the New Jersey physician persuaded him he could continue the slow, deliberate privatization<https://hbr.org/2016/12/a-transformation-is-underway-at-u-s-veterans-affairs-we-got-an-inside-look%20The%20case%20study%20conducted%20by%20Harvard%20Business%20School%20on%20the%20transformation%20underway%20at%20VA> of the VA and deliver other wins to Trump on issues like employee accountabilityhttps://www.va.gov/accountability/Adverse_Actions_Report.pdf (read: easier firing of civil servants).

Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask Congresshttps://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf for more money<http://www.modernhealthcare.com/article/20170927/NEWS/170929901> to fund<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/> the popular program<https://www.stripes.com/news/congress-approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>. Shulkin made a difficult decision<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>). And, Shulkin has presided over the terminationhttps://www.va.gov/accountability/Adverse_Actions_Report.pdf of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/> problems at the VA's Washington hospital and proposing to kill the VA's support<https://www.politico.com/story/2017/12/06/homeless-veterans-benefits-trump-207781> for homeless veterans, before walking back that idea in the face of public outcry.

Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought

in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>> and Trump campaign operative Cam Sandoval, began working late last year<<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html>> to engineer Shulkin's exit<https://www.washingtonpost.com/amphtml/world/national-security/white-house-targets-va-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html>. According to the Washington Post<https://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376>, these nominees have actively sought to sabotage Shulkin's tenure, going so far as to call congressional leaders and lobby them to push for Shulkin's ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

It is against this backdrop that Shulkin must wage his third and most personal battle: a fight over two internal ethics investigations by the VA's inspector general. The first investigation was triggered by Washington Post reporting<https://www.washingtonpost.com/investigations/va-chief-took-in-wimbledon-river-cruise-on-european-work-trip/2017/09/29/c1f17046-a458-11e7-8c37-e1d99ad6aa22_story.html> about Shulkin's trip to meet with veterans officials in Europe—a trip that included a detour to Wimbledon, and a few days of vacation too. The VA's inspector general scorched Shulkin<https://www.washingtonpost.com/politics/veterans-affairs-chief-shulkin-staff-misled-ethics-officials-about-european-trip-report-finds/2018/02/14/f7fbc020-0c3a-11e8-8b0d-891602206fb7_story.html> in its report on this trip, finding that permission to bring his wife had been predicated on a falsified email from Shulkin's chief of staff and that Shulkin had impermissibly ordered his staff into travel concierge duty. Shulkin pushed back, retaining counsel to dissect the IG report, and he even suggested<<http://thehill.com/policy/defense/374009-va-secretary-says-he-wont-resign-doubles-down-on-allegations-aides-email-was>> that his chief of staff's email had been hacked. (It was not<<http://thehill.com/policy/defense/376045-watchdog-former-top-va-aides-email-was-not-hacked>>.) A day later, however, Shulkin's chief of staff announced<<https://www.militarytimes.com/veterans/2018/02/16/va-chief-of-staff-resigns-amid-secretarys-travel-scandal/>> her retirement, and Shulkin said<https://www.washingtonpost.com/world/national-security/va-secretary-shulkin-under-fire-for-europe-trip-to-appear-before-house-panel/2018/02/14/0c65702e-11c2-11e8-8ea1-c1d91fcec3fe_story.html?utm_term=.aa7311c9a3f1> he would repay the government for the cost of his wife's airfare.

A second investigation, regarding Shulkin's use of his protective security detail, is reportedly percolating<<http://thehill.com/homenews/administration/376568-va-watchdog-preparing-report-on-shulkin-misuse-of-security-detail>> in the VA inspector general's office now. That assessment will reportedly criticize Shulkin for inappropriate use of his security detail for personal errands. On its face, the allegations aren't that damning; they show Shulkin to be an inexperienced government executive who's used to different rules in the private sector and also indicate his naiveté about how certain things will play on the proverbial front page of the Washington Post. But these errors come at a time when the Trump administration can ill afford another ethics scandal after similar abuses at HUD<https://www.washingtonpost.com/politics/using-his-position-for-private-gain-hud-lawyers-warned-ben-carson-risked-running-afoul-of-ethics-rules-by-enlisting-son/2018/01/31/bb20c48e-0532-11e8-8777-2a059f168dd2_story.html>, Interior<<http://thehill.com/homenews/administration/377497-interior-dept-spent-139k-on-construction-project-labeled-secretarys>>, and HHS<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>>, with the latter resulting in Secretary Tom Price's resignation. A Cabinet secretary aligned more closely with the White House than Shulkin, or with more political allies across the administration, could probably survive these investigations with barely a flesh wound. For Shulkin's tenure at VA, they may end up being fatal, to the extent they provide a pretext for the White House to replace Shulkin with a more trusted partisan.

At this point, Shulkin's fate rests with Trump. Although Trump has largely benefited from Shulkin's service, the president must now decide whether he's better off with a competent leader like Shulkin, or

a closer political ally who might march more in step with the base. The potential contenders include Energy Secretary Rick Perry (who said Wednesday<<http://abcnews.go.com/Politics/wireStory/latest-rick-perry-va-job-53748413>> he doesn't want the job), one of the 88 retired generals who endorsed<<https://www.politico.com/story/2016/09/retired-generals-admirals-endorse-trump-227755>> Trump in 2016, or veterans in Congress like Sens. Joni Ernst or Tom Cotton, whose chances are lower because of their importance to the Republicans' razor-thin Senate majority. Whether Shulkin stays or goes, the primary battle he waged, over the future of the VA, will continue. Trump is arguably better off keeping Shulkin around to keep waging this battle, and veterans are arguably better off with that outcome too.

(b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\) \(6\)](https://www.cnas.org/people/(b) (6))> and adjunct professor of law at Georgetown University. The views expressed are the author's alone and not representative of his organization.

From: (b) (6) <(b) (6)@cnas.org>
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Bcc:
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Attachments:

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com/2017/11/09/us/politics/obamacare-veterans-affairs-koch-brothers-health.html> Concerned Veterans for America<<https://cv4a.org/>> and many of Trump's allies in Congress, who would like to<<https://cv4a.org/project/taskforce/>> focus the VA on service-related care like mental health and contract for everything else from the private sector. Shulkin has tried, with some success, to forge a middle path<<https://www.nytimes.com/2017/07/10/us/politics/house-senate-veteran-affairs-committees.html>> with congressional leaders in the House and Senate.

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Since being confirmed in February 2017, Shulkin has largely delivered on those pledges. The VA has continued to purchase private-sector care for veterans—so much so that it has needed to ask Congress<https://www.va.gov/opa/choiceact/documents/Fact_Sheet_Extension_VCP_Funds.pdf> for more money<<http://www.modernhealthcare.com/article/20170927/NEWS/170929901>> to fund<<https://federalnewsradio.com/veterans-affairs/2017/12/on-tight-deadlines-house-couples-veterans-choice-funding-extension-with-potential-cr/>> the popular program<<https://www.stripes.com/news/congress-approves-emergency-funding-for-va-choice-prevents-delays-of-veterans-care-1.503641>>. Shulkin made a difficult decision<<https://federalnewsradio.com/veterans-affairs/2017/11/under-10-year-cerner-contract-va-to-follow-dods-same-ehr-implementation-path/>> on electronic health records that the Trump administration has touted as an example of public-private partnership (although that contract now appears stalled<<http://www.healthcareitnews.com/news/shulkin-va-cerner-ehr-deal-paused-over-interoperability-concerns>>). And, Shulkin has presided over the termination<https://www.va.gov/accountability/Adverse_Actions_Report.pdf> of hundreds of VA employees, something the president praised in his State of the Union address this year. But Shulkin has made a few missteps, too, including presiding over continuing<<https://www.usatoday.com/story/news/politics/2018/03/07/va-veterans-affairs-failures-left-patients-danger-washington-dc-hospital-years-investigation/396914002/>> problems at the VA's Washington hospital and proposing to kill the VA's support<<https://www.politico.com/story/2017/12/06/homeless-veterans-benefits-trump-207781>> for homeless veterans, before walking back that idea in the face of public outcry.

Unfortunately, none of this success has helped Shulkin battle with more partisan appointees brought in by the Trump administration. Some of these appointees, including former beer executive Jake Leinenkugel<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>> and Trump campaign operative Cam Sandoval, began working late last year<<https://www.nytimes.com/2018/02/15/us/veterans-affairs-david-shulkin.html>> to engineer Shulkin's exit<https://www.washingtonpost.com/amhtml/world/national-security/white-house-targets-vas-deputy-secretary-as-a-warning-shot-to-agencys-leader/2018/02/08/cc052006-0d11-11e8-95a5-c396801049ef_story.html>. According to the Washington Post<https://www.washingtonpost.com/politics/its-killing-the-agency-ugly-power-struggle-paralyzes-trumps-plan-to-fix-veterans-care/2018/03/08/1c33d6fe-2085-11e8-badd-7c9f29a55815_story.html?utm_term=.496fb2a75376>, these nominees have actively sought to sabotage Shulkin's tenure, going so far as to call congressional leaders and lobby them to push for Shulkin's ouster. In response, Shulkin has isolated himself from these senior appointees, reportedly barring their access to his 10th floor executive suite and asking White House chief of staff John Kelly for permission to fire them. (Permission has thus far been denied.) This political battle has consumed more and more of Shulkin's time in recent months, threatening his reform agenda and ability to deliver more political wins for the president.

It is against this backdrop that Shulkin must wage his third and most personal battle: a fight over two internal ethics investigations by the VA's inspector general. The first investigation was triggered by Washington Post reporting<https://www.washingtonpost.com/investigations/va-chief-took-in-wimbledon-river-cruise-on-european-work-trip/2017/09/29/c1f17046-a458-11e7-8c37-e1d99ad6aa22_story.html> about Shulkin's trip to meet with veterans officials in Europe—a trip that included a detour to Wimbledon, and a few days of vacation too. The VA's inspector general scorched Shulkin<https://www.washingtonpost.com/politics/veterans-affairs-chief-shulkin-staff-misled-ethics-officials-about-european-trip-report-finds/2018/02/14/f7fbc020-0c3a-11e8-8b0d-891602206fb7_story.html> in its report on this trip, finding that permission to bring his wife had been predicated on a falsified email from Shulkin's chief of staff and that Shulkin had impermissibly ordered his staff into travel concierge duty. Shulkin pushed back, retaining counsel to dissect the IG report, and he even suggested<<http://thehill.com/policy/defense/374009-va-secretary-says-he-wont-resign-doubles-down-on-allegations-aides-email-was>> that his chief of staff's email had been hacked. (It was not<<http://thehill.com/policy/defense/376045-watchdog-former-top-va-aides-email-was-not-hacked>>.) A day later, however, Shulkin's chief of staff announced<<https://www.militarytimes.com/veterans/2018/02/16/va-chief-of-staff-resigns-amid-secretarys-travel-scandal/>> her retirement, and Shulkin said<https://www.washingtonpost.com/world/national-security/va-secretary-shulkin-under-fire-for-europe-trip-to-appear-before-house-panel/2018/02/14/0c65702e-11c2-11e8-8ea1-c1d91fcec3fe_story.html?utm_term=.aa7311c9a3f1> he would repay the government for the cost of his wife's airfare.

A second investigation, regarding Shulkin's use of his protective security detail, is reportedly percolating<<http://thehill.com/homenews/administration/376568-va-watchdog-preparing-report-on-shulkin-misuse-of-security-detail>> in the VA inspector general's office now. That assessment will reportedly criticize Shulkin for inappropriate use of his security detail for personal errands. On its face, the allegations aren't that damning; they show Shulkin to be an inexperienced government executive who's used to different rules in the private sector and also indicate his naïveté about how certain things will play on the proverbial front page of the Washington Post. But these errors come at a time when the Trump administration can ill afford another ethics scandal after similar abuses at HUD<https://www.washingtonpost.com/politics/using-his-position-for-private-gain-hud-lawyers-warned-ben-carson-risked-running-afoul-of-ethics-rules-by-enlisting-son/2018/01/31/bb20c48e-0532-11e8-8777-2a059f168dd2_story.html>, Interior<<http://thehill.com/homenews/administration/377497-interior-dept-spent-139k-on-construction-project-labeled-secretarys>>, and HHS<<https://www.nytimes.com/2017/10/05/dining/leinenkugel-beer-wisconsin.html>>, with the latter resulting in Secretary Tom Price's resignation. A Cabinet secretary aligned more closely with the White House than Shulkin, or with more political allies across the administration, could probably survive these investigations with barely a flesh wound. For Shulkin's tenure at VA, they may end up being fatal, to the extent they provide a pretext for the White House to replace Shulkin with a more trusted partisan.

At this point, Shulkin's fate rests with Trump. Although Trump has largely benefited from Shulkin's service, the president must now decide whether he's better off with a competent leader like Shulkin, or a closer political ally who might march more in step with the base. The potential contenders include Energy Secretary Rick Perry (who said Wednesday<<http://abcnews.go.com/Politics/wireStory/latest-rick-perry-va-job-53748413>> he doesn't want the job), one of the 88 retired generals who endorsed<<https://www.politico.com/story/2016/09/retired-generals-admirals-endorse-trump-227755>> Trump in 2016, or veterans in Congress like Sens. Joni Ernst or Tom Cotton, whose chances are lower because of their importance to the Republicans' razor-thin Senate majority. Whether Shulkin stays or goes, the primary battle he waged, over the future of the VA, will continue. Trump is arguably better off keeping Shulkin around to keep waging this battle, and veterans are arguably better off with that outcome too.

(b) (6) is a senior fellow at the Center for a New American Security<[https://www.cnas.org/people/\(b\) \(6\)](https://www.cnas.org/people/(b) (6))> and adjunct professor of law at Georgetown University. The views expressed are the author's alone and not representative of his organization.

From: (b) (6) @gmail.com>
To: Shulkin, David J., MD
</o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: [EXTERNAL] I want to thank you
Date: Tue Mar 13 2018 21:40:22 CDT
Attachments:

Dr. Shulkin

I just went on the presidential email website, and begging president Trump not to remove and replace you, yes there's a lot to be done, yes I'm dying from exposure to Agent Orange through Blue Water Navy Vietnam service, but we cannot take a 4th Secretary of the VA in 4 years, this would destroy it in what is already there. I'm behind you 100% And I just want you to know that.

Capt. (b) (6) USMM Ret. (Last 4 SS # (b) (6))
USN Veteran USS Ranger CVA 61 (1974-1977)
1105 West Spencer Street
Plant City, Florida 33563
Cell 813.707. (b) (6)

From: Google Alerts
<googlealerts-noreply@google.com>
To: (b) (6) </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: [EXTERNAL] Google Alert - Shulkin
Date: Tue Mar 13 2018 07:05:45 CDT
Attachments:

Shulkin
Daily update · March 13, 2018

NEWS

David Shulkin Makes Late Play for Most Corrupt Trump Cabinet Member

Vanity Fair

Veteran's Affairs Secretary David Shulkin's tenure got off to a promising start, at least by Trump administration standards: a former hospital administrator and renowned academic, the Obama-era appointee was the only Cabinet nominee unanimously confirmed by the Senate. Yet in recent weeks, ...

Axios: Trump now sees Shulkin as a "major problem" - Hot Air

Donald Trump Should Not Be Calling Fox & Friends Hosts For Policy Advice - SPIN

Report: Trump called a Fox & Friends host with Koch links during a meeting with the VA Secretary -

Media Matters for America (blog)

Full Coverage

Flag as irrelevant

VA Leadership on Shaky Ground after Another Damaging Report

Nonprofit Quarterly

Last week was not a great week for the VA. On Wednesday, Veterans Affairs Secretary David J. Shulkin announced that VA hospitals across the country will soon be under new leadership following the release of a 142-page investigative report that sheds light on numerous of the agency's programs' ...

Flag as irrelevant

The Trump Administration's Campaign to Weaken Civil Service Ramps Up at the VA

ProPublica

Shulkin, Trump and CVA have all touted it as a major accomplishment, as have lawmakers and veterans groups. The White House referred questions to the VA, where spokesman Cashour said the law "is one of the most significant federal civil service reforms in decades and is helping instill across the ...

Trump's VA Is Purging Civil Servants - POLITICO Magazine

Full Coverage

Flag as irrelevant

Dayton VA names new leader: What we know

Dayton Daily News

Two days before the announcement of Dietrich's appointment, U.S. Department of Veterans Affairs Secretary David Shulkin announced sweeping plans to reorganize the VA starting with the national headquarters and the consolidation of oversight of 23 hospitals. USA Today reported that if Shulkin ...

Flag as irrelevant

The problems with Trump's scandal-ridden Cabinet start right at the top
mySanAntonio.com

Veterans Affairs Secretary David Shulkin, whose chief of staff resigned after the department inspector general found she falsified an email to justify sending Shulkin's wife on a trip to Denmark and Britain at department expense, a trip on which Shulkin was also faulted for accepting free Wimbledon tickets.

Flag as irrelevant

Larry Kudlow and the Trump-TV feedback loop
GANT News

With the current secretary, David Shulkin, under increasing scrutiny, Trump “surprised Shulkin by dialing in” Hegseth on speaker phone during a meeting earlier this month. “Trump talks to Hegseth regularly and enjoys watching him on 'Fox and Friends,’” Axios reported. To date, only one prominent Fox ...

Flag as irrelevant

Wave Of Firings At VA Targets Working Staff, Not Top Officials
The National Memo (blog)

Shulkin advocated for the measure, called the VA Accountability and Whistleblower Protection Act, by highlighting a case in which the agency had to wait 30 days to fire a worker caught watching porn with a patient. “I do not see this as a tool that's going to lead to mass firings,” Shulkin said last June.

Flag as irrelevant

The American Legion Lobbies For Medical Marijuana
Weed News (blog)

So far Shulkin has been unwilling to commit the V.A. to studying medical cannabis. In a December 2017 letter to U.S. Representative Tim Walz, Shulkin stated the “VA is committed to researching and developing effective ways to help Veterans cope with post-traumatic stress disorder and chronic pain ...

Flag as irrelevant

Only Congress can end horror stories at the VA
The Hill

Now that the horrifying details of yet another scathing report from the U.S. Department of Veterans Affairs (VA) Inspector General (IG) are out, Congress must pass bold and meaningful legislation that will transform the way we deliver care to veterans. If Congress does not respond to this latest crisis with ...

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From: **Ha, Richard** Richard.Ha1@va.gov  
Subject: FOIA 18-11960-F: 1/8 Partial Initial Agency Decision
Date: November 30, 2018 at 2:00 PM
To: foia@americanoversight.org

RH

[Email 1 of 8 due to size limitations]

November 30, 2018

In Reply Refer To: 001B
FOIA Request: 18-11960-F

Daniel McGrath, Staff Attorney
Austin Evers, Executive Director
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005
foia@americanoversight.org

Dear Mr. McGrath:

This is the Second Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated and received August 23, 2018, and assigned FOIA tracking number **18-11960-F**. You requested:

All records reflecting communications (including emails, email attachments, text messages, messages on messaging platforms (such as Slack, GChat or Google Hangouts, Lync, Skype, or WhatsApp), telephone call logs, calendar invitations/entries, meeting notices, meeting agendas, informational material, talking points, any handwritten or electronic notes taken during any oral communications, summaries of any oral communications, or other materials) between any of the individuals listed

- Veterans Affairs Officials
 - Darin Selnick, Senior Advisor to the Secretary
 - Casin Spero, Special Advisor
 - Individuals within the Offices of the Secretary and Deputy Secretary: David Shulkin, Former Secretary, and anyone acting on his behalf
 - Vivieca Wright Simpson, Former Chief of Staff
 - Pete O'Rourke, Former Chief of Staff, Former Acting Secretary, and Senior Advisor to the Secretary; and anyone acting on his behalf
 - Robert Wilkie, Secretary, and anyone acting on his behalf
 - Jacquelyn Hayes-Byrd, Acting Chief of Staff and Deputy Chief of Staff
 - Thomas Bowman, Deputy Secretary, and anyone acting on his behalf
 - Any political appointee* in the immediate Office of the Secretary or Deputy Secretary during the applicable time period not previously listed above
- Outside Recipients
 - Dan Caldwell
 - Nathan Anderson
 - Shannon Hough
 - Pete Hegseth
 - Any email address ending in @cv4a.org or @cvafoundation.org
 - Isaac "Ike" Perlmutter
 - Bruce Moskowitz
 - Marc Sherman
- All email communications between any of the individuals listed in Column A and any external individuals or organizations (i.e. emails with addresses ending in .com/.org/.net/.edu) that

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individuals or organizations (i.e., emails with addresses ending in com/org/net/mil/edu) that mention one or more of the following search terms in the subject line, body of the email, or attachment:

1. "Concerned Veterans"
2. "Concerned Vets"
3. CVA
4. CV4A

Please provide all responsive records from January 20, 2017, through the date of the search."

There is substantial overlap between this FOIA request and your prior FOIA request **18-07426-F**, as some redacted records released for your FOIA request **18-07426-F** are also responsive to FOIA request **18-11960-F**.

Reasonable Searches Dated September 6, 2018, September 18, 2018, October 12, 2018, October 16, 2018, October 18, 2018, and November 15, 2018

On September 6, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below ten (10) custodians from January 20, 2017, to September 6, 2018:

1. Wilkie, Robert L., Jr., VA Secretary;
2. Shulkin, David, former VA Secretary;
3. O'Rourke, Peter M., former VA Acting Secretary;
4. Bowman, Thomas, former VA Deputy Secretary;
5. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
6. Wright-Simpson, Vivieca, former VA Chief of Staff;
7. Selnick, Darin, former VA White House Senior Advisor;
8. Lukach, Michael, former VA White House Senior Advisor;
9. Leinenkugel, Jake, former VA White House Senior Advisor; and,
10. Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches.

On October 12, 2018, and October 16, 2018, the OSVA FOIA Officer searched though former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to June 22, 2018. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. These October 12, 2018, and October 16, 2018, searches yielded forty-four (44) pages, which OSVA released redacted as pages Bates-numbered 243-286 to you for FOIA request **18-07426-F**.

On September 18, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Chief of Staff Jacquelyn Hayes-Byrd's emails and calendars from November 8, 2016, to June 22, 2018. OSVA used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. This search yielded two hundred fifty-five (255) pages, which OSVA released redacted as pages Bates-numbered 287-541 to you for FOIA request **18-07426-F**.

On October 18, 2018, the OSVA FOIA office searched through the email boxes and calendars, from January 20, 2017, to June 22, 2018, of: David Shulkin, Thomas Bowman, Vivieca Wright-Simpon, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded three hundred twenty-eight (328) pages, which OSVA released redacted as pages Bates-numbered 542-813 and 816-871 to you for FOIA request **18-07426-F**.

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On November 15, 2018, the OSVA FOIA office searched through the email boxes and calendars from June 23, 2018, to September 6, 2018, of:

1. Wilkie, Robert L., Jr., VA Secretary;
2. O'Rourke, Peter M., former VA Acting Secretary;
3. Bowman, Thomas, former VA Deputy Secretary;
4. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
5. Wright-Simpson, Vivieca, former VA Chief of Staff;
6. Selnick, Darin, former VA White House Senior Advisor;
7. Lukach, Michael, former VA White House Senior Advisor;
8. Leinenkugel, Jake, former VA White House Senior Advisor; and,
9. Spero, Casin D, former VA White House Liaison.

The November 15, 2018, search yielded two pages, which OSVA released redacted as pages Bates-numbered 814-815 for your FOIA request **18-07426-F**.

Partial Initial Agency Decision

Using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms "Concerned Veterans of America," "CVA," and "cv4a.org" to search through former VA Secretary David Shulkin's email boxes for responsive records. The OSVA FOIA Officer also used the same search key terms through the email boxes of the following custodians: Robert Wilkie, Peter O'Rourke, David Shulkin, Thomas Bowman, Jacquelyn Hayes-Byrd, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero.

- This Clearwell search yielded approximately four hundred (400) documents totaling approximately five thousand (5,000) pages. OSVA now releases to you one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank). OSVA will release approximately one hundred twenty (120) redacted documents totaling approximately fourteen hundred (1,400) pages to you in the future. After reviewing the three thousand five hundred twenty-four (3,524) pages, OSVA redacts some information with FOIA Exemptions 4, 5, 6, 7(C).

5 U.S.C. § 552(b)(4) exempts from disclosure "trade secrets and commercial or financial information obtained from a person and privileged or confidential." Redacted information includes voluntary proposal submission verbiage, technical processes, technical approaches, and partnership or subcontracting agreements. The release of this information would likely lead to substantial competitive harm in reverse-engineering of the vendors' technical approaches, processes, partnership, subcontracting, and business and labor strategies. RMS Indus. v. DOD, No. C-92-1545, slip op. at 7 (N.D. Cal. Nov. 24, 1992) (protecting "descriptions of equipment and the names of contacts, customers, key employees, and subcontractors" because "bidders only submit such information if it will not be released to their competitors"); BDM Corp. v. SBA, 2 Gov't Disclosure Serv. (P-H) ¶ 81,189, at 81,495 (D.D.C. Mar. 20, 1981) (protecting names of consultants and subcontractors, performance, cost, and equipment information).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials and

consultants reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts internal government deliberations, thoughts, opinions, recommendations, and proposed solutions from federal employees and consultants reviewing VA programs in their professional capacities, as well as non-final or draft documents. The information contained in the responsive records is both predecisional and deliberative because it reflects preliminary opinions, proposed solutions, and recommendations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees and consultants to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, proposing changes to, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials and consultants to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Under the attorney-client and work product privileges, the VA redacts portions of records, emails, and communications between VA employees and attorneys analyzing and discussing legal issues for the VA and its employees. The release of this information would impede the ability of VA employees and attorneys to speak openly and frankly about legal issues concerning the VA or its employees. The release of this information would also compromise the legal positions of the VA and its employees.

5 U.S.C. § 552(b)(6) exempts from required disclosure "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal employees and private citizens; we however release the names and VA email addresses of VA Senior Executives. Federal civilian employees and private citizens retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal civilian employees and private citizens whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, except names and VA email addresses of VA Senior Executives, we find that there is no public interest in knowing the names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal civilian employees and private citizens. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a

VA-18-0457-A-003528

Coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. Releasing even a single VA username reveals the pattern to ascertain VA usernames that VA employees use to log into VA Systems of Records; releasing VA usernames exposes the VA, its employees, and its contractors to potential hacking and information technology security liabilities and risks. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed." Long v. Immigration & Customs Enf't, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

5 U.S.C. § 552(b)(7)(C) exempts from required disclosure information law enforcement information the disclosure of which "could reasonably be expected to constitute an unwarranted invasion of personal privacy." Redacted information includes names and email addresses of White House employees with security clearances, as well as Redacted information includes names, identities, email addresses, and VA usernames of VA law enforcement employees. The release of this information would risk impersonation of these White House employees with security clearances also working on national security and law enforcement matters, as well as jeopardizing their health and safety and those the White House employees are charged with protecting. The release of this information would risk impersonation of VA law enforcement personnel and jeopardize the health and safety of not only law enforcement personnel, but those persons the VA law enforcement personnel protect including the VA Secretary.

5 U.S.C. § 552(b)(7)(E) exempts from required disclosure information that "would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law." Redacted information includes VA usernames of VA law enforcement employees and shared VA email groups, for which VA law enforcement officials plan their law enforcement operations and protection of VA personnel. The release of this information would compromise the safety of VA law enforcement personnel and VA employees.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:

Name: John Buck

Email Address: vaofoiiaservice@va.gov

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Office of Government Information Services (OGIS)

Email Address: ogis@nara.gov

Fax: 202-741-5769

Mailing address:

National Archives and Records Administration

8601 Adelphi Road

College Park, MD 20740-6001

FOIA Appeal

This concludes OSVA's partial IAD to request **18-11960-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,

Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachments

- Redacted one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank).

Richard Ha, JD, CIPP/G
OSVA FOIA/Privacy Officer
Office of the Executive Secretary
Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA)
202-632-5286 o
202-309-3072 c
Richard.ha1@va.gov
Telework Weds
CWS 2nd Mon

These messages and attachments are For Official Use Only, not to be shared outside intended parties, and may be exempt from disclosure pursuant to 5 U.S.C. § 552(b)(3) prohibiting the release of information that another statute prohibits; 41 U.S.C. § 4702(b) prohibiting the release of unincorporated proposals; 41 U.S.C. § 423(a) prohibiting the

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preventing the release of uncompleted proposals; 26 U.S.C. § 6103 prohibiting the release of bid or proposal information or evaluations before award; 26 U.S.C. § 6103 prohibiting the release of tax identification numbers; 5 U.S.C. § 552(b)(4) prohibiting the release of confidential commercial information; 5 U.S.C. § 552(b)(5) under the deliberative process, attorney-client, and work product privileges; and 5 U.S.C. § 552(b)(6) protecting personally identifiable information. If you received these messages and attachments in error, you must inform the FOIA Officer and destroy them immediately. The VA reserves its discovery rights including, but not limited to, objections, privileges, motions, etc.



18-11960-F
OSVA...-18.pdf



1006-1507
CVA_R...ted.pdf



996-1005
CVA_R...ted.pdf

From: **Ha, Richard** Richard.Ha1@va.gov  
Subject: RE: FOIA 18-11960-F: 2/8 Partial Initial Agency Decision
Date: November 30, 2018 at 2:00 PM
To: foia@americanoversight.org

RH

[Email 2 of 8 due to size limitations]

November 30, 2018

In Reply Refer To: 001B
FOIA Request: 18-11960-F

Daniel McGrath, Staff Attorney
Austin Evers, Executive Director
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005
foia@americanoversight.org

Dear Mr. McGrath:

This is the Second Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated and received August 23, 2018, and assigned FOIA tracking number **18-11960-F**. You requested:

All records reflecting communications (including emails, email attachments, text messages, messages on messaging platforms (such as Slack, GChat or Google Hangouts, Lync, Skype, or WhatsApp), telephone call logs, calendar invitations/entries, meeting notices, meeting agendas, informational material, talking points, any handwritten or electronic notes taken during any oral communications, summaries of any oral communications, or other materials) between any of the individuals listed

- Veterans Affairs Officials
 - Darin Selnick, Senior Advisor to the Secretary
 - Casin Spero, Special Advisor
 - Individuals within the Offices of the Secretary and Deputy Secretary: David Shulkin, Former Secretary, and anyone acting on his behalf
 - Vivieca Wright Simpson, Former Chief of Staff
 - Pete O'Rourke, Former Chief of Staff, Former Acting Secretary, and Senior Advisor to the Secretary; and anyone acting on his behalf
 - Robert Wilkie, Secretary, and anyone acting on his behalf
 - Jacquelyn Hayes-Byrd, Acting Chief of Staff and Deputy Chief of Staff
 - Thomas Bowman, Deputy Secretary, and anyone acting on his behalf
 - Any political appointee* in the immediate Office of the Secretary or Deputy Secretary during the applicable time period not previously listed above
- Outside Recipients
 - Dan Caldwell
 - Nathan Anderson
 - Shannon Hough
 - Pete Hegseth
 - Any email address ending in @cv4a.org or @cvafoundation.org
 - Isaac "Ike" Perlmutter
 - Bruce Moskowitz
 - Marc Sherman
- All email communications between any of the individuals listed in Column A and any external individuals or organizations (i.e., emails with addresses ending in com/.org/.net/.mil/.edu) that mention one or more of the following search terms in the subject line, body of the email, or attachment:
 1. "Concerned Veterans"

VA-18-0457-A-003532

2. "Concerned Vets"
3. CVA
4. CV4A

Please provide all responsive records from January 20, 2017, through the date of the search."

There is substantial overlap between this FOIA request and your prior FOIA request **18-07426-F**, as some redacted records released for your FOIA request **18-07426-F** are also responsive to FOIA request **18-11960-F**.

Reasonable Searches Dated September 6, 2018, September 18, 2018, October 12, 2018, October 16, 2018, October 18, 2018, and November 15, 2018

On September 6, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below ten (10) custodians from January 20, 2017, to September 6, 2018:

1. Wilkie, Robert L., Jr., VA Secretary;
2. Shulkin, David, former VA Secretary;
3. O'Rourke, Peter M., former VA Acting Secretary;
4. Bowman, Thomas, former VA Deputy Secretary;
5. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
6. Wright-Simpson, Vivieca, former VA Chief of Staff;
7. Selnick, Darin, former VA White House Senior Advisor;
8. Lukach, Michael, former VA White House Senior Advisor;
9. Leinenkugel, Jake, former VA White House Senior Advisor; and,
10. Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches.

On October 12, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to June 22, 2018. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. These October 12, 2018, and October 16, 2018, searches yielded forty-four (44) pages, which OSVA released redacted as pages Bates-numbered 243-286 to you for FOIA request **18-07426-F**.

On September 18, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Chief of Staff Jacquelyn Hayes-Byrd's emails and calendars from November 8, 2016, to June 22, 2018. OSVA used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. This search yielded two hundred fifty-five (255) pages, which OSVA released redacted as pages Bates-numbered 287-541 to you for FOIA request **18-07426-F**.

On October 18, 2018, the OSVA FOIA office searched through the email boxes and calendars, from January 20, 2017, to June 22, 2018, of: David Shulkin, Thomas Bowman, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded three hundred twenty-eight (328) pages, which OSVA released redacted as pages Bates-numbered 542-813 and 816-871 to you for FOIA request **18-07426-F**.

On November 15, 2018, the OSVA FOIA office searched through the email boxes and calendars from June 23, 2018, to September 6, 2018, of:

1. Wilkie, Robert L., Jr., VA Secretary;

VA-18-0457-A-003533

1. Wilkie, Robert L., Jr., VA Secretary;
2. O'Rourke, Peter M., former VA Acting Secretary;
3. Bowman, Thomas, former VA Deputy Secretary;
4. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
5. Wright-Simpson, Vivieca, former VA Chief of Staff;
6. Selnick, Darin, former VA White House Senior Advisor;
7. Lukach, Michael, former VA White House Senior Advisor;
8. Leinenkugel, Jake, former VA White House Senior Advisor; and,
9. Spero, Casin D, former VA White House Liaison.

The November 15, 2018, search yielded two pages, which OSVA released redacted as pages Bates-numbered 814-815 for your FOIA request **18-07426-F**.

Partial Initial Agency Decision

Using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms "Concerned Veterans of America," "CVA," and "cv4a.org" to search through former VA Secretary David Shulkin's email boxes for responsive records. The OSVA FOIA Officer also used the same search key terms through the email boxes of the following custodians: Robert Wilkie, Peter O'Rourke, David Shulkin, Thomas Bowman, Jacquelyn Hayes-Byrd, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero.

This Clearwell search yielded approximately four hundred (400) documents totaling approximately five thousand (5,000) pages. OSVA now releases to you one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank). OSVA will release approximately one hundred twenty (120) redacted documents totaling approximately fourteen hundred (1,400) pages to you in the future. After reviewing the three thousand five hundred twenty-four (3,524) pages, OSVA redacts some information with FOIA Exemptions 4, 5, 6, 7(C).

5 U.S.C. § 552(b)(4) exempts from disclosure "trade secrets and commercial or financial information obtained from a person and privileged or confidential." Redacted information includes voluntary proposal submission verbiage, technical processes, technical approaches, and partnership or subcontracting agreements. The release of this information would likely lead to substantial competitive harm in reverse-engineering of the vendors' technical approaches, processes, partnership, subcontracting, and business and labor strategies. RMS Indus. v. DOD, No. C-92-1545, slip op. at 7 (N.D. Cal. Nov. 24, 1992) (protecting "descriptions of equipment and the names of contacts, customers, key employees, and subcontractors" because "bidders only submit such information if it will not be released to their competitors"); BDM Corp. v. SBA, 2 Gov't Disclosure Serv. (P-H) ¶ 81,189, at 81,495 (D.D.C. Mar. 20, 1981) (protecting names of consultants and subcontractors, performance, cost, and equipment information).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials and consultants reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts internal government deliberations, thoughts, opinions, recommendations, and proposed solutions from federal employees and consultants reviewing VA programs in their professional capacities, as well as non-final or draft documents. The information contained in the responsive records is both predecisional and deliberative because it reflects preliminary opinions, proposed solutions, and recommendations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees and consultants to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, proposing changes to, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials and consultants to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D.C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Under the attorney-client and work product privileges, the VA redacts portions of records, emails, and communications between VA employees and attorneys analyzing and discussing legal issues for the VA and its employees. The release of this information would impede the ability of VA employees and attorneys to speak openly and frankly about legal issues concerning the VA or its employees. The release of this information would be an invasion of the attorney-client privilege. VA-18-0457-A-003534

training about legal issues concerning the VA or its employees. The release of this information would also compromise the legal positions of the VA and its employees.

5 U.S.C. § 552(b)(6) exempts from required disclosure "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal employees and private citizens; we however release the names and VA email addresses of VA Senior Executives. Federal civilian employees and private citizens retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal civilian employees and private citizens whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, except names and VA email addresses of VA Senior Executives, we find that there is no public interest in knowing the names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal civilian employees and private citizens. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. Releasing even a single VA username reveals the pattern to ascertain VA usernames that VA employees use to log into VA Systems of Records; releasing VA usernames exposes the VA, its employees, and its contractors to potential hacking and information technology security liabilities and risks. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed." Long v. Immigration & Customs Enf't, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

5 U.S.C. § 552(b)(7)(C) exempts from required disclosure information law enforcement information the disclosure of which "could reasonably be expected to constitute an unwarranted invasion of personal privacy." Redacted information includes names and email addresses of White House employees with security clearances, as well as Redacted information includes names, identities, email addresses, and VA usernames of VA law enforcement employees. The release of this information would risk impersonation of these White House employees with security clearances also working on national security and law enforcement matters, as well as jeopardizing their health and safety and those the White House employees are charged with protecting. The release of this information would risk impersonation of VA law enforcement personnel and jeopardize the health and safety of not only law enforcement personnel but those persons the VA

VA-18-0457-A-003535

the health and safety of not only law enforcement personnel, but those persons the VA law enforcement personnel protect including the VA Secretary.

5 U.S.C. § 552(b)(7)(E) exempts from required disclosure information that "would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law." Redacted information includes VA usernames of VA law enforcement employees and shared VA email groups, for which VA law enforcement officials plan their law enforcement operations and protection of VA personnel. The release of this information would compromise the safety of VA law enforcement personnel and VA employees.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:

Name: John Buck

Email Address: vacofoiaservice@va.gov

Office of Government Information Services (OGIS)

Email Address: ogis@nara.gov

Fax: 202-741-5769

Mailing address:

National Archives and Records Administration

8601 Adelphi Road

College Park, MD 20740-6001

FOIA Appeal

This concludes OSVA's partial IAD to request **18-11960-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,

Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachments

- Redacted one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535

VA-18-0457-A-003536

intentionally left blank).

Richard Ha, JD, CIPP/G
OSVA FOIA/Privacy Officer
Office of the Executive Secretary
Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA)
202-632-5286 o
202-309-3072 c
Richard.ha1@va.gov
Telework Weds
CWS 2nd Mon

These messages and attachments are For Official Use Only, not to be shared outside intended parties, and may be exempt from disclosure pursuant to 5 U.S.C. § 552(b)(3) prohibiting the release of information that another statute prohibits; 41 U.S.C. § 4702(b) prohibiting the release of unincorporated proposals; 41 U.S.C. § 423(a) prohibiting the release of bid or proposal information or evaluations before award; 26 U.S.C. § 6103 prohibiting the release of tax identification numbers; 5 U.S.C. § 552(b)(4) prohibiting the release of confidential commercial information; 5 U.S.C. § 552(b)(5) under the deliberative process, attorney-client, and work product privileges; and 5 U.S.C. § 552(b)(6) protecting personally identifiable information. If you received these messages and attachments in error, you must inform the FOIA Officer and destroy them immediately. The VA reserves its discovery rights including, but not limited to, objections, privileges, motions, etc.



2150-2151
CVA_R...ted.pdf



1536-2149
CVA_R...ted.pdf

From: **Ha, Richard** Richard.Ha1@va.gov 
Subject: RE: FOIA 18-11960-F: 3/8 Partial Initial Agency Decision
Date: November 30, 2018 at 2:02 PM
To: foia@americanoversight.org

RH

[Email 3 of 8 due to size limitations]

November 30, 2018

In Reply Refer To: 001B
FOIA Request: 18-11960-F

Daniel McGrath, Staff Attorney
Austin Evers, Executive Director
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005
foia@americanoversight.org

Dear Mr. McGrath:

This is the Second Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated and received August 23, 2018, and assigned FOIA tracking number **18-11960-F**. You requested:

All records reflecting communications (including emails, email attachments, text messages, messages on messaging platforms (such as Slack, GChat or Google Hangouts, Lync, Skype, or WhatsApp), telephone call logs, calendar invitations/entries, meeting notices, meeting agendas, informational material, talking points, any handwritten or electronic notes taken during any oral communications, summaries of any oral communications, or other materials) between any of the individuals listed

- Veterans Affairs Officials
 - Darin Selnick, Senior Advisor to the Secretary
 - Casin Spero, Special Advisor
 - Individuals within the Offices of the Secretary and Deputy Secretary: David Shulkin, Former Secretary, and anyone acting on his behalf
 - Vivieca Wright Simpson, Former Chief of Staff
 - Pete O'Rourke, Former Chief of Staff, Former Acting Secretary, and Senior Advisor to the Secretary; and anyone acting on his behalf
 - Robert Wilkie, Secretary, and anyone acting on his behalf
 - Jacquelyn Hayes-Byrd, Acting Chief of Staff and Deputy Chief of Staff
 - Thomas Bowman, Deputy Secretary, and anyone acting on his behalf
 - Any political appointee* in the immediate Office of the Secretary or Deputy Secretary during the applicable time period not previously listed above
- Outside Recipients
 - Dan Caldwell
 - Nathan Anderson
 - Shannon Hough
 - Pete Hegseth
 - Any email address ending in @cv4a.org or @cvafoundation.org
 - Isaac "Ike" Perlmutter
 - Bruce Moskowitz
 - Marc Sherman
- All email communications between any of the individuals listed in Column A and any external individuals or organizations (i.e., emails with addresses ending in com/.org/.net/.mil/.edu) that mention one or more of the following search terms in the subject line, body of the email, or attachment:

1 "Concerned Veterans"

VA-18-0457-A-003539

1. Concerned Veterans
2. "Concerned Vets"
3. CVA
4. CV4A

Please provide all responsive records from January 20, 2017, through the date of the search."

There is substantial overlap between this FOIA request and your prior FOIA request **18-07426-F**, as some redacted records released for your FOIA request **18-07426-F** are also responsive to FOIA request **18-11960-F**.

Reasonable Searches Dated September 6, 2018, September 18, 2018, October 12, 2018, October 16, 2018, October 18, 2018, and November 15, 2018

On September 6, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below ten (10) custodians from January 20, 2017, to September 6, 2018:

1. Wilkie, Robert L., Jr., VA Secretary;
2. Shulkin, David, former VA Secretary;
3. O'Rourke, Peter M., former VA Acting Secretary;
4. Bowman, Thomas, former VA Deputy Secretary;
5. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
6. Wright-Simpson, Vivieca, former VA Chief of Staff;
7. Selnick, Darin, former VA White House Senior Advisor;
8. Lukach, Michael, former VA White House Senior Advisor;
9. Leinenkugel, Jake, former VA White House Senior Advisor; and,
10. Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches.

On October 12, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to June 22, 2018. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. These October 12, 2018, and October 16, 2018, searches yielded forty-four (44) pages, which OSVA released redacted as pages Bates-numbered 243-286 to you for FOIA request **18-07426-F**.

On September 18, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Chief of Staff Jacquelyn Hayes-Byrd's emails and calendars from November 8, 2016, to June 22, 2018. OSVA used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. This search yielded two hundred fifty-five (255) pages, which OSVA released redacted as pages Bates-numbered 287-541 to you for FOIA request **18-07426-F**.

On October 18, 2018, the OSVA FOIA office searched through the email boxes and calendars, from January 20, 2017, to June 22, 2018, of: David Shulkin, Thomas Bowman, Vivieca Wright-Simpon, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded three hundred twenty-eight (328) pages, which OSVA released redacted as pages Bates-numbered 542-813 and 816-871 to you for FOIA request **18-07426-F**.

On November 15, 2018, the OSVA FOIA office searched through the email boxes and calendars from June 23, 2018, to September 6, 2018, of:

VA-18-0457-A-003540

1. Wilkie, Robert L., Jr., VA Secretary;
2. O'Rourke, Peter M., former VA Acting Secretary;
3. Bowman, Thomas, former VA Deputy Secretary;
4. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
5. Wright-Simpson, Vivieca, former VA Chief of Staff;
6. Selnick, Darin, former VA White House Senior Advisor;
7. Lukach, Michael, former VA White House Senior Advisor;
8. Leinenkugel, Jake, former VA White House Senior Advisor; and,
9. Spero, Casin D, former VA White House Liaison.

The November 15, 2018, search yielded two pages, which OSVA released redacted as pages Bates-numbered 814-815 for your FOIA request **18-07426-F**.

Partial Initial Agency Decision

Using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms "Concerned Veterans of America," "CVA," and "cv4a.org" to search through former VA Secretary David Shulkin's email boxes for responsive records. The OSVA FOIA Officer also used the same search key terms through the email boxes of the following custodians: Robert Wilkie, Peter O'Rourke, David Shulkin, Thomas Bowman, Jacquelyn Hayes-Byrd, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero.

⁵ This Clearwell search yielded approximately four hundred (400) documents totaling approximately five thousand (5,000) pages. OSVA now releases to you one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank). OSVA will release approximately one hundred twenty (120) redacted documents totaling approximately fourteen hundred (1,400) pages to you in the future. After reviewing the three thousand five hundred twenty-four (3,524) pages, OSVA redacts some information with FOIA Exemptions 4, 5, 6, 7(C).

5 U.S.C. § 552(b)(4) exempts from disclosure "trade secrets and commercial or financial information obtained from a person and privileged or confidential." Redacted information includes voluntary proposal submission verbiage, technical processes, technical approaches, and partnership or subcontracting agreements. The release of this information would likely lead to substantial competitive harm in reverse-engineering of the vendors' technical approaches, processes, partnership, subcontracting, and business and labor strategies. RMS Indus. v. DOD, No. C-92-1545, slip op. at 7 (N.D. Cal. Nov. 24, 1992) (protecting "descriptions of equipment and the names of contacts, customers, key employees, and subcontractors" because "bidders only submit such information if it will not be released to their competitors"); BDM Corp. v. SBA, 2 Gov't Disclosure Serv. (P-H) ¶ 81,189, at 81,495 (D.D.C. Mar. 20, 1981) (protecting names of consultants and subcontractors, performance, cost, and equipment information).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials and consultants reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts internal government deliberations, thoughts, opinions, recommendations, and proposed solutions from federal employees and consultants reviewing VA programs in their professional capacities, as well as non-final or draft documents. The information contained in the responsive records is both predecisional and deliberative because it reflects preliminary opinions, proposed solutions, and recommendations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees and consultants to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, proposing changes to, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials and consultants to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Under the attorney-client and work product privileges, the VA redacts portions of records, emails, and communications between VA employees and attorneys analyzing and discussing legal issues for the VA and its employees. The release of this information would impede the ability of VA employees and attorneys to speak openly and

VA-18-0457-A-003541

frankly about legal issues concerning the VA or its employees. The release of this information would also compromise the legal positions of the VA and its employees.

5 U.S.C. § 552(b)(6) exempts from required disclosure "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal employees and private citizens; we however release the names and VA email addresses of VA Senior Executives. Federal civilian employees and private citizens retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal civilian employees and private citizens whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, except names and VA email addresses of VA Senior Executives, we find that there is no public interest in knowing the names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal civilian employees and private citizens. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. Releasing even a single VA username reveals the pattern to ascertain VA usernames that VA employees use to log into VA Systems of Records; releasing VA usernames exposes the VA, its employees, and its contractors to potential hacking and information technology security liabilities and risks. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed." Long v. Immigration & Customs Enf't, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

5 U.S.C. § 552(b)(7)(C) exempts from required disclosure information law enforcement information the disclosure of which "could reasonably be expected to constitute an unwarranted invasion of personal privacy." Redacted information includes names and email addresses of White House employees with security clearances, as well as Redacted information includes names, identities, email addresses, and VA usernames of VA law enforcement employees. The release of this information would risk impersonation of these White House employees with security clearances also working on national security and law enforcement matters, as well as jeopardizing their health and safety and those the White House employees are charged with protecting. The release of this information would risk impersonation of VA law enforcement personnel and jeopardize

VA-18-0457-A-003542

the health and safety of not only law enforcement personnel, but those persons the VA law enforcement personnel protect including the VA Secretary.

5 U.S.C. § 552(b)(7)(E) exempts from required disclosure information that "would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law." Redacted information includes VA usernames of VA law enforcement employees and shared VA email groups, for which VA law enforcement officials plan their law enforcement operations and protection of VA personnel. The release of this information would compromise the safety of VA law enforcement personnel and VA employees.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:

Name: John Buck

Email Address: vacofoiaservice@va.gov

Office of Government Information Services (OGIS)

Email Address: ogis@nara.gov

Fax: 202-741-5769

Mailing address:

National Archives and Records Administration

8601 Adelphi Road

College Park, MD 20740-6001

FOIA Appeal

This concludes OSVA's partial IAD to request **18-11960-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,

Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachments

- Redacted one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages. Bates-numbered as 996-4547 (with 1508-1535

VA-18-0457-A-003543

intentionally left blank).

Richard Ha, JD, CIPP/G
OSVA FOIA/Privacy Officer
Office of the Executive Secretary
Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA)
202-632-5286 o
202-309-3072 c
Richard.ha1@va.gov
Telework Weds
CWS 2nd Mon

These messages and attachments are For Official Use Only, not to be shared outside intended parties, and may be exempt from disclosure pursuant to 5 U.S.C. § 552(b)(3) prohibiting the release of information that another statute prohibits; 41 U.S.C. § 4702(b) prohibiting the release of unincorporated proposals; 41 U.S.C. § 423(a) prohibiting the release of bid or proposal information or evaluations before award; 26 U.S.C. § 6103 prohibiting the release of tax identification numbers; 5 U.S.C. § 552(b)(4) prohibiting the release of confidential commercial information; 5 U.S.C. § 552(b)(5) under the deliberative process, attorney-client, and work product privileges; and 5 U.S.C. § 552(b)(6) protecting personally identifiable information. If you received these messages and attachments in error, you must inform the FOIA Officer and destroy them immediately. The VA reserves its discovery rights including, but not limited to, objections, privileges, motions, etc.



2635-2985
CVA_R...ted.pdf



2632-2634
CVA_R...ted.pdf

From: **Ha, Richard** Richard.Ha1@va.gov  
Subject: RE: FOIA 18-11960-F: 4/8 Partial Initial Agency Decision
Date: November 30, 2018 at 2:04 PM
To: foia@americanoversight.org

RH

[Email 4 of 8 due to size limitations]

November 30, 2018

In Reply Refer To: 001B
FOIA Request: 18-11960-F

Daniel McGrath, Staff Attorney
Austin Evers, Executive Director
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005
foia@americanoversight.org

Dear Mr. McGrath:

This is the Second Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated and received August 23, 2018, and assigned FOIA tracking number **18-11960-F**. You requested:

All records reflecting communications (including emails, email attachments, text messages, messages on messaging platforms (such as Slack, GChat or Google Hangouts, Lync, Skype, or WhatsApp), telephone call logs, calendar invitations/entries, meeting notices, meeting agendas, informational material, talking points, any handwritten or electronic notes taken during any oral communications, summaries of any oral communications, or other materials) between any of the individuals listed

- Veterans Affairs Officials
 - Darin Selnick, Senior Advisor to the Secretary
 - Casin Spero, Special Advisor
 - Individuals within the Offices of the Secretary and Deputy Secretary: David Shulkin, Former Secretary, and anyone acting on his behalf
 - Vivieca Wright Simpson, Former Chief of Staff
 - Pete O'Rourke, Former Chief of Staff, Former Acting Secretary, and Senior Advisor to the Secretary; and anyone acting on his behalf
 - Robert Wilkie, Secretary, and anyone acting on his behalf
 - Jacquelyn Hayes-Byrd, Acting Chief of Staff and Deputy Chief of Staff
 - Thomas Bowman, Deputy Secretary, and anyone acting on his behalf
 - Any political appointee* in the immediate Office of the Secretary or Deputy Secretary during the applicable time period not previously listed above
- Outside Recipients
 - Dan Caldwell
 - Nathan Anderson
 - Shannon Hough
 - Pete Hegseth
 - Any email address ending in @cv4a.org or @cvafoundation.org
 - Isaac "Ike" Perlmutter
 - Bruce Moskowitz
 - Marc Sherman
- All email communications between any of the individuals listed in Column A and any external individuals or organizations (i.e., emails with addresses ending in com/.org/.net/.mil/.edu) that mention one or more of the following search terms in the subject line, body of the email, or attachment:

1 "Concerned Veterans"

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1. Concerned Veterans
2. "Concerned Vets"
3. CVA
4. CV4A

Please provide all responsive records from January 20, 2017, through the date of the search."

There is substantial overlap between this FOIA request and your prior FOIA request **18-07426-F**, as some redacted records released for your FOIA request **18-07426-F** are also responsive to FOIA request **18-11960-F**.

Reasonable Searches Dated September 6, 2018, September 18, 2018, October 12, 2018, October 16, 2018, October 18, 2018, and November 15, 2018

On September 6, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below ten (10) custodians from January 20, 2017, to September 6, 2018:

1. Wilkie, Robert L., Jr., VA Secretary;
2. Shulkin, David, former VA Secretary;
3. O'Rourke, Peter M., former VA Acting Secretary;
4. Bowman, Thomas, former VA Deputy Secretary;
5. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
6. Wright-Simpson, Vivieca, former VA Chief of Staff;
7. Selnick, Darin, former VA White House Senior Advisor;
8. Lukach, Michael, former VA White House Senior Advisor;
9. Leinenkugel, Jake, former VA White House Senior Advisor; and,
10. Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches.

On October 12, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to June 22, 2018. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. These October 12, 2018, and October 16, 2018, searches yielded forty-four (44) pages, which OSVA released redacted as pages Bates-numbered 243-286 to you for FOIA request **18-07426-F**.

On September 18, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Chief of Staff Jacquelyn Hayes-Byrd's emails and calendars from November 8, 2016, to June 22, 2018. OSVA used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. This search yielded two hundred fifty-five (255) pages, which OSVA released redacted as pages Bates-numbered 287-541 to you for FOIA request **18-07426-F**.

On October 18, 2018, the OSVA FOIA office searched through the email boxes and calendars, from January 20, 2017, to June 22, 2018, of: David Shulkin, Thomas Bowman, Vivieca Wright-Simpon, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded three hundred twenty-eight (328) pages, which OSVA released redacted as pages Bates-numbered 542-813 and 816-871 to you for FOIA request **18-07426-F**.

On November 15, 2018, the OSVA FOIA office searched through the email boxes and calendars from June 23, 2018, to September 6, 2018, of:

VA-18-0457-A-003547

1. Wilkie, Robert L., Jr., VA Secretary;
2. O'Rourke, Peter M., former VA Acting Secretary;
3. Bowman, Thomas, former VA Deputy Secretary;
4. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
5. Wright-Simpson, Vivieca, former VA Chief of Staff;
6. Selnick, Darin, former VA White House Senior Advisor;
7. Lukach, Michael, former VA White House Senior Advisor;
8. Leinenkugel, Jake, former VA White House Senior Advisor; and,
9. Spero, Casin D, former VA White House Liaison.

The November 15, 2018, search yielded two pages, which OSVA released redacted as pages Bates-numbered 814-815 for your FOIA request **18-07426-F**.

Partial Initial Agency Decision

Using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms "Concerned Veterans of America," "CVA," and "cv4a.org" to search through former VA Secretary David Shulkin's email boxes for responsive records. The OSVA FOIA Officer also used the same search key terms through the email boxes of the following custodians: Robert Wilkie, Peter O'Rourke, David Shulkin, Thomas Bowman, Jacquelyn Hayes-Byrd, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero.

⁵ This Clearwell search yielded approximately four hundred (400) documents totaling approximately five thousand (5,000) pages. OSVA now releases to you one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank). OSVA will release approximately one hundred twenty (120) redacted documents totaling approximately fourteen hundred (1,400) pages to you in the future. After reviewing the three thousand five hundred twenty-four (3,524) pages, OSVA redacts some information with FOIA Exemptions 4, 5, 6, 7(C).

5 U.S.C. § 552(b)(4) exempts from disclosure "trade secrets and commercial or financial information obtained from a person and privileged or confidential." Redacted information includes voluntary proposal submission verbiage, technical processes, technical approaches, and partnership or subcontracting agreements. The release of this information would likely lead to substantial competitive harm in reverse-engineering of the vendors' technical approaches, processes, partnership, subcontracting, and business and labor strategies. RMS Indus. v. DOD, No. C-92-1545, slip op. at 7 (N.D. Cal. Nov. 24, 1992) (protecting "descriptions of equipment and the names of contacts, customers, key employees, and subcontractors" because "bidders only submit such information if it will not be released to their competitors"); BDM Corp. v. SBA, 2 Gov't Disclosure Serv. (P-H) ¶ 81,189, at 81,495 (D.D.C. Mar. 20, 1981) (protecting names of consultants and subcontractors, performance, cost, and equipment information).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials and consultants reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts internal government deliberations, thoughts, opinions, recommendations, and proposed solutions from federal employees and consultants reviewing VA programs in their professional capacities, as well as non-final or draft documents. The information contained in the responsive records is both predecisional and deliberative because it reflects preliminary opinions, proposed solutions, and recommendations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees and consultants to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, proposing changes to, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials and consultants to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Under the attorney-client and work product privileges, the VA redacts portions of records, emails, and communications between VA employees and attorneys analyzing and discussing legal issues for the VA and its employees. The release of this information would impede the ability of VA employees and attorneys to speak openly and

VA-18-0457-A-003548

frankly about legal issues concerning the VA or its employees. The release of this information would also compromise the legal positions of the VA and its employees.

5 U.S.C. § 552(b)(6) exempts from required disclosure "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal employees and private citizens; we however release the names and VA email addresses of VA Senior Executives. Federal civilian employees and private citizens retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal civilian employees and private citizens whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, except names and VA email addresses of VA Senior Executives, we find that there is no public interest in knowing the names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal civilian employees and private citizens. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. Releasing even a single VA username reveals the pattern to ascertain VA usernames that VA employees use to log into VA Systems of Records; releasing VA usernames exposes the VA, its employees, and its contractors to potential hacking and information technology security liabilities and risks. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed." Long v. Immigration & Customs Enf't, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

5 U.S.C. § 552(b)(7)(C) exempts from required disclosure information law enforcement information the disclosure of which "could reasonably be expected to constitute an unwarranted invasion of personal privacy." Redacted information includes names and email addresses of White House employees with security clearances, as well as Redacted information includes names, identities, email addresses, and VA usernames of VA law enforcement employees. The release of this information would risk impersonation of these White House employees with security clearances also working on national security and law enforcement matters, as well as jeopardizing their health and safety and those the White House employees are charged with protecting. The release of this information would risk impersonation of VA law enforcement personnel and jeopardize

VA-18-0457-A-003549

the health and safety of not only law enforcement personnel, but those persons the VA law enforcement personnel protect including the VA Secretary.

5 U.S.C. § 552(b)(7)(E) exempts from required disclosure information that "would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law." Redacted information includes VA usernames of VA law enforcement employees and shared VA email groups, for which VA law enforcement officials plan their law enforcement operations and protection of VA personnel. The release of this information would compromise the safety of VA law enforcement personnel and VA employees.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:

Name: John Buck

Email Address: vacofoiaservice@va.gov

Office of Government Information Services (OGIS)

Email Address: ogis@nara.gov

Fax: 202-741-5769

Mailing address:

National Archives and Records Administration

8601 Adelphi Road

College Park, MD 20740-6001

FOIA Appeal

This concludes OSVA's partial IAD to request **18-11960-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,

Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachments

- Redacted one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages. Bates-numbered as 996-4547 (with 1508-1535

VA-18-0457-A-003550

intentionally left blank).

Richard Ha, JD, CIPP/G
OSVA FOIA/Privacy Officer
Office of the Executive Secretary
Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA)
202-632-5286 o
202-309-3072 c
Richard.ha1@va.gov
Telework Weds
CWS 2nd Mon

These messages and attachments are For Official Use Only, not to be shared outside intended parties, and may be exempt from disclosure pursuant to 5 U.S.C. § 552(b)(3) prohibiting the release of information that another statute prohibits; 41 U.S.C. § 4702(b) prohibiting the release of unincorporated proposals; 41 U.S.C. § 423(a) prohibiting the release of bid or proposal information or evaluations before award; 26 U.S.C. § 6103 prohibiting the release of tax identification numbers; 5 U.S.C. § 552(b)(4) prohibiting the release of confidential commercial information; 5 U.S.C. § 552(b)(5) under the deliberative process, attorney-client, and work product privileges; and 5 U.S.C. § 552(b)(6) protecting personally identifiable information. If you received these messages and attachments in error, you must inform the FOIA Officer and destroy them immediately. The VA reserves its discovery rights including, but not limited to, objections, privileges, motions, etc.



2152-2631
CVA_R...ted.pdf

From: **Ha, Richard** Richard.Ha1@va.gov 
Subject: RE: FOIA 18-11960-F: 5/8 Partial Initial Agency Decision
Date: November 30, 2018 at 2:06 PM
To: foia@americanoversight.org

RH

[Email 5 of 8 due to size limitations]

November 30, 2018

In Reply Refer To: 001B
FOIA Request: 18-11960-F

Daniel McGrath, Staff Attorney
Austin Evers, Executive Director
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005
foia@americanoversight.org

Dear Mr. McGrath:

This is the Second Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated and received August 23, 2018, and assigned FOIA tracking number **18-11960-F**. You requested:

All records reflecting communications (including emails, email attachments, text messages, messages on messaging platforms (such as Slack, GChat or Google Hangouts, Lync, Skype, or WhatsApp), telephone call logs, calendar invitations/entries, meeting notices, meeting agendas, informational material, talking points, any handwritten or electronic notes taken during any oral communications, summaries of any oral communications, or other materials) between any of the individuals listed

- Veterans Affairs Officials
 - Darin Selnick, Senior Advisor to the Secretary
 - Casin Spero, Special Advisor
 - Individuals within the Offices of the Secretary and Deputy Secretary: David Shulkin, Former Secretary, and anyone acting on his behalf
 - Vivieca Wright Simpson, Former Chief of Staff
 - Pete O'Rourke, Former Chief of Staff, Former Acting Secretary, and Senior Advisor to the Secretary; and anyone acting on his behalf
 - Robert Wilkie, Secretary, and anyone acting on his behalf
 - Jacquelyn Hayes-Byrd, Acting Chief of Staff and Deputy Chief of Staff
 - Thomas Bowman, Deputy Secretary, and anyone acting on his behalf
 - Any political appointee* in the immediate Office of the Secretary or Deputy Secretary during the applicable time period not previously listed above
- Outside Recipients
 - Dan Caldwell
 - Nathan Anderson
 - Shannon Hough
 - Pete Hegseth
 - Any email address ending in @cv4a.org or @cvafoundation.org
 - Isaac "Ike" Perlmutter
 - Bruce Moskowitz
 - Marc Sherman
- All email communications between any of the individuals listed in Column A and any external individuals or organizations (i.e., emails with addresses ending in com/.org/.net/.mil/.edu) that mention one or more of the following search terms in the subject line, body of the email, or attachment:

1 "Concerned Veterans"

VA-18-0457-A-003553

1. Concerned Veterans
2. "Concerned Vets"
3. CVA
4. CV4A

Please provide all responsive records from January 20, 2017, through the date of the search."

There is substantial overlap between this FOIA request and your prior FOIA request **18-07426-F**, as some redacted records released for your FOIA request **18-07426-F** are also responsive to FOIA request **18-11960-F**.

Reasonable Searches Dated September 6, 2018, September 18, 2018, October 12, 2018, October 16, 2018, October 18, 2018, and November 15, 2018

On September 6, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below ten (10) custodians from January 20, 2017, to September 6, 2018:

1. Wilkie, Robert L., Jr., VA Secretary;
2. Shulkin, David, former VA Secretary;
3. O'Rourke, Peter M., former VA Acting Secretary;
4. Bowman, Thomas, former VA Deputy Secretary;
5. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
6. Wright-Simpson, Vivieca, former VA Chief of Staff;
7. Selnick, Darin, former VA White House Senior Advisor;
8. Lukach, Michael, former VA White House Senior Advisor;
9. Leinenkugel, Jake, former VA White House Senior Advisor; and,
10. Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches.

On October 12, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to June 22, 2018. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. These October 12, 2018, and October 16, 2018, searches yielded forty-four (44) pages, which OSVA released redacted as pages Bates-numbered 243-286 to you for FOIA request **18-07426-F**.

On September 18, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Chief of Staff Jacquelyn Hayes-Byrd's emails and calendars from November 8, 2016, to June 22, 2018. OSVA used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. This search yielded two hundred fifty-five (255) pages, which OSVA released redacted as pages Bates-numbered 287-541 to you for FOIA request **18-07426-F**.

On October 18, 2018, the OSVA FOIA office searched through the email boxes and calendars, from January 20, 2017, to June 22, 2018, of: David Shulkin, Thomas Bowman, Vivieca Wright-Simpon, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded three hundred twenty-eight (328) pages, which OSVA released redacted as pages Bates-numbered 542-813 and 816-871 to you for FOIA request **18-07426-F**.

On November 15, 2018, the OSVA FOIA office searched through the email boxes and calendars from June 23, 2018, to September 6, 2018, of:

VA-18-0457-A-003554

1. Wilkie, Robert L., Jr., VA Secretary;
2. O'Rourke, Peter M., former VA Acting Secretary;
3. Bowman, Thomas, former VA Deputy Secretary;
4. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
5. Wright-Simpson, Vivieca, former VA Chief of Staff;
6. Selnick, Darin, former VA White House Senior Advisor;
7. Lukach, Michael, former VA White House Senior Advisor;
8. Leinenkugel, Jake, former VA White House Senior Advisor; and,
9. Spero, Casin D, former VA White House Liaison.

The November 15, 2018, search yielded two pages, which OSVA released redacted as pages Bates-numbered 814-815 for your FOIA request **18-07426-F**.

Partial Initial Agency Decision

Using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms "Concerned Veterans of America," "CVA," and "cv4a.org" to search through former VA Secretary David Shulkin's email boxes for responsive records. The OSVA FOIA Officer also used the same search key terms through the email boxes of the following custodians: Robert Wilkie, Peter O'Rourke, David Shulkin, Thomas Bowman, Jacquelyn Hayes-Byrd, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero.

⁵ This Clearwell search yielded approximately four hundred (400) documents totaling approximately five thousand (5,000) pages. OSVA now releases to you one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank). OSVA will release approximately one hundred twenty (120) redacted documents totaling approximately fourteen hundred (1,400) pages to you in the future. After reviewing the three thousand five hundred twenty-four (3,524) pages, OSVA redacts some information with FOIA Exemptions 4, 5, 6, 7(C).

5 U.S.C. § 552(b)(4) exempts from disclosure "trade secrets and commercial or financial information obtained from a person and privileged or confidential." Redacted information includes voluntary proposal submission verbiage, technical processes, technical approaches, and partnership or subcontracting agreements. The release of this information would likely lead to substantial competitive harm in reverse-engineering of the vendors' technical approaches, processes, partnership, subcontracting, and business and labor strategies. RMS Indus. v. DOD, No. C-92-1545, slip op. at 7 (N.D. Cal. Nov. 24, 1992) (protecting "descriptions of equipment and the names of contacts, customers, key employees, and subcontractors" because "bidders only submit such information if it will not be released to their competitors"); BDM Corp. v. SBA, 2 Gov't Disclosure Serv. (P-H) ¶ 81,189, at 81,495 (D.D.C. Mar. 20, 1981) (protecting names of consultants and subcontractors, performance, cost, and equipment information).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials and consultants reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts internal government deliberations, thoughts, opinions, recommendations, and proposed solutions from federal employees and consultants reviewing VA programs in their professional capacities, as well as non-final or draft documents. The information contained in the responsive records is both predecisional and deliberative because it reflects preliminary opinions, proposed solutions, and recommendations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees and consultants to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, proposing changes to, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials and consultants to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Under the attorney-client and work product privileges, the VA redacts portions of records, emails, and communications between VA employees and attorneys analyzing and discussing legal issues for the VA and its employees. The release of this information would impede the ability of VA employees and attorneys to speak openly and

VA-18-0457-A-003555

frankly about legal issues concerning the VA or its employees. The release of this information would also compromise the legal positions of the VA and its employees.

5 U.S.C. § 552(b)(6) exempts from required disclosure "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal employees and private citizens; we however release the names and VA email addresses of VA Senior Executives. Federal civilian employees and private citizens retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal civilian employees and private citizens whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, except names and VA email addresses of VA Senior Executives, we find that there is no public interest in knowing the names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal civilian employees and private citizens. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. Releasing even a single VA username reveals the pattern to ascertain VA usernames that VA employees use to log into VA Systems of Records; releasing VA usernames exposes the VA, its employees, and its contractors to potential hacking and information technology security liabilities and risks. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed." Long v. Immigration & Customs Enf't, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

5 U.S.C. § 552(b)(7)(C) exempts from required disclosure information law enforcement information the disclosure of which "could reasonably be expected to constitute an unwarranted invasion of personal privacy." Redacted information includes names and email addresses of White House employees with security clearances, as well as Redacted information includes names, identities, email addresses, and VA usernames of VA law enforcement employees. The release of this information would risk impersonation of these White House employees with security clearances also working on national security and law enforcement matters, as well as jeopardizing their health and safety and those the White House employees are charged with protecting. The release of this information would risk impersonation of VA law enforcement personnel and jeopardize

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the health and safety of not only law enforcement personnel, but those persons the VA law enforcement personnel protect including the VA Secretary.

5 U.S.C. § 552(b)(7)(E) exempts from required disclosure information that "would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law." Redacted information includes VA usernames of VA law enforcement employees and shared VA email groups, for which VA law enforcement officials plan their law enforcement operations and protection of VA personnel. The release of this information would compromise the safety of VA law enforcement personnel and VA employees.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:

Name: John Buck

Email Address: vacofoiaservice@va.gov

Office of Government Information Services (OGIS)

Email Address: ogis@nara.gov

Fax: 202-741-5769

Mailing address:

National Archives and Records Administration

8601 Adelphi Road

College Park, MD 20740-6001

FOIA Appeal

This concludes OSVA's partial IAD to request **18-11960-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,

Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachments

- Redacted one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages. Bates-numbered as 996-4547 (with 1508-1535

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intentionally left blank).

Richard Ha, JD, CIPP/G
OSVA FOIA/Privacy Officer
Office of the Executive Secretary
Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA)
202-632-5286 o
202-309-3072 c
Richard.ha1@va.gov
Telework Weds
CWS 2nd Mon

These messages and attachments are For Official Use Only, not to be shared outside intended parties, and may be exempt from disclosure pursuant to 5 U.S.C. § 552(b)(3) prohibiting the release of information that another statute prohibits; 41 U.S.C. § 4702(b) prohibiting the release of unincorporated proposals; 41 U.S.C. § 423(a) prohibiting the release of bid or proposal information or evaluations before award; 26 U.S.C. § 6103 prohibiting the release of tax identification numbers; 5 U.S.C. § 552(b)(4) prohibiting the release of confidential commercial information; 5 U.S.C. § 552(b)(5) under the deliberative process, attorney-client, and work product privileges; and 5 U.S.C. § 552(b)(6) protecting personally identifiable information. If you received these messages and attachments in error, you must inform the FOIA Officer and destroy them immediately. The VA reserves its discovery rights including, but not limited to, objections, privileges, motions, etc.



2986-3336
CVA_R...ted.pdf

From: **Ha, Richard** Richard.Ha1@va.gov 
Subject: RE: FOIA 18-11960-F: 6/8 Partial Initial Agency Decision
Date: November 30, 2018 at 2:07 PM
To: foia@americanoversight.org

RH

[Email 6 of 8 due to size limitations]

November 30, 2018

In Reply Refer To: 001B
FOIA Request: 18-11960-F

Daniel McGrath, Staff Attorney
Austin Evers, Executive Director
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005
foia@americanoversight.org

Dear Mr. McGrath:

This is the Second Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated and received August 23, 2018, and assigned FOIA tracking number **18-11960-F**. You requested:

All records reflecting communications (including emails, email attachments, text messages, messages on messaging platforms (such as Slack, GChat or Google Hangouts, Lync, Skype, or WhatsApp), telephone call logs, calendar invitations/entries, meeting notices, meeting agendas, informational material, talking points, any handwritten or electronic notes taken during any oral communications, summaries of any oral communications, or other materials) between any of the individuals listed

- Veterans Affairs Officials
 - Darin Selnick, Senior Advisor to the Secretary
 - Casin Spero, Special Advisor
 - Individuals within the Offices of the Secretary and Deputy Secretary: David Shulkin, Former Secretary, and anyone acting on his behalf
 - Vivieca Wright Simpson, Former Chief of Staff
 - Pete O'Rourke, Former Chief of Staff, Former Acting Secretary, and Senior Advisor to the Secretary; and anyone acting on his behalf
 - Robert Wilkie, Secretary, and anyone acting on his behalf
 - Jacquelyn Hayes-Byrd, Acting Chief of Staff and Deputy Chief of Staff
 - Thomas Bowman, Deputy Secretary, and anyone acting on his behalf
 - Any political appointee* in the immediate Office of the Secretary or Deputy Secretary during the applicable time period not previously listed above
- Outside Recipients
 - Dan Caldwell
 - Nathan Anderson
 - Shannon Hough
 - Pete Hegseth
 - Any email address ending in @cv4a.org or @cvafoundation.org
 - Isaac "Ike" Perlmutter
 - Bruce Moskowitz
 - Marc Sherman
- All email communications between any of the individuals listed in Column A and any external individuals or organizations (i.e., emails with addresses ending in com/.org/.net/.mil/.edu) that mention one or more of the following search terms in the subject line, body of the email, or attachment:

1 "Concerned Veterans"

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1. Concerned Veterans
2. "Concerned Vets"
3. CVA
4. CV4A

Please provide all responsive records from January 20, 2017, through the date of the search."

There is substantial overlap between this FOIA request and your prior FOIA request **18-07426-F**, as some redacted records released for your FOIA request **18-07426-F** are also responsive to FOIA request **18-11960-F**.

Reasonable Searches Dated September 6, 2018, September 18, 2018, October 12, 2018, October 16, 2018, October 18, 2018, and November 15, 2018

On September 6, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below ten (10) custodians from January 20, 2017, to September 6, 2018:

1. Wilkie, Robert L., Jr., VA Secretary;
2. Shulkin, David, former VA Secretary;
3. O'Rourke, Peter M., former VA Acting Secretary;
4. Bowman, Thomas, former VA Deputy Secretary;
5. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
6. Wright-Simpson, Vivieca, former VA Chief of Staff;
7. Selnick, Darin, former VA White House Senior Advisor;
8. Lukach, Michael, former VA White House Senior Advisor;
9. Leinenkugel, Jake, former VA White House Senior Advisor; and,
10. Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches.

On October 12, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to June 22, 2018. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. These October 12, 2018, and October 16, 2018, searches yielded forty-four (44) pages, which OSVA released redacted as pages Bates-numbered 243-286 to you for FOIA request **18-07426-F**.

On September 18, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Chief of Staff Jacquelyn Hayes-Byrd's emails and calendars from November 8, 2016, to June 22, 2018. OSVA used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. This search yielded two hundred fifty-five (255) pages, which OSVA released redacted as pages Bates-numbered 287-541 to you for FOIA request **18-07426-F**.

On October 18, 2018, the OSVA FOIA office searched through the email boxes and calendars, from January 20, 2017, to June 22, 2018, of: David Shulkin, Thomas Bowman, Vivieca Wright-Simpon, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded three hundred twenty-eight (328) pages, which OSVA released redacted as pages Bates-numbered 542-813 and 816-871 to you for FOIA request **18-07426-F**.

On November 15, 2018, the OSVA FOIA office searched through the email boxes and calendars from June 23, 2018, to September 6, 2018, of:

VA-18-0457-A-003561

1. Wilkie, Robert L., Jr., VA Secretary;
2. O'Rourke, Peter M., former VA Acting Secretary;
3. Bowman, Thomas, former VA Deputy Secretary;
4. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
5. Wright-Simpson, Vivieca, former VA Chief of Staff;
6. Selnick, Darin, former VA White House Senior Advisor;
7. Lukach, Michael, former VA White House Senior Advisor;
8. Leinenkugel, Jake, former VA White House Senior Advisor; and,
9. Spero, Casin D, former VA White House Liaison.

The November 15, 2018, search yielded two pages, which OSVA released redacted as pages Bates-numbered 814-815 for your FOIA request **18-07426-F**.

Partial Initial Agency Decision

Using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms "Concerned Veterans of America," "CVA," and "cv4a.org" to search through former VA Secretary David Shulkin's email boxes for responsive records. The OSVA FOIA Officer also used the same search key terms through the email boxes of the following custodians: Robert Wilkie, Peter O'Rourke, David Shulkin, Thomas Bowman, Jacquelyn Hayes-Byrd, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero.

⁵ This Clearwell search yielded approximately four hundred (400) documents totaling approximately five thousand (5,000) pages. OSVA now releases to you one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank). OSVA will release approximately one hundred twenty (120) redacted documents totaling approximately fourteen hundred (1,400) pages to you in the future. After reviewing the three thousand five hundred twenty-four (3,524) pages, OSVA redacts some information with FOIA Exemptions 4, 5, 6, 7(C).

5 U.S.C. § 552(b)(4) exempts from disclosure "trade secrets and commercial or financial information obtained from a person and privileged or confidential." Redacted information includes voluntary proposal submission verbiage, technical processes, technical approaches, and partnership or subcontracting agreements. The release of this information would likely lead to substantial competitive harm in reverse-engineering of the vendors' technical approaches, processes, partnership, subcontracting, and business and labor strategies. RMS Indus. v. DOD, No. C-92-1545, slip op. at 7 (N.D. Cal. Nov. 24, 1992) (protecting "descriptions of equipment and the names of contacts, customers, key employees, and subcontractors" because "bidders only submit such information if it will not be released to their competitors"); BDM Corp. v. SBA, 2 Gov't Disclosure Serv. (P-H) ¶ 81,189, at 81,495 (D.D.C. Mar. 20, 1981) (protecting names of consultants and subcontractors, performance, cost, and equipment information).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials and consultants reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts internal government deliberations, thoughts, opinions, recommendations, and proposed solutions from federal employees and consultants reviewing VA programs in their professional capacities, as well as non-final or draft documents. The information contained in the responsive records is both predecisional and deliberative because it reflects preliminary opinions, proposed solutions, and recommendations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees and consultants to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, proposing changes to, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials and consultants to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Under the attorney-client and work product privileges, the VA redacts portions of records, emails, and communications between VA employees and attorneys analyzing and discussing legal issues for the VA and its employees. The release of this information would impede the ability of VA employees and attorneys to speak openly and

VA-18-0457-A-003562

frankly about legal issues concerning the VA or its employees. The release of this information would also compromise the legal positions of the VA and its employees.

5 U.S.C. § 552(b)(6) exempts from required disclosure "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal employees and private citizens; we however release the names and VA email addresses of VA Senior Executives. Federal civilian employees and private citizens retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal civilian employees and private citizens whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, except names and VA email addresses of VA Senior Executives, we find that there is no public interest in knowing the names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal civilian employees and private citizens. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. Releasing even a single VA username reveals the pattern to ascertain VA usernames that VA employees use to log into VA Systems of Records; releasing VA usernames exposes the VA, its employees, and its contractors to potential hacking and information technology security liabilities and risks. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed." Long v. Immigration & Customs Enf't, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

5 U.S.C. § 552(b)(7)(C) exempts from required disclosure information law enforcement information the disclosure of which "could reasonably be expected to constitute an unwarranted invasion of personal privacy." Redacted information includes names and email addresses of White House employees with security clearances, as well as Redacted information includes names, identities, email addresses, and VA usernames of VA law enforcement employees. The release of this information would risk impersonation of these White House employees with security clearances also working on national security and law enforcement matters, as well as jeopardizing their health and safety and those the White House employees are charged with protecting. The release of this information would risk impersonation of VA law enforcement personnel and jeopardize

VA-18-0457-A-003563

the health and safety of not only law enforcement personnel, but those persons the VA law enforcement personnel protect including the VA Secretary.

5 U.S.C. § 552(b)(7)(E) exempts from required disclosure information that "would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law." Redacted information includes VA usernames of VA law enforcement employees and shared VA email groups, for which VA law enforcement officials plan their law enforcement operations and protection of VA personnel. The release of this information would compromise the safety of VA law enforcement personnel and VA employees.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:

Name: John Buck

Email Address: vacofoiaservice@va.gov

Office of Government Information Services (OGIS)

Email Address: ogis@nara.gov

Fax: 202-741-5769

Mailing address:

National Archives and Records Administration

8601 Adelphi Road

College Park, MD 20740-6001

FOIA Appeal

This concludes OSVA's partial IAD to request **18-11960-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,

Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachments

- Redacted one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages. Bates-numbered as 996-4547 (with 1508-1535

VA-18-0457-A-003564

intentionally left blank).

Richard Ha, JD, CIPP/G
OSVA FOIA/Privacy Officer
Office of the Executive Secretary
Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA)
202-632-5286 o
202-309-3072 c
Richard.ha1@va.gov
Telework Weds
CWS 2nd Mon

These messages and attachments are For Official Use Only, not to be shared outside intended parties, and may be exempt from disclosure pursuant to 5 U.S.C. § 552(b)(3) prohibiting the release of information that another statute prohibits; 41 U.S.C. § 4702(b) prohibiting the release of unincorporated proposals; 41 U.S.C. § 423(a) prohibiting the release of bid or proposal information or evaluations before award; 26 U.S.C. § 6103 prohibiting the release of tax identification numbers; 5 U.S.C. § 552(b)(4) prohibiting the release of confidential commercial information; 5 U.S.C. § 552(b)(5) under the deliberative process, attorney-client, and work product privileges; and 5 U.S.C. § 552(b)(6) protecting personally identifiable information. If you received these messages and attachments in error, you must inform the FOIA Officer and destroy them immediately. The VA reserves its discovery rights including, but not limited to, objections, privileges, motions, etc.



3337-3707
CVA_R...ted.pdf

From: **Ha, Richard** Richard.Ha1@va.gov 
Subject: RE: FOIA 18-11960-F: 7/8 Partial Initial Agency Decision
Date: November 30, 2018 at 2:11 PM
To: foia@americanoversight.org

RH

[Email 7 of 8 due to size limitations]

November 30, 2018

In Reply Refer To: 001B
FOIA Request: 18-11960-F

Daniel McGrath, Staff Attorney
Austin Evers, Executive Director
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005
foia@americanoversight.org

Dear Mr. McGrath:

This is the Second Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated and received August 23, 2018, and assigned FOIA tracking number **18-11960-F**. You requested:

All records reflecting communications (including emails, email attachments, text messages, messages on messaging platforms (such as Slack, GChat or Google Hangouts, Lync, Skype, or WhatsApp), telephone call logs, calendar invitations/entries, meeting notices, meeting agendas, informational material, talking points, any handwritten or electronic notes taken during any oral communications, summaries of any oral communications, or other materials) between any of the individuals listed

- Veterans Affairs Officials
 - Darin Selnick, Senior Advisor to the Secretary
 - Casin Spero, Special Advisor
 - Individuals within the Offices of the Secretary and Deputy Secretary: David Shulkin, Former Secretary, and anyone acting on his behalf
 - Vivieca Wright Simpson, Former Chief of Staff
 - Pete O'Rourke, Former Chief of Staff, Former Acting Secretary, and Senior Advisor to the Secretary; and anyone acting on his behalf
 - Robert Wilkie, Secretary, and anyone acting on his behalf
 - Jacquelyn Hayes-Byrd, Acting Chief of Staff and Deputy Chief of Staff
 - Thomas Bowman, Deputy Secretary, and anyone acting on his behalf
 - Any political appointee* in the immediate Office of the Secretary or Deputy Secretary during the applicable time period not previously listed above
- Outside Recipients
 - Dan Caldwell
 - Nathan Anderson
 - Shannon Hough
 - Pete Hegseth
 - Any email address ending in @cv4a.org or @cvafoundation.org
 - Isaac "Ike" Perlmutter
 - Bruce Moskowitz
 - Marc Sherman
- All email communications between any of the individuals listed in Column A and any external individuals or organizations (i.e., emails with addresses ending in com/.org/.net/.mil/.edu) that mention one or more of the following search terms in the subject line, body of the email, or attachment:

1 "Concerned Veterans"

VA-18-0457-A-003567

1. Concerned Veterans
2. "Concerned Vets"
3. CVA
4. CV4A

Please provide all responsive records from January 20, 2017, through the date of the search."

There is substantial overlap between this FOIA request and your prior FOIA request **18-07426-F**, as some redacted records released for your FOIA request **18-07426-F** are also responsive to FOIA request **18-11960-F**.

Reasonable Searches Dated September 6, 2018, September 18, 2018, October 12, 2018, October 16, 2018, October 18, 2018, and November 15, 2018

On September 6, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below ten (10) custodians from January 20, 2017, to September 6, 2018:

1. Wilkie, Robert L., Jr., VA Secretary;
2. Shulkin, David, former VA Secretary;
3. O'Rourke, Peter M., former VA Acting Secretary;
4. Bowman, Thomas, former VA Deputy Secretary;
5. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
6. Wright-Simpson, Vivieca, former VA Chief of Staff;
7. Selnick, Darin, former VA White House Senior Advisor;
8. Lukach, Michael, former VA White House Senior Advisor;
9. Leinenkugel, Jake, former VA White House Senior Advisor; and,
10. Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches.

On October 12, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to June 22, 2018. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. These October 12, 2018, and October 16, 2018, searches yielded forty-four (44) pages, which OSVA released redacted as pages Bates-numbered 243-286 to you for FOIA request **18-07426-F**.

On September 18, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Chief of Staff Jacquelyn Hayes-Byrd's emails and calendars from November 8, 2016, to June 22, 2018. OSVA used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. This search yielded two hundred fifty-five (255) pages, which OSVA released redacted as pages Bates-numbered 287-541 to you for FOIA request **18-07426-F**.

On October 18, 2018, the OSVA FOIA office searched through the email boxes and calendars, from January 20, 2017, to June 22, 2018, of: David Shulkin, Thomas Bowman, Vivieca Wright-Simpon, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded three hundred twenty-eight (328) pages, which OSVA released redacted as pages Bates-numbered 542-813 and 816-871 to you for FOIA request **18-07426-F**.

On November 15, 2018, the OSVA FOIA office searched through the email boxes and calendars from June 23, 2018, to September 6, 2018, of:

VA-18-0457-A-003568

1. Wilkie, Robert L., Jr., VA Secretary;
2. O'Rourke, Peter M., former VA Acting Secretary;
3. Bowman, Thomas, former VA Deputy Secretary;
4. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
5. Wright-Simpson, Vivieca, former VA Chief of Staff;
6. Selnick, Darin, former VA White House Senior Advisor;
7. Lukach, Michael, former VA White House Senior Advisor;
8. Leinenkugel, Jake, former VA White House Senior Advisor; and,
9. Spero, Casin D, former VA White House Liaison.

The November 15, 2018, search yielded two pages, which OSVA released redacted as pages Bates-numbered 814-815 for your FOIA request **18-07426-F**.

Partial Initial Agency Decision

Using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms "Concerned Veterans of America," "CVA," and "cv4a.org" to search through former VA Secretary David Shulkin's email boxes for responsive records. The OSVA FOIA Officer also used the same search key terms through the email boxes of the following custodians: Robert Wilkie, Peter O'Rourke, David Shulkin, Thomas Bowman, Jacquelyn Hayes-Byrd, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero.

This Clearwell search yielded approximately four hundred (400) documents totaling approximately five thousand (5,000) pages. OSVA now releases to you one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank). OSVA will release approximately one hundred twenty (120) redacted documents totaling approximately fourteen hundred (1,400) pages to you in the future. After reviewing the three thousand five hundred twenty-four (3,524) pages, OSVA redacts some information with FOIA Exemptions 4, 5, 6, 7(C).

5 U.S.C. § 552(b)(4) exempts from disclosure "trade secrets and commercial or financial information obtained from a person and privileged or confidential." Redacted information includes voluntary proposal submission verbiage, technical processes, technical approaches, and partnership or subcontracting agreements. The release of this information would likely lead to substantial competitive harm in reverse-engineering of the vendors' technical approaches, processes, partnership, subcontracting, and business and labor strategies. RMS Indus. v. DOD, No. C-92-1545, slip op. at 7 (N.D. Cal. Nov. 24, 1992) (protecting "descriptions of equipment and the names of contacts, customers, key employees, and subcontractors" because "bidders only submit such information if it will not be released to their competitors"); BDM Corp. v. SBA, 2 Gov't Disclosure Serv. (P-H) ¶ 81,189, at 81,495 (D.D.C. Mar. 20, 1981) (protecting names of consultants and subcontractors, performance, cost, and equipment information).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials and consultants reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts internal government deliberations, thoughts, opinions, recommendations, and proposed solutions from federal employees and consultants reviewing VA programs in their professional capacities, as well as non-final or draft documents. The information contained in the responsive records is both predecisional and deliberative because it reflects preliminary opinions, proposed solutions, and recommendations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees and consultants to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, proposing changes to, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials and consultants to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D.C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Under the attorney-client and work product privileges, the VA redacts portions of records, emails, and communications between VA employees and attorneys analyzing and discussing legal issues for the VA and its employees. The release of this information would impede the ability of VA employees and attorneys to speak openly and

VA-18-0457-A-003569

frankly about legal issues concerning the VA or its employees. The release of this information would also compromise the legal positions of the VA and its employees.

5 U.S.C. § 552(b)(6) exempts from required disclosure "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal employees and private citizens; we however release the names and VA email addresses of VA Senior Executives. Federal civilian employees and private citizens retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal civilian employees and private citizens whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, except names and VA email addresses of VA Senior Executives, we find that there is no public interest in knowing the names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal civilian employees and private citizens. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. Releasing even a single VA username reveals the pattern to ascertain VA usernames that VA employees use to log into VA Systems of Records; releasing VA usernames exposes the VA, its employees, and its contractors to potential hacking and information technology security liabilities and risks. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed." Long v. Immigration & Customs Enf't, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

5 U.S.C. § 552(b)(7)(C) exempts from required disclosure information law enforcement information the disclosure of which "could reasonably be expected to constitute an unwarranted invasion of personal privacy." Redacted information includes names and email addresses of White House employees with security clearances, as well as Redacted information includes names, identities, email addresses, and VA usernames of VA law enforcement employees. The release of this information would risk impersonation of these White House employees with security clearances also working on national security and law enforcement matters, as well as jeopardizing their health and safety and those the White House employees are charged with protecting. The release of this information would risk impersonation of VA law enforcement personnel and jeopardize

VA-18-0457-A-003570

the health and safety of not only law enforcement personnel, but those persons the VA law enforcement personnel protect including the VA Secretary.

5 U.S.C. § 552(b)(7)(E) exempts from required disclosure information that "would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law." Redacted information includes VA usernames of VA law enforcement employees and shared VA email groups, for which VA law enforcement officials plan their law enforcement operations and protection of VA personnel. The release of this information would compromise the safety of VA law enforcement personnel and VA employees.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:

Name: John Buck

Email Address: vacofoiaservice@va.gov

Office of Government Information Services (OGIS)

Email Address: ogis@nara.gov

Fax: 202-741-5769

Mailing address:

National Archives and Records Administration

8601 Adelphi Road

College Park, MD 20740-6001

FOIA Appeal

This concludes OSVA's partial IAD to request **18-11960-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,

Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachments

- Redacted one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages. Bates-numbered as 996-4547 (with 1508-1535, VA-18-0457-A-003571)

intentionally left blank).

Richard Ha, JD, CIPP/G
OSVA FOIA/Privacy Officer
Office of the Executive Secretary
Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA)
202-632-5286 o
202-309-3072 c
Richard.ha1@va.gov
Telework Weds
CWS 2nd Mon

These messages and attachments are For Official Use Only, not to be shared outside intended parties, and may be exempt from disclosure pursuant to 5 U.S.C. § 552(b)(3) prohibiting the release of information that another statute prohibits; 41 U.S.C. § 4702(b) prohibiting the release of unincorporated proposals; 41 U.S.C. § 423(a) prohibiting the release of bid or proposal information or evaluations before award; 26 U.S.C. § 6103 prohibiting the release of tax identification numbers; 5 U.S.C. § 552(b)(4) prohibiting the release of confidential commercial information; 5 U.S.C. § 552(b)(5) under the deliberative process, attorney-client, and work product privileges; and 5 U.S.C. § 552(b)(6) protecting personally identifiable information. If you received these messages and attachments in error, you must inform the FOIA Officer and destroy them immediately. The VA reserves its discovery rights including, but not limited to, objections, privileges, motions, etc.



3708-4078
CVA_R...ted.pdf

From: **Ha, Richard** Richard.Ha1@va.gov 
Subject: RE: FOIA 18-11960-F: 8/8 Partial Initial Agency Decision
Date: November 30, 2018 at 2:12 PM
To: foia@americanoversight.org

RH

[Email 8 of 8 due to size limitations]

November 30, 2018

In Reply Refer To: 001B
FOIA Request: 18-11960-F

Daniel McGrath, Staff Attorney
Austin Evers, Executive Director
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005
foia@americanoversight.org

Dear Mr. McGrath:

This is the Second Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated and received August 23, 2018, and assigned FOIA tracking number **18-11960-F**. You requested:

All records reflecting communications (including emails, email attachments, text messages, messages on messaging platforms (such as Slack, GChat or Google Hangouts, Lync, Skype, or WhatsApp), telephone call logs, calendar invitations/entries, meeting notices, meeting agendas, informational material, talking points, any handwritten or electronic notes taken during any oral communications, summaries of any oral communications, or other materials) between any of the individuals listed

- Veterans Affairs Officials
 - Darin Selnick, Senior Advisor to the Secretary
 - Casin Spero, Special Advisor
 - Individuals within the Offices of the Secretary and Deputy Secretary: David Shulkin, Former Secretary, and anyone acting on his behalf
 - Vivieca Wright Simpson, Former Chief of Staff
 - Pete O'Rourke, Former Chief of Staff, Former Acting Secretary, and Senior Advisor to the Secretary; and anyone acting on his behalf
 - Robert Wilkie, Secretary, and anyone acting on his behalf
 - Jacquelyn Hayes-Byrd, Acting Chief of Staff and Deputy Chief of Staff
 - Thomas Bowman, Deputy Secretary, and anyone acting on his behalf
 - Any political appointee* in the immediate Office of the Secretary or Deputy Secretary during the applicable time period not previously listed above
- Outside Recipients
 - Dan Caldwell
 - Nathan Anderson
 - Shannon Hough
 - Pete Hegseth
 - Any email address ending in @cv4a.org or @cvafoundation.org
 - Isaac "Ike" Perlmutter
 - Bruce Moskowitz
 - Marc Sherman
- All email communications between any of the individuals listed in Column A and any external individuals or organizations (i.e., emails with addresses ending in com/.org/.net/.mil/.edu) that mention one or more of the following search terms in the subject line, body of the email, or attachment:

1 "Concerned Veterans"

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1. Concerned Veterans
2. "Concerned Vets"
3. CVA
4. CV4A

Please provide all responsive records from January 20, 2017, through the date of the search."

There is substantial overlap between this FOIA request and your prior FOIA request **18-07426-F**, as some redacted records released for your FOIA request **18-07426-F** are also responsive to FOIA request **18-11960-F**.

Reasonable Searches Dated September 6, 2018, September 18, 2018, October 12, 2018, October 16, 2018, October 18, 2018, and November 15, 2018

On September 6, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below ten (10) custodians from January 20, 2017, to September 6, 2018:

1. Wilkie, Robert L., Jr., VA Secretary;
2. Shulkin, David, former VA Secretary;
3. O'Rourke, Peter M., former VA Acting Secretary;
4. Bowman, Thomas, former VA Deputy Secretary;
5. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
6. Wright-Simpson, Vivieca, former VA Chief of Staff;
7. Selnick, Darin, former VA White House Senior Advisor;
8. Lukach, Michael, former VA White House Senior Advisor;
9. Leinenkugel, Jake, former VA White House Senior Advisor; and,
10. Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches.

On October 12, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to June 22, 2018. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. These October 12, 2018, and October 16, 2018, searches yielded forty-four (44) pages, which OSVA released redacted as pages Bates-numbered 243-286 to you for FOIA request **18-07426-F**.

On September 18, 2018, and October 16, 2018, the OSVA FOIA Officer searched through former VA Acting Chief of Staff Jacquelyn Hayes-Byrd's emails and calendars from November 8, 2016, to June 22, 2018. OSVA used the search terms Sherman, Perlmutter, Moskowitz, and @frenchangel59.com. This search yielded two hundred fifty-five (255) pages, which OSVA released redacted as pages Bates-numbered 287-541 to you for FOIA request **18-07426-F**.

On October 18, 2018, the OSVA FOIA office searched through the email boxes and calendars, from January 20, 2017, to June 22, 2018, of: David Shulkin, Thomas Bowman, Vivieca Wright-Simpon, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded three hundred twenty-eight (328) pages, which OSVA released redacted as pages Bates-numbered 542-813 and 816-871 to you for FOIA request **18-07426-F**.

On November 15, 2018, the OSVA FOIA office searched through the email boxes and calendars from June 23, 2018, to September 6, 2018, of:

VA-18-0457-A-003575

1. Wilkie, Robert L., Jr., VA Secretary;
2. O'Rourke, Peter M., former VA Acting Secretary;
3. Bowman, Thomas, former VA Deputy Secretary;
4. Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
5. Wright-Simpson, Vivieca, former VA Chief of Staff;
6. Selnick, Darin, former VA White House Senior Advisor;
7. Lukach, Michael, former VA White House Senior Advisor;
8. Leinenkugel, Jake, former VA White House Senior Advisor; and,
9. Spero, Casin D, former VA White House Liaison.

The November 15, 2018, search yielded two pages, which OSVA released redacted as pages Bates-numbered 814-815 for your FOIA request **18-07426-F**.

Partial Initial Agency Decision

Using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms "Concerned Veterans of America," "CVA," and "cv4a.org" to search through former VA Secretary David Shulkin's email boxes for responsive records. The OSVA FOIA Officer also used the same search key terms through the email boxes of the following custodians: Robert Wilkie, Peter O'Rourke, David Shulkin, Thomas Bowman, Jacquelyn Hayes-Byrd, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero.

⁵ This Clearwell search yielded approximately four hundred (400) documents totaling approximately five thousand (5,000) pages. OSVA now releases to you one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank). OSVA will release approximately one hundred twenty (120) redacted documents totaling approximately fourteen hundred (1,400) pages to you in the future. After reviewing the three thousand five hundred twenty-four (3,524) pages, OSVA redacts some information with FOIA Exemptions 4, 5, 6, 7(C).

5 U.S.C. § 552(b)(4) exempts from disclosure "trade secrets and commercial or financial information obtained from a person and privileged or confidential." Redacted information includes voluntary proposal submission verbiage, technical processes, technical approaches, and partnership or subcontracting agreements. The release of this information would likely lead to substantial competitive harm in reverse-engineering of the vendors' technical approaches, processes, partnership, subcontracting, and business and labor strategies. RMS Indus. v. DOD, No. C-92-1545, slip op. at 7 (N.D. Cal. Nov. 24, 1992) (protecting "descriptions of equipment and the names of contacts, customers, key employees, and subcontractors" because "bidders only submit such information if it will not be released to their competitors"); BDM Corp. v. SBA, 2 Gov't Disclosure Serv. (P-H) ¶ 81,189, at 81,495 (D.D.C. Mar. 20, 1981) (protecting names of consultants and subcontractors, performance, cost, and equipment information).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials and consultants reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts internal government deliberations, thoughts, opinions, recommendations, and proposed solutions from federal employees and consultants reviewing VA programs in their professional capacities, as well as non-final or draft documents. The information contained in the responsive records is both predecisional and deliberative because it reflects preliminary opinions, proposed solutions, and recommendations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees and consultants to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, proposing changes to, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials and consultants to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Under the attorney-client and work product privileges, the VA redacts portions of records, emails, and communications between VA employees and attorneys analyzing and discussing legal issues for the VA and its employees. The release of this information would impede the ability of VA employees and attorneys to speak openly and

VA-18-0457-A-003576

frankly about legal issues concerning the VA or its employees. The release of this information would also compromise the legal positions of the VA and its employees.

5 U.S.C. § 552(b)(6) exempts from required disclosure "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal employees and private citizens; we however release the names and VA email addresses of VA Senior Executives. Federal civilian employees and private citizens retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal civilian employees and private citizens whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, except names and VA email addresses of VA Senior Executives, we find that there is no public interest in knowing the names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal civilian employees and private citizens. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. Releasing even a single VA username reveals the pattern to ascertain VA usernames that VA employees use to log into VA Systems of Records; releasing VA usernames exposes the VA, its employees, and its contractors to potential hacking and information technology security liabilities and risks. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed." Long v. Immigration & Customs Enf't, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

5 U.S.C. § 552(b)(7)(C) exempts from required disclosure information law enforcement information the disclosure of which "could reasonably be expected to constitute an unwarranted invasion of personal privacy." Redacted information includes names and email addresses of White House employees with security clearances, as well as Redacted information includes names, identities, email addresses, and VA usernames of VA law enforcement employees. The release of this information would risk impersonation of these White House employees with security clearances also working on national security and law enforcement matters, as well as jeopardizing their health and safety and those the White House employees are charged with protecting. The release of this information would risk impersonation of VA law enforcement personnel and jeopardize

VA-18-0457-A-003577

the health and safety of not only law enforcement personnel, but those persons the VA law enforcement personnel protect including the VA Secretary.

5 U.S.C. § 552(b)(7)(E) exempts from required disclosure information that "would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law." Redacted information includes VA usernames of VA law enforcement employees and shared VA email groups, for which VA law enforcement officials plan their law enforcement operations and protection of VA personnel. The release of this information would compromise the safety of VA law enforcement personnel and VA employees.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:

Name: John Buck

Email Address: vacofiaservice@va.gov

Office of Government Information Services (OGIS)

Email Address: ogis@nara.gov

Fax: 202-741-5769

Mailing address:

National Archives and Records Administration

8601 Adelphi Road

College Park, MD 20740-6001

FOIA Appeal

This concludes OSVA's partial IAD to request **18-11960-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,

Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachments

- Redacted one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages. Bates-numbered as 996-4547 (with 1508-1535

VA-18-0457-A-003578

intentionally left blank).

Richard Ha, JD, CIPP/G
OSVA FOIA/Privacy Officer
Office of the Executive Secretary
Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA)
202-632-5286 o
202-309-3072 c
Richard.ha1@va.gov
Telework Weds
CWS 2nd Mon

These messages and attachments are For Official Use Only, not to be shared outside intended parties, and may be exempt from disclosure pursuant to 5 U.S.C. § 552(b)(3) prohibiting the release of information that another statute prohibits; 41 U.S.C. § 4702(b) prohibiting the release of unincorporated proposals; 41 U.S.C. § 423(a) prohibiting the release of bid or proposal information or evaluations before award; 26 U.S.C. § 6103 prohibiting the release of tax identification numbers; 5 U.S.C. § 552(b)(4) prohibiting the release of confidential commercial information; 5 U.S.C. § 552(b)(5) under the deliberative process, attorney-client, and work product privileges; and 5 U.S.C. § 552(b)(6) protecting personally identifiable information. If you received these messages and attachments in error, you must inform the FOIA Officer and destroy them immediately. The VA reserves its discovery rights including, but not limited to, objections, privileges, motions, etc.



4342-4547
CVA.Re...ted.pdf



4079-4341
CVA_R...ted.pdf



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

February 14, 2019

In Reply Refer To: 001B
FOIA Request: 18-11960-F

Daniel McGrath, Staff Attorney
Austin Evers, Executive Director
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005
foia@americanoversight.org

Dear Mr. McGrath:

This is the Second Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated and received August 23, 2018, and assigned FOIA tracking number **18-11960-F**. You requested: All records reflecting communications (including emails, email attachments, text messages, messages on messaging platforms (such as Slack, GChat or Google Hangouts, Lync, Skype, or WhatsApp), telephone call logs, calendar invitations/entries, meeting notices, meeting agendas, informational material, talking points, any handwritten or electronic notes taken during any oral communications, summaries of any oral communications, or other materials) between any of the individuals listed

- Veterans Affairs Officials
 - Darin Selnick, Senior Advisor to the Secretary
 - Casin Spero, Special Advisor
 - Individuals within the Offices of the Secretary and Deputy Secretary: David Shulkin, Former Secretary, and anyone acting on his behalf
 - Vivieca Wright Simpson, Former Chief of Staff
 - Pete O'Rourke, Former Chief of Staff, Former Acting Secretary, and Senior Advisor to the Secretary; and anyone acting on his behalf
 - Robert Wilkie, Secretary, and anyone acting on his behalf
 - Jacquelyn Hayes-Byrd, Acting Chief of Staff and Deputy Chief of Staff
 - Thomas Bowman, Deputy Secretary, and anyone acting on his behalf
 - Any political appointee* in the immediate Office of the Secretary or Deputy Secretary during the applicable time period not previously listed above
- Outside Recipients
 - Dan Caldwell
 - Nathan Anderson
 - Shannon Hough
 - Pete Hegseth
 - Any email address ending in @cv4a.org or @cvafoundation.org
 - Isaac "Ike" Perlmutter
 - Bruce Moskowitz
 - Marc Sherman
- All email communications between any of the individuals listed in Column A and any external individuals or organizations (i.e., emails with addresses ending in com/.org/.net/.mil/.edu) that mention one or more of the following search terms in the subject line, body of the email, or attachment:
 - a. "Concerned Veterans"
 - b. "Concerned Vets"
 - c. CVA

d. CV4A

Please provide all responsive records from January 20, 2017, through the date of the search.”

There is substantial overlap between FOIA request **18-11960-F** and your prior FOIA request **18-07426-F**, as there are responsive records responsive to both FOIA requests.

18-11960-F: 2nd Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

On September 6, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below ten (10) custodians from January 20, 2017, to September 6, 2018:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) Shulkin, David, former VA Secretary;
- 3) O'Rourke, Peter M., former VA Acting Secretary;
- 4) Bowman, Thomas, former VA Deputy Secretary;
- 5) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 6) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 7) Selnick, Darin, former VA White House Senior Advisor;
- 8) Lukach, Michael, former VA White House Senior Advisor;
- 9) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 10) Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches via the Clearwell e-discovery platform.

On September 11, 2018, using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms “Concerned Veterans of America,” “CVA,” and “cv4a.org” to search through former VA Secretary David Shulkin’s email boxes for responsive records. The OSVA FOIA Officer also used the same search key terms through the email boxes of the following custodians: Robert Wilkie, Peter O’Rourke, Thomas Bowman, Jacquelyn Hayes-Byrd, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero.

This Clearwell search yielded one hundred eighty-two (182) documents totaling three thousand five hundred thirty-one (3,531) pages. On November 30, 2018, OSVA released to you one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank).

OSVA now releases the remaining three (3) documents and their attachments totaling seven (7) pages, Bates-numbered as 4548-4554. OSVA intends to conduct follow-up searches with your key terms. After reviewing the seven (7) pages, OSVA redacts some information with FOIA Exemptions 5 and 6.

5 U.S.C. § 552(b)(5) exempts from disclosure “inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency.” Under the attorney-client and work product privileges, the VA redacts portions of records, emails, and communications between VA employees and attorneys analyzing and discussing legal issues for the VA and its employees. The release of this information would impede the ability of VA employees and attorneys to speak openly and frankly about legal issues concerning the VA or its employees. The release of this information would also compromise the legal positions of the VA and its employees.

5 U.S.C. § 552(b)(6) exempts from required disclosure “personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.” FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information

available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal employees and private citizens; we however release the names and VA email addresses of VA Senior Executives. Federal civilian employees and private citizens retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal civilian employees and private citizens whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, except names and VA email addresses of VA Senior Executives, we find that there is no public interest in knowing the names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal civilian employees and private citizens. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. Releasing even a single VA username reveals the pattern to ascertain VA usernames that VA employees use to log into VA Systems of Records; releasing VA usernames exposes the VA, its employees, and its contractors to potential hacking and information technology security liabilities and risks. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed." Long v. Immigration & Customs Enf't, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

18-11960-F: 11/30/18, Initial Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

Of the searches dated September 6, 2018, and September 11, 2018, yielding one hundred eighty-two (182) documents totaling three thousand five hundred thirty-one (3,531) pages, OSVA released seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages on November 30, 2018. These pages were Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank).

On November 30, 2018, after reviewing the three thousand five hundred twenty-four (3,524) pages, OSVA redacted some information with FOIA Exemptions 4, 5, 6, 7(C). 5 U.S.C. § 552(b)(4) exempts from disclosure "trade secrets and commercial or financial information obtained from a person and privileged or confidential." Redacted information includes voluntary proposal submission verbiage, technical processes, technical approaches, and partnership or subcontracting agreements. The release of this information would likely lead to substantial competitive harm in reverse-engineering of the vendors' technical approaches, processes, partnership, subcontracting, and business and labor strategies. RMS Indus. v. DOD, No. C-92-1545, slip op. at 7 (N.D. Cal. Nov. 24, 1992) (protecting "descriptions of equipment and the names of contacts, customers, key employees, and subcontractors" because "bidders only

submit such information if it will not be released to their competitors"); BDM Corp. v. SBA, 2 Gov't Disclosure Serv. (P-H) ¶ 81,189, at 81,495 (D.D.C. Mar. 20, 1981) (protecting names of consultants and subcontractors, performance, cost, and equipment information).

5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials and consultants reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts internal government deliberations, thoughts, opinions, recommendations, and proposed solutions from federal employees and consultants reviewing VA programs in their professional capacities, as well as non-final or draft documents. The information contained in the responsive records is both predecisional and deliberative because it reflects preliminary opinions, proposed solutions, and recommendations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees and consultants to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, proposing changes to, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials and consultants to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996).

5 U.S.C. § 552(b)(7)(C) exempts from required disclosure information law enforcement information the disclosure of which "could reasonably be expected to constitute an unwarranted invasion of personal privacy." Redacted information includes names and email addresses of White House employees with security clearances, as well as Redacted information includes names, identities, email addresses, and VA usernames of VA law enforcement employees. The release of this information would risk impersonation of these White House employees with security clearances also working on national security and law enforcement matters, as well as jeopardizing their health and safety and those the White House employees are charged with protecting. The release of this information would risk impersonation of VA law enforcement personnel and jeopardize the health and safety of not only law enforcement personnel, but those persons the VA law enforcement personnel protect including the VA Secretary.

5 U.S.C. § 552(b)(7)(E) exempts from required disclosure information that "would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law." Redacted information includes VA usernames of VA law enforcement employees and shared VA email groups, for which VA law enforcement officials plan their law enforcement operations and protection of VA personnel. The release of this information would compromise the safety of VA law enforcement personnel and VA employees.

18-07426-F: 11/20/18, 2nd Partial IAD & Reasonable Searches Dated 5/8/18, 9/18/18, 10/12/18, 10/16/18, & 11/15/18

On October 12, 2018, and October 16, 2018, the OSVA FOIA office searched though former VA

Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to June 22, 2018. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. These October 12, 2018, and October 16, 2018, searches yielded forty-four (44) pages, which the VA released redacted as pages Bates-numbered 243-286 on November 20, 2018.

On September 18, 2018, and October 16, 2018, the OSVA FOIA office searched through former VA Acting Chief of Staff Jacquelyn Hayes-Byrd's emails and calendars from November 8, 2016, to June 22, 2018. OSVA used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded two hundred fifty-five (255) pages, which OSVA released redacted as pages Bates-numbered 287-541 on November 20, 2018.

On October 18, 2018, the OSVA FOIA office searched through the email boxes and calendars, from January 20, 2017, to June 22, 2018, of: 1) Bowman, Thomas, former VA Deputy Secretary; 2) Wright-Simpson, Vivieca, former VA Chief of Staff; 3) Selnick, Darin, former VA White House Senior Advisor; 4) Lukach, Michael, former VA White House Senior Advisor; 5) Leinenkugel, Jake, former VA White House Senior Advisor; and 6) Spero, Casin D, former VA White House Liaison. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded two hundred seventy-two (272) pages, which OSVA released redacted as pages Bates-numbered 542-813 on November 20, 2018.

On November 15, 2018, the OSVA FOIA office searched through the email boxes and calendars from June 23, 2018, to September 6, 2018, including of:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) O'Rourke, Peter M., former VA Acting Secretary;
- 3) Bowman, Thomas, former VA Deputy Secretary;
- 4) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 5) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 6) Selnick, Darin, former VA White House Senior Advisor;
- 7) Lukach, Michael, former VA White House Senior Advisor;
- 8) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 9) Spero, Casin D, former VA White House Liaison.

The November 15, 2018, search yielded two pages, which OSVA release redacted as pages Bates-numbered 814-815 on November 20, 2018.

Our May 8, 2018 (our search cut-off date) search yielded fifty-six (56) pages of email communication to or from Jared Kushner. On November 20, 2018, OSVA released these fifty-six (56) pages redacted as pages Bates-numbered 816-871.

After reviewing six hundred twenty-nine (629) pages Bates-numbered 243-871, OSVA redacted some information with FOIA Exemptions 4, 5, 6, and 7(C). Pages bates-numbered 872-995 are intentionally left blank.

18-07426-F: 9/14/18, Initial Partial IAD & Reasonable Searches Dated 5/8/18

On May 8, 2018, our search cut-off date, we searched through former VA Secretary David Shulkin's emails and calendars from February 14, 2017 (the date he became VA Secretary), to March 30, 2018 (the date he left VA). We searched through VA Secretary Robert Wilkie's emails and calendars from April 1, 2018 (the date he became VA Acting Secretary) to May 8, 2018.

We searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from February 15, 2018 (the date he became VA Acting Chief of Staff), to May 3, 2018. VA will conduct a follow-up search of former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to May 8, 2018.

OSVA searched for any emails to or from Mr. Perlmutter, Dr. Moskowitz, and Mr. Kushner. Our search thus far yielded two hundred ninety-eight (298) pages, of which fifty-six (56) pages require consultation with the White House FOIA Liaison. After reviewing two hundred forty-two (242) pages, OSVA redacted some information with FOIA Exemptions 5, 6, 7(C), and 7(E). Bates-numbered as 1-242 on September 14, 2018.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:

Name: John Buck

Email Address: vacofoiaservice@va.gov

Office of Government Information Services (OGIS)

Email Address: ogis@nara.gov

Fax: 202-741-5769

Mailing address:

National Archives and Records Administration

8601 Adelphi Road

College Park, MD 20740-6001

FOIA Appeal

This concludes OSVA's second partial IAD to request **18-11960-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

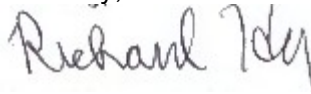
Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date

Mr. McGrath, Esq., & Mr. Evers
Page 7
February 14, 2019

of this letter.

Sincerely,

A handwritten signature in dark ink, appearing to read "Richard Ha".

Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachment - Redacted three (3) documents totaling seven (7) pages, Bates-numbered as 4548-4554

From: (b) (6) (OGC) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6)
To: (b) (6) </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)
>
Cc: (b) (6) (OGC)
</o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
Bcc:
Subject: (b) (6) Financial Disclosure Report
Date: Wed May 02 2018 08:41:55 CDT
Attachments:

Mr. (b) (6)

I have reviewed your report and have the following questions and comments.

Please include a (b) (5)

[REDACTED]

(b) (5)

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

(b) (5)

[REDACTED]

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[REDACTED]

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(b) (5)

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]


[REDACTED]

[REDACTED]

(b) (5)

(b) (5)

(b) (5)



Thank you.

(b) (6)



Senior Ethics Attorney/

Deputy Ethics Official

(202) 461-

From: (b) (6) </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6)>
Cc: (b) (6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6)>
Bcc:
Subject: Re: VSO Meetings
Date: Mon Apr 30 2018 14:00:40 CDT
Attachments:

Thank you!!

From: (b) (6) @va.gov>
Date: Monday, April 30, 2018 at 2:57 PM
To: Department of Veterans Affairs Department of Veterans Affairs <casin.spero@va.gov>
Cc: (b) (6) @va.gov>
Subject: VSO Meetings

May 1 – 9:00am – (b) (6) DAV

May 3 – 8:00am – (b) (6), VVA

May 3 – 3:30pm – (b) (6), AMVETS

May 4 – 9:00am, (b) (6), VFW

May 4 – 1:30pm – (b) (6), CVA

May 8 - 2:00pm, (b) (6), PVA

TBD – (b) (6) from AL (she is out of town until May 14.)

From: (b) (6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6)
To: (b) (6) </o=va/ou=exchange
administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)
Cc: (b) (6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6)
Bcc:
Subject: VSO Meetings
Date: Mon Apr 30 2018 13:57:50 CDT
Attachments:

May 1 – 9:00am – (b) (6) DAV

May 3 – 8:00am – (b) (6), VVA

May 3 – 3:30pm – (b) (6), AMVETS

May 4 – 9:00am, (b) (6), VFW

May 4 – 1:30pm – (b) (6), CVA

May 8 - 2:00pm, (b) (6), PVA

TBD – (b) (6) from AL (she is out of town until May 14.)



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

May 2, 2019

In Reply Refer To: 001B
FOIA Request: 18-11960-F

Daniel McGrath, Staff Attorney
Austin Evers, Executive Director
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005
foia@americanoversight.org; daniel.mcgrath@americanoversight.org

Dear Mr. McGrath:

This is the Third Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated and received August 23, 2018, and assigned FOIA tracking number **18-11960-F**. You requested: All records reflecting communications (including emails, email attachments, text messages, messages on messaging platforms (such as Slack, GChat or Google Hangouts, Lync, Skype, or WhatsApp), telephone call logs, calendar invitations/entries, meeting notices, meeting agendas, informational material, talking points, any handwritten or electronic notes taken during any oral communications, summaries of any oral communications, or other materials) between any of the individuals listed

- Veterans Affairs Officials
 - Darin Selnick, Senior Advisor to the Secretary
 - Casin Spero, Special Advisor
 - Individuals within the Offices of the Secretary and Deputy Secretary: David Shulkin, Former Secretary, and anyone acting on his behalf
 - Vivieca Wright Simpson, Former Chief of Staff
 - Pete O'Rourke, Former Chief of Staff, Former Acting Secretary, and Senior Advisor to the Secretary; and anyone acting on his behalf
 - Robert Wilkie, Secretary, and anyone acting on his behalf
 - Jacquelyn Hayes-Byrd, Acting Chief of Staff and Deputy Chief of Staff
 - Thomas Bowman, Deputy Secretary, and anyone acting on his behalf
 - Any political appointee* in the immediate Office of the Secretary or Deputy Secretary during the applicable time period not previously listed above
- Outside Recipients
 - Dan Caldwell
 - Nathan Anderson
 - Shannon Hough
 - Pete Hegseth
 - Any email address ending in @cv4a.org or @cvafoundation.org
 - Isaac "Ike" Perlmutter
 - Bruce Moskowitz
 - Marc Sherman
- All email communications between any of the individuals listed in Column A and any external individuals or organizations (i.e., emails with addresses ending in com/.org/.net/.mil/.edu) that mention one or more of the following search terms in the subject line, body of the email, or attachment:
 - a. "Concerned Veterans"
 - b. "Concerned Vets"
 - c. CVA

d. CV4A

Please provide all responsive records from January 20, 2017, through the date of the search.”

There is substantial overlap between FOIA request **18-11960-F** and your prior FOIA request **18-07426-F**, as there are responsive records responsive to both FOIA requests.

18-11960-F: 3rd Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

On September 6, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below ten (10) custodians from January 20, 2017, to September 6, 2018:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) Shulkin, David, former VA Secretary;
- 3) O'Rourke, Peter M., former VA Acting Secretary;
- 4) Bowman, Thomas, former VA Deputy Secretary;
- 5) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 6) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 7) Selnick, Darin, former VA White House Senior Advisor;
- 8) Lukach, Michael, former VA White House Senior Advisor;
- 9) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 10) Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches via the Clearwell e-discovery platform.

On September 11, 2018, using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms “Concerned Veterans of America,” “CVA,” and “cv4a.org” to search through former VA Secretary David Shulkin’s email boxes for responsive records. The OSVA FOIA Officer also used the same search key terms through the email boxes of the following custodians: Robert Wilkie, Peter O’Rourke, Thomas Bowman, Jacquelyn Hayes-Byrd, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero. This Clearwell search yielded one hundred eighty-two (182) documents totaling three thousand five hundred thirty-one (3,531) pages. OSVA intends to conduct follow-up searches with your key terms and additional custodians.

On November 30, 2018, OSVA released to you one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank), redacted with FOIA Exemptions 4, 5, 6, 7(C), and 7(E). On February 14, 2019, OSVA released three (3) documents and their attachments totaling seven (7) pages, Bates-numbered as 4548-4554, redacted with FOIA Exemptions 5 and 6.

On or about February 12, 2019, you objected to OSVA’s FOIA Exemption 5 redactions to pages Bates-numbered 1003-1004 (VA-Bill Frist emails), 1030-1031 (talking points), and 1126-1132 (VA-CVA emails). OSVA is still re-reconsidering the FOIA Exemption 5 redactions to pages Bates-numbered 1003-1004.

Pages Bates-numbered 1126-1132

After reconsidering the redactions to pages Bates-numbered 1126-1132, OSVA releases them with fewer FOIA Exemption 5 redactions. 5 U.S.C. § 552(b)(5) exempts from disclosure “inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency.” Under the deliberative process privilege and consultant corollary doctrine, the consulting advice, recommendations, notes, analyses, and discussions between government employees and consultants may be withheld if the consultants are advocating for the government’s interest and not their own financial interests. DOI v.

Klamath, 532 U.S. 1, 20 (2001). In this instance, the Concerned Veterans for America do not have a financial interest in VA taking certain actions. The Concerned Veterans for America advocate for their own beliefs and on behalf of veterans without any financial stake from VA. Some VA leaders have sought out the advice and counsel of the Concerned Veterans for America.

The Tenth Circuit rejected a claim that a consultant should be disqualified from serving as a consultant solely on the basis of his "deep-seated views" on the subject in question. Stewart v. DOI, 554 F.3d 1236, 1245 (10th Cir. 2009). Instead, the court noted that the consultant was not seeking a government benefit (beyond the intellectual satisfaction of having his advice followed) and that he was functioning "akin to an agency employee." *Id.* Furthermore, as the court pointed out, it would be "unusual" if agencies restricted themselves to seeking expert advice from those with no published record of their views on their areas of expertise. *Id.* Similarly, the Concerned Veterans for America do not seek a government benefit beyond the intellectual satisfaction of having their advice followed.

On pages 1126-1128, Darin Selnick, Senior Advisor to the VA Secretary, has sought the advice and counsel of Concerned Veterans for America. VA has released the Ten (10) Key Components or recommendations of the Concerned Veterans for America referenced in their public "Fixing Veterans Healthcare" Report. VA also releases VA's recommendations referenced in their public Integrated Report and Independent Assessments.

VA has redacted purported weaknesses, identified by the Concerned Veterans for America, of VA's Integrated Report and Independent Assessment C. VA has also redacted how Concerned Veterans for America noted that draft legislation may addresses their recommendations and VA's. Disclosure of the information withheld under this exemption could cause confusion in that others may believe the non-final information, if released, constituted final VA decisions. Some draft legislation was not codified as final legislation. Furthermore, the release of the redacted information would negatively impact the ability of consultants and federal employees to openly and frankly consider issues amongst themselves when evaluating and analyzing draft legislation, government programs, purported problems, and proposed solutions.

Pages Bates-Numbered 1030-1031

After reconsidering the redactions of talking points to pages Bates-numbered 1030-1031, OSVA still believes those redactions are warranted. Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts portions of talking points. The redacted information is both predecisional and deliberative because it reflects preliminary opinions and recommendations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996); Access Reports v. DOJ, 926

F.2d 1192, 1196-97 (D.C. Cir. 1991) ("talking points" memoranda are predecisional); ACLU v. DHS, 738 F. Supp. 2d 93, 112 (D.D.C. 2010) (talking points are predecisional because "the document itself suggests that a public statement was anticipated at the time of its creation, and given that no official statement has yet been made, the talking points remain ripe recommendations that are ready for adoption or rejection by the Department"); Sec. Fin. Life Ins. Co., No. 03-102-SBC, 2005 WL 839543, at *11 (D.D.C. Apr. 12, 2005) ("The undisputed evidence establishes that these [talking points] are deliberative."); Judicial Watch, Inc. v. U.S. Dep't of Commerce, 337 F. Supp. 2d 146, 174 (D.D.C. 2004) (protecting "talking points" and recommendations on how to answer questions); St. Louis Sewer Dist., No. 10-2103, at *18 (E.D. Mo. Mar. 2, 2012) (deliberative process privilege protected e-mail communications, "press releases, talking points and 'Q & A,' drafts, and briefing materials).

18-11960-F: 2/14/19, 2nd Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

From the aforementioned searches dated September 6, 2018, and September 11, 2018, OSVA released three (3) documents and their attachments totaling seven (7) pages, Bates-numbered as 4548-4554, on February 14, 2019, redacted with FOIA Exemptions 5 and 6.

5 U.S.C. § 552(b)(6) exempts from required disclosure "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal employees and private citizens; we however release the names and VA email addresses of VA Senior Executives. Federal civilian employees and private citizens retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal civilian employees and private citizens whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, except names and VA email addresses of VA Senior Executives, we find that there is no public interest in knowing the names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal civilian employees and private citizens. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. Releasing even a single VA username reveals the pattern to ascertain VA usernames that VA employees use to log into VA Systems of Records; releasing VA usernames exposes the VA, its employees, and its contractors to potential hacking and information technology security liabilities and risks. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these

employees would be readily discoverable on the Internet if this court ordered their names disclosed.” Long v. Immigration & Customs Enf’t, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

18-11960-F: 11/30/18, Initial Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

Of the searches dated September 6, 2018, and September 11, 2018, OSVA released seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages on November 30, 2018, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank), on November 30, 2018.

After reviewing the three thousand five hundred twenty-four (3,524) pages, OSVA redacted some information with FOIA Exemptions 4, 5, 6, 7(C), and 7(E). 5 U.S.C. § 552(b)(4) exempts from disclosure “trade secrets and commercial or financial information obtained from a person and privileged or confidential.” Redacted information includes voluntary proposal submission verbiage, technical processes, technical approaches, and partnership or subcontracting agreements. The release of this information would likely lead to substantial competitive harm in reverse-engineering of the vendors’ technical approaches, processes, partnership, subcontracting, and business and labor strategies. RMS Indus. v. DOD, No. C-92-1545, slip op. at 7 (N.D. Cal. Nov. 24, 1992) (protecting “descriptions of equipment and the names of contacts, customers, key employees, and subcontractors” because “bidders only submit such information if it will not be released to their competitors”); BDM Corp. v. SBA, 2 Gov’t Disclosure Serv. (P-H) ¶ 81,189, at 81,495 (D.D.C. Mar. 20, 1981) (protecting names of consultants and subcontractors, performance, cost, and equipment information).

5 U.S.C. § 552(b)(7)(C) exempts from required disclosure information law enforcement information the disclosure of which “could reasonably be expected to constitute an unwarranted invasion of personal privacy.” Redacted information includes names and email addresses of White House employees with security clearances, as well as Redacted information includes names, identities, email addresses, and VA usernames of VA law enforcement employees. The release of this information would risk impersonation of these White House employees with security clearances also working on national security and law enforcement matters, as well as jeopardizing their health and safety and those the White House employees are charged with protecting. The release of this information would risk impersonation of VA law enforcement personnel and jeopardize the health and safety of not only law enforcement personnel, but those persons the VA law enforcement personnel protect including the VA Secretary.

5 U.S.C. § 552(b)(7)(E) exempts from required disclosure information that “would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law.” Redacted information includes VA usernames of VA law enforcement employees and shared VA email groups, for which VA law enforcement officials plan their law enforcement operations and protection of VA personnel. The release of this information would compromise the safety of VA law enforcement personnel and VA employees.

18-07426-F: 11/20/18, 2nd Partial IAD & Reasonable Searches Dated 5/8/18, 9/18/18, 10/12/18, 10/16/18, & 11/15/18

On October 12, 2018, and October 16, 2018, the OSVA FOIA office searched though former VA Acting Secretary Peter O’Rourke’s emails and calendars from May 4, 2018, to June 22, 2018. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz,

@frenchangel59.com, and Kushner. These October 12, 2018, and October 16, 2018, searches yielded forty-four (44) pages, which the VA released redacted as pages Bates-numbered 243-286 on November 20, 2018.

On September 18, 2018, and October 16, 2018, the OSVA FOIA office searched through former VA Acting Chief of Staff Jacquelyn Hayes-Byrd's emails and calendars from November 8, 2016, to June 22, 2018. OSVA used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded two hundred fifty-five (255) pages, which OSVA released redacted as pages Bates-numbered 287-541 on November 20, 2018.

On October 18, 2018, the OSVA FOIA office searched through the email boxes and calendars, from January 20, 2017, to June 22, 2018, of: 1) Bowman, Thomas, former VA Deputy Secretary; 2) Wright-Simpson, Vivieca, former VA Chief of Staff; 3) Selnick, Darin, former VA White House Senior Advisor; 4) Lukach, Michael, former VA White House Senior Advisor; 5) Leinenkugel, Jake, former VA White House Senior Advisor; and 6) Spero, Casin D, former VA White House Liaison. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded two hundred seventy-two (272) pages, which OSVA released redacted as pages Bates-numbered 542-813 on November 20, 2018.

On November 15, 2018, the OSVA FOIA office searched through the email boxes and calendars from June 23, 2018, to September 6, 2018, including of:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) O'Rourke, Peter M., former VA Acting Secretary;
- 3) Bowman, Thomas, former VA Deputy Secretary;
- 4) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 5) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 6) Selnick, Darin, former VA White House Senior Advisor;
- 7) Lukach, Michael, former VA White House Senior Advisor;
- 8) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 9) Spero, Casin D, former VA White House Liaison.

The November 15, 2018, search yielded two pages, which OSVA release redacted as pages Bates-numbered 814-815 on November 20, 2018.

Our May 8, 2018 (our search cut-off date) search yielded fifty-six (56) pages of email communication to or from Jared Kushner. On November 20, 2018, OSVA released these fifty-six (56) pages redacted as pages Bates-numbered 816-871.

After reviewing six hundred twenty-nine (629) pages Bates-numbered 243-871, OSVA redacted some information with FOIA Exemptions 4, 5, 6, and 7(C). Pages bates-numbered 872-995 are intentionally left blank.

18-07426-F: 9/14/18, Partial IAD & Reasonable Searches Dated 5/8/18

On May 8, 2018, our search cut-off date, we searched through former VA Secretary David Shulkin's emails and calendars from February 14, 2017 (the date he became VA Secretary), to March 30, 2018 (the date he left VA). We searched through VA Secretary Robert Wilkie's emails and calendars from April 1, 2018 (the date he became VA Acting Secretary) to May 8, 2018.

We searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from February 15, 2018 (the date he became VA Acting Chief of Staff), to May 3, 2018. VA will

Mr. McGrath, Esq., & Mr. Evers
Page 7
May 2, 2019

conduct a follow-up search of former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to May 8, 2018.

OSVA searched for any emails to or from Mr. Perlmutter, Dr. Moskowitz, and Mr. Kushner. Our search thus far yielded two hundred ninety-eight (298) pages, of which fifty-six (56) pages require consultation with the White House FOIA Liaison. After reviewing two hundred forty-two (242) pages, OSVA redacted some information with FOIA Exemptions 5, 6, 7(C), and 7(E). Bates-numbered as 1-242 on September 14, 2018.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:

Name: John Buck

Email Address: vacofoiaservice@va.gov

Office of Government Information Services (OGIS)

Email Address: ogis@nara.gov

Fax: 202-741-5769

Mailing address:

National Archives and Records Administration

8601 Adelphi Road

College Park, MD 20740-6001

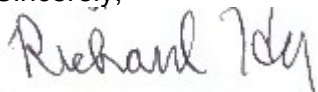
FOIA Appeal

This concludes OSVA's third partial IAD to request **18-11960-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,



Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachment - Redacted pages Bates-numbered 1124-1132

From: Darin Selnick (b) (6)
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
Cc:
Bcc:
Subject: [EXTERNAL] Choice 2.0
Date: Mon Apr 17 2017 10:14:26 CDT
Attachments: CVA Matrix Taskforce Report to IA to Draft Leg.docx
VHCTF and Sec 201 Comparison Table.docx

Owner: Darin Selnick <(b) (6)>
Filename: CVA Matrix Taskforce Report to IA to Draft Leg.docx
Last Modified: Mon Apr 17 10:14:26 CDT 2017

Key Components/Independent Assessment/Draft Legislation

Key Components	VA Commissioned Independent Assessment	Draft Legislation
Separate the VA's payor and provider functions into separate institutions.	<p>Assessment C – Page 139</p> <p>6.2.3.5 Separate VA's Payer and Provider Functions into Discrete Organizations</p> <p>The idea here is to reorganize the way that VA manages Veteran health care risk and pays for medical services, by standing up within VA a new, dedicated payer organization, which would become responsible for all health care funding and contracting/payment activity for VA. At the same time, VA's direct -provider network would be separated out as its own distinct organization, removed from the payer function, and solely dedicated to operating hospitals and providing medical services to Veterans.</p>	(b) (5)
Establish the Veterans Health Insurance Program (VHIP) as a program office in the Veterans Health Administration.	<p>Assessment C – Page 139</p> <p>6.2.3.5 Separate VA's Payer and Provider Functions into Discrete Organizations</p> <p>by standing up within VA a new, dedicated payer organization, which would become responsible for all health care funding and contracting/payment activity for VA.</p> <p>the VA payer entity would presumably also engage in contracts with other, outside provider networks, and would make decisions about how to allocate resources and pay providers to best implement VA health benefits.</p> <p>would manage VA health care funding in a manner similar to a traditional insurance entity.</p>	
Establish the Veterans Accountable Care Organization (VACO) as a non-profit government corporation fully separate from Department of Veterans Affairs.	<p>Integrated Report – Page 26</p> <p>Alternative governance models do exist. One was introduced by the Commission on the Future for America's Veterans, which proposed that Congress "establish a new entity with characteristics not unlike a federal government 'not for profit' corporation" that would be empowered with "unencumbered" authority to use all the assets of VHA to "maximize benefits to Veterans."</p>	

Key Components	VA Commissioned Independent Assessment	Draft Legislation
Institute a VA Medical Center realignment procedure (MRAC) modeled after the Defense Base Realignment and Closure Act of 1990 (BRAC).	Integrated Report – Page xiv, 26 Empower a board or commission to reshape geographic service areas and optimize facilities resourcing and lines of service (along the lines of the Defense Base Realignment and Closure Commission process used for military installations).	(b) (5)
Require the VHA to report publicly on all aspects of its operation, including quality, safety, patient experience, timeliness, and cost-effectiveness.	Integrated Report – Page 2 The Congressional Budget Office (CBO) has previously reported to Congress on the challenges of comparing the costs of VA and non-VA care, citing the scarcity of cost-accounting data for Veterans' care and the complete absence of data on non-VA care received by Veterans who are also treated by VA. We do recognize that the value of Veterans' health care, defined as health care outcomes relative to costs, should inform efforts for improvement.	
Preserve the VA health benefit for current enrollees who prefer it, while offering an option to seek coverage from the private sector. VetsCare Federal Veterans satisfied with VA health care would be able to maintain their existing coverage, with no changes. Veterans in this plan would have full access to the VA's health care system, the VACO. VetsCare Choice Like VA employees, our veterans should be free to choose their own source of health insurance. This program would be called VetsCare Choice, and offers veterans the ability to purchase heavily discounted private health coverage.	Assessment C – Page 140 new VA payer entity would contract with the VA provider entity, with the latter becoming the primary provider network for delivering benefits. VA provider facilities might be shifted to specialized aspects of clinical service where they have greatest comparative advantage and value. Assessment C – Page 137 Incorporate All VA Purchased Care Initiatives into a Single Program within VA Assessment C – Page 133 One way to prioritize access to purchased care plausibly could involve making purchased care resources more readily available as a choice to Veterans in lower or higher-priority groups, with the aim of easing demand on VA's direct-care system. any version of this step would involve tying the priority group scheme to purchased care so that Veterans in the highest priority groups would have enhanced access to outside services.	

Key Components/Independent Assessment/Draft Legislation

Key Components	VA Commissioned Independent Assessment	Draft Legislation
VetsCare Choice (Cont.)	<p>Assessment C – Page 134</p> <p>6.2.2.4 Create a VA Subsidy for Veterans to Obtain Health Insurance Coverage Through ACA Exchanges or Other Sources</p> <p>Rather than directly providing or paying for care, VA under this step would pay a subsidy directly to Veterans, who would then use the money to purchase health insurance coverage, either through the health care exchanges established by the Affordable Care Act, or through traditional private health coverage</p>	
<p>VetsCare Senior</p> <p>Enrolled veterans over the age of 65, and those who qualify for Medicare due to disability, would gain the option of using their VA funds to defray the costs of Medicare premiums and supplemental coverage (“Medigap”).</p>	<p>6.2.2.4 Create a VA Subsidy for Veterans to Obtain Health Insurance Coverage Through ACA Exchanges or Other Sources</p> <p>VA under this step would pay a subsidy directly to Veterans, who would then use the money to purchase health insurance coverage, either through the health care exchanges established by the Affordable Care Act, or through traditional private health coverage, <i>or through other insurance mechanisms (including Medicare).</i></p>	(b) (5)
<p>Reform health insurance coverage for future veterans.</p> <p>Eligibility for sponsored health coverage would be based on the current Priority Group requirements. However, Priority Groups 1–3, would be even more highly prioritized. The program would also assist veterans in Priority Groups 4-6.</p>	<p>Assessment did not (b) (5)</p> <p>(b) (5)</p>	
<p>Offer veterans’ access to the Federal Long Term Care Insurance Program.</p>	<p>Assessment did not (b) (5)</p> <p>(b) (5)</p>	
<p>Create a VetsCare Implementation Commission, a nonpartisan legislative branch agency, to implement the legislation</p>	<p>Integrated Report – Page xiv, 26</p> <p>Establish a governance board to develop fundamental policy, define the strategic path, insulate VHA leadership from direct political interaction, and ensure accountability for the achievement of established performance measures. In the near term, several models could be tailored to address these policy issues in an objective and unbiased manner. Congress could charter a commission modeled after the 1955 U.S. President’s Commission on Veterans’ Pensions.</p>	

Owner: Darin Selnick <(b) (6)>
Filename: VHCTF and Sec 201 Comparison Table.docx
Last Modified: Mon Apr 17 10:14:26 CDT 2017



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Taskforce Report Recommendations Reflect on the Independent Assessment

Fixing Veterans Health Care Taskforce Report	VA Commissioned Independent Assessment
1. Separate the VA's payer and provider functions into separate institutions.	<p>Assessment C – Page 139</p> <p>6.2.3.5 Separate VA's Payer and Provider Functions into Discrete Organizations</p> <p>The idea here is to reorganize the way that VA manages Veteran health care risk and pays for medical services, by standing up within VA a new, dedicated payer organization, which would become responsible for all health care funding and contracting/payment activity for VA. At the same time, VA's direct -provider network would be separated out as its own distinct organization, removed from the payer function, and solely dedicated to operating hospitals and providing medical services to Veterans.</p>
2. Establish the Veterans Health Insurance Program (VHIP) as a program office in the Veterans Health Administration.	<p>Assessment C – Page 139</p> <p>6.2.3.5 Separate VA's Payer and Provider Functions into Discrete Organizations</p> <p>by standing up within VA a new, dedicated payer organization, which would become responsible for all health care funding and contracting/payment activity for VA.</p> <p>the VA payer entity would presumably also engage in contracts with other, outside provider networks, and would make decisions about how to allocate resources and pay providers to best implement VA health benefits.</p> <p>would manage VA health care funding in a manner similar to a traditional insurance entity.</p>
3. Establish the Veterans Accountable Care Organization (VACO) as a non-profit government corporation fully separate from Department of Veterans Affairs.	<p>Integrated Report – Page 26</p> <p>Alternative governance models do exist. One was introduced by the Commission on the Future for America's Veterans, which proposed that Congress "establish a new entity with characteristics not unlike a federal government 'not for profit' corporation" that would be empowered with "unencumbered" authority to use all the assets of VHA to "maximize benefits to Veterans."</p>
4. Institute a VA Medical Center realignment procedure (MRAC) modeled after the Defense Base Realignment and Closure Act of 1990 (BRAC).	<p>Integrated Report – Page xiv, 26</p> <p>Empower a board or commission to reshape geographic service areas and optimize facilities resourcing and lines of service (along the lines of the Defense Base Realignment and Closure Commission process used for military installations).</p>

CVA Member Briefing
October 7, 2015

VA-18-0457-C-000007



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<p>5. Require the VHA to report publicly on all aspects of its operation, including quality, safety, patient experience, timeliness, and cost-effectiveness.</p>	<p>Integrated Report – Page 2 The Congressional Budget Office (CBO) has previously reported to Congress on the challenges of comparing the costs of VA and non-VA care, citing the scarcity of cost-accounting data for Veterans' care and the complete absence of data on non-VA care received by Veterans who are also treated by VA. We do recognize that the value of Veterans' health care, defined as health care outcomes relative to costs, should inform efforts for improvement.</p>
<p>6. Preserve the traditional VA health benefit for current enrollees who prefer it, while offering an option to seek coverage from the private sector:</p> <p>VetsCare Federal Veterans who are satisfied with VA health care would be able to maintain their existing coverage, with no changes to benefits or cost-sharing. Veterans in this plan would have full access to the VA's integrated health care system, the Veterans Accountable Care Organization.</p> <p>VetsCare Choice Like VA employees, our veterans should be free to choose their own source of health insurance. This program would be called VetsCare Choice, and offers veterans the ability to purchase heavily discounted private health coverage.</p>	<p>Assessment C – Page 140 new VA payer entity would contract with the VA provider entity, with the latter becoming the primary provider network for delivering benefits. VA provider facilities might be shifted to specialized aspects of clinical service where they have greatest comparative advantage and value.</p> <p>Assessment C – Page 137 6.2.3.3 Incorporate All VA Purchased Care Initiatives into a Single Program Within VA</p> <p>Assessment C – Page 133 One way to prioritize access to purchased care plausibly could involve making purchased care resources more readily available as a choice to Veterans in lower or higher-priority groups, with the aim of easing demand on VA's direct-care system. any version of this step would involve tying the priority group scheme to purchased care so that Veterans in the highest priority groups would have enhanced access to outside services.</p> <p>Assessment C – Page 134 6.2.2.4 Create a VA Subsidy for Veterans to Obtain Health Insurance Coverage Through ACA Exchanges or Other Sources</p> <p>Rather than directly providing or paying for care, VA under this step would pay a subsidy directly to Veterans, who would then use the money to purchase health</p>



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<p>VetsCare Senior Enrolled veterans over the age of 65, and those who qualify for Medicare due to disability, would gain the option of using their VA funds to defray the costs of Medicare premiums and supplemental coverage (“Medigap”).</p>	<p>insurance coverage, either through the health care exchanges established by the Affordable Care Act, or through traditional private health coverage</p> <p>6.2.2.4 Create a VA Subsidy for Veterans to Obtain Health Insurance Coverage Through ACA Exchanges or Other Sources</p> <p>VA under this step would pay a subsidy directly to Veterans, who would then use the money to purchase health insurance coverage, either through the health care exchanges established by the Affordable Care Act, or through traditional private health coverage, or through other insurance mechanisms (including Medicare).</p>
<p>7. Reform health insurance coverage for future veterans. Eligibility for sponsored health coverage would be based on the current Priority Group requirements. However, veterans with service-connected disabilities—i.e., those in Priority Groups 1 through 3—would be even more highly prioritized The program would also assist disadvantaged veterans, such as those in Priority Groups 4 through 6.</p>	<p>Assessment did not (b) (5)</p> <p>(b) (5)</p>
<p>8. Offer veterans’ access to the Federal Long Term Care Insurance Program.</p>	<p>Assessment did not (b) (5)</p>
<p>9. Create a VetsCare Implementation Commission, a nonpartisan legislative branch agency, to implement the Veterans Independence Act.</p>	<p>Integrated Report – Page xiv, 26 Establish a governance board to develop fundamental policy, define the strategic path, insulate VHA leadership from direct political interaction, and ensure accountability for the achievement of established performance measures. In the near term, several models could be tailored to address these policy issues in an objective and unbiased manner. Congress could charter a commission modeled after the 1955 U.S. President’s Commission on Veterans’ Pensions.</p>
<p>10. VHA needs accountability</p>	<p>Assessment I p. 43 VHA employees want to move from a bureaucratic, political, and siloed organization to one defined by accountability, trust, and efficiency.</p>



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

May 8, 2019

In Reply Refer To: 001B
FOIA Request: 18-11960-F

Daniel McGrath, Staff Attorney
Austin Evers, Executive Director
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005
foia@americanoversight.org; daniel.mcgrath@americanoversight.org

Dear Mr. McGrath:

This is the Fourth Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated and received August 23, 2018, and assigned FOIA tracking number **18-11960-F**. You requested: All records reflecting communications (including emails, email attachments, text messages, messages on messaging platforms (such as Slack, GChat or Google Hangouts, Lync, Skype, or WhatsApp), telephone call logs, calendar invitations/entries, meeting notices, meeting agendas, informational material, talking points, any handwritten or electronic notes taken during any oral communications, summaries of any oral communications, or other materials) between any of the individuals listed

- Veterans Affairs Officials
 - Darin Selnick, Senior Advisor to the Secretary
 - Casin Spero, Special Advisor
 - Individuals within the Offices of the Secretary and Deputy Secretary: David Shulkin, Former Secretary, and anyone acting on his behalf
 - Vivieca Wright Simpson, Former Chief of Staff
 - Pete O'Rourke, Former Chief of Staff, Former Acting Secretary, and Senior Advisor to the Secretary; and anyone acting on his behalf
 - Robert Wilkie, Secretary, and anyone acting on his behalf
 - Jacquelyn Hayes-Byrd, Acting Chief of Staff and Deputy Chief of Staff
 - Thomas Bowman, Deputy Secretary, and anyone acting on his behalf
 - Any political appointee* in the immediate Office of the Secretary or Deputy Secretary during the applicable time period not previously listed above
- Outside Recipients
 - Dan Caldwell
 - Nathan Anderson
 - Shannon Hough
 - Pete Hegseth
 - Any email address ending in @cv4a.org or @cvafoundation.org
 - Isaac "Ike" Perlmutter
 - Bruce Moskowitz
 - Marc Sherman
- All email communications between any of the individuals listed in Column A and any external individuals or organizations (i.e., emails with addresses ending in com/.org/.net/.mil/.edu) that mention one or more of the following search terms in the subject line, body of the email, or attachment:
 - a. "Concerned Veterans"
 - b. "Concerned Vets"
 - c. CVA

d. CV4A

Please provide all responsive records from January 20, 2017, through the date of the search.”

There is substantial overlap between FOIA request **18-11960-F** and your prior FOIA request **18-07426-F**, as there are responsive records responsive to both FOIA requests.

18-11960-F: 4th Partial IAD & Reasonable Searches Dated 12/19/18 & 5/2/19

On December 19, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below twelve (12) custodians from January 20, 2017, to December 19, 2018:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) Shulkin, David, former VA Secretary;
- 3) O'Rourke, Peter M., former VA Acting Secretary;
- 4) Byrne, Jim, current VA Acting Deputy Secretary;
- 5) Bowman, Thomas, former VA Deputy Secretary;
- 6) Powers, Pam, current VA Chief of Staff;
- 7) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 8) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 9) Selnick, Darin, former VA White House Senior Advisor;
- 10) Lukach, Michael, former VA White House Senior Advisor;
- 11) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 12) Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches via the Clearwell e-discovery platform.

On May 2, 2019, using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms “Concerned Veterans of America,” “CVA,” “cv4a.org,” “CV4A,” “Concerned Vets,” and “Concerned Veterans” to search through the email boxes of the aforementioned twelve (12) custodians. Excluding the previous Clearwell search results for the First through Third Partial Initial Agency Decisions, this May 2, 2019, Clearwell search yielded approximately two hundred twenty (220) emails and their attachments totaling approximately five thousand (5,000) pages.

Of the approximate two hundred twenty (220) emails and their attachments totaling approximately five thousand (5,000) pages, OSVA now releases fourteen (14) emails and their attachments totaling five hundred seventy-four (574) pages, Bates-numbered as 4555-5128. After reviewing the five hundred seventy-four (574) pages, OSVA redacts some information with FOIA Exemptions 5 and 6.

5 U.S.C. § 552(b)(5) exempts from required disclosure “inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency.” Under the attorney-client and work product privileges, the VA redacts portions of records, emails, and communications between VA employees and attorneys relating to federal lawsuits against the VA. The release of this information would impede the ability of VA employees and attorneys to speak openly and frankly about legal issues concerning lawsuits against the VA. The release of this information would also compromise the VA’s legal positions for its lawsuits.

5 U.S.C. § 552(b)(6) exempts from required disclosure “personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.” FOIA Exemption 6 permits VA to withhold a document or information within a

document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal employees and private citizens; we however release the names and VA email addresses of VA Senior Executives. Federal civilian employees and private citizens retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal civilian employees and private citizens whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, except names and VA email addresses of VA Senior Executives, we find that there is no public interest in knowing the names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal civilian employees and private citizens. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. Releasing even a single VA username reveals the pattern to ascertain VA usernames that VA employees use to log into VA Systems of Records; releasing VA usernames exposes the VA, its employees, and its contractors to potential hacking and information technology security liabilities and risks. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed." Long v. Immigration & Customs Enf't, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

Thus far, OSVA has released to you four thousand nine hundred seventy-eight (4,978) pages for FOIA requests **18-07426-F** and **18-11960-F**. Please kindly consider whether "Concerned Vet" or "Concerned Veterans" are limiting enough search terms. As reflected in the five hundred seventy-four (574) pages released to you, those search terms yield emails from private citizens claiming to be a "concerned vet" or "concerned veterans," as well as emails referencing the National Association of Concerned Veterans.

18-11960-F: 3rd Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

On September 6, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below ten (10) custodians from January 20, 2017, to September 6, 2018:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) Shulkin, David, former VA Secretary;
- 3) O'Rourke, Peter M., former VA Acting Secretary;
- 4) Bowman, Thomas, former VA Deputy Secretary;
- 5) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 6) Wright-Simpson, Vivieca, former VA Chief of Staff;

- 7) Selnick, Darin, former VA White House Senior Advisor;
- 8) Lukach, Michael, former VA White House Senior Advisor;
- 9) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 10) Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches via the Clearwell e-discovery platform.

On September 11, 2018, using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms "Concerned Veterans of America," "CVA," and "cv4a.org" to search the email boxes of: former VA Secretary David Shulkin, Robert Wilkie, Peter O'Rourke, Thomas Bowman, Jacquelyn Hayes-Byrd, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero. This Clearwell search yielded one hundred eighty-two (182) documents totaling three thousand five hundred thirty-one (3,531) pages.

On November 30, 2018, OSVA released to you one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank), redacted with FOIA Exemptions 4, 5, 6, 7(C), and 7(E). On February 14, 2019, OSVA released three (3) documents and their attachments totaling seven (7) pages, Bates-numbered as 4548-4554, redacted with FOIA Exemptions 5 and 6.

On or about February 12, 2019, you objected to OSVA's FOIA Exemption 5 redactions to pages Bates-numbered 1003-1004 (VA-Bill Frist emails), 1030-1031 (talking points), and 1126-1132 (VA-CVA emails). OSVA is still re-considering the FOIA Exemption 5 redactions to pages Bates-numbered 1003-1004.

Pages Bates-numbered 1126-1132

After reconsidering the redactions to pages Bates-numbered 1126-1132, OSVA releases them with fewer FOIA Exemption 5 redactions. 5 U.S.C. § 552(b)(5) exempts from disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Under the deliberative process privilege and consultant corollary doctrine, the consulting advice, recommendations, notes, analyses, and discussions between government employees and consultants may be withheld if the consultants are advocating for the government's interest and not their own financial interests. DOI v. Klamath, 532 U.S. 1, 20 (2001). In this instance, the Concerned Veterans for America do not have a financial interest in VA taking certain actions. The Concerned Veterans for America advocate for their own beliefs and on behalf of veterans without any financial stake from VA. Some VA leaders have sought out the advice and counsel of the Concerned Veterans for America.

The Tenth Circuit rejected a claim that a consultant should be disqualified from serving as a consultant solely on the basis of his "deep-seated views" on the subject in question. Stewart v. DOI, 554 F.3d 1236, 1245 (10th Cir. 2009). Instead, the court noted that the consultant was not seeking a government benefit (beyond the intellectual satisfaction of having his advice followed) and that he was functioning "akin to an agency employee." *Id.* Furthermore, as the court pointed out, it would be "unusual" if agencies restricted themselves to seeking expert advice from those with no published record of their views on their areas of expertise. *Id.* Similarly, the Concerned Veterans for America do not seek a government benefit beyond the intellectual satisfaction of having their advice followed.

On pages 1126-1128, Darin Selnick, Senior Advisor to the VA Secretary, has sought the advice and counsel of Concerned Veterans for America. VA has released the Ten (10) Key Components or recommendations of the Concerned Veterans for America referenced in their public "Fixing Veterans Healthcare" Report. VA also releases VA's recommendations referenced in their public Integrated Report and Independent Assessments.

VA has redacted purported weaknesses, identified by the Concerned Veterans for America, of VA's Integrated Report and Independent Assessment C. VA has also redacted how Concerned Veterans for America noted that draft legislation may addresses their recommendations and VA's. Disclosure of the information withheld under this exemption could cause confusion in that others may believe the non-final information, if released, constituted final VA decisions. Some draft legislation was not codified as final legislation. Furthermore, the release of the redacted information would negatively impact the ability of consultants and federal employees to openly and frankly consider issues amongst themselves when evaluating and analyzing draft legislation, government programs, purported problems, and proposed solutions.

Pages Bates-Numbered 1030-1031

After reconsidering the redactions of talking points to pages Bates-numbered 1030-1031, OSVA still believes those redactions are warranted. Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts portions of talking points. The redacted information is both predecisional and deliberative because it reflects preliminary opinions and recommendations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996); Access Reports v. DOJ, 926 F.2d 1192, 1196-97 (D.C. Cir. 1991) ("talking points" memoranda are predecisional); ACLU v. DHS, 738 F. Supp. 2d 93, 112 (D.D.C. 2010) (talking points are predecisional because "the document itself suggests that a public statement was anticipated at the time of its creation, and given that no official statement has yet been made, the talking points remain ripe recommendations that are ready for adoption or rejection by the Department"); Sec. Fin. Life Ins. Co., No. 03-102-SBC, 2005 WL 839543, at *11 (D.D.C. Apr. 12, 2005) ("The undisputed evidence establishes that these [talking points] are deliberative."); Judicial Watch, Inc. v. U.S. Dep't of Commerce, 337 F. Supp. 2d 146, 174 (D.D.C. 2004) (protecting "talking points" and recommendations on how to answer questions); St. Louis Sewer Dist., No. 10-2103, at *18 (E.D. Mo. Mar. 2, 2012) (deliberative process privilege protected e-mail communications, "press releases, talking points and 'Q & A,'" drafts, and briefing materials).

18-11960-F: 2/14/19, 2nd Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

From the aforementioned searches dated September 6, 2018, and September 11, 2018, OSVA released three (3) documents and their attachments totaling seven (7) pages, Bates-numbered as 4548-4554, on February 14, 2019, redacted with FOIA Exemptions 5 and 6.

18-11960-F: 11/30/18, Initial Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

Of the searches dated September 6, 2018, and September 11, 2018, OSVA released seventy-nine (79) documents totaling three thousand five hundred twenty-four (3,524) pages on November 30, 2018, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank), on November 30, 2018.

After reviewing the three thousand five hundred twenty-four (3,524) pages, OSVA redacted some information with FOIA Exemptions 4, 5, 6, 7(C), and 7(E). 5 U.S.C. § 552(b)(4) exempts from disclosure “trade secrets and commercial or financial information obtained from a person and privileged or confidential.” Redacted information includes voluntary proposal submission verbiage, technical processes, technical approaches, and partnership or subcontracting agreements. The release of this information would likely lead to substantial competitive harm in reverse-engineering of the vendors’ technical approaches, processes, partnership, subcontracting, and business and labor strategies. RMS Indus. v. DOD, No. C-92-1545, slip op. at 7 (N.D. Cal. Nov. 24, 1992) (protecting “descriptions of equipment and the names of contacts, customers, key employees, and subcontractors” because “bidders only submit such information if it will not be released to their competitors”); BDM Corp. v. SBA, 2 Gov’t Disclosure Serv. (P-H) ¶ 81,189, at 81,495 (D.D.C. Mar. 20, 1981) (protecting names of consultants and subcontractors, performance, cost, and equipment information).

5 U.S.C. § 552(b)(7)(C) exempts from required disclosure information law enforcement information the disclosure of which “could reasonably be expected to constitute an unwarranted invasion of personal privacy.” Redacted information includes names and email addresses of White House employees with security clearances, as well as Redacted information includes names, identities, email addresses, and VA usernames of VA law enforcement employees. The release of this information would risk impersonation of these White House employees with security clearances also working on national security and law enforcement matters, as well as jeopardizing their health and safety and those the White House employees are charged with protecting. The release of this information would risk impersonation of VA law enforcement personnel and jeopardize the health and safety of not only law enforcement personnel, but those persons the VA law enforcement personnel protect including the VA Secretary.

5 U.S.C. § 552(b)(7)(E) exempts from required disclosure information that “would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law.” Redacted information includes VA usernames of VA law enforcement employees and shared VA email groups, for which VA law enforcement officials plan their law enforcement operations and protection of VA personnel. The release of this information would compromise the safety of VA law enforcement personnel and VA employees.

18-07426-F: 11/20/18, 2nd Partial IAD & Reasonable Searches Dated 5/8/18, 9/18/18, 10/12/18, 10/16/18, & 11/15/18

On October 12, 2018, and October 16, 2018, the OSVA FOIA office searched through former VA Acting Secretary Peter O’Rourke’s emails and calendars from May 4, 2018, to June 22, 2018. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. These October 12, 2018, and October 16, 2018, searches yielded forty-four (44) pages, which the VA released redacted as pages Bates-numbered 243-286 on November 20, 2018.

On September 18, 2018, and October 16, 2018, the OSVA FOIA office searched through former VA Acting Chief of Staff Jacquelyn Hayes-Byrd's emails and calendars from November 8, 2016, to June 22, 2018. OSVA used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded two hundred fifty-five (255) pages, which OSVA released redacted as pages Bates-numbered 287-541 on November 20, 2018.

On October 18, 2018, the OSVA FOIA office searched through the email boxes and calendars, from January 20, 2017, to June 22, 2018, of: 1) Bowman, Thomas, former VA Deputy Secretary; 2) Wright-Simpson, Vivieca, former VA Chief of Staff; 3) Selnick, Darin, former VA White House Senior Advisor; 4) Lukach, Michael, former VA White House Senior Advisor; 5) Leinenkugel, Jake, former VA White House Senior Advisor; and 6) Spero, Casin D, former VA White House Liaison. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded two hundred seventy-two (272) pages, which OSVA released redacted as pages Bates-numbered 542-813 on November 20, 2018.

On November 15, 2018, the OSVA FOIA office searched through the email boxes and calendars from June 23, 2018, to September 6, 2018, including of:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) O'Rourke, Peter M., former VA Acting Secretary;
- 3) Bowman, Thomas, former VA Deputy Secretary;
- 4) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 5) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 6) Selnick, Darin, former VA White House Senior Advisor;
- 7) Lukach, Michael, former VA White House Senior Advisor;
- 8) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 9) Spero, Casin D, former VA White House Liaison.

The November 15, 2018, search yielded two pages, which OSVA release redacted as pages Bates-numbered 814-815 on November 20, 2018.

Our May 8, 2018 (our search cut-off date) search yielded fifty-six (56) pages of email communication to or from Jared Kushner. On November 20, 2018, OSVA released these fifty-six (56) pages redacted as pages Bates-numbered 816-871.

After reviewing six hundred twenty-nine (629) pages Bates-numbered 243-871, OSVA redacted some information with FOIA Exemptions 4, 5, 6, and 7(C). Pages bates-numbered 872-995 are intentionally left blank.

18-07426-F: 9/14/18, Partial IAD & Reasonable Searches Dated 5/8/18

On May 8, 2018, our search cut-off date, we searched through former VA Secretary David Shulkin's emails and calendars from February 14, 2017 (the date he became VA Secretary), to March 30, 2018 (the date he left VA). We searched through VA Secretary Robert Wilkie's emails and calendars from April 1, 2018 (the date he became VA Acting Secretary) to May 8, 2018.

We searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from February 15, 2018 (the date he became VA Acting Chief of Staff), to May 3, 2018. VA will conduct a follow-up search of former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to May 8, 2018.

OSVA searched for any emails to or from Mr. Perlmutter, Dr. Moskowitz, and Mr. Kushner. Our search thus far yielded two hundred ninety-eight (298) pages, of which fifty-six (56) pages require consultation with the White House FOIA Liaison. After reviewing two hundred forty-two (242) pages, OSVA redacted some information with FOIA Exemptions 5, 6, 7(C), and 7(E). Bates-numbered as 1-242 on September 14, 2018.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:

Name: John Buck

Email Address: vacofoiaservice@va.gov

Office of Government Information Services (OGIS)

Email Address: ogis@nara.gov

Fax: 202-741-5769

Mailing address:

National Archives and Records Administration

8601 Adelphi Road

College Park, MD 20740-6001

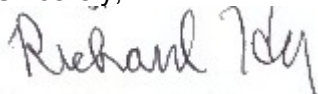
FOIA Appeal

This concludes OSVA's fourth partial IAD to request **18-11960-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,



Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachment - Redacted pages Bates-numbered 4555-5128

From: (b) (6) D.
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
(b) (6)
To: Jake Leinenkugel
<(b) (6) gmail.com>; (b) (6)
<(b) (6) yahoo.com>; (b) (6)
<(b) (6) bushcenter.org>
Cc: (b) (6)
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
(b) (6)
Bcc:
Subject: VSO Meeting - Draft Invitee List
Date: Thu Dec 13 2018 14:30:31 EST
Attachments: Draft Invite List_VSO Meeting.xlsx

Gentlemen,

I wanted to run this draft list of VSO representatives for the January meeting by the three of you as Commission leaders for your review and comment. During my meeting with SVAC staff yesterday I informed them that we would be copying them on the invites and asking them to stress the importance of attendance. They reminded me that the Senate can have a hard time engaging the national commanders, but they will do their best to encourage participation.

The team finalized a rough agenda that I will be sending around for comments later, but it will be a moving target as we get invites out and nail down attendees. Other briefings such as Warrior Care Network and the suicide prevention EO are also being scheduled for workgroup teams.

Please let me know if there are other groups/individuals we should invite, or if you feel a different/additional representative from an organization should participate.

Thank you!

(b) (6)

Owner: (b) (6) D. </o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
Filename: Draft Invite List_VSO Meeting.xlsx
Last Modified: Thu Dec 13 13:30:31 CST 2018

Organization	Title	Name
American Legion	National Commander	(b) (6)
	Executive Director	(b) (6)
VFW	Commander in Chief	(b) (6)
	Executive Director	(b) (6)
PVA	National President	(b) (6)
	Executive Director	(b) (6)
DAV	National Commander	(b) (6)
	Assistant Executive Director	(b) (6)
VVA	National President	(b) (6)
	director of Policy and Government	(b) (6)
AMVETS	National Commander	(b) (6)
	Executive Director	(b) (6)
SVA	President & CEO	(b) (6)
	Vice President of Research	Dr. (b) (6)
Team RWB	Executive Director	(b) (6)
Team Rubicon	Executive Director	(b) (6)
Mission Continuum	President	(b) (6)
Indy Fund	CEO	(b) (6)
CVA	Executive Director	Dan Caldwell

From: (b) (6) D.
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
(b) (6)
To: Jake Leinenkugel
<(b) (6) gmail.com>; (b) (6)
<(b) (6) yahoo.com>; (b) (6)
<(b) (6) bushcenter.org>
Cc: (b) (6)
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
(b) (6)
Bcc:
Subject: VSO Meeting - Draft Invitee List
Date: Thu Dec 13 2018 14:29:35 EST
Attachments: Draft Invite List_VSO Meeting.xlsx

Gentlemen,

I wanted to run this draft list of VSO representatives for the January meeting by the three of you as Commission leaders for your review and comment. During my meeting with SVAC staff yesterday I informed them that we would be copying them on the invites and asking them to stress the importance of attendance. They reminded me that the Senate can have a hard time engaging the national commanders, but they will do their best to encourage participation.

The team finalized a rough agenda that I will be sending around for comments later, but it will be a moving target as we get invites out and nail down attendees. Other briefings such as Warrior Care Network and the suicide prevention EO are also being scheduled for workgroup teams.

Please let me know if there are other groups/individuals we should invite, or if you feel a different/additional representative from an organization should participate.

Thank you!

(b) (6)

Owner: (b) (6) D. </o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
Filename: Draft Invite List_VSO Meeting.xlsx
Last Modified: Thu Dec 13 13:29:35 CST 2018

Organization	Title	Name
American Legion	National Commander	(b) (6)
	Executive Director	(b) (6)
VFW	Commander in Chief	(b) (6)
	Executive Director	(b) (6)
PVA	National President	(b) (6)
	Executive Director	(b) (6)
DAV	National Commander	(b) (6)
	Assistant Executive Director	(b) (6)
VVA	National President	(b) (6)
	director of Policy and Government	(b) (6)
AMVETS	National Commander	(b) (6)
	Executive Director	(b) (6)
SVA	President & CEO	(b) (6)
	Vice President of Research	Dr. (b) (6)
Team RWB	Executive Director	(b) (6)
Team Rubicon	Executive Director	(b) (6)
Mission Continuum	President	(b) (6)
Indy Fund	CEO	(b) (6)
CVA	Executive Director	Dan Caldwell

From: (b) (6) D.
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
(b) (6)
To: Jake Leinenkugel
<(b) (6) gmail.com>; (b) (6)
<(b) (6) yahoo.com>; (b) (6)
<(b) (6) bushcenter.org>
Cc: (b) (6)
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
(b) (6)
Bcc:
Subject: VSO Meeting - Draft Invitee List
Date: Thu Dec 13 2018 14:28:58 EST
Attachments: Draft Invite List_VSO Meeting.xlsx

Gentlemen,

I wanted to run this draft list of VSO representatives for the January meeting by the three of you as Commission leaders for your review and comment. During my meeting with SVAC staff yesterday I informed them that we would be copying them on the invites and asking them to stress the importance of attendance. They reminded me that the Senate can have a hard time engaging the national commanders, but they will do their best to encourage participation.

The team finalized a rough agenda that I will be sending around for comments later, but it will be a moving target as we get invites out and nail down attendees. Other briefings such as Warrior Care Network and the suicide prevention EO are also being scheduled for workgroup teams.

Please let me know if there are other groups/individuals we should invite, or if you feel a different/additional representative from an organization should participate.

Thank you!

(b) (6)

Owner: (b) (6) D. </o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
Filename: Draft Invite List_VSO Meeting.xlsx
Last Modified: Thu Dec 13 13:28:58 CST 2018

Organization	Title	Name
American Legion	National Commander	(b) (6)
	Executive Director	(b) (6)
VFW	Commander in Chief	(b) (6)
	Executive Director	(b) (6)
PVA	National President	(b) (6)
	Executive Director	(b) (6)
DAV	National Commander	(b) (6)
	Assistant Executive Director	(b) (6)
VVA	National President	(b) (6)
	director of Policy and Government	(b) (6)
AMVETS	National Commander	(b) (6)
	Executive Director	(b) (6)
SVA	President & CEO	(b) (6)
	Vice President of Research	Dr. (b) (6)
Team RWB	Executive Director	(b) (6)
Team Rubicon	Executive Director	(b) (6)
Mission Continuum	President	(b) (6)
Indy Fund	CEO	(b) (6)
CVA	Executive Director	Dan Caldwell

From: (b) (6)
To: (b) (6) <(b) (6)@gmail.com>
Cc: D.
Bcc: </o=exchangelabs/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Subject: [EXTERNAL] Re: FW: (b) (6) Financial Disclosure Report
Date: Wed Dec 12 2018 13:56:00 EST
Attachments:

Done.

On Mon, Dec 10, 2018 at 4:20 PM (b) (6) D. <(b) (6)@va.gov> wrote:

Do you understand what he is saying?

From: (b) (6) I. (OGC)" <(b) (6)@va.gov>
Date: Monday, December 10, 2018 at 4:19 PM
To: (b) (6) D." <(b) (6)@va.gov>
Subject: RE: (b) (6) Financial Disclosure Report

(b) (6)

We are getting closer-

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[REDACTED]

(b) (5)

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[REDACTED]

[REDACTED]

(b) (5)

[REDACTED]

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Sent: Monday, December 10, 2018 2:03 PM
To: (b) (6) I. (OGC) <(b) (6) va.gov>
Subject: Re: (b) (6) Financial Disclosure Report

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I note the earlier version of your report

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(b) (6)

Thank you.

(b) (6)

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From: (b) (5) I. (OGC)
Sent: Tuesday, November 13, 2018 3:00 PM
To: (b) (5) D. <(b) (5) va.gov>
Subject: RE: (b) (5) Financial Disclosure Report

(b) (5)

I was trying to close out my last few remaining reports and noted that I had the following (b) (5)

Thanks for the follow up..

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From: (b) (5) I. (OGC)
Sent: Monday, July 30, 2018 8:10 AM
To: (b) (5) D. <(b) (5) va.gov>
Subject: FW: (b) (5) Financial Disclosure Report

(b) (6)

I was reviewing my pending 2 78s and noted that you had revised the

(b) (6)

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[REDACTED]

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[REDACTED]

[REDACTED]

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[REDACTED]

From: (b) (6) I. (OGC)
Sent: Friday, July 20, 2018 3:47 PM
To: (b) (6) D. <(b) (6) va.gov>
Cc: (b) (6) (OGC) <(b) (6) va.gov>
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Cc: (b) (6) (OGC) <(b) (6) va.gov>
Subject: Re: (b) (6) Financial Disclosure Report

Hi (b) (6)

I am making the (b) (6)

To be clear, I wasn't even (b) (6)

Thanks,

(b) (6)

From: (b) (6) I. (OGC)" <(b) (6) va.gov>
Date: Wednesday, July 18, 2018 at 3:23 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Cc: (b) (6) (OGC)" <(b) (6) va.gov>
Subject: RE: (b) (6) Financial Disclosure Report

(b) (6)

I have reviewed your annual report and have the following questions and comments.

Please include the (b) (6)

(b) (6)

(b) (5)

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

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(b) (5)

Thanks for the follow up.

(b) (6)

(b) (6)

Senior Ethics Attorney/

Deputy Ethics Official

(202) 461- (b) (6)

From: (b) (6) I. (OGC)
Sent: Wednesday, June 20, 2018 5:24 PM
To: (b) (6) D. <(b) (6) va.gov>
Cc: (b) (6) (OGC) <(b) (6) va.gov>
Subject: RE: (b) (6) Financial Disclosure Report

(b) (6)

I have certified your (b) (5)

(b) (6)

From: (b) (6) D.
Sent: Wednesday, June 20, 2018 4:57 PM
To: (b) (6) I. (OGC) <(b) (6) va.gov>
Cc: (b) (6) (OGC) <(b) (6) va.gov>
Subject: Re: (b) (6) Financial Disclosure Report

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Date: Wednesday, June 20, 2018 at 4:56 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Cc: (b) (6) (OGC)" <(b) (6) va.gov>
Subject: RE: (b) (6) Financial Disclosure Report

Correct.

From: (b) (6) D.
Sent: Wednesday, June 20, 2018 4:33 PM
To: (b) (6) I. (OGC) <(b) (6) va.gov>
Cc: (b) (6) (OGC) <(b) (6) va.gov>
Subject: Re: (b) (6) Financial Disclosure Report

After further review of the (b) (6)

From: (b) (6) I. (OGC)" <(b) (6) va.gov>
Date: Wednesday, June 20, 2018 at 4:08 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Cc: (b) (6) (OGC)" <(b) (6) va.gov>
Subject: RE: (b) (6) Financial Disclosure Report

Correct. Is your (b) (6)

(b) (6)

From: (b) (6) D.
Sent: Wednesday, June 20, 2018 3:20 PM
To: (b) (6) I. (OGC) <(b) (6) va.gov>
Cc: (b) (6) (OGC) <(b) (6) va.gov>
Subject: Re: (b) (6) Financial Disclosure Report

The (b) (5)

From: (b) (6) I. (OGC)" <(b) (6) va.gov>
Date: Wednesday, June 20, 2018 at 2:49 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Cc: (b) (6) (OGC)" <(b) (6) va.gov>
Subject: RE: (b) (6) Financial Disclosure Report

(b) (6)

Per the chart below, whether the (b) (5)

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(b) (5)

(b) (5)

[REDACTED]

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[REDACTED]

(b) (5)

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[REDACTED]

[REDACTED]

(b) (5)

From: (b) (5) D.
Sent: Wednesday, June 20, 2018 2:10 PM
To: (b) (5) I. (OGC) <(b) (5) va.gov>
Cc: (b) (5) (OGC) <(b) (5) va.gov>
Subject: Re: (b) (5) Financial Disclosure Report

From: (b) (5)

Any guidance much appreciated.

Thanks,

(b) (5)

From: (b) (5) I. (OGC)" <(b) (5) va.gov>
Date: Wednesday, June 20, 2018 at 1:13 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (5) va.gov>
Cc: (b) (5) (OGC)" <(b) (5) va.gov>
Subject: RE: (b) (5) Financial Disclosure Report

(b) (5)

Thanks for the follow up.

Even though (b) (5)

Senior Ethics Attorney/

Deputy Ethics Official

(202) 461-

From: (b) (6) D.

Sent: Wednesday, June 20, 2018 12:48 PM

To: (b) (6) I. (OGC) <(b) (6) va.gov>

Cc: (b) (6) (OGC) <(b) (6) va.gov>

Subject: Re: Financial Disclosure Report

My account should be finishing this today.

On your other concerns, you are aware that (b) (6)

[REDACTED]

If you would like to discuss further, please feel free to contact me.

Thank you,

(b) (6)

From: "(b) (6) I. (OGC)" <(b) (6) va.gov>
Date: Wednesday, May 2, 2018 at 9:41 AM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Cc: "(b) (6) (OGC)" <(b) (6) va.gov>
Subject: (b) (6) Financial Disclosure Report

Mr. (b) (6)

I have reviewed your report and have the following questions and comments.

Please include a (b) (6)

[REDACTED]

(b) (5) [Redacted]

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(b) (5) [Redacted]

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(b) (5)

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[REDACTED]

[REDACTED]

(b) (5)

Thank you.

(b) (6)

(b) (6)

Senior Ethics Attorney/

Deputy Ethics Official

(202) 461-

(b) (6)

From: Dan Caldwell <(b) (6) cv4a.org>
To: (b) (6) D.
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: [EXTERNAL] RE: COVER Commission Meetings
Date: Tue Dec 11 2018 09:49:32 EST
Attachments:

(b) (6) – thanks for reaching out. I have some thoughts I can share re: Arizona. Lets find a time to chat.

Thank you for the invite as well to the hearing in January. You guys are doing good work.

Give my regards to Jake.

Thanks,

Dan Caldwell

Executive Director

Concerned Veterans for America

C: [602] 999-(b) (6)

Confidentiality:

The information contained in, and attached to, this communication may be confidential, and is intended only for the use of the recipient named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication, or any of its contents, is strictly prohibited. If you have received this communication in error, please re-send this communication to the sender and delete the original message and any copy of it from your computer system. Thank you.

From: (b) (6) D. <(b) (6) va.gov>
Sent: Thursday, December 06, 2018 11:10 AM
To: Dan Caldwell <(b) (6) cv4a.org>
Subject: COVER Commission Meetings

Hi Dan,

Wanted to touch base on a couple of COVER Commission items coming up. These are both close hold items as we have not yet published our upcoming meetings in the federal register.

1. In February, the full Commission will travel to Arizona, with the original intent of visiting the Northern Arizona VA Healthcare System in Prescott for 2 day. We have decided to possibly add stops in Tucson and Phoenix during the week as well. Given your experience with Veterans issues in the state, I wanted to reach out to see if there are any groups, non-profits, public entities, or state/local level programs we should meet with/evaluate as it relates to our mission to evaluate mental healthcare services at VA. I can provide you with more info on or scope if it helps, but anything that comes to mind is worth us looking into.

2. At the end of January, the Commission will likely be in DC and looking to meet with Veterans groups, and would welcome your presence if you are available. More to follow.

Again, I do ask you to keep these items close hold while we notify our other VSO partners and publish the notice of meeting.

Thanks,

(b) (6)

From: (b) (6) D.
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6)
<(b) (6) gmail.com>
Cc:
Bcc:
Subject: FW: (b) (6) Financial Disclosure Report
Date: Mon Dec 10 2018 16:20:21 EST
Attachments:

Do you understand what he is saying?

From: (b) (6) I. (OGC)" <(b) (6) va.gov>
Date: Monday, December 10, 2018 at 4:19 PM
To: (b) (6) D." <(b) (6) va.gov>
Subject: RE: (b) (6) Financial Disclosure Report

(b) (6)

We are getting closer-

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Sent: Friday, July 20, 2018 3:47 PM
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(b) (6)

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(b) (6)

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(b) (6)

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(b) (6)

(b) (6)

Senior Ethics Attorney/

Deputy Ethics Official

(202) 461-

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Sent: Wednesday, June 20, 2018 5:24 PM
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Cc: (b) (6) (OGC)" <(b) (6) va.gov>
Subject: RE: (b) (6) Financial Disclosure Report

Correct.

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To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Cc: (b) (6) (OGC)" <(b) (6) va.gov>
Subject: RE: (b) (6) Financial Disclosure Report

Correct. Is your (b) (6) ?

(b) (6)

From: (b) (6) D.
Sent: Wednesday, June 20, 2018 3:20 PM

To: (b) (6) I. (OGC) <(b) (6) va.gov>
Cc: (b) (6) (OGC) <(b) (6) va.gov>
Subject: Re: (b) (6) Financial Disclosure Report

The (b) (6)

From: (b) (6) I. (OGC)" <(b) (6) va.gov>
Date: Wednesday, June 20, 2018 at 2:49 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Cc: (b) (6) (OGC)" <(b) (6) va.gov>
Subject: RE: (b) (6) Financial Disclosure Report

(b) (6)

Per the chart below, whether the (b) (6)

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(b) (6)

(b) (6)

(b) (6) [Redacted]

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[Redacted]

[Redacted]

[Redacted]

From: (b) (6) D.
Sent: Wednesday, June 20, 2018 2:10 PM
To: (b) (6) I. (OGC) <(b) (6) va.gov>
Cc: (b) (6) (OGC) <(b) (6) va.gov>
Subject: Re: (b) (6) Financial Disclosure Report

From (b) (6)

(b) (6)

Any guidance much appreciated.

Thanks,

(b) (6)

From: (b) (6) I. (OGC)" <(b) (6) va.gov>
Date: Wednesday, June 20, 2018 at 1:13 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Cc: (b) (6) (OGC)" <(b) (6) va.gov>
Subject: RE: (b) (6) Financial Disclosure Report

(b) (6)

Thanks for the follow up.

Even though (b) (6)

(b) (6)

(b) (6)

(b) (6)

Senior Ethics Attorney/

Deputy Ethics Official

(202) 461- (b) (6)

From: (b) (6) D.
Sent: Wednesday, June 20, 2018 12:48 PM
To: (b) (6) I. (OGC) <(b) (6) va.gov>
Cc: (b) (6) (OGC) <(b) (6) va.gov>
Subject: Re: (b) (6) Financial Disclosure Report

(b) (6)

My account should be finishing this today.

On your other concerns, you are aware that (b) (6)

(b) (6)

If you would like to discuss further, please feel free to contact me.

Thank you,

(b) (6)

From: "(b) (6) I. (OGC)" <(b) (6) va.gov>
Date: Wednesday, May 2, 2018 at 9:41 AM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Cc: "(b) (6) (OGC)" <(b) (6) va.gov>
Subject: (b) (6) Financial Disclosure Report

Mr. (b) (6)

I have reviewed your report and have the following questions and comments.

Please include (b) (6)

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(b) (6)

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(b) (6)

[REDACTED]

[REDACTED]

(b) (6)

[REDACTED]

Thank you.

(b) (6)

[REDACTED]

(b) (6)

[REDACTED]

Senior Ethics Attorney/

Deputy Ethics Official

(202) 461- (b) (6)

From: (b) (6) D.
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>

To: (b) (6) CV4A.ORG <(b) (6) cv4a.org>

Cc:

Bcc:

Subject: COVER Commission Meetings

Date: Thu Dec 06 2018 11:10:13 EST

Attachments:

Hi Dan,

Wanted to touch base on a couple of COVER Commission items coming up. These are both close hold items as we have not yet published our upcoming meetings in the federal register.

1. In February, the full Commission will travel to Arizona, with the original intent of visiting the Northern Arizona VA Healthcare System in Prescott for 2 day. We have decided to possibly add stops in Tucson and Phoenix during the week as well. Given your experience with Veterans issues in the state, I wanted to reach out to see if there are any groups, non-profits, public entities, or state/local level programs we should meet with/evaluate as it relates to our mission to evaluate mental healthcare services at VA. I can provide you with more info on or scope if it helps, but anything that comes to mind is worth us looking into.

2. At the end of January, the Commission will likely be in DC and looking to meet with Veterans groups, and would welcome your presence if you are available. More to follow.

Again, I do ask you to keep these items close hold while we notify our other VSO partners and publish the notice of meeting.

Thanks,

(b) (6)

From: (b) (6) yahoo.com
<(b) (6) yahoo.com>
To: Wilkie, Robert L., Jr.
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: [EXTERNAL] BWN Vets
Date: Mon Dec 03 2018 10:16:13 EST
Attachments:

Mr. Wilkie:

First let me congratulate you on your appointment to Secretary of the VA. You have a most difficult job ahead of you and correcting the many wrongs at the VA is going to take masterful leadership and I trust you are the man for the job that can get things straightened out. I wish you the utmost success in your efforts.

The reason for my email today is to encourage you to support HR299 for all of us so called Blue Water Navy Veterans. I spent the entire year of 1972 onboard the USS Kitty Hawk CVA 63. We were assigned to the Gulf of Tonkin, oftentimes called Yankee Station. I was an aviation electrician at this time and I worked on the RA5C Vigilante aircraft assigned to squadron RVAH-7. As an Aviation Electrician it was my job to correct any issue that may come up with the airplane's electrical systems to include all flight controls as well as all instrumentation and their associated systems. This oftentimes entailed crawling all over those airplanes returned from flying over Vietnam.

At issue here is were the blue Water Navy personnel affected by agent orange exposure? I don't think there is anyone today that can accurately and scientifically prove that, one way are the other. I just know that in 2007 at the age of 56 I was diagnosed with prostate cancer. I had to have it removed and the aftereffects of removal on the prostate are no fun, at all! A few years later I was diagnosed with type 2 diabetes and currently have neuropathy in both feet. I have lost all feeling in the balls of my feet.

During all the test for the prostate cancer a tumor was found on my right kidney. That was surgically removed and so far has not returned.

Now the question here is are my diseases caused by agent orange exposure? Honestly, I do not know and neither does anybody else. I do, however know that no other male member of my family has had prostate cancer or any of the other diseases I seem to have gotten.

My DD-214 states on it in plane english "Served in Vietnam" and I received a Vietnam service medal.

This policy of "Boots on the Ground" ONLY is seriously flawed in that the VA can not know if someone that had Boots on the Ground were anymore exposed to agent orange than I was sitting off the coast of Vietnam on an aircraft carrier.

It doesn't take a rocket scientist to know that anything sprayed over ground will eventually wind up in the ocean. When millions of tons of Agent Orange was sprayed over Vietnam, and given the monsoons they have their, It just make sense that the chemical would wind up in the ocean, in this the Gulf of Tonkin. I'm sure you know that ships sucked up water from the Gulf of Tonkin and desalted it and that water was used for everything you'd normally use water for. Cooking food, drinking, washing clothes

and etc. I believe it was in this manner that the Blue Water Navy were exposed to agent orange.

I apologize this is so long but i want you to understand whats happening in the real word, outside all the political moves made, meetings and discussions held and etc. It's guys like me that are dealing with the damage done to our bodies due to Agent Orange exposure. We live with this every single day of our lives.

I ask for you to support HR299 as we really and honestly need the help to cope with these diseases.

Sincerely

(b) (6)

From: ADA ADVOCATE (b) (6)
(b) (6) gmail.com>
To: (b) (6) L. (ORM)
</o=exchangelabs/ou=exchange administrative group
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(b) (6)>; (b) (6), VBAVACO
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(b) (6)>; (b) (6) - Pine City, MN - Contractor
(b) (6) usps.gov>; (b) (6) (ORM)
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(b) (6) - Tampa, FL
<(b) (6) @usps.gov>; (b) (6), VBAVACO
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(b) (6)>; Wilkie, Robert L., Jr.
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(b) (6) Murphy, Thomas, VBASTL
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[REDACTED] eeoc.gov
<[REDACTED]@eeoc.gov>; [REDACTED] (ORM)
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[REDACTED] (Cardin)
[REDACTED] s@cardin.senate.gov>; [REDACTED]
[REDACTED] @eeoc.gov>; [REDACTED]
[REDACTED] @gmail.com>; [REDACTED] (ORM)
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[REDACTED] osc.gov>; [REDACTED] @usdoj.gov
<[REDACTED]@usdoj.gov>; [REDACTED] (ORM)
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(fydibohf23spdlt)/cn=recipients/cn= [REDACTED]
[REDACTED]

Cc:

Bcc:

Subject: [WARNING: ATTACHMENT UNSCANNED][EXTERNAL] Re: OFFICIAL
CORRESPONDENCE: Referral of Complaint for Final Agency Decision

Date: Sun Nov 25 2018 22:05:09 EST

Attachments: #1 Withdrawal of Request for EEOC Hearing with the EEO Complaint Process Notice of
Def Report-2.pdf

#2 FAD OEDCA proof of mailing 2018-11-19 21.30.04-4.pdf

#3 [REDACTED]-FAD-23 November 2018.pdf

#6 19 June 2018 Request to update Records without VA and ORM involvement-3.pdf
1 md-110.pdf

5977dir11-1.pdf

5977hbk07-1.pdf

CFR Ref ORM Recuse and Delegation of Authority.pdf

General Dunford and General Honore,

I am reaching back out to both of you as leaders and mentors as I am of military mind which VA has
triggered[and re-triggered] for over 10 months now. All I know is what the military taught me when it
comes to mission and taking care of soldiers/veterans.

I have followed your guidance [and your staff's guidance] Ref: (1) Lean forward in the fox hole, (2) follow rules, regulations and policies, and (3) report illegal activity to outside agencies (See Exhibit 4).

I even had General Shadley change his PTSD prevention meeting on 13 April to convince VA's District RA manager, (b) (6) and (b) (6) to follow the 1973 and ADA Civil Rights Act (which they refused) ([https://www.youtube.com/watch?v=\[REDACTED\]](https://www.youtube.com/watch?v=[REDACTED]) youtu). Also see 30 July 2018 ([https://www.youtube.com/watch?v=\[REDACTED\]](https://www.youtube.com/watch?v=[REDACTED])).

BLUF: When it comes to soldiers, veterans and military, I want to be part of the solution vs the problem.

However, the military has taught me to speak out against violations.

I cannot allow them (VA) to continue to hurt others who are service disabled veterans and ADA Reps (e.g. (b) (6) and (b) (6)).

General Dunford you witnessed first hand how my world class athletes and my company, E2 support Veterans through our running/coaching at the marine corps marathon, Army Ten Miler and Wounded Warrior Games.

To say nothing about how they (VA, ORM, Dr. (b) (6) and UPS) abuse my husband [who is service disabled veteran], our son, and NOW OTHERS ((b) (6) and (b) (6) is unacceptable.

My family [and I] have waited 11 months for justice. OSHA Regional said not to expect justice because everyone is involved. Whether this is a true statement or not, based on what we have experienced, everything is an illusion/game and we simply want the abuse to stop. We want to heal from this 11 month battle. We get it. Civil Rights in the US is an illusion right? All I know is, I would rather pretend to fight for civil rights overseas then fight for civil rights for my husband in our own backyard.

Either way, I want my family and I to heal. I especially dont want others (service disabled Veterans) to experience what we gone through. There has to be a better way then taking everything we have and suggesting that welfare is the best option while the perpetrators abuse their powers and wast tax dollars.

If we want justice, we need to go outside of VA and reach out to the public. OSHA said make a movie. I say, Leaders, please kindly respond to the following:

(1) General Dunford, I respectfully ask that you provide an update on how the Army is going to block Veterans Affairs ORM from locking in pre made EEOC claims in the Army's server (Exhibit 4)

(2) Danny, I respectfully ask Senator Cardin to get involve with [REDACTED] case as it is 3 months overdue for no reason. VA should have your ADA violations answers at their finger tips according to Executive order 13164. I gave you the answers in 1 day. A reasonable person might guess that VA is holding back because they dont want you to know their answers.

(3) Ashley, please ask Congressman Ruppersberger to ask VA the following: (1) Why did [REDACTED] offer to send a false investigative report to OEDCA?

(4) (b) (6) and (b) (6) please protect (b) (6) and (b) (6) from retaliation until our EEOC court case is over. Also please read the attached ORM/EEOC regulations and explain why the pre-made claims are still in the counselors report?

(5) Mr. (b) (6) please get with (b) (6) and train her on the OSHA law. Also help (b) (6) understand why you denied (b) (6) and I an OSHA assessment when this simple OSHA request is offered [and entitled] to everyone. More specifically, Mr. (b) (6) why did you deny our VA OSHA inspection when (b) (6) was in the hospital suffering from a stroke and drooped face? OSHA Regional informed us that you have an executive order that requires VA to perform their own inspection? I wonder what does it take for you to do your job? Are you waiting for someone to die? or did you not want to conduct the OSHA inspection because it would reveal (b) (6) and (b) (6) Civil Rights abuse?

(6) Dr. (b) (6) please tell us how much tax payers paid you to conduct your EEO investigation? According to your website, your company earned over \$500,000 last year. Did you earn this money as an EEO Investigator? Who trained you? We were wondering because you failed to follow 110. What regulations are you following? Why did you accept (b) (6) and (b) (6) perjured affidavits after I informed you that you have a moral obligation to stop the drama?

We are more interested in why you falsified the July affidavit? Why did you exclude Exhibit 17? Exhibit 17 is significant because it pin points VA leadership.

(7) (b) (6) you state on your letter of reprimand response that leaders should be held accountable for their actions. The penalty for lying on affidavits is up to 5 years. Do you believe that leaders should serve up to 5 years for every time they perjured themselves?

(8) (b) (6) and (b) (6) do you believe in civil rights? If so, what do you think the punishment should be for every time a leader is found guilty for civil rights violation?

(9) (b) (6) what should the punishment be for a VA ADA Officer of the Court who violated the ADA law? What about an Officer of the Court who directs scapegoats into violating rights?

(10) (b) (6) and (b) (6) you cancelled my white house hotline complaint without telling me. Did you have anything else to do with my PTSD claim being postponed in Aug? I ask because on 29 Oct, I asked (b) (6) failed to confirm your report.

(11) (b) (6) If (b) (6) did not turn in (b) (6) personnel records, medical records, dependents records, beneficiaries records to you, where did she turn them into? Why did she use your name?

(12) (b) (6) who do you really work for? Why did you disregard my 62 claims on 16 June and replace them with VA's 9 outdated claims? Why did you not recuse yourself? Why did you sign for ORM ref: transmittal letter (Volume1)?

Why are the transmittal letter not completed as per regulations (e.g., electronic, section tracking, and

etc? see 110). Why did you back date the transmittal letter from 19 Oct to 10 Oct? Why did you ignore the information about the perjured affidavits (e.g., (b) (6) (b) (6) (b) (6) (b) (6) (b) (6) (b) (6) Why as a United States Postal Rep, did you feel it was okay to commit mail fraud without fear? What are your thoughts the punishment be ref: how long should one spend behind bars for mail fraud?

(13) Dr. (b) (6) you fabricated (b) (6) medical records in VA's favor. The federal offense for actions is 5-10 years and loss of medical license. Do you agree?

(14) (b) (6) as the VA's District Reasonable Accommodation manager, you stated on 13 April 2018 (see: [https://www.youtube.com/watch?v=\(b\) \(6\)](https://www.youtube.com/watch?v=(b) (6))

and in your affidavit that you did not require additional medical records. Do you still agree with this statement?

If addition, you stated that (b) (6) repeated several times during the 13 April meeting how she had been triggered. Are you familiar with PTSD and how it causes set back for those of us who suffer from PTSD?

If so, what should be the punishment for District Reasonable Accommodation Managers who violate rights?

(15) (b) (6) and (b) (6) the penalty for medical privacy violations are 5 years. Do you agree? If, so are you prepared to serve the time behind bars? If anyone can prove perjury on your affidavits?

(16) (b) (6), the penalty for lying on affidavits is 5 years. Do you agree? What should the punishment be for someone who violates the retaliation? What should the penalty be for investigators like yourself, who fail to follow the required inspections manual, 0700?

(17) (b) (6), do you feel guilty for not contributing to the EEO process when asked in June? What should the punishment be for leadership who ignores their duty to tell the truth?

(18) Mr. Wilkie, your policies are not being followed as per what you are briefing the public. You staff is apparently keeping critical information from you. More specifically, (b) (6) and (b) (6) is cancelling out/deleting information from you and other leaders. How are you going to correct this issue? Shouldn't these individuals [and (b) (6)] be relieved or put behind bars as per regulations as their offense is a federal offense.

(19) (b) (6) as an VA Whistle Blower Rep, you have had (b) (6) information since June. What are you doing with it? What do you do when the evidence is clear regarding civil rights and safety issues? Do you work with (b) (6) She is responsible for Whistle blower inquiries.

(20) Mr. (b) (6) on 8 March, you informed me to change the doctors Clinical records. You also informed me that VA leadership was involved and bees get more with honey than vinegar. Why did the leadership want the Dr's clinical records changed? Did you lock in RA in the RAPID's system on 8 March and send it to (b) (6) If so, why could (b) (6) deny this? (b) (6) states he was informed on 30 March that RA was needed?

(21) General Shadley and (b) (6) please provide your thoughts about 13 April interactive meeting.

(22) Dr. (b) (6) please explain your thoughts about your experience with VA and (b) (6) reasonable accommodations and FMLA.

(23) Ms. (b) (6) is this a game? Do we need to go to the press? What does one need to do to get simple justice? I have cc'd the rules, regulation and policies which are not being followed. Please help me understand since this is a conflict of interest case, the case need to have been sent to OEDCA in June. Now since OEDCA gave the case to (b) (6) in June, it should have gone to an outside agency?

How are you going to endure whoever judges this case is fair as we have met conflict at every corner of the EEO process.

We want to be part of the solution vs the problem.

(b) (6)

ADA Rep for Wounded Warriors, Soldiers, Veterans and (b) (6)

On Fri, Nov 23, 2018 at 9:09 PM ADA ADVOCATE (b) (6) <(b) (6)@gmail.com> wrote:

2 of 2

Concern about (b) (6) and Ms (b) (6) handling this case.

Attached please find proof of how (b) (6) hid pre-made claims in the Army system and did not update it hence, why she cannot send the investigative file to ODECA.

and the receipt that ORM and ODECA should have the motion to withdrawal, hard copies and disk to review.

Again, Ms (b) (6) and Ms (b) (6) we request that (b) (6) and Ms. (b) (6) recuse themselves. We also request that you please address our concerns as this case is of public interest.

V/R

ADA Advocate for Wounded Warriors, Soldiers and (b) (6)

On Fri, Nov 23, 2018 at 9:01 PM ADA ADVOCATE (b) (6) <(b) (6)@gmail.com>

wrote:

ORM Directors, Ms (b) (6) and Ms (b) (6)

1 of 2

Our concern is OEDCA receiving our concerns vs a fraud "investigative report" and (b) (6) withdrawal memo (See Attached).

This morning, (b) (6) sent the attached email message to (b) (6) ref: sending the "Investigative Files" for a FAD.

As you know, the Investigative Files do not reflect the truth. The disk that we sent to ORM and OEDCA provides evidence OEDCA should review.

I mention our concern about (b) (6) not sending (b) (6) information to OEDCA because in June, we requested that OEDCA accept our case as per directive 110, VA should not have conducted the investigation. In addition, the Third Party, (b) (6) (Post Service) was caught using ORM's "outdated" 9 claims vs (b) (6) 62 "updated" claims (See Attached). Furthermore, your office (Ms. (b) (6)) signed for OEDCA in June (See Attached). This means, your office has control of what OEDCA reviews to include the truth.

BLUF: How do we stop wasting time and ensure that OEDCA receives (b) (6) "entire complaint file and disk vs. the INVESTIGATIVE FILES? OEDCA cannot make a decision on false facts.

Please let (b) (6) know how you are going to resolve his concern as we thought you were supposed to fill the shoes of EEOC. As of date, we have reviewed your name on most of ORM's documents to include the counselors reports, Army Secure files, emails and etc.

We look forward to your response.

V/A

(b) (6)

ADA Advocate for Wounded Warrior, Veterans and (b) (6)
How do we ensure our concerns are addressed?

As EEO directors, you should not continue to allow Ms (b) (6) and Ms (b) (6) be used as scapegoats.

Please follow 110 as you are supposed to fill the shoes of EEOC.

Again, please assure us that the false report will not be sent to ODECA.

----- Forwarded message -----

From: ADA ADVOCATE (b) (6) <(b) (6)@gmail.com>
Date: Fri, Nov 23, 2018 at 10:05 AM
Subject: Re: OFFICIAL CORRESPONDENCE: Referral of Complaint for Final Agency Decision
To: ADA ADVOCATE (b) (6) <(b) (6)@gmail.com>, (b) (6) VBAVACO
<(b) (6)@va.gov>, (b) (6) L. (ORM) <(b) (6)@va.gov>, (b) (6) VBAVACO
<(b) (6)@va.gov>, (b) (6), FL (b) (6) @usps.gov>, (b) (6)
(ORM) <(b) (6)@va.gov>
Cc: (b) (6) @comcast.net (b) (6) @comcast.net>

(b) (6)
Please be advise this complaint is against
" the processing" of the complaint with you and (b) (6) (e.g.,pre made claims and locking these
items in the Army Server). It is also against (b) (6) (e.g., ex parte meeting with Third Party, (b) (6)

I am not sure if having (b) (6) as (b) (6) representative/counselor is a good thought due to
reasons mentioned on the record.

Thanks in Advance
Ref: Removing our case from ORM.
V/R

(b) (6)
ADA Rep for Wounded Warriors, Veterans, Soldiers and (b) (6)

On Fri, Nov 23, 2018 at 9:31 AM (b) (6) L. (ORM) (b) (6) @va.gov> wrote:

Good Morning Ms. (b) (6)

Please see the attached Referral of Complaint for Final Agency Decision for your client. If you have any
questions or concerns please feel free to contact your case manager, (b) (6)

Thank you,

(b) (6)

VA Central Office (VACO) EEO Assistant

U.S Department of Veterans Affairs

Office of Resolution Management (08)

1575 I Street, NW Washington, DC 20005

Phone: 202-461-(b) (6)

(b) (6) (b) (6)@va.gov

Owner: ADA ADVOCATE (b) (6) (b) (6) gmail.com>
Filename: #1 Withdrawal of Request for EEOC Hearing with the EEO Complaint Process
Notice of Def Report-2.pdf
Last Modified: Sun Nov 25 21:05:09 CST 2018

U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION
Washington Field Office

(b) (6)	EEOC Case No: 570-2018-01295X
Complainant,	
v.	Agency No: VA-200C-0020-2018101982
	Administrative Judge not yet assigned
Robert L. Wilkie, Secretary for Department of Veterans Affairs	Date: November 17, 2018
Agency.	

WITHDRAWAL OF REQUEST FOR EEOC HEARING
DISSATISFACTION WITH THE EEO COMPLAINT PROCESS
NOTICE OF DEFICIENCIES IN REPORT OF INVESTIGATION AND
COMPLAINT FILE

Complainant, through his representative, hereby requests to withdraw his request for an EEOC Hearing and to request an immediate Final Agency Decision (FAD) from the Department of Veterans Affairs' Office of Employment Complaint Discrimination Adjudication pursuant 29 CFR 1614.110 (b), VA Directive 5977 and VA Handbook 5977.

Complainant, through his representative, is dissatisfied with the (1) VA, (2) ORM, (3) the U.S. Postal Services and (4) Contractor, Dr. (b) (6) processing of his EEO Complaint. On May 15, 2018, the VA's Office of Resolution Management determined this was a conflict case and they reassigned

investigation to the U.S. Postal Service on May 16, 2018. Complainant requests the VA and/or the U.S. Postal Service, as applicable, review and take action to address the complaints under the appropriate statutes, regulations, Management Directives. Please refer to enclosed DVD-ROM titled "ROI Review and Complaint 11/16/2018" for details. Specifically, please take notice of my original complaints and how VA, ORM, (b) (6) and D (b) (6) Contractor manipulated the complaints in VA's favor.

Complainant, through his representative, states there are deficiencies in the Report of Investigation and the Complaint File.

On 9-10 Oct 2018, I sent proof of VA perjured affidavits (**Exhibit 1 and Disk location: #0**) and reminded Dr. (b) (6) that she had an obligation to inform the staff. On October 22, 2018, I received the CD ROM from the U.S. Postal Service containing the Report of Investigation and the Complaint file (**Exhibit 2**).

My main concern is on August 28, 2018, I filed a Request for a Hearing under the provisions of Management Directive 110 and 29 CFR 1614.109 (**Exhibit 3**) and documents sent to EEOC after August 28, 2018 were not listed in the record (**Exhibit 4 and Disk location 1CD Boz, #1, 4-Evidence and 4-EEOC**). Other significant issue follows:

- (1) Veterans Affairs paid for the Contractor which is against regulation (**Exhibit 5**).
- (2) My 96- page Affidavit [with Exhibit 17] had been falsified (**Exhibit 6**)
- (3) Perjury (**Exhibit 13 and Disk location #0**).
- (4) Mail Fraud (**Exhibit 7**)

- (5) Agency using my affidavit answers to update the transmittal records found in Volume **(6 page FOIA Report vs 8 pages See: Exhibit 8)**
- (6) Pre-made claims not being updated then locked into an Army system **(See Disk location #0).**
- (7) Documents hidden in volume #28 to hide OSHA Safety Issues and Reasonable Accommodation Denials **(Exhibit 9).**
- (8) My 2016 RA document hidden and manipulated in (b) (6) file **(Affidavit B). This is significant because when they denied me effective** Reasonable Accommodation on 11 Jan 2018 my health went down and my disability which was manageable turned into a stroke and my deformed face in the first place **(Exhibit 10).**

I would also like to note for the record that on October 4, 2018 (one month after I removed my case from ORM to EEOC), Dr. (b) (6) submitted VA's affidavits at 9:00 am. Later that day at 5:15 pm., the Chief Administrative Judge issued a Show Cause Order demanding the Agency complete the Report of Investigation and forward the Complaint file to the Washington Field Office and serve a copy on the complainant **(Exhibit 11).**

At first glance of the Report of Investigation Report and Complaint File, I immediately discovered false facts **(See attached Disk location #0).** Also please review how ORM stored pre-made claims and an incorrect counselor's report in the Army's server **(See Disk location #0).** This issue has been reported to General Dunford, 19th Chairman Combined Joint Chief of Staff, Joe Dunford.

A thorough scrub of the Agency's Files along with recommended corrections to include more readable images are incorporated herein on the

DVD-ROM titled "ROI Review and Complaint 11/16/2018". (See: Disk Files 0# to 7) background information is found on the following tape-recorded interactive videos:

(1). [https://youtu.be/\[REDACTED\]](https://youtu.be/[REDACTED]) (RA interactive meeting 30 July 2018 with [REDACTED] and [REDACTED])

(2) [https://www.youtube.com/watch?v=\[REDACTED\]](https://www.youtube.com/watch?v=[REDACTED]) A Interactive meeting, 13 April 2018: [REDACTED] General [REDACTED] ADA Rep and mentor), [REDACTED] EO Certified and ADA Rep) and [REDACTED] (ADA Rep) and [REDACTED] Also see how the abuse has it affected our sons, [REDACTED] who is currently having a set-back dealing with the issue ([https://www.youtube.com/watch?v=\[REDACTED\]](https://www.youtube.com/watch?v=[REDACTED]) and step son, [REDACTED] request this case stay transparent as per OSHA Regional as it is case which OSHA has denied me a safety risk assessment before and while I was in the hospital due to VA's Executive Order (**Exhibit 12**). According to OSHA, VA is allowed to inspect themselves and if they decide to not conduct an OSHA inspection, they could not do anything about it. In addition, Concerns addressed about the process to ORM, VA, OEDC [REDACTED] Spin Off) are located at **Exhibit 13** and additional concerns about the Contractor is found at **Exhibit 14**.

As of date I have request assistant through my ADA representative from the following: (1) Congressmen, (2) Congresswomen, (3) Office of Special Counsel, (4) VA IG, (5) IV Whistle Blower, (6) VA ORM; (7) VA House Committee, and OSHA Local, Regional and VA OSHA (See DISK File location #0)

(7) My wife and I are service disabled Veteran. This incident has gone on for over 1 year we have uncovered too much information and want our family to heal. We humbly request for your help as this case effects the public and is of public interest.

I request **reasonable accommodations in expediting this case as it has become as health and safety issue. It has** affected my health [and my families health] emotional, physically, and financially as the overwhelming and indisputable evidence show **(See Attached Disk, Folder 1 to 6).**

On October 31, 2018, I informed the Agency's counsel that I would be reviewing the records and would be forwarding the deficiencies to her. This is the formal transmittal of those deficiencies.

(b) (6)

Complainant Representative

(b) (6)
Fort George G. Meade, MD 20755
(410) 858- (cell)
(410) 874- (fax)

(b) (6) @gmail.com

(b) (6)

Complainant

(b) (6)
Fort George G. Meade, MD 20755
(678) 472- (Cell)
(410) 874- (Fax)

(b) (6) @comcast.net

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that the foregoing documents (WITHDRAWAL OF REQUEST FOR EEOC HEARING, DISSATISFACTION WITH THE EEO COMPLAINT PROCESS, NOTICE OF DEFICIENCIES IN REPORT OF INVESTIGATION AND COMPLAINT FILE with Exhibits A-E)

were served to the following parties by the means indicated below on the date indicated below.

Administrative Judge:

(b) (6)
Supervisory Administrative Judge
EEOC – Washington Field Office
131 M ST NE
Washington DC 20507

By Fax to: 202-419-(b) (6)
By Email to: (b) (6)@eoc.gov

Agency Representative:

Department of Veterans Affairs
Office of Resolution Management
Office of Policy and Compliance (08B)
810 Vermont Avenue NW
Washington, DC 20420

By Fax to: 202-501-(b) (6)
By Certified Mail Return Receipt Requested

Department of Veterans Affairs
Office of Employment Discrimination Complaint Adjudication
810 Vermont Avenue NW
Washington, DC 20420

By Certified Mail Return Receipt Requested

Department of Veterans Affairs
Office of the Inspector General
810 Vermont Avenue NW
Washington, DC 20420

By Certified Mail Return Receipt Requested

(b) (6)

Office of General Counsel
Personnel Law Group Attorney

By Email to: (b) (6)@va.gov

U.S. Postal Service – Case Manager Representative:

(b) (6)

EEO Specialist
U.S. Postal Service

By Email to: (b) (6)@usps.gov

This 19 day of November, 2018

(b) (6)

Complainant's Representative

(b) (6)

Fort George G. Meade

Cell (410) 858 (b) (6)

Fax (410) 874 (b) (6)

Email: (b) (6)@gmail.com

Owner: ADA ADVOCATE (b) (6) (b) (6) gmail.com>
Filename: #2 FAD OEDCA proof of mailing 2018-11-19 21.30.04-4.pdf
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810 Vermont Ave NW
Washington DC 20420

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<input type="checkbox"/> Adult Signature Restricted Delivery	\$

Postage	\$
Total Postage and Fees	\$

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810 Vermont Ave NW
Washington DC 20420

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[Redacted] MD Hq General
200 S 1st St
Baltimore MD 21202

PS Form 3800, August 2006

See Reverse for Instructions

CPU CRADLEROCK
6810 CRADLEROCK WAY STE A
COLUMBIA
MD
21045-4809
232090-5555
(800)275-8777
11/19/2018 8:41 PM

Product Description	Sale Qty	Final Price
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PM 1-Day	1	\$18.90
Lg Flat Rate		
Box		

(Domestic)
(WASHINGTON, DC 20420)
(Flat Rate)
(Expected Delivery Date)
(Wednesday 11/21/2018)

Certified	1	\$3.45
(@@USPS Certified Mail #)		
(70161970000096538989)		

Return	1	\$2.75
Receipt		
(@@USPS Return Receipt #)		
(9590940235377305792645)		

PM 1-Day	1	\$18.90
Lg Flat Rate		
Box		

(Domestic)
(WASHINGTON, DC 20420)
(Flat Rate)
(Expected Delivery Date)
(Wednesday 11/21/2018)

Certified	1	\$3.45
(@@USPS Certified Mail #)		
(70131090000168720355)		

Return	1	\$2.75
Receipt		
(@@USPS Return Receipt #)		
(9590940236097305191611)		

PM 1-Day	1	\$6.70
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Flat Rate Env
(Domestic)
(BALTIMORE, MD 21202)
(Flat Rate)
(Expected Delivery Date)
(Wednesday 11/21/2018)

Certified	1	\$3.45
(@@USPS Certified Mail #)		
(70131090000168720249)		

Return	1	\$2.75
Receipt		
(@@USPS Return Receipt #)		
(9590940236097305191710)		

Total	\$63.10
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Credit Card Remitd	\$63.10
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VA-18-0457-D-000079

4633

Scanned with CamScanner

Page 79 of 574

Owner: ADA ADVOCATE (b) (6) (b) (6) <(b) (6) gmail.com>
Filename: #3 (b) (6) (b) (6) -FAD-23 November 2018.pdf
Last Modified: Sun Nov 25 21:05:09 CST 2018



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF RESOLUTION MANAGEMENT
810 Vermont Avenue, NW
Washington, DC 20420

In reply refer to: 08

November 23, 2018

VIA: E-mail

Department of Veterans Affairs
Office of Employment Discrimination
Complaint Adjudication (00D)
810 Vermont Ave., NW
Washington, DC 20420

SUBJECT: Referral of Complaint for Final Agency Decision – [REDACTED]
Case Number VA-200C-0020-2018101982 , Filed February 28, 2018.

1. Enclosed is the investigative file pertaining to the above referenced complaint.
Please issue a Final Agency Decision (FAD).

2. We are referring this matter to your office for a FAD because:

The complainant expressly requested to withdraw his hearing request from EEOC and requested a FAD in writing. The complainant made this request on November 17, 2018.

3. We will notify you immediately if the matter is settled, if the complainant withdraws the complaint, if the complainant files a civil action that appears to raise some or all of the matters alleged in this complaint, or if we learn that the complainant requested a hearing without notifying us of that fact.

4. Questions concerning this referral should be directed to [REDACTED] Case Manager, at (202) 461-[REDACTED]. We have advised the complainant of this referral by copy of this letter.

Sincerely,

[REDACTED]

L. [REDACTED]
VACO District Manager

cc: [REDACTED]
[REDACTED]
Fort George G. Meade, MD 20755

Page 2
Referral of Complaint for Final Agency Decision

[REDACTED]
VA-200C-0020-2018101982

[REDACTED]

[REDACTED]

Fort George G. Meade, MD 20755

[REDACTED] Director, Office of Client Relations

[REDACTED] EEO Director

[REDACTED] EEO Specialist

Owner: ADA ADVOCATE (b) (6) (b) (6) gmail.com>
Filename: #6 19 June 2018 Request to update Records without VA and ORM involvement-3.
pdf
Last Modified: Sun Nov 25 21:05:09 CST 2018

19 June 2018

Subject: Notice of Amendment of the EEO complaint for (b) (6) EEO NO, VA -20DR-0020-2018 101982. **Request to update records.**

1. This is a **conflict of interest case** that was removed from ORM to the Post Office on 16 May 2018. Request the following:

- Remove case number VA-20 DR -0020 -2018 101 82
- Add the new case number: VA -20DR-0020-2018 101982
- Submitted the new case number in the system for tracking and as per VA Handbook 5977

2. Please update the contractor's Authorization Letter. David Shulkin, Secretary was fired by the Presidents months ago (**Exhibit 3**).

3. Please review the initial, "timely [certified mail] complaints" dated 22 Feb 2016 (**Exhibit 4**) and 17 May (**Exhibit 2**).

4. As per the conflict with ORM, (b) (6) (**Exhibit 7**), the initial timely 21 each claims reflect the event occurring from 16 Dec 2016 to 21 Feb (**Exhibit 4**). These claims were certified by mail and timely (**Exhibit 4**). These items should have been updated as promised (**Exhibit 7**). Instead, ORM, Mr. (b) (6) used his 4 each example/claims (**Exhibit 6**) instead of submitting my 21 timely claims (**Exhibit 4**). Therefore, and as per VA Handbook 5977, claims that show and pattern and support the initial claim can be added.

5. Please update ORM's counseling summary to reflect the facts. In the summary, it states that the complainant refused mediation (**Exhibit 8**). This is not a fact. This needs to be updated before it goes to district court. VA refused mediation (**Exhibit 10A-10C**). More specifically and according to VA Handbook should the aggrieved person reject an agency's offer of resolution, it may result in the limitation of the Agency's payment of attorneys or subject matter expert fees or cost.

6. Please change #3, of the 17 May, 2016 Notice of Acceptance letter (**Exhibit 11**) to reflect the truth. Not all nine items were accepted by the claimant (**See Exhibit 9B**). Line #3 states that the March 30, 2018 Notice of Acceptance letter submitted by ORM, (b) (6) (**Exhibit 9A**) contained 9 events occurring from November 2017 to February 21, 2018. ORM failed to update 30 March document (**Exhibit 9B**). Concerns were submitted via certified mail on 4 April (**Exhibit 9C**).

7. Issues in the formal process was mentioned to Ms A (b) (6) on 2 April (**Exhibit 9A-C**) and never updated or mentioned in any of the Notice of Acceptance letters or provided to the ORM investigators.

8. Please update the attached May 17, 2018 Notice of Acceptance Memorandum, paragraph #4 to read: We are in receipt of your **May 9, 2018 and May 16, 2018** [vs May 14, 2018] request. The claims were submitted on 16 May, 2018 the date the case was removed from ORM/VA due to conflict of interested (**Exhibit 1**). The concern is: this document specifically states the 9 claims were accepted. This is not a fact (**Exhibit 4 and 9C**). The event should start in 2016 when the harassment started as per 5977.

9. I challenge ORM's (b) (6) claim denial, in 17 May 2018, Notice of Amendment of the EEO Complaint (**Exhibit 11**). Please re-add paragraph #4 page 2, reference: (b) (6) *Lead Management Analyst, set limits on the mediation process by refusing to remove Complaint's letter of reprimand from his personnel records before the initial mediation.* This claim should have not been removed because ORM falsified information (**Exhibit 10**). Mediation is voluntary as per 5977. During the informal phase, Mediation never happened and No confidentiality agreement was ever signed (**Exhibit 10**). VA management refused to go to mediation (**Exhibit 10C**). However, the complainant agreed to media mediation (**Exhibit 10A**). Furthermore, This complaint is a retaliation claim for challenging (b) (6) Note: ORM (b) (6) update this document after it was removed from VA ORM. She did not make the correction/update 30 March Acceptance letters, nor did she update 17 May 2018 Acceptance letter, hence why this case CANNOT return to ORM and/or VA. This claim should have never been dismissed.

As per 5977, please add the following "claims that are "like" to the claim raised in the pending complaint:

10. On or about 16 May 2018, VA/ORM gave the Post Office Manager, 9 "outdated" claim and interfered with the EEO Process in retaliation (**Exhibit 1A**).

11. On or about 17 May 2018, ORM, (b) (6) falsified the Notice of Acceptance letter (**Exhibit 11**) in retaliation and after it was removed from VA/ORM.

12. On or about 4 June, 2018, (b) (6) willfully violated the ADA law by denying the complainant **administration leave** (**Exhibit A-A1**) and in retaliation. This was done after the EEO complaint was removed from VA/ORM due to conflict of interested.

13. On or about 11 June 2018 (b) (6) and (b) (6) R District RA Coordinator willfully violated the ADA law by denying the complainant Reasonable Accommodation **"no fault" leave** (**Exhibit B**) This was done in retaliation and in an effort to burn out FMLA sick and regular leave.

14. On or about 12 June 2018, (b) (6) and Chris (b) (6) violated the ADA law by denying the complainant **RA FMLA sick leave**. This was done in retaliation and in an effort to burn out **FMLA sick and regular leave** (**Exhibit J**).

15. On or about 12 June 2018, (b) (6) and (b) (6) violated the complainant's ADA rights by denying RA **advance sick leave**. This was done in retaliation and in an effort to burn out FMLA sick and regular leave.

16. On or about 13 June 2018, (b) (6) failed to contact complainant's doctor when he willfully denied his RA request. This was done maliciously with the intent to harm.

17. On or about 17 June 2018, (b) (6) and (b) (6) willfully violated the ADA law by ignoring a board certified doctor's advice. This was done maliciously with the intent to do further harm and against the doctor's restrictions.

18. On 19 June 2018 (1) (b) (6) and (3) (b) (6) willful violated the complaints ADA rights denying by denying his ADA representative to support him while setting him up to fail in the VA building vs telework from home.

19. On 19 June 2018, (1) (b) (6) and (3) (b) (6) violated the complainants ADA rights by failing to describe how the ineffective RA (1) was better than a board certified Doctor's Restrictions and how their RA caused undue hardship.

20. On or about 29 March to date, (b) (6) and (b) (6) willfully conspired to (1) run out the complainants FMLA sick, and regular leave in an effort to cause harm and against board certified doctors restriction. This was done maliciously and with the intent to harm.

(b) (5)

(b) (5)

Owner: ADA ADVOCATE (b) (6) (b) (6) gmail.com>
Filename: 1 md-110.pdf
Last Modified: Sun Nov 25 21:05:09 CST 2018



U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

**EQUAL EMPLOYMENT OPPORTUNITY
MANAGEMENT DIRECTIVE FOR
29 C.F.R. PART 1614 (EEO-MD-110),**

AS REVISED, AUGUST 5, 2015

August, 2015

EEO MD-110

Management Directive

ii

August, 2015**EEO MD-110**

**EQUAL EMPLOYMENT OPPORTUNITY COMMISSION
EQUAL EMPLOYMENT OPPORTUNITY
MANAGEMENT DIRECTIVE**

EEO MD-110**EFFECTIVE DATE: August, 5, 2015****TO THE HEADS OF FEDERAL AGENCIES**

1. **SUBJECT. FEDERAL SECTOR COMPLAINTS PROCESSING MANUAL**
2. **PURPOSE.** The purpose of this Directive is to provide federal agencies with Commission policies, procedures, and guidance relating to the processing of employment discrimination complaints governed by the Commission's regulations in 29 C.F.R. Part 1614. Federal agencies covered by 29 C.F.R. Part 1614 are responsible for developing and implementing their own equal employment programs, including alternative dispute resolution programs, and complaint processing procedures consistent with the Commission's regulations. It is the Commission's responsibility to direct and further the implementation of the policy of the government of the United States to provide equal opportunity in federal employment and to prohibit discrimination in employment because of race, color, religion, sex, national origin, age, disability, genetic information, or retaliation. Pursuant to its obligations and statutory authority, the Commission issues such rules, regulations, orders, and instructions including management directives, as it deems necessary and appropriate to carry out its responsibilities to communicate federal equal employment opportunity management policy, requirements, guidance and information to federal agencies. The Commission's instructions are directive in nature, and heads of federal agencies are responsible for prompt and effective compliance with Commission Management Directives and Bulletins. This complaint processing manual will ensure that agency personnel responsible for complaints processing are in possession of all current Commission guidance materials so that the Commission's policies, procedures, and regulations are consistently and uniformly applied government-wide. The manual consists of several chapters with subject headings identified in the table of contents. Some chapters are issued in connection with specific sections of the regulations. Other chapters include guidance and direction on topics, which we know from our experience processing complaints under previous regulations, are needed and are applicable to Part 1614. This manual will be supplemented by new and revised materials, as they are issued. The Commission's objective is for this manual to

Management Directive**iii**

VA-18-0457-D-000090

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August, 2015**EEO MD-110**

assist federal agency personnel in administering the discrimination complaint process.

3. **SUPERSESSION.** This directive supercedes EEO MD-110 issued November 9, 1999, and Management Bulletin MB-100-1, issued October 24, 2003.
4. **AUTHORITY.** This Directive is issued pursuant to EEOC's obligations and authority under section 717 of Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000e-16; section 501 and 505 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. §§ 791 and 794a; section 15 of the Age Discrimination in Employment Act of 1967, as amended, 29 U.S.C. §633a; section 6(d) of the Fair Labor Standards Act of 1938, as amended (the Equal Pay Act), 29 U.S.C. § 206(d); section 211 of the Genetic Information Nondiscrimination Act of 2008, 42 U.S.C. § 2000ff10; Reorganization Plan No. 1, 3 C.F.R. § 321(1078) and Executive Order 11478, 3 C.F.R. § 803 (1966-1970 Compilation) reprinted in 42 U.S.C. § 2000e note, issued in 1969 and 12106, 44 Fed. Reg. 1053 (1979).
5. **POLICY INTENT.** The policy objective of this Directive is to ensure that federal personnel responsible for processing employment discrimination complaints do so consistently and in accordance with the Commission's regulations set out at 29 C.F.R. Part 1614, and with the guidance, policies and procedures contained in this Directive and in the attached manual.
6. **APPLICABILITY AND SCOPE.** The provisions of this Directive apply to all federal agencies covered by 29 C.F.R. Part 1614.
7. **RESPONSIBILITIES.** Heads of federal agencies are responsible for ensuring that employment discrimination complaints are processed fairly, promptly, and in strict accordance with the complaint processing procedures set out in 29 C.F.R. Part 1614 and with the guidance incorporated in paragraph eight of this Directive. Since the Commission's guidance is binding in nature, federal agencies are required to comply with it.
8. **POLICIES AND PROCEDURES.** The Commission's specific policies, procedures and guidance related to the processing of federal sector employment discrimination are contained in this Complaints Processing Manual. All statements of guidance that the Commission approves become Commission guidance. Care has been taken to delineate any agency action that is suggested

Management Directive

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August, 2015

EEO MD-110

rather than required by Commission policy. All time frames stated here are in calendar days.

9. **INQUIRIES.** Unless otherwise specifically noted in the manual, further information concerning this Directive or guidance contained in the attached manual may be obtained by contacting:

Equal Employment Opportunity Commission
Office of Federal Operations
Federal Sector Programs
131 M. Street, N.E.
Washington, DC 20507
Telephone: (202) 663-4599

August 5, 2015
Date

s/Jenny R. Yang
Jenny R. Yang
Chair

Management Directive MD-110

Management Directive

v

VA-18-0457-D-000092

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August, 2015

EEO MD-110

PREAMBLE

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PREAMBLE

**HISTORY OF THE FEDERAL SECTOR
EQUAL EMPLOYMENT OPPORTUNITY COMPLAINT PROCESS**

This section examines the history of the federal sector equal employment opportunity (EEO) complaint process. It provides an overview of the historical authority that transferred the responsibility for the federal sector EEO process from the Civil Service Commission (CSC) to the Equal Employment Opportunity Commission (EEOC or the Commission).

I. HISTORICAL AUTHORITY

The Government first recognized a policy of nondiscrimination in federal employment during the 1940s. Specifically, in July 1948, President Harry S. Truman issued the first Executive Order to declare a policy of nondiscrimination in federal employment.¹ Executive Order 9980 prohibited discrimination in federal employment on the bases of race, color, religion, or national origin.² Executive Order No. 9980, 13 Fed. Reg. 4,311 (July 28, 1948). The Order designated the head of each department to be personally responsible for insuring that employment decisions were based “solely on merit and fitness,” and it required the head of each department to designate a Fair Employment Officer to appraise department personnel actions, receive discrimination complaints, and take necessary corrective or disciplinary action. *Id.* The Fair Employment Officer’s decisions were appealable to the head of the department. *Id.* Executive Order 9980 also established a Fair Employment Board (FEB) in the CSC to advise department heads on issues related to fair employment, disseminate information relevant to fair employment programs, and coordinate department programs. *Id.* The FEB was authorized “to review decisions made by the head of any department which are appealed . . . or referred to the Board by the head of the department for advice, and to make recommendations to such head.” *Id.*

President Dwight D. Eisenhower carried forward the Government’s nondiscrimination policy when he issued Executive Order 10590, which superseded Executive Order 9980. Executive Order No. 10590, 20 Fed. Reg. 409 (Jan. 19, 1955). The Order required each department or agency head to establish procedures to provide a complainant with a fair hearing and the opportunity to appeal their case. *Id.* Executive Order 10590 re-designated the Fair Employment Officer as an Employment Policy Officer and abolished the FEB, replacing it with the

¹ In 1941, President Franklin D. Roosevelt signed Executive Order 8802, which prohibited government contractors from engaging in employment discrimination based on race, creed, color, or national origin. Executive Order No. 8802, 6 Fed. Reg. 3,109 (June 27, 1941).

² President Truman concurrently issued Executive Order 9981, which ordered desegregation of the U.S. Armed Forces. Executive Order No. 9981, 13 Fed. Reg. 4,313 (July 26, 1948).

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President's Committee on Government Employment Policy. Id. The Committee's authority was limited, however, to reviewing cases and rendering advisory opinions to the agency or department heads before issuance of a final agency action. Id.

In March 1961, President John F. Kennedy issued Executive Order 10925, which amended Executive Order 10590. Executive Order 10925 replaced the President's Committee on Government Employment Policy with the President's Committee on Equal Employment Opportunity.³ Executive Order No. 10925, 26 Fed. Reg. 1,977 (Mar. 8, 1961). The Order charged this new committee with studying federal employment practices and recommending additional steps to fully achieve the policy of nondiscrimination. Id. The Committee was empowered with the authority to impose sanctions for violations of the Executive Order. Id.

In September 1965, President Lyndon B. Johnson issued Executive Order 11246, which superseded Executive Order 10590 but retained the prohibition on discrimination in federal employment on the bases of race, color, creed, or national origin. Executive Order No. 11246, 30 Fed. Reg. 12,319 (Sept. 28, 1965). Notably, Executive Order 11246 returned appellate review of final agency actions to the CSC and authorized the CSC to issue regulations and orders necessary to carry out its responsibilities.⁴ Id. The Order required each department and agency head to comply with the CSC's procedures, and to establish and maintain a positive program of equal employment opportunity. Id.

In August 1969, President Richard Nixon further amended Executive Order 11246 by issuing Executive Order 11478, which required department and agency heads to "establish and maintain an affirmative program of equal employment opportunity for all civilian employees and applicants for employment." Executive Order No. 11478, 34 Fed. Reg. 12,985 (Aug. 12, 1969). President Nixon tasked the CSC with reviewing and evaluating agency programs. Id. Executive Order 11478 also required agencies to "provide access to counseling for employees who feel aggrieved and . . . encourage the resolution of employee problems on an informal basis." Id.

By 1970, despite the issuance of numerous Executive Orders addressing nondiscrimination, employment discrimination remained a significant problem in the federal government. Legislative History of the Equal Employment Opportunity Act of 1972 (U.S. Government Printing Office, Washington, D.C., H.R. 1746, Pub. L. No. 92-261, 1972 at p. 1728 [hereinafter: Legislative History (1972)]). Congress did not find the administrative procedures established by

³ Executive Order 10925 also added "creed" as a prohibited basis of discrimination and prohibited federal government contractors from discriminating on account of race. Executive Order No. 10925, 26 Fed. Reg. 1977 (Mar. 8, 1961).

⁴ Executive Order 11246 also imposed nondiscrimination requirements on contractors and subcontractors as a condition of doing business with the federal government. Executive Order No. 11246, 30 Fed. Reg. 12,319 (Sept. 28, 1965).

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the CSC to be effective. Id. at 82. The CSC rarely reversed agency decisions and was criticized for failing to address systemic discrimination. Id. at 82-84. In addition, testimony presented to Congress suggested that federal employees had little faith in the complaint process and often feared retaliation for challenging discriminatory employment practices. Id. at 83. Furthermore, Congress “found that inadequate remedies existed to make aggrieved persons whole,” including the unavailability of back pay as an administrative remedy and procedural obstacles potentially limiting the ability of federal employees to bring claims against the federal government, such as sovereign immunity. Id. As a result, Congress passed the Equal Employment Opportunity Act of 1972, which amended Title VII to extend its coverage to include federal employees while retaining the CSC’s role in the administrative process.⁵ Id. Additionally, Congress passed the Rehabilitation Act of 1973, which prohibited the federal government from discriminating against qualified individuals with disabilities and required federal agencies to establish affirmative action programs to provide greater employment opportunities for individuals with disabilities. Rehabilitation Act of 1973, Pub. L. No. 93-112, 87 Stat. 355 (1973).

Despite the passage of the Equal Employment Opportunity Act and the Rehabilitation Act, there were still several problems with the federal complaint/appeals process. The CSC’s procedural regulations were viewed as fundamentally biased against complainants, and the complaint process itself was difficult for individual complainants to navigate. U.S. Department of Labor, Civil Rights Center, To Eliminate Employment Discrimination (1975)). Furthermore, by the 1970s, seventeen federal agencies and departments were responsible for enforcing forty different nondiscrimination statutes and executive orders. EEOC History: 35th Anniversary: 1965 – 2000: The Law, <http://www.eeoc.gov/eeoc/history/35th/thelaw/index.html>. As a result, in 1978, President Jimmy Carter submitted two reorganization plans to Congress to eliminate duplication and conflict by placing the responsibility for coordinating all federal EEO programs exclusively with the Commission. Reorganization Plan No. 1 of 1978, 43 Fed. Reg. 19,807 (May 5, 1978); Reorganization Plan No. 2 of 1978, 43 Fed. Reg. 36,037 (Aug. 15, 1978).

President Carter issued Executive Order 12067 to implement Reorganization Plan No. 1 and transfer the functions of the Equal Employment Opportunity Coordinating Council (EEOCC) to the EEOC. Executive Order No. 12067, 43 Fed. Reg. 28,967 (Jan. 3, 1979). Executive Order 12067 delineated the Commission’s responsibility for “develop[ing] uniform standards, guidelines, and policies” for promoting and furthering equal employment opportunity without regard to race, color, religion, sex, national origin, age, or handicap. Id. Executive Order 12067 required department and agency heads to comply with the Commission’s final rules, regulations, policies, procedures, and orders. Id.

⁵ In 1974, Congress amended the Equal Pay Act (EPA) and Age Discrimination in Employment Act (ADEA) to extend coverage to the federal sector. P. Law No. 93-259, 88 Stat. 58 & 88 Stat. 74 (Apr. 8, 1974). Initially, the CSC was responsible for the enforcement of the EPA and the ADEA with respect to the federal sector. Id.

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After President Carter submitted his Reorganization Plans to Congress in 1978, Congress passed the Civil Service Reform Act of 1978, which abolished the CSC and distributed its functions primarily among three agencies: the EEOC; a newly established Office of Personnel Management (OPM); and the Merit Systems Protection Board (MSPB), which replaced the CSC. Civil Service Reform Act of 1978, Pub. L. No. 95-454, 92 Stat 1111 (1978). The Reorganization Plan gave the Commission responsibility over the hearings and appeals functions for certain cases involving employment discrimination. *Id.* In December 1978, President Carter issued Executive Order 12106, which transferred additional CSC functions to the Commission and amended Executive Order 11478 by adding disability and age as protected bases. Executive Order No. 12106, 44 Fed. Reg. 1,053 (Jan. 3, 1979). President Carter also issued Executive Orders 12107 implementing the Civil Service Reform Act of 1978 and Reorganization Plan No. 2. Executive Order No. 12107, 44 Fed. Reg. 1,055 (Jan. 3, 1979). In June 1979, President Carter signed Executive Order 12144, which transferred certain equal pay and age discrimination enforcement functions to the Commission. Executive Order No. 12144, 44 Fed. Reg. 37,193 (June 26, 1979).

II. The Late 1970s-1980

Prior to the Commission obtaining authority over the federal sector EEO process, the CSC had authority to issue regulations and orders with respect to the processing of federal sector EEO complaints. As a result of Executive Order 11246, the CSC issued its initial regulations pertaining to complaint processing at 5 C.F.R. Part 1613, effective April 3, 1966. 5 C.F.R. Part 713 *et seq.* These regulations provided time frames for filing complaints, required agency investigations, a hearing by an agency panel or an agency appointed hearing officer, a final decision by the agency head or a designee, and a process allowing complainants to file appeals with the CSC's Board of Appeals and Review. *Id.* After President Johnson issued Executive Order 11375, in October 1967, which prohibited discrimination in federal employment on the basis of sex, the CSC amended its regulations to require that sex discrimination complaints be processed the same as other EEO complaints. Fed. Reg. 15,631 (Nov. 10, 1967). In 1969, the CSC revised its regulations. Significant changes to the regulations included: complainants were required to participate in informal counseling prior to filing a formal complaint, and complaints examiners were prohibited from being employees of the respondent agency. *Id.* The CSC subsequently amended its regulations several times between 1972 and 1979.

When the Commission gained authority over the CSC's functions regarding federal sector employment discrimination in 1979, it decided to keep the existing process in place until a detailed study could be completed. EEOC Adoption and Amendment of Civil Service Commission Federal Employee Discrimination Complaint Regulations, 43 Fed. Reg. 60,900 (Dec. 29, 1978). Thus, the Commission adopted the CSC regulations with only minor technical changes. 43 Fed. Reg. 60,900 (Dec. 29, 1978). The regulations were moved from 5 C.F.R. Part 713 and re-designated at 29 C.F.R. Part 1613, effective Jan. 1, 1979. *Id.* at 60,901.

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In the early 1980s, the Commission amended its regulations with respect to the issue of remedies for complainants alleging discrimination in violation of the Rehabilitation Act. Specifically, in October 1981, the Commission amended its regulations to authorize back pay to applicants for federal employment who successfully proved disability discrimination in order to comply with the 1978 amendments to the Rehabilitation Act of 1973. Complaints of Handicap Discrimination in the Federal Government, 46 Fed. Reg. 51,384 (Oct. 20, 1981). The 1978 amendments provided that prevailing complainants of disability discrimination were entitled to the same remedies as those provided under Title VII. Id. The Commission's amendments deleted the provision in the regulations prohibiting back pay awards to applicants aggrieved by disability discrimination. Id.

During the mid-1980s, the Commission significantly revised its regulations governing the processing of federal sector complaints. Initially, the regulations were amended in 1985, to provide for a special panel to resolve conflicts between the MSPB and the Commission. EEOC and Merit Systems Protection Board Regulations for Special Panel Proceedings, 50 Fed. Reg. 53,897 (Dec. 27, 1985). Subpart D, "Processing Mixed Case Complaints," was amended to provide for a means to refer cases to a special panel, the organization of the special panel, and the procedures of the panel. Id. Subsequently, the Commission revised its regulations, effective November 30, 1987. 1987 Revisions to Federal Employee Discrimination Complaint Procedures, 52 Fed. Reg. 41,920 (Oct. 30, 1987). The revised regulations encompassed numerous changes including providing additional grounds for dismissing complaints, as well as providing a right of appeal for complainants alleging breach of a settlement agreement. Id. In addition, the Commission in 1987 renamed complaints examiners "Administrative Judges" (effective March 30, 1987) in order to "reflect more accurately the nature of the position." Nomenclature Change to Federal Employee Discrimination Complaint Procedures, 52 Fed. Reg. 10,085 (Mar. 30, 1987).

III. THE 1990s TO THE PRESENT

The 1990s also represented a time of significant change to the Commission's regulations governing the processing of federal sector complaints. The Commission issued revised regulations effective October 1, 1992. 57 Fed. Reg. 12,634 (Apr. 10, 1992). These revisions moved the regulations from 29 C.F.R. Part 1613 to 29 C.F.R. Part 1614. Id. Part 1614 was organized differently than the prior version of the regulations. Id. Specifically, Part 1613 contained separate subparts for each type of complaint (Title VII complaints, age complaints, mixed case complaints, etc.). Part 1614 consolidated the procedures as much as possible in an effort to avoid repetition. Id. One noteworthy change encompassed in the 1992 revisions was extending the time limit to contact an EEO Counselor from 30 days to 45 days. Id. at 12,635.

Pursuant to the recommendations of a Federal Sector Workgroup, comprised of representatives from various offices throughout the EEOC, the Commission revised its regulations again in 1999, effective November 9, 1999. 1999 Revisions to EEOC Federal Employee Discrimination

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Complaint Procedures, 64 Fed. Reg. 37,644 (July 12, 1999)(codified at 29 C.F.R. Part 1614). Some of the significant changes to the regulations included: a requirement that agencies establish an alternative dispute resolution program, providing additional grounds for dismissal, providing Commission Administrative Judges with the authority to dismiss complaints, and making Administrative Judge decisions final decisions without potential agency modification. Id. at 37,644-37,645; 37,650. In addition, the revised regulations implemented changes to the provisions governing class complaints to ensure that complaints “raising class claims are not unjustifiably denied class certification and are resolved under the appropriate legal standards consistent” with the federal courts. Id. at 37,651. Moreover, the Commission issued guidance regarding its new regulations in EEO Management Directive-110 (MD-110) (Nov. 9, 1999).

In 1992, Congress amended Section 501 of the Rehabilitation Act to adopt the employment nondiscrimination standards of the Americans with Disabilities Act (ADA). 67 Fed. Reg. 35,732 (May 21, 2002). Effective June 20, 2002, the Commission deleted from its regulations the text of its old Section 501 regulation, at 29 C.F.R. § 1614.203. Id. The new text of § 1614.203 provides, in pertinent part, that the standards used to determine whether Section 501 of the Rehabilitation Act has been violated in a complaint alleging employment discrimination shall be the standards applied under the ADA. 67 Fed. Reg. 35,735 (May 21, 2002).

In an effort to clarify its procedures on mixed case complaints, the Commission issued EEO Management Bulletin 100-1 (EEO MB 100-1) on October 24, 2003. This bulletin advises agencies to delete from their copies of EEO MD-110 Section II.B.4.d in Chapter 4. EEO-MB 100-1 (Oct. 24, 2003). This section advised agency representatives to file a motion with an MSPB Administrative Judge to consolidate matters that were not within their jurisdiction with matters that were properly before the MSPB Administrative Judge. Id. The MSPB notified the Commission that this section was improper because it constituted a request for an MSPB Administrative Judge to hear matters that may not be within the jurisdiction of the MSPB. Id.

In 2004, the process that led to the current regulatory revisions began when the Commission created a workgroup to develop consensus recommendations from the Commissioners for improvements to the federal sector EEO complaint process. The workgroup considered a number of items including testimony and submissions from a November 12, 2002, Commission meeting on federal sector reform, staff proposals, and submissions from internal and external stakeholders including the National Employment Lawyers Association and the Commission’s union. The workgroup determined that while there was no consensus among the Commissioners for large-scale revision of the federal sector EEO process, there was agreement on several discrete changes to the existing regulations that would clarify or build on the 1999 Part 1614 revisions.

Based on the workgroup’s recommendations, a Notice of Proposed Rulemaking (NPRM) was drafted that amended certain sections of 29 C.F.R. 1614. The Commission approved the draft NPRM on June 2, 2008, circulated it to federal agencies on June 4, 2008, pursuant to Executive Order 12067, and gave agencies two months to submit comments. Thirty-three (33) agencies or

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agency components submitted comments. After coordination with the Office of Management and Budget (OMB) and the commenting agencies, the Commission formally submitted the draft NPRM to OMB for review under Executive Order 12866 on July 27, 2009.

The Commission approved the NPRM on December 9, 2009, and published it in the Federal Register on December 21, 2009. The Commission received 35 public comments: 14 from federal agencies; 6 from individuals; 5 from civil rights groups; 5 from members of the bar; and 5 from unions or other groups. The Commission issued the Final Rule, with public comments discussed in the preamble, on July 25, 2012.

The final rule contains a number of key revisions to 29 C.F.R. Part 1614:

- As part of the Commission's authority to review agency programs for compliance with Commission directives and guidelines that promote equal employment opportunity in the federal workplace, the Commission can issue notices to agencies when non-compliance is found and not corrected.
- Agencies can seek approval from the Commission to conduct pilot projects in which the complaint processing procedures vary from the requirements of Part 1614.
- A complaint that alleges that a proposal or preliminary step to taking a personnel action is discriminatory can be dismissed, unless the complainant alleges that the proposal is retaliatory.
- An agency that has not completed its investigation in a timely manner must inform the complainant in writing that the investigation is not complete, provide an estimated date of completion, and remind the complainant that s/he has a current right to request a hearing or file a lawsuit.
- An Administrative Judge's decision on the merits of a class complaint is a final decision, rather than a recommended decision, which an agency can implement or appeal.
- Agencies must submit appeals and complaint files to the Commission in a digital format, unless they can establish good cause for not doing so. Complainants are encouraged to submit digital filings.

The rule also required that the Commission provide guidance regarding the changes made by the final rule and continue to assess the federal sector EEO complaint process with a view to further improvements.

The Commission is now in the process of considering more significant changes to the federal sector complaint process than those issued in the Final Rule adopted in 2012. An Advanced Notice of Proposed Rulemaking (ANPRM) was issued in Feb. 2015 asking federal agencies,

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employees and the public to consider how the Commission's federal sector complaint process currently works and whether wholesale revisions to the process are needed. The Commission received approximately 100 comments in response. After review of those comments, the Commission intends to issue a NPRM to amend the 1614 regulations. A final revised 1614 regulation may incorporate changes to the processing of complaints and therefore to MD-110. Nonetheless, because the 2012 Final Rule is already in effect and there is a need to provide agencies with guidance on how to implement important changes made in that rule, the Commission believes it is necessary to issue this revised MD-110.

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August, 2015**EEO MD-110****CHAPTER 1****U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION AND AGENCY
AUTHORITY AND RESPONSIBILITY****I. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION**

The Equal Employment Opportunity Commission (the Commission) enforces five federal laws that prohibit employment discrimination against applicants for federal employment, current federal employees, or former federal employees: [Title VII of the Civil Rights Act of 1964, as amended](#) (prohibiting discrimination on the basis of race, color, religion, sex, or national origin); the [Equal Pay Act of 1963](#) (prohibiting agencies from paying different wages to men and women performing equal work in the same work place); the [Age Discrimination in Employment Act of 1967, as amended](#) (prohibiting discrimination against persons age 40 or older); [Sections 501 and 505 of the Rehabilitation Act of 1973, as amended](#) (prohibiting discrimination on the basis of disability); and [Title II of the Genetic Information Nondiscrimination Act of 2008](#) (prohibiting discrimination based on genetic information).

The Commission provides leadership and guidance to federal agencies on all aspects of the federal government's equal employment opportunity program. The Commission ensures federal agency and department compliance with Commission regulations, provides technical assistance to federal agencies concerning EEO complaint adjudication, monitors and evaluates federal agencies' affirmative employment programs, develops and distributes federal sector educational materials and conducts training for stakeholders, provides guidance and assistance to our Administrative Judges who conduct hearings on EEO complaints, and adjudicates appeals from administrative decisions made by federal agencies on EEO complaints.

To carry out these duties, the Commission is authorized to issue rules, regulations, orders, and instructions governing the federal sector pursuant to Section 717(b) of Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e-16(b); Section 15(b) of the Age Discrimination in Employment Act of 1967, 29 U.S.C. § 633a(b); Section 505(a)(1) of the Rehabilitation Act of 1973, 29 U.S.C. § 794a(a)(1); the Genetic Information Nondiscrimination Act of 2008, 42 U.S.C. § 2000ff10; the Fair Labor Standards Act, 29 U.S.C. § 201 *et seq.*; Section 303 of the Notification and Federal Employee Antidiscrimination and Retaliation Act of 2002 (No FEAR Act), Pub. L. No. 107-174; Executive Order 12067, 43 Fed. Reg. 28,967 (June 30, 1978); and Executive Order 11478, 34 Fed. Reg. 12,985 (Aug. 8, 1969), *as amended* by Executive Order 12106 (Dec. 28, 1978). It is pursuant to these authorities that the Commission issues this Management Directive.

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In furtherance of its mission, to stop and remedy unlawful employment discrimination, the Commission will from time to time review agency programs and provide guidance regarding whether they are in compliance with the Commission's rules, regulations, orders, management directives, management bulletins, and any other instructions issued by the Commission. See 29 C.F.R. § 1614.102(e). It is the intent of the Commission to assist agencies in perfecting their EEO programs and to avoid or rectify any deficiencies in their programs that prevent them from reaching the statutory mandate of being model workplaces free from unlawful discrimination.

II. FEDERAL AGENCY

In this Management Directive the term

“Federal Agency” or **“Agency,”** refers to military departments as defined in 5 U.S.C. § 102, executive agencies as defined in 5 U.S.C. § 105, the U.S. Postal Service, the Postal Regulatory Commission, the Tennessee Valley Authority, the National Oceanic and Atmospheric Administration Commissioned Corps, the Government Printing Office (except for complaints under the Rehabilitation Act), and the Smithsonian Institution. See 29 C.F.R. § 1614.103(b). The term also may include such other agencies, administrations, or bureaus (sub-components) as may be established within the above-listed that are given the authority to establish a separate unit tasked with implementing an agency program consistent with the requirements of 29 C.F.R. § 1614.102.

Federal agencies are required by statute not to engage in discrimination on the bases of race, color, religion, sex, national origin, age, disability, genetic information, or retaliation. They are also responsible for providing any reasonable accommodations throughout the EEO process for the aggrieved/complainant. A federal employee, former employee, or job applicant who believes s/he was discriminated against has a right to file a complaint with the agency's office responsible for its EEO programs. Federal agencies must offer pre-complaint counseling or EEO alternative dispute resolution (EEO ADR) to individuals who allege that they were discriminated against by the agency. If pre-complaint counseling or EEO ADR does not resolve the dispute(s), the individual can file a formal discrimination complaint with the agency's EEO office. The agency may dismiss the complaint for certain procedural reasons or conduct an investigation. At the conclusion of the investigation, the agency will issue a notice that provides the complainant with the option of either requesting a hearing before a Commission Administrative Judge or having the agency issue a final agency decision. The final agency action can be appealed to the Commission, or the complainant may file a civil action in a U.S. District Court. The authority the agency has to investigate and resolve complaints of discrimination stems from the statutory obligation that states that federal

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agencies have the primary responsibility to ensure nondiscrimination in employment. 42 U.S.C. § 2000e-16(e).

In this Management Directive, the term

“Final Agency Action” refers to an agency’s last and final action on a complaint of employment discrimination. The final agency action may be in the form of a final agency decision, a final agency order implementing an Administrative Judge’s decision, or a final determination on a breach of settlement agreement claim.

“Final Agency Decision” refers to a decision on a complaint of discrimination made by the agency, without an Administrative Judge, that is appealable to the Commission. It includes agency decisions to dismiss or agency decisions on the merits.

“Final Agency Order” refers to a decision by an agency to implement or not implement an Administrative Judge’s decision, which is appealable to the Commission. Where the agency’s final order does not fully implement the Administrative Judge’s decision, the agency must simultaneously appeal to the Commission.

“Final Agency Determination” refers to an agency determination as to whether there was a breach of a settlement agreement that is appealable to the Commission.

In light of the significant responsibility agencies have for ensuring the integrity of the EEO process, agency programs must comply with the rules, regulations, orders, and instructions issued by the Commission to ensure that complaints of employment discrimination are resolved fairly and quickly. 29 C.F.R. § 1614.102(e) clearly sets forth both the authority of the Commission over the federal sector EEO programs and the duty of federal agencies to maintain EEO programs in a manner consistent with the mandatory directives of the Commission.

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III. EEO DIRECTOR'S INDEPENDENT AUTHORITY AND REPORTING RELATIONSHIPS

In this Management Directive the term

“EEO Director” - refers to the Director of the Office of Equal Employment Opportunity, Director of Civil Rights, EEO Officer, or any other title used for the position that is responsible for carrying out the responsibilities set forth in 29 C.F.R. § 1614.102(c).

A. Federal Agencies Must Appoint an EEO Director Who Shall Be Responsible for - See 29 C.F.R. § 1614.102(c):

1. implementing continuing affirmative employment programs to promote equal employment opportunity, see 29 C.F.R. § 1614.102(c)(1), and Commission issued Directives and Guidance (such as MD-715 and its Instructions) for specific information;
2. identifying and eliminating discriminatory employment practices and policies, including the counseling of individuals and the fair and impartial investigations of complaints; and
3. advising the agency head on matters related to equal employment opportunity.

B. The EEO Director Must Report Directly to the Agency Head

To ensure that federal agencies achieve their goal of being a model workplace, all managers and employees must view/consider equal employment opportunity as an integral part of the agency's strategic mission. Commission regulations require that the EEO Director “be under the immediate supervision of the agency head.” 29 C.F.R. § 1614.102(b)(4). The purpose of this requirement is to ensure that the EEO Director has the access and authority to ensure that the agency truly considers the elimination of workplace discrimination to be a fundamental aspect of the agency's mission.

Where such sub-components are authorized, the EEO Director shall be under the immediate supervision of the head of the sub-component. The sub-component EEO Director may, in the alternative, report to either the EEO Director of the parent organization or to the head of the parent organization.

In order to maintain and exercise the independent authority required of the position, the EEO Director cannot be placed under the supervision of the agency's Chief Human Capital Officer or other officials responsible for executing and

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advising on personnel actions or providing the agency with a legal defense to claims of discrimination, such as the Office of General Counsel.

By placing the EEO Director under the immediate supervision of the head of the agency, the agency underscores the importance of equal employment opportunity to the mission of each federal agency and ensures that the EEO Director is able to act with the greatest degree of independence.

This unfettered relationship allows the agency head to have a clear understanding of EEO factors when making organizational decisions. Placing the EEO Director under the authority of others within the agency may undermine the EEO Director's independence, especially where the person or entity to which the EEO Director reports is involved in, or would be affected by, the actions of the EEO Director in the performance of his/her implementation of the agency program set forth in 29 C.F.R. § 1614.102.

IV. AVOIDING CONFLICTS OF INTEREST

Federal agencies have a unique role to play in ensuring equal employment opportunity. First, every agency head has a statutory obligation to eradicate unlawful employment discrimination that may occur within the agency. This anti-discrimination responsibility is what requires federal agencies to administer a fair and impartial investigative process designed to determine the validity of complaints, as well as to employ affirmative efforts to root out discrimination and ensure equal employment opportunity. The agency head designates the Director of the Office responsible for the agency's EEO programs to carry out this obligation.

At the same time, the agency head has a fiduciary obligation to defend the agency against legal challenges brought against it (agency defensive function), including charges of discrimination. The agency head designates the General Counsel of the agency (or an agency representative) to carry out this obligation.

In this Management Directive, the term

“Agency Representative” refers to any or all agency employees, (for example Defense Counsel, agency counsel, or legal representative), whose job duties include defending the agency's personnel policies and/or actions. The term is not limited to attorneys employed in an agency's Office of General Counsel or Office of Legal Counsel. The term also includes attorneys in the Office of Human Capital and non-attorney employees whose job duties include defending the agency's personnel policies and/or actions, for example, labor relations specialists.

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Some may view the agency's investigative process as inherently biased because the agency accused of discrimination is the same agency that is charged with administering the EEO investigative process. Nevertheless, the statute requires that an agency comply with rules, regulations, orders and instructions which shall include the issuance of a "final action" on a complaint of discrimination, and Commission regulations establish a comprehensive system through which agencies must issue these final agency actions. Moreover, as the Commission's regulations make clear, and as this management directive reinforces, a federal agency head is obligated to protect both the integrity of the agency's EEO process and the legal interests of the agency.

It is important to reiterate that prior to the issuance of the final agency action, the agency is responsible for the fair, impartial processing and resolution of complaints of employment discrimination. Because the agency carries this responsibility of impartially processing discrimination complaints, conflicts of interest can arise when agency representatives in offices, programs, or divisions within the agency with a legal defensive role play a part in the impartial processing. This does not mean that any involvement in the EEO process by the Office of General Counsel or Office of Human Capital automatically creates a potential conflict, but instead refers to impermissible involvement in the EEO process by those employees or units of employees designated to represent the agency in adversarial proceedings. See [Complainant v. Dep't. of Defense](#), EEOC Appeal No. 0120084008 (June 6, 2014) (finding that an agency representative should not interfere with the development of the EEO investigative record by "us[ing] the power of its office to intimidate a complainant or her witnesses"); see also [Rucker v. Dep't. of the Treasury](#), EEOC Appeal No. 0120082225 (Feb. 4, 2011) (stating an agency "should be careful to avoid even the appearance that it is interfering with the EEO process."

While the information in the following sections illustrates the conflicts that may compromise the integrity of the impartial EEO complaint process, it is not intended to imply that agency representatives are a negative influence on the process. Many agency representatives provide meaningful contributions to the EEO in the workplace by educating managers and employees, consulting senior leaders with lessons learned from workplace disputes, and seeking to protect the agency by advising leadership to end a discriminatory practice as soon as it becomes apparent. This section focuses on the narrow occasions where the intersection of responsibilities creates a conflict affecting the impartiality of the complaint process.

A. Separation of EEO Complaint Program from the Agency's Personnel Function

The EEO complaint program is an integral part of the agency's "affirmative program to promote equal opportunity and to identify and eliminate discriminatory practices and policies." See 29 C.F.R. § 1614.102(a). To carry out this function in an impartial manner, the agency's personnel function must be kept separate from the EEO complaint process. The same agency official(s) responsible for executing and advising on personnel actions may not also be responsible for managing, advising, or overseeing the EEO pre-complaint or

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complaint processes. The EEO processes often scrutinize and challenge the motivations and impacts of personnel actions and decisions. In order to maintain the integrity of the EEO investigative and decision-making processes, those EEO functions must be kept separate from the personnel function.

B. Complaints That Present Potential Conflicts of Interest

1. When the Alleged Responsible Management Official Is the Head of the Agency

A conflict of interest may exist when the responsible management official alleged to have engaged in discriminatory conduct is the agency head or a member of the immediate staff of the agency head, or occupies a high-level position of influence in the agency. Real or perceived conflict may occur as a result of the undue influence that the high-level official may have over the EEO Director and other involved agency personnel. Whether this conflict is real or presents the appearance of a conflict, the matter must be addressed through procedures designed to safeguard the integrity of the EEO complaint process. For example, when an EEO complaint alleges that the agency head or a member of his/her immediate staff has engaged in discrimination, the agency head should recuse himself/herself from the decision-making process, and engage an official outside his/her chain of command to issue a final action on the case. Agencies with questions regarding unique conflict issues may contact the Office of Federal Operations (OFO) for additional guidance.

2. When the Alleged Responsible Management Official Is the EEO Director or Supervisor in the EEO Office

If an employee wishes to file a complaint alleging discrimination by the EEO Director or another supervisor in the EEO office, a real or perceived conflict may exist because the interests of the responding official would challenge the objectivity or perceived objectivity of the EEO office. This matter must be addressed through procedures designed to safeguard the integrity of the EEO complaint process. For example, when an EEO complaint alleges that the EEO Director or a member of his/her immediate staff discriminated, the EEO Director shall recuse himself/herself and retain a third party to conduct the counseling, and investigation and draft the final agency decision for the agency head to issue.

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C. Agencies Must Avoid Conflicts of Interest in Processing Complaints

Agencies are required to develop an impartial factual record in accordance with the instructions contained in this Management Directive. See 29 C.F.R. § 1614.108(b). Therefore, agencies must develop procedures for investigating complaints in which it is perceived that the EEO office would have an actual or perceived conflict of interest. In developing an impartial record where a conflict of interest or the appearance of a conflict exists, agencies should consider the following:

1. Formal or Informal Arrangements

Agencies should consider whether the EEO program would be best served by entering into a formal contract with a third party or whether an informal arrangement with a third party would suffice. When establishing a formal contract, many agencies enter into interagency agreements with other agencies to handle one or more of the stages in the EEO process. See Appendix A for a sample Interagency Agreement. Other agencies have developed informal arrangements with a third party, whereby the third party provides EEO services on an as-needed basis.

Agencies should consider the best source from which to obtain a third party. Agencies have reported using private contractors, parallel sub-components within a department or agency, and other federal agencies. The Commission does not endorse any particular type of third party over any other. However, agencies should ensure that the third party adheres to the applicable requirements established in this Management Directive.

2. Stages of the EEO Process

Agencies should assess the stages of the EEO complaint process at which the assistance of a third party would be most effective. Many agencies assign a third party the responsibility of providing counseling, administering EEO ADR, conducting the investigation, and/or writing the accept/dismiss letter and/or the final agency action. Pursuant to 29 C.F.R. § 1614.110(a), the agency is responsible for issuing a final order either fully implementing an Administrative Judge's decision or not fully implementing and appealing the Administrative Judge's decision; pursuant to 29 C.F.R. § 1614.110(b), the agency is responsible for taking final action by issuing a final agency decision (FAD). Although the agency must issue the final action, it may assign a third party to write the final action and review the final action before issuance.

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August, 2015**EEO MD-110****D. Separation of EEO Complaint Program from Agency's Defensive Function**

Heads of agencies must manage the dual obligations of carrying out fair and impartial investigations of complaints that result in final agency determinations as to whether discrimination has occurred and defending the agency against claims of employment discrimination. Only through the vigilant separation of the investigative and defensive functions can this inherent tension be managed.

Ensuring a clear separation between the agency's EEO complaint program and the agency's defensive function is thus the essential underpinning of a fair and impartial investigation, enhancing the credibility of the EEO office and the integrity of the EEO complaints process.

There must be a firewall between the EEO function and the agency's defensive function. The firewall will ensure that actions taken by the agency to protect itself from legal liability will not negatively influence or affect the agency's process for determining whether discrimination has occurred and, if such discrimination did occur, for remedying it at the earliest stage possible.

It is important for the EEO Director to be provided with sufficient legal resources (either directly or through contracts) so that the legal analyses necessary for reaching final agency decisions can be made within the autonomous EEO office.

At a minimum, however, the agency representative in EEO complaints may not conduct legal sufficiency reviews of EEO matters. Legal sufficiency reviews in the EEO process involve legal analysis made by the EEO office during the processing of EEO complaints, such as acceptance/dismissal of complaints, legal theories utilized by the EEO office during investigations, and legal determinations made in final agency actions. The optimal situation is for the EEO office to have sufficient internal legal resources. However, when necessary and requested by the EEO office, legal sufficiency reviews conducted outside the EEO office must be handled by individuals that are separate and apart from the agency's defensive function.

Similarly, impartiality or the appearance of impartiality is not ensured by simply rotating agency representatives within the same office and is undermined where the agency representative's associates are assigned the legal sufficiency function in EEO cases from the representative's caseload.

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V. DELEGATION OF AUTHORITY TO RESOLVE DISPUTES

The agency must designate an individual to attend settlement discussions convened by a Commission Administrative Judge or to participate in EEO alternative dispute resolution (ADR) attempts. Agencies should include an official with settlement authority during all settlement discussions and at all EEO ADR meetings (Note: The agency's official with settlement authority should not be the responsible management official or agency official directly involved in the case. This is not a general prohibition on those officials from being present at appropriate settlement discussions and participating, only that they are not the officials with the settlement authority.) The probability of achieving resolution of a dispute improves significantly if the designated agency official has the authority to agree immediately to a resolution reached between the parties. If an official with settlement authority is not present at the settlement or EEO ADR negotiations, such official must be immediately accessible to the agency representative during settlement discussions or EEO ADR.

VI. EEO OFFICIALS CANNOT SERVE AS REPRESENTATIVES

EEO officials must have the confidence of the agency and its employees. It is inconsistent with their neutral roles for EEO Counselors, EEO Investigators, EEO Program Managers, or EEO Directors to represent agencies or complainants in the EEO complaint process. Therefore, persons in these positions cannot serve as representatives for complainants or for agencies in connection with the processing of discrimination complaints. See 29 C.F.R. § 1614.605(c) (disqualification of representatives for conflict of duties).

VII. SPECIAL EMPHASIS PROGRAM

The head of the agency shall designate an Equal Employment Opportunity Officer(s) and such Special Emphasis Program Managers, clerical, and administrative support as may be necessary to carry out the functions described in Part 1614 in all organizational units of the agency and at all agency installations. 29 C.F.R. § 1614.102(b)(4).

Special Emphasis Program Managers should include managers of the Program for Employees with Disabilities, the Federal Women's Program, the Hispanic Employment Program and such other programs as may be required by the Office of Personnel Management or the particular agency.

An agency head may delegate authority under this part to one or more designees. 29 C.F.R. § 1614.607.

VIII. AGENCY STATISTICAL REPORTING REQUIREMENTS FOR THE COMPLAINT PROCESS

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August, 2015**EEO MD-110****A. Annual Federal Equal Employment Opportunity Statistical Report of Discrimination Complaints**

The Commission requires each covered agency to use EEOC Form 462, Annual Federal Equal Employment Opportunity Statistical Report of Discrimination Complaints, to provide an annual report of the status of all pre-complaints and formal complaints processed under its EEO complaints program. See 29 C.F.R. § 1614.602(a). The Commission annually provides detailed instructions for reporting the data in an EEOC Form 462 User's Instruction Manual located on the Guidance page of the Commission's electronic document submission portal.

B. Quarterly and Fiscal Year EEO Complaint Statistics Required by Title III of the No FEAR Act

Pursuant to 29 C.F.R. § 1614.703, agencies are required to post cumulative quarterly and fiscal year EEO complaint statistics, titled "Equal Employment Opportunity Data Posted Pursuant to Title III of the Notification and Federal Employee Antidiscrimination and Retaliation Act of 2002 (No FEAR Act), Pub. L. No. 107-174," on the home page of the agency's public website. Agencies should provide a hyperlink to the statistical data entitled "No FEAR Act Data." Section 1614.704 of 29 C.F.R. sets forth the list of statistical data the agency must post. Additional information regarding No FEAR Act posting is found at <http://www.eeoc.gov/federal/directives/index.cfm>.

C. Annual Report to Congress, the Commission and the U.S. Attorney General Required by Title II of the No FEAR Act

Title II of the No FEAR Act of 2002 requires each federal agency to submit to Congress, the Commission and the Attorney General an annual report that includes the agency's fiscal year Equal Employment Opportunity complaint statistics among other requirements. More information on the No FEAR Act annual report requirements can be found in [5 C.F.R. §§ 724.301-302](#). All No FEAR Act reports should be sent to:

Chair of the Equal Employment Opportunity Commission
c/o Office of Federal Operations
Attention: No FEAR Act Report Coordinator
P.O. Box 77960
Washington, DC 20013

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No FEAR Act reports may soon also be submitted electronically through the Commission's electronic document submission portal.

Other Commission reporting requirements are set forth in Management Directive 715 issued in October 2003 which is located on the Commission's website at <http://www.eeoc.gov/federal/directives/md715.cfm>.

IX. PROGRAM REVIEW PROCEDURES FOR COMPLIANCE

Agency programs will be reviewed for compliance with Commission rules, regulations, orders, Management Directives, Management Bulletins, or any other instructions issued by the Commission. Due to the variation in the requirements set forth in the above issuances the method of review may vary, depending on the requirement(s) at issue. A review may result from multiple sources: 1) monitoring agency submissions including complaint files, plans, and reports; 2) monitoring correspondence and news media for reports of agency action or non-action indicative of compliant or noncompliant activity; 3) requesting information directly from the agency; and 4) on-site visits or virtual conferences.

Pursuant to 29 C.F.R. § 1614.102(e), in cases where any of an agency's EEO programs or activities are found not to be in compliance with a Commission issuance, the agency will be notified of such non-compliance, and the agency will be given the opportunity to respond to the Commission. The agency's response should contain a statement of the agency's compliance, a plan to bring the program or activity into compliance, or a justification as to why the agency will not comply. Failure to respond or an inadequate agency response will result in escalation to the next step in this process.

A. Notice to Agency of Non-Compliance

In cases where noncompliance is discovered, the agency EEO Director or responsible Program Manager will be notified in writing of the noncompliance. The notice will include:

- 1) the requirement with which the Commission believes that the agency is not in compliance and the source of that requirement;
- 2) a statement explaining how the Commission became aware of the noncompliance;
- 3) a statement as to how the agency is not in compliance and the basis for that conclusion;

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- 4) a stated reasonable period of time to cure the noncompliance with recommended actions; and
- 5) a stated reasonable period of time in which the agency may establish that it is, in fact, in compliance or a stated reasonable period of time to establish a justification for the noncompliance.

B. Written Notice to Head of Federal Agency

The Chair of the Commission may issue a notice to the head of the agency whose program is noncompliant when an agency head fails to be responsive and/or where efforts to assist the agency in reaching compliance through the steps set forth in Section IX.A. The notice to the agency head will include:

- 1) the compliance requirement with which the Commission believes the agency is not complying and the source of that compliance requirement;
- 2) a statement explaining how the Commission became aware of the noncompliance;
- 3) the efforts undertaken by the Commission's Office of Federal Operations to obtain compliance;
- 4) the agency response to the Commission's efforts; and
- 5) a stated period of time within which the agency head must respond with a plan to bring the program into compliance.

C. Public Notification of Non-Compliance

Where the head of the agency fails to respond timely and in good faith with a plan that the Director of Federal Operations believes is sufficient to bring the agency program into compliance, the Chair of the Commission will publically identify the noncompliant agency and the factual bases surrounding the noncompliance.

1. The Chair will evaluate the repercussions and reach of the effect of the noncompliance on equal employment opportunity and publish or publically identify the fact of noncompliance in a manner reflective of the reach and severity of the harm.

2. Public identification may occur by using, among other means, publication in the Annual Report to Congress, a press release, posting some form of notice of noncompliance on the Commission's public website, or any other means the Chair deems appropriate.

X. PILOT PROJECTS

Unless prohibited by law or executive order, the Commission, in its discretion and for good cause shown, may grant agencies prospective variances from the complaint processing procedures prescribed in 29 C.F.R. Part 1614. Variances will permit agencies to conduct pilot projects of proposed changes to the complaint processing requirements of 29 C.F.R. Part 1614 that may later be made permanent through regulatory change. See 29 C.F.R. § 1614.102(f).

A. Request for Pilot Authority

Agencies requesting variances must submit in writing a request for pilot authority. In its written request, the agency requesting a variance must:

1. identify the specific section(s) of 29 C.F.R. Part 1614 from which it wishes to deviate and provide a summary description of what it proposes to do instead;
2. provide information clearly defining the stages in the pilot project and how matters will progress to completion within the pilot project;
3. explain the expected benefits and expected effect on the EEO complaints process of the proposed pilot project;
4. certify that the pilot project will ensure fairness and neutrality with the ultimate goal of achieving equality of employment opportunity;
5. state how the agency intends to maintain an adequate record for a potential hearing or appeal;
6. submit information demonstrating the agency's current status of operating within regulatory guidelines for complaint processing (information should include EEO Form 462 timeliness indicators, Management Directive 715 self-assessment, and any third-party evaluations, such as Commission program evaluations, Office of Inspector General evaluation reports, or Government Accountability Office reports);
7. provide a written description of the knowing and voluntary opt-in provision for participants;

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8. indicate the proposed duration of the pilot project;
9. describe the method to be used to inform agency employees and applicants of the pilot project; and
10. explain the method by which it intends to evaluate the success of the pilot project on an interim basis and at the completion of the pilot project, including identification of well-defined, clear, and measurable objectives and their connection to program objectives, the criteria for determining pilot project performance, a way to isolate the effects of the pilot project, and how data will be collected for evaluation purposes.

B. Process for Submitting, Reviewing, and Approving Pilot Projects

The Commission will annually review and evaluate requests for pilot authority. Agencies should submit their request electronically at the end of the second quarter of the fiscal year, and the Commission will make its determination by the end of the third quarter. All approved pilot projects will begin at the beginning of the next fiscal year and terminate not more than 24 months later, unless extended (see below). The process for approval of pilot authority follows:

1. The Commission announces the opening period of the request for pilot authority at the end of the second quarter of the fiscal year (March 31).
2. Agencies submit requests to the Office of Federal Operations by April 15.
3. The Office of Federal Operations reviews requests and makes recommendations (completed by May 15).
4. The Office of Federal Operations submits requests and recommendations to the Commission by May 15.
5. The Commission review, including a briefing period regarding the requests for variances and recommendations from the Office of Federal Operations, will be completed within 30 days (or by June 15).
6. The Commission votes on approval of requests for pilot authorities.
7. The Office of Federal Operations sends Commission determinations to proposing agencies.
8. Pilot projects must begin the first day of the next fiscal year (October 1).

9. The 24-month maximum time frame for pilot projects will permit agencies to accept complaints into the pilot projects for up to 24 months and allow agencies a reasonable amount of time to conclude the processing of those complaints.
10. Agencies administering pilot projects must submit quarterly reports to the Office of Federal Operations with information on the total complainants opting into the pilot project, the average age of complaints with the pilot project, and updated pilot project evaluation data. See Section X.A.10 of this Chapter.
11. Agencies administering pilot projects must submit a final evaluation report at the conclusion of the pilot project. The report must provide a detailed evaluation of the results of the pilot project and be submitted to the Commission within 90 days of the conclusion of the pilot project.

Variances will not be granted for individual cases and will usually not be granted for more than 24 months. The Director of the Office of Federal Operations for good cause shown may grant requests for extensions of variances for up to an additional 12 months. Additionally, the Director of the Office of Federal Operations may terminate an agency's pilot authority if the agency fails to comply with the requirements of the variance. Prior to termination of the pilot authority, the Director of the Office of Federal Operations will send a notice to the agency requesting information on compliance with the variance provisions.

Electronic submission of pilot authority requests must be made using email transmission of all documents to federalsectoreeo@eeoc.gov or through the Commission's electronic document submission portal.

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CHAPTER 2

EQUAL EMPLOYMENT OPPORTUNITY PRE-COMPLAINT PROCESSING

I. INTRODUCTION

A. Counseling Generally¹

The EEO process begins when a person who believes s/he has been aggrieved meets with an EEO Counselor.² For further information on coverage under the statutes, [see Section 2.III.A.1 in “Threshold Issues” of the Commission’s Compliance Manual.](#)

In this Management Directive, the term

“EEO Counselor” refers to any agency or contracted employee who, serving as a neutral, provides an aggrieved individual with his/her rights and obligations under equal employment opportunity laws, gathers limited data and may attempt an informal resolution where ADR is not offered or accepted, pursuant to 29 C.F.R. § 1614.

The EEO Counselor provides vital information regarding the EEO process and other processes that may be available to the aggrieved individual, gathers basic information regarding the matter(s) from the aggrieved individual, and attempts to informally resolve the matter(s) if the matter does not go to the alternative dispute resolution program. The EEO Counselor plays a vital role in ensuring prompt and efficient processing of the formal complaint. This section of the Management Directive provides Commission guidance and procedures that EEO Counselors should follow when presented with individual and class claims of discrimination.

¹ Please note: there is no pre-counseling phase of the 29 C.F.R. § 1614 process.

² The Commission consistently has held that a person may satisfy the criterion of EEO Counselor contact by initiating contact with any agency official logically connected with the EEO process, even if that official is not an EEO Counselor, and by exhibiting an intent to begin the EEO process. [See Hyman v. Dep’t. of the Navy](#), EEOC Appeal No. 0120100060 (May 26, 2011); [Martell v. Dep’t. of Commerce](#), EEOC Appeal No. 0120110980 (Dec. 21, 2000); [Lodge v. Social Security Administration](#), EEOC Appeal No. 0120110847 (May 12, 2011).

All **time periods** set out in this Management Directive are stated in calendar days unless otherwise indicated. The first day counted is the day after the event from which the time period begins to run and the last day of the period shall be included unless it falls on a Saturday or Sunday or federal holiday, in which case the period shall be extended to include the next business day. All time periods are subject to waiver, estoppel, and equitable tolling. See the [Commission's Compliance Manual](#), "Threshold Issues" 915-003, Section 2-IV Timeliness for further information.

B. Full-Time EEO Counselors

Agencies should use full-time EEO Counselors whenever possible. If an agency must rely on EEO Counselors for whom EEO counseling is a collateral-duty, agencies should consider the following best practices: (1) include a timeliness component in the performance plan of the collateral-duty EEO Counselors; (2) implement an agency policy to remove collateral duties from EEO Counselors for tardiness or inferior work product; and (3) provide incentives for good performance by using on-the-spot awards, letters to supervisors, and awards presentations.³ The Commission also expects agencies to use the step-by-step guide at Appendix B to develop or refine its own counseling procedures.

C. EEO Counselor Training Requirements

Continuing education and training for employees working in federal sector EEO is vitally important to promoting the goals and objectives of equal employment opportunity. This Chapter establishes mandatory training requirements for EEO Counselors. See Section II below for mandatory training requirements.

D. EEO Counseling and Investigations

An EEO Counselor, whether agency or contracted, may not serve as an investigator in a dispute in which s/he provided counseling to the aggrieved person. The EEO Counselor's role is to provide an environment for open dialogue leading to an informal resolution prior to the filing of a complaint. The role is compromised if the EEO Counselor also serves as an investigator of the complaint, as the role of the investigator is that of a neutral fact finder who

³For more information, please review the Commission's report "[Attaining a Model Agency Program: Efficiency](#)" (2004).

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collects and discovers factual information concerning the claim(s) in the complaint under investigation and prepares an investigative summary.

The Commission also discourages agencies from allowing an EEO Counselor to act as an investigator in a different dispute. Combining the roles of EEO Counselor and investigator (even with regard to different disputes) can create a perception of bias and potentially confuse individuals with regard to the purpose of the counseling process. Therefore, the Commission recommends against using EEO Counselors as investigators, except as a last resort.

E. EEO Counseling and EEO ADR

Both EEO alternative dispute resolution (ADR) and EEO counseling are essential to the prompt resolution of claims of discrimination. The opportunity for informal resolution is important. EEO ADR is a term used to describe a variety of approaches to resolving conflict that differ from traditional adjudicatory methods or adversarial methods. EEO ADR provides a means of improving the efficiency of the federal EEO complaint process by attempting early and informal resolution of EEO disputes without the filing of a complaint.

When an aggrieved person seeks pre-complaint counseling, the EEO Counselor must fully inform the individual of:

1. how the agency EEO ADR program works;
2. the opportunity to participate in the program where the agency agrees to offer EEO ADR in a particular case; and
3. the right to file a formal complaint if EEO ADR does not achieve a resolution.

See Chapter 3 of this Management Directive for more detailed EEO ADR information.

II. MANDATORY EEO COUNSELOR TRAINING REQUIREMENTS

A. Minimum Requirements

To ensure quality counseling throughout the federal sector, the Commission requires that new EEO Counselors, including contract and collateral-duty EEO Counselors, receive a minimum of thirty-two (32) hours of EEO Counselor

training prior to assuming counseling duties. In addition to the training for new EEO Counselors, all EEO Counselors are required to receive at least eight (8) hours of continuing EEO Counselor training each fiscal year.

The Commission has developed training courses to satisfy these minimum requirements, and it offers them to agencies through the Commission's Revolving Fund Program on a fee-for-service basis.⁴ Agencies may also develop their own courses to satisfy this requirement as long as the training meets the minimum standards set forth by the Commission.

B. Minimum Standards for Thirty-Two-Hour Training Course

New EEO Counselors must receive at a minimum, training in the following areas before an agency assigns them to provide EEO counseling to aggrieved persons:

1. an overview of the entire EEO process set forth under 29 C.F.R. Part 1614, emphasizing important time frames in the EEO process, providing an overview of counseling class complaints, and analyzing fragmentation issues (see Chapter 5, Section III of this Management Directive for a discussion of fragmentation);
2. a review of the roles and responsibilities of an EEO Counselor, as described in this Chapter and in the appendices to this Management Directive;
3. an overview of the statutes that the Commission enforces, including [Title VII of the Civil Rights Act of 1964, as amended](#) (prohibiting discrimination on the basis of race, color, religion, sex, or national origin); the [Equal Pay Act of 1963](#) (prohibiting agencies from paying different wages to men and women performing equal work in the same work place); the [Age Discrimination in Employment Act of 1967, as amended](#) (prohibiting discrimination against persons age 40 or older); [Sections 501 and 505 of the Rehabilitation Act of 1973, as amended](#) (prohibiting discrimination against people with disabilities); and [Title II of the Genetic Information Nondiscrimination Act of 2008](#) (prohibiting discrimination based on genetic information);
4. an explanation of the theories of discrimination, including the disparate treatment, adverse impact, and reasonable accommodation theories, and

⁴ For more information about EEOC training courses, visit the Commission's website at <http://www.eeoc.gov/federal/training/index.cfm>.

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providing more detailed instructions concerning class actions and issues attendant to fragmentation;

5. a review of the practical development of issues through role-playing or other practices designed to have attendees practice providing EEO counseling, including the initial intake session with an aggrieved person, identifying claims, writing reports, and attempting resolution;
6. a review of other procedures available to aggrieved persons: the right to go directly to court under the Age Discrimination in Employment Act after notice to the Commission; mixed case processing issues, including the right of election; class complaints processing issues; and the negotiated grievance procedure, including the right of election;
7. an overview of the remedies available for each law, such as compensatory damages, attorney's fees, and costs available to prevailing parties; and
8. an overview of the agency's informal and formal EEO ADR processes.

C. Standards for Continuing Training Requirements

Once new EEO Counselors complete the minimum requirements, they must receive a minimum of eight hours of continuing EEO counseling training during every fiscal year thereafter. The purpose of this continuing training requirement is to keep EEO Counselors informed of developments in EEO practice, law, and guidance, as well as to enhance and develop their counseling skills. Accordingly, agencies should conduct a needs assessment to determine specific areas for training. The Commission anticipates that this training will include segments on legal and policy updates, regulatory and statutory changes, counseling skills development, and EEO ADR program updates.

III. THE ROLES AND RESPONSIBILITIES OF AN EEO COUNSELOR

When an aggrieved individual seeks EEO counseling, the EEO Counselor begins their role of educator and must ensure that the aggrieved individual understands his/her rights and responsibilities in the EEO process, including the option to participate in EEO ADR. The EEO Counselor will also perform the roles of information gatherer, and facilitator, and possibly translator, messenger, and suggestion maker as set forth below. The EEO Counselor must perform several tasks in all cases, regardless of whether the aggrieved individual ultimately participates in EEO ADR, including:

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1. Advise the aggrieved individual about the EEO complaint process under 29 C.F.R. Part 1614. The EEO Counselor should explain the reasonable accommodations available throughout the EEO process. The EEO Counselor should explain the agency EEO ADR program, stating that the program is available to the aggrieved individual or advising whether the program will be made available. The EEO Counselor should further explain that if the EEO ADR program is available, the aggrieved individual will have to decide whether to seek pre-complaint resolution through the EEO ADR process or through the traditional EEO counseling process. In this regard, the EEO Counselor should inform the aggrieved individual about the differences between the two processes. (Educator)
2. Determine the claim(s) and basis(es) raised by the aggrieved individual. (Information gatherer)
3. Conduct a limited inquiry during the initial interview with the aggrieved individual for the purpose of determining jurisdictional questions. This includes determining whether there may be issues relating to the timeliness of the individual's EEO Counselor contact and obtaining information relating to this issue. It also includes obtaining enough information concerning the claim(s) and basis(es) so as to enable the agency to properly identify the legal claim raised if the individual files a complaint at the conclusion of the EEO counseling process. (Information gatherer)

Use of the term "initial interview" in this context is not intended to suggest that during the first meeting with the aggrieved person an EEO Counselor must obtain all of the information s/he needs to determine the claim(s) or basis(es). Nor does it mean that if the aggrieved individual decides to participate in EEO ADR, the EEO Counselor is prevented from contacting them to obtain such additional information as s/he needs for this specific purpose.

4. Seek a resolution of the dispute at the lowest possible level, unless the agency offers EEO ADR and the aggrieved individual agrees to participate in the EEO ADR program. If the dispute is resolved in counseling, the EEO Counselor must document the resolution. (Facilitator, translator, messenger, and suggestion maker)
5. Advise the aggrieved individual of his/her right to file a formal discrimination complaint if attempts to resolve the dispute through EEO counseling or EEO ADR are unsuccessful. (Educator)

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6. Prepare a report sufficient to document that the EEO Counselor undertook the required counseling actions and to resolve any jurisdictional questions that arise. (Report Writer)
7. Advise the aggrieved person that their identity will not be revealed unless the aggrieved person authorizes them to reveal it or they file a formal complaint with the agency. (Educator)

The Commission has developed a guide for EEO counseling that agencies may use in developing or refining their own procedures. (See Appendix B of this Management Directive).

IV. INITIAL INTERVIEW SESSION

A. Provide Required Written Notice

At the initial session or as soon as possible thereafter, the EEO Counselor must provide all aggrieved individuals written notice of their rights and responsibilities. 29 C.F.R. § 1614.105(b). The Commission has set forth this information in the “EEO Counselor Checklist,” in Appendix C of this Management Directive.

B. Provide Information on Other Procedures as Required

Depending upon the facts and circumstances of the case, an aggrieved person may have options other than the Part 1614 procedure available in pursuit of a discrimination claim. The individual, in some cases, may have to elect the process s/he wishes to pursue. Election options apply in age discrimination complaints, mixed case complaints, Equal Pay Act complaints, and claims where certain negotiated grievance procedures apply. In addition, procedures may be available through the Office of Special Counsel. As such, EEO Counselors must be familiar with these procedures and be able to identify such cases when the aggrieved person first seeks counseling. See Appendices D and E of this Management Directive.⁵

⁵ See Chapter 4, Section II, of this Management Directive, for additional guidance on the election process applicable to mixed case complaints.

C. Explain Statutes and Regulations

EEO Counselors must have a good working knowledge of the complaint processing regulations in Part 1614 and a sufficient familiarity with federal anti-discrimination statutes, regulations and Commission guidance that will enable them to identify bases and claims correctly. These statutes are:

1. [Title VII of the Civil Rights Act of 1964, as amended](#)

Title VII prohibits discrimination based on race, color, religion, sex, and national origin. It also prohibits reprisal or retaliation for participating in the discrimination complaint process or for opposing any employment practice that the individual reasonably and in good faith believes violates Title VII.

Title VII's prohibition against sex discrimination includes discrimination on the basis of pregnancy, sexual orientation and gender identity including transgender status.

A claim of discrimination based on sexual orientation is inherently a claim of sex discrimination. [Baldwin v. Dep't. of Transportation](#), EEOC Appeal No. 0120133080 (July 15, 2015). A claim of discrimination based on gender identity or transgender status is also a claim of sex discrimination. [Macy v. Dep't. of Justice](#), EEOC Appeal No. 0120120821 (Apr. 20, 2012). EEO Offices should therefore process such complaints under 29 C.F.R. Part 1614 as claims of sex discrimination, unless complainant specifically requests to use a different process. For additional information, see [Addressing Sexual Orientation and Gender Identity Discrimination in Federal Civilian Employment](#)

2. [Age Discrimination in Employment Act of 1967, as amended \(ADEA\)](#)

The ADEA prohibits discrimination in employment on the basis of age (40 years or older). It also prohibits retaliation against individuals exercising their rights under the statute. Unlike Title VII and the Rehabilitation Act, the ADEA allows persons claiming age discrimination to go directly to court, after giving the Commission 30 days' notice of the intent to file such an action, without utilizing an agency's administrative complaint procedures. If, however, an individual chooses to file an administrative complaint, s/he must exhaust administrative remedies before proceeding to court. As with Title VII complaints, a complainant exhausts administrative remedies 180 days after filing a formal complaint, if the

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agency has not taken a final action, or 180 days after filing an appeal with the Commission if the Commission has not issued a decision.

3. [Rehabilitation Act of 1973, as amended](#)

The Rehabilitation Act prohibits discrimination on the basis of mental and physical disabilities, as well as retaliation for exercising rights under the Act. The Rehabilitation Act requires that agencies make reasonable accommodations to the known physical or mental limitations of an applicant or qualified employee with a disability unless the agency can demonstrate that the accommodations would impose an undue hardship on the operation of its program. (Congress amended the Rehabilitation Act of 1973 in October 1992 to provide that the standards used to determine whether non-affirmative action employment discrimination has occurred shall be the standards applied under [Title I of the Americans with Disabilities Act](#). See § 503(b) of the Rehabilitation Act Amendments of 1992, Pub. L. No. 102-569, 106 Stat 4344 (Oct. 29, 1992); 29 U.S.C. § 791(g).) (Congress amended the Rehabilitation Act again when it issued the [Americans with Disabilities Act Amendments Act of 2008](#).) This statute broadly interprets the definition of disability by adding “major bodily functions” as a major life activity and by directing that the determination of whether an impairment substantially limits a major life activity should be determined based on the impairment’s effect in its active state (for impairments that are episodic or in remission) and should be determined without taking into account the ameliorative effects of mitigating measures, such as medication.

4. [Equal Pay Act of 1963 \(EPA\)](#)

The EPA prohibits sex-based wage discrimination. It prohibits federal agencies from paying employees of one sex lower wages than those of the opposite sex for performing substantially equal work. Substantially equal work means that the jobs require equal skills, effort, and responsibility, and that the jobs are performed under similar working conditions.⁶ The EPA also prohibits retaliation for exercising rights under the Act.

5. [Lilly Ledbetter Fair Pay Act of 2009](#)

⁶Sex-based claims of wage discrimination may also be raised under Title VII; individuals so aggrieved may thus claim violations of both statutes simultaneously. EPA complaints are processed under Part 1614. In the alternative, an EPA complainant may go directly to a court of competent jurisdiction on the EPA claim.

The [Lilly Ledbetter Fair Pay Act of 2009](#) amended Title VII of the Civil Rights Act of 1964 to provide that an individual subjected to compensation discrimination under Title VII, the Age Discrimination in Employment Act of 1967, or the Americans with Disabilities Act of 1990 may file a complaint within forty-five (45) days of any of the following:

- a. When a discriminatory compensation decision or other discriminatory practice affecting compensation is adopted;
- b. When the individual becomes subject to a discriminatory compensation decision or other discriminatory practice affecting compensation; or
- c. When the individual's compensation is affected by the application of a discriminatory compensation decision or other discriminatory practice, including each time the individual receives compensation that is based in whole or in part on such compensation decision or other practice.

The Act also has a retroactive effective date of May 28, 2007, and applies to all claims of discriminatory compensation pending on or after that date.

6. [Genetic Information Nondiscrimination Act of 2008 \(GINA\)](#)

GINA prohibits discrimination by federal agencies based on an individual's genetic information, which includes the results of genetic tests to determine whether the individual is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. Specifically, the law prohibits the use of genetic information in making employment decisions, restricts the acquisition of genetic information by federal agencies, imposes strict confidentiality requirements, and prohibits retaliation against individuals who oppose actions made unlawful by GINA. The remedies available under GINA are the same as those available under Title VII and the Rehabilitation Act.

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7. [Commission Regulations, Guidelines, and Policy Directives](#)

The Commission has issued regulations that address the application of federal nondiscrimination law to the federal government. The regulations governing the processing of federal sector discrimination complaints are contained in Title 29 of the Code of Federal Regulations (C.F.R.), Part 1614. The regulations set out the EEO Counselor's obligations enumerated in Section II of this Chapter.

Other Commission regulations and guidelines address the substantive provisions of federal nondiscrimination law. For example, 29 C.F.R. Part 1630 sets forth Commission regulations applicable to the Rehabilitation Act. EEO Counselors should be familiar with Part 1630 in order to counsel individuals who present claims of disability discrimination.⁷ The Commission also has disseminated enforcement guidance on discrete issues and areas of nondiscrimination law, such as "[Enforcement Guidance: Vicarious Employer Liability for Unlawful Harassment by Supervisors](#)," issued June 18, 1999, and "[Revised Enforcement Guidance on Reasonable Accommodation and Undue Hardship under the Americans with Disabilities Act](#)," issued October 17, 2002. These documents and other Enforcement Guidance are available on the Commission's website at http://www.eeoc.gov/laws/guidance/enforcement_guidance.cfm in the Enforcement Guidance and Related Documents section.

⁷ The Commission has issued guidelines covering all of the substantive bases of prohibited discrimination. EEO Counselors should be familiar with 29 C.F.R. Part 1604 (Guidelines on Sex Discrimination) and Appendix to Part 1604 (Questions and Answers on the Pregnancy Discrimination Act); Part 1605 (Guidelines on Religious Discrimination); Part 1606 (Guidelines on National Origin Discrimination); Part 1620 (The Equal Pay Act); Part 1625 (the Age Discrimination in Employment Act); and Part 1635 (Guidelines on the Genetic Information Nondiscrimination Act).

V. THE LIMITED INQUIRY

Once the EEO Counselor has determined the basis(es) and claim(s) adhering to the guidance set forth below, s/he should conduct a limited inquiry. Prior to any resolution attempts, a limited inquiry should be conducted in all counseling. The purpose of the limited inquiry is to obtain information to determine jurisdictional questions if a formal complaint is filed and is performed regardless of whether the aggrieved person subsequently chooses EEO ADR. The limited inquiry also is used to obtain information for settlement purposes if the person chooses EEO counseling over EEO ADR, or does not have the right to choose between EEO counseling and EEO ADR, for example where the agency has specified in its written EEO ADR procedures that the matter is inappropriate for EEO ADR. For further information, see Chapter 3 Section III.C of this Management Directive.

While the scope of the inquiry will vary based on the complexity of the claims, the inquiry is intended to be limited and is not intended to substitute for the in-depth fact-finding required in the investigative stage of formal complaint process. The EEO Counselor must at all times control the inquiry. If the aggrieved person or agency personnel raise objections to the scope or nature of the inquiry, the EEO Counselor shall seek guidance and assistance from the EEO Director. If the EEO Counselor has problems with the inquiry, s/he should immediately notify the EEO Director.

Appendix B includes suggested methods for conducting the inquiry. This guidance may be used to supplement established procedures.

A. Determining the Claim(s)**1. Fragmentation**

The EEO Counselor plays a crucial role in the complaint process. As discussed in more detail in Chapter 5, Section III of this Management Directive, EEO Counselors must assist the aggrieved individual in articulating the claim so as to avoid fragmenting the claim. EEO Counselors must review the materials set forth in Section III of Chapter 5 and become familiar with the concept of fragmentation.

2. Identifying the claim(s)

At the initial interview, the EEO Counselor must determine what action(s) the agency has taken or is taking that causes the aggrieved person to believe s/he is the victim of discrimination. Before the EEO Counselor begins the inquiry, s/he must be certain that the claim(s) are clearly

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defined and the aggrieved person agrees with how the agency defines the claim(s). The EEO Counselor must also determine, based on his/her understanding of the claims, whether special procedures apply. For further information about special procedures, see Chapter 4 of this Management Directive.

If a claim is like or related to a previously filed complaint, then the complaint should be amended to include that claim when the agency can complete the development of an impartial and appropriate factual record within 360 days of when the original complaint was filed. If the claim is not like or related to a previously filed complaint, or where an impartial and appropriate record cannot be developed within 360 days of when the original complaint was filed, the claim should be processed as a separate complaint. Commission regulations require agencies to consolidate complaints for processing unless it is impossible to do so. See 29 C.F.R. § 1614.606. In a process set forth in Chapter 5, Section III.B of this Management Directive, a complainant shall be instructed to submit a letter to the agency's EEO Director or designee, describing the new incident(s) and stating that s/he wishes to amend his/her complaint to include the new incident(s). The EEO Director or designee shall review the request and determine the correct handling of the amendment in an expeditious manner.

B. Determining the Basis(es)

The aggrieved person must believe s/he has been discriminated against on the basis of race, color, sex (includes pregnancy, equal pay, gender identity, and sexual orientation) when discrimination based on, religion, national origin, age (40 and over), disability, genetic information, or in retaliation for having participated in activity protected by the various civil rights statutes. The EEO Counselor should determine if the aggrieved person believes that his/her problem is the result of discrimination on one or more of the bases.

C. When the Basis(es) Is Not Covered by the EEO Laws

If it is clear that the aggrieved person's problem does not involve a basis(es) set forth in the Commission's laws and regulations, the EEO Counselor should inform the aggrieved person and, if possible, provide him/her with the appropriate process for addressing the matter. If the aggrieved person insists that s/he wants to file a discrimination complaint, the EEO Counselor should conduct a final interview and issue the Notice of Right to File a Discrimination Complaint.

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Under no circumstance should the EEO Counselor attempt to dissuade a person from filing a complaint.

VI. RESOLUTION

In almost all instances, informal resolution with an EEO Counselor, freely arrived at by all parties involved in the dispute, is the best outcome of a counseling action. In seeking resolution, the EEO Counselor must listen to and understand the viewpoint of both parties so that s/he is able to assist the parties in achieving resolution. The EEO Counselor's role is to facilitate resolution, not develop, or advocate specific terms of an agreement. The EEO Counselor must be careful not to inject his/her views on settlement negotiations.⁸

Appendix C includes suggested methods for seeking resolution. This guidance may be used to supplement established agency procedures.

A. Extension of Counseling for Resolution Efforts

When the aggrieved individual and an EEO Counselor engage in resolution efforts, they may decide that they need additional time to reach an agreement. If the aggrieved person consents, the EEO office may extend the counseling period an additional period up to but not exceeding 60 days. See 29 C.F.R. § 1614.105(e).

B. Resolution of the Dispute

If, during the course of the limited inquiry, the agency and the aggrieved person agree to an informal resolution of the dispute, the terms of the resolution must be reduced to writing, clearly identify the claims resolved, and be signed by both parties⁹ to help ensure they have the same understanding of the terms of the resolution. See 29 C.F.R. § 1614.603. The Commission recommends that the EEO Counselor, with the knowledge and guidance of the EEO Director, set forth the terms as agreed to by the parties (agency and the aggrieved individual) of the informal resolution in a settlement transmitted to the parties. The letter should

⁸ As noted in Appendix C, at point "B," the EEO Counselor acts as a neutral and not as an advocate for the aggrieved person or the agency. When the aggrieved person seeks advice from the EEO Counselor, the Counselor should remind him/her of the right to representation.

⁹ Please note that in the federal EEO process, the parties are the complainant and the agency. See [Bates v. Tennessee Valley Authority](#), 851 F.2d 1366, 1368 (11th Cir. 1988). The supervisor/manager who has been accused of discrimination is not a party to the EEO complaint, although he may be subject to other legal liability. Id.

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state clearly the terms of the informal resolution and should notify the aggrieved person of the procedures available under 29 C.F.R. § 1614.504, in the event that the agency fails to comply with the terms of the resolution. Other laws may provide requirements in settlement agreements, as for example, the [Older Worker's Benefit Protection Act of 1990](#). Appendix F in this Management Directive is a recommended format for the resolution settlement.

The EEO Counselor shall transmit a signed and dated copy of the settlement to the EEO Director. The EEO Director shall retain the copy for four years or until s/he is certain that, the agreement has been fully implemented.

C. Failure to Resolve the Dispute

The aggrieved person may not be satisfied with the agency's proposed resolution of the dispute, or the agency officials may not agree to the aggrieved person's suggestions. If informal resolution is not possible, the EEO Counselor must hold a final interview with the aggrieved person and issue the Notice of Right to File a Discrimination Complaint. No further counseling should occur.

VII. THE EEO ADR PROGRAM

A. The Choice of EEO Counseling or EEO ADR

At the initial counseling session the EEO Counselor will inquire whether the aggrieved is interested in trying to resolve the matter through the agency's EEO ADR program. If the aggrieved is interested, then within a reasonable time, the agency must decide whether to offer EEO ADR to the aggrieved person. When the agency offers EEO ADR in accordance with its EEO ADR policy/procedures, and the aggrieved agrees to participate, then the agency must provide an official with settlement authority for the EEO ADR process. See Chapter 3 of this Management Directive for more information about the EEO ADR process. If the agency offers EEO ADR, then the aggrieved person must be given a reasonable time to choose whether to pursue counseling or participate in EEO ADR. If the aggrieved person chooses to participate in EEO ADR, counseling activities must end. The EEO Counselor should resume the EEO process as specified in Section VII.B of this Chapter.

To participate in EEO ADR, the aggrieved person must sign the agency's Election Form, Agreement to Mediate, or other similar form. The EEO Counselor's Report should include the signed form.

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B. Role of the EEO Counselor during EEO ADR Process

When an aggrieved person chooses to participate in the EEO ADR process, the EEO Counselor cannot attempt to resolve the matter. Once the aggrieved person selects EEO ADR, the EEO Counselor must complete the intake functions of counseling (that is, obtaining the information needed to determine the basis(es), claim(s), timeliness, and desired redress) and refer the dispute for EEO ADR processing. Once those tasks are completed, the EEO Counselor should have no further involvement in resolving the matter until s/he learns the outcome of the EEO ADR process. The role of the EEO Counselor will vary depending on whether the parties successfully resolve the dispute during EEO ADR.

1. Successful EEO ADR Outcome

The EEO Counselor shall advise the aggrieved person that if the dispute is resolved during the EEO ADR process, the terms of the agreement must be in writing, clearly identify the claims resolved, and be signed by both parties. See 29 C.F.R. § 1614.603.

2. Unsuccessful EEO ADR/Aggrieved Withdraws from ADR

The EEO Counselor shall advise the aggrieved person that if EEO ADR does not resolve the dispute, or if the matter is not resolved within ninety (90) days from the initial contact with the EEO Counselor, the aggrieved person will receive a final interview and Notice of Right to File a Formal Complaint explaining how to file a formal complaint.

In addition, the EEO Counselor must prepare the EEO Counselor's Report and conduct the final interview. The report should state whether the parties attempted EEO ADR, but cannot reveal any other information about the EEO ADR attempt.

C. Completing the EEO ADR Process

If the agency offers EEO ADR in a particular case and the aggrieved person agrees to participate, the pre-complaint processing period shall be up to ninety (90) days. See 29 C.F.R. § 1614.105(f). Should the parties successfully resolve the dispute during the EEO ADR process, they must sign a written settlement agreement. See 29 C.F.R. § 1614.603. In addition, the EEO ADR program should notify the EEO Counselor of the settlement, and provide a copy of the document.

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If the dispute is not resolved within the 90-day period, the EEO ADR program will notify the EEO Counselor, who will issue the Notice of Right to File a Discrimination Complaint, required by 29 C.F.R. § 1614.105(d), as soon as possible, but not later than the 90th day after the individual initiates the EEO process or contacts the EEO office. See 29 C.F.R. § 1614.105(f).

VIII. FINAL INTERVIEW

During the final interview with the aggrieved person, the EEO Counselor should discuss what occurred during the EEO counseling process in terms of attempts at resolution. The EEO Counselor should provide the aggrieved with information to move the matter forward and answer any questions the aggrieved may have. The EEO Counselor must not indicate whether s/he believes the discrimination complaint has merit. Since EEO counseling inquiries are conducted informally and do not involve sworn testimony or extensive documentation, the EEO Counselor (1) cannot make findings on the claim of discrimination, and (2) should not imply to the aggrieved person that his/her interpretation of the claims of the case constitutes an official finding of the agency on the claim of discrimination. See Appendix G for a sample Notice of Right to File a Discrimination Complaint.

In addition, the EEO Counselor must provide the aggrieved person with the following information:

A. Right to Pursue the Claim through the Formal Process

If the dispute has not been resolved to the satisfaction of the aggrieved person, the EEO Counselor must tell the aggrieved person that s/he has the right to pursue the claim further through the formal complaint procedure. It is the aggrieved person, and not the EEO Counselor, who must decide whether to file a formal complaint of discrimination.

B. Requirements of the Formal Complaint

The EEO Counselor must inform the aggrieved person that the complaint:

1. Must be in writing;
2. Must be specific with regard to the claim(s) that the aggrieved person raised in EEO counseling and that the person wishes to pursue;

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3. Must be signed by the complainant or complainant's attorney; and
4. Must be filed within **fifteen (15) calendar days** from the date s/he receives the Notice of Right to File a Discrimination Complaint. Written complaints filed by facsimile, electronic communication, hand delivery during business hours, U.S. mail (confirmation services recommended), or other third-party commercial carrier must meet the regulatory time frames. The date of the postmark, facsimile, electronic communication, hand delivery, delivery to a third-party commercial carrier or in person filing at the agency's EEO office is considered the date filed and must be within the requisite 15 days.

C. Time Frames to Complete the Final Interview

The EEO Counselor must conduct the final interview and issue the Notice of Right to File a Discrimination Complaint within 30 days of the date the aggrieved person brought the dispute to the EEO Counselor's attention. If, however, the aggrieved person consented to a written extension of time, the extension cannot exceed 60 days for counseling. If the aggrieved agreed to participate in EEO ADR, the counseling period may not exceed 90 days. If the dispute is not resolved at the end of the extended time period, the EEO Counselor must advise the aggrieved party in writing of his/her right to file a complaint.

The 30-day EEO counseling period (or as extended by agreement of the aggrieved party) commences when the aggrieved person (1) first initiates contact with any agency official logically connected with the EEO process and (2) exhibits an intent to begin the EEO process. The unavailability of an EEO Counselor to meet with the aggrieved person for a period of time after such initial contact does not toll the 30-day counseling period. Absent agreement from the aggrieved person to extend the time period, the EEO Counselor must conduct the final interview and issue the Notice of Right to File a Discrimination Complaint at the end of the 30-day period.

D. Name(s) of Person(s) Authorized to Receive Complaints

The EEO Counselor shall provide the aggrieved person with the names of persons authorized to receive complaints of discrimination. The EEO Counselor shall inform the aggrieved person (or his/her representative) that the complaint must be delivered to one of the authorized persons.

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In accordance with 29 C.F.R. § 1614.105(b)(2)(g), the EEO Counselor should explain that unless the aggrieved authorizes or files a formal EEO complaint, the EEO Counselor will not reveal their identity. Once the complaint is filed, the complaint file, or part of it, may be shared only with those who are involved and need access to it. This includes the EEO Director, agency EEO officials, and possibly persons whom the aggrieved person has identified as being responsible for the actions that gave rise to the complaint. The complaint file is not a public document to be released outside the EEO complaint process. The identity of the aggrieved person does not remain confidential in the formal complaint process.

F. Written Notice of Right to File a Discrimination Complaint

After the final interview and not more than 30 days after the aggrieved contacted the EEO office, the written Notice of Right to File a Discrimination Complaint must be issued. The Notice must specify that an aggrieved person has **15 calendar days** after receipt of the notice of Right to File a Discrimination Complaint to file a formal complaint (including a class complaint).

The notice must also advise the aggrieved person of the appropriate official with whom to file a complaint and of complainant's duty to inform the agency immediately when the complainant retains counsel or a representative.

The EEO Counselor must advise the aggrieved individual of his/her duty to inform the agency of a change of address if s/he should move during the pendency of the EEO process and the possible consequences for not doing so.

IX. THE EEO COUNSELOR'S REPORT

When advised that an aggrieved person has filed a formal complaint, the EEO Counselor will submit a written report pursuant to 29 C.F.R. § 1614.105(c). The report will contain relevant information about the aggrieved person, jurisdiction, claims, bases, requested remedy, and the EEO Counselor's checklist, as specified in the sample EEO Counselor's Report. See Appendix H of this Management Directive. If the aggrieved person attempted to resolve the dispute via counseling or EEO ADR, the report should state that the aggrieved person chose either traditional EEO counseling or the EEO ADR program and that the dispute was not resolved through either procedure. However, the report should **not** provide a summary of the resolution attempts, nor any opinion as to whether discrimination occurred.

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A. Time Limits

The EEO Counselor must submit to the office designated to accept formal complaints and to the aggrieved individual a copy of the EEO Counselor's Report. This must be done within **fifteen (15) days** after notification by the EEO Director or other appropriate official that a formal complaint has been filed. It is essential that the EEO Counselor maintain his/her record of counseling so that this regulatory time limit is met.

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The report must include:

1. A precise description of the claim(s) and the basis(es) identified by the aggrieved individual;
2. Pertinent documents gathered during the inquiry, if any;
3. Specific information bearing on timeliness of the counseling contact;
4. An explanation for why the counseling process was untimely, if applicable; and
5. An indication as to whether an attempt was made to resolve the complaint.

The EEO Counselor should also retain a copy of the EEO Counselor's Report for availability in the event that the original EEO Counselor's Report, submitted to the office designated to accept formal complaints, is lost or misplaced. All notes, drafts and other records of counseling efforts will be maintained by the agency after counseling is completed for a period up to four years after resolution of the case.

Appendix H is a recommended format for an EEO Counselor's report.

C. Confidentiality of Negotiations for Resolution

In order to facilitate resolution attempts, all parties involved in resolution must be free to explore all avenues of relief. Offers and statements by parties made in response to resolution attempts by the EEO Counselor cannot be used against either party during the administrative EEO process if resolution attempts fail. The EEO Counselor will not report any discussions that occur during negotiations for resolution. For confidentiality of EEO ADR activities see Chapter 3, Section II.a.3 of this Management Directive.

X. COUNSELING CLASS ACTION COMPLAINTS

Occasionally, an EEO Counselor may need to provide EEO counseling to an aggrieved person or group of individuals who seek to represent a class of persons.¹⁰ A class is defined as a group of employees, former employees, or applicants who allege that they have been or are being adversely affected by an agency personnel policy or practice that discriminates against the group on the basis of their common race, color, religion, sex, national origin, age, genetic information, disability, or retaliation. See 29 C.F.R. §§ 1614.103(a) and 1614.204; see also Chapter 8 of this Management Directive for further guidance for class actions.

The aggrieved person(s) comes to the EEO Counselor as a class agent representing the group. A class inquiry must be brought to the attention of an EEO Counselor by a class agent **within forty-five (45) calendar days** of the date when the specific policy or practice adversely affected the class agent or, if a personnel action, within 45 days of the effective date of that action.

The EEO counseling requirements for class claims are the same as those for individual claims of discrimination, but the facts must be framed to meet the requirements of 29 C.F.R. § 1614.204.

It is strongly recommended that, if class allegations are raised or an individual approaches an EEO Counselor as a class agent for counseling, the EEO Counselor immediately contact the EEO Director, or designated person, for advice and guidance.

¹⁰ This need may arise in the course of counseling an individual where the EEO Counselor identifies allegations of class discrimination.

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CHAPTER 3

ALTERNATIVE DISPUTE RESOLUTION FOR EEO MATTERS

I. INTRODUCTION

Statutes enforced by the Commission, regulations, and executive orders encourage, with very narrow, mission specific, exceptions, the use of Alternative Dispute Resolution (ADR) in resolving employment EEO disputes.¹ EEO ADR is a term used to describe a variety of approaches to resolving EEO disputes rather than traditional adjudicatory methods or adversarial methods. Examples of traditional adjudicatory methods include litigation, hearings, and agency administrative processing and appeals.

The Commission's regulations at 29 C.F.R. § 1614.102 (b)(2) require agencies to establish or make available an EEO ADR program. The EEO ADR program must be available during the pre-complaint process and the formal complaint process. The Commission regulations extend the counseling period when EEO ADR is used. See 29 C.F.R. § 1614.105(f). In the federal EEO process, the

“parties” are the agency and the aggrieved/complainant. See [Bates v. Tennessee Valley Authority](#), 851 F.2d 1366, 1368 (11th Cir. 1988). As such, the manager who was accused of discrimination does not qualify as a party because that person is not a statutorily proper defendant in the federal EEO process.

Accordingly, once the agency decides to offer EEO ADR, the accused manager has a duty to cooperate, like any witness, in the EEO ADR process, but may not be the agency official that has settlement authority.

Agencies and aggrieved individuals/complainants have realized many advantages from utilizing EEO ADR. EEO ADR offers the parties the opportunity for an early, informal resolution of disputes in a mutually satisfactory fashion. EEO ADR usually costs less and uses fewer resources than traditional administrative or adjudicative processes, particularly processes that include a hearing or litigation. Early resolution of disputes through EEO ADR can make agency resources available for mission-related programs and activities. The agency can avoid costs such as court reporters and expert witnesses. In addition, employee morale can be enhanced when agency management is viewed as open-minded and cooperative in seeking to resolve disputes through EEO ADR.

¹ Agencies may have additional responsibilities under the Alternative Dispute Resolution Act, 5 U.S.C. § 574. The EEOC does not have jurisdiction to enforce the ADRA on federal agencies.

The Commission will review an agency's program and its EEO ADR policies, upon request, for consistency with 29 C.F.R. Part 1614. For more information, please contact the Office of Federal Operations at (202) 663-4599 or OFO.EEOC@EEOC.GOV.

II. CORE PRINCIPLES OF EEO ADR

Agencies may be flexible in designing their EEO ADR programs to fit their environment and workforce, provided the programs conform to the core principles set forth below. However, the Commission believes that there are certain requirements that are absolutely necessary for the successful development of any EEO ADR program. The core principles include the concepts of fairness, flexibility, training, and evaluation. Discussed below are these concepts.

A. Fairness

Any program developed and implemented by an agency must be fair to the participants, both in perception and reality. Fairness should be manifested throughout the EEO ADR proceeding by providing, at a minimum: as much information about the EEO ADR proceeding to the parties as soon as possible; the right to be represented throughout the EEO ADR proceeding; and an opportunity to obtain legal or technical assistance during the proceeding to any party who is not represented. Fairness also requires the following elements:

1. Voluntariness

Parties must knowingly and voluntarily enter into an EEO ADR proceeding. An EEO ADR resolution can never be viewed as fair if it is involuntary. Nor can a dispute be actually and permanently resolved if the resolution is involuntary. Unless the parties have reached a resolution willingly and voluntarily, the dissatisfaction of one party could lead to conflicts within the workplace or even to charges that the resolution was coerced or reached under duress.

In addition, aggrieved parties should be assured that they are free to end the EEO ADR process at any time, and that they retain the right to proceed with the administrative EEO process if they prefer that process to EEO ADR and resolution has not been reached. Both parties should be reassured that no one can force a resolution on them, not agency management, EEO officials, or the third-party neutral. Finally, parties are more likely to approach a resolution voluntarily when they know of their right to representation at any time.

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Note: When the agency determines it to be appropriate to offer EEO ADR to an individual, there is no conflict with voluntariness when the agency requires the responsible management official to participate since s/he is not a party and is not the agency official with settlement authority. When the agency offers the individual EEO ADR and the individual agrees to participate, the parties have voluntarily entered into the EEO ADR process.

2. Neutrality

To be effective, an EEO ADR proceeding must be impartial and independent of any control by either party, in both perception and reality. Using a neutral third party as a facilitator or mediator ensures this impartiality. In this Management Directive a

“neutral” refers to a third party who has no stake in the outcome of the proceeding whose function is to assist the parties in resolving the matters at hand.

A neutral shall have no official, financial, or personal conflict of interest with respect to the issues in controversy, unless such interest is fully disclosed in writing to all parties and all parties agree that the neutral may serve. For example, s/he might be an employee of another federal agency who knows none of the parties and whose type of work differs from that of the parties. Or s/he may be an employee within the same agency as long as s/he can remain neutral regarding the outcome of the proceeding. The agency must ensure the independence and objectivity of the neutral at all times.

3. Confidentiality

Confidentiality is essential to the success of all EEO ADR proceedings. Congress recognized this fact by enhancing the confidentiality provisions contained in the [Administrative Dispute Resolution Act of 1996](#) (ADRA), specifically exempting qualifying dispute resolution communications from disclosure under the Freedom of Information Act. [See 5 U.S.C. § 574.](#) Parties who know that their EEO ADR statements and information are kept confidential will feel free to be frank and forthcoming during the proceeding, without fear that such information may later be used against them. To maintain that degree of confidentiality, there must be explicit limits placed on the dissemination of EEO ADR information. For implementation and reporting purposes, the details of a resolution can be

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disseminated to specific offices only with a need to have that information. Neither the ADRA nor the Commission's core principles require the parties to agree that a settlement must be confidential.

Confidentiality must be maintained by the parties, by any agency employees involved in the EEO ADR proceeding and in the implementation of an EEO ADR resolution, and by any neutral third party involved in the proceeding. The Commission encourages agencies to issue clear, written policies protecting the confidentiality of what is said and done during an EEO ADR proceeding in accordance with 5 U.S.C. § 574.

4. Enforceability

Enforceability is a key principle upon which a successful EEO ADR program depends. Section 1614.504 of 29 C.F.R. provides that: "Any settlement agreement knowingly and voluntarily agreed to by the parties, reached at any stage of the complaint process, shall be binding on both parties." The regulation sets forth specific procedures for enforcing such a settlement agreement. Agreements resolving claims of employment discrimination reached through EEO ADR are enforceable through this procedure.

B. Flexibility

The EEO ADR program must be flexible enough to respond to the variety of situations individual agencies face. There is not necessarily one EEO ADR model which will work for all of an agency's programs, or all of its offices within the same program. Because agencies have different missions and cultures, they have flexibility in designing their EEO ADR programs. Agencies must also exercise flexibility in implementing the EEO ADR program. This flexibility will allow agencies to adapt to changing circumstances that could not have been anticipated or predicted at the time the program was initially implemented.

C. Training

An EEO ADR program, to be successful, will require that the agency at regular intervals provide appropriate training and education on EEO ADR to its employees, managers and supervisors, neutrals, and other persons protected under the applicable laws. See 29 C.F.R. § 1614.102(b)(3).

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In order to encourage the successful operation of EEO ADR throughout the agency, all managers and supervisors must receive EEO ADR training, either through an agency-conducted program or through an external source such as another federal agency or a private contractor. The EEO ADR training must include the following, at a minimum:

1. The [ADRA](#) and its amendments, with emphasis on the federal government's interest in encouraging mutual resolution of disputes and the benefits associated with utilizing ADR;
2. The Commission's regulations and Policy Guidance with respect to EEO ADR: 29 C.F.R. §§ 1614.102(b)(2), 1614.105(f), 1614.108(b), and 1614.603 (voluntary settlement attempts);
3. The operation of the EEO ADR method or methods that the agency employs;
4. Exposure to other EEO ADR methods, including interest-based mediation, if this method is not already in use by the agency; and
5. Drafting the settlement agreement, including the notice provision pursuant to 29 C.F.R. § 1614.504, where the aggrieved party believes the agency failed to comply with the terms of the settlement agreement and any other legally required notices.

D. Evaluation

An evaluation component is essential to developing and maintaining an effective EEO ADR program, and should be in place before an EEO ADR program is implemented. The evaluation will assist in determining whether the EEO ADR program has achieved its goals and will provide feedback on how the program might be made more efficient and achieve better results. Evaluations can range from analyzing the EEO ADR data on an annual basis to interviewing the EEO ADR participants about their experience in the process.

III. DEVELOPING AN EEO ADR PROGRAM

A. Written Procedures

The agency must establish written procedures detailing the operation of its EEO ADR program. The written procedures shall include, at a minimum, the following information:

1. The type or types of EEO ADR resources and techniques that the agency offers;
2. The stages of the EEO process at which EEO ADR will be offered and the appropriate agency official(s) who makes the determination to offer EEO ADR on behalf of the agency (note the responsible management official for the alleged discrimination is not the proper agency official for this decision);
3. The time frames involved in the administrative process and the EEO ADR process;
4. The source or sources of neutrals;
5. Those matters where EEO ADR is not available and the criteria the agency uses to determine when an issue is appropriate for ADR;
6. Assurance to the aggrieved party that EEO ADR is voluntary and that s/he may terminate the EEO ADR procedure at any time and return to the informal EEO process where they will be issued a Notice of Right to File a Formal Complaint or in the formal EEO process to the place where processing had ceased;
7. Assurance to the aggrieved party that its EEO ADR program is fair and that s/he has the right to representation;
8. An explanation to the aggrieved party with respect to confidentiality, neutrality, and enforceability; and
9. An assurance that the agency will make accessible an individual with settlement authority, and that no responsible management official or agency official directly involved in the case will serve as the person with settlement authority.

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If a case is appropriate, agencies may offer EEO ADR at any stage of the EEO process. With that said, the Commission encourages agencies to resolve complaints of employment discrimination as early in the process as possible. See 29 C.F.R. § 1614.603.

1. EEO ADR during the Counseling Stage

Under 29 C.F.R. § 1614.102(b)(2), agencies must establish or make available an EEO ADR program during the pre-complaint process. Chapter 2 of this Management Directive provides additional guidance concerning the process of offering EEO ADR during counseling.

2. EEO ADR after the Complaint Is Filed

Under 29 C.F.R. § 1614.102(b)(2), agencies must establish or make available an EEO ADR program during the formal complaint process. The regulations also state: “Agencies are encouraged to incorporate alternative dispute resolution techniques into their investigative efforts in order to promote early resolution of complaints.” See 29 C.F.R. § 1614.108(b). As such, agencies must design their EEO ADR program to allow the parties to pursue EEO ADR techniques after various stages of the formal complaint processing period.

3. EEO ADR at the Hearing and Appellate Stages

The Commission encourages EEO ADR attempts by the Commission’s Administrative Judges prior to arranging a hearing. See Chapter 7 in this Management Directive. However, the parties may also pursue EEO ADR through the agency’s EEO ADR program. To do so, the parties must notify the hearing office prior to utilizing the agency’s EEO ADR program.

Similarly, EEO ADR may be beneficial at the appellate stage of the administrative process. At this stage, the parties should notify the Office of Federal Operations (OFO) of their interest in EEO ADR. They may utilize the agency’s EEO ADR program, or request a neutral from OFO.

C. Matters Inappropriate for EEO ADR

While the Commission contemplates that the majority of matters are appropriate for EEO ADR, the Commission recognizes that there are instances in which EEO ADR may not be appropriate or feasible. See [5 U.S.C. § 572\(b\)](#). Agencies may decline to offer EEO ADR for particular issues related to the agency's mission, such as security clearances, but not for broad issues such as promotions or performance evaluations. Agencies have discretion to determine whether a given dispute is appropriate for EEO ADR. However, agencies may not decline to offer EEO ADR to particular cases because of the bases involved (that is, race, color, religion, sex, national origin, age, disability, genetic information, or retaliation).

D. Dealing with Non-EEO Issues

Although the purpose of the EEO ADR program is to address disputes arising under statutes enforced by the Commission, the Commission has found that many workplace disputes brought to the process often include non-EEO issues. In designing their EEO ADR programs, agencies may provide sufficient latitude for the parties to raise and address both EEO and non-EEO issues (that is, issues that do not fall under the jurisdiction of EEO laws, statutes and regulations) in the resolution of their disputes. However, agencies are still responsible for any other statutory obligations they may have.

E. Choosing among EEO ADR Techniques

Agencies should carefully consider the needs of their workforce when selecting techniques and choose the technique or techniques that are most likely to result in the earliest successful resolution of workplace disputes.

The Commission does not mandate the use of a particular EEO ADR technique in an agency's EEO ADR program; however, the selected technique(s) must be used in a manner that is consistent with the core principles. Additionally, each agency's EEO ADR program shall make available to parties at a minimum one ADR technique which allows for the meaningful participation of all involved parties (such as mediation, facilitation, or settlement conferences). The EEO ADR program must not diminish an individual's right to pursue his/her claim under the 1614 process should EEO ADR not resolve the dispute. For example, an EEO ADR program may not require an individual to waive, as a prerequisite to participation, his/her right to an investigation, to a hearing, or to appeal the final decision to the Commission.

August, 2015**EEO MD-110****F. Time Frames of the EEO ADR Process**

An EEO ADR program must be designed around the time frames of the EEO regulations. For example, 29 C.F.R. § 1614.105(f) provides that if the parties agree to participate in the EEO ADR process, the pre-complaint processing period may be extended not to exceed ninety (90) days. This time frame must be met to be consistent with the regulation. If the dispute is not resolved in this time frame, the agency must advise the aggrieved person not later than the 90th day after the EEO Counselor contact of their right to file a formal complaint. However, resolution efforts may continue so long as the parties and the neutral agree.

Similarly, if an individual enters into an EEO ADR procedure after a formal complaint is filed, the time period for processing the complaint may be extended by agreement for not more than 90 days. If the dispute is not resolved, the complaint must be processed within the extended time period.

G. Representation of the Parties

Aggrieved persons have the right to representation throughout the complaint process, including during any EEO ADR process. While the purpose of EEO ADR is to allow the parties to fashion their own resolution to a dispute, it is important that any agency 'dispute resolution procedure' provide all parties the opportunity to bring a representative to the EEO ADR forum if they desire to do so. Note, EEO Officials are not eligible to represent aggrieved individuals/complainants in the EEO ADR process. See Chapter 1 Section VI of this Management Directive for more information.

H. Spin-Off Complaints

Nothing said or done during attempts to resolve the complaint through EEO ADR can be made the subject of an EEO complaint. Likewise, an agency's decision not to offer EEO ADR for a particular case, or an agency's failure to provide a neutral, cannot be made the subject of an EEO complaint.

I. Collective Bargaining Agreements and the Privacy Act

Agencies must be mindful of obligations they may have under collective bargaining agreements to discuss development of EEO ADR programs with representatives of appropriate bargaining units. Agencies must also be mindful of the prohibitions of disclosing information about individuals pursuant to the

Privacy Act. All pre- and post-complaint information is contained in a system of records subject to the Act. Unless the complaining party elects union representation or gives his/her written consent, such information, including the fact that a particular person has sought counseling or filed a complaint, cannot be disclosed to the union.

J. Recordkeeping

Pursuant to the Commission's authority set forth in 29 C.F.R. § 1614.602(a) to collect federal complaints processing data and pursuant to the agency's obligation to report EEO activity to the Commission, the Commission requires agencies to maintain a record of EEO ADR activity for annual reporting to the Commission no later than October 31 of each year. This information will be provided to the Commission on the Form 462.

K. Independent ADR Office

In this Management Directive

an “**Independent ADR Office**” refers to an office that functions independently of the traditional EEO Office. In addition to EEO disputes, an Independent ADR Office may attempt to informally resolve a variety of workplace concerns, such as, grievances, or general employee disagreements.²

The Commission encourages the implementation of an Independent ADR Office as a best practice. A primary advantage of an Independent ADR Office is that the agencies can resolve disputes that do not belong in the EEO process, which then permits the EEO staff to focus on the traditional EEO complaint process. While employees may go directly to the Independent ADR Office without first meeting with the EEO Counselor, an independent ADR office is not an office for the purpose of initiating the EEO process. As a result, during the first contact with an Independent ADR Office, the aggrieved individual must be informed of the need to contact an EEO Counselor and regulatory time frames, should they wish to protect their rights to take the matter through the traditional EEO process.

Where an agency permits ADR office employees to perform any collateral EEO duty (no matter how small or infrequent), the ADR office is no longer independent and therefore any contact by an aggrieved party with the ADR office staff will initiate the traditional EEO process, including EEO counseling and

² For more information, refer to the Commission's ADR report, entitled “[Part II – Best Practices in ADR \(FY 2003-FY 2004\)](#).”

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Form 462 reporting. The agency's ADR staff member must provide to the aggrieved person the same information EEO Counselors are required to provide to the aggrieved persons, meet all training requirements of an EEO Counselor, and fully carry out the EEO Counselor's roles and responsibilities. This includes providing the EEO Counselor's report to the EEO Office for issuance in a timely manner. The ninety (90) day pre-complaint processing period will begin from the first contact with the ADR office staff member. Furthermore, an EEO Counselor may not act as a neutral in a case where s/he has previously provided EEO counseling. (See Chapter 2, Section I.E of this Management Directive for guidance on the qualifications, roles, and responsibilities of an EEO Counselor).

IV. PROVIDING INFORMATION

Aggrieved persons need information about all aspects of EEO ADR in order to make an informed choice between EEO ADR and the traditional EEO complaint process. The information provided at the counseling stage largely determines whether aggrieved persons will utilize the EEO ADR process. As such, EEO ADR programs should ensure that aggrieved persons are informed of all of the various steps in the traditional EEO process before beginning the actual EEO ADR proceeding. The aggrieved persons should also learn about the benefits of resolving the EEO dispute through EEO ADR. Although an informed choice is necessary to conduct an EEO ADR proceeding, an additional value is that once aggrieved persons choose EEO ADR over other alternatives, they have made a commitment to its success.

A. Agencies Must Fully Inform Employees about the EEO Process

29 C.F.R. § 1614.105(b)(2), which covers pre-complaint processing, requires that the EEO Counselor advise the aggrieved person that s/he may choose between participation in the EEO ADR program offered by the agency and the traditional EEO counseling procedures. Before the aggrieved person makes a choice between counseling and EEO ADR, the EEO Counselor must fully inform the person about the stages of the EEO process. (See Chapter 2 of this Management Directive). The EEO Counselor also must also advise the aggrieved person about other appropriate statutory or regulatory forums, such as the Merit Systems Protection Board or a negotiated grievance process.

B. Providing Information about the EEO ADR Program

1. The EEO Counselor should provide the aggrieved person with information about the agency EEO ADR program, including, but not limited to, the following:
 - a. A definition of the term EEO “alternative dispute resolution (ADR)” – (the definitions in this Chapter can be used);
 - b. An explanation of the stages in the EEO process where EEO ADR is available;
 - c. A thorough description of the particular EEO ADR technique(s) used in the agency’s program;
 - d. A thorough description of how the program is consistent with the EEO ADR core principles in ensuring fairness (including the right to representation), which requires voluntariness, neutrality, confidentiality, and enforceability;
 - e. An explanation of procedural and substantive alternatives; and
 - f. Information regarding all of the time frames involved in the traditional EEO complaint process and the EEO ADR process.
2. Information about the agency’s EEO ADR program may be provided to the aggrieved person through discussions, memoranda, video presentations, booklets, or pamphlets. In addition, the Commission recommends that agencies issue an EEO ADR policy, which shows the agency head’s support of the EEO ADR program and encourages all employees to participate in the program.

C. Explaining the Benefits of EEO ADR

To encourage the aggrieved persons to consider participating in the EEO ADR program, they will need to understand the benefits of the EEO ADR process. The Commission recommends that the EEO ADR program prepare talking points to promote the use of EEO ADR. In particular, agencies could identify the following benefits of EEO ADR:

1. EEO ADR saves time and money, as litigation and adjudication generally costs more and can take years to reach a decision;
2. Settlement agreements do not require admissions of liability;

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3. The parties maintain considerable control over the EEO ADR process and will decide their own outcome;
4. Settlement agreements are more durable because there is buy-in from the parties;
5. EEO ADR can improve office morale and productivity by repairing the parties' relationship and avoiding the tension caused by the investigative process; and
6. Unlike decisions which are published, the terms of the settlement agreement are not routinely disclosed.

D. Informing the Employee about Filing Rights

Whether or not the aggrieved person chooses to participate in the agency's EEO ADR program, the EEO Counselor shall advise the aggrieved person of his/her rights and responsibilities in the EEO complaint process, as set forth in 29 C.F.R. § 1614.105(b).

E. Pre-EEO ADR Meeting

Once the matter is accepted into the EEO ADR program, either the neutral or a member of the EEO ADR office may hold a pre-EEO ADR meeting. The purpose of this meeting is to provide information about the EEO ADR proceeding and address preliminary matters. For example, the meeting could clarify the issues in dispute, determine the scope of authority among the participants, discuss the role of the representatives, and ask the parties to develop a list of the desired results that s/he would like to achieve through EEO ADR.

V. NEUTRALS

ADRA defines a neutral as "an individual who, with respect to an issue in controversy, functions specifically to aid the parties in resolving the controversy." [5 U.S.C. § 571\(9\)](#). The Act further states that a neutral is a:

permanent or temporary officer or employee of the Federal Government or any other individual who is acceptable to the parties to a dispute resolution proceeding. A neutral shall have no official, financial, or personal conflict

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of interest with respect to the issues in controversy, unless such interest is fully disclosed in writing to all parties and all parties agree that the neutral may serve.

[5 U.S.C. § 573 \(a\).](#)

A. Sources of Neutrals

EEO ADR proceedings are most successful where a neutral or impartial third party, with no vested interest in the outcome of a dispute, allows the parties themselves to attempt to resolve their dispute. An agency should also consider the aggrieved person's perception of the third party's impartiality in appointing a neutral for an EEO ADR proceeding. For the neutral to be effective, the participants in an EEO ADR program must perceive the neutral as completely impartial. The selection of neutrals must comply with the core principles of ADR articulated in Section II above.

An agency may use neutrals for its EEO ADR program, subject to their qualifications, from the following sources:

1. Other federal agencies/sub-components (through a federal neutral sharing program or other arrangement);
2. Private organizations, private contractors, bar associations, or individual volunteers; or
3. Within their own agency, provided that they are impartial and independent of any control by either party, in both perception and reality.

The Commission recommends that agencies disclose their source of neutrals to the parties. Many federal agencies offer external sources of neutrals. Federal Executive Boards (FEB) throughout the nation offer pools of neutrals who are available for federal agency EEO dispute resolution. Similarly, the Federal Mediation and Conciliation Service (FMCS) also provides neutrals throughout the country. Within the metropolitan Washington, D.C., area, the Department of Health and Human Services offers an interagency mediation program called the Sharing Neutrals Program. This program operates a pool of trained and experienced collateral-duty mediators who provide mediation services to agencies in exchange for like services to the program from the recipient agency. More information about these programs may be obtained online at the [Commission's federal sector ADR page](#).

In the event that an agency uses one of its own employees as a neutral, it must ensure the neutrality and impartiality of the neutral. If EEO Counselors and

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investigators are used as neutrals, the agency must ensure that they do not serve as a neutral in the same dispute in which they provided counseling or conducted an investigation. Furthermore, an agency may use EEO Counselors and investigators as neutrals if, and only if, they satisfy the minimum training requirements. Agencies should also be aware that having EEO Counselors and investigators switch roles between performing their traditional EEO duties and providing EEO ADR can be confusing to the aggrieved persons and to the EEO staff as to their role in a particular case. To avoid this confusion, agencies must clearly communicate to the aggrieved persons the function being performed by the agency employee, whether EEO counseling, investigating, or EEO ADR. To the extent possible, agencies are encouraged to designate individuals as EEO Counselors/Investigators or EEO ADR neutrals, and limit the switching of roles between the EEO and EEO ADR programs.

B. Qualifications of Neutrals

1. Training in ADR Theory and Techniques

Any person who serves as a neutral in an agency's EEO ADR program must have professional training in whatever dispute resolution technique(s) the agency utilizes in its program. The Commission will accept as sufficient such training as is generally recognized in the dispute resolution profession. For example, the Interagency Program on Sharing Neutrals administered by the Department of Health and Human Services requires the following expertise: 1) at least 20 hours of basic mediation skills training; 2) at least three co-mediations with a qualified mediator or five independent mediations and positive evaluations from a qualified trainer/evaluator; and 3) at least two references from two qualified mediators or trainer/evaluators.

2. Knowledge of EEO Law

Any person who serves as a neutral in an agency's EEO ADR program must be familiar with the following EEO laws and areas:

- a. The entire EEO process pursuant to 29 C.F.R. Part 1614, including time frames;
- b. The Civil Service Reform Act and the statutes that the Commission enforces (including Title VII of the Civil Rights Act of 1964, as amended, the Rehabilitation Act of 1973, as amended, the

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Americans with Disabilities Act Amendments Act of 2008, the Age Discrimination in Employment Act of 1967, as amended, the Equal Pay Act of 1963, as amended, and the Genetic Information Nondiscrimination Act of 2008);

- c. The theories of discrimination (for example, disparate treatment, adverse impact, harassment, and reasonable accommodation); and
- d. Remedies, including compensatory damages, costs, and attorney's fees.

C. Role of the Neutral

In any EEO ADR proceeding conducted under this Directive, the neutral is expected to be “neutral, honest, and to act in good faith.” The neutral must also act consistently with the ADRA and strive to ensure:

- 1. That EEO ADR proceedings are consistent with EEO law and Part 1614 regulations, including time frames;
- 2. That proceedings are fair and consistent with the core principles in this Chapter, particularly providing the parties the opportunity to be represented by any eligible person of his/her choosing throughout the proceeding (see Section III.G of this chapter for more information);
- 3. That an agency representative participating in EEO ADR has the authority and responsibility to negotiate in good faith and that a person with authority to approve or enter into a settlement agreement is accessible to the agency's representative;
- 4. That any agreement between the parties can be enforced, assist the parties in preparation of the written settlement agreement that includes the signatures of the appropriate agency representative and aggrieved person, and inform the parties of the review process the agency uses to ensure the terms of the agreement are enforceable;
- 5. Confidentiality, including destroying all written notes taken during the EEO ADR proceeding or in preparation for the proceeding; and
- 6. Neutrality, including having no conflict of interest with respect to the proceeding (for example, material or financial interest in the outcome, personal friend or co-worker of a party, supervisory official over a party),

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unless such interest is fully disclosed in writing to the parties and they agree that the neutral may serve.

D. Promoting Trust

Trust fosters the open and frank communication between the parties that is an essential factor in reaching a fair resolution of an EEO complaint. Once the individual has chosen EEO ADR to attempt resolution, the neutral can develop the parties' trust by:

1. Providing full information about the EEO ADR proceeding as soon as possible, including information on its impartiality, the relative merits of EEO ADR as compared with the traditional form of complaint processing, and the confidentiality of the EEO ADR process;
2. Giving the parties the opportunity to request and obtain relevant information from one another, so that they have sufficient information to make informed decisions; and
3. Explaining the safeguards that are in place to protect parties from pressures to resolve the complaint.

VI. ADR TECHNIQUES

Numerous ADR techniques are available for use by agencies in their programs. Each agency's EEO ADR program should strive to use those ADR techniques which are a best fit for their culture. While the Commission does not mandate that agencies offer any specific ADR techniques, agencies must at a minimum make available to parties one ADR technique which allows for the meaningful participation of all involved parties in the dispute. Mediation, facilitation, and settlement conferences are common ADR techniques which involve the participation of all parties to the dispute.

Techniques may be combined to provide advantageous aspects of more than one method. For example, an agency may provide coaching to one or more of the parties as a way of preparing parties for mediation. Or, an agency may provide coaching as one of the services after mediation. However, coaching alone would not be sufficient, as it does not allow for meaningful participation of all parties to the dispute. Agencies are not limited to using only one method or technique in their EEO ADR programs. They may find that using various methods in combination may also yield fruitful results and be very effective in reaching resolution. See the [Federal Workplace Conflict Management Desk Reference](#) at [ADR.gov](#) for a non-exhaustive list of ADR techniques.

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A. Mediation

In this Management Directive the term

“Mediation” refers to the process where a third-party neutral, who is not a decision maker, facilitates discussion between the parties to help them reach a mutually acceptable resolution.

In a mediation the neutral guides the process and determines when to meet with both parties in a joint session or individually, establishes a tone to help parties engage in meaningful discussion, and creates a safe environment for discussion.

B. Facilitation

Facilitation involves the use of techniques to improve the flow of information in a meeting between parties to a dispute. The techniques may also be applied to decision-making meetings where a specific outcome is desired (for example, resolution of a conflict or dispute). The term “facilitator” is often used interchangeably with the term “mediator,” but a facilitator does not typically become as involved as the mediator in the substantive issues. The facilitator focuses more on the communication processes involved in resolving a matter.

C. Settlement Conferences

In a settlement conference, disputing parties, their representatives, and a judge or referee hold a meeting designed to bring formal adversarial proceedings to a satisfactory close. The role of a settlement judge is similar to that of a mediator in that s/he assists the parties procedurally in negotiating an agreement.

VII. RESOLUTIONS MUST BE IN WRITING

If the agency and the aggrieved person agree to a resolution of the matter, the Commission regulations require that the terms of the resolution be in writing and signed by both parties to verify they have the same understanding of the terms of the resolution. See 29 C.F.R. § 1614.603; Chapter 12 of this Directive. The written agreement must state clearly the terms of the resolution and contain the procedures available under 29 C.F.R. § 1614.504, in the event that the agency fails to comply with the terms of the resolution. Written agreements must comply with [EEOC’s Enforcement Guidance on Non-Waivable Employee Rights under Enforced Statutes](#), wherein the Commission sets forth its position that:

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“an agency may not interfere with the protected right of employees to file a complaint or participate in any manner in an investigation, hearing, or proceeding under the laws enforced by the Commission.”

Additionally, any written agreement settling a claim under the Age Discrimination in Employment Act (ADEA) must also comply with the requirements of the Older Workers Benefit Protection Act of 1990 (OWBPA) Pub. L. No. 101- 433 (1990), the [ADEA, 29 U.S.C. § 626\(f\)](#), and the Commission’s regulations regarding Waiver of Rights and Claims under the ADEA at 29 C.F.R. Part 1625. Neither the ADRA nor the Commission’s core principles require the parties to agree that a settlement must be confidential.

The agency representative shall transmit a signed and dated copy of the resolution to the EEO Director. The EEO Director shall retain the copy in accordance with the appropriate National Archives and Records Administration schedules.

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CHAPTER 4

PROCEDURES FOR RELATED PROCESSES

I. INTRODUCTION

As noted in Chapter 2, Section IV.B and Appendix D of this Management Directive, different procedures apply to certain related processes. The relationship between 29 C.F.R. Part 1614 EEO complaints, Merit Systems Protection Board (MSPB) actions, grievances filed pursuant to negotiated grievance procedures, notices of intent to sue in Age Discrimination in Employment Act (ADEA) complaints, and the alternative available in Equal Pay Act (EPA) complaints are set out more specifically here. All time frames in this Chapter are expressed in calendar days.

II. MIXED CASE COMPLAINTS AND APPEALS - 29 C.F.R. § 1614.302

A. Definitions

A “mixed case complaint” is a complaint of employment discrimination filed with a federal agency based on race, color, religion, sex, national origin, age, disability, genetic information, or reprisal related to or stemming from an action that may be appealed to the MSPB. The complaint may contain only a claim of employment discrimination or it may contain additional non-discrimination claims that the MSPB has jurisdiction to address. A “mixed case appeal” is an appeal filed directly with the MSPB that alleges that an appealable agency action was effected, in whole or in part, because of discrimination on the basis of race, color, religion, sex, national origin, disability, age, genetic information, or reprisal. There is no right to a hearing before a Commission Administrative Judge on a mixed case complaint.

B. Procedures

The Commission regulations provide for processing discrimination complaints on claims that are otherwise appealable to the MSPB. Two determinations must be made to decide if the mixed case regulations apply. First, the employee must have standing to file such an appeal with the MSPB. Second, the claim that forms the basis of the discrimination complaint must be appealable to the MSPB. For information on who can file and the actions that can be appealed to the MSPB see 5 C.F.R. § 1201.3. Note that because the MSPB does not have jurisdiction to hear non-appealable matters, complaints not containing those matters should be

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processed by the agency under the 1614 process and not mixed with matters that are appealable to the MSPB through amendment, consolidation or held in abeyance. See [Complainant v. Inter-American Foundation](#), EEOC Appeal No. 0120132968, (Jan. 8, 2014) (wherein the Commission essentially overturned the doctrine of inextricably intertwined). We note, however, that a proposed action merges with the decision on an appealable matter - for example, a proposed removal merges into the decision to remove. See [Wilson v. Dep't. of Veterans Affairs](#), EEOC Appeal No. 0120122103 (September 10, 2012).

1. Election to Proceed Is Required

- a. The regulations provide that a covered individual may raise claims of discrimination in a mixed case either as a direct appeal to the MSPB or as a mixed case EEO complaint with the agency, but not both. 29 C.F.R. § 1614.302(b).
- b. Whatever action the individual files first is considered an election to proceed in that forum. 29 C.F.R. § 1614.302(b). Filing a formal EEO complaint constitutes an election to proceed in the EEO forum. Contacting an EEO Counselor or receiving EEO counseling does not constitute an election.
- c. Where an aggrieved person files an MSPB appeal and timely seeks counseling, counseling may continue pursuant to 29 C.F.R. § 1614.105, at the option of the parties. In any case, counseling must be terminated with notice of rights pursuant to 29 C.F.R. §§ 1614.105(d), (e), or (f).

2. Procedures for Handling Dual Filing

- a. Where the agency does not dispute MSPB jurisdiction
 - (1) If an individual files a mixed case appeal with the MSPB before filing a mixed case complaint with the agency, and the agency does not dispute MSPB jurisdiction, the agency must thereafter dismiss any complaint on the same claim, regardless of whether the claims of discrimination are raised in the appeal to the MSPB.¹

¹ A Commission Administrative Judge may dismiss the mixed case complaint pursuant to 29 C.F.R. § 1614.109(b).

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- (2) The agency or the Commission's Administrative Judge must advise the complainant that s/he must bring the claims of discrimination contained in the dismissed complaint to the attention of the MSPB, pursuant to 5 C.F.R. § 1201.151, et seq.
- (3) Where an agency has not accepted a complaint for processing, that is, has disposed of the complaint on procedural grounds, the resulting final agency decision is appealable to the Commission. 29 C.F.R. § 1614.302(c)(1); [Abegglen v. Dep't. of Energy](#), EEOC Appeal No. 01966055 (Oct. 9, 1998).

b. Where the agency or the MSPB Administrative Judge questions MSPB jurisdiction

The agency shall hold the mixed case complaint in abeyance until the MSPB Administrative Judge rules on the jurisdictional issue, notify the complainant that it is doing so, and instruct him/her to bring the discrimination claim to the attention of the MSPB. During this period, all time limitations for processing or filing the complaint will be tolled. An agency decision to hold a mixed case complaint in abeyance is not appealable to the Commission. If the MSPB Administrative Judge finds that MSPB has jurisdiction over the claim, the agency shall dismiss the mixed case complaint and advise the complainant of the right to petition the Commission to review the MSPB's final decision on the discrimination issue. If the MSPB Administrative Judge finds that the MSPB does not have jurisdiction over the claim, the agency shall recommence processing of the mixed case complaint as a non-mixed case EEO complaint.

c. Where a complainant files with the agency first

If an employee first files a mixed case complaint at the agency and then files a mixed case appeal with the MSPB, the agency should advise the MSPB of the prior agency filing and request that the MSPB dismiss the appeal without prejudice.

3. Processing Where MSPB Dismisses a Mixed Case Appeal Because It Finds No Jurisdiction (That Is, the Case Is Not Mixed)

- a. If an individual files a mixed case appeal with the MSPB instead of a mixed case complaint, and the MSPB subsequently dismisses the appeal as non-jurisdictional, the agency must inform the individual that s/he may contact an EEO Counselor within forty-five (45) days to raise the discrimination claim(s) and that the filing date of the mixed case appeal will be deemed to be the date the individual initially contacted the EEO Counselor.
- b. If the individual filed the appeal after the agency issued an agency final decision on the mixed case complaint or after the agency failed to issue a final decision on the mixed case complaint within 120 days, (pursuant to 5 C.F.R. § 1201.154(b)(2)), the agency must provide the complainant with a thirty (30) day notice of right to a hearing and decision from a Commission Administrative Judge or an immediate final decision by the agency pursuant to 29 C.F.R. § 1614.108(f) and thereafter proceed as in a non-mixed case.

4. Processing Mixed Case Complaints Filed at the Agency

If an employee elects to file a mixed case complaint, the agency must process the complaint in the same manner as it would any other discrimination complaint, except:

- a. Upon completion of the investigation, the agency must notify the complainant that a final decision will be issued within forty-five (45) days without a hearing before a Commission Administrative Judge.
- b. Upon the filing of a complaint, the agency must advise the complainant that if a final decision is not issued within 120 days of the date of filing the mixed case complaint, the complainant may appeal the claim to the MSPB at any time thereafter, as specified in 5 C.F.R. §§ 1201.154(a) & (b), or may file a civil action as specified in 29 C.F.R. § 1614.310(g), but not both.
- c. Also upon the filing of a complaint, the agency must notify the complainant that if s/he is dissatisfied with the agency's final decision on the mixed case complaint, s/he may appeal the claim to the MSPB (not the Commission) within thirty (30) days of receipt of the agency's final decision pursuant to 5 C.F.R. § 1201.154(a).

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- d. Within forty-five (45) days following completion of the investigation, the agency must issue a final decision without a hearing before a Commission Administrative Judge. 29 C.F.R. § 1614.302(d)(2).
- e. Upon issuance of the agency's final decision on a mixed case complaint, the agency must advise the complainant of the right to appeal the claim to the MSPB (not the Commission) within 30 days of receipt of the notice and of the right to file a civil action as provided in 29 C.F.R. §§ 1614.310 and 1614.310(a).

III. NEGOTIATED GRIEVANCE PROCEDURES - 29 C.F.R. § 1614.301

A. Where Agency Is Covered by [5 U.S.C. § 7121\(d\)](#)

1. When an aggrieved employee is covered by a collective bargaining agreement that permits claims of discrimination to be raised in a negotiated grievance procedure, the employee must elect to file an EEO complaint or a grievance. The underlying principle is that an aggrieved employee who has a choice of forums in which to proceed cannot go forward in more than one forum (unless the employing agency is exempt from coverage of [5 U.S.C. § 7121\(d\)](#)). This is true "irrespective of whether the agency has informed the individual of the need to elect or of whether the grievance has raised an issue of discrimination." 29 C.F.R. § 1614.301(a).
2. If an employee first files a grievance and thereafter files a complaint of discrimination on the same claim, the complaint must be dismissed without prejudice to the complainant's right to proceed through the negotiated grievance procedure, including the right to appeal to the Commission from a final decision as provided in subpart D of Part 1614 (Appeals and Civil Actions). The dismissal of the complaint must advise the complainant of the obligation to raise discrimination claims in the grievance process and of the right to appeal the final grievance decision to the Commission. 29 C.F.R. § 1614.301(a).

B. Where Agency Is Not Covered by [5 U.S.C. § 7121\(d\)](#)

1. The U.S. Postal Service and the Tennessee Valley Authority are examples of two agencies not covered by [5 U.S.C. § 7121\(d\)](#). In such agencies, an aggrieved individual may file a complaint pursuant to Part 1614 and also a grievance pursuant to a collective bargaining agreement involving the same claim.
2. In such agencies, complaints filed pursuant to Part 1614 may be held in abeyance where a grievance is filed on the same claim, if written notice of the abeyance is provided.
3. Complaints may be held in abeyance until a final decision is issued on the grievance.

C. Administrative Grievance Process

There is nothing that prevents an employee from using an agency's administrative process, as opposed to a negotiated grievance process, and the EEO complaint process. See [Diefenderfer v. Dep't. of Transportation](#), EEOC Appeal No. 01980578, (Oct. 7, 1998). However, the Commission has consistently held that utilization of agency procedures, union grievances, and other remedial processes does not toll the time limit for contacting an EEO Counselor. See [Black v. Dep't. of the Interior](#), EEOC Appeal No. 0120110122 (Aug. 19, 2011).

IV. AGE DISCRIMINATION COMPLAINTS

It is incumbent upon federal agency personnel responsible for processing discrimination complaints to inform complainants or potential complainants of the following procedures available to them in pursuing an age discrimination complaint.

A. Election of Administrative Process

An aggrieved person may file an administrative age discrimination complaint with the agency pursuant to 29 C.F.R. Part 1614. If the aggrieved person elects to file an administrative complaint, s/he must exhaust administrative remedies before s/he may file a civil action in U.S. District Court. Exhaustion of administrative remedies occurs when the agency takes final action or 180 days after filing the complaint if no final action is taken. See 29 C.F.R. § 1614.201; see also Chapter 9, Sections II and III of this Management Directive.

August, 2015**EEO MD-110****B. Aggrieved May Bypass Administrative Process**

Alternatively, an aggrieved person may bypass the administrative complaint process, and file a civil action directly in U.S. District Court provided that the aggrieved person first provides the Commission with a written notice of intent to sue under the ADEA. The notice to the Commission must be filed within 180 days of the date of the alleged discriminatory action. Once a timely notice of intent to sue is filed with the Commission, the aggrieved person must wait at least thirty (30) days before filing a civil action.

C. Responsibilities Regarding Notices of Intent to Sue

The following is a statement of the procedures and a delineation of the responsibilities on the part of the aggrieved person, the Commission, and the agency with respect to the filing and processing of notices of intent to sue under the ADEA.

1. The Aggrieved Person

It is the responsibility of the aggrieved person to provide the Commission with a written notice of intent to sue within 180 days of the date of the alleged discriminatory action.

- a. Notices of intent to sue must be delivered to the Commission in one of the following ways:

hand delivered to:

Equal Employment Opportunity Commission
Office of Federal Operations
Federal Sector Programs
131 M Street, NE
Washington, DC 20507

or mailed to:

Equal Employment Opportunity Commission
Office of Federal Operations
Federal Sector Programs
P.O. Box 77960

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or may soon be submitted through the Commission's electronic document submission portal or fax at (202) 663-7022.

- b. The notice of intent to sue should be dated and must contain the following information:
- (1) statement of intent to file a civil action under Section 15(d) of the Age Discrimination in Employment Act of 1967, as amended;
 - (2) name, address, and telephone number of the employee or applicant;
 - (3) name, address, and telephone number of the complainant's designated representative, if any;
 - (4) name and location of the federal agency or installation where the alleged discriminatory action occurred;
 - (5) date on which the alleged discriminatory action occurred;
 - (6) statement of the nature of the alleged discriminatory action(s); and
 - (7) signature of the complainant or the complainant's representative.

2. The Commission

- a. Upon receipt of a notice of intent to sue, the Commission will promptly notify the concerned agency (and all persons named in the notice as prospective defendants in the action, if any), in writing, of its receipt of the notice of intent to sue and will provide the agency with a copy of the notice. Commission contact with the concerned agency will normally be through the agency-headquarters-level Office of Equal Employment Opportunity or similarly designated office, as the case may be. A copy of the Commission's notification will be provided to the aggrieved person and/or his/her representative, if any. Additionally, the Commission will take any appropriate action to ensure the elimination of any unlawful practice.

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- b. Where an aggrieved person files a civil action before the agency has completed its inquiry, or before the Commission has reviewed the agency's disposition, the Commission will terminate the inquiry and will take no further action on the notice of intent to sue.

3. The Agency

Upon receipt of a notice of intent to sue, an agency must review the claim(s) of age discrimination and conduct an inquiry sufficient to determine whether there is evidence that unlawful age discrimination has occurred. Agencies may determine their method of review/inquiry and the method may vary depending on the scope and complexity of the claims. Agencies are encouraged to make good faith efforts to resolve disputes.

V. EQUAL PAY ACT COMPLAINTS

An aggrieved individual does not have to file an administrative complaint before filing a lawsuit under the Equal Pay Act (EPA). If an aggrieved individual nonetheless wants to file an administrative complaint, it will be processed like Title VII complaints under Part 1614. Complainants in EPA cases should be notified of the statute of limitations (two years or, if a willful violation is alleged, three years), which applies even if the individual files an administrative complaint, and of the right to file directly in a court of competent jurisdiction without first providing notice to the Commission or exhausting administrative remedies.

CHAPTER 5

AGENCY PROCESSING OF FORMAL COMPLAINTS

I. AGENCY SHALL ACKNOWLEDGE FORMAL COMPLAINT

Immediately upon receipt of a formal complaint of discrimination, the agency shall acknowledge receipt of the complaint in writing. The acknowledgment letter shall inform the complainant of the date on which the complaint was filed. If the complaint is mailed, the date of filing is the postmark date, not the date the agency received the complaint. Where the matter is appropriate for ADR, the agency may include a notice to that effect in its acknowledgment letter.

Commission regulations require that an EEO Counselor provide **both** the agency office designated to accept complaints and the complainant with a written report within fifteen (15) days of being advised that the complainant has filed a formal EEO complaint. 29 C.F.R. § 1614.105(c). Agencies thus should immediately notify the EEO Counselor that a complainant has filed a complaint so as to expedite the preparation and delivery of the written report.

Within a reasonable time after receipt of the written EEO Counselor report, the agency should send the complainant a second letter (commonly referred to as an "acceptance" letter), stating the claim(s) asserted and to be investigated. If the second letter's statement of the claim(s) asserted and claim(s) for investigation differs, the letter further shall explain the reasons for the difference, including whether the agency is dismissing a portion of the complaint. The agency shall advise the complainant that s/he may submit a statement to the agency concerning the agency's articulation of the claim, which shall become a part of the complaint file. (Dismissals are governed by 29 C.F.R. § 1614.107(a). Additional dismissal guidance is provided in Section IV of this Chapter of the Management Directive.) The agency shall notify the complainant of a partial dismissal by letter and further inform the complainant that there is no immediate right to appeal the partial dismissal. The agency should advise the complainant that the partial dismissal shall be reviewed either by a Commission Administrative Judge, if the complainant requests a hearing before an Administrative Judge, or by the Commission, if the complainant files an appeal of a final agency action or final agency decision. (See Section IV.C below for further discussion on the requirements of a partial dismissal.)

Unless the complainant states otherwise, copies of the acknowledgment and all subsequent actions on the complaint shall be mailed or delivered to the complainant's representative with a copy to the complainant.

II. THE AGENCY SHALL ALSO PROVIDE OTHER INFORMATION AND NOTICE OF RIGHTS

A. Agency Shall Inform the Complainant of the Agency's Obligations

1. To Investigate in a Timely Manner

The agency is required to investigate the complaint in a timely manner. The investigation must be appropriate, impartial, and completed within **180 days** of filing the complaint (as described more fully in Section V.D and in Chapter 6 of this Directive), or within the time period contained in an order from the Office of Federal Operations on an appeal from a dismissal pursuant to 29 C.F.R. § 1614.107(a). The EEO Director or designee and the complainant may agree in writing, consistent with 29 C.F.R. § 1614.108(e), to an extension of not more than **ninety (90) days**; or within the period of time set forth in 29 C.F.R. §§ 1614.108(e) or 1614.606 if there are multiple complainants with similar allegations of discrimination or complainant has filed multiple complaints which the agency has consolidated. If the agency fails to complete the investigation in 180 days, it shall issue written notice to complainant informing the complainant that it was unable to complete the investigation, the estimated date of completion, and complainant's right to file a civil action or request a hearing. See 29 C.F.R. § 1614.108(g). See Appendix K for a sample notice letter.

Agencies are required to complete investigations within the earlier of 180 days after the filing of the last complaint or 360 days after the filing of the original complaint. Regardless of amendment or consolidation of complaints, the investigation shall be complete in not more than 360 days, unless there is a written extension of not more than 90 days.

For example, if a complainant amends a complaint or files another complaint, the agency will consolidate on day 179 of the originally filed complaint, and then the investigation must be complete by the 359th day.

If the complainant wants to add another amendment on the 358th day of the investigation, the agency will have only 2 days to investigate that amendment unless the complainant agrees in writing to an extension of not more than 90 days. When no written extension exists and the agency is unable to conduct an impartial and appropriate investigation in 2 days it should not consolidate or accept the amendment rather; the agency should advise the complainant to seek counseling on the newest matter and process it as a new complaint.

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An investigation is deemed completed when the report of the investigation is served on the complainant in conjunction with the notice of the right to elect either a hearing before a Commission Administrative Judge or a final decision from the agency pursuant to 29 C.F.R. § 1614.108(f).

2. To Process Mixed Cases Timely

The Commission deems a mixed case complaint timely investigated in the same manner and applying the same time limitations as non-mixed cases. However, if a final decision is not issued on the mixed case complaint within **120 days** of filing, the complainant may appeal to the Merit Systems Protection Board (MSPB) at any time thereafter pursuant to MSPB regulation 5 C.F.R. § 1201.154(a) or may file a civil action as provided in 29 C.F.R. § 1614.310(g), but not both. See 29 C.F.R. § 1614.302(d)(1). The complainant is not entitled to a hearing before the Commission on a mixed case. See more instructions for processing these cases in Chapter 4 Section II.

3. Unilateral Extension for Sanitizing Classified Information

After providing notice to the complainant, the agency may unilaterally extend the time period or any period of extension for no more than thirty (30) days where it must sanitize a complaint file that may contain information classified pursuant to [Executive Order 12356](#) or successor orders as secret in the interest of national defense or foreign policy. 29 C.F.R. § 1614.108(e).

B. Agency Shall Inform Complainant of His/Her Rights

The agency shall provide every complainant in writing notice of all rights and responsibilities enumerated in Chapters 2, 3, and 4 of this Management Directive. This includes:

1. The Right to Request a Hearing

Except in mixed cases, the complainant has the right to request a hearing before a Commission Administrative Judge after **180 calendar days** from the filing of a formal complaint or after completion of the investigation, whichever comes first. 29 C.F.R. § 1614.106(e)(2). Complainants must request a hearing directly from the Commission's field office that has jurisdiction over the geographic area in which the complaint arose, as set forth in Appendix N of this Management Directive. See 29 C.F.R.

§ 1614.108(g). In an agency's written acknowledgment of receipt of a complaint or an amendment to a complaint, the agency shall advise the complainant of the Commission's office and address where a hearing request is to be sent as well as the agency office to which the copy of the request should be sent. The complainant shall certify to the Administrative Judge that s/he sent a copy of the request to the agency EEO office to the attention of the individual and at the address that the agency previously informed the complainant.

2. **The Right to Appeal**

The complainant has the right to appeal a dismissal, final action, or decision. Partial dismissals are not immediately appealable. See 29 C.F.R. §§ 1614.107(b) and 1614.401, and, Section IV.C of this Chapter for further guidance.

- a. Agencies shall inform the complainant that s/he may appeal within **thirty (30) days** of receipt of the dismissal, final action, or decision. Appeals may be mailed to:

Equal Employment Opportunity Commission
Office of Federal Operations
P.O. Box 77960
Washington D C 20013

or hand delivered to:

Equal Employment Opportunity Commission
Office of Federal Operations
Appellate Review Programs
131 M Street NE. Suite 5SW12G
Washington, DC 20507

or may be submitted through the Commission's electronic document submission portal or by fax at (202) 663-7022.

- b. Agencies shall provide the information at 29 C.F.R. § 1614.403 (a)-(f) (use of appeal form EEOC Form 573, Notice of Appeal/Petition (a copy of which is appended hereto as Appendix P); content of petition; service of copies on agency EEO Director; certification of delivery; and opposition brief schedule).
- c. With regard to a mixed case, if the complainant is dissatisfied with the agency's final decision on the mixed case complaint, the

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complainant may appeal the matter to the MSPB, not the Commission, within 30 days of receipt of the agency's final decision.

3. **The Right to File a Civil Action**

The complainant has the right to file a civil action in a U.S. District Court on EEO discrimination claims raised in the administrative process:

- a. Within **ninety (90) days** of receipt of a final action on an individual or class complaint if no appeal has been filed;
 - b. After **180 days** from the date of filing an individual or class complaint if an appeal has not been filed and a final action has not been taken;
 - c. Within **90 days** of receipt of the Commission's final decision on appeal; or
 - d. After **180 days** from the date of the filing of an appeal with the Commission if there has been no final decision by the Commission.
4. See Appendix C of this Management Directive, which sets forth a detailed list of a complainant's rights about which the agency must advise the complainant.

III. **AGENCIES MUST AVOID FRAGMENTING EEO COMPLAINTS**

The fragmentation, or breaking up, of a complainant's legal claim during EEO complaint processing has been a significant problem in the federal sector. For complainants, fragmented processing can compromise their ability to present an integrated and coherent claim of an unlawful employment practice for which there is a remedy under the federal equal employment statutes. For agencies and the Commission, fragmented processing substantially increases case inventories and workloads when it results in the processing of related matters as separate complaints.¹

The fragmentation of EEO claims must be prevented at all levels of the complaint process, including pre-complaint EEO counseling. This section is designed to promote

¹ See [Cobb v. Dep't. of the Treasury](#), EEOC Request No. 05970077 (Mar. 13, 1997); [Toole v. Equal Employment Opportunity Commission](#), EEOC Appeal No. 01964702 (May 22, 1997).

understanding of the concept of fragmentation and to provide guidance on avoiding fragmented complaint processing.

Note that because the MSPB does not have jurisdiction to hear non-appealable matters, complaints not containing those matters should be processed by the agency under the 1614 process and not mixed with matters that are appealable to the MSPB through amendment, consolidation or held in abeyance. See [Complainant v. Inter-American Foundation](#), EEOC Appeal No. 0120132968, (Jan. 8, 2014) (wherein the Commission essentially overturned the doctrine of inextricably intertwined). We note, however, that a proposed action merges with the decision on an appealable matter - for example, a proposed removal merges into the decision to remove. See [Wilson v. Dep't. of Veterans Affairs](#), EEOC Appeal No. 0120122103 (September 10, 2012).

This section is not designed to address claims that include both a mixed and non-mixed matters. Where the complainant has or brings an amendment which contains a mixed issue (one that can be appealed directly to the MSPB), fragmentation does not occur where the agency assigns a second complaint number and processes the non-mixed matters under the 29 C.F.R. 1614 process and the mixed matters under the 5 C.F.R. 1201 process.

A. Identifying and Defining the Claim in an EEO Complaint

1. Fragmentation often occurs at the point where the agency identifies and defines the complainant's claim, most commonly during the counseling and investigative stages. A claim refers to an assertion of an unlawful employment practice or policy for which, if proven, there is a remedy under the federal equal employment statutes. Fragmentation often results from a failure to distinguish between the claim the complainant is raising and the evidence (factual information) s/he is offering in support of that claim.

Example 1

An African-American employee complains to the EEO Counselor that his supervisor is stricter about his time and attendance than with the unit's Caucasian employees. This is a legal claim of race-based disparate treatment in the terms and conditions of the complainant's employment with regard to time and attendance. In support of this claim, the complainant tells the EEO Counselor about a number of different occasions when the supervisor denied his request for annual leave or required him to use leave because he was tardy, while treating similarly situated Caucasian employees more favorably. These specific incidents should be considered the evidence supporting the complainant's claim that

the supervisor is treating him differently because of his race with regard to his time and attendance. Fragmentation would occur if each of these incidents were considered a separate claim and processed as a separate complaint.

Example 2

A female employee complains to the EEO Counselor that she is being subjected to a hostile work environment due to the ongoing sexual harassment by her male co-workers. This is the complainant's legal claim. In support of this claim, the complainant tells the EEO Counselor of specific incidents of a sexual advance, a sexual joke and a comment of a sexual nature. These individual incidents are evidence in support of the complainant's claim and should not be considered as separate claims in and of themselves.

2. Often, when an agency identifies each piece of factual evidence (usually constituting a single incident) offered by the complainant as a separate and distinct legal claim, it ignores the complainant's real underlying issue of a pattern of ongoing discrimination.² In contrast, fragmentation rarely occurs when the complainant presents a legal claim based on a single incident (such as a particular selection decision or a termination decision) rather than a series of events.

In defining a legal claim, the agency must exercise care where a series of incidents offered by a complainant initially seem different from one another.

² See, for example, [Reid v. Dep't. of Commerce](#), EEOC Request No. 05970705 (Apr. 22, 1999); [Ferguson v. Dep't. of Justice](#), EEOC Request No. 05970792 (Mar. 30, 1999); [Manalo v. Dep't. of the Navy](#), EEOC Appeal Nos. 01960764 and 01963676 (Nov. 5, 1996), request for reconsideration denied, EEOC Request No. [05970254](#) (May 29, 1998).

Example 3

A complainant tells the EEO Counselor that she believes that the agency discriminated against her when she was not selected for a GS-14 Engineer position, when she was not detailed to serve in a similar position, and when she was denied access to a particular training program. All of these seemingly different incidents are part of the same claim of a discriminatory non-selection as the complainant has alleged that the detail and the training would have enhanced her qualifications for the GS-14 Engineer position and, therefore, are relevant to the agency's failure to select her for that position.

Practice Tip: When defining a claim, two components must be identified. First, the claim must contain a factual statement of the employment practice or policy being challenged. As already discussed, it is critical that EEO Counselors, investigators, and other EEO staff members ensure that they understand the exact nature of the complainant's concerns so that the employment practice is defined broadly enough to reflect any allegation of a pattern of ongoing discrimination. Particular attention should be given to claims involving terms and conditions of employment. In Example 1 above, the employment practice being challenged is: disparate treatment in terms and conditions of employment with regard to time and attendance policies. In Example 2 above, the employment practice is: the creation of a hostile work environment because of sexual harassment. In Example 3 above, the employment practice might be defined as: management's failure to advance the complainant's career to a GS-14 position. The second component of a legal claim is the identification of the basis (because of race, color, national origin, sex, religion, reprisal, age, disability, or genetic information) for a violation of an equal employment statute.

3. **Timeliness Issues:** One of the reasons the distinction between legal claims and supporting evidence is important is because complainants frequently raise factual incidents that occur outside of the 45-day time period for contacting an EEO Counselor. In general, for a legal claim to be timely raised, at least one of the incidents the complainant cites as evidence in support of his/her claim must have occurred within the 45-day time period for contacting an EEO Counselor. (The usual exceptions should still be made. See Section IV of this Chapter on dismissals.) If the claim itself is timely raised, the question remains as to how the agency is to treat those factual incidents that the complainant cited as evidence in support of his/her claim that occurred outside the 45-day time limit.

The answer is that an agency must consider, at least as background, all relevant evidence offered in support of a timely raised legal claim, even if the evidence involves incidents that occurred outside the 45-day time limit. This is true of supporting evidence that the complainant offered during EEO counseling as well as later in the investigative stage. During the investigation, the degree to which a certain piece of proffered evidence is relevant to the legal claim will determine what sort of investigation is necessary of that particular piece of evidence. For example, in a non-selection case, a selection decision made long before the one at issue, involving different agency officials, may have little relevance to the current claim. On the other hand, if the selecting official in the most recent non-selection also failed to select the complainant for a similar position six months before, that piece of evidence may be very relevant to the complainant's claim. Investigators should not simply disregard relevant information the complainant provided in support of his/her claim as untimely raised; nor should they send the complainant back to counseling as if the supporting evidence was a new claim to be processed as a separate complaint.

With regard to the timeliness of a claim of harassment, because the incidents that make up a harassment claim collectively constitute one unlawful employment practice, the claim is actionable, as long as at least one incident that is part of the claim occurred within the filing period. Such a claim can include incidents that occurred outside the filing period that the complainant knew or should have known were actionable at the time of their occurrence. See [Bulluck v. Dep't. of Veterans Affairs](#), EEOC Appeal No. 0120114276 (Mar. 14, 2012); [Richardson v. U.S. Postal Service](#), EEOC Appeal No. 0120111122 (Feb. 1, 2012). However, the Supreme Court has held that no recovery is available for discrete acts such as hiring, firing, and promotions that fall outside the filing period, even if they are arguably related to other discriminatory acts that occur within the filing period. [National Railroad Passenger Corp. v. Morgan](#), 536 U.S. 101 (2002). See also [EEOC Compliance Manual 915.003, Section 2: "Threshold Issues,"](#) (rev. July 21, 2005). However, as the Court recognized, an employee may use the prior discrete acts as background evidence in support of a timely harassment claim.

Practice Tip: It is critical that agencies document their actions and the reasons for those actions in the record for Administrative Judge and Commission consideration later in the process. For example, if the agency's investigator decides that a certain factual incident raised by the complainant is of little relevance to his/her claim and, therefore, decides that an investigation of that incident is very minimal, the investigator

should document that decision and the reasons for it in the investigative report.

B. A Complainant May Amend a Pending Complaint

At any time prior to the agency's mailing of the notice required by 29 C.F.R. § 1614.108(f) at the conclusion of the investigation, 29 C.F.R. § 1614.106(d) permits a complainant to amend a pending EEO complaint to add claims that are like or related to those claim(s) raised in the pending complaint.³ There is no requirement that the complainant seek counseling on these new claims. See Braxton v. U.S. Postal Service, EEOC Appeal No. 0120102410 (Oct. 29, 2010). After the complainant has requested a hearing, s/he may file a motion with the Administrative Judge to amend the complaint to include claims that are like or related to those raised in the pending complaint.

This situation most frequently occurs when an alleged discriminatory incident occurs after the filing of an EEO complaint. In the past, agencies usually made these subsequent incidents the basis of a separate EEO complaint. A separate EEO complaint is not appropriate, however, if the new incident of discrimination raises a claim that is like or related to the original complaint. Rather, the original complaint should be amended to include the new incident of discrimination.

When a complainant raises a new incident of alleged discrimination during the processing of an EEO complaint, it must be determined whether this new incident:

1. provides additional evidence offered to support the existing claim, but does not raise a new claim in and of itself;
2. raises a new claim that is like or related to the claim(s) raised in the pending complaint; or
3. raises a new claim that is **not** like or related to the claim(s) raised in the pending complaint.

In order to facilitate such a determination, the complainant shall be instructed by the investigator (or any other EEO staff person with whom complainant raises the new incident) to submit a letter to the agency's EEO Director or a designee describing the new incident(s) and stating that s/he wishes to amend his/her complaint to include the new incident(s). The EEO Director or designee shall

³ Note that technical amendments to a complaint, such as changing the name of the agency head, should be handled quickly and without adding additional case processing time.

review this request, determine whether a fair and impartial investigation of the new claims can be accomplished within 360 days of the original filed complaint, and determine the correct handling of the amendment in an expeditious manner.

1. New Incident That Is Part of the Existing Claim

If the EEO Director or designee concludes that the new incident(s) provides additional evidence offered in support of the claim raised in the pending complaint, but does not raise a new claim in and of itself, then the EEO Director or designee should instruct the investigator to include the new incident in the investigation. A copy of this letter should be sent to the complainant unless they have provided notice that they have a representative. In such a case, the acknowledgment and all subsequent actions on the complaint should be mailed or delivered to complainant's representative with a copy to the complainant, unless the complainant has stated otherwise.

Example 4

During EEO counseling and in her formal complaint, an agency employee has alleged that her co-workers were harassing her because of her gender, and she cites five examples of harassment. During the investigation, she provides an initial affidavit detailing these incidents. Shortly thereafter, the employee contacts the investigator and tells him of several new incidents of gender-based harassment by these same co-workers. In this case, these new incidents are additional evidence offered by complainant in support of her pending claim of discriminatory harassment, and the investigator should be instructed to incorporate these new facts into his investigation of the pending claim. In this instance, the investigative period is not extended beyond 180 days, except with the consent of the complainant pursuant to 29 C.F.R. § 1614.108(e).

2. **New Incident That Raises a New Claim Like or Related to the Pending Claim**

While a complaint is pending, a complainant may raise a new incident of alleged discrimination that is not part of the existing claim, but may be part of a new claim that is like or related to the pending claim. In deciding if a subsequent claim is “like or related” to the original claim, a determination must be made as to whether the later incident adds to or clarifies the original claim, and/or could have reasonably been expected to grow out of the investigation of the original claim. See [Complainant v. Dep’t. of the Army](#), EEOC Appeal No. 0120142480 (Nov. 25, 2014; [Scher v. U.S. Postal Service](#), EEOC Request No. 05940702 (May 30, 1995); [Webber v. Dep’t. of Health and Human Services](#), EEOC Appeal No. 01900902 (Feb. 28, 1990).

In accordance with 29 C.F.R. § 1614.108(f) and guidance set forth in Section II(A)(1) of this Chapter, if the EEO Director or designee concludes that the new incident(s) raises a new claim, but that this new claim is like or related to the claim(s) raised in the pending complaint, the agency must amend the pending complaint to include the new claim. Accordingly, and pursuant to 29 C.F.R. § 1614.106(e), the agency shall acknowledge receipt of an amendment to a complaint in writing and inform the complainant of the date on which the amendment was filed. The EEO Director or designee should also send a copy of the letter to the EEO Investigator who is investigating the complainant’s prior complaint with instructions to include the new incident(s) in the investigation.

Example 5

An agency employee files a race discrimination complaint alleging he was not selected for a particular supervisory position, despite his belief that he was the best qualified candidate for the job. During the investigation into his complaint, the same selecting official does not select the complainant for another supervisory position. Complainant again asserts he was not selected because of his race. This new claim of a discriminatory non-selection is sufficiently like or related to the original non-selection claim that the agency should amend the original complaint to include the subsequent non-selection.

Example 6

During the investigation into her claim that the agency is discriminating against her in the terms and conditions of her employment because her supervisor denied her developmental assignments that could lead to upward mobility in the agency, the complainant informs the investigator that her supervisor just issued her a letter of warning for attendance problems. The complainant asserts that the supervisor took this action in retaliation for her complaint about the denial of development assignments. This new claim of retaliation is related to the pending claim because it grew out of the investigation into that claim. The agency should amend the original complaint to include this subsequent, but related, claim.

Example 7

An agency employee files a complaint of discrimination when his request for a hardship transfer is denied. During the investigation into his complaint, the complainant sends a letter to the EEO office stating that he has decided to resign from the agency because of the agency's failure to transfer him and the resulting stress. He further states that he is no longer seeking the transfer as a remedy to his complaint, but asserts he is entitled to a compensatory damages award instead. The EEO office should amend the original complaint to include the complainant's new like or related claim of constructive discharge.

Pursuant to 29 C.F.R. § 1614.106(e)(2), the agency is required to complete its investigation of an EEO complaint within 180 days of the filing of a complaint unless the parties agree in writing to extend the time period. If a complaint is amended, however, this deadline is adjusted so that the agency must complete its investigation within the earlier of 180 days after the last amendment to the complaint or not more than 360 days after the filing of the original complaint.

Pursuant to 29 C.F.R. § 1614.108(g) the agency is still required to issue a notice to complainant that the investigation is not complete and estimating a time in which it will be complete. A complainant retains the right to request a hearing, even in the case of an amended complaint, after 180 days have passed since the filing of the original complaint, even if the agency's investigation has not been completed. In such a case, an Administrative Judge may develop the record through discovery and the

hearing process, or utilize other means within his/her discretion to ensure that the amended complaint is properly addressed.

3. New Incident Raises Claim That Is Not Like or Related to Pending Claim

In cases where subsequent acts of alleged discrimination do not add to or clarify the original claim, and/or could not have been reasonably expected to grow out of the investigation of the original claim, the later incident should be the subject of a separate EEO complaint. In such cases, fragmented processing of an EEO complaint is not at issue because there are two distinct and unrelated legal claims being alleged.

If the EEO Director or designee concludes that the new claim raised by the complainant is **not** like or related to the claim(s) raised in the pending complaint, then the complainant must be advised in writing that s/he should seek EEO counseling on the new claim. The postmark date of the letter (from complainant requesting an amendment) to the EEO Director or designee would be the date for time computation purposes used to determine if initial counselor contact was timely under 29 C.F.R. § 1614.105(b).

Example 8

An agency employee sought EEO counseling and filed a formal complaint concerning his allegation that the agency discriminated against him in the terms and conditions of his employment by requiring that he adhere to a specific work schedule while not imposing a similar requirement on a comparative employee. During the investigation into this complaint, the complainant tells the investigator that he was recently not selected for a position in another facility and believes this occurred as a result of discrimination. In this case, the discriminatory non-selection claim is not like or related to the adherence to the work schedule claim, as it is factually distinct and cannot reasonably be said to add to or clarify the original claim.

C. Consolidation of Complaints

As noted above, a new claim that is not like or related to a previously filed complaint provides the basis for a new, and separate, complaint. The complainant must present the new, unrelated claim to an EEO Counselor and the new claim is subject to all of the regulatory case processing requirements. In order to address a

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different fragmentation concern, 29 C.F.R. § 1614.606 requires agencies to consolidate for joint processing two or more complaints of discrimination filed by the same complainant, after appropriate notification is provided to the parties.⁴ While it is anticipated that most consolidated complaints will be investigated together, in certain circumstances, such as significant geographic distance between the sites of two complaints, consolidation does not preclude an agency from investigating each complaint separately. In all instances, however, where an individual requests a hearing, the consolidated complaints should be heard by a single Administrative Judge; or where the complainant requests a final agency decision, the agency should issue a single decision. An agency must consolidate complaints filed by the same complainant before the agency issues the notice required by 29 C.F.R. § 1614.108(f) at the conclusion of the investigation.

When a complaint has been consolidated with an earlier filed complaint, the agency must complete its investigation within the earlier of 180 days after the filing of the last complaint or not later than 360 days after the filing of the original complaint. See Section II.A.1 of this Chapter for more information on time limits. A complainant has the right to request a hearing, even in the case of consolidated complaints, after 180 days have passed since the filing of the original complaint, even if the agency's investigation is not complete. If not already consolidated, an Administrative Judge or the Commission in their discretion may consolidate two or more complaints of discrimination filed by the same complainant.

Section 1614.606 of 29 C.F.R. permits, but does not require, the consolidation of complaints filed by different complainants that consist of substantially similar allegations or allegations related to the same matter.

D. Partial Dismissals

Another method of addressing the fragmentation problem is 29 C.F.R. § 1614.107(b), which provides for no immediate right to appeal a partial dismissal of a complaint. See Section IV.C of this Chapter for a more detailed discussion of partial dismissals. Partial dismissals will be preserved and decided within the context of the rest of the complaint.

⁴ Through mandatory consolidation, the Commission seeks to address the situation where a single complainant has multiple complaints pending against an agency. Even if the complaints are unrelated, their resolution in a single proceeding may make better use of agency and Commission resources.

E. No Remands by Administrative Judges

To further avoid the fragmenting of EEO claims, Administrative Judges will not remand issues to agencies for counseling or other processing. Once a case is before an Administrative Judge, that Administrative Judge is fully responsible for processing it. Chapter 7, “Hearings,” in this Management Directive discusses more fully this provision.

F. “Spin-off” Complaints

Section 1614.107(a)(8) of 29 C.F.R. provides for the dismissal of spin-off complaints, which are complaints about the processing of existing complaints. Complaints about the processing of existing complaints should be referred to the agency official responsible for complaint processing, and/or processed as part of the original complaint, as set forth in Section IV.D of this Chapter.

G. Training

As already emphasized, the EEO Counselor and investigator have critical roles in identifying, defining, and clarifying an aggrieved employee’s legal claims. Therefore, agencies must provide all agency EEO Counselors and investigators with mandatory training in this area as well as ensure that all contract EEO Counselors and investigators have received training in this area. See Chapter 2, Section II (EEO Counselor training) and Chapter 6, Section II (investigator training) of this Management Directive.

IV. AGENCY DISMISSAL PROCESS

Circumstances under which an agency may dismiss a complaint are set forth in 29 C.F.R. § 1614.107(a). An agency’s authority to dismiss a complaint ends when a complainant requests a hearing. An agency should process dismissals expeditiously. To avoid common errors in dismissing complaints of discrimination see [EEOC, Preserving Access to the Legal System: Common Errors by Federal Agencies in Dismissing Complaints of Discrimination on Procedural Grounds](#), issued in September of 2014 on the Commission’s website.

The agency should clearly set forth its reasoning for dismissing the complaint in all dismissal decisions and include evidence in the record that supports the grounds for dismissal. For example, if the agency dismisses a claim under 29 C.F.R. § 1614.107(a)(3) because a civil action was filed by complainant, the agency should ensure that a copy of the civil complaint is included in the record.

A. Bases for Dismissals That May Exist as of the Filing of the Complaint or Develop Thereafter

1. Untimely Counseling Contact - 29 C.F.R. § 1614.107(a)(2)

- a. A claim that was not brought to the attention of an EEO Counselor in a timely manner.
- b. The complainant did not contact an EEO Counselor within **forty-five (45) days** of the discriminatory event or within **45 days** of the effective date of the personnel action, 29 C.F.R. § 1614.105(a)(1), and the complainant did not show that the 45-day contact period should be extended pursuant to 29 C.F.R. § 1614.105(a)(2). See, for example, [Ball v. U.S. Postal Service](#), EEOC Request No. 05880247 (July 6, 1988) (reasonable suspicion standard used to determine when the 45-day limitation period begins; time limit is not triggered until the complainant reasonably suspects discrimination, but before all of the facts that support the charge of discrimination have become apparent). An agency may be barred from dismissing a complaint on timeliness grounds where:
 - (1) the agency could not establish that the complainant was notified of the time limits and was otherwise aware of them, or did know and reasonably should have known that the discriminatory practice or personnel action occurred or that despite due diligence was prevented by circumstances beyond his/her control from contacting an EEO Counselor within the time limits, or for other reasons considered sufficient by the agency or the Commission; or
 - (2) the complainant contends that the claim is a part of a pattern of discrimination or establishes that there are other equitable circumstances that mitigate untimely contact. Time limits are subject to waiver, estoppel, and equitable tolling under 29 C.F.R. § 1614.604(c).

2. Untimely Filing of the Formal Complaint – 29 C.F.R. § 1614.107(a) (2)

The complainant failed to file a formal complaint within **fifteen (15) days** of his/her receipt of the EEO Counselor’s Notice of Right to File a Formal Complaint in an individual complaint, 29 C.F.R. § 1614.105(d), or in a class complaint, 29 C.F.R. § 1614.204(c). The agency has the burden of proving that the complainant received the notice and that the notice clearly informed the aggrieved person of the 15-day filing time frame. See, for example, [Paoletti v. U.S. Postal Service](#), EEOC Request No. 05950259 (Aug. 17, 1995). This time limit is also subject to waiver, estoppel, and equitable tolling under 29 C.F.R. § 1614.604(c).

3. Failure to State a Claim - 29 C.F.R. § 1614.107(a)(1)

The complainant failed to state a claim under 29 C.F.R. § 1614.103. This may include a claim that does not allege discrimination on a basis encompassed in one of the statutes applicable to federal sector employees. In determining whether a complaint states a claim, the proper inquiry is whether the conduct if true would constitute an unlawful employment practice under the EEO statutes. [Cobb v. Dep’t. of the Treasury](#), EEOC Request No. 05970077 (Mar. 13, 1997) (a complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the complainant cannot prove a set of facts in support of the claim which would entitle the complainant to relief; the trier of fact must consider all of the alleged harassing incidents and remarks and, considering them together in the light most favorable to the complainant, determine whether they are sufficient to state a claim). See also [Burlington Industries, Inc. v. Ellerth](#), 524 U.S. 742, 752-753 (1998) (referencing cases in which courts of appeals considered whether various employment actions were sufficient to state a claim under the civil rights laws). Dismissal for failure to state a claim also may be appropriate where the complainant named the improper agency. See 29 C.F.R. § 1614.106(a).

An agency shall accept a complaint from any aggrieved employee or applicant for employment who believes that s/he was discriminated against by that agency because of race, color, religion, sex, national origin, age, disabling condition, genetic information, or retaliation. The Commission has long defined an “aggrieved employee” as one who suffers a present harm or loss with respect to a term, condition, or privilege of employment for which there is a remedy. [Diaz v. Dep’t. of the Air Force](#), EEOC Request No. 05931049 (Apr. 21, 1994); see also [Wildberger v. Small Business Administration](#), EEOC Request No. 05960761 (Oct. 8, 1998). An agency is required to address EEO complaints only when filed by an individual who has suffered direct,

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personal deprivation at the hands of the employer; the agency's act must have caused some concrete effect on the aggrieved person's employment status. [Quinones v. Dep't. of Defense](#), EEOC Request No. 05920051 (Mar. 12, 1992).

Further, it is inappropriate for an individual to use the EEO process to lodge a collateral attack against another proceeding. For example, [see Schneider v. U.S. Postal Service](#), EEOC Request No. 05A01065 (Aug. 16, 2002) (affirming agency dismissal of complaint alleging discriminatory delay in submission of worker's compensation claim as collateral attack on OWCP claim process); [Jones v. Dep't. of the Army](#), EEOC Request No. 05A00428 (Mar. 1, 2002) (affirming dismissal of complaint regarding polygraph examination as a collateral attack on the agency's internal investigation of disappearance of agency property); or [Lingad v. U.S. Postal Service](#), EEOC Request No. 05930106 (June 25, 1993) (holding that discriminatory actions taken to influence the outcome of decision rendered under the negotiated grievance procedure is outside the purview of EEO process). The proper forum to raise these kinds of issues is within the process itself. An agency should dismiss these complaints as failures to state a claim.

When an individual alleges retaliation in a complaint, they do not need to make a showing of an adverse employment action. [See Burlington Northern & Santa Fe Railway Co. v. White](#), 548 U.S. 53, 68 (2006); [EEOC Compliance Manual 915.003 Section 8-Retaliation II.D.3](#) (May 20, 1998) (any adverse treatment that is based upon a retaliatory motive and is reasonably likely to deter the charging party or others from engaging in protected activity states a claim). The significance of the act of alleged retaliation will often depend upon the particular circumstances. For example, in [Isom v. U.S. Postal Service](#), EEOC Appeal No. 0120113627 (Nov. 7, 2012), the complainant alleged that he was required to perform both forklift and jitney duties. The record revealed that other employees were required to perform either forklift or jitney duties but not both and that the supervisor involved was under pressure to discipline complainant for refusing an assignment even if the discipline was not warranted. The Commission found a viable claim of retaliation was stated and remanded the case to the agency to process.

4. Abuse of Process - 29 C.F.R. § 1614.107(a)(9)

Section 1614.107(a)(9) of 29 C.F.R. is the appropriate provision under which an agency may dismiss a complaint on the extraordinary grounds of abuse of process.

- a. Abuse of process is defined as a clear pattern of misuse of the process for ends other than that which it was designed to accomplish. See [Buren v. U.S. Postal Service](#), EEOC Request No. 05850299 (Nov. 18, 1985); [Kleinman v. U.S. Postal Service](#), EEOC Appeal No. 01943637 (September 22, 1994); [Sessoms v. U.S. Postal Service](#), EEOC Appeal No. 01973440 (June 11, 1998). The Commission has a strong policy in favor of preserving a complainant's EEO rights whenever possible. The occasions in which application of the standards are appropriate must be rare, because of the strong policy in favor of preserving a complainant's EEO rights whenever possible. See generally [Love v. Pullman](#), 404 U.S. 522 (1972); [Wrenn v. Equal Employment Opportunity Commission](#), EEOC Appeal No. 01932105 (Aug. 19, 1993). Therefore, such dismissals must be taken only in cases where there is a clear misuse or abuse of the administrative process.
- b. In order to determine whether a complaint, or a number of consolidated complaints, should be dismissed for this reason under 29 C.F.R. § 1614.107(a)(9), the agency or Administrative Judge must strictly apply the criteria established by the Commission on this issue.⁵ This requires an analysis of whether the complainant evidences an ulterior purpose to abuse or misuse the EEO process. Agencies are cautioned that numerous complaint filings alone is not a sufficient basis for determining that there has been an abuse of the process. However, multiple filings on the same issues, lack of specificity in the allegations, and the filing of complaints on allegations previously raised, may be considered in deciding whether a complainant has engaged in a pattern of abuse of the EEO process. All pending complaints from a complainant which satisfy these criteria should be consolidated for dismissal under this section.
- c. Cases in which the Commission has found an abuse of the EEO process include those where, upon review of the complainant's

⁵ The Commission retains the authority on appeal to protect its administrative processes from abuse by either party.

record, including the number and types of complaints filed, the Commission has concluded that the complainant has pursued a scheme involving the misuse and misapplication of the EEO process for an end other than that which it was designed to accomplish.

- (1) For example, in reviewing a complainant's prior complaints, the Commission has found abuse of process where the complainant presented similar or identical allegations, evidencing a pattern of initiating the complaint process whenever the agency did anything that dissatisfied the complainant. [Hooks v. U.S. Postal Service](#), EEOC Appeal No. 01953852 (Nov. 28, 1995).
- (2) The Commission has also found abuse of process when the complainant presented similar or identical allegations related to the complainant's dissatisfaction with the EEO process itself. [Goatcher v. U.S. Postal Service](#), EEOC Request No. 05950557 (Oct. 18, 1996). The complainant in [Goatcher](#) filed numerous complaints concerning the agency's purported denial of access to sufficient equipment and storage for EEO claims, denial of official time for such claims, inadequate EEO counseling, agency monitoring of time spent in the EEO process, and failure to maintain her anonymity during EEO counseling.
- (3) In [Sessoms v. U.S. Postal Service](#), EEOC Appeal No. 01973440 (June 11, 1998), the Commission noted that the appellant was experienced in the EEO process, but that he pursued a clear pattern of abuse of the EEO process by filing numerous frivolous complaints. The Commission noted, "A definite pattern of initiating the complaint machinery with respect to any matter with which appellant was dissatisfied has developed . . . clearly has amounted to an abuse of process." See also [Kessinger v. U.S. Postal Service](#), EEOC Appeal No. 01976399 (June 8, 1999) (clear pattern of abuse from multiple filings, totaling over 160 complaints and 150 appeals, many of which were duplicate complaints of earlier, dismissed filings; the Commission found the complainant's actions an intentional effort to clog the agency's in-house administrative machinery); [Stoyanov v. Dep't. of the Navy](#), EEOC Appeal Nos. 0120113142, 0120113817, and 0120114019 (Dec. 6, 2011) (clear pattern of abuse from multiple filings many of which concerned

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selections for positions for which complainant was not eligible to apply).

- d. The Commission has stressed in such cases that a party cannot be permitted to utilize the EEO process to circumvent other administrative processes; nor can individuals be permitted to overburden the EEO system, which is designed to protect individuals from discriminatory practices.

Example 1

The complainant originally filed a complaint of discrimination in non-selection for promotion. Subsequently, he repeatedly filed complaints of reprisal, alleging that the agency was denying him official time to prepare EEO complaints, denying him the use of facilities and storage space for his EEO materials, providing improper EEO counseling, and unfairly keeping tabs on the amount of official time he was spending on his EEO complaints. Many of the allegations in these complaints were vague, and raised allegations previously raised in earlier complaints. In fact, he had on several occasions copied a previous complaint on which he would write a new date in order to file new complaint. Over the course of several months, he filed a total of 25 complaints in this manner. The agency could consolidate the subsequent complaints and dismiss them under 29 C.F.R. § 1614.107(a) for abuse of process. The complainant had demonstrated a pattern of abuse of the process, involving multiple complaints containing identical or similar allegations. (See, for example, [Kessinger v. U.S. Postal Service](#), EEOC Appeal No. 01976399 (June 8, 1999); [Story v. U.S. Postal Service](#), EEOC Request No. 05970083 (May 22, 1998).)

Example 2

The complainant originally filed a complaint of discrimination in non-selection for promotion. Subsequently she filed a total of 15 complaints, many alleging specific and distinct acts of reprisal for her prior EEO activity. Based on the number of complaints alone, the agency attempted to dismiss them all for abuse of process.

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There was insufficient evidence to dismiss the complaints for abuse of process. Evidence of numerous complaint filings, in and of itself, is not a sufficient basis for determining that there has been an abuse of the process. In this case, there was no evidence that the complainant's ulterior purpose was to abuse the EEO process, or that she was misusing the process for ends other than that which it was designed to accomplish. It may be appropriate, however, for the agency to consolidate the individual complaints for processing. (See, for example, [Manley v. Dep't. of the Air Force](#), EEOC Appeal No. 01975901 (May 29, 1998); and [Donnelly v. Dep't. of Energy](#), EEOC Appeal No. 01972171 (Nov. 17, 1997) for decisions rejecting agency contentions of abuse of process.)

5. States the Same Claim - 29 C.F.R. §1614.107(a)(1)

The complaint states the same claim that is pending before or had been decided by the agency or Commission except in those cases where a class action complaint is pending.⁶ The Commission has interpreted this regulation to require that the complaint must set forth the "identical matters" raised in a previous complaint filed by the same complainant, in order for the subsequent complaint to be rejected. [Terhune v. U.S. Postal Service](#), EEOC Request No. 05950907 (July 18, 1997); [Russell v. Dep't. of the Army](#), EEOC Request No. 05910613 (Aug. 1, 1991) (interpreting 29 C.F.R. § 1613.215(a)(1), the predecessor of 29 C.F.R. § 1614.107(a)(1)).

6. Complainant Files a Civil Action - 29 C.F.R. § 1614.107(a)(3)

The complainant files a civil action concerning the same allegation, at least **one hundred eighty (180) days** after s/he filed his/her administrative complaint. The requirement in 29 C.F.R. § 1614.409 that the civil action shall be dismissed only if it was filed pursuant to 29 C.F.R. § 1614.408 evidences the intent of the Commission to restrict the dismissals of EEO complaints for filing a civil action to those civil actions which were brought under the statutes enforced by the Commission. Where a complainant has not filed a civil action pursuant to the specific statutes listed in 29 C.F.R. § 1614.408, the complaint may not be dismissed

⁶ In that case, an individual complaint will be subsumed under the class complaint. See Chapter 8 Section III of this Management Directive for detailed information on when a case should be subsumed.

pursuant to 29 C.F.R. § 1614.107(a)(3). See [Krumholz v. Dep't. of Veterans Affairs](#), EEOC Appeal No. 01934799 (Dec. 15, 1993), aff'd, EEOC Request No. [05940346](#) (Oct. 21, 1994).

7. Issue Has Been Decided - 29 C.F.R. § 1614.107(a)(3)

The same issue has been decided by a court of competent jurisdiction and the complainant was a party to the lawsuit. Commission regulations mandate dismissal of the EEO complaint under these circumstances so as to prevent a complainant from simultaneously pursuing both administrative and judicial remedies on the same matters, wasting resources, and creating the potential for inconsistent or conflicting decisions. [Stromgren v. Dep't. of Veterans Affairs](#), EEOC Request No. 05891079 (May 7, 1990); [Sandy v. Dep't. of Justice](#), EEOC Appeal No. 01893513 (Oct. 19, 1989). The proper inquiry to determine whether dismissal is warranted is whether the issues in the EEO complaint and the civil action are the same, that is, whether the acts of alleged discrimination are identical. [Bellow v. U.S. Postal Service](#), EEOC Request No. 05890913 (Nov. 27, 1989). The factual allegations and not the bases or the precise relief requested should be the crux of the legal analysis.

8. Allegation Raised in Negotiated Grievance Proceeding - 29 C.F.R. § 1614.107(a)(4)

The complainant has raised the allegation in a negotiated grievance procedure that permits allegations of discrimination, indicating an election to pursue a non-EEO process. Section 1614.301(a) of 29 C.F.R. provides that “a person wishing to file a complaint or a grievance on a matter of alleged employment discrimination must elect to raise the matter under either part 1614 or the negotiated grievance procedure, but not both.” This subsection also provides that an election to proceed under 1614 is indicated by the “filing of a written complaint,” while an election to proceed under a negotiated grievance procedure is indicated by the “filing of a timely written grievance.” See [Casey v. Dep't. of Veterans Affairs](#), EEOC Appeal No. 01944605 (Aug. 9, 1995).⁷ The withdrawal of a

⁷ An agency cannot deny a complainant his statutory and regulatory right to file an EEO complaint because the union exercised its right to file its own grievance pursuant to the terms of a Collective Bargaining Agreement. See [Callahan v. Dep't. of the Interior](#), EEOC Appeal No. 0120110309 (Jan. 5, 2012) (complainant stated that the union filed a grievance without his knowledge and there was no evidence in the record that complainant was involved in filing the grievance); see also [Cate v. Dep't. of the Army](#), EEOC Appeal No. 0120110083 (Nov. 21, 2011).

grievance does not abrogate its effect for purposes of an election. [Bracket v. Dep't. of the Air Force](#), EEOC Request No. 05910383 (Aug. 8, 1991).

9. Appeal Made to MSPB - 29 C.F.R. § 1614.107(a)(4)

The complainant has elected to appeal the claim to the Merit Systems Protection Board, rather than file a mixed case complaint under 29 C.F.R. § 1614.302.

10. Complaint Alleges a Preliminary Step - 29 C.F.R. § 1614.107(a)(5)

The complaint alleges that a proposal to take or a preliminary step in taking a personnel action is discriminatory. This provision requires the dismissal of complaints that allege discrimination “in any preliminary steps that do not, without further action, affect the person: for example, progress reviews or improvement periods that are not a part of any official file on the employee.” 57 Fed. Reg. 12,643 (Apr. 10, 1992); *see*, for example, [McAlhaney v. U.S. Postal Service](#), EEOC Request No. 05940949 (July 7, 1995). However, if the complaint alleges that a proposal to take or a preliminary step in taking a personnel action is retaliatory, the complaint should not be dismissed because a proposed action could be considered adverse treatment in the context of reprisal if it is reasonably likely to deter protected activity.⁸ *See* [Brown v. Dep't. of Defense](#), EEOC Appeal No. 0120103139 (Dec. 8, 2010) (complainant’s claim that the agency discriminated against him when it placed him on a performance improvement plan stated a viable claim of retaliation). In addition, if the individual alleges that the preliminary step was part of a pattern of harassing the individual for a prohibited reason, the complaint cannot be dismissed under this section because the preliminary step has already affected the employee. *See*, for example, [Noone v. Central Intelligence Agency](#), EEOC Request No. 05940422 (Jan. 23, 1995); *see also* [Bennett v. U.S. Postal Service](#), EEOC Appeal No. 0120111470 (Jan. 5, 2012).

11. Complaint is Moot - 29 C.F.R. § 1614.107(a)(5)

A complaint may be dismissed as moot where there is no reasonable expectation that the alleged violation will recur, and interim relief or

⁸ Dismissal of allegedly retaliatory proposals and other preliminary steps may be appropriate under 29 C.F.R. § 1614.107(a)(1) if the alleged retaliatory actions are not “materially adverse,” that is, would not dissuade a reasonable employee in complainant’s circumstances from engaging in protected activity. *See* [Burlington Northern & Santa Fe Railway Co. v. White](#), 548 U.S. 53, 68 (2006).

events have completely and irrevocably eradicated the effects of the alleged violation. See [Wildberger v. Small Business Administration](#), EEOC Request No. 05960761 (Oct. 8, 1998), (citing [County of Los Angeles v. Davis](#), 440 U.S. 625 (1979)). When such circumstances exist, no relief is available, and there is no need for a determination of the rights of the parties. The Commission has also held, however, that where a complainant has made a timely request for compensatory damages, an agency must address the issue of compensatory damages before it can dismiss a complaint for mootness. See, for example, [Salazar v. Dep't. of Justice](#), EEOC Request No. 05930316 (Feb. 9, 1994).⁹

12. Dissatisfaction with the Processing of a Complaint - 29 C.F.R. § 1614.107(a)(8)

The complaint alleges dissatisfaction with the processing of a previously filed complaint. See discussion in Section IV.D of this Chapter of the Management Directive.

B. Dismissals that Generally Occur after the Agency Accepts the Complaint Based on Complainant's Actions or Inactions

1. The Complainant Cannot Be Located - 29 C.F.R. § 1614.107(a)(6)

The regulations permit dismissal where the complainant cannot be located. The provision requires that the agency make reasonable efforts to locate the complainant and inform the complainant that s/he must respond to the agency's notice of proposed dismissal within **fifteen (15) days** sent to his/her last known address. A matter may not be "dismissed" under this section until after the complaint has been filed. See [Clairborne v. Dep't. of the Air Force](#), EEOC Appeal No. 01972713 (Mar. 19, 1998).

2. The Complainant Failed to Respond or Proceed in a Timely Fashion - 29 C.F.R. § 1614.107(a)(7)

⁹ A different situation is presented where an agency unilaterally and unconditionally promises in writing to provide the full and complete remedy as defined by the Administrative Judge. Although the complaint is "moot" in the sense that the guarantee of complete relief completely and irrevocably eradicates the effects of the alleged violation, the Administrative Judge will not dismiss the complaint as moot, but will issue an order determining the appropriate remedy. The purpose of this requirement is to ensure that the complainant will be able to seek enforcement of the agency's agreement to provide full relief should the agency fail to do so. See Chapter 7, Section III.D.15 of this Management Directive.

The regulations permit dismissal where the complainant has failed to respond to a written “request to provide relevant information or to otherwise proceed” within **15 days** of receipt, provided that the request contained notice of the proposed dismissal and further provided that there is otherwise insufficient available information to adjudicate the claim. The regulation further states that an agency may not dismiss on this basis where the record includes sufficient information to issue a decision. See [Delancy v. U.S. Postal Service](#), EEOC Appeal No. 0120111686 (Mar. 13, 2012). The Commission also has held that the regulation is applicable only in cases where there is a clear record of delay or contumacious conduct by the complainant. See [Martinez v. U.S. Postal Service](#), EEOC Appeal No. 0120113028 (Nov. 2, 2011) (dismissal of complaint for failure to cooperate was improper where there was insufficient evidence to support a conclusion that complainant purposely engaged in delay or contumacious conduct, and there was sufficient information in the record to have permitted the agency to continue the investigation, including extensive information as to the alleged discriminatory action and the responsible officials).

C. Processing of Partially Dismissed Complaints

There is no immediate right to appeal a partial dismissal of a complaint. Where an agency believes that some but not all of the claims in a complaint should be dismissed for the reasons contained in 29 C.F.R. § 1614.107(a), the agency must notify the complainant in writing of its determination, set forth its rationale for that determination, and notify the complainant that the allegations will not be investigated. The agency must place a copy of the notice in the investigative file. The agency should advise the complainant that an Administrative Judge shall review its dismissal determination if s/he requests a hearing on the remainder of the complaint, but the complainant may not appeal the dismissal until a final action is taken by the agency on the remainder of the complaint. See 29 C.F.R. § 1614.107(b).

1. Where a Hearing Is Requested

If the complainant requests a hearing from an Administrative Judge, the Administrative Judge will evaluate the agency’s reasons for believing that a portion of the complaint met the standards for dismissal before holding the hearing. If the Administrative Judge believes that all or part of the agency’s reasons are not well taken, the entire complaint or all of the portions not meeting the standards for dismissal will continue in the hearing process. The parties may conduct discovery to develop the record for all portions of the complaint continuing in the hearing process. The

Administrative Judge's decision on the partial dismissal will become part of the Administrative Judge's final decision on the complaint and may be appealed by either party after final action is taken on the complaint.

2. Where a Final Decision by the Agency Is Requested

Where a complainant requests a final decision by the agency without a hearing, the agency will issue a decision addressing all claims in the complaint, including its rationale for dismissing claims, if any, and its findings on the merits of the remainder of the complaint. The complainant may appeal the agency's decision, including any partial dismissals, to the Commission.

Agency decisions shall include the following:

- a. findings of fact and conclusions of law on the merits of each issue in the complaint;
- b. appropriate remedies and relief in accordance with subpart E of part 1614 when discrimination is found;
- c. notice of right to appeal to the Commission (with EEOC Form 573, Notice of Appeal/Petition attached), unless the complaint involves a mixed case, where the agency should provide notice of right to appeal to the MSPB (not the Commission) within thirty (30) days of receipt of the agency final decision;
- d. notice of right to file a civil action in a U.S. District Court;
- e. the name of the proper defendant in any such lawsuit; and
- f. the applicable time limits for appeals and lawsuits.

D. Allegations of Dissatisfaction Regarding Processing of Pending Complaints

1. If a complainant is dissatisfied with the processing of his/her pending complaint, whether or not it alleges prohibited discrimination as a basis for dissatisfaction, including that agency counsel/representatives improperly interfered during the investigation of the complaint, s/he should be referred to the agency official responsible for the quality of complaints processing. Agency officials should earnestly attempt to resolve dissatisfaction with the complaints process as early and expeditiously as possible.

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2. The agency official responsible for the quality of complaints processing must add a record of the complainant's concerns and any actions the agency took to resolve the concerns, to the complaint file maintained on the underlying complaint. If no action was taken, the file must contain an explanation of the agency's reason(s) for not taking any action.
3. A complainant must always raise his/her concerns first with the agency, in the above manner. However, in cases where the complainant's concerns have not been resolved informally with the agency, the complainant may present those concerns to the Commission at either of the following stages of processing:
 - a. Where the complainant has requested a hearing, to the Commission's Administrative Judge when the complaint is under the jurisdiction of the Administrative Judge; or
 - b. Where the complainant has not requested a hearing, to the Commission's Office of Federal Operations (OFO) on appeal.

A complainant must raise any dissatisfaction with the processing of his/her complaint before the Administrative Judge issues a decision on that complaint, the agency takes final action on the complaint, or either the Administrative Judge or the agency dismisses the complaint. The complainant has the burden of showing improper processing. No concerns regarding improper processing raised after a decision will be accepted by the agency, the Administrative Judge, or OFO.

Where the Administrative Judge or OFO finds that an agency has improperly processed the original complaint and that such improper processing has had a material effect on the processing of the original complaint, the Administrative Judge or OFO may impose sanctions on the agency as deemed appropriate. For example, where the complainant asserts that the agency's investigation of the complaint was improper, the Administrative Judge may determine whether the complainant has properly characterized the investigation and whether the agency's failure properly to investigate the complaint had a material effect on the processing of the complaint. Or, for example, where the complainant asserts that agency counsel or representatives improperly directed, or interfered with, the investigation of the complaint, the Administrative Judge may determine whether the Agency did, in fact, interfere in the investigation, and whether such interference so undermined the neutrality of the investigation that it materially affected the processing of the complaint. If the Administrative Judge finds that the processing of the

complainant's complaint was materially affected by the agency's actions, the Administrative Judge shall issue an appropriate order addressing the deficiencies in the investigation. If the Administrative Judge finds that although the agency's actions were inconsistent with its requirements under the 29 C.F.R. Part 1614 regulations, but had no material effect on the processing of the complaint, the Administrative Judge, in the exercise of his/her discretion, may suggest that the complainant submit a letter to the following Commission office for consideration regarding the agency's conduct:

Equal Employment Opportunity Commission
Office of Federal Operations
Federal Sector Programs
131 M Street, NE
Washington, DC 20507

Electronic submission may be made using email transmission of documents to federalsectoreeo@eoc.gov or by using the Commission's electronic document submission portal.

Where the complainant contends that an agency improperly denied him/her official time and the Administrative Judge or OFO finds in the complainant's favor, the Administrative Judge or OFO may order the agency to restore such personal leave as the complainant may have used in lieu of official time.

V. CONDUCTING THE INVESTIGATION

A. Agency Retains Responsibility

Agencies are responsible for conducting an appropriate investigation of complaints filed against them. An agency may contract out an investigation or may arrange for another agency to conduct the investigation, but the agency remains responsible for the content and timeliness of the investigation.

B. Investigations Must Be Timely Completed

Investigations must be completed within **180 days**¹⁰ of filing a complaint or within the time period contained in an order from the Office of Federal

¹⁰ If the complaint is a mixed case, the investigation must be finished within 120 days. MSPB

Operations to investigate a complaint following an appeal from a dismissal, unless the EEO Director or designee and the complainant agree in writing to an extension of not more than an additional **ninety (90) days**. Where a complaint has been amended or consolidated with another complaint, the investigation must be completed within the earlier of 180 days after the filing of the last complaint or not later than 360 days after the filing of the original complaint. A complainant has the right to file a civil action or request a hearing, even in the case of consolidated complaints, after 180 days have passed since the filing of the original complaint, even if the agency's investigation has not been completed.

Agencies are required to complete investigations within the earlier of 180 days after filing last complaint or 360 days after the filing of the original complaint. Regardless of amendment of or consolidation of complaints, the investigation shall be complete in not more than 360 days.

For example, if a complainant amends a complaint or files another complaint the agency will consolidate on day 179 of the originally filed complaint, and then the investigation must be complete by the 359th day.

If the complainant wants to add another amendment on the 358th day of the investigation, the agency will have only 2 days to investigate that amendment. If the agency is unable to conduct an impartial and appropriate investigation in 2 days it should not consolidate or accept the amendment; rather, the agency should advise the complainant to seek counseling on the newest matter and process it as a new complaint.

C. Failure to Complete Investigation within Time Limit

If the investigation is not completed within the 180-day time limit, the agency must send a notice to complainant informing him/her that the investigation is not complete, providing an estimated date by which it will be complete and explaining that s/he has a right to request a hearing from a Commission Administrative Judge or to file a civil action in the appropriate U.S. District Court. The notice must be in writing, must describe the hearing process including some explanation of discovery and burdens of proof, and must acknowledge that its issuance does not bar complainant from seeking sanctions. A sample notice is provided at Appendix K.

regulation 5 C.F.R. § 1201.154(b)(2).

D. What Must Be Done for an Investigation to Be Considered Appropriate

A timely completed investigation means that within the applicable time period the agency must complete several actions:

1. The complaint must be appropriately investigated in a manner consistent with Chapter 6 of this Management Directive. An appropriate factual record is one that allows a reasonable fact finder to draw conclusions as to whether discrimination occurred.
2. Copies of the investigative file, including a summary of the investigation must be provided to the complainant(s)¹¹; and
3. The agency must give complainant a notice of his/her right to request a hearing (if it is not a mixed case), within 30 days from receipt of the investigative file, , or of the right to request a final action by the agency pursuant to 29 C.F.R. § 1614.110.

VI. FINAL ACTIONS

There are two types of final actions by agencies. One is a final action by an agency following a decision by an Administrative Judge. The other is a final action in all other circumstances.

A. Final Action by Agency Following an Administrative Judge's Decision

When an Administrative Judge issues a decision under 29 C.F.R. §§ 1614.109 (b), (g), or (i), or § 1614.204(d)(7), the agency shall take final action on the complaint by issuing an order **within forty (40) days** of the date of its receipt of the Administrative Judge's decision. The agency's final order shall inform the complainant as to whether the agency will fully implement that decision. The term "fully implement" means that the agency adopts without modification the decision of the Administrative Judge. The agency's final order shall further inform the complainant of his/her right to file an appeal with the Commission, the right to file a civil action in a U.S. District Court, the name of the proper defendant in such appeal or civil action, and the applicable time limits for such appeals or civil actions. If the agency's final order does not fully implement the decision of the Administrative Judge, the agency shall file an appeal with the Commission in accordance with 29 C.F.R. § 1614.403, appending a copy of its

¹¹ See Chapter 6 of this Management Directive for the nature and content of an investigative summary.

appeal to the final order, simultaneously with its issuance of a decision to the complainant. A copy of EEOC Form 573, Notice of Appeal/Petition - Complainant, shall be attached to the final order.

When an Administrative Judge issues a decision under 29 C.F.R. § 1614.204(j), the agency shall take final action on the complaint by issuing an order **within sixty (60) days** of the date of its receipt of the Administrative Judge's decision. The agency's final order shall inform the class agent as to whether the agency will fully implement that decision. The term "fully implement" means that the agency adopts without modification the decision of the Administrative Judge. The agency's final order further shall inform the class agent of his/her right to file an appeal with the Commission, the right to file a civil action in a U.S. District Court, the name of the proper defendant in such appeal or civil action, and the applicable time limits for such appeals or civil actions. If the agency's final order does not fully implement the decision of the Administrative Judge, the agency shall file an appeal with the Commission in accordance with 29 C.F.R. § 1614.403, appending a copy of its appeal to the final order, simultaneously with its issuance of a decision to the class agent. A copy of EEOC Form 573, Notice of Appeal/Petition, shall be attached to the final order.

B. Final Actions in All Other Circumstances

When an agency dismisses an entire complaint under 29 C.F.R. § 1614.107(a), receives a request for an immediate final decision, or does not receive a reply to the notice issued under 29 C.F.R. § 1614.108(f), the agency will take final action by issuing a final decision. The final decision consists of findings by the agency on the merits of each claim in the complaint, or, as appropriate, the rationale for dismissing any claims in the complaint and, when discrimination is found, appropriate remedies, and relief in accordance with subpart E of Part 1614. The agency will issue the final decision within sixty (60) days of receiving notification that a complainant has requested an immediate final decision from the agency, or within 60 days of the end of the thirty (30)-day period for the complainant to request a hearing or an immediate final decision where the complainant has not requested a hearing or a decision. The final decision shall contain notice of the right to appeal the final action to the Commission, the right to file a civil action in a U.S. District Court, the name of the proper defendant in any such lawsuit, and the applicable time limits for appeals and lawsuits. A copy of EEOC Form 573, Notice of Appeal/Petition, shall be attached to the final decision/determination.

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CHAPTER 6 DEVELOPMENT OF IMPARTIAL AND APPROPRIATE FACTUAL RECORDS

I. INTRODUCTION

Section 1614.108(b) of Title 29 C.F.R. requires that “the agency shall develop an impartial and appropriate factual record upon which to make findings on the claims raised by the written complaint.” An appropriate factual record is one that allows a reasonable fact finder to draw conclusions as to whether discrimination occurred. Pursuant to that regulation, this Chapter prescribes the Equal Employment Opportunity Commission’s standards for impartiality and appropriateness in factual findings on formal complaints of discrimination. Further, because continuing education and training for employees working in federal EEO is vitally important, this Chapter also establishes a mandatory minimum training requirement for all investigators, including contract and collateral-duty investigators.

This Chapter is intended to ensure that federal agencies consistently develop sound factual bases for findings on claims raised in equal employment opportunity complaints while retaining the maximum flexibility in the use of fact-finding techniques and in the use of established dispute resolution plans. This Management Directive is not intended as an exhaustive guide for conducting investigations, but represents the standard that the Commission expects in an investigation.

II. MINIMUM TRAINING REQUIREMENTS FOR ALL INVESTIGATORS

All new EEO Investigators, including contract and collateral-duty investigators, must have completed at least thirty-two (32) hours of investigator training before conducting investigations. In addition to the training requirement for new investigators, all investigators are required to receive at least eight hours of continuing investigator training every fiscal year. The Commission has developed training courses to satisfy this requirement and offers them to agencies through its Revolving Fund Program on a fee-for-service basis. Agencies may also develop their own courses to satisfy this requirement or contract with others to provide training, as long as the training meets the standards provided below.

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A. Standards for New Investigator Training Requirement

The agency should provide training on the following:

1. An overview of the entire EEO process pursuant to 29 C.F.R. Part 1614. This segment must emphasize important time frames in the EEO process, including relevant time frames for investigation.
2. The role and responsibility of an EEO Investigator, as described in this Management Directive.
3. A thorough presentation of the relevant statutes, including Title VII of the Civil Rights Act of 1964, as amended (includes the Pregnancy Act of 1978), the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act, as amended, the Age Discrimination in Employment Act of 1967, as amended, the Equal Pay Act of 1963, as amended, and Title II of the Genetic Information Nondiscrimination Act of 2008, 42 U.S.C. § 2000ff et seq. This module must explain the theories of discrimination relevant to these statutes, including disparate treatment, adverse impact, and reasonable accommodation theories. This module must provide detailed instruction concerning issues attendant to fragmentation. See Chapter 5, Section III of this Management Directive.
4. Case management issues, including information on practical techniques concerning the timely investigation of complaints.
5. Remedies, including compensatory damages, attorney's fees, and costs. This module must provide investigators with practical information on how to gather relevant information in cases where remedies, attorney's fees, and costs are at issue.
6. Investigative techniques, such as the gathering and analysis of evidence. Participants should be provided with an opportunity to get practical, hands-on experience during this module on topics such as interviewing witnesses, making credibility determinations, and the gathering and reviewing of documentary and electronic evidence. Participants should be provided with case studies to work with so that investigative skills can be effectively developed.

August, 2015**EEO MD-110****B. Standards for Continuing Investigator Training**

The continuing eight hours of investigator training every fiscal year is intended to keep EEO Investigators informed of developments in EEO practice, law, and guidance, as well as to enhance and develop investigatory skills. Agencies are encouraged to conduct a needs assessment to determine specific investigative staff training needs. The Commission anticipates that these eight hours of continuing investigator training will include segments on legal and policy updates, regulatory and statutory changes, and investigative skills development.

III. RESPONSIBILITIES**A. Director of Equal Employment Opportunity**

The Director of Equal Employment Opportunity shall ensure that 1) all new investigators receive at least thirty-two (32) hours of introductory investigator training before conducting investigations and that all investigators receive at least eight hours of continuing investigator training every year; 2) the claim(s) in a complaint are thoroughly investigated; 3) all employees of the agency cooperate in the investigation; and 4) witness testimony is given under oath or affirmation and without a promise that the agency will keep the testimony or information provided confidential. See 29 C.F.R. § 1614.102(c)(5).

The EEO Director will also ensure that individual complaints are properly and thoroughly investigated and that all final actions are issued in a timely manner in accordance with 29 C.F.R. § 1614.110. The EEO Director also must ensure that there is no conflict of interest or appearance of conflict of interest in the investigation of complaints. See Chapter 1 Section 4 of this Management Directive for more information.

B. Equal Employment Opportunity Investigator

The Equal Employment Opportunity Investigator is a person officially designated and authorized to conduct inquiries into claims raised in EEO complaints. The authorization includes the authority to administer oaths and to require employees to furnish testimony under oath or affirmation without a promise of confidentiality. The investigator does not make or recommend a finding of discrimination.

A new investigator must have received, at a minimum, thirty-two (32) hours of investigator training before s/he conducts an investigation; experienced investigators must receive eight hours of training every fiscal year thereafter.

C. Complainant

The complainant must cooperate in the investigation and keep the agency informed of his/her current address. If an agency is unable to locate the complainant, the agency may dismiss the complaint, provided that reasonable efforts have been made to locate the complainant and the complainant has not responded within fifteen (15) days of the notice of proposed dismissal. 29 C.F.R. § 1614.107(a)(6).

Where the agency has provided the complainant with a written request to provide relevant information or otherwise proceed with the complaint, coupled with a 15-day notice of proposed dismissal, a failure to respond could result in dismissal of the complaint. See 29 C.F.R. § 1614.107(a)(7); Chapter 5, Section IV.B.1 of this Management Directive.

IV. INVESTIGATION

An investigation of a formal complaint of discrimination is an official review or inquiry, by persons authorized to conduct such review or inquiry, into claims raised in an EEO complaint.

The investigative process is non-adversarial. That means that the investigator is obligated to collect evidence regardless of the parties' positions with respect to the items of evidence.

A copy of the complaint shall be provided to the investigator prior to the commencement of the investigation.

Models for the analysis of common types of discrimination cases appear at Appendix J to this Management Directive.

A. Methods of Investigation

Investigative inquiries may be made using a variety of fact-finding models, such as the interview or the fact-finding conference, and a variety of devices, such as requests for information, position statements, exchange of letters or memoranda,

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interrogatories, and affidavits. The inquiry/review process may also incorporate some of the features of a dispute resolution plan.

B. Purpose of the Investigation

The purpose of the investigation is 1) to gather facts upon which a reasonable fact finder may draw conclusions as to whether an agency subject to coverage under the statutes that the Commission enforces in the federal sector has violated a provision of any of those statutes; and 2) if a violation is found, to have a sufficient factual basis from which to fashion an appropriate remedy.¹

C. General Investigative Requirements

The investigation shall include a thorough review of the circumstances under which the alleged discrimination occurred; the treatment of members of the complainant's group as compared with the treatment of other similarly situated employees, if any;² and any policies and/or practices that may constitute or appear to constitute discrimination, even though they have not been expressly cited by the complainant.

¹ The Commission enforces: (1) Section 717 of Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000e-16; (2) Sections 501 and 505 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. §§ 791 and 794a; (3) Section 15 of the Age Discrimination in Employment Act of 1967, as amended, 29 U.S.C. § 633a; (4) the Equal Pay Act, Section 6(d) of the Fair Labor Standards Act of 1938, as amended, 29 U.S.C. § 296(d); and (5) Title II of the Genetic Information Nondiscrimination Act of 2008, 42 U.S.C. § 2000ff et seq.

² Investigators are reminded that even where the complainant is unable to provide comparative data and the investigator similarly cannot obtain any such information, the investigator still must determine whether there is other evidence that may establish unlawful discrimination. In O'Connor v. Consolidated Coin Caterers Corp., 517 U.S. 308 (1996), the Supreme Court ruled that comparative evidence is not an essential element of a prima facie case of discrimination, but the complainant must come forward with sufficient evidence to create an inference of discrimination; that is, enough evidence that, if not rebutted, would support an inference that the agency's actions resulted from discrimination. Furnco Construction Co. v. Waters, 438 U.S. 567, 576 (1978). The Commission has issued enforcement guidance on O'Connor, entitled "EEOC Enforcement Guidance on O'Connor v. Consolidated Coin Caterers Corp.," (September 18, 1996), which is available on the Commission's website at http://www.eeoc.gov/laws/guidance/enforcement_guidance.cfm, in the "Enforcement Guidance and Related Documents" section.

D. Failure to Complete Investigation within Time Limit

Agencies are required to complete investigations within the earlier of 180 days after the filing of the last complaint or 360 days after the filing of the original complaint. Regardless of amendment of or consolidation of complaints, the investigation shall be complete in not more than 360 days, unless there is a written extension of not more than 90 days.

For example, if a complainant amends a complaint or files another complaint the agency will consolidate on day 179 of the originally filed complaint, then the investigation must be complete by the 359th day.

If the complainant wants to add another amendment on the 358th day of the investigation, the agency will have only 2 days to investigate that amendment unless the complainant agrees in writing to an extension of not more than 90 days. When no written extension exists and the agency is unable to conduct an impartial and appropriate investigation in 2 days it should not consolidate or accept the amendment rather, the agency should advise the complainant to seek counseling on the newest matter and process it as a new complaint.

See Chapter 5, Section V.C of this Management Directive regarding an agency's failure to complete the investigation in a timely manner.

V. THE ROLE OF THE INVESTIGATOR**A. Collecting and Discovering Factual Information**

The role of the investigator is to collect and to discover factual information concerning the claim(s) in the complaint under investigation and to prepare an investigative summary.

B. Variety of Methods Available

The investigator may accomplish his/her mission in a variety of ways. The investigator may function as:

1. a presiding official at a fact-finding conference;
2. an examiner responsible for developing material evidence;

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3. an issuer of requests for information in the form of requests for the production of documents, interrogatories, and affidavits;
4. a face-to-face interviewer in on-site visits; and/or,
5. any other role so long as appropriate investigative techniques/methods are utilized.

C. Investigator Must Be Unbiased and Objective

In whatever the mix of fact-finding activity selected for a particular case, the investigator must be and must maintain the appearance of being unbiased, objective, and thorough. S/he must be neutral in his/her approach to factual development. The investigator is not an advocate for any of the parties or interests and should refrain from developing allegiances to them. In addition, the following rules must be observed:

1. The person assigned to investigate shall not occupy a position in the agency that is directly or indirectly under the jurisdiction of the head of that part of the agency in which the complaint arose.
2. The investigator, if a contract investigator, shall not have been hired by or be obligated to the person(s) involved in the claims giving rise to the complaint. For example, where the contract monitor of EEO investigation contracts is alleged to have been involved in discriminatory activity, the use of the usual contract investigator would create an apparent bias because there is at best the appearance that the contract investigator could not be impartial.
3. An agency is prohibited, in some situations, from using its own immediate investigative resources, even though the investigation of discrimination complaints in the federal service is primarily an agency function and responsibility. In such cases the agency shall use alternatives, such as contract investigators or other outside sources. See Chapter I, Section IV of this Management Directive for additional information regarding conflict of interest cases. Such situations include, but are not limited to:
 - a. Particularly sensitive cases involving high-level officials (for example, complainant is an immediate subordinate of the head of the agency and the head of the agency is alleged to have taken discriminatory action).

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- b. Potential conflict of interest (for example, complainant is an employee in the EEO office and names the EEO Director as the person taking the wrongful action).
- c. A small agency unable to carry out an unexpected EEO workload (for example, an agency with fewer than 450 employees, has a staff of part-time or ad hoc EEO Investigators, and is unable to absorb an additional investigative caseload).

D. Investigator Must Be Thorough

This means identifying and obtaining all relevant evidence from all sources regardless of how it may affect the outcome. Investigators need not expend the same amount of investigatory effort on each case, however. The proper scope of an investigation is dictated by the facts at issue. Investigators should not take a cookie-cutter, one-size-fits-all approach, as that wastes resources and delays resolution of the complaint. The investigation and the amount of effort expended should be appropriate to determine the claims raised by the complaint. An appropriate investigation is one that allows a reasonable fact finder to draw conclusions as to whether discrimination occurred.

An investigator should ensure that his/her questions are answered by a witness with personal knowledge of the facts rather than by a party's representative. The investigator need not concern himself/herself with balancing the amount of evidence supporting the complainant as compared with the amount of evidence supporting the agency. To ensure a balanced record, it is necessary only to exhaust those sources likely to support the complainant and the respondent. An investigation conducted in this manner might reveal that there is ample evidence to support the complainant's claims and no evidence to support the agency's version of the facts, or vice versa. Nevertheless, this investigation would be thorough. The best type of investigations allow for complainant to provide rebuttal evidence with sufficient time for the investigator to address any issues raised within the regulatory time frames.

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VI. EVIDENCE

A. Quality of Evidence

Evidence will be gathered from the complainant, witnesses, and other sources. In order to support findings and, ultimately, decisions, this evidence should be material to the complaint, relevant to the issue(s) raised in the complaint, and as reliable as possible.

1. Material Evidence

Evidence is material when it relates to one or more of the issues raised in the complaint or raised by the agency's answer to it. To determine whether evidence is material, one must look to the claims of discriminatory conduct and resultant harm contained in the complaint and the agency's answers to the claims. If the evidence relates to one or more of those claims, then it relates to the issues presented in the complaint, and it is material.

2. Relevant Evidence

Evidence is relevant if it tends to prove or disprove a material issue raised by a complaint. Relevancy and materiality are often used interchangeably. Generally, relevance is the more important concept in an investigation. If evidence is not relevant, whether it is material is of little consequence. A test of relevance is to ask, "What does this evidence tend to prove?" If the answer is that it tends to prove or disprove a proposition that is related to the complaint, then the evidence is relevant.

3. Reliable Evidence

Evidence is reliable if it is dependable or trustworthy. Evidence should not be ignored because it is of questionable reliability. Such evidence may lead to evidence that is reliable.

Some factors to consider in determining whether testimony is reliable are: whether the witness's testimony is based on his/her own experience and personal knowledge, or based on rumor, hearsay, or innuendo; whether the testimony is a statement of fact or is merely a conclusion; and whether witnesses have an interest in the outcome of the complaint, or are otherwise biased.

Some factors to consider in determining whether documents are reliable are: whether they were prepared in response to the investigation or whether they are maintained in the ordinary course of business; whether they are obtained from the custodian of records or the author of the document; and whether the documents are signed and/or dated.

The federal rules of evidence were designed to set limits on the reliability of documents and testimony entered in evidence in court. Such formal rules will not be strictly applied in the collection of evidence for the investigation of federal equal employment opportunity complaints. Such rules may be used, however, as a guide in assessing the evidentiary weight to be given particular items of evidence.

B. Types of Evidence

There are many types of evidence which can be obtained on the issues raised in an equal employment complaint. The three basic types of evidence are direct evidence, circumstantial evidence, and statistical evidence.

1. Direct Evidence

Direct evidence is evidence that proves a fact without resort to inference or presumption. Black's Law Dictionary (9th ed. 2009). For example, in the morning the ground is covered with snow. If you looked out the window the night before and saw it snowing then, you have direct evidence that it snowed during the night. You need not draw any inference to reach the factual conclusion that it snowed during the night.

Direct evidence is relevant in cases involving disparate treatment where the question is whether the employer intentionally treated employees differently because of a protected factor. It is also relevant in cases involving the effect of policies where the question is whether the policy disparately treats all employees in the protected class.

Direct evidence is rare. The statement, "I would never hire you for that job because you are a woman," is direct evidence of discrimination on the basis of sex in hiring, but would not be direct evidence if the issue involved a performance appraisal, for example.

Agencies must take care to distinguish between direct evidence of bias and direct evidence of discrimination. Direct evidence of bias may be strong but circumstantial evidence of discrimination in a particular case. For

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example, the statement, “I would never hire a woman for that job,” is direct evidence of bias, as not directed towards any specific person. See [Heim v. State of Utah](#), 8 F.3d 1541, 1546 (10th Cir. 1993). In contrast, a statement to a complainant that you “may be getting too old to understand the store’s new computer programs” was deemed direct evidence of discrimination in [Wright v. Southland Corp.](#), 187 F.3d 1287, 1304 (11th Cir. 1999) because it was directed at a specific person.

2. Circumstantial Evidence

Circumstantial evidence is evidence based on inference. [Black’s Law Dictionary](#) (9th ed. 2009). In other words, the fact finder must draw an inference from the evidence to reach a factual conclusion.

For example, if you looked out the window at night and the ground was bare, but when you look out the window the next morning, there is snow on the ground, the snow on the ground is circumstantial evidence that it snowed during the night. From the presence of snow on the ground, you reasonably may infer that it snowed during the night. You have drawn an inference to reach the factual conclusion that it snowed during the night.

There are different types of circumstantial evidence. For example, comparative evidence must be sought in every case alleging disparity in treatment on a basis protected by a law enforced by the Commission. Comparative evidence is evidence regarding how similarly situated persons outside of the complainant’s protected groups were treated.

In general, similarly situated means that the persons who are being compared are so situated that it is reasonable to expect that they would receive the same treatment as the complainant in the context of a particular employment decision. It is important to remember that individuals may be similarly situated for one employment decision, but not for another. For example, a female GS-4 clerk-typist may be similarly situated to a male GS-7 paralegal in a discrimination case involving the approval of annual leave where the same rules are applied to both employees by the same supervisor or where both are in the same unit or subject to the same chain of command. The investigator would be obligated to find out whether there were persons, not named by the complainant but similarly situated, whose treatment could be compared to the complainant’s treatment.³ Both

³ While comparative evidence is important, it is not always available, and an investigator may be able to obtain other evidence of discrimination. So while the investigator should make an effort to obtain comparative evidence, s/he also should make an effort to determine whether there may be other evidence

the complainant and the responding management official should provide a list of comparators for the challenged action.

Other types of circumstantial evidence may include general statements indicative of bias (see the example in “Direct Evidence,” above), conduct (for example, a selecting official repeatedly has selected only males for job vacancies, despite the availability of best-qualified female candidates), or environment (for example, an absence of Hispanics in the workplace despite their availability in the relevant labor force). Circumstantial evidence may overlap with statistical evidence.

3. Statistical Evidence

Statistical evidence or a survey of the general environment may be conducted as appropriate. For example, this evidence may be probative when claims involve the comparative treatment of groups, as in a claim of a pattern or practice of discrimination, or the adverse effect of an agency policy or practice.

C. Sources of Evidence

1. The Complainant

The complaint will generally provide the initial information concerning the bases, issues, and incidents that gave rise to the complaint of discrimination. The complaint may also indicate the reason, if any was given, for any adverse employment decision. Additional background and detailed information must be obtained from the complainant and recorded through written questions and answers (interrogatories), recorded interviews (using handwritten notes or verbatim transcription), an exchange of letters or memoranda, or a fact-finding conference. This information should include medical documentation, where necessary. Witness testimony intended to be made a part of the complaint file should be made under oath or affirmation or penalty of perjury.

Volume II of the Commission’s Compliance Manual will assist in developing inquiries. That volume contains substantive topics arranged in sections. Most sections contain advice on what questions to ask when certain issues are raised. The Commission’s Compliance Manual is

equally probative of discrimination.

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published commercially and is available at many libraries and at the Commission's district, area, and field offices. In addition, newly issued sections of the Compliance Manual and Commission policy guidance on issues such as reprisal, definition of disability, reasonable accommodation, and sexual harassment are available on the Commission's website at: <http://www.eeoc.gov/laws/guidance/compliance.cfm>.

2. The Agency

Information from the agency may be obtained initially through a request for information. Consult the agency EEO Director for instructions concerning to whom to direct the request.

Follow-up information should be obtained in a variety of ways, including further requests, affidavits, interrogatories, or a fact-finding conference.

In most instances, the individual who initiated or enforced the decision or engaged in the action about which the complaint was filed should be interviewed early in the investigation. His/her reasons for the action will often open other avenues to explore.

For this reason, a management official's explanation of a challenged action should be detailed and specific. In a non-selection type case, stating the person selected was better qualified or a better fit for the position is insufficient standing alone. Interview notes and any explanation should include a narrative as to why the management official believes the selectee was a better candidate.

3. Witnesses

Witnesses can be identified by asking the complainant, the official involved in the alleged discriminatory action, or other obvious witnesses if they are aware of other persons who might have information related to the complaint. Witnesses need not be employees at the respondent agency.

- a. The EEO staff may be of some assistance in discovering other witnesses, but they should rarely be witnesses themselves. Their information will usually be hearsay and their participation as witnesses would compromise their objectivity. Information should be obtained from its primary source.
- b. Witness bias should be noted when it is discovered. The following should be noted: 1) favorable feelings toward a party based on a

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mutual alliance, family ties, or close friendship; 2) hostility to a party, because of a past disagreement; and 3) self-interest in the outcome of the complaint are some indicators of potential bias. The indicators should be made a part of the record, and efforts should be made to corroborate the testimony. The weight accorded the evidence by the fact finder adduced from such witnesses will be governed by the degree to which it can be determined that the bias colored the testimony.

4. Documentary Evidence

All relevant documents should be obtained. The complainant, the supervisor, the manager who took the personnel action, or the personnel office of the agency may be sources to help identify relevant documents.

Statistical evidence usually can be obtained through the EEO Office or the personnel office of the agency.

D. Evidence on the Question of Remedies

The investigator should gather evidence that will allow for an appropriate remedy to be fashioned. This essentially means that a determination of the parameters of relief should be made and the appropriate inquiries developed. Agencies should be aware that, during the investigative process, they need to address evidence that may be used in connection with framing remedies. Evidence on the question of remedies may include evidence of a complainant's interim earnings or subsequent promotions (in a discharge or non-promotion case), compensatory damages, or other mitigating factors. For a source of information concerning compensatory damages, see [Enforcement Guidance; Compensatory and Punitive Damages Available under § 102 of the Civil Rights Act of 1991](#), N-915.002 (July 14, 1992).⁴

⁴ The Commission prepared this Enforcement Guidance for use in both public and private EEO litigation. The discussion in the Enforcement Guidance concerning punitive damages does not apply to federal sector EEO.

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VII. WITNESSES AND REPRESENTATIVES IN THE FEDERAL EEO PROCESS

The procedures outlined here relate specifically to the processing of individual complaints of discrimination under 29 C.F.R. § 1614.108. The principles reflected in these procedures, however, should also guide the processing of class complaints of discrimination under 29 C.F.R. § 1614.204.

A. Disclosure of Investigative Material to Witnesses

1. To the Complainant

The complainant must receive a copy of the complaint file and a transcript of the hearing, if a hearing is held. The complainant should be given the opportunity to receive a copy of the complaint file and hearing transcript in an electronic format as an alternative to the paper files/documents. The complainant should receive the same copy of the complaint file as the agency counsel does and where a hearing was requested as the Administrative Judge does.

2. To Other Witnesses

During the investigation, the investigator may disclose information and documents to a witness who is a federal employee where the investigator determines that the disclosure of the information or documents is necessary to obtain information from the witness, for example, to explain the claims in a complaint or to explain a manager's articulated reason for an action in order to develop evidence bearing on that reason. Explanations of a witness' credibility are helpful, and the investigator should include observations on credibility without making a final conclusion as to credibility.

B. Travel Expenses**1. Witness Employed by the Federal Government**

Section 1614.605(f) of 29 C.F.R. requires that a witness be in an official duty status when his/her presence is required or authorized by agency or Commission officials in connection with a complaint. A witness is entitled to travel expenses. If a witness is employed at an agency other than the one against which the complaint is brought and must travel to provide the attestation or testimony, the witness is entitled to reimbursement for travel expenses. The current employing agency of a federal employee must initially authorize and pay the employee's travel expenses and is entitled to reimbursement from the responding agency, which is ultimately responsible for the cost of the employee's travel. [John Booth - Travel Expenses of Witness - Agency Responsible](#), File: B-235845, 69 Comp. Gen. 310 (1990). An agency would not be responsible for paying the travel expenses of non-federal witnesses.

2. Complainant or Applicant Not Employed by Federal Government

The agency is not responsible, however, for paying the travel expenses of a complainant or applicant who is not employed by the federal government. Although the complainant who, for purposes of his/her complaint is a witness, may once have been employed by the agency against whom s/he complains, the termination of the employment status with the federal government also terminates any federal obligation to pay travel expenses associated with prosecution of the complaint. [Expenses of Outside Applicant Complainant to Travel to Agency EEO Hearing](#), File: B-202845, 61 Comp. Gen. 654 (1982).

C. Official Time

Section 1614.605 of 29 C.F.R. provides that individuals/complainants are entitled to a representative of their choice during the administrative EEO pre-complaint counseling and at all stages of the administrative EEO complaint process. Both the complainant and the representative, if they are employees of the agency where the complaint arose and was filed, are entitled to a reasonable amount of official time to present the complaint and to respond to agency requests for information, if otherwise on duty. 29 C.F.R. § 1614.605(b). Former employees of an agency who initiate the EEO process concerning an adverse action relating to their prior employment with the agency are employees within the meaning of 29 C.F.R. § 1614.605, and their representatives, if they are current employees of the agency,

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are entitled to official time. Witnesses who are federal employees, regardless of whether they are employed by the respondent agency or some other federal agency, shall be in a duty status when their presence is authorized or required by Commission or agency officials in connection with the complaint.

1. Reasonable Amount of Official Time

“Reasonable” is defined as whatever is appropriate, under the particular circumstances of the complaint, in order to allow a complete presentation of the relevant information associated with the complaint and to respond to agency requests for information. The actual number of hours to which complainant and his/her representative are entitled will vary, depending on the nature and complexity of the complaint and considering the mission of the agency and the agency’s need to have its employees available to perform their normal duties on a regular basis. The complainant and the agency should arrive at a mutual understanding as to the amount of official time to be used prior to the complainant’s use of such time. Time spent commuting to and from home should not be included in official time computations because all employees are required to commute to and from their federal employment on their own time.

2. Meeting and Hearing Time

Most of the time spent by complainants and their representatives during the processing of a typical complaint is spent in meetings and hearings with agency officials or with the Commission Administrative Judges. Whatever time is spent in such meetings and hearings is automatically deemed reasonable. Both the complainant and the representative are to be granted official time for the duration of such meetings or hearings and are in a duty status regardless of their tour of duty. If a complainant or representative has already worked a full week and must attend a hearing or meeting on an off day, that complainant or representative is entitled to official time, which may require that the agency pay overtime. The complainant should notify the agency of the meeting and hearing schedule as soon as possible.

3. Preparation Time

Since presentation of a complaint involves preparation for meetings and hearings, as well as attendance at such meetings, conferences, and hearings, complainants and their representatives are also afforded a reasonable amount of official time, as defined above, to prepare for meetings and hearings. They are also to be afforded a reasonable amount of official time to prepare the formal complaint and any appeals that may be filed with the Commission, even though no meetings or hearings are involved. However, because investigations are conducted by agency or Commission personnel, the regulation does not envision large amounts of official time for preparation purposes. Consequently, “reasonable,” with respect to preparation time (as opposed to time actually spent in meetings and hearings), is generally defined in terms of hours, not in terms of days, weeks, or months. Again, what is reasonable depends on the individual circumstances of each complaint. See [Murry v. General Services Administration](#), EEOC Appeal No. 0120093069 (July 26, 2012).

4. Aggregate Time Spent on EEO Matters by Representative

The Commission considers it reasonable for agencies to expect their employees to spend most of their time doing the work for which they are employed. Therefore, an agency may restrict the overall hours of official time afforded to a representative, for both preparation purposes and for attendance at meetings and hearings, to a certain percentage of that representative’s duty hours in any given month, quarter, or year. Such overall restrictions would depend on the nature of the position occupied by the representative, the relationship of that position to the mission of the agency, and the degree of hardship imposed on the mission of the agency by the representative’s absence from his/her normal duties. The amount of official time to be afforded to an employee for representational activities will vary with the circumstances.

Moreover, 29 C.F.R. § 1614.605(c) provides that in cases where the representation of a complainant or agency would conflict with the official or collateral duties of the representative, the Commission or the agency may, after giving the representative an opportunity to respond, disqualify the representative. At all times, the complainant is responsible for proceeding with the complaint, regardless of whether s/he has a designated representative.

The Commission does not require agencies to provide official time to employee representatives who are representing complainants in cases

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against other federal agencies. However, the Commission encourages agencies to provide such official time.

5. Requesting Official Time

The agency must establish a process for deciding how much official time it will provide a complainant. Agencies further must inform complainants, their representatives, and others who may need official time, such as witnesses, of the process and how to claim or request official time.

6. Denial of Official Time

If the agency denies a request for official time, either in whole or in part, the agency must include a written statement in the complaint file noting the reasons for the denial. If the agency's denial of official time is made before the complaint is filed, the agency shall provide the complainant with a written explanation for the denial, which it will include in the complaint file if the complainant subsequently files a complaint. Where a request for official time is denied in whole or part while an Administrative Judge is presiding over the matter, a copy of the agency's denial of official time with the requisite explanation should be provided to the Administrative Judge when provided to the requestor.

D. Duty Status/Tour of Duty

For purposes of these regulations, "duty status" means the complainant's or representative's normal hours of work.

It is expected that the agency will, to the extent practical, schedule meetings during the complainant's normal working hours and that agency officials shall provide official time for complainants and representatives to attend such meetings and hearings.

If meetings, conferences, and hearings are scheduled outside of the complainant's or the representative's normal work hours, agencies should adjust or rearrange the complainant's or representative's work schedule to coincide with such meetings or hearings, or grant compensatory time or official time to allow an approximately equivalent time off during normal hours of work. The selection of the appropriate method for making the complainant or representative available in any individual circumstance shall be within the discretion of the agency.

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Any reasons for an agency's denial of official time should be fully documented and made a part of the complaint file, and if an Administrative Judge is presiding over the matter at the time of the request, then it should be provided to the Administrative Judge at the same time as it is provided to the requestor.

Witnesses, who are federal employees, regardless of their tour of duty and whether they are employed by the respondent agency or another federal agency, must be in a duty status when their presence is authorized or required by Commission or agency officials in connection with a complaint.

E. Use of Government Property

The complainant's or complainant's non-attorney representative's use of government property (copiers, telephones, word processors, computers, internet, printers, and email) must be authorized prior to their use by the agency and must not cause undue disruption of agency operations.

VIII. COMPLAINT FILE

A. Contents of the Complaint File

The complaint file must include all various documents and information acquired during the fact-finding under this Directive. The complaint file will be assembled as an electronic document, unless the agency has demonstrated good cause as to why the agency cannot produce a digital copy of the file, in which case a paper file may be submitted. While cost alone does not constitute good cause why an agency cannot submit files in a digital format, OFO will consider facts such as undue cost, undue burden, national security concerns, and other reasonable bases. The complaint file must contain all documents pertinent to the complaint, and be in the form and format as provided in Appendix L, as demonstrated in the sample complaint file available on the Commission's website at www.eeoc.gov/federal/.

B. Complaint Files Should Not Include

The complaint file should not include confidential documentation concerning the substance of attempts to resolve the complaint during informal counseling or during any alternative dispute resolution procedure.

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Agencies should not place non-relevant information in complaint files. Where names, social security numbers, home addresses, and any other personal identifying information are not relevant, that information should be redacted before the document containing them is included in the complaint file. Relevant information that should not be redacted includes management and/or comparative employees'/applicants' names. Once a document is included in the complaint file, the complainant has a right to the entire file. All parties including the agency representative, the complainant and his/her counsel, and the Administrative Judge should all have the same complaint file, either without redactions or containing the same redactions.⁵

D. Features of the Complaint File

The digital complaint file shall have the following features:

1. File should be image over text or run through OCR text recognition such that it is a searchable document.
2. It should contain digital bookmarks identifying key documents, exhibits, and sections of the file as specified below. Bookmarks should be labeled in a manner that clearly identifies the key documents, (for example, EEO Counselor's Report, rather than generic labels) within each identified section.⁶
3. It should contain a typed summary of the investigation signed and dated by the investigator and containing a discussion and analysis of the evidence. See Section IX of this Chapter.

E. Organization of the Complaint File

Agencies should organize complaint files in the following manner, with digital bookmarks specifically identifying the section and key documents therein.

⁵ Except for Memorandums of Understandings (MOUs) currently in place for national security purposes, any previous information from the Commission's offices regarding redactions, upon which agencies are relying to redact complaint files, is hereby obsolete.

⁶ Where an agency has shown good cause as to why it cannot submit the complaint file in a digital format and received an exception letter to file a paper file, the agency should substitute the word "tab" for "section" in the below guidance.

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Title Page - should contain at a minimum the information set forth in the sample at Appendix L.

Section 1 - should contain the formal complaint (bookmarked) and documents submitted by the complainant.

Section 2 - should contain the EEO Counselor's report (bookmarked) and all documents generated in the informal process pursuant to 29 C.F.R. § 1614.105(c). Included here should be the notice of right to file a complaint (bookmarked) pursuant to 29 C.F.R. § 1614.105(d).

Section 3 - should contain the agency's notice of claims to be investigated (bookmarked) pursuant to Section IV.A.1 of this Chapter. Copies of any other documents bearing on delineation of the claims to be investigated should also be included. Documents pertaining to the partial dismissal of claim(s) (bookmarked) and/or the notice of late investigation should be included in this tab.

Section 4 - should contain documented attempts at resolution; including any settlement agreement reached on any aspect of the complaint (bookmarked); however, documentation should not include the substance of such attempts.

Section 5 - should contain any documentation of appellate activity and any decisions affecting the processing of the complaint if any (bookmarked).

Section 6 - should contain the summary of investigation/summary analysis of the facts (bookmarked). The summary should cite to exhibits and evidence (bookmarked) and be signed and dated by the investigator.

Section 7 - should contain the investigative evidence and documents in a logical order. The notice of incomplete investigation pursuant to 29 C.F.R. § 1614.108(g), if one was issued, should be included.

Section 8 - (if applicable) should contain all pre-hearing submissions, including those relevant to summary judgment, and all discovery documentation, and motions, orders, exhibits (bookmarked), and transcripts (bookmarked).

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Section 9 - (if applicable) should contain all submissions from an administrative hearing, including motions, exhibits (bookmarked), and transcripts (bookmarked).

Section 10 - (if applicable) should contain the decision(s) of the Commission's Administrative Judge (bookmarked).

Section 11 - should contain the Final Agency Action (bookmarked) and any documentation related to service on the parties.

Section 12 - should contain any miscellaneous material.

If an agency has submitted a digital complaint file to a Commission Administrative Judge documents added after the original complaint file was compiled may be submitted in a separate PDF file that must contain a title page and bookmarks to the applicable sections of the original file where the documents belong.

F. Availability of Complaint Files

The complainant and his/her representative shall be entitled to one copy each of the complaint file and investigative summary either at the time that the investigation is completed or when the agency sends the complainant the notice required by 29 C.F.R. § 1614.108(f), whichever is earlier. The complainant and his/her representative should be given the option to receive these documents in a digital and/or paper medium.

G. Disposition of Complaint Files

1. Effective December 8, 1998, the National Archives and Records Administration (NARA) revised [General Records Schedule \(GRS\) 1, Item 25, titled Equal Employment Opportunity Records](#), provides:

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Equal Employment Opportunity Records.

a. Official Discrimination Complaint Files.

Originating agency's file containing complaints with related correspondence, reports, exhibits, withdrawal notices, copies of decisions, records of hearings and meetings, and other records. Cases resolved within the agency, by the Commission, or by a U.S. Court.⁷

Authorized Disposition

Destroy four years after resolution of case.

2. The agency originating the equal employment opportunity case will retain the original ("official") file during the appeals process and send only duplicate copies of documents to the Commission for use in the appeal. The agency sending the duplicates will certify that the file contains everything that is in the original.
3. The Commission will create documents relating to the appeal, but will file such documents apart from the materials sent by the originating agency. After resolution of the appeal, the Commission will destroy all duplicate materials, but will retain the appeals documentation for four years. The originating agency will retain the original file for four years after resolution of the case. The Commission will retain the appeals documentation and will answer Freedom of Information Act requests on the appeals file. The Commission will maintain the security of documents as required by Federal Statutes and Executive Orders.
4. The originating agency will be responsible for retiring the original case file to the Federal Records Center, and answering Freedom of Information Act requests on the original file. Requests for disclosure, which the Commission determines are requests for the agency's complaint file, will be forwarded to the agency for a response.
5. Further information concerning the disposition of records under this section may be obtained by reviewing [NARA GRS 1](#), which is available on the NARA website at www.nara.gov or by contacting:

⁷ See Section VIII of this Chapter for a description of the documents contained in the complaint file. This schedule applies regardless of whether case files are in paper or electronic format.

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Equal Employment Opportunity Commission
Office of Federal Operations
P.O. Box 77960
Washington, D C 20013

Telephone: (202) 663-4599

IX. THE INVESTIGATIVE SUMMARY

The investigative summary is a narrative document that succinctly states the issues and delineates the evidence addressing both sides of each issue in the case. The summary should state facts (supported in the complaint file) sufficient to sustain a conclusion(s). The summary should cite to evidence and the exhibits collected.

X. COMPLAINANTS' OPPORTUNITY TO REVIEW THE INVESTIGATIVE FILE

Within the appropriate time frame for finishing an investigation under 29 C.F.R. § 1614.108(e), and prior to issuance of the notice required by 29 C.F.R. § 1614.108(f), agencies are encouraged to allow complainants and their designated representatives an opportunity to examine the investigative file and to notify the agency, in writing, of any perceived deficiencies in the investigation prior to transferring the case to the Commission for a hearing or prior to taking a final action without a hearing. A copy of the complainant's notification to the agency of perceived deficiencies must be included in the investigative file together with a written description by the agency of the corrective action taken.

If the agency agrees with alleged deficiencies in the investigation as identified by the complainant, the agency must immediately correct them. If the investigation period has ended or is about to end, the agency should request agreement from the complainant to extend the investigation period pursuant to 29 C.F.R. § 1614.108(e). If the agency does not agree with the complainant's claimed deficiencies in the investigative file, the agency will prepare a statement explaining the rationale for the disagreement and include it in the investigative file along with the complainant's notice of claimed deficiencies.

When the agency affords the complainant the opportunity to review the draft report of investigation, it should also afford the agency representative the same option.

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XI. SANCTIONS FOR FAILURE TO COOPERATE DURING THE INVESTIGATION

Agencies and complainants each have a duty to cooperate with the investigator during the investigation. See 29 C.F.R. § 1614.108(c)(1). Pursuant to 29 C.F.R. § 1614.108(c)(3), a party to a complaint - the complainant as well as the agency - may be subject to sanctions where it fails without good cause shown to respond fully and in a timely fashion to a request of the investigator for documents, records, comparative data, statistics, affidavits, or the attendance of witnesses. The investigator shall make a note in the investigative file concerning the party's failure without good cause shown to comply with a request for information or the attendance of witnesses, and the decision maker (Administrative Judge during the hearing process or the agency where the complainant requests a final agency decision) or the Commission on appeal may, in appropriate circumstances:

1. draw an adverse inference that the requested information, or the testimony of the requested witness, would have reflected unfavorably on the party refusing to provide the requested information;
2. consider the matters to which the requested information or testimony pertains to be established in favor of the opposing party;
3. exclude other evidence offered by the party failing to produce the requested information or witness;
4. issue a decision fully or partially in favor of the opposing party; or
5. take such other actions as it deems appropriate.

An investigator should inform the party from which it seeks documents, records, comparative data, statistics, affidavits, or the attendance of witnesses that failure to comply with the request may lead to the imposition of sanctions from the decision maker or the Commission on appeal. An investigator may, in an initial request for information or the attendance of witnesses, advise the party that, absent good cause shown, the party has a duty to respond fully and in a timely fashion to the investigator's request and that failure to do so may result in the imposition of the sanctions set forth at 29 C.F.R. § 1614.108(c)(3). Where the investigator does not so inform the party upon making the request, s/he may advise the party upon the party's failure to comply with the request. If the investigator properly advised the party that a failure to comply with the request may result in the sanctions set forth at 29 C.F.R. § 1614.108(c)(3), the decision maker or Commission on appeal may impose such sanctions upon receipt and review of the complaint/appeal file.

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XII. SANCTIONS FOR FAILURE TO DEVELOP AN IMPARTIAL AND APPROPRIATE FACTUAL RECORD

Section 1614.108(b) of 29 C.F.R. requires that an agency develop an impartial and appropriate factual record upon which to make findings on the claims raised in the written complaint. The Commission's regulations explain that an appropriate factual record is one that allows a reasonable fact finder to draw conclusions as to whether discrimination occurred." 29 C.F.R. § 1614.108(b). The Commission's Administrative Judges and the Office of Federal Operations have the authority to issue sanctions against an agency for its failure to develop an impartial and appropriate factual record in appropriate circumstances.⁸

Where it is clear that the agency failed to develop an impartial and appropriate factual record, an Administrative Judge may exercise his/her discretion to issue sanctions. In such circumstances, the sanctions listed in 29 C.F.R. § 1614.109(f)(3) are available. See [Petersel v. U.S. Postal Service](#), EEOC Appeal No. 0720060075 (Oct. 30, 2008)(Administrative Judge properly drew an adverse inference against the agency when the investigative report failed to include any comparative data on other employees); [Royal v. Dep't. of Veterans Affairs](#), EEOC Appeal No. 0720070045 (September 25, 2009)(finding that the agency's delay in completing the investigation within the 180-day regulatory period is no small noncompliance matter and warrants a sanction). Even when an agency eventually completes the investigation during the hearing stage an Administrative Judge may issue sanctions in appropriate circumstances.⁹

Before an Administrative Judge may sanction an agency for failing to develop an impartial and appropriate factual record, the Administrative Judge must issue an order to

⁸ The Commission recognizes that agencies will not always meet their regulatory burden to conduct such comprehensive investigations, such as when amendments to complaints or consolidation of complaints occur late in the process. It is the Commission's intent that where a hearing is properly requested and where there has been no investigation or there is an incomplete or inadequate investigation, the record in the case shall be developed under the supervision of the Administrative Judge assigned to the case. See, for example, [Menoken v. Social Security Administration](#), EEOC Appeal No. 01A32052 (Jan. 3, 2005); but see also [Cox v. Social Security Administration](#), EEOC Appeal No. 0720050055 (Dec. 24, 2009) (finding that the purpose of discovery in the hearing process is to perfect the record, but it is not a substitute for an appropriate investigation; moreover, not every complainant chooses the option of requesting a hearing).

¹⁰ See [Myvett v. Court Services & Offender Supervision Agency](#), EEOC Appeal No. 0120103671 (Feb. 8, 2011), request for reconsideration denied, EEOC Request No. [0520110349](#) (Nov. 21, 2011) (upholding Administrative Judge's sanctions where agency submitted complaint file without a report of investigation and almost nine months later submitted a report of investigation to the Administrative Judge after failing to reply to two Orders to Complete the Investigation).

the agency or request the documents, records, comparative data, statistics, or affidavits. 29 C.F.R. § 1614.109(f)(3). Such order or request shall make clear that sanctions may be imposed and the type of sanction that could be imposed for failure to comply with the order unless the agency can show good cause for that failure. See [Rountree v. Dep't. of the Treasury](#), EEOC Appeal No. 07A00015 (July 17, 2001). The notice to show cause to the agency may, in appropriate circumstances, provide the agency with an opportunity to take such action as the Administrative Judge deems necessary to correct the deficiencies in the record. This may include curing the defects in the investigation caused by improper interference by the agency's general counsel, if possible; and/or disqualifying counsel from continuing to represent the agency before the Commission. The Administrative Judge also shall provide the agency with a reasonable period of time within which to take the action that the Administrative Judge has deemed necessary. Only on the failure of the agency to comply with the Administrative Judge's order or request and the notice to show cause may the Administrative Judge impose a sanction or the sanctions identified in the order or request.¹⁰

XIII. OFFER OF RESOLUTION

The Commission encourages the resolution of complaints at all times in the complaint process through a variety of settlement mechanisms. Section 1614.109(c) of 29 C.F.R. provides for one of these mechanisms by permitting agencies to make an "offer of resolution" to complainants. The Commission believes that this provision will provide incentive for agencies and complainants to resolve complaints and that it will conserve agency resources where settlement reasonably should occur. If a complainant does not accept an offer of resolution made in accordance with the requirements of 29 C.F.R. § 1614.109(c) and subsequently obtains less relief than had been offered, the complainant's attorney's fees will be limited, as described below. It should be emphasized that the offer of resolution is only one mechanism by which complaints may be settled.

A. Elements of the Offer

An offer of resolution made pursuant to 29 C.F.R. § 1614.109(c) can be made to a complainant who is represented by an attorney at any time after the filing of a formal

¹⁰ Where an agency did not complete an investigation of late-filed amendments to complaints or late-consolidated complaints because the complainant either requested a hearing before the full investigatory period ended or the amendments and consolidation occurred late in the process, sanctions for inadequate records would be inappropriate. Sanctions only would be appropriate where a party subsequently fails to comply with an order or request of the Administrative Judge that puts the party on notice of the type of sanction that may be imposed for noncompliance.

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complaint until thirty (30) days before a hearing. If, however, the complainant is not represented by an attorney, an offer of resolution cannot be made before the case is assigned to an Administrative Judge for a hearing. (These time and representation provisions apply only to offers of resolution and do not restrict the parties from discussing settlement or engaging in an alternate dispute resolution process in an effort to resolve an EEO complaint.)

Complainants have 30 days from receipt of an offer of resolution to consider the offer and decide whether to accept it. Offers of resolution must be in writing and must explain to the complainant the possible consequences of failing to accept the offer. The agency's offer, to be acceptable, must include attorney's fees and costs, and must specify any non-monetary relief. The agency may offer a lump sum payment that includes all forms of monetary liability, including attorney's fees and costs, or the payment may itemize the amounts and types of monetary relief being offered. Complainant's acceptance of the offer must also be in writing. Upon acceptance, the complaint is settled in full and processing ceases.

If a complainant decides not to accept the offer, the agency takes no immediate action, and the complaint continues to be processed normally. After the hearing is completed, if the Administrative Judge (or the Commission on appeal) concludes that discrimination has occurred, but provides for less relief than the amount offered by the agency earlier in its offer of resolution, then the agency may use complainant's decision not to accept its offer of resolution to argue for a reduction in its obligation to pay complainant's attorney's fees. In general, if a complainant fails to accept a properly made offer, and the relief ordered on the complaint is not more favorable than the offer, then the complainant will not receive payment from the agency for attorney's fees or costs incurred after the expiration of the 30-day acceptance period.

It should be noted, however, that an exception to this general rule exists where the interests of justice would not be served. An example of an appropriate use of the interests of justice exception is where the complainant received an offer of resolution, but was informed by a responsible agency official that the agency would not comply in good faith with the offer (for example, would unreasonably delay implementation of the relief offered). If the complainant did not accept the offer for that reason, and then obtained less relief than was obtained in the offer, it would be unjust to deny attorney's fees and costs.

A complainant's failure to accept an offer of resolution does not preclude the agency from making other offers of resolution or either party from seeking to negotiate a settlement of the complaint at any time.

When comparing the relief offered in an offer of resolution with that actually obtained, the Commission intends that non-monetary as well as monetary relief be considered.

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Although a comparison of non-monetary relief may be inexact and difficult in some cases, non-monetary relief can be significant and cannot be overlooked. Attorney's fees and costs incurred after the offer of resolution may not be included in the amount actually obtained for comparison purposes. For guidance, parties may wish to refer to court cases deciding issues involving an offer of judgment made pursuant to Rule 68 of the Federal Rules of Civil Procedure. See, for example, [Marek v. Chesney](#), 473 U.S. 1 (1985). While not identical, the Commission's offer of resolution provision was modeled on the Rule 68 offer of judgment process.

B. Model Language for the Offer

The preamble to the Commission's regulations noted that this Management Directive would include model language for agency use in extending offers of resolutions:

This offer of resolution is made in full satisfaction of the claims of employment discrimination that you have made against [name of agency] in [identify the complaint by number or other clear and unambiguous designation]. This offer includes all of the monetary and/or non-monetary relief to which you are entitled, including attorney's fees and costs.

[For complainants who are not represented by counsel include this paragraph:]

Your acceptance of this offer must be made in writing and postmarked or received in this office **within thirty (30) days** of your receipt of the offer. If you accept this offer, please indicate your acceptance on the enclosed original offer by signing on the line appearing above your name and include the date of your acceptance on the line appearing adjacent to your name. You should send or deliver your acceptance of the offer to the undersigned at the address specified below.

[For complainants represented by counsel, substitute the following paragraph:]

The complainant's acceptance of this offer must be made in writing and postmarked or received in this office **within thirty (30) days** of **your** receipt of the offer. If the complainant accepts this offer, please indicate **your** acceptance on the enclosed original offer by signing on the line appearing above your name and include the date of your acceptance on the line appearing adjacent

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to your name. Please also obtain the signature of the complainant, which should be placed on the line appearing above [his/her] name and include the date of [his/her] acceptance on the line appearing adjacent to [his/her] name. This offer will not be deemed to have been accepted without the signature of both you and the complainant. You should send or deliver your acceptance of the offer to the undersigned at the address specified below.

[The following paragraphs must be included in offers sent to ALL complainants:]

If you do not accept this offer of resolution and the relief that you are eventually awarded by the Administrative Judge, or the Equal Employment Opportunity Commission on appeal, is less than the amount offered, you will not receive payment for the attorney's fees or costs that you incur after the expiration of the 30-day acceptance period for this offer. The only exception to this rule is where the Administrative Judge or Commission rules that the interests of justice require that you receive your full attorney's fees and costs.

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CHAPTER 7 HEARINGS

I. INTRODUCTION

The hearing is an adjudicatory proceeding that completes the process of developing a full and appropriate record. A hearing provides the parties with a fair and reasonable opportunity to explain and supplement the record and, in appropriate instances, to examine and cross-examine witnesses. Hearings are governed by 29 C.F.R. § 1614.109.¹ An Administrative Judge from the Commission adjudicates claims of discrimination and issues decisions. Unless the agency issues a final order within forty (40) days of receipt of the Administrative Judge's decision in a non-class action pursuant to 29 C.F.R. § 1614.110(a), the Administrative Judge's decision becomes the final action of the agency. A complainant may appeal an agency's final action or dismissal of a complaint. An agency may appeal as provided in 29 C.F.R. § 1614.110(a). 29 C.F.R. §§ 1614.401(a) & (b).

Section 1614.108(f) of 29 C.F.R. generally provides, among other things, that within 180 days from the complainant's filing of his/her complaint, an agency shall provide the complainant with a copy of the investigative file and shall notify the complainant that within thirty (30) days of the complainant's receipt of the investigative file that the complainant has the right to request a hearing and decision from an Administrative Judge or a final agency decision from the agency.² Regardless of whether the investigation is complete, the agency's duty to send this notice and the complainant's right to receive it are not dependent on the agency's completion of the investigation.

If the agency does not send the notice required in 29 C.F.R. § 1614.108(f) within the applicable time limits, it must send a notice informing the complainant that it has not yet finished the investigation and providing an estimate as to when the investigation will be completed. See 29 C.F.R. § 1614.108(g). The notice should notify the complainant that they do not have to wait for the investigation to be completed and may request a hearing or file a civil action in an appropriate U.S. District Court. Further, the notice will contain information regarding the hearing process.

¹ Additional information regarding hearings and the hearing process can be found in the [U.S. Equal Opportunity Commission's Handbook for Administrative Judges](#), July 1, 2002.

² Section 1614.108(f) of 29 C.F.R. specifically provides that the agency has a duty to send the notice within 180 days of the filing of the complaint or, where a complaint has been amended, the earlier of 180 days from the date of the last amendment or 360 days from the filing of the first complaint, whichever is earlier; within a time period set forth in an order from the Commission; or within any period of extension provided under 29 C.F.R. § 1614.108(e).

A complainant must submit the hearing request directly to the Commission's district or field office having jurisdiction over the geographic area in which the complaint arose, as set forth in Appendix N of this Management Directive, and provide a copy of the request to the agency. See 29 C.F.R. § 1614.108(h). (The Commission has prepared a hearing request form that agencies may provide to complainants for their use in requesting a hearing, which advises complainants that they are to send a copy of the request to the agency. See Appendix M.) Upon receipt of the request for a hearing, the Commission's district or field office will assign the case to an Administrative Judge who will issue Orders/Notices as appropriate to the case and provide the parties with a Commission Hearings Unit No. or docket number, and if the agency did not receive a copy of the complainant's request for a hearing, will require that the agency forward a copy of the complaint file within fifteen (15) days.

In an agency's written acknowledgment of receipt of a complaint or an amendment to a complaint, the agency shall advise the complainant of the Commission's office and address where a hearing request is to be sent as well as the agency office to which the copy of the request should be sent. In the absence of the required notice from the agency, the complainant may request a hearing at any time after 180 days have elapsed from the filing of the complaint by submitting his/her written hearing request directly to the appropriate Commission district or field office indicated in the agency's acknowledgment letter. 29 C.F.R. § 1614.108(h). In the case of accepted class complaints, a Commission Administrative Judge will, pursuant to 29 C.F.R. § 1614.204(h), conduct a hearing on the complaint in accordance with 29 C.F.R. §§ 1614.109(a) - (f).

Generally, an Administrative Judge will conduct a hearing on the merits of a complaint unless: 1) the parties mutually resolve the complaint and the hearing request is withdrawn; 2) the hearing request is otherwise voluntarily withdrawn; 3) the Administrative Judge dismisses the complaint; or 4) the Administrative Judge determines that material facts are not in genuine dispute and issues an order limiting the scope of the hearing or issues a decision without a hearing pursuant to 29 C.F.R. § 1614.109(g). The Administrative Judge will issue a decision on a complaint and shall order appropriate remedies and relief when discrimination has been found within 180 days of his/her receipt of the complaint file from the agency, unless the Administrative Judge makes a written determination that, in his/her discretion, good cause exists for extending the time for issuing a decision. 29 C.F.R. § 1614.109(i).³

³ A decision issued within 180 days may include a finding of discrimination, an order that the agency provide relief, and pay the complainant's attorney's fees. The Administrative Judge then would issue a second decision subsequent to the end of this 180-day period concerning the quantum of relief and attorney's fees. In this situation, the agency's 40-day period for taking final action on the Administrative Judge's decision and determining whether it will implement the decision begins on its receipt of the second decision and the hearing file. 29 C.F.R. § 1614.110(a).

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II. THE ROLE OF THE AGENCY AT THE HEARING STAGE

A. Forward Complaint File to the Commission

Within fifteen (15) days of its receipt of a copy of the complainant's request for a hearing sent to a Commission district or field office, the agency shall send a copy of the complaint file, including the investigative file, to the district or field office. The agency also shall send a copy of the complaint and investigative file(s) to the complainant and his/her representative, if it has not previously done so. The complaint file sent to the complainant or his/her representative must be identical to the complaint file sent to the Commission's district or field office. See Chapter 6, Section VIII of this directive for more information regarding the complaint file. The complainant and his/her representative shall be given the option of receiving these documents in paper or digital format.

B. Hearing Room and Production of Witnesses

The agency is responsible for arranging for an appropriately sized room in which to hold the hearing and must ensure that all approved witnesses who are federal employees are notified of the date and time of the hearing and the approximate time that their presence will be required. This includes making space available with appropriate virtual conferencing equipment for hearings and/or other proceedings as required by the Administrative Judge. The agency is responsible for ensuring the appearance and travel arrangements to the hearing site of approved witnesses who are federal employees. Note: the Administrative Judge may order the agency to provide any reasonable accommodations for parties, witnesses, or representatives appearing before the Commission as well as any required foreign language interpreters.

C. Hearings Are Closed to the Public

Access to the hearing room and the record of the hearing shall be restricted in accordance with the Commission's regulation. See 29 C.F.R. § 1614.109(e).

D. Verbatim Hearing Transcripts and Court Reporters

The agency shall arrange and pay for a verbatim transcript (provided in electronic format for the Administrative Judge and the complainant, unless otherwise requested) of the hearing proceedings pursuant to 29 C.F.R. § 1614.109(h)

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regardless of whether the Administrative Judge issues a decision. All exhibits submitted to the Administrative Judge and admitted into evidence shall become a part of the complaint file and at the discretion of the Administrative Judge may be referred to the court reporter to be appended to the transcript. Agencies should instruct reporters with whom they contract to submit bills to the agency. The Administrative Judge may require the court reporter to submit the original and all copies (usually two) of the transcript to the Administrative Judge, who can provide verification of transcript receipt and the number of pages in the transcript. Contracts with court reporting firms must require delivery of the transcript to the Administrative Judge within a customary time frame determined by the court reporting firm within the jurisdiction, not to exceed twenty-one (21) days unless the Administrative Judge requires delivery of the transcript by a certain date after the close of the hearing. If the Administrative Judge identifies a problem with timely delivery of the transcript or any other difficulty, s/he should contact the agency directly to resolve the dispute. The agency shall take any steps necessary to ensure that the transcript is provided as expeditiously as possible. Absent a specific memorandum of understanding with the Commission, the agency may not use employees of that agency to transcribe the proceedings.

As a matter of information, the General Services Administration maintains a list of court reporters available to agencies in the [GSA eLibrary](#).

E. The Site of the Hearing

Appendix N of the Management Directive is a list of the addresses of the Commission district and field offices, their geographic jurisdictions, and where federal employees and applicants should send hearing requests. Hearing requests are sent to the district office having jurisdiction over the agency facility where the complaint arose. In an agency's written acknowledgment of a complaint or an amendment to a complaint, the agency must advise the complainant of the Commission office and its address where a request for a hearing shall be sent. Where two or more complaints have been consolidated and the Commission district or field offices identified in the agency's complaint acknowledgment letter differ, the office identified in the last filed complaint will govern the location of the office to which the hearing request shall be made. Should the agency's organizational component where the complaint arose not fall within one of the geographical jurisdictions shown in Appendix N, the agency should contact the following office for guidance:

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Equal Employment Opportunity Commission
 Office of Field Programs
 Attention: Hearings Coordinator
 131 M Street, NE.
 Washington, DC 20507

Email at: info@eeoc.gov

Upon receipt of a hearing request, the Administrative Judge assigned to hear the complaint will determine the site of the hearing. Within his/her discretion, the Administrative Judge is authorized to conduct the hearing in the Commission district or field office, in a Commission area or local office, at the agency's organizational component where the complaint arose or at such other location or by virtual conference as s/he may determine appropriate within a local commuting distance from the agency's component unless otherwise agreed to by the parties. In determining the hearing site, the Administrative Judge should consider factors such as the location of the parties; the location of the Commission district, area, and local offices; the number and location of witnesses; the location of records; travel distances for the Administrative Judge, the parties, and witnesses; travel costs; the availability of sources of transportation; and other factors as may be appropriate including the availability of appropriate virtual conferencing equipment.

Similarly, where an Administrative Judge is considering whether the hearing should be held by video conferencing, there are a number of factors that should be considered before electing to proceed. These factors include the availability and proximity to the participants of the video-conferencing facilities;⁴ the adequacy of the available video-conferencing facilities, including any technological issues; the cost to the respondent agency (if any) balanced against the savings in travel time for all parties and the Administrative Judge; the number of expected participants; and the objections of the parties, if any. Should a party object to conducting the hearing by video conference, the Administrative Judge will document for the record both the nature of the objection and his/her ruling on the objection,

⁴ "Proximity" in this instance refers to whether the facility is within reasonable commuting distance for the hearing participants. The Commission notes, however, that considerations of proximity will generally exclude the use of video conferencing when all participants and the Administrative Judge are located within commuting distance of an appropriate location for an in-person hearing. But cf. Louthen v. U.S. Postal Service, EEOC Appeal No. 01A44521 (May 17, 2006) (telephone hearing inappropriate where, inter alia, all participants including the Administrative Judge were present in same city on hearing date).

including the reasons therefore.⁵ See [Allen v. U.S. Postal Service](#), EEOC Appeal No. 01A51259 (Aug. 21, 2006).

If the Administrative Judge sets a hearing by video conference or a hearing site that is outside the local commuting area of the agency's organizational component where the complaint arose, the agency must bear all reasonable video-conferencing costs if any, or travel expenses of complainants, their authorized representatives, agency representatives, and all witnesses approved by the Administrative Judge, except that an agency does not have the authority to pay the travel expenses of the complainant or the complainant's witnesses or representatives if they are not federal employees.

F. Request for Change in Venue

Should either party desire that a hearing be held within the jurisdictional area of another Commission district office, it must submit a request, in writing, to the other party and to the Administrative Judge assigned to the case in the appropriate Commission district or field office having jurisdiction over the agency's organizational component where the complaint arose. In its request, the party must set out, in detail, its reasons and justification for the requested change. The other party may have an opportunity to respond to the change in venue. The Administrative Judge will rule on the request only after the directors of the concerned Commission district offices or their designees have conferred on the matter.

G. Agency Costs

The agency's obligation is limited to those costs that are legally payable in advance by the agency. See [Expenses of Outside Applicant/Complainant to Travel to Agency EEO Hearing](#), File: B-202845, 61 Comp. Gen. 654 (1982). See also [John Booth--Travel Expenses of Witness -- Agency Responsible](#), File: B-235845, 69 Comp. Gen. 310 (1990).

⁵ In this regard, the Commission contemplates that the Administrative Judge will provide the parties advance notice of his/her intention to proceed by video conference, allowing opportunity for the parties to object prior to the time the hearing is convened. Objections to video conference raised on appeal will be reviewed by the Commission under the abuse of discretion standard, on a case-by-case basis. See [Louthen](#), EEOC Appeal No. 01A44521.

August, 2015**EEO MD-110****III. THE ROLE OF THE ADMINISTRATIVE JUDGE**

Once an Administrative Judge is appointed, the Administrative Judge has full responsibility for the adjudication of the complaint. 29 C.F.R. § 1614.109(a). The agency cannot dismiss a case that has been referred to the Commission for a hearing. 29 C.F.R. § 1614.107(a).

A. Administrative Judge's Review of the Record

An Administrative Judge shall review the record developed by the agency and determine whether additional documentation is necessary. If a determination is made that additional documentation is necessary, the Administrative Judge may order the appropriate party to produce the additional documentation.

If after reviewing the file, the Administrative Judge determines that the investigation is inadequate due to the agency's failure to complete the investigation within the time limits set forth in 29 C.F.R. § 1614.108(e), or the agency has not cooperated in the discovery process as required by 29 C.F.R. § 1614.109(f)(3), the Administrative Judge may take the following actions:

1. Subject the agency to adverse inference findings in favor of the complainant;
2. Consider the issues to which the requested information or testimony pertains to be favorable to the complainant;
3. Exclude other evidence offered by the agency;
4. Permit the complainant to obtain a summary disposition in his/her favor (that is, default judgment) on some or all of the issues without a hearing; or
5. Take other action deemed appropriate, including, but not limited to, requiring the agency to pay any costs incurred by the complainant in taking depositions or in conducting any other form of discovery.

The Commission has the authority to issue sanctions in the administrative hearing process because it was granted, through statute, the power to issue such rules and regulations that it deems necessary to enforce the prohibition on employment discrimination. See [Waller v. Dep't. of Transportation](#), EEOC Appeal No. 0720030069 (May 25, 2007), [request for reconsideration denied](#), EEOC Request No. 0520070689 (Feb. 26, 2009). In this respect, the Commission has determined "that delegating to its Administrative Judges the authority to issue sanctions

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against agencies, and complainants, is necessary and is an appropriate remedy which effectuates the policies of the Commission.” Id.

However, before an Administrative Judge may sanction an agency for failing to develop an impartial and appropriate factual record or for not cooperating in the discovery process, the Administrative Judge must issue an order to the agency or request the documents, records, comparative data, statistics, or affidavits. 29 C.F.R. § 1614.109(f)(3). Such order or request shall make clear that sanctions may be imposed and the type of sanction that could be imposed for failure to comply with the order unless the agency can show good cause for that failure. See [Rountree v. Dep’t. of the Treasury](#), Appeal No. 07A00015 (July 17, 2001). In appropriate circumstances, the order or request may provide the agency with an opportunity to take such action as the Administrative Judge deems necessary to correct the deficiencies in the record within a specified reasonable period of time. Only on the failure of the agency to comply with the Administrative Judge’s order or request and the notice to show cause may the Administrative Judge impose a sanction or the sanctions identified in the order or request.

B. Developing the Record in Complaints with Inadequate Records

Section 1614.108(h) of 29 C.F.R. authorizes a complainant to request a hearing before an Administrative Judge where the respondent agency has not completed the investigation within the required time limit and where the complainant has not agreed in writing with the agency to extend the time for completing the investigation.⁶ This provision reflects the Commission’s intent that complainants be permitted to move their cases forward in the complaint process where an agency has not complied with the regulation by completing a timely investigation. Further, it is the Commission’s intent that where a hearing is properly requested and where there has been no investigation or there is an incomplete or inadequate investigation, the record in the case shall be developed under the supervision of the Administrative Judge assigned to the case. The record can be developed through the parties’ use of discovery and/or through the Administrative Judge’s orders for the production of documents and witnesses.

⁶ Where an agency did not complete an investigation of late-filed amendments to complaints or late-consolidated complaints because the complainant either requested a hearing before the full investigatory period ended or the amendments and consolidation occurred late in the process, sanctions for inadequate records would be inappropriate. Sanctions only would be appropriate where a party subsequently fails to comply with an order or request of the Administrative Judge that puts the party on notice of the type of sanction that may be imposed for noncompliance.

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Section 1614.109(a) of 29 C.F.R. provides that upon appointment, the Administrative Judge will assume full responsibility for adjudication of the complaint, including overseeing the development of the record. The Commission intends that the Administrative Judge will take complete control of the case once a hearing is requested. Administrative Judges will preside over any necessary supplementation of the record in the hearing process without resort to remands of complaints to agencies for additional investigations. If an Administrative Judge determines that there is an incomplete or inadequate investigation, s/he may, however, issue an order directing the agency to complete its investigation within a specified period of time set forth in the order or directing that the agency show cause for its failure to complete the investigation within the 180-day period.

Where an agency has not completed a timely investigation or has prepared an inadequate investigation, the Administrative Judge may issue an order on his/her own initiative or upon request by either party requiring a party to produce documents, records, comparative data, statistics, or the attendance of witnesses. Such order or request shall make clear that sanctions may be imposed and the type of sanction that could be imposed for failure to comply with the order within the specified time set forth in the order without good cause shown.⁷ See, for example, [Rountree v. Dep't. of the Treasury](#), EEOC Appeal No. 07A00015 (July 17, 2001). Where the agency or complainant fails without good cause shown to respond fully and in a timely fashion to the Administrative Judge's order and/or the party has not otherwise cooperated in the discovery process, the Administrative Judge may impose sanctions pursuant to 29 C.F.R. § 1614.109(f)(3).⁸ A showing that the noncomplying party acted in bad faith is

⁷ Where the Administrative Judge's order or request does not put a party on notice that it could be sanctioned for noncompliance or does not put the party on notice of the type of sanction that the Administrative Judge intends to impose, the Administrative Judge must issue a separate notice to show cause to the party for an explanation as to why the sanction should not be imposed and provide an opportunity to cure the noncompliance before imposing the sanction. This rule applies in all instances where the Administrative Judge intends to impose a sanction on a party for a failure to comply with an order or request that does not make clear what sanction(s) may be imposed for noncompliance.

⁸ See for example, [Johnson v. Dep't. of the Air Force](#), EEOC Appeal No. 0120090115 (May 6, 2010), request for reconsideration denied, EEOC Request [0520100394](#) (July 30, 2010)(OFO affirmed Administrative Judge's dismissal of complainant's request for a hearing as a sanction for the failure to respond to discovery requests); [Cox v. Social Security Administration](#), EEOC Appeal No. 0720050055 (Dec. 24, 2009)(OFO affirmed Administrative Judge's default judgment against the agency based upon the Administrative Judge's finding that the agency failed to: adequately develop the factual record prior to hearing; respond to the complainant's initial request for admissions and subsequent written discovery requests; comply with the Administrative Judge's Order to Produce witnesses for depositions and timely

not required. See [Kramer v. Dep't. of Justice](#), EEO Appeal No. 07A10108 (September 11, 2003), request for reconsideration denied, EEOC Request No. [05A40050](#) (Dec. 8, 2003); [Cornell v. Dep't. of Veterans Affairs](#), EEOC Appeal No. 01974476 (Nov. 24, 1998). Additionally, the Administrative Judge may, as a result of a discovery order issued pursuant to 29 C.F.R. § 1614.109(f)(3)(v), require the agency to bear the costs for the complainant to obtain depositions or any other discovery because the agency has failed to complete its investigation timely as required by 29 C.F.R. § 1614.108(e) or has failed to investigate the allegations adequately pursuant to Chapter 6 of this Management Directive.⁹ See also Section IV.F of this Chapter.

If either party is requested by the Administrative Judge to produce additional documents, that party shall also furnish a copy of those documents to the opposing party at the time they are submitted to the Administrative Judge.

C. Dismissal of Complaint by Administrative Judge

The Administrative Judge may dismiss complaints within his/her jurisdiction pursuant to 29 C.F.R. § 1614.107(a) on his/her own initiative, after notice to the parties, or upon an agency's motion to dismiss a complaint. (See 29 C.F.R. § 1614.109(b) and Chapter 5, Section IV of this Management Directive.) Before dismissing a complaint, the Administrative Judge must ensure that the claim has not been fragmented inappropriately into more than one complaint. A series of subsequent events or instances involving the same claim should not be treated as separate complaints, but should be added to and treated as part of the first claim. See Chapter 5, Section III of this Management Directive for an extended discussion on fragmentation.

D. Administrative Judge's Authority

The Administrative Judge has full responsibility for the adjudication of the complaint, which includes, but is not limited to, the following:

1. Issue decisions on complaints.

respond to the Administrative Judge's Order to Show Cause why a default judgment should not be entered against the agency).

⁹ See for example, [Waller v. Dep't. of Transportation](#), EEOC Appeal No. 0720030069 (May 25, 2007), (finding that Administrative Judges may award attorney's fees and costs as a sanction against federal agencies for the violation of an Administrative Judge's Order and that awarding attorney's fees and costs as a sanction ensures the integrity and efficiency of the administrative process).

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2. Administer oaths.
3. Regulate the conduct of hearings.
4. Limit the number of witnesses so as to exclude irrelevant and repetitious evidence.
5. Order discovery or the production of documents and witnesses by serving orders on both parties.

The Administrative Judge has independent authority under 29 C.F.R. § 1614.109(f) to order the production of information, documents, records, comparative data, statistics, affidavits, or the attendance of witnesses.

6. Issue protective orders not to disclose information.
7. Exclude any person who is disruptive from the hearing or who is a witness so that s/he cannot hear the testimony of other witnesses.¹⁰
8. Issue summary judgment (decisions without a hearing) if there are no genuine issues of material fact in dispute.
9. Limit the hearing to the issues in dispute.
10. Impose appropriate sanctions on parties who fail to comply with orders or requests.

The Administrative Judge has the authority to impose sanctions on a party if s/he fails to comply without good cause with orders or requests. See 29 C.F.R. § 1614.109(f)(3). In addition, the Administrative Judge may impose sanctions where a party fails to appear or be prepared for a conference (for example, for status or settlement discussions) or hearing pursuant to an order of the

¹⁰ The Administrative Judge may apply Rule 615 of the Federal Rules of Evidence to the exclusion of witnesses:

At the request of a party the court shall order witnesses excluded so that they cannot hear the testimony of other witnesses, and it may make the order of its own motion. This rule does not authorize exclusion of (1) a party who is a natural person, or (2) an officer or employee of a party which is not a natural person designated as its representative by its attorney, or (3) a person whose presence is shown by a party to be essential to the presentation of the party's cause, or (4) a person authorized by statute to be present.

Administrative Judge.¹¹ Sanctions may be imposed on the agency for failure to produce an approved witness who is a federal employee.¹² Sanctions may be imposed for failure to comply with orders to compel, requests for information, documents, or admissions where the information is solely in the control of that party.¹³ Similarly, if a party fails to provide an adequate explanation for the failure to respond fully and in a timely manner to a request and the information is solely in the control of that party, the Administrative Judge may impose sanctions.¹⁴ Sanctions for failing to comply with the orders or requests discussed above include, but are not limited to, the authority to:

- (a) draw an adverse inference that the requested information would have reflected unfavorably on the party refusing to provide the requested information;
- (b) consider the issues to which the requested information pertains to be established in favor of the opposing party;
- (c) exclude other evidence offered by the party failing to produce the requested information;
- (d) enter a decision fully or partially in favor of the opposing party; and
- (e) take such other actions as appropriate.¹⁵

¹¹ See for example, [Council v. Dep't. of Veterans Affairs](#), EEOC Appeal No. 0120080321 (Apr. 9, 2010)(OFO affirmed the Administrative Judge's dismissal of complainant's request for a hearing as a sanction for her failure to prosecute her case when she failed to timely submit a previously ordered Pre-Hearing Statement or otherwise proceed with her complaint).

¹² See also [LeBlanc v. U.S. Postal Service](#), EEOC Appeal No. 01981419 (May 5, 1999)(upholding sanctions against an agency for its failure to even attempt to produce a former employee for hearing).

¹³ See for example, [Johnson v. Dep't. of the Air Force](#), EEOC Appeal No. 0120090115 (May 6, 2010) (OFO affirmed Administrative Judge's dismissal of complainant's request for a hearing as a sanction for the failure to respond to discovery requests).

¹⁴ See for example, [Johnson](#), (OFO upheld the Administrative Judge's dismissal of complainant's hearing request, stating that when the complainant responded to the Administrative Judge's order to show cause, he did not explain his failure to respond to discovery as he was ordered to do, but instead argued the merits of his case).

¹⁵ See Section III.D of this Chapter in this Management Directive, for a discussion of placing a party on notice that sanctions may be imposed before ordering their imposition. However, see also [Council v. Dep't. of Veterans Affairs](#), EEOC Appeal No. 0120080321 (Apr. 9, 2010) in which OFO

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11. Calculate compensatory damage awards.

Before holding a hearing, the Administrative Judge may require the complainant, after receipt of an agency motion or otherwise, to declare whether or not s/he is seeking compensatory damages as relief for the discrimination or retaliation alleged in the complaint, and to proffer or produce evidence demonstrating entitlement to compensatory damages. If a complainant fails to proffer or produce such evidence, the Administrative Judge may, in his/her discretion, deem the claim for damages to be waived.

Where the complainant has claimed compensatory damages and where the Administrative Judge determines, on the merits of the complaint, entitlement to compensatory damages because of intentional discrimination or retaliation, the Administrative Judge will calculate the amount of compensatory damages to be awarded by the respondent agency. In complaints where compensatory damages have been claimed and a hearing is held, the Administrative Judge may, in his/her discretion, develop the record on the compensatory damages claim during the hearing on the merits of the complaint or may bifurcate the proceeding and develop the record on the compensatory damages claim after a finding of discrimination.

12. Order a medical examination.

Administrative Judges have the authority to order, in very limited circumstances, as detailed below, that a complainant undergo a medical examination on motion of the agency. A request by the agency that a complainant undergo a medical examination must notify the complainant, the complainant's representative, and the Administrative Judge, of the proposed time, place, manner, conditions, and scope of the examination and the person or persons by whom it is to be made. The Administrative Judge must approve all such requests.

In making a determination of whether to order a medical examination, an Administrative Judge may be guided by the principles and cases arising under Rule 35 of the Federal Rules of Civil Procedure governing the physical and mental examinations of persons. The burden of proof in

upheld the Administrative Judge's dismissal of the complainant's hearing request even when an order to show cause had not been issued, pointing out that when the Administrative Judge issued the Acknowledgement and Order it advised the parties that failure to follow Orders may result in sanctions pursuant to 29 C.F.R. 1614.109(f)(3).

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supporting a request for such an examination requires an affirmative showing that each condition as to which examination is sought is genuinely in controversy and that good cause exists for ordering each particular examination. Such requests must be narrowly tailored to elicit only the evidence necessary to develop the record with regard to the specific issue.

The agency requesting the examination has the burden of proving that the examination is reasonably necessary. For example, merely showing that the complainant has made a claim for compensatory damages is not sufficient to meet the agency's burden of proof. In determining whether such a request is reasonable, the Administrative Judge will consider: whether the complainant has asserted a claim for compensatory damages sufficient to place his/her mental or physical condition in controversy; and whether the request is made for good cause shown, that is, that the examination is reasonably necessary to determine the existence and extent of an asserted injury. The Commission has held that evidence from a health care professional is not a mandatory prerequisite to establishing entitlement to compensatory damages. [Sinnott v. Dep't. of Defense](#), EEOC Appeal No. 01952872 (September 19, 1996); [Lawrence v. U.S. Postal Service](#), EEOC Appeal No. 01952288 (1996); [Carpenter v. Dep't. of Agriculture](#), EEOC Appeal No. 01945652 (July 17, 1995). A complainant's own testimony, along with the circumstances of a particular case, may suffice to sustain the complainant's burden in this regard. Therefore, independent medical examinations will not be appropriate in every case in which a claim for compensatory damages is made. See "Requests for Private Information Should Be Limited" at Section IV.B.4 in this Chapter of this Management Directive for more information.

Some factors to be considered in determining whether an agency has shown that a complainant has asserted a claim for damages sufficient to place his/her mental or physical condition in controversy include: 1) the type and extent of mental or physical harm claimed; 2) whether the harm alleged is ongoing or is merely a past harm with no current effects on the complainant; 3) whether the complainant has offered expert testimony concerning the nature and/or extent of the alleged harm or intends to offer such testimony; and 4) whether the complainant has sufficiently asserted a connection between the asserted harm and the alleged discrimination sufficient to establish a causal relationship between the harm and the alleged discrimination.

Some factors to be considered in determining whether an agency requesting a mental or physical examination has shown good cause for

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such examination include: 1) the nature and severity of the alleged harm and the likelihood that the requested examination will elicit relevant evidence as to the existence and/or extent of the alleged harm; 2) whether there is already sufficient evidence in the record as to the nature and extent of the asserted harm; and 3) whether the information sought could be obtained through other less intrusive discovery techniques, such as interrogatories, depositions, or requests for the production of witnesses or documents.

Even where the above criteria may have been satisfied by the agency requesting the examination, the decision to order such examination at the hearing stage is solely within the discretion of the Administrative Judge.

Upon receipt of a request from the agency for a medical examination, the complainant may file a motion for a protective order, stating objections to the request or order. See Section IV.D.2.b of this Chapter. The decision to order such examination at the hearing stage remains solely within the discretion of the Administrative Judge.

13. Calculate and award the amount of attorney's fees or costs.

Where a party is represented by an attorney, an Administrative Judge is authorized to award a complainant reasonable attorney's fees and costs (including expert witness fees) incurred in the processing of a complaint where the Administrative Judge issues a decision finding discrimination in violation of Title VII and/or the Rehabilitation Act, the Administrative Judge issues an order sanctioning the agency, or where the award of attorney's fees or costs may otherwise be appropriate and authorized. Any award of attorney's fees or costs shall be paid by the respondent agency. Where the Administrative Judge determines that a complainant is entitled to an award of attorney's fees or costs, the Administrative Judge will calculate the amount of such award in accordance with 29 C.F.R. § 1614.501(e)(2)(ii)(B) and Chapter 11 of this Management Directive.

When the Administrative Judge determines an entitlement to attorney's fees or costs, the complainant's attorney must submit a verified statement of attorney's fees (including expert witness fees) and other costs, as appropriate, to the Administrative Judge within thirty (30) days of receipt of the decision, unless otherwise directed, and must submit a copy of the statement to the agency. A statement of attorney's fees and costs must be accompanied by an affidavit executed by the attorney of record itemizing the attorney's charges for legal services. The agency may respond to a statement of attorney's fees and costs within thirty (30) days of its receipt.

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The verified statement, accompanying affidavit, and any agency response shall be made a part of the complaint file. The Administrative Judge will issue a decision determining the amount of attorney's fees and costs due within sixty (60) days of receipt of the statement and affidavit.

14. Engage the parties or encourage the parties to engage in settlement discussions.

The Administrative Judge may engage the parties in discussion aimed at reaching a settlement agreement or may allow the parties such time as they may need to discuss settlement. The Administrative Judge further may hold a hearing in abeyance to allow the parties to engage in alternate forms of dispute resolution. (For a more detailed discussion of alternative dispute resolution, see Chapter 3 of this Management Directive.)

15. Issue an order determining full relief.

Administrative Judges shall issue an order awarding full relief where the agency unilaterally and unconditionally promises in writing to provide the full and complete remedy as defined by the Administrative Judge. To permit him/her to determine the appropriate remedy for the complaint, the Administrative Judge may require the parties to submit statements of full relief, may receive evidence including testimony, and/or require oral argument. After issuing the order and a determination of the appropriate remedy, the Administrative Judge shall return the hearing file to the agency, which shall have forty (40) days to take final action. 29 C.F.R. § 1614.110(a). Once the agency takes final action, the complainant will have thirty days within which to file an appeal. 29 C.F.R. § 1614.402(a). If the agency fails to provide the full and complete remedy as promised, the complainant may seek compliance from the agency and, failing that, file an appeal with the Commission. See 29 C.F.R. § 1614.504(a); see also [Miller v. Dep't. of the Treasury](#), EEOC Request No. 05980345 (July 20, 1998); [Perlingiero v. Dep't. of the Navy](#), EEOC Appeal No. 01941176 (Feb. 24, 1995); [Poirrier v. Dep't. of Veterans Affairs](#), EEOC Appeal No. 01933308 (May 5, 1994).

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16. Hold a hearing in abeyance.

An Administrative Judge may hold a hearing in abeyance in the event that a party is unable to proceed with the hearing for reasons such as illness, military assignment, or other good cause shown.

E. Summary Judgment (Decisions without a Hearing)

1. On Motion of a Party

A party who believes that some or all material facts are not in genuine dispute may file a motion for summary judgment with the Administrative Judge at least fifteen (15) days prior to the hearing, or at such earlier time as required by the Administrative Judge. The Administrative Judge may, in the acknowledgment order, specify a date for filing such a motion and provide for extending that time in certain circumstances. A copy of any such motion shall be served on the opposing party.

The opposing party will have 15 days from the receipt of the statement in which to file any opposition to the statement.

After considering the request and the opposing submission, if any, the Administrative Judge may deny the request, order that discovery be permitted on the facts involved, limit the hearing to the issues remaining in dispute (if any), issue a decision without a hearing, or make such other rulings as are appropriate.

2. On Administrative Judge's Determination

If the Administrative Judge determines that some or all of the material facts are not in genuine dispute, s/he may, after giving notice to the parties and providing them an opportunity to respond within 15 days of receipt of the notice, issue an order limiting the scope of the hearing or issue a summary judgment decision without conducting a hearing.

3. Oral Argument or Testimony on Summary Judgment Motion

At his/her discretion, the Administrative Judge may provide notice requiring the parties to appear and present oral argument or testimony on a motion for summary judgment.

4. Legal Standard for the Use of Summary Judgment

Summary judgment is proper when “material facts are not in genuine dispute.” 29 C.F.R. § 1614.109(g). Only a dispute over facts that are truly material to the outcome of the case should preclude summary judgment. [Anderson v. Liberty Lobby, Inc.](#), 477 U.S. 242, 248 (1986) (only disputes over facts that might affect the outcome of the suit under the governing law, and not irrelevant or unnecessary factual disputes, will preclude the entry of summary judgment). For example, when a complainant is unable to set forth facts necessary to establish one essential element of a prima facie case, a dispute over facts necessary to prove another element of the case would not be material to the outcome. [Celotex v. Catrett](#), 477 U.S. 317, 322-323 (1986).

Moreover, a mere recitation that there is a factual dispute is insufficient. The party opposing summary judgment must identify the disputed facts in the record with specificity or demonstrate that there is a dispute by producing affidavits or records that tend to disprove the facts asserted by the moving party. In addition, the non-moving party must explain how the facts in dispute are material under the legal principles applicable to the case. 29 C.F.R. § 1614.109(g)(2); [Celotex](#), 477 U.S. at 322-324; [Patton v. U.S. Postal Service](#), EEOC Request No. 05930055 (July 1, 1993) (summary judgment proper where complainant made only a general pleading that his job performance was good but set forth no specific facts regarding his performance and identified no specific inadequacies in the investigation).

F. **Transmittal of the Decision and Hearing Record**

At the conclusion of the hearing stage the Administrative Judge shall send to the parties (the agency representative, the agency EEO Director or EEO Office, the complainant, and the complainant’s representative) copies of the record produced at the hearing stage of the process, including the transcript of the hearing, if any, as well as the decision.

The Administrative Judge may, when necessary, release the transcript prior to the issuance of the decision, for example, when the transcript is needed to prepare a post-hearing brief or to prepare for a hearing on relief.

The Administrative Judge may issue a decision from the bench after the conclusion of the hearing, in lieu of issuing a written decision.

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IV. DISCOVERY

A. Introduction

1. General

The purpose of discovery is to enable a party to obtain relevant information for preparation of the party's case. Both parties are entitled to reasonable development of evidence on issues raised in the complaint, and the Administrative Judge may limit the quantity and timing of discovery.

A reasonable amount of official time shall be allowed to prepare requests for discovery and to respond to discovery requests. (See Chapter 6, Section VII.C of this Management Directive.)

2. Avoidance of Delay

The discovery instructions that follow are intended to provide a simple method of discovery. They will be interpreted and applied so as to avoid delay and to facilitate adjudication of the case. The parties are expected to initiate and complete needed discovery with a minimum of intervention by the Commission's Administrative Judge. The parties are further expected to use discovery judiciously for its intended purpose only.

B. Right to Seek Discovery

1. Notice of Right to Seek Discovery

The Administrative Judge shall send the parties an acknowledgment order advising the parties that they may commence discovery. It is the Commission's policy that the parties are entitled, pursuant to 29 C.F.R. § 1614.109(b), to the reasonable development of evidence on the issues raised in the complaint.

2. Discovery Is Designed to Supplement the Record

It is anticipated that discovery will ordinarily involve supplementing the existing record. There may be situations in which the record does not have to be supplemented.

3. Discovery Time Frames Will Be Strictly Regarded

Discovery must be completed by such time ordered by the Administrative Judge. Parties may request to extend the time for discovery beyond the time limit set. The Administrative Judge may modify the time frame for completing discovery either by extending it or by curtailing it as the Administrative Judge may determine. To be considered, any request for extension must be made prior to the expiration of the time limit by motion and accompanied with a proposed order and shall state whether the opposing party agrees or objects to the motion or order.

4. Requests for Private Information Should Be Limited

Agency requests for the medical records of complainants should only occur to establish or challenge disability status or the right to reasonable accommodation in Rehabilitation Act cases, or when a complainant is asserting a claim for compensatory damages and has sought medical treatment for one or more stress-related conditions. In such instances, agency requests for medical records shall be narrowly tailored to the condition(s) and temporal scope at issue. As discussed in detail in Chapter 11, Section VII, complainants are not required to prove compensatory damages through medical records or other expert evidence. See [Lawrence v. U.S. Postal Service](#), EEOC Appeal No. 01952288 (Apr. 18, 1996) (citing [Carle v. Dep't. of the Navy](#), EEOC Appeal No. 01922369 (Jan. 5, 1993)).

Where a complainant is pro se, agencies must request the Administrative Judge's prior permission before making requests for medical information, and the Administrative Judge shall advise the parties of this provision at the initial status conference. The Administrative Judge shall also explain that a complainant should contact the Administrative Judge to request a protective order if the complainant believes agency counsel is seeking overly broad or intrusive medical records through discovery requests.

Similarly, agency requests for wage information should only occur when the complainant is making a back pay claim and has received compensation for subsequent employment. Agencies are not authorized and must request prior permission from the Administrative Judge before making requests for production of a complainant's tax records except with respect to W-2 (earned income) and Schedule C (profit or loss) documents.

August, 2015EEO MD-110**C. Methods of Discovery****1. Evidence may be developed using a variety of methods, including:****a. Interrogatories**

Absent specific authorization from the Administrative Judge, a party may submit no more than one set of interrogatories and a set of interrogatories shall not exceed thirty (30) in number including all discrete subparts.

b. Depositions

Generally the party requesting depositions will pay for them. A failure to appear at a properly scheduled deposition may result in the non-appearing party bearing the cost of the missed session. Agencies must make federal employees available for depositions and such depositions shall be taken on official time. The agency may be liable for costs incurred if such persons are not made available on the clock for depositions or other discovery or if such persons fail to appear.

c. Stipulations

Stipulations are strongly encouraged.

d. Requests for Admissions

Absent specific authorization from the Administrative Judge, a request for admissions shall not exceed 30 in number including all discrete subparts. This limit does not apply, however, to admissions relating to the authenticity or genuineness of documents.

e. Requests for the Production of Documents

Absent specific authorization from the Administrative Judge, requests must be specific, identifying the document or types of documents requested. A set of document requests shall not exceed 30 in number including all discrete subparts.

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2. **Where possible, more informal methods of discovery should be employed**

In many instances, discovery should proceed on an informal basis, including unrecorded meetings and conference calls designed to exchange information. For example, if a primary purpose of discovery is to determine the scope and content of a material witness's testimony, it may be sufficient that there be a meeting scheduled with the witness and that the discovery be conducted on an informal basis. If that method proves unsatisfactory, a more formal method of discovery may be used.

When information gathering and hearing preparation takes place outside the scope of formal discovery, agencies may not restrict access to non-management employees who voluntarily cooperate with informal discovery.

- a. The parties may agree that a witness be made available for questioning without the production of a transcript or tape recording where the purpose is to discover the availability of other evidence, either documentary or testimonial.
- b. The parties may agree to the questioning of witnesses using a tape-recording device, provided that any such tape will not be accepted in evidence without authentication. Such authentication can be presumed where the opposing party is provided a copy of the tape at the close of the discovery session and it is identical to the tape proffered in evidence.

D. Discovery Procedures

1. **Commencing Discovery**

a. **Requests for authorization to commence**

Unless the Administrative Judge requires that a party request authorization to commence discovery, parties may begin discovery upon receipt of the Administrative Judge's acknowledgment order.

If the Administrative Judge requires that a party request authorization to commence discovery, the request must state the method(s) and scope of discovery requested and its relevance to the issue(s) in the complaint.

August, 2015EEO MD-110b. Exchange of requests

Upon receipt of the Administrative Judge's authorization to begin discovery or acknowledgment order that does not require the parties to seek authorization, the parties must, within twenty (20) calendar days or such period of time ordered by the Administrative Judge, exchange initial requests for discovery. If a party does not submit an initial discovery request to opposing party within that period, the Administrative Judge may determine that the party has waived its right to pursue discovery.

The parties must cooperate with each other in honoring requests for relevant, non-repetitive documentary and testimonial evidence. The parties shall not use any form of discovery or discovery scheduling for harassment, for unjustified delay, to increase litigation expenses, or for any improper purpose. The Administrative Judge will resolve discovery disputes only after the parties have made a good faith effort to resolve the dispute.

(1) Where to address discovery

Requests for discovery should be addressed to the agency representative, complainant, and complainant's representative of record, and not to the Administrative Judge, unless requested by the Administrative Judge. Where a party addresses a request for discovery to the Administrative Judge, the Administrative Judge may, at his/her discretion, return the request to the party submitting the discovery request with instructions to serve it on the appropriate party, or may forward the request to the appropriate party. Where a party inappropriately submits a discovery request to the Administrative Judge, the required time frame for submitting the request to the appropriate party will not stop running unless the Administrative Judge rules otherwise. Copies of discovery requests should not be provided to the Administrative Judge unless a motion to compel or a response to a motion to compel is being filed or if otherwise directed by the Administrative Judge.

(2) Criteria for requests

The request should be: 1) as specific as possible and 2) reasonably calculated to discover non-repetitive, material evidence.

2. Response to Discovery Request

Unless otherwise ordered, the opposing party/representative must serve his/her response to the request for discovery within thirty (30) calendar days from the date of service of the request. If service of the request was by mail, the opposing party/representative may add five days to the date that the response is due. A response means:

- a. Compliance with the request - voluntary cooperation with discovery requests is encouraged;
- b. Written opposition to the request/motion for a protective order - such opposition shall set forth a basis for finding that the request is irrelevant, overburdening, repetitious, or privileged;
- c. Written agreement or stipulation obviating the request - stipulations of fact are favored as a means of resolving discovery issues;
- e. Request for extension of time - extension of time to comply or to produce a written agreement shall not exceed 15 calendar days.

3. Failure to Respond to Request for Discovery

- a. Failure to fully respond to a request for discovery within 30 calendar days of receipt of the request, or as otherwise ordered by the Administrative Judge, shall form the basis for a motion to compel discovery, provided the parties have made a good faith effort to resolve the dispute. Parties engaging in good faith settlement efforts may request an extension from the Administrative Judge.
- b. A motion to compel must be filed within ten (10) calendar days after the expiration date for responding to a request for discovery, or as otherwise ordered by the Administrative Judge. When filing a motion, the moving party must certify that s/he conferred with the opposing party, or made a good faith effort to do so, to attempt

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to resolve the discovery dispute. See [Fed. R. Civ. P. 37\(a\)\(1\)](#); [Apex Oil Co. v. Belcher Co.](#), 855 F.2d 1009, 1020 (2d Cir. 1988) (failure to confer in good faith over discovery disputes multiplied the proceedings and justified sanctions).

- c. A motion to compel compliance with a request for discovery must be addressed to the Administrative Judge and the moving party must certify that a copy was served on the opposing party.
- d. Any statement in opposition to the motion must be filed within ten (10) calendar days of service of the motion and the responding party must certify that a copy was served on the moving party.
- e. A party's failure to raise an objection to a discovery request within the time period to respond to it may be determined by the Administrative Judge to be a waiver of that party's ability to object to the request at a later date.

4. Administrative Judges Will Rule Expeditiously on Discovery Issues

Following the filing of an opposition, if any, to the motion to compel discovery, the Administrative Judge will rule expeditiously on the request for discovery. In the alternative, the Administrative Judge may, in the interest of expediting the hearing, order that the document(s), witness(es), or other evidence at issue be produced at the hearing. Where the Administrative Judge finds that the request for discovery that is the subject of the motion to compel is irrelevant, overburdening, repetitious, or privileged, the Administrative Judge will deny the motion to compel and may, upon the request of the party opposing the motion to compel, or upon the Administrative Judge's own initiative, issue such protective orders as the Administrative Judge determines appropriate.

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5. Administrative Judge's Orders to Comply

- a. In considering a motion to compel compliance, the Administrative Judge will consider whether the following factors apply:
 - (1) the discovery is calculated to produce or lead to the production of material evidence that is not repetitious of facts or documents already in the complaint file,
 - (2) the discovery does not concern privileged or restricted information, and
 - (3) the discovery is not overly burdensome.
- b. Where a motion to compel discovery is approved, in whole or in part, the Administrative Judge shall issue a written order to comply with the request. The parties shall have 15 calendar days or such other time period ordered by the Administrative Judge to comply with a discovery order.

6. Failure to Respond or Comply with Administrative Judge's Order May Result in Sanctions

A failure to respond or follow an order to comply with a request for discovery may result in sanctions. See Section III.D.10 of this Chapter.

E. **Failure to Request Discovery Implies Waiver of Subsequent Requests for Documents**

It is the intention of the Commission that the parties utilize the informal or formal discovery procedures provided for in this Chapter to develop the record in the complaint or that the record be developed to the extent necessary through the Administrative Judge's orders for documents, information, and witnesses. Under previous Commission guidance, the failure to request discovery did not imply a waiver of the opportunity of the parties to make requests for documents and witnesses at the hearing. Allowing parties this opportunity at the time of the hearing, regardless of whether the discovery process was invoked, is not consistent with sound administrative economy and with the expeditious processing of complaints. Accordingly, where a party has not timely requested discovery or has not otherwise timely requested that the Administrative Judge order the opposing party to produce documents, the party's request for documents for the first time at the time of the hearing, or at a pre-hearing conference held just

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prior to the hearing, will be disallowed unless the Administrative Judge, in his/her discretion, rules otherwise.

F. Cost of Discovery

The parties shall initially bear their own costs with regard to discovery, unless the Administrative Judge requires the agency to bear the costs for the complainant to obtain depositions or any other discovery because the agency has failed to complete its investigation timely as required by 29 C.F.R. § 1614.108(e) or has failed to investigate the allegations adequately pursuant to Chapter 6 of this Management Directive.

V. EXCLUSION AND DISQUALIFICATION

All participants in the EEO hearing process have a duty to maintain the decorum required for a fair and orderly proceeding and to obey orders of the Administrative Judge. Any person who engages in improper behavior or contumacious conduct (as defined in Section V.A.3 of this Chapter) at any time subsequent to the docketing of a complaint for a hearing is subject to sanction. Section 1614.109(e) of 29 C.F.R. provides that persons may be excluded from the hearing for contumacious conduct or misbehavior that obstructs the hearing. It further provides that if the complainant's or agency's representative engages in misconduct or refuses to obey an order of the Administrative Judge, the Commission may suspend or disqualify the representative from future hearings, refer the matter to an appropriate licensing authority, or both.

A. Exclusion from a Hearing

An Administrative Judge has the power to regulate the conduct of a hearing and to exclude any person from a hearing for contumacious conduct or misbehavior that obstructs the hearing. See 29 C.F.R. § 1614.109(e). The Administrative Judge may exclude any disruptive person, including the complainant, an agency official, or a representative, including agency or complainant counsel. This sanction generally applies to conduct occurring in the Administrative Judge's presence at any point during the hearing process, including prehearing proceedings and teleconferences as well as the hearing itself. It also applies to a representative's refusal to obey orders of the Administrative Judge. The exclusion bars the individual, for the duration of the hearing process, from further participation in the case in which the misconduct occurs. (In contrast, a disqualification of a representative applies to future hearings. The procedure for disqualification is in Section V.B below.)

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The authority of an Administrative Judge to impose an exclusion under 29 C.F.R. § 1614.109(e) derives from the judicial doctrine of the “inherent powers” of the forum. For example, courts have certain implied powers that are necessary to the exercise of all others. [Chambers v. NASCO, Inc.](#), 501 U.S. 32 (1991). “Courts of justice are universally acknowledged to be vested, by their very creation, with power to impose silence, respect, and decorum, in their presence, and submission to their lawful mandates.” *Id.* at 43 (quoting [Anderson v. Dunn](#), 19 U.S. 224 (Wheat.) 227 (1821)). “These powers are ‘governed not by rule or statute but by the control necessarily vested in courts to manage their own affairs so as to achieve the orderly and expeditious disposition of cases.’” *Id.* (quoting [Link v. Wabash R. Co.](#), 370 U.S. 626, 630-31 (1962)).

Inherent powers must be exercised with restraint and discretion. *Id.* In considering the imposition of sanctions, Administrative Judges must take steps to ensure fairness to the parties and the effectiveness of the sanction in furthering the orderly conclusion of the hearing process. Sanctions should be proportional to the nature and degree of the improper conduct. Administrative Judges may look to rules of ethics, common law, statutes, and case law to determine the propriety and nature of a sanction. With respect to sanctions against a representative, the Administrative Judge should be mindful that a party to the EEO process is entitled to be represented by an individual of that party’s choice, and the representative is expected to be an advocate for the party’s interests. Nonetheless, by virtue of their position, all representatives also have a particular responsibility to respect the order and authority of the EEO process. See subsection 4 below.

1. Relationship to other sanctions

In addition to exclusion under 29 C.F.R. § 1614.109(e) for misconduct, other sanctions may be imposed for failure to obey orders of an Administrative Judge. Section 1614.109(f)(3) of 29 C.F.R. provides that when the complainant, the agency, or its employees fail without good cause shown to respond fully and in timely fashion to an order of an Administrative Judge, or requests for the investigative file, for documents, records, comparative data, statistics, affidavits, or the attendance of witnesses, the Administrative Judge shall impose sanctions in appropriate circumstances.

Sanctions under 29 C.F.R. § 1614.109(f) may be evidentiary, monetary, or both. The failure of a party to produce evidence or obey an order may support the drawing of an adverse inference about a matter in dispute, the exclusion of other evidence offered by that party, or a decision on the merits in favor of the other party. Monetary sanctions include attorney’s fees and the costs of discovery. See 29 C.F.R. § 1614.109(f)(3).

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2. Preventive measures

To lessen the need for resort to exclusion or other sanctions, Administrative Judges may instruct the parties in the initial order and/or at the outset of the hearing to maintain professional conduct and speech. The parties should be informed that engaging in improper conduct or failing to comply with orders of the Administrative Judge or Commission regulations may result in sanctions under 29 C.F.R. § 1614.109. Giving such a warning is within the Administrative Judge's discretion however. Any asserted failure to advise the parties of the potential for sanctions does not limit the Administrative Judge's authority to impose a sanction.

3. General standard for exclusion

A person's conduct is contumacious when it is "willfully stubborn and disobedient." Black's Law Dictionary (6th ed. 1990). Contumacious behavior or disruptive conduct may include any unprofessional or disrespectful behavior; degrading, insulting, or threatening verbal remarks or conduct; the use of profanity; or conduct engaged in for the purpose of improperly delaying the hearing.¹⁶ A finding of contumacious conduct or disruptive behavior may be based on a series of disruptive incidents, a pattern of acts, or a single sufficiently obstructive episode.¹⁷ Normally, any pattern should be manifest within a single case. However, the Administrative Judge may take into consideration other improper conduct engaged in by the individual on any previous occasion before that judge, if

¹⁶ In [Bradley v. U.S. Postal Service](#), EEOC Appeal Nos. 01952244, 01963827 (September 18, 1996), the Commission rejected the complainant's contention that he was denied a fair hearing because the Administrative Judge had complainant and his representative escorted from the hearing room under guard and terminated the hearing. The Commission found that complainant's representative "engaged in contumacious conduct of the worst kind: asking questions which the witnesses could not comprehend, then berating the witnesses for failing to answer; repeatedly testifying rather than asking questions; vociferously arguing on the record with the agency representative and the Administrative Judge; defying the authority of the Administrative Judge with regard to evidentiary rulings and the conduct of the hearing; and threatening the Administrative Judge over an evidentiary ruling." Misconduct does not have to rise to this level to be subject to sanction. Any one of the types of misconduct noted in [Bradley](#) would alone be sufficient.

¹⁷ See [In re Chaplain](#), 621 F.2d 1272, 1276 (4th Cir. 1980) ("contempt of court may be found based on the cumulative impact of a series of actions, no one of which standing alone would be sufficient: 'It is only necessary that a contumacious act be 'a volitional [one] done by one who knows or should reasonably be aware that his conduct is wrongful.'") (citations omitted).

the Administrative Judge had clearly described the misconduct for the record in the earlier proceeding or the misconduct is otherwise clearly apparent from the record.

In addition, there may be situations in which a decision to exclude a person may take into consideration prior misconduct before a different Administrative Judge or the Commission. For example, in the first instance of misconduct, the Administrative Judge, in his/her discretion and as part of the sanction, may publicize the sanction to other Administrative Judges or require the sanctioned individual to disclose the sanction to other Administrative Judges. This should be done in appropriate circumstances, taking into account the nature and degree of the misconduct. If the sanctioned individual engages in further improper conduct in a subsequent hearing before the same or a different Administrative Judge, the prior sanction should be considered in determining whether to exclude the individual from the subsequent hearing. To that end, the Administrative Judge also may ask an individual, on the record, to disclose whether or not s/he ever had previously been sanctioned in any way before the Commission.

4. Standard for exclusion of representative

Representatives may also be excluded for refusal to follow the orders of an Administrative Judge or other improper conduct, in addition to “contumacious conduct or misbehavior that obstructs the hearing.” Representatives have a special duty to maintain the dignity of the EEO process and to preserve the order and authority of the EEO forum and must act accordingly.

If a party’s representative engages in repetitive misconduct or conduct justifying exclusion, the Commission also will consider imposing a suspension or disqualification through the procedure described in Section B below. If the representative is an attorney, s/he also may be referred to the appropriate bar association for disciplinary action as provided in Section C below.

5. Procedure for exclusion

Unless the improper conduct is so egregious as to compromise the order required for a fair and orderly proceeding, the Administrative Judge normally should first warn the offending person to stop the conduct. The warning should give notice that if the conduct continues, the person will be excluded from the hearing.

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When imposing the sanction, the Administrative Judge must ensure that the record includes a clear and specific description of the nature of the misconduct. The record must include the particular details of what the person said or did, rather than a conclusory characterization.¹⁸ The Administrative Judge may place the information on the record through a statement at the hearing or, if the misconduct occurred in a teleconference or other proceeding without a court reporter, by inclusion in a prehearing conference memorandum or order or through a written statement provided to the individual. Any gestures or actions that would not be apparent from the hearing transcript should be clearly described for the record. If the person used profanity or other improper or threatening language before the Administrative Judge while off the record or at a proceeding that is not being transcribed, the Administrative Judge should relate the particular language used in a statement on the record or other written statement made a part of the record.

An Administrative Judge's decision to exclude a person from a hearing is final. There is no right to an interlocutory appeal of an exclusion decision. A party may raise the issue as part of an appeal of the final order on the case when the party asserts it has been deprived the opportunity for a fair hearing.

If the complainant engages in obstructive misconduct or contumacious conduct, the Administrative Judge should warn the complainant as described above and consider recessing the hearing for a short time to restore order. If the complainant's misconduct is extreme or persistent, the Administrative Judge may, pursuant to 29 C.F.R. §§ 1614.109(b) and 1614.107(a)(7), dismiss the case for failure to cooperate or issue a decision if the record is sufficient to permit adjudication. 29 C.F.R. § 1614.109(g).

If the complainant's representative is excluded, the complainant should be given the option of proceeding without his/her representative. If the agency's representative is excluded, the Administrative Judge must notify the agency of the exclusion. In either case, the Administrative Judge may, in his/her discretion, continue the hearing to allow time for the designation of a new representative or, in appropriate circumstances, terminate the

¹⁸ For example, the description might state that the party's representative, despite a warning to remain at his seat, "repeatedly rose out of his chair, walked around the hearing room, and pointed his finger close to the witness's face while berating the witness in a loud voice and cutting short the witness's answers, making the following statements to the witness:"

hearing, and decide the case based on the record if the record is sufficient to permit adjudication.

The Administrative Judge also may impose an evidentiary sanction against either party as provided in 29 C.F.R. § 1614.109(f)(3). For example, when misconduct has prevented or hindered the development of evidence, the Administrative Judge may draw an adverse inference; consider the matter to be established in favor of the opposing party; exclude other evidence; or issue a decision fully or partially in favor of the opposing party. See 29 C.F.R. § 1614.109(f)(3). The standard for imposing such a sanction must be the same for both complainants and agencies. A sanction should be proportional to the level of the misconduct and reflect the degree to which the misconduct has impeded a full and fair hearing.

B. Disqualification of a Representative from Future Hearings

1. Standard for suspension and disqualification¹⁹

In the case of repeated or flagrant improper conduct by a representative, the Administrative Judge or the Commission may take further action. Section 1614.109(e) of 29 C.F.R. provides that the Commission, after notice and an opportunity to be heard, may suspend or disqualify from representing complainants or agencies in future Commission hearings any representative who refuses to follow the Administrative Judge's orders or otherwise engages in improper conduct. These provisions apply not only to conduct at the hearing stage of the case but also to all other actions taken by a representative in the course of an EEO proceeding, including the appeal. A disqualification applies to future representation of a party before the Commission, at both the hearing and appellate stages.

2. Procedure for suspension and disqualification

Before suspension or disqualification from future hearings, the representative must be given:

¹⁹ In addition to disqualification under 29 C.F.R. § 1614.109(e) for misconduct, the term “disqualification” is also used when the representation of a complainant or agency would conflict with the official or collateral duties of the representative. Under 29 C.F.R. § 1614.605(c), in that circumstance, the Commission or the agency may, after giving the representative an opportunity to respond, disqualify the representative. In contrast to disqualification for misconduct, a disqualification for conflict of interest under 29 C.F.R. § 1614.605(c) applies only to the particular case. Parties shall disclose and reasonably attempt to avoid all conflicts of interest.

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- a. notice of the specific conduct that is the basis for the proposed disqualification;
- b. notice of the proposed sanction; and
- c. the opportunity to be heard.

A show cause order accomplishes this notice. The show cause order must describe in detail the incident(s) constituting the grounds for suspension or disqualification,²⁰ describe the proposed sanction, and give the representative a period of time in which to explain in writing why s/he should not be suspended or disqualified.

For improper conduct or a refusal to follow orders at the hearing stage, the Administrative Judge will issue the show cause order and certify the matter to the Director, Office of Federal Operations, for a determination. In addition, the Administrative Judge may, separately or simultaneously, issue an order excluding the representative from the hearing process in the case at bar, in accordance with the provisions discussed above. If the representative is an attorney, referral to the appropriate bar association normally should be considered as well, pursuant to Section C below.

For improper conduct during the appeal, the Office of Federal Operations will issue the show cause order. In all cases, the representative must submit his/her response to the Director of the Office of Federal Operations. The Director or his/her designee will issue a final order, which is not appealable.

An order suspending or disqualifying a representative from future hearings must specify the time period the penalty will be in effect, which must be commensurate with the severity of the conduct.

When the Administrative Judge or the Commission proposes to suspend or disqualify the agency's representative, a copy of the show cause order and subsequent decision must be provided to the agency's EEO Director.

²⁰ The conduct must be described with specificity and detail, as explained in Section A. 5 above with respect to exclusion.

C. Referral of Attorney Representatives to Bar Association

Section 1614.109(e) of 29 C.F.R. provides that the Administrative Judge or the Commission may refer to the disciplinary committee of the appropriate bar association any attorney who refuses to follow the orders of an Administrative Judge or who otherwise engages in improper conduct. This may be done independently of, or in conjunction with, any proposed or final exclusion, suspension, or disqualification.

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CHAPTER 8

COMPLAINTS OF CLASS DISCRIMINATION IN THE FEDERAL GOVERNMENT

I. INTRODUCTION

Section 1614.204 of Title 29 C.F.R. provides for processing class complaints of discrimination. A class is defined as a group of employees, former employees, or applicants who are alleged to have been adversely affected by an agency personnel policy or practice which discriminates against the group on the basis of their common race, color, religion, sex, national origin, age, genetic information, or disability. A class complaint is a written complaint of discrimination filed on behalf of the class by the agent of the class, alleging that the class is so numerous that a consolidated complaint by the members of the class is impractical, that there are questions of fact common to the class, that the claims of the agent of the class are typical of the claims of the class, and that the agent of the class and, if represented, the representative will fairly and adequately protect the interests of the class.

The regulatory requirements for class complaints at 29 C.F.R. § 1614.204 provide a structure different from that for individual complaints. For class complaints, there is a four-stage process. The first stage is the establishment of a class complaint. At this stage, the class agent is required to seek counseling from an agency EEO Counselor and file a complaint. The second stage is a determination from a Commission Administrative Judge, subject to agency final action, implementing or appealing the Administrative Judge's decision on class certification. The third stage, assuming that the complaint has been certified as a class action, involves a final decision from an Administrative Judge on the merits of the class complaint. The agency can either fully implement or appeal. If the agency appeals the Administrative Judge's final decision, it only has to appeal the parts of the decision that it is contesting. The fourth stage, where there has been a finding of class-based discrimination, is the determination of the claims for relief of the individual class members.

II. PRE-CERTIFICATION PROCEDURES

A. Pre-Complaint Processing

Section 1614.204(b) of 29 C.F.R. provides that, as with an individual complainant, an employee who seeks to represent a class of employees must seek counseling and undergo pre-complaint processing in accordance with 29 C.F.R. § 1614.105 and Chapter 2 of this Management Directive, with one exception, discussed below. Section 1614.105(a)(1) of 29 C.F.R. requires that an employee must seek counseling within forty-five (45) days of the discriminatory event. The

agency shall extend the 45-day time limit when the individual shows that s/he was not notified of the time limits and was not aware of them, that s/he did not know and reasonably should not have known that the discriminatory practice or personnel action occurred, that despite due diligence s/he was prevented by circumstances beyond his/her control from contacting the EEO Counselor within the time limits, or for other reasons considered sufficient by the agency or the Commission. See 29 C.F.R. § 1614.105(a)(2). The time period may be waived by the agency and is subject to estoppel and equitable tolling. See 29 C.F.R. § 1614.604(c). If the complaint is not resolved on the thirtieth (30th) day following initial EEO counseling, the EEO Counselor must give the agent written notice that s/he has **fifteen (15) days** from receipt of the notice to file a formal complaint. 29 C.F.R. § 1614.204(c)(2).

The counseling period may be extended up to an additional **sixty (60) days** if, prior to the expiration of the 30-day period, the aggrieved person agrees with the agency in writing to postpone the final interview.

The one exception to the mandatory counseling prerequisite allows a complainant to move for class certification at any reasonable point in the process when it becomes apparent that there are class implications to the claim raised in an individual complaint. 29 C.F.R. § 1614.204(b).¹ The Commission intends that “reasonable point in the process” be interpreted to allow a complainant to seek class certification when s/he knows or suspects that the complaint has class implications, that is, the complaint potentially involves questions of law or fact common to a class and the complainant’s claim is typical of that of the class. Undue delay in moving for certification will lead to denial of the class certification by the Administrative Judge. If a complainant moves for class certification after completing the pre-complaint process contained in 29 C.F.R. § 1614.105, no additional counseling is required. See 29 C.F.R. § 1614.204(b). Instead, the agency or the Administrative Judge, as appropriate, must advise the complainant of his/her rights and responsibilities as the class agent.

B. Filing and Presentation of the Class Complaint

As with an individual complaint, a class complaint must be filed with the agency that allegedly discriminated against the putative class. 29 C.F.R. § 1614.106(a). A class complaint must be signed by the class agent (the complainant) or a class representative and must identify the policy or practice adversely affecting the

¹ The term “move” in this context means that the complainant must make his/her intention to process the complaint as a class action clear. A complainant may make his/her intention clear through a letter, a formal motion, or any means that effectively informs the agency or Administrative Judge of the complainant’s intent to pursue a class action.

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class as well as the specific action or policy affecting the class agent. 29 C.F.R. § 1614.204(c)(1).

Within thirty (30) days of an agency's receipt of a class complaint, including the agency's receipt of the class complaint during its investigation of the aggrieved person's individual complaint, an agency must designate an agency representative and forward the complaint, along with a copy of the EEO Counselor's Report and any other relevant information about the complaint, to the Commission. 29 C.F.R. § 1614.204(d)(1). When **any** complaint is filed, an agency must take care to preserve any and all evidence with potential relevance to the class complaint. This is a continuing obligation that begins as soon as the complaint is filed, even before the class has been certified, and continues throughout the processing of the complaint.

The agency must forward the class complaint to the Commission district office having jurisdiction over the agency facility where the complaint arose. Appendix N to this Management Directive is a list of the addresses of the Commission district and field offices, their geographic jurisdictions, and where federal employees and applicants should submit hearing requests.

Should the agency's organizational component where the complaint arose not fall within one of the geographical jurisdictions shown, the agency should contact the following office for guidance:

Equal Employment Opportunity Commission
Office of Field Programs
Attn: Hearings Coordinator
131 M Street, NE
Washington, DC 20507

Email at: info@eeoc.gov

III. INDIVIDUAL COMPLAINTS FILED ON BASES AND ISSUES IDENTICAL TO CLASS COMPLAINTS

When a complainant who is a potential member of a class action files an individual complaint between the time a class complaint is filed and a final certification decision is issued, the agency must determine whether there are claims in the individual complaint that are identical to those that are presented in the class complaint. If the agency determines that claims in the individual and class complaints are identical, then the agency shall issue a written decision notifying the complainant that the portion of the complaint raising claims identical to the class complaint will

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be held in abeyance during the pendency of the decision to accept or reject the class complaint.² The agency decision shall notify the complainant of his/her right to appeal the abeyance determination to the Commission.³ The agency decision must also contain, at a minimum, a description of the individual claims at issue; a description of the class complaint with the definition of the putative class; the class complaint counseling report; and the status of the class action, including the Commission field office to which the class complaint has been sent for a determination on certification, if applicable.

If, however, the agency finds that the claim in the individual complaint is not identical to the class claim then the individual complaint shall continue to be processed by the agency.

The Administrative Judge may dismiss a class complaint, or any portion, because it does not meet the prerequisites for certification or for any of the procedural grounds listed in §1614.107. If a potential class complaint is dismissed by the Administrative Judge, the Agency's final order adopting the dismissal shall include notification to the class agent(s) that his/her complaint will be processed as an individual complaint, or that the individual complaint is also dismissed in accordance with §1614.107. In addition, **within forty (40) days** of receipt of an Administrative Judge's decision dismissing a putative class complaint the agency shall issue an acknowledgment of receipt of an individual complaint as required by 29 C.F.R. §1614.106(e) and process each individual complaint that was held in abeyance because of the class complaint.

If a class complaint is certified, all individual complaints that raise claims identical to the definition of the class claim(s) shall be subsumed within the class complaint. When the class claim proceeds to a hearing on the merits, the subsumed individual claim(s) may be presented during the liability stage by the class agent, or at the remedy stage by the individual complainant. If class-wide discrimination is **not found**, the agency shall process each individual claim that was subsumed into the class complaint. See 29 C.F.R. §1614.204(1)(2).

- (a) For an individual claim to be subsumed in an accepted class complaint, it must be identical in all respects to the class claim(s), including the issue and basis of discrimination alleged. When an individual complaint raises multiple claims, only those claims that are identical to those raised in the class complaint will be subsumed in it. The non-identical claims in the individual complaint shall be processed separately under the individual complaint process.

² As a point of clarification, claims that are held prior to class certification are stated to be held in "abeyance" and claims that are referenced as being "subsumed" are claims that become part of the class action following class certification. When an individual complaint raises multiple claims, only those claims that are identical to those in the class complaint with respect to basis and issue are properly held in abeyance or subsumed. The non-identical claims in the individual complaint shall be processed separately by the agency under the individual complaint process.

³ See [Roos v. U.S. Postal Service](#), EEOC Request No. 05920101 (Feb. 13, 1992).

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(b) When an agency makes a decision not to process an individual claim because it is identical to and subsumed by an accepted class complaint, it shall issue a decision advising the individual complainant of his/her right to appeal to OFO for a ruling on whether the individual claim should be subsumed in the accepted class claim(s). The agency decision must also contain, at a minimum, a description of the individual complaint at issue and a description of the certified class complaint and underlying certification decision(s).

IV. CERTIFICATION OR DISMISSAL - 29 C.F.R. § 1614.204(d)

The Commission will assign an Administrative Judge (or in some limited circumstances a complaints examiner from another agency may be assigned) to issue a decision on certification of the complaint. 29 C.F.R. § 1614.204(d).

A. Class Complaint Criteria

A class complaint will be dismissed if:

1. The complaint does not meet all of the prerequisites of a class complaint under 29 C.F.R. § 1614.204(a)(2) (that is, numerosity, commonality, typicality, and adequacy of representation);
2. The claims lack specificity and detail pursuant to 29 C.F.R. § 1614.204(d)(4);
3. The complaint meets any of the criteria for dismissal pursuant to 29 C.F.R. § 1614.107(a), "Dismissals of Complaints."

The Administrative Judge shall deny class certification when the complainant has unduly delayed in moving for certification. See 29 C.F.R. § 1614.204(b).

B. Developing the Evidence for Purpose of Certification Determination

The Administrative Judge may direct the complainant or agency to submit additional information relevant to the issue of certification. See 29 C.F.R. § 1614.204(d)(1).

V. CERTIFICATION DECISION - 29 C.F.R. § 1614.204(d)(7)

A. Administrative Judge Issues Decision on Certification

The Administrative Judge shall issue a decision on whether to certify or dismiss a class complaint. When appropriate, the Administrative Judge may decide to certify a class conditionally, for a reasonable period of time, until a complainant finds representation. For example, if the record on a class complaint satisfies the numerosity, typicality, and commonality requirements for class certification, the Administrative Judge may “conditionally” certify the class for a reasonable period of time so that the class agent may secure adequate representation. Administrative Judges should refer complainants to any attorney referral systems that may be operating in the Commission district offices or other attorney referral services for assistance in obtaining adequate legal representation.

Even after a class is certified, the Administrative Judge remains free to modify the certification order or dismiss the class complaint in light of subsequent developments. See [General Telephone Co. v. Falcon](#), 457 U.S. 147, 160 (1982). The Administrative Judge has the authority, in response to a party’s motion or on his/her own motion, to redefine a class, subdivide it, or dismiss it if the Administrative Judge determines that there is no longer a basis for the complaint to proceed as a class complaint. [Hines v. Dep’t. of the Air Force](#), EEOC Request No. 05940917 (Jan. 29, 1996).

B. Transmittal of Decision

The Administrative Judge shall transmit his/her decision to accept or dismiss a class complaint to the agency and the agent. The agency shall take final action by issuing a final order within forty (40) days of receipt of the Administrative Judge’s decision. The final order shall notify the agent whether the agency will implement the decision of the Administrative Judge. If the final order does not fully implement the decision of the Administrative Judge, the agency shall simultaneously appeal the Administrative Judge’s decision in accordance with 29 C.F.R. § 1614.403 and append a copy of the appeal to the final order. The Commission has prepared a form that agencies may use to file appeals with the Commission. A copy of that form is attached as Appendix O.

If the decision is to accept (certify) the class complaint, Commission regulations require the agency to notify all class members. 29 C.F.R. § 1614.204(e)(1). The agency must use all reasonable means to notify all class members of the acceptance of the complaint within 15 days of receipt of the Administrative Judge’s decision or within a reasonable time frame specified by the Administrative Judge. (See Section VI.A, below.)

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An Administrative Judge's decision to dismiss the class complaint at the certification stage will inform the agent that the complaint is being filed on that date as an individual complaint and will be processed under subpart A, that the complaint is also dismissed as an individual complaint in accordance with 29 C.F.R. § 1614.107(a), or, in the case of a complaint forwarded to the Administrative Judge during the agency's investigation of the complaint, that the complaint is being returned to the agency and will continue from the point that processing ceased with the referral of the complaint to the Administrative Judge.

C. Right to Appeal the Administrative Judge's Decision

The Administrative Judge's decision whether to accept or dismiss the class complaint is subject to final agency action. The Administrative Judge shall transmit his/her decision to the agency, with a copy to the complainant and the complainant's representative, if any. The agency has forty (40) days from receipt of the Administrative Judge's decision to take final action by issuing a final order informing the complainant as to whether the agency will fully implement the decision. If the agency informs the complainant that it does not intend to fully implement the decision, the agency must simultaneously file an appeal with the Commission and append a copy of the appeal to the final order served on the complainant. The agency may use the form appended hereto as Appendix O to file its appeal with the Commission. The complainant will have thirty (30) days from receipt of the final order to file an appeal and the agency shall provide the complainant with a copy of EEOC Form 573, Notice of Appeal/Petition - Complainant (Appendix P).

VI. NOTIFICATION - 29 C.F.R. § 1614.204(e)

A. Timing and Method of the Notice

Within **fifteen (15) calendar days** of the agency's receipt of the Administrative Judge's decision certifying a class complaint or such time frame specified by the Administrative Judge, the agency shall use reasonable means, such as hand delivery, mailing to the last known address, or distribution (such as through inter-office mail or email) to notify all class members of the certification of the class complaint. An agency may file a motion with the Administrative Judge seeking a stay in the distribution of the notice for the purpose of determining whether it will fully implement or appeal the Administrative Judge's decision.

The "reasonable means" used by agencies for notification should be those most likely to provide an opportunity for class members to know about the complaint. Conspicuous posting on bulletin boards to which all potential class members have easy access may constitute adequate notice in some situations.

B. Content of the Notice

The notice must contain:

1. the name of the agency or organizational segment, its location, and the date of acceptance of the complaint;
2. the definition of the class and a description of the issues accepted;
3. an explanation of the binding nature of the decision or resolution of the complaint on class members;
4. the name, address, and telephone number of the class representative; and
5. a copy of the Administrative Judge's decision certifying the class.

C. Individuals May Not Opt Out

The class members may not “opt out” of the defined class; however, they do not have to participate in the class or file a claim for individual relief. All class members will have the opportunity to object to any proposed settlement and to file claims for individual relief if discrimination is found.

D. Settlement Notice

All class members must receive notice of any settlement or decision on the class complaint whether or not they participated in the action. See Section VII of this Chapter.

VII. DEVELOPING THE EVIDENCE - 29 C.F.R. § 1614.204(f)**A. The Process of Developing the Evidence**

The Administrative Judge shall advise both parties that they will have at least sixty (60) days to develop evidence. 29 C.F.R. § 1614.204(f)(1). They can do this in the same manner as in individual cases, that is, through interrogatories, depositions, requests for admissions, stipulations, or production of documents. The parties may object to production on the grounds that the information sought is irrelevant, overly burdensome, repetitious, or privileged. The Administrative Judge has the authority to impose sanctions on a party if that party fails to comply without good cause with rulings on requests for information, documents, or

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admissions. An adverse inference may be appropriate where the information is solely in the control of that party. Similarly, if a party fails to provide an adequate explanation for the failure to respond fully and in a timely manner to a request, the Administrative Judge may impose sanctions. Adverse inferences are appropriate when the information is solely in the control of that party. These sanctions include, but are not limited to, the authority to:

1. draw an adverse inference that the requested information would have reflected unfavorably on the party refusing to provide the requested information;
2. consider the issues to which the requested information pertains to be established in favor of the opposing party;
3. exclude other evidence offered by the party failing to produce the requested information; and/or
4. recommend that a decision be entered in favor of the opposing party.⁴

B. Use of Agency Resources and Facilities by Class Agent

The class agent and his/her non-attorney representative should be permitted reasonable access to and/or use of agency facilities (copiers, telephones, computers, internet, fax machines, email, printers, etc.) for preparation of the case as long as there is no undue disruption of agency operations. The class agent and/or non-attorney representative may not use agency resources and facilities in the preparation of the class case without obtaining the prior approval of the designated agency official.

⁴ The Administrative Judge's order to the parties should make clear what sanctions or other actions may be imposed for a failure to comply with the order within the time set forth therein. Where an order did not put a party on notice that it could be sanctioned for a noncompliance or did not put the party on notice of the type of sanction that the Administrative Judge now seeks to impose, the Administrative Judge must issue a notice to show cause to the party for an explanation why the sanction should not be imposed and provide an opportunity to cure the noncompliance before imposing the sanction.

VIII. RESOLUTION - 29 C.F.R. § 1614.204(g)**A. Resolution by the Parties**

The complaint may be resolved by agreement of the agency and the agent at any time pursuant to the notice and approval procedure contained in 29 C.F.R. § 1614.204(g)(4).

B. Notice of Proposed Resolution

If a resolution is proposed, notice must be given to all class members in the same manner as the notification of certification of the class was given. The notice must include a copy of the proposed resolution, set out the relief, if any, that the agency will grant, and inform the class members that the resolution will bind all members of the class. The notice must also inform class members of the right to submit objections to the settlement. The notice further must inform the parties of the name and address of the Administrative Judge assigned to the complaint.

The agency shall provide the Administrative Judge with a copy of the proposed resolution and the notice sent to the parties.

C. Administrative Judge Shall Review Resolution

1. The Administrative Judge shall review and issue a decision concerning the fairness, adequacy, and reasonableness of the proposed resolution. Within **thirty (30) days** of the date of a class member's receipt of the notice of proposed resolution, the class member may file a petition with the Administrative Judge noting objections to the settlement if the petitioner (class member) believes that the settlement benefits only the class agent or is otherwise not fair, adequate, and reasonable to the class as a whole. The Administrative Judge will review the proposed resolution after the expiration of the 30-day period allowed for petitions and consider any petitions received. If the judge determines that the resolution is not fair, adequate, and reasonable, s/he will vacate the proposed resolution and may replace the class agent with the petitioner or other class member who is eligible to serve as class agent.
2. An Administrative Judge's decision that a resolution is not fair, adequate, and reasonable vacates the agreement between the class agent and the agency. The decision must inform the class agent, the petitioner, class members, and the agency of the right to appeal the decision to the Commission. The decision must include a copy of EEOC Form 573,

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Notice of Appeal/Petition (Appendix P). The agency may use the separate form at Appendix O for filing its appeal with the Commission.

3. An Administrative Judge's decision that a resolution is fair, adequate, and reasonable binds all members of the class. The decision must inform the petitioner of the right to appeal the decision to the Commission. The decision must include a copy of EEOC Form 573, Notice of Appeal/Petition (Appendix P).

IX. HEARING - 29 C.F.R. §§ 1614.204(h) and (i)

A. Hearing Procedures

Hearing procedures in certified class complaints are the same as those applied to hearings in individual complaints of discrimination and are set out in 29 C.F.R. § 1614.109.

B. Site of the Class Hearing

The Administrative Judge assigned to hear the certified class complaint will, upon expiration of the period allowed for preparation of the class case, set a date for a hearing and determine the site of the hearing. Within his/her discretion, the Administrative Judge is authorized to conduct the hearing in the Commission district office, in a Commission area or local office, at the agency's organizational component where the complaint arose, or at such other location as s/he may determine appropriate. In determining the hearing site, the Administrative Judge should consider factors such as the location of the parties; the location of the Commission district, area, and local offices; the number and location of witnesses; the location of records; travel distances for the Administrative Judge, the parties, and witnesses; travel costs; the availability of sources of transportation; and other factors as may be appropriate.

Should an agency desire that a hearing be held at a location within the jurisdictional area of another Commission district office, it must submit a request, in writing, to the Commission office that determined the class certification issue. In its request, the agency must identify the location of the desired place of hearing and must set out, in detail, its reasons and justification for the requested change. The Administrative Judge will rule on the request only after the directors of the concerned Commission district offices have conferred on the matter.

C. Travel Expenses

If the Administrative Judge sets a hearing site that is outside the local commuting area of the agency's organizational component where the complaint arose, the agency must bear all reasonable travel and per diem expenses of class agents, their authorized representatives, agency representatives, and all witnesses approved by the Administrative Judge, except that an agency does not have the authority to pay the travel expenses of complainant's witnesses who are not federal employees.

The agency's obligation is limited to those costs which are legally payable in advance by the agency. See [Expenses of Outside Applicant/Complainant to Travel to Agency EEO Hearing](#), File: B-202845, 61 Comp. Gen. 654 (1982); see also [John Booth \(Travel Expenses of Witness \(Agency Responsible](#), File: B-235845, 69 Comp. Gen. 310 (1990).

D. Official Time for Agency Employees

Any employee testifying at a hearing is entitled to official time for the time s/he spends testifying as well as a reasonable amount of time for travel to and from the hearing. The class agent and agent's representative, if employees of the agency where the complaint arose and was filed, are entitled to official time for actual time spent at the hearing and for a reasonable amount of time spent preparing for the hearing.

An agency may permit its employees to use official time in preparing and presenting a class complaint which arose in another agency.

X. ADMINISTRATIVE JUDGE'S DECISION ON THE MERITS OF THE CLASS COMPLAINT

The Administrative Judge shall transmit his/her decision on the complaint to the parties. If there is a finding of discrimination, the decision shall include systemic relief for the class, and any individual relief, where appropriate, with regard to the personnel action or policy that gave rise to the complaint. The decision shall be sent to the agency together with the entire record, including the transcript.

If the Administrative Judge finds no class relief appropriate, s/he shall determine if any finding of individual discrimination is warranted and, if so, shall issue a decision on the appropriate relief to be provided by the agency. 29 C.F.R. § 1614.204(i).

August, 2015EEO MD-110**XI. AGENCY FINAL ACTIONS - 29 C.F.R. §§ 1614.204(j) and (k)****A. Action on Administrative Judge's Decision**

Within sixty (60) days of receipt of the Administrative Judge's decision, the agency must issue a final order either fully implementing or simultaneously appealing the Administrative Judge's decision. If the agency does not issue the final order within sixty (60) days of receipt of the Administrative Judge's decision, the Administrative Judge's decision becomes the final action of the agency. 29 C.F.R. § 1614.204(j)(2).

The agency must transmit its final order to the class agent within five days of the expiration of the 60-day period.

B. Agency Final Action Requirements

The agency's final order on a class complaint must be in writing; notify the class agent whether the agency will fully implement the decision of the Administrative Judge; and contain a notice of the right to appeal to the Equal Employment Opportunity Commission, the right to file a civil action, and the applicable time limits. If the final order does not fully implement the decision of the Administrative Judge, the agency shall simultaneously file an appeal in accordance with 29 C.F.R. § 1614.403 and append a copy of the appeal to the final order. See 29 C.F.R. § 1614.204(j)(1).

C. Binding Nature of Agency Final Action Implementing Administrative Judge's Decision

The final agency action implementing the Administrative Judge's decision finding discrimination will be binding on all members of the class and on the agency. A final agency action implementing the Administrative Judge's decision finding no discrimination is not binding on a class member's individual complaint. Class members may not "opt out" of the class action while it is pending. See Section V.C of this Chapter.

D. Notification of Agency Final Action

The agency shall notify class members and the class representative of its final action through the same media employed to give notice of the existence of the class complaint. The notice, where appropriate, shall include information concerning the rights of class members to seek individual relief and of the procedures to be followed. Notice shall be given by the agency within ten (10) days of the transmittal of its final action to the agent.

XII. RELIEF FOR INDIVIDUAL CLASS MEMBERS - 29 C.F.R. § 1614.204(i)**A. Claims for Individual Relief by Class Members Where Discrimination Is Found**

Where a finding of discrimination against a class is made, there is a presumption of discrimination as to each member of the class. The agency has the burden of proving by clear and convincing evidence that a class member is not entitled to relief. See 29 C.F.R. § 1614.204(i)(3).

Within thirty (30) days of receipt of notification of the final agency action implementing the Administrative Judge's decision, a class member who believes that s/he is entitled to individual relief must file a written claim with the head of the agency, or with the agency's EEO Director.

The claim must include a specific, detailed showing that:

1. The claimant is a class member who was affected by the discriminatory policy or practice; and
2. The discriminatory action occurred within the period of time for which the Administrative Judge found class-wide discrimination in his/her decision.

B. Timing of Agency Decision on Individual Claims for Relief

Within **ninety (90) calendar days** of receiving an individual claim, the agency must issue a final decision on that claim. The agency's final decision must include a notice of the right to file an appeal or a civil action within the applicable time limits. The decision must include a copy of EEOC Form 573, Notice of Appeal/Petition (Appendix P).

August, 2015EEO MD-110**C. Oversight of Individual Claims for Relief**

1. Where an Administrative Judge finds that the agency discriminated against the class, the Administrative Judge should include in his/her order a provision that establishes a mechanism for review of individual claims pursuant to 29 C.F.R. § 1614.204(l)(3). Under that section, a class member must file a claim with the agency within thirty (30) days of his/her receipt of notification from the agency of its final order and the agency must issue a final order within ninety (90) days of its receipt of the claim. That section further provides that Administrative Judges retain jurisdiction over the complaint in order to resolve any disputed claims of class members and may hold hearings or otherwise supplement the record on a claim filed by a class member.
2. To implement this section, an Administrative Judge's order should advise the agency to inform him/her in writing within sixty (60) days of the agency's receipt of a claim from a class member that it intends to dispute the class member's claim, and provide a copy of such notice to the class member. Once the agency informs the Administrative Judge and the class member of its intent to dispute the class member's claim, the Administrative Judge will issue an order tolling the 90-day period within which the agency is required to issue a decision on the class member's claim.
3. The Administrative Judge's order will advise the agency to provide a statement in support of its decision to dispute the class member's claim and any supporting evidence within fifteen (15) days of the agency's receipt of the Administrative Judge's order, providing a copy of any such submission to the class member. The class member will have 15 days from the date of service of the agency's submission to respond to the agency's submission and may file a statement and documents in support of his/her claim, providing a copy of any such submission to the agency. If service of the submission was by mail, the class member may add three days to the date that the response is due. The Administrative Judge has the discretion to enlarge the 15-day period at the written request of either party or on his/her own motion. If a party seeks an enlargement of the 15-day period, that party must provide a copy of its written request to the other party.
4. The Administrative Judge thereafter may determine whether s/he needs additional information or should hold a hearing in order to further develop the record regarding the class member's claim. At the conclusion of fact finding, the Administrative Judge will issue a decision concerning the class member's claim and forward the decision to the class member and

the agency. The decision will advise the agency that the 90-day period for issuing a final order on the claim will resume upon its receipt of the Administrative Judge's decision. The agency must issue a final order regarding the class member's claim within the 90-day period. If the agency does not issue the final order within the 90-day period, the Administrative Judge's decision will become the final order of the agency.

5. The agency's final action on a class member's claim must inform the class member of the right to appeal the decision to the Office of Federal Operations or to file a civil action, and it must include EEOC Form 573, Notice of Appeal/Petition (Appendix P).

D. Limits on the Duration of a Finding of Class-Wide Discrimination

The agency or the Commission may find class-wide discrimination and order remedial action for any policy or practice in existence within forty-five (45) days of the class agent's initial contact with the EEO Counselor. Relief may be ordered for the time the policy or practice was in effect. Under the pattern of discrimination theory, incidents occurring earlier than 45 days before contact with the EEO Counselor must also be remedied provided the initial contact with the EEO Counselor was timely and the earlier incidents were part of the same continuing policy or practice found to have been discriminatory. Where contact with the EEO Counselor is timely as to one of the events comprising the continuing violation, then the counseling contact is timely as to the entire violation. See 29 C.F.R. § 1614.204(l)(3). This 45-day time period does not limit the two-year time period for which back pay can be recovered by a class member.

E. Where Class-Wide Discrimination Is Not Found

The agency shall, **within sixty (60) calendar days** of issuance of the final decision, acknowledge receipt of an individual complaint as required in 29 C.F.R. § 1614.106(d) and process in accordance with the provisions of subpart A each individual complaint that was subsumed into the class complaint.

If it is found that the class agent or any other member of the class is a victim of discrimination, the relief provisions of 29 C.F.R. § 1614.501 shall apply.

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XIII. REPRISAL

Federal employees who are agents, claimants, representatives of agents or claimants, witnesses, or agency officials having responsibility for processing class complaints may file individual discrimination complaints if they believe they have been subjected to restraint, interference, coercion, or reprisal because of their involvement in the presentation and/or processing of a class complaint. EEO counseling must precede the filing of such complaints.

Retaliation claims can be the subject of class actions where the plaintiffs establish a general practice of retaliation against employees who oppose discriminatory practices or exercise rights protected under Title VII. See, [Holsey v. Armour & Co.](#), 743 F.2d 199, 216-217 (4th Cir. 1984), cert denied, 470 U.S. 1028 (1985). The Commission has held that reprisal is an appropriate basis for a class when there is a showing that specific reprisal actions were taken against a group of people for challenging agency policies, or where reprisal was routinely visited on the class members. See [Levitoff v. Dep't. of Agriculture](#), EEOC Appeal No. 01913685 (Mar. 17, 1992), request to reopen denied, EEOC Request No. [05920601](#) (Sept. 10, 1992); as cited in [Powell, et. al. v. Dep't. of the Navy](#), EEOC Appeal No. 01974349 (Aug. 2, 2000).

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CHAPTER 9 APPEALS TO THE COMMISSION

I. INTRODUCTION

Sections 1614.401(a)-(e) of 29 C.F.R. identify those entitled to file appeals to the Commission. 29 C.F.R. § 1614.402(a) provides that appeals to the Commission must be filed by complainant **within thirty (30) days**¹ of receipt of an agency's final action - that is, a dismissal, final agency decision (FAD), final order, or final determination. If an attorney of record represents the complainant, the 30-day time limit shall begin to run from the date of receipt by the attorney of the agency's final action. If an agency determines not to implement the decision of an Administrative Judge either in full or in part, it must notify the complainant of its determination in a final order issued **within forty (40) days** of its receipt of the Administrative Judge's decision and it must simultaneously file an appeal with the Commission, in a digital format acceptable to the Commission, absent a good showing why the agency cannot submit digital records. See Chapter 6, Section VIII for more information on what constitutes good cause shown. The complainant may file an appeal with the Commission in either a digital format acceptable to the Commission or by mail. For information regarding appeals submissions see Section IV of this Chapter.

The complainant shall furnish a copy of the appeal to the agency at the same time it is filed with the Commission. In or attached to the appeal to the Commission, the complainant must certify the date and method by which service was made on the agency.

The individual complainant should use EEOC Form 573, Notice of Appeal/Petition. A copy of the Form is attached as Appendix P to this Management Directive. The agency shall attach a copy of EEOC Form 573 to all final actions and dismissals of equal employment complaints. The Commission has prepared a separate form that agencies may use to file appeals with the Commission. A copy of that form is attached as Appendix O.

¹ All time limits stated in this Management Directive are in calendar days. The time limits in Part 1614 are subject to waiver, estoppels, and equitable tolling. 29 C.F.R. § 1614.604(c). For further guidance, see [EEOC Compliance Manual](#), Section 2 "Threshold Issues," IV-D, Timeliness.

II. ADVISING THE PARTIES OF THEIR APPEAL RIGHTS

A. Rights Following Administrative Judge Issuance of a Decision

1. Merits/Class Certification Cases

- a. In a decision on the merits of a non-class complaint or concerning the issue of certification of a class action, the Administrative Judge shall advise the parties that the agency has forty (40) days from the date of its receipt of the Administrative Judge's decision to review the decision and to take final action on the decision by issuing a final order. The 40-day period within which the agency must take final action does not commence until the Administrative Judge issues an order advising the agency that the decision of the Administrative Judge is the final decision and that the agency must take final action within 40 days of its receipt thereof. Where an Administrative Judge issues a decision finding discrimination, the 40-day period will not commence until the Administrative Judge issues a final decision regarding remedies and attorney's fees.²
- b. In a decision on the merits of a class complaint, the Administrative Judge shall advise the parties that the agency has sixty (60) days from the date of its receipt of the Administrative Judge's decision to review the decision and to take final action on the decision by issuing a final order. The 60-day period within which the agency must take final action does not commence until the Administrative Judge issues an order advising the agency that the decision of the Administrative Judge is the final decision and that the agency must take final action within 60 days of its receipt thereof.³
- c. The Administrative Judge should inform the complainant of the following:

² If service of the Administrative Judge's decision was by mail without the use of certified mail/return receipt, the agency may add five days to the date that the final action is due. This rule, adding five days to the date of service, shall apply in all instances where the party being served has the right to take an action within a period of time following such service, except where the serving party uses certified mail/return receipt and can establish the date of actual receipt.

³ Due to the potential complexity of class complaints that proceed through litigation, the 60-day period is intended to provide agencies adequate time to review the Administrative Judge's decision on liability and relief.

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- (1) where the agency's final action/final order advises the complainant that the agency accepts the Administrative Judge's decision, the agency will advise the complainant that s/he has thirty (30) days from the date the complainant receives the agency's final order to file an appeal of the final order.
- (2) the agency's failure to take final action by issuing a final order within this 40- or 60-day review period will be deemed acceptance of the Administrative Judge's decision;
- (3) the complainant's 30-day period for filing an appeal of the agency's final order/Administrative Judge's decision begins at the conclusion of the agency's 40- or 60-day review period;
- (4) where the agency's final action/final order advises the complainant that the agency has determined not to fully implement the Administrative Judge's decision, the agency must file an appeal of the Administrative Judge's decision simultaneously with notifying the complainant of its determination (providing the complainant with a copy of the appeal) and advise the complainant of his/her right to file a separate appeal of the Administrative Judge's decision within 30 days of the complainant's receipt of the agency's final order.

2. Procedural Dismissal

When the Administrative Judge issues a procedural dismissal, s/he must advise the complainant that the complainant will have the right to file an appeal of the agency's final order within 30 days of the complainant's receipt thereof.

3. Class Action Settlement Agreements

A petition to vacate a resolution may be filed with the Administrative Judge asserting that the resolution favors only the class agent or is not fair, adequate, and reasonable to the class as a whole. An Administrative Judge's decision that a class action settlement agreement is fair, adequate, and reasonable binds all members of the class. The decision must inform the petitioner of the right to appeal the decision to the Commission. The decision must include a copy of EEOC Form 573, Notice of Appeal/Petition.

An Administrative Judge's decision that a resolution is not fair, adequate, and reasonable vacates the agreement between the class agent and the agency. The decision must inform the class agent, the petitioner, class members, and the agency, of the right to appeal the decision to the Commission. The decision must include a copy of EEOC Form 573, Notice of Appeal/Petition (Appendix P). The agency may use the separate form at Appendix O for filing its appeal with the Commission.

B. Agency Final Action

1. Agency Final Action

An agency final action involves agency issuance of a final order to the complainant. The final order informs the complainant whether the agency will fully implement the decision of the Administrative Judge and contains notice of the complainant's right to appeal to the Commission. The term "fully implement" means that the agency adopts without modification the decision of the Administrative Judge. If the agency's final order advises the complainant that the agency will not fully implement the decision of the Administrative Judge, the agency must file an appeal of the decision with the Commission simultaneously with issuing the final order to the complainant. In this way, an agency will take final action on a complaint referred to an Administrative Judge by issuing a final order, but it will not be provided with the opportunity of introducing new evidence or writing a new decision in the case. The agency may use the form attached hereto as Appendix O to file its appeal with the Commission. Whether the agency's final order advises the complainant that the agency will or will not fully implement the Administrative Judge's decision, the agency must provide the complainant with a copy of EEOC Form 573, Notice of Appeal/Petition (Appendix P).

2. Notice of Rights

a. Full Implementation

Where the agency issues a final order in which it agrees to fully implement the Administrative Judge's decision, the order must inform the complainant that s/he has the right to file an appeal of the Administrative Judge's decision and agency's final order.

The agency further must inform the complainant that s/he must file an appeal within 30 days of his/her receipt of the agency's final order and the agency must provide the complainant with a copy of EEOC Form 573, Notice of Appeal/Petition (Appendix P).

August, 2015**EEO MD-110****b. Less than Full Implementation**

Where the agency issues a final order through which it informs the complainant that it does not intend to fully implement the Administrative Judge's final decision, the agency's final order must inform the complainant that the agency, simultaneously with the issuance of its final order to the complainant, has filed an appeal of the Administrative Judge's decision with the Commission. The agency may use the form appended hereto at Appendix O to file its appeal with the Commission.

The agency must provide the complainant with a copy of the appeal. The final order further must inform the complainant of the following:

(1) the complainant may file a separate appeal of the agency's final order;

(2) the Commission, as a general rule and in the absence of a separate appeal from the complainant, will review only the agency's decision not to fully implement the Administrative Judge's decision; and

(3) if the complainant contends that the Administrative Judge erred either in any rulings made during the pendency of the action or in the decision, the complainant must file a separate appeal from the agency's final order to challenge such errors.

The final order must inform the complainant that any such appeal must be filed within 30 days of the complainant's receipt of the final order, and the agency must provide the complainant with a copy of EEOC Form 573, Notice of Appeal/Petition (Appendix P).

C. Agency Final Decision

In any case where the agency issues a final decision (for example, where the complainant elects to have the agency issue a final decision following completion of the investigation), the agency must inform the complainant of his/her right to file an appeal with the Commission and provide the complainant with a copy of EEOC Form 573, Notice of Appeal/Petition (Appendix P). The agency further must inform the complainant that any such appeal must be filed within 30 days of complainant's receipt of the agency's final decision.

D. Agency Procedural Decision

Where the agency issues a decision dismissing a complaint in its entirety pursuant to 29 C.F.R. § 1614.107(a), the agency must inform the complainant of his/her right to file an appeal with the Commission and provide the complainant with a copy of EEOC Form 573, Notice of Appeal/Petition (Appendix P). The agency further must inform the complainant that any such appeal must be filed within 30 days of complainant's receipt of the agency's dismissal decision.

E. Mixed Case Complaints

The agency must advise the complainant that s/he may appeal a final agency decision on a mixed case complaint by filing the appeal with the **Merit Systems Protection Board (not the Commission)**. The agency further must inform the complainant that any such appeal must be filed within 30 days of his/her receipt of the agency's decision. For a fuller discussion concerning the processing of mixed cases, see Chapter 4, Section II of this Management Directive.

III. PERSONS WHO MAY APPEAL

The Commission's regulations governing appeals to the Commission are located at subpart D of 29 C.F.R. Part 1614. Section 1614.401 of 29 C.F.R. sets out who may appeal to the Commission when an issue of employment discrimination is raised either alone or in connection with a grievance, settlement, or a Merit Systems Protection Board (MSPB) claim.

A. A Complainant May Appeal

1. An agency's dismissal of or final action on a complaint.⁴

⁴ An agency's final action on a complaint may include either 1) a dismissal, see 29 C.F.R. § 1614.107(a); 2) a final order from the agency stating whether it will fully implement the decision of the Administrative Judge, see 29 C.F.R. § 1614.110(a); 3) a final agency decision on the merits of the complaint where the complainant requested an immediate final decision pursuant to 29 C.F.R. § 1614.108(f); or 4) an agency's final determination on its alleged noncompliance with a settlement agreement in accordance with 29 C.F.R. § 1614.504. See 29 C.F.R. § 1614.110(b). The regulations further provide that the agency must file an appeal with the Commission at the same time it serves the final order on the complainant following receipt of a decision from an Administrative Judge where it does not intend to fully implement the decision. The agency's filing of an appeal of an Administrative Judge's decision that it does not intend to fully implement will result in the Commission's review of the agency's decision not to fully implement the Administrative Judge's decision. The complainant need not file a separate appeal to have the Commission review the agency's actions. Where, however, the complainant contends that the Administrative Judge erred either in any rulings made during the pendency of the action

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1. If it determines not to fully implement an Administrative Judge's decision to dismiss or on the merits of a complaint, in an appeal filed simultaneously with the final order served on the complainant.⁵
2. If it determines, in a class complaint, not to fully implement an Administrative Judge's certification decision or a decision on the merits, in an appeal filed simultaneously with the final order served on the agent.

The agency may use the form appended hereto at Appendix O to file its appeal with the Commission.

C. An Agency May Appeal

An Administrative Judge's decision to vacate a proposed resolution of a class complaint on the grounds that it is not fair, adequate, and reasonable to the class as a whole. The agency may use the form appended hereto at Appendix O to file its appeal with the Commission

D. A Class Agent May Appeal

1. An Administrative Judge's decision accepting or dismissing all or part of a class complaint.⁶

or in the decision, the complainant would need to file an appeal from the agency's final order to challenge such errors.

If an agency fails to take any action during the 40-day period, the Administrative Judge's decision would be deemed ratified and the complainant would be entitled to file an appeal of the Administrative Judge's decision as ratified after the expiration of the 40-day period. The agency would not be permitted to cross-appeal or challenge any aspect of the Administrative Judge's decision in this situation.

⁵ If the agency issues a final order to the complainant stating that it does not intend to fully implement the decision of the Administrative Judge but fails to file an appeal, the agency's final order has no effect on the Administrative Judge's decision. If the agency fails properly to issue a final order and file an appeal simultaneously with the issuance of the order, the Administrative Judge's decision will be deemed ratified by the agency upon the expiration of the agency's 40-day period for accepting or not accepting the Administrative Judge's decision.

⁶ Included is a dismissal of a complaint that does not meet the prerequisites of a class complaint as enumerated in 29 C.F.R. § 1614.204(a)(2) where the decision to dismiss informs the class agent that the complaint is being filed as an individual complaint. The Office of Federal Operations, Appellate Review Programs, will provide expedited consideration (within 90 days of receipt of appeal) of class complaints that are dismissed for failure to meet the prerequisites of a class complaint. See 29 C.F.R. § 1614.405(b).

2. An agency final action on the merits of the complaint.
3. An Administrative Judge's decision to vacate a proposed resolution of a class complaint on the grounds that it is not fair, adequate, and reasonable to the class as a whole.⁷
4. An agency's alleged noncompliance with a settlement agreement in accordance with 29 C.F.R. § 1614.504.

E. A Class Member or Petitioner May Appeal

1. An Administrative Judge's decision finding a proposed resolution fair, adequate, and reasonable to the class as a whole if the class member filed a petition to vacate the resolution; or finding that the petitioner is not a member of the class and did not have standing to challenge the resolution.
2. An Administrative Judge's decision that a proposed resolution is not fair, adequate and reasonable to the class as a whole.⁸
3. An agency's final action on a claim for individual relief under a class complaint.
4. An agency's alleged noncompliance with a resolution in accordance with 29 C.F.R. § 1614.504.

F. A Grievant May Appeal

1. A final decision of the agency.
2. A final decision of the arbitrator.

⁷ See 29 C.F.R. § 1614.204(g)(4). A petition to vacate a resolution may be filed with the Administrative Judge asserting that the resolution favors only the class agent or is not fair, adequate, and reasonable to the class as a whole. The petitioner may file an appeal with the Commission if the Administrative Judge finds the resolution fair, adequate, and reasonable to the class as a whole. If the Administrative Judge finds the agreement not fair, adequate, and reasonable, the class agent, class members, and the agency may file an appeal.

⁸ As noted above, where the Administrative Judge finds the agreement not fair, adequate, and reasonable, the class agent, class members, and the agency may file an appeal. If the Administrative Judge finds that the agreement is fair, adequate, and reasonable, only the petitioner may file an appeal.

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3. A final decision of the Federal Labor Relations Authority (FLRA) on the grievance.
4. **Exception:** A grievant may not appeal under subpart D of Part 1614, when the dispute initially raised in the negotiated grievance procedure is:
 - a. still ongoing in that process,
 - b. in arbitration,
 - c. before the FLRA,
 - d. appealable to the Merit Systems Protection Board (MSPB), or
 - e. if 5 U.S.C. § 7121(d) is inapplicable to the involved agency.

IV. FILING THE APPEAL AND RESPONSE

A. How to Appeal

1. The complainant, agent, grievant or individual class claimant (hereinafter appellant) must file an appeal by mailing the appeal to:

Equal Employment Opportunity Commission
 Office of Federal Operations
 P.O. Box 77960
 Washington, DC 20013
 Fax: (202) 663-7022

As an alternative the appeal may be submitted through facsimile or the Commission's electronic document submission portal.

The complainant should use EEOC Form 573, Notice of Appeal/Petition – Complainant (Appendix P) and should indicate what is being appealed.

2. Unless it has shown good cause why it is unable to do so,⁹ the agency must file an appeal with the Commission in digital format, either by using the Commission's electronic document submission portal or by some other approved method. See 29 C.F.R. § 1614.403(g). The agency may file its

⁹ For a showing of good cause the agency must submit a written request to the Director of the Office of Federal Operations identifying why they cannot meet the digital filing requirements and when they expect to be able to meet the digital filing requirements.

appeal by using the form appended hereto at Appendix O to file its appeal with the Commission and/or by providing the Commission with a copy of the order it sends to the complainant.

3. Where an agency files an appeal simultaneously with providing the complainant with a final order indicating that it does not intend to fully implement the decision of the Administrative Judge, the complainant need not file a separate appeal as a prerequisite to Commission review of the propriety of the agency's decision not to implement the Administrative Judge's decision. If, however, the complainant believes that other issues presented in his/her complaint and addressed by the Administrative Judge were wrongly decided, or if the complainant believes that the Administrative Judge's decision contained errors, the complainant should file an appeal from the agency's final order in order to ensure that the Commission will address these issues as well. Although the Commission has the right to review all of the issues in a complaint on appeal, it also has the discretion not to do so and may focus only on the issues specifically raised on appeal.

B. Service of Notice of Appeal

The complainant on appeal shall furnish a copy of the appeal to the agency at the same time it is filed with the Commission. In or attached to the appeal to the Commission, the complainant must certify the date and method by which service was made on the agency.

The agency must certify to the Commission that it has provided the complainant with a copy of the order in which it advised the complainant that it did not intend to fully implement the Administrative Judge's decision, that it informed the complainant of his/her right to file an appeal of its decision and provided the complainant with information as to how s/he may file an appeal, and that it provided the complainant with a copy of EEOC Form 573, Notice of Appeal/Petition (Appendix P).

C. Appeal Will Be Acknowledged

OFO will docket and acknowledge in writing the receipt of an appeal. Where both the agency and the complainant file appeals based on the same complaint following the agency's issuance of an order stating that it does not intend to fully implement the decision of the Administrative Judge, the Commission shall consolidate the appeals under a single Commission Appeal No. and consider both appeals simultaneously.

August, 2015**EEO MD-110****D. Dismissal of Appeal**

If a party files an appeal beyond the applicable time limits, the Commission may dismiss the appeal. The agency should advise the complainant in its dismissal decision or final order that if s/he files his/her appeal beyond the thirty (30)-day period set forth in the Commission's regulations, s/he should provide an explanation as to why his/her appeal should be accepted despite its untimeliness. If the complainant cannot explain why his/her untimeliness should be excused in accordance with 29 C.F.R. § 1614.604, the Commission may dismiss the appeal as untimely.

E. Briefs and Supporting Documents

The complainant may file a brief or statement in support of his/her appeal with the Office of Federal Operations. The optional brief or statement must be filed within thirty (30) days of filing the notice of appeal and a copy of it must be sent to the other party.

The agency may file a brief or statement in support of its final action. The brief or statement must be filed within twenty (20) days of filing its appeal, and in accordance with 29 C.F.R. § 1614.403(g), must be filed in a digital format acceptable to the Commission (see Appendix L).

F. Statements in Opposition to an Appeal

Any statement or brief in opposition to an appeal must be submitted to OFO and served on the opposing party within thirty (30) days of receipt of the statement or brief supporting the appeal. Where both the complainant and the agency file appeals and briefs or statements in support of their appeals, both parties may file statements in opposition to the appeal of the other party. If no brief or statement supporting the appeal is filed, the party opposing the appeal must file its opposition within sixty (60) days of the receipt of the appeal.

G. Submission of Case File

Absent notice from the Commission that it has the case file from the hearing on the same matter, the agency must submit the complaint file to OFO within thirty (30) days of notification that the complainant has filed an appeal or within thirty (30) days of submission of an appeal by the agency. If the complaint was adjudicated by an Administrative Judge, the complaint file must include copies of all documents issued by or served on the Administrative Judge, including, but not limited to, all correspondence to and from the Administrative Judge, orders from

the Administrative Judge, and motions and briefs of the parties. Agencies should develop internal procedures that will ensure the prompt submission of complaint files upon a determination not to fully implement an Administrative Judge's decision or notice that a complainant has filed an appeal.

The agency must submit appeals and complete complaint case file(s) to the Commission's Office of Federal Operations in a digital format unless they can show good cause for not doing so. Complainants and their representative(s), if applicable, are strongly encouraged to file all documents in a digital format. See, 29 C.F.R. §1614.403(g). All documents may be uploaded to the Commission's electronic document submission portal. If a CD is used, it is preferred that all documents be provided in a PDF format.

The electronic complaint file must at a minimum have the following features:

- Electronic bookmarks corresponding to the file index and section dividers of the paper file, if a paper file was created;
- Sequentially numbered pages starting with the first page of the file. **All pages** in the report of investigation must be accounted for in the page numbering of the document, including the cover page and any administrative documents, in order for the numbers in the paper file to match precisely the numbers in the electronic file. An individual entering page number 150 into Adobe Acrobat should come to the exact same page as an individual turning to page 150 of the paper file. Administrative documents added after the paper file was compiled may be submitted in a separate PDF file.

H. Signatures on Electronic Documents

It is the Commission's policy to support, encourage, and in the case of agency submissions on appeal, mandate the use of digital documents in lieu of paper for documentation sent to the Commission specifically under the authority of 29 C.F.R. § 1614.403(g). A digital document used by a person, agency, or other entity shall have the same force and effect as those documents not produced by electronic means.

In support of the policy, the Commission considers electronic signatures on such submissions as having the same force and effect as signatures and records produced by hand or other non-electronic means. "Electronic signature" means any digital symbol, sound, or process attached to or logically associated with a digital record and executed or adopted by a person with the intent to sign the record. The Commission will accept an array of digital objects to serve as an

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electronic signature. These objects can range from keyboarded characters (for example, “/s/Jane Doe”), a graphical image of a handwritten signature, or an authenticated process that creates an electronic signature. An electronic signature is considered attached to or logically associated with a digital record if the electronic signature is linked to the record during transmission and storage.

V. APPELLATE PROCEDURE

A. Where Record Is Complete

Where the record is complete, OFO shall issue a decision in accordance with 29 C.F.R. § 1614.405.

B. Where Record Requires Supplementation

While the Commission retains the right to supplement the record on appeal, it is intended that this right will be exercised only in rare instances to avoid a miscarriage of justice.

1. Where the record requires supplementation, OFO may require additional information from one or both of the parties. OFO may supplement the record by an exchange of letters, memoranda, or investigation. Each party shall provide copies of such supplemental information to the other party at the time it is submitted to OFO.
2. Where the record is so incomplete as to require remand to the agency in order to complete the investigation, the Commission shall designate a time period between **thirty (30) and ninety (90) days** within which the agency must complete the investigation. During the period of remand, the appeal will be held in abeyance and the complaint will be monitored by OFO. Upon completion of the investigation, the agency must provide the complainant with a copy of its supplemental record and findings and return the completed record to OFO. The complainant may, **within fifteen (15) days** of receipt of the supplemental record, submit a statement concerning the supplemental record to OFO. Upon receipt by OFO, the supplemental record will be included in the appeal file and the appeal will be processed appropriately.

C. Sanctions

Absent good cause shown, there is no legitimate basis for either party to an appeal to fail to comply with the appellate procedures in 29 C.F.R. § 1614.404 or to fail to respond fully and in a timely fashion to a request for information. Accordingly, where either party to an appeal fails to comply with the appellate procedures in 29 C.F.R. § 1614.404 or fails to respond fully and in a timely fashion to requests for information, without good cause shown, OFO shall, in appropriate circumstances, impose any of the following sanctions:

1. draw an adverse inference that the requested information would have reflected unfavorably on the party refusing to provide the requested information;¹⁰
2. consider the matters to which the requested information or testimony pertains to be established in favor of the opposing party;
3. issue a decision fully or partially in favor of the opposing party; or
4. take such other actions as appropriate.

See 29 C.F.R. § 1614.404(c). OFO will aggressively utilize sanctions if parties fail, without good cause shown, to comply with the appellate procedures or to respond fully and timely to information requests.¹¹ Sanctions may be used to effectuate the policies of the Commission by both deterring the non-complying party from similar conduct in the future and by providing an equitable remedy to the opposing party.

Before OFO issues sanctions on either party to an appeal, it will provide the party with a notice to show cause why the sanctions identified in the notice should not be imposed. The notice to show cause will identify the specific conduct that is the

¹⁰ See for example, [Smith v. Dep't. of Transportation \(Federal Aviation Administration\)](#), EEOC DOC 0320080085, (Mar. 21, 2012) (finding that because the agency failed to comply with OFO's explicit order to produce comparative evidence, the agency was subject to sanctions for its noncompliance, including the drawing of an adverse inference that the requested comparative evidence would have reflected unfavorably on the agency).

¹¹ The Commission has exercised its inherent authority to enforce its Part 1614 regulations by ordering sanctions in response to various violations. See for example, [Vu v. Social Security Administration](#), EEOC Appeal No. 0120072632 (Jan. 20, 2011)(finding that the agency was subject to sanctions for its failure to submit the complete complaint file); [DaCosta v. Dep't. of Education](#), EEOC Appeal No. 01995992 (Feb. 25, 2000)(Commission issued sanction against agency for failure to complete timely investigation).

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basis for the finding of noncompliance and will describe the proposed sanction(s) to be imposed. The notice to show cause will further provide the non-complying party with an opportunity to cure its noncompliance within a reasonable period of time, to be noted in the order. If the party fails to cure its noncompliance or to otherwise show good cause why sanctions should not be imposed, OFO shall impose the sanctions identified in its notice.¹²

D. Appeals Decisions Are Final

An appellate decision issued under 29 C.F.R. § 1614.405(a) is final pursuant to 29 C.F.R. § 1614.407 unless a timely request for reconsideration is filed by a party to the case. A party may request reconsideration **within thirty (30) days** of receipt of a decision of the Commission, which the Commission in its discretion may grant, if the party demonstrates that 1) the appellate decision involved a clearly erroneous interpretation of material fact or law, or 2) the decision will have a substantial impact on the policies, practices, or operations of the agency. See 29 C.F.R. § 1614.405(c); Section VII of this Chapter.

¹² Sanctions usually will be contained in the decision of the Commission on appeal. If the sanction is contained in a separate order and not the decision on the appeal, the sanction is not immediately reviewable. Once OFO issues a decision on an appeal, the sanctioned party may request reconsideration pursuant to 29 C.F.R. § 1614.405(c). If the sanction is issued while a matter is pending review under 29 C.F.R. § 1614.405(c) or is contained in a 29 C.F.R. § 1614.405(c) decision, there is no administrative review available.

VI. STANDARDS OF REVIEW ON APPEAL

Generally, standards of review delineate the nature of the inquiry on appeal by establishing the extent to which the reviewing body will substitute its own judgment for that of the prior decision-maker. The Commission has essentially employed a de novo standard of review in issuing appeals decisions since it took over the federal sector EEO function from the Civil Service Commission pursuant to Reorganization Plan No. 1 of 1978.

The decision on an appeal from an agency's dismissal or final action shall be based on a de novo review, except that the review of the factual findings in a decision by an Administrative Judge issued pursuant to 29 C.F.R. § 1614.109(i) and 29 C.F.R. § 1614.204(i) shall be based on a substantial evidence standard of review. This Section of the Management Directive will ensure a degree of uniformity and predictability in assessing case development and in processing appeals.

A. Review of Final Decisions Issued by the Agency

Appeals of final decisions or actions issued by agencies, duly filed pursuant to 29 C.F.R. § 1614.401(a), (d), or (e) will be considered by the Commission in the following manner:

1. Agency dismissals pursuant to 29 C.F.R. § 1614.107 and final decisions on the merits of individual complaints pursuant to 29 C.F.R. § 1614.110(b) shall be reviewed de novo.
2. The de novo standard requires that the Commission examine the record without regard to the factual and legal determinations of the previous decision maker. On appeal the Commission will review the documents, statements, and testimony of record, including any timely and relevant submissions of the parties, and the Commission will issue its decision based on the Commission's own assessment of the record and its interpretation of the law.
3. As a general rule, no new evidence will be considered on appeal unless there is an affirmative showing that the evidence was not reasonably available prior to or during the investigation or during the hearing process. The Commission may request supplementation of the record. See 29 C.F.R. § 1614.404(b).
4. Following de novo review, the Commission will issue decisions on the appeals of decisions issued pursuant to 29 C.F.R. § 1614.110(b) based on a preponderance of the evidence.

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5. Where appropriate, and after the requisite analysis, the Commission may adopt the findings and conclusions of the final decision issued by the agency. Such an adoption does not short-cut the review process, but merely serves to expedite communication of the result of the review.

B. Review of Decisions Issued by Administrative Judges

The Commission shall consider an appeal by either an agency or a complainant following a final action based on a decision from an Administrative Judge issued pursuant to 29 C.F.R. § 1614.109(g) (summary judgment decisions), 29 C.F.R. § 1614.109(i) (decisions on individual complaints), and 29 C.F.R. §§ 1614.204(d) and (i) (decisions on class complaints), duly filed pursuant to 29 C.F.R. § 1614.401 et seq., in the following manner:

1. The review of the post-hearing factual findings in an Administrative Judge's decision shall be based on a substantial evidence standard of review. In [Universal Camera Corp. v. National Labor Relations Board](#), 340 U.S. 474, 477 (1951), the Supreme Court noted that substantial evidence "is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. . . . It 'must do more than create a suspicion of the existence of the fact to be established. [I]t must be enough to justify, if the trial were to a jury, a refusal to direct a verdict when the conclusion sought to be drawn from it is one of fact for the jury.'" [Citations omitted.]
2. Applying the substantial evidence review standard, the Commission will give deference to an Administrative Judge's post-hearing factual findings based on evidence in the record. Factual determinations will be distinguished from legal determinations, and the Administrative Judge's factual determinations will be given deference. For example, a credibility determination of an Administrative Judge based on the demeanor or tone of voice of a witness will be accepted unless documents or other objective evidence so contradicts the testimony of the witness or the testimony of the witness otherwise so lacks in credibility that a reasonable fact finder would not credit it.
3. A finding of discriminatory intent will be treated as a factual finding subject to the substantial evidence review standard. See [Pullman-Standard Co. v. Swint](#), 456 U.S. 273, 293 (1982).

4. Legal determinations will be reviewed de novo on appeal.
 - a. Legal determinations in decisions, whether made by an Administrative Judge or by the agency, will be reviewed using a de novo standard. There will be no presumption that the previous decision-maker was correct in his/her interpretation or application of the law.
 - b. An Administrative Judge's decision to issue a decision without a hearing pursuant to 29 C.F.R. § 1614.109(g) will be reviewed de novo. The substantial evidence standard of review will apply only to decisions rendered following a hearing and will not apply to decisions issued on summary judgment or to decisions issued without a hearing with the consent of the parties.
5. As a general rule, no new evidence will be considered on appeal unless there is an affirmative showing that the evidence was not reasonably available prior to or during the hearing. The Commission may request supplementation of the record. See 29 C.F.R. § 1614.404(b).

C. The Responsibility of the Parties

1. On appeal, the burden is squarely on the party challenging the Administrative Judge's decision to demonstrate that the Administrative Judge's factual determinations are not supported by substantial evidence. This burden does not exist in a de novo review. The appeals statements of the parties, both supporting and opposing the Administrative Judge's decision, are vital in focusing the inquiry on appeal so that it can be determined whether the Administrative Judge's factual determinations are supported by substantial evidence.
2. In an appropriate case, and in instances where a party fails to submit a statement or brief in support of his/her appeal, the Commission may issue a summary decision.

VII. RECONSIDERATION

A. Reconsideration Is Not an Appeal

A request for reconsideration is not a second appeal to the Commission. A party may request reconsideration within **thirty (30) days** of receipt of a Commission decision. The Commission, in its discretion, may grant the request if the party demonstrates that:

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1. The appellate decision involved a clearly erroneous interpretation of material fact or law; or
2. The decision will have a substantial impact on the policies, practices, or operations of the agency. 29 C.F.R. §§ 1614.405(c)(1) & (2).

The Commission reserves the right to reopen any decision on its own motion. See Parnell v. Dep't. of Veterans' Affairs, EEOC Request No. 0520100031 (Dec. 7, 2009).

B. Reconsideration Procedures

1. Requests for reconsideration and any supporting statement or brief must be filed with the Office of Federal Operations (OFO) **within thirty (30) days** of receipt of a decision of the Commission and a statement or brief in opposition to a request for reconsideration must be filed **within twenty (20) days** of receipt of another party's timely request for reconsideration. OFO will accept statements or briefs in support of the request from complainants by fax transmittal, provided they are no more than ten (10) pages long. Agency briefs must be submitted in an approved digital format. The request must also include proof of service on the opposing party.
2. The requesting party must submit any supporting documents or brief at the time the request is filed. The burden is on the requesting party to make a substantial showing that its request meets one of the two prerequisites for a granting of reconsideration.
3. The opposing party shall have **20 days** from receipt of another party's timely request for reconsideration in which to submit any brief or statement in opposition. Such brief or statement must be served on the requesting party and proof of service must be included with the submission to OFO. OFO will accept briefs or statements in opposition to the request from complainants by fax transmittal, provided they are no more than 10 pages long. Agency briefs must be submitted in an approved digital format.
4. Failure to provide a proof of service or to submit comments within the prescribed time frame will result in the denial of the request, or the option not to consider the party's untimely statement or brief.

C. Reconsideration Decision Is Final

The Commission's decision on a request for reconsideration is final, and there is no further right by either party to request reconsideration. If the decision remands the complaint for further agency consideration, the parties retain the rights of appeal and reconsideration with respect to any subsequent decision.

VIII. REMEDIES**A. An Agency Shall Provide Full Relief after a Finding of Discrimination**

When the agency or the Commission finds that the agency has discriminated against an applicant or employee, the agency shall provide an appropriate remedy as explained in 29 C.F.R. Part 1614, subpart E.

B. Clear and Convincing Standard Needed to Limit Relief; Duty to Cure Discrimination Remains

1. When an Administrative Judge, agency, or the Commission finds that discrimination existed, but also finds by clear and convincing evidence that the agency would have made the same employment decision even absent the discrimination, the agency shall nevertheless take all steps necessary to eliminate the discriminatory practice and ensure that it does not recur.
2. Back pay, computed in the manner prescribed by 5 C.F.R. § 550.805, shall be awarded from the date the individual would have entered on duty, assumed the duties of the position at issue, or not been removed from the position unless clear and convincing evidence indicates that the applicant or employee would not have been selected for, placed into, or removed from the position even absent discrimination. The complainant has the obligation to mitigate damages.

C. Relief in Individual Cases

A discussion of the relief available in individual cases is set forth in Chapter 11 of this Management Directive.

August, 2015**EEO MD-110****D. Relief in Class Cases**

A discussion of the relief available in class cases is set forth in Chapter 8, Section XI, of this Management Directive.

IX. COMPLIANCE**A. Relief Ordered in a Decision on Appeal**

1. Compliance with Orders of the Equal Employment Opportunity Commission in final federal appeals decisions is mandatory. Section 717(b) of Title VII, 42 U.S.C. § 2000e-16(b) provides that the Commission shall have authority to enforce prohibitions against discrimination in the federal government “through appropriate remedies, including reinstatement or hiring of employees with or without back pay as will effectuate the policies of this section and shall issue rules, regulations, orders and instructions as it deems necessary and appropriate to carry out its responsibilities.”
2. The ordered relief shall be provided in full not later than one hundred twenty (120) days after receipt of the final decision unless otherwise ordered in the decision. A decision is considered final when it is issued. The 120-day period includes the 30-day period in which the complainant can file a request for reconsideration, as well as the 90-day period in which the complainant can file a civil action.
3. A complainant may petition OFO to seek enforcement of a Commission Order. 29 C.F.R. § 1614.503(a). The petition shall be submitted to OFO and shall set forth the basis for the complainant's assertion that the agency is not complying with the decision. If a petition is docketed acknowledgment letters will be sent to both parties identifying the new docket number and advising them of the right to submit a brief or to comment on the issue(s) in dispute.
4. Where the Director of OFO is unable to obtain satisfactory compliance with the final decision, the Director shall submit appropriate findings and recommendations for enforcement to the Commission pursuant to 29 C.F.R. § 1614.503(d). Among other things, the Commission may certify the matter to the Office of Special Counsel pursuant to a memorandum of understanding. See 29 C.F.R. § 1614.503(f) or issue a notice to show cause for noncompliance to the head of an agency that has failed to comply with a Commission order pursuant to 29 C.F.R. § 1614.503(e).

5. Where the Commission has determined that an agency is not complying with a prior decision and wishes to complete administrative efforts, the Commission shall notify the complainant of his/her right to seek judicial review of the agency's refusal to order the relief or commence a de novo proceeding. See 29 C.F.R. § 1614.503(g).

B. Interim Relief

1. Interim relief where the agency files a request for reconsideration of a decision regarding removal, separation, or suspension continuing beyond the date of the request for reconsideration:
 - a. When the agency requests reconsideration and the case involves removal, separation, or suspension continuing beyond the date of the request for reconsideration, and when the decision orders retroactive restoration, the agency shall comply with the decision to the extent of the temporary or conditional restoration of the employee to duty status in the position specified by the Commission, pending the outcome of the agency's request for reconsideration. 29 C.F.R. § 1614.502(b).
 - b. The agency must notify the complainant that his/her restoration is temporary or conditional at the same time it seeks reconsideration. Failure of the agency to provide notification will result in the dismissal of the agency's request. 29 C.F.R. § 1614.502(b)(3).
 - c. When the agency seeks reconsideration of a decision that included an award of payments of amounts owed, the agency may delay such payment provided it advises the complainant of its delay and further informs the complainant that it will pay interest on any award ultimately determined to be owed to the complainant. 29 C.F.R. § 1614.502(b)(2).
2. Interim relief where an agency appeals from a decision of an Administrative Judge in a case involving separation, or suspension continuing beyond the date of the appeal, and when the Administrative Judge's decision orders retroactive restoration:
 - a. The agency shall comply with the decision to the extent of the temporary or conditional restoration of the employee to duty status in the position specified in the decision, pending the outcome of the agency appeal. The employee may decline the offer of interim relief. 29 C.F.R. § 1614.505(a)(1).

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- b. An agency may decline to return a complainant to his/her place of employment if it determines that the return or presence of the complainant will be unduly disruptive to the work environment. However, the agency must provide prospective pay and benefits. 29 C.F.R. § 1614.505(a)(5).
- c. An agency also may delay the payment of other amounts, exclusive of pay and benefits, when it files an appeal of an Administrative Judge's decision. If an agency declines to make such payments, it will be required to pay interest on these amounts from the date of the decision until payment is made if the outcome of the appeal requires the agency to make the payment. 29 C.F.R. § 1614.505(a)(3).
- d. An agency must inform the Commission and the complainant in writing that it will delay making required payments at the same time that it files its appeal that it will delay making the payments of any amounts owed pending resolution of the appeal. See 29 C.F.R. § 1614.505(a)(4). If an agency fails to inform either the complainant or the Commission and fails further to make the payments required by the decision being appealed, the Commission will dismiss the appeal. The complainant must file a request for dismissal with the Commission within twenty-five (25) days of the date of service of the agency's appeal and provide the agency with a copy of the request. The agency will have fifteen (15) days from receipt of the complainant's request to file a response. 29 C.F.R. § 1614.505(b).

C. Sanctions

- 1. There is no legitimate basis for delay in complying with a Commission order, particularly in those cases where the Commission has ordered relief after a finding of discrimination.
- 2. OFO will aggressively utilize sanctions if the agency fails to implement the relief ordered.
- 3. OFO may recommend that the Commission take enforcement action where an agency does not comply with a Commission order, or, as directed by the Commission, refer the matter to another appropriate agency. See 29 C.F.R. § 1614.503(d). The Commission may issue a show cause notice to the head of the federal agency that is in noncompliance or refer the matter to the Office of Special Counsel for enforcement action. See 29 C.F.R. §§ 1614.503(e) and (f).

4. OFO may issue a notice to the complainant that the administrative process for securing compliance has been exhausted. See 29 C.F.R. § 1614.503(g). Such a notice will inform the complainant of the right to file a civil action for enforcement of the Commission decision and to seek judicial review of the agency's refusal to implement the relief ordered by the Commission, or of the right to commence proceedings pursuant to the appropriate statute.
5. An OFO notice to the complainant advising that the administrative process for securing compliance has been exhausted may be issued after the Commission determines an agency is not complying with a prior decision, when an agency fails or refuses to submit a report of compliance required by the Commission, or upon receipt of a request from the complainant. In determining whether to issue such a notice, OFO will consider such factors as whether the agency is making reasonable efforts to comply with the Commission order or, if the notice is requested by the complainant, whether the complainant has legal representation to secure enforcement in court. After issuing such a notice, the Commission ordinarily will terminate its administrative processing of the complaint. Processing will continue, however, if the Director of OFO determines that continued processing would effectuate the purposes of the laws enforced by the Commission.

D. Priority Consideration for Cases Remanded for Investigation

Agencies should give priority to cases remanded for an investigation if this is necessary to comply with the time frames contained in a Commission order. OFO will issue sanctions against agencies when it determines that agencies are not making reasonable efforts to comply with a Commission order to investigate a complaint.

E. Remand of Dismissed Claims

Where a complainant's appeal includes a dismissed claim that the Administrative Judge has affirmed but that OFO reverses either on appeal or on reconsideration, OFO shall remand the dismissed claim to the Administrative Judge for further processing in accordance with 29 C.F.R. § 1614.109. Where a complainant appeals from an agency final decision that includes a dismissed claim that OFO reverses, OFO shall remand the dismissed claim to the agency and include an order directing the agency to process the matter in accordance with 29 C.F.R. § 1614.108, except that OFO may order the completion of the investigation within a time period shorter than 180 days.

August, 2015**EEO MD-110****F. Complainant May File an Appeal Alleging a Breach of a Settlement Agreement**

Where a complainant files an appeal alleging a breach of a settlement agreement and the Commission determines that the agreement was breached, the complainant may request enforcement of the settlement agreement or may request reinstatement of the underlying complaint at the point at which the processing of the complaint was stopped. See Chapter 10, Section II (A)(3) for more information about settlement agreement appeals. Where a complaint is reinstated for further processing, both the agency and the complainant would be returned to the status quo ante at the time that the parties entered into the settlement agreement, which would require the complainant to return any benefits received pursuant to the agreement. See [Christensen v. Dep't. of Homeland Security](#), EEOC Appeal No. 0120081918 (September 17, 2008) (citing [Armour v. Dep't. of Defense](#), EEOC Appeal No. 01965593 (June 24, 1997)).

G. Complainant May Appeal to the Commission for Enforcement of an Agency Final Action

A complainant may file an appeal with the Commission for enforcement of an agency's final action through which the agency has accepted the decision of an Administrative Judge. 29 C.F.R. §§ 1614.504(a) - (c). The complainant first must notify the agency's EEO Director of the agency's alleged noncompliance with the final action within thirty (30) days of when the complainant knew or should have become aware of the agency's noncompliance. If the agency has not responded to the complainant's notice within thirty-five (35) days, the complainant may file an appeal with the Commission. If the agency has responded to the complainant's notice before the complainant files an appeal with the Commission, the complainant must file an appeal within 30 days of his/her receipt of the agency's response.

H. Compliance Reports Required by Commission Appellate Decisions Containing Orders for Corrective Action

The implementation paragraph found in Commission appellate decision orders provides that a compliance report shall be submitted within thirty (30) calendar days of the completion of all ordered corrective action.

The compliance report must contain 1) supporting documentation for all ordered corrective action, and 2) evidence that copies of all submissions in support of compliance were sent to the complainant. See Appendix Q for a Quick Reference Chart describing the documentation required to satisfy compliance with the most common orders found in the Commission appellate decisions.

Compliance reports, like all other agency submissions on appeal, must be submitted in a digital format acceptable to the Commission (see Appendix L) unless an agency has shown good cause why they are unable to submit in a digital format. Submissions may be made using the Commission's electronic submission portal, or by copying the digital file onto a CD and submitted to:

(The designated Compliance Officer)
Office of Federal Operations
Equal Employment Opportunity Commission
Post Office Box 77960
Washington, DC 20013

All submissions must reference the compliance docket number assigned to the compliance action.

X. CIVIL ACTIONS

Filing a civil action terminates Commission processing of an appeal. See 29 C.F.R. § 1614.409.

XI. NOTICE REQUIREMENTS

Agencies are required to notify complainants of their rights to appeal to the Commission and to file a civil action within the specified limitations periods. Agencies must also notify complainants of their statutory right to request court appointment of counsel for representation in connection with the filing of civil actions, which arise from Title VII, GINA, and the Rehabilitation Act. See [Hilliard v. Volcker](#), 659 F.2d 1125 (D.C. Cir. 1981). Therefore, agencies subject to 29 C.F.R. Part 1614 are required to include the appropriate language in every decision on complaints which allege discrimination. Sample language is provided in Chapter 10, Section IV of this Management Directive.

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CHAPTER 10 ADMINISTRATIVE APPEALS, CIVIL ACTIONS, AND APPOINTMENT OF COUNSEL

I. INTRODUCTION

Aggrieved persons must be made aware of administrative and civil action time limitations which potentially may bar an aggrieved person's ability to file appeals and civil actions. All time periods set out in this Management Directive are stated in calendar days unless otherwise indicated. The first day counted is the day after the event from which the time period begins to run and the last day of the period shall be included unless it falls on a Saturday or Sunday or federal holiday, in which case the period shall be extended to include the next business day. All time periods are subject to waiver, estoppel and equitable tolling.

All parties should be aware that attorney's fees may be awarded at the administrative level and beyond under Title VII of the Civil Rights Act of 1964 (see 42 U.S.C. § 2000e-16), Title II of the Genetic Information Nondiscrimination Act of 2008, (42 U.S.C. § 2000ff), and the Rehabilitation Act of 1973, (see 29 U.S.C. § 791), but that attorney's fees are not available at the administrative level under the Age Discrimination in Employment Act, (29 U.S.C. § 633a) or the Equal Pay Act, (29 U.S.C. § 206(d)).

Finally, the agency must advise complainants that they can request that a U.S. District Court appoint counsel for them after they file suit in that court.

II. ADMINISTRATIVE APPEALS

A. Time Limits for Appeals to the Commission - 29 C.F.R. § 1614.402

The following time limits apply for filing an appeal to the Commission:

1. Appeals limits for complainant's appeal of an agency's final action on or dismissal of individual complaints of discrimination: Within thirty (30) days of receipt of the dismissal or final action. See 29 C.F.R. § 1614.401(a).
2. Appeals limits for decisions on class complaints of discrimination under 29 C.F.R. § 1614.402(a):
 - a. a class agent or an agency may appeal an Administrative Judge's decision accepting or dismissing all or part of a class complaint; a class agent may appeal a final action on a class complaint; a class

member may appeal a final action on a claim for individual relief under a class complaint; and

- b. a class member, a class agent, or an agency may appeal a final decision on a petition pursuant to 29 C.F.R. § 1614.204(g)(4). See 29 C.F.R. § 1614.401(c). Appeals filed by class agents or class members described in 29 C.F.R. § 1614.401(c) must be filed within thirty (30) days of receipt of the final action or final decision on a petition pursuant to 29 C.F.R. § 1614.204(g)(4). Appeals filed by agencies on an Administrative Judge's decision accepting or dismissing all or part of a class complaint must be filed within (30) days of receipt of the hearing file and decision. Appeals filed by agencies on an Administrative Judge's decision on the merits of a class complaint must be filed within sixty (60) days of receipt of the hearing file and decision.
3. Appeals limits for allegations of noncompliance with a settlement agreement or an Administrative Judge's decision that has not been appealed to the Commission or been the subject of a civil action under 29 C.F.R. § 1614.504:
 - a. Within thirty (30) days of the complainant's receipt of an agency's determination on an allegation of noncompliance.
 - b. Thirty-five (35) days after the complainant serves the agency with an allegation of noncompliance, if the agency has not issued a determination.

Notice to the EEO Director of noncompliance is a prerequisite to the filing of an appeal alleging breach of a settlement agreement.¹

4. Appeals limits on final grievance decisions in employment discrimination claims where 5 U.S.C. § 7121(d) applies to the agency: Within 30 days of receipt of the final decision of an agency, an arbitrator, or the Federal Labor Relations Authority when employment discrimination was raised.

¹ As a prerequisite to the agency determination, 29 C.F.R. § 1614.504(a) provides :

If the complainant believes that the agency has failed to comply with the terms of a settlement agreement or final decision, the complainant shall notify the EEO Director, in writing, of the alleged noncompliance within 30 days of when the complainant knew or should have known of the alleged noncompliance.

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5. Limits on petitions for consideration of final decisions of the MSPB on mixed case appeals and mixed case complaints (5 C.F.R. § 1201.151 et seq. and 5 U.S.C. § 7702):²
 - a. Within 30 days of receipt of the final MSPB decision.
 - b. Within 30 days after the decision of a MSPB field office becomes final.
6. Appeals limits for an agency's appeal if the agency's final order following a decision by an Administrative Judge does not fully implement the decision of the Administrative Judge:
 - a. Within forty (40) days of receipt of the Administrative Judge's decision.
 - b. Under 29 C.F.R. § 1614.401(b), an agency is required to file an appeal to the Commission if the agency's final order does not fully implement the decision of the Administrative Judge. The Commission's use of the word "may" in 29 C.F.R. § 1614.401(b) is not inconsistent with this requirement. The agency has the option to appeal if it is not satisfied with the Administrative Judge's decision. If the agency chooses not to appeal, however, it must fully implement the Administrative Judge's decision. In other words, when the agency decides whether it will fully implement the Administrative Judges' decision, it is also deciding whether to appeal; a decision to fully implement means that it is not appealing while a decision not to fully implement means that it is appealing.

B. Appeals to the Commission Regarding Compliance with Settlement Agreements and Final Action - 29 C.F.R. § 1614.504(a)

In addition to providing for appeals to the Commission by complainants alleging breach of a settlement agreement, 29 C.F.R. § 1614.504(a) provides that a complainant may file an appeal alleging agency noncompliance with a final action through which the agency has accepted the decision of an Administrative Judge. The complainant first must present his/her allegations of noncompliance to the EEO Director. The complainant thereafter may appeal:

² The Commission will only accept petitions for review of final MSPB decisions.

1. Within thirty (30) days of the complainant's receipt of an agency's determination on the allegation of noncompliance; or
2. Thirty-five (35) days after the complainant serves the agency with the allegation of noncompliance, if the agency has not issued a determination.

C. Petitions to Consider MSPB Decisions

A petition to the Commission to consider a final MSPB decision on a mixed case appeal or on the appeal of a final decision on a mixed case complaint, under 29 C.F.R. § 1614.303 and 29 C.F.R. § 1614.304, must be in writing and must include:

1. The name and address of the petitioner and of petitioner's representative (if any);
2. A statement of the reasons why the decision of the MSPB is alleged to be incorrect, only with regard to the issues of discrimination based on race, color, religion, sex, national origin, age, disability or genetic information;
3. A copy of the decision issued by the MSPB; and
4. The signature of the petitioner or representative, if any. See Chapter IX Section IV.H of this management directive for information on electronic signatures.

D. Appeal to MSPB on Mixed Case Complaint

At the time the agency issues its final decision on a mixed case complaint the agency shall advise the complainant of the right to appeal the decision to the MSPB (not the Commission) within thirty (30) days of receipt of the agency's final decision provided at 29 C.F.R. § 1614.302(d)(3).

III. CIVIL ACTIONS

A. Time Limits for Civil Actions

1. Title VII, Age Discrimination in Employment Act, the Genetic Information Nondiscrimination Act, Rehabilitation Act - 29 C.F.R. § 1614.407.

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A complainant who has filed a non-mixed individual complaint, an agent who has filed a class complaint, or a claimant who has filed a claim for individual relief in a class action complaint may file a civil action in an appropriate U.S. District Court:

- a. Within ninety (90) days of receipt of an agency's final action on an individual complaint, or final decision on a class complaint, if no appeal has been filed.
- b. After 180 days from the date of filing an individual or class complaint if no appeal has been filed and no final action on an individual complaint or no final decision on a class complaint has been issued.
- c. Within 90 days after receipt of the Commission's final decision on appeal.
- d. After 180 days from the date of filing an appeal with the Commission if there has been no final decision by the Commission.

2. The Equal Pay Act - 29 C.F.R. § 1614.408

Regardless of whether the individual complainant pursued any administrative complaint processing, a complainant may file a civil action in a court of competent jurisdiction within two years or, if the violation is willful, within three years of the date of the alleged violation of the Equal Pay Act. Recovery of back wages is limited to two years prior to the date of filing suit, or to three years if the violation is willful; liquidated damages in an amount equal to lost back wages may also be awarded. The filing of an administrative complaint does not toll the time for filing a civil action.

B. Termination of the Commission Processing

Filing a timely civil action under any of these statutes terminates Commission processing of an appeal. See 29 C.F.R. § 1614.409. If a civil action is filed after an appeal has also been filed, the parties are requested to notify the Commission of this event in writing.

C. Mixed Case Complaints

The Civil Rights Act of 1991 did not extend the time limit for filing a civil action in mixed case complaints. See 29 C.F.R. § 1614.310, which sets forth the statutory rights to file a civil action in mixed case complaints.

IV. NOTICE OF COMPLAINANT'S RIGHT TO REQUEST COURT APPOINTMENT OF COUNSEL AND STATEMENT OF RIGHT TO APPEAL

Consistent with the court's holding in [Hilliard v. Volcker](#), 659 F.2d 1125 (D.C. Cir. 1981), it is the Commission's policy to require all federal agencies subject to the Management Directive to inform complainants, in writing, of their statutory right to request court appointment of counsel for representation in connection with the filing of civil actions that arise under Title VII, the Genetic Information Nondiscrimination Act, and the Rehabilitation Act.

In [Hilliard](#), the court held that agencies must inform complainants unsuccessful in the administrative process that, in the event they file a civil action, the court has discretionary authority to appoint counsel for them. A litigant who fails to request counsel should not be penalized because an agency has been remiss in its duty to inform the complainant of the court's authority.

Therefore, all federal agencies subject to 29 C.F.R. Part 1614 **must** include the following language in **every** final action or final decision on complaints which allege discrimination of race, color, religion, sex, national origin, age, disability, genetic information, and/or retaliation:

Within 30 days of your receipt of the final action or final decision (as appropriate), you have the right to appeal this final action or final decision to:

Equal Employment Opportunity Commission
Office of Federal Operations
P.O. Box 77960
Washington, DC 20013

You also have the right to file a civil action in an appropriate U.S. District Court. If you choose to file a civil action, you may do so

- within 90 days of receipt of this final action or final decision (as appropriate) if no appeal has been filed, or

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- within 90 days after receipt of the EEOC's final decision on appeal, or
- after 180 days from the date of filing an appeal with the Commission if there has been no final decision by the Commission.

You must name the person who is the official agency head or department head as the defendant. Agency or department means the national organization, and not just the local office, facility, or department in which you might work. Do not name just the agency or department. In your case, you must name _____ as the defendant. [The Administrative Judge or agency must supply the name of the proper person.] You must also state the official title of the agency head or department head. Failure to provide the name or official title of the agency head or department head may result in dismissal of your case.

If you decide to file a civil action, under Title VII or under the Rehabilitation Act, and if you do not have or cannot afford the services of an attorney, you may request that the Court appoint an attorney to represent you and that the Court permit you to file the action without payment of fees, costs, or other security. **The grant or denial of the request is within the sole discretion of the Court.** Filing a request for an attorney does not extend your time in which to file a civil action. Both the request and the civil action MUST BE FILED WITHIN NINETY (90) CALENDAR DAYS of the date you receive the final action or final decision (as appropriate) from the agency or the Commission.

CHAPTER 11 REMEDIES

I. INTRODUCTION

In federal EEO law, there is a strong presumption that a complainant who prevails in whole or in part on a claim of discrimination is entitled to full relief which places him/her in the position s/he would have been in absent the agency's discriminatory conduct. See [Albermarle Paper Co. v. Moody](#), 422 U.S. 405, 418-419 (1975).

This Chapter of the Management Directive sets forth guidance for use by agencies and persons seeking remedial relief in a variety of areas, including: back pay, front pay, attorney's fees and costs, awards of compensatory damages, and other forms of equitable relief. This guidance applies only to the federal sector administrative process.

II. NON-DISCRIMINATORY PLACEMENT

When an agency or the Commission finds that an employee of the agency was discriminated against, the agency shall provide the individual with non-discriminatory placement into the position s/he would have occupied absent the discrimination. For cases in which the employee is not selected for a position or promotion due to discrimination, this would include an offer of placement into the position sought, or a substantially equivalent position. See [Carson v. Dep't. of Justice](#), EEOC Appeal No. 0120100078 (Feb. 16, 2012).

The offer should be made retroactive to the date of the selection in question. The individual should receive all step or pay increases and monetary benefits associated with the position. See [Stewart v. Dep't. of Homeland Security](#), EEOC Request No. 0520070124 (Nov. 14, 2011). A "substantially equivalent position" is a position within the same commuting area. [Bakken v. Dep't. of Transportation](#), EEOC Appeal No. 0120093529 (Aug. 8, 2011).

When the relief ordered includes the offer of a position or a promotion, the offer shall be made to the complainant in writing, providing the complainant fifteen (15) days from receipt of the offer to notify the agency of the acceptance or rejection. Failure to respond within the 15-day time limit shall be construed as a declination. Any back pay liability shall cease to accrue with either the actual placement of the complainant into the position in question, or with the date the offer was declined.

In cases involving a discriminatory termination, the agency should offer to reinstate the complainant to his/her former position retroactive to the date of the termination. See [Oni v. Dep't. of the Treasury](#), EEOC Appeal No. 0720100015 (Oct. 11, 2011). The complainant should also receive all applicable benefits and step or pay increases.

In some cases, there is evidence that discrimination was one of multiple motivating factors for an employment action. In these “mixed motive” cases, the agency does not have to offer complainant the position sought if it can demonstrate by clear and convincing evidence that it would have taken the same action even absent the discrimination. See [Montante v. Dep’t. of Transportation](#), EEOC Appeal No. 0120110240 (Nov. 9, 2011), [request for reconsideration denied](#), EEOC Request No. 0520120259 (June 8, 2012). If the agency is able to make this demonstration, the complainant is not entitled to personal relief such as reinstatement, hiring, or promotion. The complainant may still be entitled to declaratory relief, injunctive relief, and/or attorneys’ fees and costs. Id.

When an individual accepts an offer of employment as a remedy for discrimination, s/he shall be deemed to have performed service for the agency during the period he would have served but for the discrimination for all purposes except for meeting service requirements for completion of a required probationary or trial period.

III. BACK PAY

A. Back Pay Issues

When an agency or the Commission finds that an employee of the agency was discriminated against, the agency shall provide the individual with non-discriminatory placement into the position s/he would have occupied absent the discrimination, with back pay computed in the manner prescribed by 5 C.F.R. § 550.805. See 29 C.F.R. § 1614.501(c)(1). The purpose of a back pay award is to restore to the complainant the income he would have otherwise earned but for the discrimination. See [Albemarle Paper Co. v. Moody](#), 422 U.S. at 418-419 (1975); [Davis v. U.S. Postal Service](#), EEOC Petition No. 04900010 (Nov. 29, 1990). A number of discriminatory personnel actions can generate back pay. The most common actions generating back pay are: removals, suspensions, denials of promotions, and failure to hire.

Interest on back pay shall be included in the back pay computation. The back pay computation should also include any applicable step increases or pay differentials. See [Morrow v. U.S. Postal Service](#), EEOC Appeal No. 0720070058 (Nov. 13, 2009) (ordering the agency to provide complainant with a back pay award which included interest, overtime, and night pay differential). Under Title VII, GINA, and the Rehabilitation Act, back pay is limited to two years prior to the date the discrimination complaint was filed.

B. Determining Gross Back Pay

Back pay includes all forms of compensation and reflects fluctuations in working time, overtime rates, penalty overtime, Sunday premium and night work, changing rates of pay, transfers, promotions, and privileges of employment. The Commission also construes “benefits” broadly to include annual leave, sick leave, health insurance, and retirement contributions. [Vereb v. Dep’t. of Justice](#), EEOC Petition No. 04980008 (Feb. 26, 1999); [Holly v. U.S. Postal Service](#), EEOC Petition No. 04A50003 (Nov. 2, 2005).

[T]he Commission recognizes that precise measurement cannot always be used to remedy the wrong inflicted, and therefore, the computation of back pay awards inherently involves some speculation. [Hanns v. U.S. Postal Service](#), EEOC Petition No. 04960030 (September 18, 1997). The Commission has held that uncertainties involved in a back pay determination should be resolved against the agency that has already been found to have committed acts of discrimination. *Id.* See also [Davis v. U.S. Postal Service](#), EEOC Petition No. 04900010 (Nov. 29, 1990); and [Besemer v. U.S. Postal Service](#), EEOC Petition No. 04890005 (Dec. 14, 1989).

C. Overtime or Premium Pay as a Component of Back Pay

Back pay will be required to cover any overtime or premium pay that would have been worked absent discrimination. The parties often disagree over whether overtime would have been worked and to what extent overtime could have been earned. The overtime component of a back pay award should generally be calculated based upon the average amount of overtime worked by similarly situated employees. [Haines v. U.S. Postal Service](#), EEOC Petition No. 04A50018 (Nov. 23, 2005); [Holly v. U.S. Postal Service](#), EEOC Petition No. 04A50003 (Nov. 2, 2005). If the position is unique, such that a comparison with a similarly situated employee is not possible, the agency should calculate overtime based on the actual overtime worked by the person who was selected for the position. See, for example, [Bowman v. U.S. Postal Service](#), EEOC Appeal No. 0120112333 (Oct. 3, 2011), [request for reconsideration denied](#), EEOC Request No. [0520120091](#) (Mar. 16, 2012).

D. Retirement Deductions and Back Pay

The Commission has held that make whole relief requires the agency to make retroactive tax-deferred contributions to the complainant’s retirement account for the relevant period. To the extent complainant would have received agency contributions to a retirement fund as a component of her salary, she is entitled to have her retirement benefits adjusted as part of her back pay award, including sums which the account would have earned during the relevant period. The

agency should provide its calculations of the amount of contributions to the agency's retirement system that both it and complainant would have made during her absence, as well as the earnings which would have accrued. See [Kretschmar v. Dep't. of the Navy](#), EEOC Petition No. 04A40044 (Mar. 25, 2005).

E. Interim Earnings Deducted from Back Pay

If the complainant lost a job or did not receive a position due to discrimination, the complainant has the responsibility of mitigating the harm by looking for other work. [Ghannam v. Agency for International Development](#), EEOC Appeal No. 01990574 (June 22, 2004). Wages earned by the employee while separated from the agency are commonly called "interim wages." The agency should deduct the interim wages earned by the complainant from the amount of back pay owed to the complainant as provided for in Title VII. [42 U.S.C. § 2000e \(5\)\(g\)](#). If the agency believes that the complainant did not do enough to mitigate lost wages, it must prove so by a preponderance of the evidence. See [McNeil v. U.S. Postal Service](#), EEOC Request No. 05960436 (Dec. 9, 1999).

However, income that the complainant could have earned while still holding the position at the agency should not be subtracted or offset from back pay. "Moonlight" employment is employment that the employee could have engaged in even while federally employed. See 5 C.F.R. § 550.805(e)(1). See [Paulk v. U.S. Postal Service](#), EEOC Petition No. 04A10026 (Oct. 4, 2001) (Commission found that petitioner's overtime earnings were earned from his working 65-80 hours per week in a position he acquired during the period subsequent to his termination from the agency, and thus petitioner could not have held both the supplemental job and the job he lost because of discrimination, and therefore, the agency properly offset these earnings from complainant's back pay award).

F. Worker's Compensation Benefits May Be Partially Deductible from Back Pay

A Federal Employees' Compensation Act (FECA) award is meant to compensate for lost wages and/or reparation for physical injury. A claim of back pay against a Federal agency during the same time period covered by a FECA claim would have the potential for a double recovery of back pay. Any portion of a FECA award attributable to lost wages during the back pay period in a discrimination finding will be deducted from the back pay award. The portion of the FECA award that is paid as reparation for physical injuries is not related to wages earned and should not be deducted.

If the agency contends that receipt of workers' compensation would result in double recovery, the agency must determine what portion of the FECA benefits, if any, applied to back pay, leave and other benefits, and what portion of

complainant's FECA benefits applied to reparation for physical injuries. See Ulloa v. U.S. Postal Service, EEOC Petition No. 04A30025 (Aug. 3, 2004).

G. Availability for Work – Prerequisite for Receipt of Back Pay

The applicable regulations provide that the amount of back pay awarded shall be reduced by the amounts earnable with reasonable diligence by the person discriminated against. Thus, the complainant has a duty to mitigate or lessen damages by making a reasonable good faith effort to find other employment. This means that the complainant must seek a substantially equivalent position, that is, a position that affords virtually identical compensation, job responsibilities, working conditions, status, and promotional opportunities as the position he was discriminatorily denied. See Knott v. U.S. Postal Service, EEOC Appeal No. 0720100049 (July 5, 2010).

As a general rule, a complainant must be ready, willing, and able to work during the period of back pay recovery in order to receive back pay. The Commission has stated that if an agency can present persuasive evidence that complainant was not able to work during the back pay period, back pay would not be awarded; however, the agency has the burden of proof. Morman v. Dep't. of Defense (Defense Commissary Agency), EEOC Petition No. 04A10006 (July 31, 2002). The back pay regulation 5 C.F.R. § 550.805(c) provides that periods of unavailability may not be included in the back pay period unless such periods of time are the result of an illness or injury related to an unjustified or unwarranted personnel action. When a complainant receives workers' compensation due to an agency's failure to provide reasonable accommodation, this does not preclude a back pay award. The receipt of workers' compensation benefits does not indicate that a person was unable to work during the back pay period. See McClendon v. U.S. Postal Service, EEOC Petition No. 04960013 (May 22, 1997).

H. Unemployment Compensation Not Deducted from Back Pay – the Collateral Source Rule

Unemployment compensation is an interim source of income, but it is a collateral source in the sense that it comes from the state – not the federal employer. An employer cannot set off or mitigate its damages through a collateral source – in this case the state's payment of unemployment compensation even though the employer might have contributed to the source.

When a back payment is made where unemployment had been received, in theory the unemployment compensation represents an overpayment from the state and is due to the state. See Morra-Morrison v. U.S. Postal Service, EEOC Petition No. 04980023 (June 2, 1999). This process of recoupment is generally a matter between the complainant and the state.

I. Tax Consequences of a Lump Sum Payment of Back Pay

The Commission has recognized that an agency is liable for any increased tax liability resulting from receipt of a lump sum of back pay in a single tax year. When an individual receives back pay as a lump sum payment, s/he is entitled to a tax offset payment for the tax year in which she received the payment. Additionally, the individual will have the burden of establishing the amount of his/her increased federal income tax liability to the agency. See [Mohar v. U.S. Postal Service](#), EEOC Appeal No. 0720100019 (Aug. 29, 2011); [Teresita Lorenzo v. Dep't. of Defense Education Activity](#), EEOC Petition No. 01A61644 (September 29, 2005); [Warren Goetze v. Dep't. of the Navy](#), EEO Appeal No. 01991530 (Aug. 23, 2001).

J. Liquidated Damages (ADEA and EPA only)

Liquidated damages in Fair Labor Standards Act cases are generally monetary awards equal to, and in addition to, the back pay due to the complainant when a violation is found to be willful or in reckless disregard of the statutes.

In Equal Pay Act cases, willfulness is not a required factor for liquidated damages. Such damages are available for a violation of the EPA unless the agency can prove that it acted in “good faith” and reasonably believed that its actions did not violate the EPA. A finding of willfulness under the EPA, however, may extend the limitations period on back pay from two (2) years to three (3) years.

Since an EPA claim may also be brought as a sex-based wage discrimination claim under Title VII, compensatory damages may also be available if the claim is brought under both statutes.

While liquidated damages for willful violations of the ADEA are available in the private sector under 29 U.S.C. Sec. 626(b), they are not available under the federal sector provisions at Sec. 633a (b). See [Jacobson v. Shalala](#), EEO Request No. 05930689, (June 2, 1994); [Falks v. Rubin](#), EEOC Request No. 05960250, (September 6, 1996); [Amaro v. Potter](#), EEOC Appeal No. 0120020929, (May 29, 2003).

K. Restoration of Leave

Where there has been a finding of discrimination, the complainant is entitled to back pay for time lost from work during the applicable periods, as well as the restoration of any leave used because of the agency’s discriminatory actions. [Cox v. Social Security Administration](#), EEOC Appeal No. 0720050055 (Dec. 24, 2009). For example, the restoration of leave taken for purposes of avoiding or

recovering from a discriminatory hostile work environment is a valid component of equitable relief. See [Burton v. Dep't. of Justice](#), EEOC Appeal No. 0720090046 (June 9, 2011); see also [Lamb v. Social Security Administration](#), EEOC Appeal No. 0120103232 (Mar. 21, 2012) (leave restoration ordered where denial of reasonable accommodation resulted in leave usage); [Complainant v. Dep't. of Defense](#), EEOC Appeal No. 0120084008 (June 6, 2014) (leave restoration ordered where leave used in lieu of improperly denied official time).

IV. FRONT PAY

Front pay is an equitable remedy that compensates an individual when reinstatement is not possible in certain limited circumstances. The Commission has held that front pay may be awarded in lieu of reinstatement when: (1) no position is available; (2) a subsequent working relationship between the parties would be antagonistic; or (3) the employer has a record of long-term resistance to anti-discrimination efforts. [Brinkley v. U.S. Postal Service](#), EEOC Request No. 05980429 (Aug. 12, 1999). The fact that front pay is awarded in lieu of reinstatement implies that the complainant is able to work but cannot do so because of circumstances external to the complainant. See [Cook v. U.S. Postal Service](#), EEOC Appeal No. 01950027 (July 17, 1998).

The Commission has held that front pay is an equitable remedy to be awarded for a reasonable future period required for the victim of discrimination to reestablish his rightful place in the job market. See [Deidra Brown-Fleming v. Dep't. of Justice](#), EEOC Petition No. 0420080016 (Oct. 28, 2010).

V. OTHER FORMS OF EQUITABLE RELIEF

As appropriate, the agency shall also:

1. Cancel an unwarranted personnel action and restore the employee to the status s/he occupied prior to the discrimination;
2. Expunge any adverse materials relating to the discriminatory employment practice from the agency's records;¹ and

¹ See [Sipriano v. Dep't. of Homeland Security](#), EEOC Appeal No. 0120103167 (Jan. 20, 2011), request for reconsideration denied, EEOC Request No. [0520110313](#) (May 12, 2011) (ordering the agency to expunge all documentation relating to a discriminatory termination from complainant's records); [Farrington v. Dep't. of Homeland Security](#), EEOC Appeal No. 0720090011 (Jan. 19, 2011), request for reconsideration denied, EEOC Request No. [0520110295](#) (May 12, 2011) (ordering the agency to expunge evaluation reports and documents referencing a discriminatory investigation).

3. Provide the individual with a full opportunity to participate in the employee benefit that was denied - for example, training, preferential work assignments, or overtime scheduling.²

When the finding of discrimination involves a performance appraisal, the appropriate relief should include raising the rating to that which the individual would have received absent the discrimination. [McKenzie v. Dep't. of Justice](#), EEOC Appeal No. 0120100034 (July 7, 2011); [Hairston v. Dep't. of Education](#), EEOC Appeal No. 0120071308 (Apr. 15, 2010). In addition, the individual is entitled to all benefits and awards that s/he would have received if she had achieved the higher performance appraisal rating. [Cook v. Dep't. of Labor](#), EEOC Appeal No. 0720080045 (Feb. 22, 2010).

It is also appropriate to order training for agency personnel found to have engaged in discrimination, and to consider taking disciplinary action against those officials who engaged in the discrimination.³ See [James v. Dep't. of Agriculture](#), EEOC Appeal No. 0120073831 (September 22, 2009), request for reconsideration denied, EEOC Request No. [0520100086](#) (Mar. 22, 2010) (ordering the agency to provide the Selecting Official who discriminated against complainant 16 hours of EEO training and to consider taking disciplinary action against the official). The Commission does not consider training to be “discipline.” See [Morrow v. U.S. Postal Service](#), EEOC Appeal No. 0720070058 (Nov. 13, 2009).

For example, in [Burton v. Dep't. of Justice](#), EEOC Appeal No. 0720090046 (June 9, 2011), one of the responsible management officials found to have engaged in unlawful discrimination and retaliation was a high-level management official who set the leadership tone for the entire facility, and, thus, requiring five hours of EEO training for all facility management and supervisory staff was appropriate. See also [Kitson v. Dep't. of Justice](#), EEOC Appeal No. 0720100052 (Feb. 15, 2011), request for reconsideration denied, EEOC Request No. [0520110312](#) (June 10, 2011) (ordering the agency to provide training for upper-level employees at an agency facility following a finding of discriminatory non-selection); [Wagner v. Dep't. of Transportation](#), EEOC Appeal No. 0120103125 (Dec. 1, 2010) (ordering the agency to provide EEO training to all employees at an agency facility following a finding that agency managers and employees subjected complainant to a hostile work environment).

The Commission has also found that, in cases involving discriminatory policies or practices, the appropriate relief includes ordering the agency to “cease and desist” from adhering to that policy or practice. For example, in [Smith v. Dep't. of the Navy](#), EEOC

² See 29 C.F.R. § 1614.501(c).

³ In fact, the Commission strongly urges that agencies include consideration of disciplinary action in all agency orders on findings of intentional discrimination. In certain circumstances, training may be ordered for additional agency managers and staff.

Appeal No. 0120082983 (Feb. 16, 2010), request for reconsideration denied, EEOC Request No. [0520100287](#) (July 9, 2010), the Commission ordered the agency to cease and desist from requiring that all contact with EEO Counselors be arranged by management officials.

Following a finding of discrimination, the agency should take steps to ensure that the same type of action does not recur. In Cheeks v. Dep't. of the Army, EEOC Appeal No. 0120091345 (Feb. 1, 2012), the agency was found to have engaged in racial harassment. The agency was ordered to take all necessary steps to ensure that complainant had no contact with the supervisor responsible for the harassment, as well as to provide complainant with a designated management official to whom he could report any subsequent acts of harassment. See also Ighile v. Dep't. of Justice, EEOC Appeal No. 0720110010 (Apr. 13, 2012) (ordering the agency to cease and desist from all hostile conduct directed to complainant, and take appropriate action to ensure that his co-workers cease and desist from any hostile conduct).

VI. ATTORNEY'S FEES AND COSTS

A. Introduction

Attorney's fees and costs shall be awarded in accordance with 29 C.F.R. § 1614.501(e).

In federal EEO law, there is a strong presumption that a complainant who prevails in whole or in part on a claim of discrimination is entitled to an award of attorney's fees and costs. More specifically, complainants who prevail on claims alleging discrimination in violation of Title VII of the Civil Rights Act of 1964, as amended, and the Rehabilitation Act of 1973, as amended, are presumptively entitled to an award of attorney's fees and costs, unless special circumstances render such an award unjust. 29 C.F.R. § 1614.501(e)(1). (Complainants prevailing on claims under the Age Discrimination in Employment Act of 1967, as amended, and the Equal Pay Act of 1963, as amended, are not entitled to attorney's fees at the administrative level.) Only where a Title VII, GINA, or Rehabilitation Act complainant rejects an offer of resolution made in accordance with 29 C.F.R. § 1614.109(c) and does not obtain more relief than the agency had offered, or in the rarest of other circumstances, might an agency limit or deny an award of fees.

B. Determination of Prevailing Party Status

1. A "prevailing party," within the meaning of Section 706(k) of Title VII, 42 U.S.C. § 2000e-5(k), is a complainant who has succeeded on any significant issue that achieved some of the benefit the complainant sought in filing the complaint. Texas State Teachers Ass'n v. Garland I.S.D., 489

U.S. 782 (1989). The Commission has relied on a two-part test set forth in [Miller v. Staats](#), 706 F.2d 336 (D.C. Cir. 1983), for determining whether a complainant is a prevailing party. [Baldwin v. Dep't. of Health & Human Services](#), EEOC Request No. 05910016 (Apr. 12, 1991). To satisfy the first part of the test, the complainant must have substantially received the relief sought. *Id.* To satisfy the second part of the test, there must be a determination that the complaint was a catalyst motivating the agency to provide the relief. *Id.* (citing [Miller](#), 706 F.2d at 341). A purely technical or *de minimis* success is insufficient to confer “prevailing party” status. [Texas State Teachers Ass’n](#), at 792.

2. The touchstone is whether the actual relief on the merits materially alters the legal relationship between the parties by modifying the agency’s behavior in a way that directly benefits the complainant. [Farrar v. Hobby](#), 506 U.S. 103 (1992); [Bragg v. Dep’t. of the Navy](#), EEOC Appeal No. 01945699 (Mar. 7, 1996). Even an award of nominal monetary damages may be sufficient to meet this standard. [Farrar](#). Monetary relief is not required; non-monetary relief such as reinstatement or a higher performance rating is sufficient. *Id.*
3. An attorney who represents himself is not entitled to an award of fees. [Kay v. Ehrler](#), 499 U.S. 432 (1991). Neither a non-attorney nor a federal employee (including attorneys) who represents a complainant is entitled to an award of fees. 29 C.F.R. § 1614.501(e)(1)(iii).

C. Presumption of Entitlement

1. A prevailing complainant is presumptively entitled to fees and costs unless special circumstances render such an award unjust. 29 C.F.R. § 1614.501(e)(1)(i); [New York Gaslight Club, Inc. v. Carey](#), 447 U.S. 54 (1983); [Thomas v. Dep’t. of State](#), EEOC Appeal No. 01932717 (June 10, 1994). Special circumstances should be construed narrowly. The following arguments are not sufficient to show special circumstances:
 - a. the complainant did not need an attorney;
 - b. the complainant’s attorney worked for a public interest organization;
 - c. the complainant’s attorney accepted the case *pro bono*;
 - d. the complainant’s attorney was paid from some private fee agreement;
 - e. the complainant was able to pay the costs of the case;

- f. the agency acted in good faith;
- g. the agency took prompt action in remedying the discrimination;
- h. the financial burden of any fee would fall to the taxpayers;
- i. the agency has limited funds.

See [Blanchard v. Bergeron](#), 489 U.S. 87 (1989); [Roe v. Cheyenne Mountain Conference Resort, Inc.](#), 124 F.3d 1221 (10th Cir. 1997); [Jones v. Wilkinson](#), 800 F.2d 989 (10th Cir. 1986); [Fields v. City of Tarpon Springs](#), 721 F.2d 318 (11th Cir. 1983); [Copeland v. Marshall](#), 641 F.2d 880 (D.C. Cir. 1980); see also [Wise v. Dep't. of Veterans Affairs](#), EEOC Request No. 05920056 (Apr. 1, 1992).

2. Agencies are not required to pay for attorney's fees for services rendered during the pre-complaint process unless an Administrative Judge issues a decision finding discrimination, the agency issues a final order that does not implement the decision, and the Commission upholds the Administrative Judge's decision on appeal. If the agency agrees to fully implement the Administrative Judge's decision, it cannot be compelled to pay attorney's fees for fees incurred during the pre-complaint process, except that fees may be recovered for a reasonable period of time for services performed in reaching the decision whether to represent the complainant. 29 C.F.R. § 1614.501(e)(1)(iv). The agency and the complainant can agree, however, that the agency will pay attorney's fees for pre-complaint process representation. Id.
3. No attorney's fees may be awarded under the Age Discrimination in Employment Act, see [Coomes v. Social Security Administration](#), EEOC Appeal No. 0720120010 (Oct. 12, 2012), or Equal Pay Act, see [Jacobsen v. Dep't. of the Navy](#), EEOC Appeal Nos. 0720100046 and 0720100047 (September 7, 2012), for services performed at the administrative level. [Lowenstein v. Baldridge](#), 38 Fair Empl. Prac. Cas. (BNA) 466 (D.D.C. 1985); 29 C.F.R. § 1614.501(e)(1).

D. Awards to Prevailing Parties in Negotiated Settlements

1. A complainant who prevails through a negotiated settlement is entitled to attorney's fees and costs under the same standards as any other prevailing party. [Maher v. Gagne](#), 448 U.S. 122 (1980); [Copeland v. Marshall](#), 641 F.2d 880 (D.C. Cir. 1980); [EEOC v. Madison Community Unit Sch. Dist. 12](#), 818 F.2d 577 (7th Cir. 1987); [Cerny v. Dep't. of the Navy](#), EEOC Request No. 05930899 (Oct. 19, 1994). A settlement agreement that fails, however, to preserve the issue of fees and costs will operate as an implicit waiver of fees and costs. [Wakefield v. Matthews](#), 852 F.2d 482 (9th Cir. 1988); [Elmore v. Shuler](#), 787 F.2d 601 (D.C. Cir. 1986). The Commission strongly encourages parties to resolve fee and cost issues by negotiated settlement.⁴
2. The Administrative Judge will not review a negotiated fee agreement for fairness or reasonableness, except in class cases. [Foster v. Boise-Cascade, Inc.](#), 577 F.2d 335 (5th Cir.) (per curiam), *reh'g denied*, 581 F.2d 267 (5th Cir. 1978); [Jones v. Amalgamated Warbasse Houses, Inc.](#), 721 F.2d 881 (2d Cir. 1983), *cert. denied*, 466 U.S. 944 (1984). In class cases, the Administrative Judge should review the agreement to ensure that the negotiated fee is fair and reasonable to all parties.

E. Awards of Costs and Fees for Expert and Non-Lawyer Services

1. A prevailing complainant is entitled to recovery of his/her costs. Costs include those costs authorized by 28 U.S.C. § 1920. 29 C.F.R. § 1614.501(e)(2)(ii)(C). These include: witness fees; transcript costs; and printing and copying costs. In addition, reasonable out-of-pocket expenses may include all costs incurred by the attorney that are normally charged to a fee-paying client in the normal course of providing representation. [Hafiz v. Dep't. of Defense](#), EEOC Petition No. 04960021 (July 11, 1997). These costs may include such items as mileage, postage, telephone calls, and photocopying.
2. A prevailing complainant is entitled to expert fees as part of recoverable attorney's fees. 42 U.S.C. § 1988. The fee is not limited to per diem expenditures, but includes all expenses incurred in connection with the

⁴ Where the parties enter into a settlement agreement that provides for but does not quantify the amount of attorney's fees and costs, the attorney should submit his/her statement of fees and costs and supporting documentation to the agency for determination of the amount due. The agency should issue a decision on fees within 60 days of receipt of the statement and supporting documentation. *See* 29 C.F.R. § 1614.501(e)(2)(ii)(A). If the complainant disputes the amount awarded, s/he may file an appeal with the Commission.

retention of an expert. Id. Recovery is generally limited to testifying experts, but fees may be awarded for non-testifying experts if the complainant can show that the expert's services were reasonably necessary to the case.

3. A prevailing complainant is entitled to compensation for the work of law clerks, paralegals, and law students under the supervision of members of the bar, at market rates, 29 C.F.R. § 1614.501(e)(1)(iii), but not for clerical services. [Missouri v. Jenkins](#), 491 U.S. 274 (1989).
4. Reasonable costs incurred directly by a prevailing complainant (for example, one who is unrepresented or who is represented by a non-lawyer) are compensable. Hafiz, supra. Costs must be proved in the same manner as fees are, and the complainant must provide documentation, such as bills or receipts.
5. Witness fees shall be awarded in accordance with 28 U.S.C. § 1821, except that no award shall be made for a federal employee who is in a duty status when made available as a witness. 29 C.F.R. § 1614.501(e)(2)(iii).

F. Computation of Attorney's Fees

1. Attorney's fees will be computed by determining the "lodestar." The "lodestar" is the number of hours reasonably expended multiplied by a reasonable hourly rate. [Hensley v. Eckerhart](#), 461 U.S. 424, 434 (1983). By regulation, the Commission uses the same basis for calculating the amount of attorney's fees. 29 C.F.R. § 1614.501(e)(2)(ii)(B).
 - a. All hours reasonably spent in processing the complaint are compensable. Fees shall be paid for services performed by an attorney after the filing of a written complaint, provided that the attorney provides reasonable notice of representation to the agency, Administrative Judge, or Commission, except that fees are allowable for a reasonable period of time prior to the notification of representation for any services performed in reaching a determination to represent the complainant. 29 C.F.R. § 1614.501(e)(1)(iv).
 - b. Fees for services rendered during the pre-complaint process may be awarded only under the circumstances set forth above in Section III.B. See 29 C.F.R. § 1614.501(e)(1)(iv).
 - c. An attorney is eligible for work performed at the appeals stage for an award of fees, provided the complainant prevails at this stage.

- d. The number of hours should not include excessive, redundant, or otherwise unnecessary hours. [Hensley](#), 461 U.S. at 434; [Bernard v. Dep't. of Veterans Affairs](#), EEOC Appeal No. 01966861 (July 17, 1998). The presence of multiple counsel at hearing or deposition may be considered duplicative in certain situations, such as where one or more counsel had little or no participation or where the presence of multiple counsel served to delay or prolong the hearing or deposition. [Hodge v. Dep't. of Transportation](#), EEOC Request No. 05920057 (Apr. 23, 1992). The presence of multiple counsel is not necessarily duplicative, however, and is often justifiable. Time spent on clearly meritless arguments or motions, and time spent on unnecessarily uncooperative or contentious conduct may be deducted. [Luciano v. Olsten Corp.](#), 109 F.3d 111 (2d Cir. 1997); [Clanton v. Allied Chemical Corp.](#), 416 F. Supp. 39 (E.D. Va. 1976).
- e. A reasonable hourly rate is a rate based on “prevailing market rates in the relevant community” for attorneys of similar experience in similar cases. [Cooley v. Dep't. of Veterans Affairs](#), EEOC Request No. 05960748 (July 30, 1998) (quoting [Blum v. Stenson](#), 465 U.S. 886 (1984)). A higher rate for time spent at hearing may be reasonable if trial work would command a higher rate under prevailing community standards. Where multiple attorneys have worked on the case, the rate for each attorney should be determined separately. The limits on hourly rates contained in the Equal Access to Justice Act are not applicable.
- f. The applicable rate for fee awards to public interest attorneys is the prevailing hourly rate for the community in general. [Hodge v. Dep't. of Transportation](#), EEOC Request No. 05920057 (Apr. 23, 1992). In [Save Our Cumberland Mountains, Inc. v. Hodel](#), 857 F.2d 1516 (D.C. Cir. 1988), the court held that the prevailing market rate should also be used to determine fee awards to private, for-profit attorneys who represent certain clients at reduced rates, which reflect “non-economic” goals. See also [Cooley v. Dep't. of Veterans Administration](#), EEOC Request No. 05960748 (July 30, 1998); [Hatfield v. Dep't. of the Navy](#), EEOC Appeal No. 01892909 (Dec. 12, 1989).
- g. The hours spent on unsuccessful claims should be excluded in considering the amount of a reasonable fee only where the unsuccessful claims are distinct in all respects from the successful claims. [Hensley v. Eckerhart](#), 461 U.S. 424 (1983).

- h. The degree of success is an important factor in calculating an award of attorney's fees. [Farrar v. Hobby](#), 506 U.S. 103 (1992). In determining the degree of success, the relief obtained (including both monetary and equitable relief) should be considered in light of the complainant's goals. [City of Riverside v. Rivera](#), 477 U.S. 561 (1986); [Cullins v. Georgia Department of Transportation](#), 29 F.3d 1489 (1994). Where the complainant achieved only limited success, the complainant should receive only the amount of fees that is reasonable in relation to the results obtained. [Hensley v. Eckerhart](#), 461 U.S. 424 (1983); [Cerny v. Dep't. of the Navy](#), EEOC Request No. 05930899 (Oct. 19, 1994). However, a reasonable fee may not be determined by mathematical formula based on monetary relief obtained. [Riverside](#) at 563; [Cullins](#) at 1493. The determination of the degree of success should be made on a case-by-case basis. In many cases, an award of equitable relief only or a small award of monetary damages may reflect a high degree of success. Failure to obtain the maximum damages allowable or a large monetary award generally does not reflect limited success.
2. There is a strong presumption that the lodestar represents the reasonable fee. 29 C.F.R. § 1614.501(e)(2)(ii)(B). In limited circumstances, the lodestar figure may be adjusted upward or downward, taking into account the degree of success, the quality of representation, and long delay caused by the agency. The lodestar may be adjusted only under the circumstances described in this subpart.
- a. An award of attorney's fees may be enhanced in cases of exceptional success. The complainant must show that such an enhancement is necessary to determine a reasonable fee. [City of Burlington v. Dague](#), 505 U.S. 557 (1992). Conversely, a fee award may be reduced in cases of limited success. [Texas State Teachers Ass'n v. Garland I.S.D.](#), 489 U.S. 782 (1989). However, there is no requirement that fee awards be proportional to the amount of monetary damages awarded. [City of Riverside v. Rivera](#), 477 U.S. 561 (1986).
 - b. An award of attorney's fees may be enhanced where the quality of representation is exceptional. [McKenzie v. Kennickell](#), 875 F.2d 330 (D.C. Cir. 1989). Conversely, the award of attorney's fees may be reduced where the quality of representation was poor, the attorney's conduct resulted in undue delay or obstruction of the process, or where settlement likely could have been reached much earlier but for the attorney's conduct. [Lanasa v. City of New](#)

Orleans, 619 F. Supp. 39 (E.D. La. 1985); Barrett v. Kalinowski, 458 F. Supp. 689 (M.D. Pa. 1978).

- c. The lodestar may not be enhanced to compensate for the risk of non-payment, risk of losing the case, or difficulty finding counsel. City of Burlington v. Dague, 505 U.S. 557 (1992).
 - d. A lodestar may be adjusted to compensate for a long delay where the delay is caused by the agency. Pennsylvania v. Delaware Valley Citizens' Council, 483 U.S. 711 (1987).
 - e. If the Administrative Judge or agency determines that an adjustment to the lodestar is appropriate, the Administrative Judge or agency may calculate the adjustment by either adding or subtracting a lump sum from the lodestar figure or by adding or subtracting a percentage of the lodestar. The Administrative Judge or agency has discretion to determine the amount of the adjustment. Normally, the adjustment should be no more or less than 75% of the lodestar figure. The Administrative Judge or agency must provide a detailed written explanation of why the adjustment was made, and what factors supported the adjustment. Coutin v. Young & Rubicam Puerto Rico, Inc., 124 F.3d 331 (1st Cir. 1997).
 - f. The party seeking to adjust the lodestar, either up or down, has the burden of justifying the deviation. Copeland v. Marshall, 641 F.2d 880, 892 (D.C. Cir. 1980); Brown v. Dep't. of Commerce, EEOC Appeal No. 01944999 (May 17, 1996).
3. Where a complainant rejects an offer of resolution and the final decision is not more favorable than the offer, attorney's fees and costs incurred after the expiration of the thirty (30)-day acceptance period are not compensable. 29 C.F.R. § 1614.109(c)(3). This regulation further provides that an Administrative Judge may award attorney's fees and costs despite the complainant's failure to accept an offer of resolution where "the interests of justice would not be served" by a denial of fees. An example of when fees would be appropriate is where the complainant received an offer of resolution, but was informed by a responsible agency official that the agency would not comply in good faith with the offer (for example, would unreasonably delay implementation of the relief offered). A complainant who rejected the offer for that reason, and who obtained less relief than was contained in the offer of resolution, would not be denied attorney's fees in this situation.

G. Contents of Fee Application and Procedure for Determination

1. When the decision-making authority, that is, the agency, an Administrative Judge, or the Commission, issues a decision finding discrimination, the decision normally should provide, under the standards set forth above, for the complainant's entitlement to attorney's fees and costs. The complainant's attorney then must submit a verified statement of attorney's fees (including expert witness fees) and other costs, as appropriate, to the agency or Administrative Judge within thirty (30) days of receipt of the decision and must submit a copy of the statement to the agency. 29 C.F.R. § 1614.501(e)(2)(i).⁵

A statement of attorney's fees and costs must be accompanied by an affidavit executed by the attorney of record itemizing the attorney's charges for legal services. A verified statement of fees and costs shall include the following:

- a. a list of services rendered itemized by date, number of hours, detailed summary of the task, rate, and attorney's name;
- b. documentary evidence of reasonableness of hours, such as contemporaneous time records, billing records, or a reasonably accurate substantial reconstruction of time records;
- c. documentary evidence of reasonableness of rate, such as an affidavit stating that the requested rate is the attorney's normal billing rate, a detailed affidavit of another attorney in the community familiar with prevailing community rates for attorneys of comparable experience and expertise, a resume, a list of cases handled, or a list of comparable cases where a similar rate was accepted; and
- d. documentation of costs.

[National Ass'n of Concerned Veterans v. Secretary of Defense](#), 675 F.2d 1319 (D.C. Cir. 1982). A fee award may be reduced for failure to provide adequate documentation. If seeking an adjustment to the lodestar figure, the fee application shall clearly identify the specific circumstances of the case that support the requested adjustment. Id.

⁵ Where the Commission finds discrimination in a case in which the agency takes final action under 29 C.F.R. § 1614.110(a), the Commission will remand the case to the Administrative Judge for a determination of attorney's fees. Where the decision on appeal originates from a case handled exclusively by the agency (that is, where the complainant elected a final agency decision under 29 C.F.R. § 1614.110(b)), the Commission will remand the case to the agency for a determination of attorney's fees.

2. The agency may respond to the statement of fees and costs within 30 days of its receipt. If the agency contests the fee request, it must provide equally detailed documentation in support of its arguments. Id.
3. Discovery into the reasonableness of the hours or rate is permissible, but discouraged. The Administrative Judge has discretion to grant or deny permission to conduct discovery by interrogatory or document request.
4. The Administrative Judge or agency will issue a decision determining the amount of attorney's fees or costs due within 60 days of receipt of the statement and affidavit. 29 C.F.R. § 1614.501(e)(2)(ii)(A). The decision should provide a written explanation of any award of fees and costs, including, as appropriate, findings of fact, analysis, and legal conclusions. 29 C.F.R. § 1614.501(e)(2)(ii)(A). The decision must include a notice of right to appeal to the Commission.
5. The Commission encourages the parties to resolve fee and cost issues by negotiated settlement during the 30-day period for filing a fee petition. The Administrative Judge will not review a negotiated fee agreement for fairness or reasonableness, except in class cases.
6. If the Administrative Judge decides to bifurcate the liability and damages determinations in a case, the decision on liability should provide for entitlement to attorney's fees and the subsequent decision on damages should also include the determination of the amount of the award of fees and costs. The complainant's attorney should be directed to submit the statement of fees and costs within 30 days of receipt of the decision finding liability. The attorney may submit a supplemental petition for fees incurred during the damages phase of the case.

H. Miscellaneous Issues

1. An Administrative Judge may award interim fees pendente lite⁶ where the complainant has prevailed on an important non-procedural allegation of discrimination in the course of the case. [Hanrahan v. Hampton](#), 446 U.S. 754 (1980); [Trout v. Garrett](#), 891 F.2d 332 (D.C. Cir. 1989). However, interim awards should be granted only under special circumstances, such as where a complainant's attorney has invested substantial time and resources into a case over a long period of time.

⁶ Pendente lite is Latin for awaiting the litigation (lawsuit). It is applied to court orders (such as temporary child support) which are in effect until the case is tried, or rights that cannot be enforced until the lawsuit is over.

2. A prevailing complainant is entitled to an award of fees for time spent on a fee claim including time spent defending the award on appeal. [Southeast Legal Defense Group v. Adams](#), 657 F.2d 1118 (9th Cir. 1981); [Lund v. Affleck](#), 587 F.2d 75 (1st Cir. 1978). However, the Administrative Judge may reduce or eliminate fees for time spent on litigating the fee award where fee claims are exorbitant or the time devoted to preparing a fee claim is excessive. [Gagne v. Maher](#), 594 F.2d 336 (2d Cir. 1979), *aff'd*, [448 U.S. 122](#) (1980). A reasonableness standard applies. [Black v. Dep't. of the Army](#), EEOC Request No. 05960390 (Dec. 9, 1998).
3. Even absent a finding of discrimination, the Administrative Judge has authority to impose attorney's fees and costs as an appropriate sanction for refusal to obey discovery or other orders. 29 C.F.R. § 1614.109(f)(3)(v). For example, a complainant may be entitled to attorney's fees when the agency fails without good cause shown to respond to discovery requests, [Shine v. U.S. Postal Service](#), EEOC Appeal No. 01972201 (Dec. 12, 1998), or falsifies documents or testimony, [Wichy v. Dep't. of the Air Force](#), EEOC Appeal No. 01962972 (September 25, 1998). Fees and costs may be awarded for work associated with efforts to secure discovery compliance, even when the complainant does not prevail on the merits. [Stull v. Dep't. of Justice](#), EEOC Appeal No. 01942827 (June 15, 1995).
4. Attorney's fees are available for work pursuing claim for damages. [Rivera v. National Aeronautics & Space Administration](#), EEOC Appeal No. 0120111416 (July 19, 2011).

VII. COMPENSATORY DAMAGES

Compensatory damages are awarded to compensate a complaining party for losses or suffering inflicted due to the discriminatory act or conduct. See *Carey v. Piphus* 435 U.S. 247, 254 (1978)(purpose of damages is to “compensate persons for injuries caused by the deprivation of constitutional rights”). Compensatory damages “may be had for any proximate consequences which can be established with requisite certainty.” 22 Am Jur 2d Damages § 45 (1965) Compensatory damages include damages for past pecuniary loss (out-of-pocket loss), future pecuniary loss, and nonpecuniary loss (emotional harm). See [Goetze v. Dep’t. of the Navy](#), EEOC Appeal No. 01991530 (Aug. 23, 2001).

A. Entitlement to Seek Compensatory Damages

1. Pursuant to Section 102(a) of the Civil Rights Act of 1991, a complainant who establishes his/her claim of unlawful discrimination may receive, in addition to equitable remedies, compensatory damages for past and future pecuniary losses (that is, out of pocket expenses) and non-pecuniary losses (for example, pain and suffering, mental anguish). 42 U.S.C. § 1981a(b)(3). For an employer with more than 500 employees, the limit of liability for future pecuniary and non-pecuniary damages is \$300,000. Id. Complainants prevailing on claims under the Age Discrimination in Employment Act of 1967, as amended, and the Equal Pay Act of 1963, as amended, are not entitled to compensatory damages at the administrative level.
2. Under Section 102 of the Civil Rights Act of 1991, compensatory damages may be awarded for past pecuniary losses, future pecuniary losses, and non-pecuniary losses that are directly or proximately caused by the agency’s discriminatory conduct. However, Section 102 prohibits such awards for an employment practice that is unlawful because of its disparate impact. [Compensatory and Punitive Damages Available under Section 102 of the Civil Rights Act of 1991](#) (July 14, 1992).
3. However, Section 102 also provides that an agency is not liable for compensatory damages in cases of disability discrimination where the agency demonstrates that it made a good faith effort to accommodate the complainant’s disability.

An agency can demonstrate a good faith effort by proving that it consulted with the individual with a disability and attempted to identify and make a reasonable accommodation. [Schauer v. Social Security Administration](#), EEOC Appeal No. 01970854 (July 12, 2001); compare [Luellen v. U.S. Postal Service](#), EEOC Appeal No. 01951340 (Dec. 23, 1996) (agency demonstrated good faith effort where it consulted with complainant and

her physicians in attempting to identify a reasonable accommodation, despite the fact that these efforts were not sufficient to afford complainant a reasonable accommodation); [Morris v. Dep't. of Defense](#), EEOC Appeal No. 01962984 (Oct. 1, 1998) (agency did not make a good faith effort to identify and provide a reasonable accommodation for complainant where it did not make any attempt to find an available office position for complainant in spite of his repeated requests.).

4. The Commission may set out the amount of compensatory damages to be awarded by the respondent agency in its decisions. Alternatively, the Commission may remand the matter to the agency for a determination of the amount of compensatory damages.

B. Legal Principles

1. Non-Pecuniary Damages

Non-pecuniary damages are losses that are not subject to precise quantification including emotional pain and injury to character, professional standing, and reputation. Compensatory damages are awarded to compensate for losses or suffering inflicted due to discrimination. Punitive damages are not available against the federal government.

The particulars of what relief may be awarded, and what proof is necessary to obtain that relief, are set forth in detail in the Commission Notice No. 915.002, [Compensatory and Punitive Damages Available under Section 102 of the Civil Rights Act of 1991](#) (July 14, 1992). Briefly stated, the complainant must submit evidence to show that the agency's discriminatory conduct directly or proximately caused the losses for which damages are sought. *Id.* at 11-12, 14; [Rivera v. Dep't. of the Navy](#), EEOC Appeal No. 01934157 (July 22, 1994).

The amount awarded should reflect the extent to which the agency's discriminatory action directly or proximately caused harm to the complainant and the extent to which other factors may have played a part. [The Commission Notice No. 915.002, Compensatory and Punitive Damages Available Under Section 102 of the Civil Rights Act of 1991](#) (July 14, 1992) at 11-12. The amount of non-pecuniary damages should also reflect the nature and severity of the harm to the complainant, and the duration or expected duration of the harm. *Id.* at 14.

In [Carle v. Dep't. of the Navy](#), the Commission explained that "objective evidence" of non-pecuniary damages could include a statement by the complainant explaining how s/he was affected by the discrimination. EEOC Appeal No. [01922369](#) (Jan. 5, 1993). Non-pecuniary damages must be limited to

the sums necessary to compensate the injured party for the actual harm and should take into account the severity of the harm and the length of the time the injured party has suffered from the harm. [Carpenter v. Dep't. of Agriculture](#), EEOC Appeal No. 01945652 (July 17, 1995).

Objective evidence of compensatory damages can include statements from complainant concerning his emotional pain or suffering, inconvenience, mental anguish, loss of enjoyment of life, injury to professional standing, injury to character or reputation, injury to credit standing, loss of health, and any other non-pecuniary losses that are incurred as a result of the discriminatory conduct. *Id.* Statements from others including family members, friends, health care providers, or other EEO Counselors (including clergy) could address the outward manifestations or physical consequences of emotional distress, including sleeplessness, anxiety, stress, depression, marital strain, humiliation, emotional distress, loss of self-esteem, excessive fatigue, significant weight loss or gain, or a nervous breakdown. *Id.* Complainant's own testimony, along with the circumstances of a particular case, can suffice to sustain his burden in this regard. *Id.* The more inherently degrading or humiliating the defendant's action is, the more reasonable it is to infer that a person would suffer humiliation or distress from that action. *Id.*

Evidence from a health care provider or other expert is not a mandatory prerequisite for recovery of compensatory damages for emotional harm. See [Lawrence v. U.S. Postal Service](#), EEOC Appeal No. 01952288 (Apr. 18, 1996) (citing [Carle v. Dep't. of the Navy](#), EEOC Appeal No. 01922369 (Jan.. 5, 1993)). The absence of supporting evidence, however, may affect the amount of damages appropriate in specific cases. *Id.*

Non-pecuniary damages must be limited to compensation for the actual harm suffered as a result of the agency's discriminatory actions. See [Carter v. Duncan-Huggans, Ltd.](#), 727 F.2d 1225 (D.C. Cir. 1994); [The Commission Notice No. 915.002, Compensatory and Punitive Damages Available Under Section 102 of the Civil Rights Act of 1991](#) (July 14, 1992) at 13. A proper award should take into account the severity of the harm and the length of time that the injured party suffered the harm. See [Carpenter](#), *supra*. Additionally, the amount of the award should not be "monstrously excessive" standing alone, should not be the product of passion or prejudice, and should be consistent with the amount awarded in similar cases. See [Jackson v. U.S. Postal Service](#), EEOC Appeal No. 01972555 (Apr. 15, 1999), citing [Cygnar v. City of Chicago](#), 865 F. 2d 827, 848 (7th Cir. 1989). Finally, we note that in determining non-pecuniary compensatory damages, the Commission has also taken into consideration the nature of the agency's discriminatory actions. See [Utt v. U.S. Postal Service](#), EEOC Appeal No. 0720070001 (Mar. 26, 2009); [Brown-Fleming v. Dep't. of Justice](#), EEOC Appeal No. 0120082667 (Oct. 28, 2010).

2. Past Pecuniary Damages

Compensatory damages may be awarded for pecuniary losses that are directly or proximately caused by the agency's discriminatory conduct. See [The Commission Notice No. 915.002, Compensatory and Punitive Damages Available under Section 102 of the Civil Rights Act of 1991](#) (July 14, 1992) at 8. Pecuniary losses are out-of-pocket expenses incurred as a result of the agency's unlawful action, including job-hunting expenses, moving expenses, medical expenses, psychiatric expenses, physical therapy expenses, and other quantifiable out-of-pocket expenses. *Id.* Past pecuniary losses are losses incurred prior to the resolution of a complaint through a finding of discrimination, or a voluntary settlement. *Id.* at 8-9.

In a claim for pecuniary compensatory damages, complainant must demonstrate, through appropriate evidence and documentation, the harm suffered as a result of the agency's discriminatory action. [Rivera v. Dep't. of the Navy](#), EEOC Appeal No. 01934156 (July 22, 1994); [The Commission Notice No. 915.002, Compensatory and Punitive Damages Available Under Section 102 of the Civil Rights Act of 1991](#) (July 14, 1992), at 11-12, 14; [Carpenter v. Dep't. of Agriculture](#), EEOC Appeal No. 01945652 (July 17, 1995). Objective evidence in support of a claim for pecuniary damages includes documentation showing actual out-of-pocket expenses with an explanation of the expenditure. See [The Commission Notice No. 915.002, Compensatory and Punitive Damages Available Under Section 102 of the Civil Rights Act of 1991](#) (July 14, 1992) at 11-12; [Carle v. Dep't. of the Navy](#), EEOC Appeal No. 01922369 (Jan. 5, 1993). The agency is only responsible for those damages that are clearly shown to be caused by the agency's discriminatory conduct. *Id.* To recover damages, the complainant must prove that the employer's discriminatory actions were the cause of the pecuniary loss. [The Commission Notice No. 915.002, Compensatory and Punitive Damages Available Under Section 102 of the Civil Rights Act of 1991](#) (July 14, 1992) at 8.

3. Future Pecuniary Damages

Future pecuniary losses are losses that are likely to occur after resolution of a complaint. See [Compensatory and Punitive Damages Available under Section 102 of the Civil Rights Act of 1991](#), the Commission Notice No. 915.002 at 9 .

An award for the loss of future earning potential considers the effect that complainant's injury will have on her ability in the future to earn a salary comparable with what she earned before the injury. [Brinkley v. U.S. Postal Service](#), EEOC Request No. 05980429 (Aug. 12, 1999) citing [McKnight v. General Motors Corp.](#), 973 F.2d 1366, 1370 (7th Cir. 1992). Where complainant has shown that her future earning power has been diminished as a result of the agency's discrimination, the Commission has awarded future pecuniary damages for the loss of future earning capacity. See [Morrison v. U.S. Postal Service](#),

EEOC Appeal No. 07A50003 (Apr. 18, 2006) (citing [Brinkley](#), *supra*); [Hernandez v. U.S. Postal Service](#), EEOC Appeal No. 07A30005 (July 16, 2004). Proof of entitlement to loss of future earning capacity involves evidence suggesting that the individual's injuries have narrowed the range of economic opportunities available to her. [Carpenter v. Dep't. of Agriculture](#), EEOC Appeal No. 01945652 (July 17, 1995). Generally, the party seeking compensation for loss of earning capacity needs to provide evidence which demonstrates with reasonable certainty or reasonable probability that the loss has been sustained. *Id.*, (citing [Annotation, Evidence of Impaired Earnings Capacity](#), 18 A.L.R. 3d 88, 92 (1968)). Such evidence need not prove that the injured party will, in the near future, earn less than she did previously, but that “[her] injury has caused a diminution in [her] ability to earn a living.” [Carpenter](#), *supra*, (citing [Gorniak v. Nat’l R.R. Passenger Corp.](#), 889 F.2d 481, 484 (3d Cir. 1989)).

CHAPTER 12 SETTLEMENT AUTHORITY

I. INTRODUCTION

Public policy favors the amicable settlement of disputes. It is clear that this policy in favor of settlement of disputes applies particularly to employment discrimination cases. See, for example, [Sears Roebuck & Co. v. Equal Employment Opportunity Comm.](#), 581 F.2d 941 (D.C. Cir. 1978); [Shaw v. Library of Congress](#), 479 F. Supp. 945 (D.D.C. 1979). Agencies are encouraged to seek resolution of EEO complaints through settlement at any time during the administrative or judicial process. Agencies and EEO complainants should be creative in considering settlement terms. In this Chapter, we discuss the authority for settlements of EEO disputes and various options for those settlements.

II. AUTHORITY

Title VII of the Civil Rights Act of 1964 expressly encourages the settlement of employment discrimination disputes without litigation. Courts have consistently encouraged the settlement of discrimination claims and have upheld those settlements when challenged. See, for example, [Occidental Life Insurance Co. v. Equal Employment Opportunity Comm.](#), 432 U.S. 355 (1977); [Alexander v. Gardner-Denver Co.](#), 415 U.S. 36 (1974).

The Supreme Court held in [Chandler v. Roudebush](#), 425 U.S. 840 (1976), that federal employees have the same rights under the employment discrimination statutes as private sector employees, thus recognizing the right of federal employees to enter into voluntary settlements with federal agencies. As a result, Section 717 of Title VII of the Civil Rights Act of 1964 authorizes agencies to fashion settlements of EEO disputes in resolution of such claims. The same analysis applies to disputes brought under Section 501 or 505 of the Rehabilitation Act of 1973, Section 15 of the Age Discrimination in Employment Act of 1967, and the Equal Pay Act. See [Matter of Albert D. Parker](#), 64 Comp. Gen. 349 (1985).

Conciliation and voluntary settlement are critical to efforts to eradicate employment discrimination, both in the public and private sectors. The legislative history of Section 717 of Title VII is unequivocal in stressing that the broadest latitude exists in determining the appropriate remedy for achieving this end.¹

¹ [1. S. Rep. No. 92-415](#), 92nd Cong., 1st Sess. 15 (1971), reprinted in Senate Comm. on Labor and Public Welfare, 92nd Cong., 2d Sess., [Legislative History of the Equal Employment Opportunity Act of 1972](#), at 424 (Comm. Print 1972).

The Equal Employment Opportunity Commission's strong support for settlement attempts at all stages of the EEO complaint process is codified in 29 C.F.R. § 1614.603, which states, "Each agency shall make reasonable efforts to voluntarily settle complaints of discrimination as early as possible in, and throughout, the administrative processing of complaints, including the pre-complaint counseling stage."² Settlement agreements entered into voluntarily and knowingly by the parties are binding on the parties. Settlements may not involve waiver of remedies for future violations. Settlements of age discrimination complaints must also comply with the requirements of the Older Workers Benefits Protection Act, 29 U.S.C. § 626, involving waivers of claims. That is, a waiver in settlement of an age discrimination complaint must be knowing and voluntary.³

The Department of Justice's Office of Legal Counsel has affirmed the broad authority of agencies to settle EEO disputes by applying remedies a court could order if the case were to go to trial. In an opinion interpreting the authority of an agency to settle a Title VII class complaint, the Department's Office of Legal Counsel advised that a complainant can obtain in settlement whatever the agency concludes, in light of the facts and recognizing the inherent uncertainty of litigation, that a court could order as relief in that case if it were to go to trial. In the case it reviewed, which alleged discrimination in classification decisions, the Office of Legal Counsel determined that the agency could agree not to reclassify positions of specific employees downward because a court could enjoin reclassification of the positions of those employees if the court found some cognizable danger of recurrent violation. The Office of Legal Counsel found the proposed settlement valid under Title VII, even though the Office of Personnel Management contended that the agency's authority to reclassify pursuant to applicable statutes, rules, and regulations cannot be superseded by settlement.

The relief provided by an agency to settle an EEO dispute cannot be greater than the relief a court could order if that particular dispute were to go to trial. For example, assume that a GS-9 employee files an EEO complaint alleging discrimination in the denial of a promotion to the level of a GS-11. If the employee has met the time-in-grade and any other job-related requirements, it is appropriate to offer in settlement a retroactive promotion to GS-11. It would not be appropriate, however, to propose a promotion to a GS-12 position for which the employee has not met the requirements. However, if an individual was denied promotion to a GS-11 position and one or more

² One of the mechanisms for settling complaints is the offer of resolution, which is set forth in 29 C.F.R. § 1614.109(c). Offers of resolution are not, however, the only way to settle complaints; they are a particular method, which, in certain circumstances, can limit an agency's liability for attorney's fees and costs.

³ Section (f)(2) of the OWBPA in conjunction with Sections (f)(1)(A) through (E) set forth the minimum standards. A settlement agreement is knowing and voluntary when the complainant is given a reasonable period of time to consider the settlement agreement, and the waiver is worded in a reasonably understandable way, specifically refers to rights or claims under the ADEA, and does not waive future rights. In addition, the settlement agreement must provide something of value in exchange for the waiver and must advise the complainant to consult with an attorney before signing the agreement.

individuals who got the promotion at that time were subsequently promoted to GS-12 based on a career ladder, then it may be appropriate to offer a GS-12 position in settlement of the complaint.

On the other hand, parties are encouraged to be creative in resolving an employment dispute and may agree to settle a complaint for relief that may be different than that which a court might order, as long as it is no greater than what a court might order. For example, an agency may settle a complaint involving the termination of an employee by agreeing to pay for or provide outplacement services to help the former employee find a new job, provided that the cost of the outplacement services does not exceed the total monetary relief a court could order if the complainant were to prevail in the case. In another example, an agency could agree to reassign a complainant to a different supervisor or office in a settlement of a complaint, alleging discriminatory failure to promote, where the complainant and the supervisor who made the promotion decision do not get along.

III. TITLE VII AUTHORITY INDEPENDENT OF BACK PAY ACT

The Comptroller General of the United States has considered objections to settlements of EEO disputes in a number of cases. In these decisions, the Comptroller General has confirmed the authority of agencies to enter into settlements of EEO claims and considered ancillary questions about settlements.

In one of these decisions, the Comptroller General affirmed that Title VII contains authority for remedying employment discrimination and this authority is independent of the authority contained in the Back Pay Act to provide back pay only where a finding has been made of “an unwarranted and unjustified personnel action.” 5 U.S.C. § 5596. “The connection between Title VII and the Back Pay Act arises only because the Commission has provided in its regulations on remedial actions that when discrimination is found, an award of back pay under Title VII is to be computed in the same manner as under the Back Pay Act regulations.” [Equal Employment Opportunity Commission, Informal Settlement of Discrimination Complaints](#), 62 Comp. Gen. 239, 242 (1983). The authority to award back pay is derived from Title VII; the regulations borrow the formula for calculating the amount of back pay owed from the Back Pay Act.

The independent Title VII authority to settle EEO claims is significant because, unlike the Back Pay Act, Section 717 of Title VII does not limit awards of back pay to situations where there has been a finding of an unjustified or unwarranted personnel action. Thus, there is no impediment to an award of back pay as part of a settlement without a finding of discrimination.

When evaluating the risk of litigation versus the cost of settlement, agencies should include the cost of a federal retirement annuity in their consideration, if an annuity would

become payable immediately. This reflects the actual cost to the government of the proposed settlement and should be considered when deciding whether the settlement is in the interest of the government. This calculation may lead an agency to explore alternative solutions, such as purchasing a private annuity. The purchase of a private annuity may not be desirable in all instances, but can be considered as a possible alternative. Following are some examples that reflect this calculation:

1. An employee at a GS-14, step 10, separates at age 50 with 25 years of service. His only annuity eligibility is for a deferred annuity at age 62. The present value of this deferred benefit (when the employee is age 50) is \$259,992. If, under the terms of a settlement agreement, his separation is changed to an involuntary separation (thus entitling him to an immediate discontinued service retirement benefit), the value of the benefit is \$691,546. Thus, the cost to the government resulting from the settlement is the difference, or an additional \$431,554.
2. An employee at a GS-14, step 10, separates at age 55 with 30 years of service, and therefore is eligible for an immediate annuity. The value of this annuity is \$843,800. If, in settlement, she is retroactively promoted to a GS-15, step 10, for three years, the value of her annuity becomes \$992,669. This means the settlement costs the government an additional \$148,869 in retirement annuities.
3. An employee at GS-14, step 10, separates at age 56 with 30 years of service and is eligible for an immediate annuity valued at \$825,588. If, pursuant to a settlement, he is retroactively considered a law enforcement officer for 20 years of his federal career, the value of his retirement benefit becomes \$1,027,344. Thus, the settlement adds \$201,756 to the government's cost of his retirement.
4. An employee at a GS-14, step 10, separates at age 50 with 25 years of service. When the employee is 55, the value of her deferred annuity payable at age 62 is \$364,653. If the employee is returned to the agency's rolls for five years, enabling her to retire immediately, her retirement benefit has a value of \$1,044,361. This settlement would add \$679,708 to the government's costs.
5. In settlement, the level of a GS-12, step 10, employee is retroactively changed to GS-14, step 10, for a period of three years. Assuming that she is entitled to an immediate annuity, the value of her retirement benefit is raised from \$582,132 to \$817,945. Thus, the additional cost to the government of this settlement is \$235,813.

IV. NO FINDING OF DISCRIMINATION NECESSARY FOR SETTLEMENTS

It has long been the practice in both the private sector and the federal sector for

employers and agencies to enter into settlements that contain cash payments where there has been neither a finding of discrimination, either judicially or administratively, nor an admission by the employer or agency of any wrongdoing.

The Comptroller General has supported these settlements, stating “it is beyond question that an agency has the general authority to informally settle a discrimination complaint and to award back pay with a retroactive promotion or reinstatement in an informal settlement without a specific finding of discrimination.” [Equal Employment Opportunity Commission, Informal Settlement of Discrimination Complaints](#), 62 Comp. Gen. 239, 242 (1983).

V. CASH AWARDS WITHOUT CORRESPONDING PERSONNEL ACTIONS

Settlements of EEO disputes may contain monetary payments that are independent of any personnel action, provided that the monetary payment does not exceed the amount of back pay, attorney’s fees,⁴ costs, or damages⁵ the employee would have been entitled to in the case if discrimination had been actually found.

The Comptroller General has considered settlements of EEO disputes comprised of monetary payments unconnected to personnel actions on at least two occasions and held that they were authorized and appropriate:

[W]e conclude that Federal agencies have the authority in informally settling discrimination complaints filed under Title VII of the Civil Rights Act of 1964, as amended, to make awards of backpay, attorney’s fees, or costs, without a corresponding personnel action and without a finding of discrimination, provided that the amount of the award agreed upon must be related to backpay and may not exceed the maximum amount that would be recoverable under Title VII if a finding of discrimination were made.

Id. at 244; [Matter of Albert D. Parker](#), 64 Comp. Gen. 349 (1985).

VI. PERSONNEL ACTIONS WITH LUMP SUM PAYMENTS

An agency may informally settle an EEO complaint by providing a lump sum payment as

⁴ Attorney’s fees are not available during the administrative process of complaints brought under the Age Discrimination in Employment Act or the Equal Pay Act.

⁵ The Commission has the authority to award compensatory damages during the administrative process. [Gibson v. West](#), 527 U.S. 212 (1999). Agencies, therefore, are authorized to pay compensatory damages in a settlement during the administrative process. Compensatory damages should be calculated separately from back pay, other benefits, and fees and are limited to no more than \$300,000.

a retroactive personnel action in lieu of back pay. As long as the settlement does not exceed the relief to which the complainant would be entitled if a finding of discrimination had been made, it is authorized.

If the settlement provides for a retroactive personnel action, all appropriate contributions to the retirement funds must be made. Settlements may resolve claims actually made and also claims that could be made, provided that the factual predicate for the claims that could be made has occurred. For example, an agency may settle a complainant's formal complaint, alleging failure to promote and include relief for the complainant's retaliation claim, which has not been raised, except in the settlement discussions.

Since the Civil Rights Act of 1991 provided for award of compensatory damages in appropriate cases, settlements often provide for one lump sum amount covering monetary relief, even when there is a personnel action involved as well. In these cases, parties can agree to an overall figure in the settlement that represents damages, back pay, and attorney's fees. That figure can reflect the maximum amount a court could award, and need not be limited to an amount that the agency believes a complainant can prove in court. The settlement agreement does not need to contain a separate breakdown of the lump sum showing individual amounts of back pay, damages, and fees. The lump sum agreed to by the parties can be equal to or less than the total amount of back pay, damages, and fees that would be awarded if a finding of discrimination were made. A lump sum cannot, under any circumstances, exceed the amount that the agency concludes, in light of the facts and recognizing the inherent uncertainty of litigation, a court could award if a lawsuit were brought.

If a lump sum settlement is intended to award enhanced retirement benefits as part of its terms, the rates of basic pay or grade and step deemed to be received by the complainant, and the periods during which each rate of pay was received, must be specified in the settlement terms. OPM advises that if this specific information is not set out in the settlement document, the terms of the settlement will not be included in the calculation of the complainant's retirement benefits.

VII. IMPLEMENTING SETTLEMENT AGREEMENTS

There may be some instances where a proposed informal settlement appears to be at odds with normal personnel procedure or practice contained in regulations implementing Title 5 of the United States Code or processing guidance of the Office of Personnel Management. Such situations could arise where Office of Personnel Management regulations or guidance foresee personnel actions taken in the normal course of business and do not generally discuss personnel actions taken pursuant to court order or a settlement. Title VII provides authority to enter into settlements of EEO complaints,⁶

⁶ As noted earlier in this Chapter, the same analysis applies to EEO complaints filed under the Rehabilitation Act of 1973, the Age Discrimination in Employment Act of 1967, and the Equal Pay Act of 1963.

and, likewise, Title VII provides authority for agencies to effectuate the terms of those settlements.

Chapter 32, Section 6(b) of OPM's [Guide to Processing Personnel Actions](#) describes the procedure for documenting personnel actions taken as the result of a settlement agreement, court order, or Commission or MSPB decision. The purpose of this procedure is to protect the privacy of the employee.

Rather than including personal and irrelevant settlement information on the employee's SF-50, the SF-50 may be processed with the computer code "HAM." ("HAM" is a computer code that prints on the SF-50 a citation to 5 C.F.R. § 250.101.) If an agency's computer system does not permit the use of the citation "HAM," then the SF-50 may cite to 5 C.F.R. § 250.101. This section of the Code of Federal Regulations indicates that the personnel action is processed under an appropriate legal authority.

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**APPENDIX A EEO-MD-110
INTERAGENCY AGREEMENT
BETWEEN
THE U.S. [NON CONFLICT AGENCY]
AND
THE U.S. [AGENCY]**

A. Purpose, Authority, and Scope

The U.S. [Non Conflict AGENCY (hereinafter “NC Agency”) and the U.S. [AGENCY] (hereinafter “agency”) hereby agree that, in accordance with the terms of this Interagency Agreement (hereinafter “Agreement”) and the Economy Act, 31 U.S.C. § 1535, the NC agency shall assume responsibility for investigating the following Equal Employment Opportunity (EEO) complaint filed with the agency:

[Complainant] v. [AGENCY] [Case No.]

Through this interagency acquisition, the agency is obtaining needed investigative services from the NC agency on a reimbursable basis.

B. Responsibilities of the NC Agency

With respect to the matters identified in Part A of this Agreement, and pursuant to 29 C.F.R. § 1614.607, the agency herein officially delegates authority to the NC agency as follows:

1. The NC agency shall investigate the complaint in accordance with 29 C.F.R. § 1614.108(b)-(e).
2. The NC agency shall prepare an investigative file and an investigative summary.
3. Upon conclusion of the investigation, the NC agency shall forward the investigative file to the agency to continue processing in accordance with 29 C.F.R. Part 1614.

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With respect to the complaint identified under Part A of this Agreement, the agency agrees to assume the following responsibilities:

1. The agency shall transmit the complaint file to the NC agency for investigation within seven calendar days of the date that this Agreement is signed by the NC agency and received by the agency by fax or mail, whichever is earlier.
2. The agency shall cooperate fully with the NC agency staff assigned to the investigation of the complaint covered by this Agreement. This cooperation shall include, but not be limited to, the following:
 - a. making agency officials and employees available for interviews, conferences, and statements under oath with the NC agency at times and places designated by the NC agency, including any employees deemed by the NC agency to be witnesses necessary to furnish information pertinent to the complaint. This includes the obligation to provide official time to these employees and to pay their necessary travel expenses;
 - b. promptly responding to any written or oral requests for information received from the NC agency;
 - c. designating and making available an agency official who is authorized to discuss and enter into a voluntary settlement of the complaint; and
 - d. ensuring that the agency representative:
 - i. not request, or be provided with, any EEO complaint record document during the investigation;
 - ii. not be present when the investigator meets with a witness or a potential witness, except at the express request of the witness. Agency representatives may inform witnesses that they have the right to have an agency representative present when they meet with the investigator; and
 - iii. not speak to witnesses concerning their testimony prior to or during the investigation unless the contact with the agency representative was initiated by the witness.
3. Upon receipt of the investigative file from the NC agency, the agency will notify the complainant in accordance with 29 C.F.R. § 1614.108(f).

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- a. The agency will reimburse the NC agency, as provided below and in accordance with Parts D and E of this Agreement, actual costs associated with the NC agency's investigation, to include the following:
 - i. Reimbursement to the NC agency for all time spent by the assigned NC agency personnel to investigate the complaint and prepare the investigative file;
 - ii. Reimbursement to the NC agency for all time spent by the NC agency clerical personnel for clerical work related to the investigation of the complaint and preparation of the investigative file; and
 - iii. Reimbursement to the NC agency of standard rate factor (28%) of the salary rates reimbursed in Sections (i) and (ii), above, for benefits and other costs associated with the administration of this Agreement.
- b. The agency will pay, as provided below and in accordance with Parts D and E of this Agreement the following costs:
 - i. Payment for all air, hotel, per diem, and other travel expenses as authorized by the Federal Travel Regulations for travel by the NC agency personnel required to investigate the complaint;
 - ii. Payment for all costs for the services of a qualified court reporter (not an agency employee) to take verbatim affidavits or statements and prepare transcripts in connection with any investigative proceeding;
 - iii. Payment for all copying services of a commercial vendor determined to be necessary to reproduce the investigative file; and
 - iv. Payment for all other actual costs agreed to by agency prior to incurrence of the cost, as may be necessary to the NC agency's investigation of the complaint.

D. NC Agency's Right to Determine Investigative Method

The NC agency reserves the right to determine the investigative techniques and procedures to be utilized in the investigation of the complaint identified in Part A of this Agreement. In the event that the NC agency elects to have verbatim affidavits or statements of the witnesses made at fact-finding conferences or other investigative

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proceedings, the agency agrees, subject to a ten (10) working day advance request by the NC agency to take all necessary steps to procure the services of a qualified court reporter to transcribe investigative proceedings and to prepare transcripts of those proceedings. **The NC agency shall not arrange and provide court reporter services on a reimbursable basis.** All arrangements shall be made by the agency and all bills for transcription services and transcripts shall be sent directly to the agency. Such bills shall not be sent to the NC agency.

The agency is responsible for ensuring that a requested court reporter is available on the day and at the time and location specified by the NC agency. The original transcript of any proceeding and any copies ordered shall be sent directly to the NC agency within the time frame deemed necessary by the NC agency, but not later than **ten calendar days** from the date of the investigative proceeding.

E. Procedure for Reimbursement

1. Upon completion of the investigation, the NC agency shall present to the agency an itemized billing statement of the costs and expenses and the total hours expended by the assigned NC agency personnel for services related to the investigation of the complaint pursuant to Part C. 4. a. of this Agreement.

As appropriate, the itemized billing statement shall include a standard rate factor for employee benefits and administration (28%, as provided in Part C. 4. a. of this Agreement). The time expended by the assigned NC agency personnel investigating the complaint shall include time spent in a travel status and for other time spent on the investigation either during or after normal duty hours.

The statement shall also include a recitation of the total dollar amount to be reimbursed to the NC agency by the agency. Such amount shall be calculated by multiplying the total hours expended by the official hourly rate of the assigned NC agency personnel based on the individual's official grade and step and in accordance with the applicable federal pay schedule.

Upon presentation of the itemized billing statement, collection shall be effected by the NC agency via the U.S. Treasury's intra-governmental payment and collection system (IPAC) using the following agency accounting data:

Agency Location Code: _____
 Appropriation Code: _____
 DUNS/BPN Number: _____

Collection shall be made no later than **thirty calendar days** of the billing. The NC agency's liaison regarding billing is [Name], [phone number]. The agency's

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liaison regarding this Agreement is _____,
 _____ [please insert name, phone number].

2. In the event that the complaint is settled, withdrawn by the complainant, or canceled by the agency prior to the NC agency's completion of the investigation, the NC agency shall present the agency an itemized billing statement for all hours expended by the assigned NC agency personnel up to such time as the complaint is settled, withdrawn, or canceled and costs incurred by the NC agency.

3. Travel expenses relating to the investigation shall be paid by the agency at General Schedule Administration rates as travel is performed. **Travel shall not be arranged and paid for by the NC agency on a reimbursable basis.** When the agency's designated contact person for the complaint is notified by the NC agency that travel arrangements are necessary with respect to the investigation of the complaint, the contact person shall arrange or cause to be arranged all round-trip travel arrangements to include all airline scheduling and tickets, lodging accommodations at the destination and authorized per diem.

Prior to travel, the agency shall deliver the necessary airline tickets (either by paper or notification of availability of electronic ticket), confirmation of lodging arrangements, and any travel advance as authorized by the Federal Travel Regulations to the designated NC agency personnel. Upon completion of the travel, the NC agency shall present the agency with the necessary information and documents for the agency to prepare a travel claim for the signature of the personnel investigating the complaint. The agency shall promptly process and settle such travel claims.

F. Agreement Effective Date, Term Modification, and Termination

This Agreement will become effective when signed by both the agency and the NC agency and will remain in effect until completion of the investigation and final payment of costs as set forth herein is made by the agency, the complaint is settled, withdrawn by the complainant or cancelled by the agency and final payment of costs as set forth herein is made by the agency. The NC agency and the agency may modify this Agreement by written consent. The NC agency or the agency may terminate this Agreement by giving 30 days advance written notice to the other.

Should a disagreement arise on the interpretation of the provisions of this agreement, or amendments and/or revisions thereto, that cannot be resolved at the operating level, the area(s) of disagreement shall be stated in writing by each party and presented to the other party for consideration. If agreement on interpretation is not reached within thirty (30) days, the parties shall forward the written presentation of the disagreement to respective higher officials for appropriate resolution.

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G. Signatures and Date

FOR THE U.S. [AGENCY]:

[Name]

Date

[Title]

FOR THE U.S. [NC AGENCY]:

[Name]

Date

[Title]

APPENDIX B EEO-MD-110 EEO COUNSELING TECHNIQUES

This attachment can be used to develop or refine counseling techniques when traditional counseling is selected. Below are suggested methods to follow in each step of the counseling process.

EEO counseling consists of the following steps:

1. Preparing for the effort
2. Holding discussions
3. Assessing the situation
4. Determining appropriate resolution technique(s)
5. Using informal resolution technique(s)

In reviewing each step, the EEO Counselor must remember that each informal resolution situation will be different and each EEO Counselor will have his/her own style. There will probably be times when the EEO Counselor will need to make modifications to fit the situation.

A. Meeting with the Aggrieved Person

1. Initial Actions

- a. Upon contact by an aggrieved person, the EEO Counselor should record the date and set an appointment for the initial counseling session to discuss the dispute. Before the initial meeting, the EEO Counselor should advise the aggrieved person of his/her right to be accompanied, advised, and represented by a representative at any stage in the complaint process, including the counseling stage, and explain the reasonable accommodation(s) available throughout the EEO process.

Also, the EEO Counselor must advise the aggrieved person that the aggrieved person will remain anonymous during counseling unless s/he chooses not to remain anonymous. 29 C.F.R. § 1614.105(g).

- b. The EEO Counselor should begin the initial meeting with the aggrieved person by explaining the role of the EEO Counselor. The EEO Counselor should then give him/her an opportunity to explain the problem. The EEO Counselor should create an atmosphere which is open to good communication and dialogue.
- c. The EEO Counselor should listen attentively in order to get an understanding of the issues involved (the facts as the aggrieved person sees them and the action(s) alleged to be discriminatory). Once the aggrieved person has had the opportunity to relate the dispute fully, the EEO Counselor will be in a better position to define the claims(s) and

basis(es) involved, determine if the problem comes under the purview of the anti-discrimination laws, and determine if special procedures apply.

- d. The EEO Counselor should find out if the aggrieved person tried to resolve the problem or brought the problem to the agency's attention before seeking counseling and, if so, how. Part of the problem might be that s/he did not use the appropriate mechanisms to handle the problem prior to seeking counseling and, if properly handled, the problem may be easily resolved.
- e. The EEO Counselor should ask the aggrieved person whether s/he is willing to meet with agency officials.
- f. If the dispute is to be handled under Part 1614, the EEO Counselor should provide the aggrieved person with an overview of informal counseling and the discrimination complaint process under Part 1614, including required notifications and time frames, and answer any questions s/he may have about counseling and the complaint process.
- g. If a dispute involves employment discrimination and the aggrieved person chooses to have his/her case processed by the agency, the EEO Counselor must provide counseling, regardless of whether the EEO Counselor believes the case has merit.

2. Disputes Not Involving Discrimination

After listening to and asking questions of the aggrieved person, it may become apparent that s/he is not alleging discrimination on one or more of the bases protected by the anti-discrimination laws. For example, a person may allege that s/he was the target of reprisal for union activities. In the absence of facts to show that the union activities are related to participation in protected EEO activities or related to opposing discriminatory practices, the EEO Counselor can offer other alternatives for redress.

3. Disputes Involving Prohibited Discrimination

When the dispute involves an allegation of discrimination, the EEO Counselor should proceed with the initial counseling session and do the following:

- a. Determine whether special procedures apply (i.e., mixed case, negotiated grievance procedure, or age). Also, advise the aggrieved individual how the agency's EEO alternative dispute resolution (ADR) process works in counseling and of the aggrieved person's option to choose EEO ADR during the counseling stage of the process where the agency agrees to offer EEO ADR in the particular case.

- b. Find out as many specifics as possible concerning the individual's reasons for believing discrimination has occurred.
- c. Ask the aggrieved person what it would take, in his/her view, to resolve the problem. For example: The aggrieved person alleges race discrimination in an agency's selection of trainees for a computer training program. The EEO Counselor should determine what the aggrieved person will accept to resolve the problem. Suppose the aggrieved person will accept being placed at the top of the agency's waiting list for the next available opening. The EEO Counselor may be able to resolve this dispute by presenting the offer to agency officials as a first step. If the agency agrees, the EEO Counselor has avoided the need to formulate a resolution strategy.

Learning early on exactly what it is that the aggrieved person is seeking may well provide the basis for a prompt resolution and save everyone time.

- d. Make sure the aggrieved person understands that s/he cannot be forced to agree to any proposed solutions or to reach an agreement with the agency and that s/he may file a formal complaint.
- e. Conclude the initial EEO counseling session by making sure that the procedural requirements of 29 C.F.R. Part 1614 were followed and that enough information was obtained to attempt resolution.

B. Meeting with Agency Officials

- 1. Explain the aggrieved person's allegations and summarize the reasons or facts s/he gave for believing there has been discrimination. The aggrieved person's name can be used only if anonymity has been waived in writing.
- 2. Explain or answer any questions about EEO counseling and the federal complaint process. Emphasize that the EEO Counselor's role is to attempt to resolve a dispute. If counseling is successful and resolution is reached, then the need to file a formal complaint is avoided.
- 3. Give the agency an opportunity to present its position on the matters raised by the aggrieved person and ask agency officials to suggest ways the problem might be resolved.
- 4. Try to get a sense of the relationship between the aggrieved person and the responding agency official (assuming the aggrieved person did not request anonymity). Is the relationship hostile, perhaps because of past dealings? Is the agency official interested in meeting with the aggrieved person?

5. Make sure that agency officials understand that the agency cannot be forced to enter into an agreement as a result of EEO counseling.

C. **Considering Factors in Situation**

The EEO Counselor's approach to a given situation will depend on several factors, including the following:

1. Nature of the alleged discriminatory acts and characteristics of the dispute between the parties.
2. Relationship between the aggrieved person and the agency.
3. Whether the EEO Counselor must gather facts beyond those provided by the aggrieved person and the agency.
4. Acceptance by the aggrieved person and the agency of various resolution techniques.
5. The EEO Counselor's willingness to participate in various resolution techniques.

D. **Conducting the Inquiry**

1. **Focus on the Issue(s) and Basis(es)**

The EEO Counselor may be required to interview witnesses and review agency records. An inquiry into an EEO dispute begins when the EEO Counselor attempts to gather information following the initial meeting with the aggrieved person. Upon completion of this initial meeting with the aggrieved person, the claim(s) raised should be clearly defined and the basis(es), *i.e.*, race, color, sex (including equal pay, pregnancy, transgender, and sex stereotypes), religion, national origin, age, reprisal, genetic information, and/or disability, identified. The EEO Counselor should keep in mind that the aggrieved person is best able to assist in defining the issue(s) since s/he is an involved party. The EEO Counselor should not conclude an initial interview with the aggrieved party without a clear understanding of the issue(s) and basis(es).

The direction the inquiry will take depends upon the EEO Counselor's understanding of the issue(s) and basis(es). If the issue(s) involves a personnel action, it will be necessary to identify the action with as much specificity as possible. For example, if the aggrieved person alleges discrimination in a promotion action, the EEO Counselor must at least determine the position applied for, and whether the aggrieved person was qualified, was on the list of best qualified candidates, was interviewed, and whether a selection was made. This information will help to focus the inquiry on the specific portion of the personnel action at issue. The EEO Counselor must include dates to ensure that the dispute

was raised in a timely manner. For those issues that involve actions other than personnel actions documented by an SF-50, the data gathering approach is the same, but gathering information can be more difficult.

2. Data Gathering from Witnesses and Agency Records

- a. Once the claims(s) and basis(es) are defined, the EEO Counselor will need to determine if it is necessary to gather information from sources other than the aggrieved person and agency representative in order to attempt resolution. Potential sources of information could include witnesses and written documentation or records.

If the EEO Counselor determines that witness interviews are necessary, s/he should attempt to interview witnesses who have direct knowledge of a particular situation. The EEO Counselor should limit witness interviews to those persons who can provide information that will help the EEO Counselor better understand the dispute so that resolution can be attempted. Sometimes witness interviews will be the only source of information other than information obtained from the aggrieved person and the agency. Such disputes would include allegations of harassment, either sexual or otherwise, or situations where the issue raised is one of inappropriate conduct or treatment based on a prohibited reason.

- b. Early in the process, the EEO Counselor must determine what documents control the action taken; *i.e.*, whether there is a written agency procedure that must be followed in certain situations. For example, if the issue involves a promotion action, the EEO Counselor should decide if it is necessary to review the applicable promotion plan and, if so, determine where the plan is maintained. The EEO Counselor may be able to obtain needed information from official personnel folders, supervisors' working files, or wherever the personnel action is maintained, such as a promotion folder. By making inquiries, the EEO Counselor will soon learn where such documents are kept and who maintains the records.

When looking at individual records, the EEO Counselor should keep in mind that his/her role is to achieve informal resolution at the lowest possible level, so the number of records reviewed should be kept to a minimum. Only records of the aggrieved person and of those who allegedly received different, more favorable treatment should be examined in an effort to achieve informal resolution.

The EEO Counselor's first contact may be at the personnel office, but the EEO Counselor may determine other sources for obtaining needed documents.

For situations which EEO Counselors encounter often, the following types of issues will require review of certain records:

- (1) Promotion - The promotion folder should include the vacancy announcement, job description, ranking/rating factors, and SF- 171 or applications of at least the aggrieved person and the selectee. The EEO Counselor should notify the personnel office that an EEO inquiry was made concerning a promotion action. The EEO Counselor should request that documents relating to the promotion action, which might ordinarily be destroyed, be retained while the inquiry is pending.
- (2) Time and Attendance - Agency regulations/orders on time and attendance, time and attendance records of the aggrieved person and person(s) the aggrieved person is comparing himself/herself to, and how each is treated.
- (3) Training - Agency procedures for requesting and recommending training, any forms required, and training approved or denied with reason(s).
- (4) Appraisal/Rating - Agency regulations/orders on system implementation and administration, elements and standards, performance requirements, rating of the aggrieved person, and ratings prepared by same rating and/or reviewing official of similarly situated employees.

- c. In reviewing documentation, the EEO Counselor should copy only documents needed in the discussions that will follow the initial inquiry. Notes should be kept, but the identity of comparators should not be revealed to the aggrieved person. Review of documents should be restricted to those that relate to the issue(s) raised by the aggrieved person and are necessary to resolve the concerns informally at the lowest possible level.

EEO counseling will often involve the use of various techniques to bring about early resolution. For example, it may include:

- (1) Holding separate meetings, followed by joint meetings, and then telephone contact to work out details of an agreement;
- (2) Holding a joint meeting to set forth the facts as both sides see them, followed by separate meetings with the parties in which the various possibilities for resolution are explored; or
- (3) Conducting a conference call or separate telephone calls to the

parties during which the dispute is resolved. Care should be taken to protect anonymity unless waived.

E. Developing a Resolution Strategy for 30-Day Counseling Period

1. Joint Meetings (An aggrieved person must agree to a joint meeting)

a. Advantages:

- (1) Gives the aggrieved person and the agency an opportunity to present the facts as each sees them and to clarify points of confusion or misunderstanding.
- (2) Gives the parties an opportunity to explore directly with each other the means for resolving issues underlying the problems.
- (3) Helps the parties establish a more constructive working relationship by getting a better understanding of each other's concerns.
- (4) Enables the parties to "shake hands" on any agreements reached and to work together to put them in writing.
- (5) Allows the EEO Counselor better control of the process, making sure that the parties treat each other as equals and that threats or coercion are not used.

b. Disadvantages:

- (1) Risks a blow-up, a hardening of positions, and increased antagonism.
- (2) May require the parties to call a recess to explore changes in position with others (e.g., counsel).
- (3) May be difficult to schedule.
- (4) Can be costly when the parties are in different locations.

c. The EEO Counselor Should Use This Approach When:

- (1) The parties' positions are based on different facts or different perceptions of the same facts.
- (2) The parties have not had an opportunity to talk with each other or would like a way to reopen discussions.

- (3) The EEO Counselor is confident that s/he will be able to control the joint meeting.

2. Separate Meetings

a. Advantages:

- (1) Allows the EEO Counselor to learn more about the parties' specific concerns and priorities.
- (2) Allows the EEO Counselor to explore alternatives.
- (3) Allows the parties to ask questions they do not want to ask in front of the other party.
- (4) Prevents the possibility of intimidation.
- (5) May be easier to schedule than a joint meeting.

b. Disadvantages:

- (1) May lead the parties to wonder what the EEO Counselor is saying to the other side.
- (2) Unless the resolution reached through separate meetings is re-stated in a joint meeting or through a conference call, the parties do not have the opportunity to talk with each other to make sure each has the same interpretation of the agreement. It is easier for the parties to blame the EEO Counselor for any future misunderstanding about the resolution.
- (3) May put the EEO Counselor in the position of having to pass messages back and forth between parties. Misunderstanding of the messages may occur in their transmission.

c. The EEO Counselor Should Use This Approach When:

- (1) The parties' hostility and antagonism can get in the way of substantive discussions.
- (2) The EEO Counselor needs a better understanding of issues and priorities to be able to control a subsequent joint meeting.
- (3) The EEO Counselor needs to help one or both parties be realistic about possible solutions.

- (4) Scheduling is a problem.
- (5) The parties do not have a current relationship.
- (6) One party is afraid to meet with the other.

3. **Telephone Communication**

a. **Advantages:**

- (1) May be easier to schedule and quicker than joint meetings.
- (2) Less costly.
- (3) For advantages of conference calls, refer to advantages of joint meetings.
- (4) For advantages of separate calls, refer to advantages of separate meetings.

b. **Disadvantages:**

- (1) Impersonal communication resulting from the inability to see how the person is responding to what is said. Harder to gain the rapport needed to explore issues and alternatives.
- (2) For disadvantages of conference calls, refer to disadvantages of joint meetings. Note: It may be easier to hang up the telephone than leave a meeting chaired by an EEO Counselor.
- (3) For disadvantages of separate calls, refer to disadvantages of separate meetings.

c. **The EEO Counselor Should Use This Approach When:**

- (1) The parties are in different locales and are not logistically able to meet face to face.
- (2) The issues are comparatively easy to deal with, such as those based on a misunderstanding or incorrect information.
- (3) The EEO Counselor needs more information to determine if counseling is productive, and scheduling a meeting for this purpose is too time-consuming.

4. Attempting Resolution

When the EEO Counselor has a good grasp of the issues involved and has decided on which EEO counseling technique to use, s/he is ready to attempt resolution. Resolution of an EEO problem means that the aggrieved person and the agency come to terms with a problem and agree on a solution. The EEO Counselor should generally concentrate on resolving individual cases independently; but, when appropriate, the EEO Counselor should ask for assistance from the EEO Director in reaching a solution or correcting a problem. When asking the EEO Director for help, the EEO Counselor should relate what s/he has learned in the inquiry (using the aggrieved person's name only if s/he has given permission) and be prepared to recommend specific action.

There is no set formula for a EEO Counselor to follow in attempting a resolution using the techniques described. The EEO Counselor can attempt resolution by talking with the parties separately or together. The EEO Counselor can talk with them together only if the aggrieved person has given permission; otherwise, they must be spoken with separately.

The following subsections highlight barriers faced when attempting resolution and provide guidance on how to attempt resolution using the EEO counseling techniques of joint meetings, separate meetings, and telephone communication.

5. Obstacles to Informal Resolution

In order to resolve an EEO dispute, the agency and the aggrieved person must agree on a solution. However, only the agency has the authority to resolve an EEO dispute. Like most situations involving two parties, the EEO Counselor can expect obstacles to resolution of EEO disputes. These obstacles can be put up by both parties. The challenge is to overcome these obstacles and work out a solution.

Sometimes obstacles can be overcome by bringing the parties together and having them candidly discuss their attitude toward working out a solution. Other times, obstacles can be lessened by helping the parties explore possible outcomes if the dispute is escalated to the formal complaint level. However, the EEO Counselor must recognize that not all obstacles can be overcome and attempts at resolution should end when it is apparent that the parties are unable to come to an agreement.

a. Some agency obstacles are listed below:

- (1) "There was no discrimination so nothing should be done."
- (2) "The decision at issue was correctly made, procedures were correct, and nothing should be done for the aggrieved person."

- (3) “Resolution will encourage frivolous complaints.”
- (4) “Subordinates and supervisors will lose respect for a manager who settles rather than fights.”
- b. Aggrieved persons may also impose obstacles to successful resolutions of problems. Such obstacles may include:
 - (1) “Discrimination must be punished.”
 - (2) “My manager must be disciplined.”
 - (3) “My manager must apologize.”
 - (4) “No remedy is sufficient.”
 - (5) “The agency must pay punitive damages.”¹

F. Attempting Resolution Using the Joint Meeting Technique

This subsection outlines the steps and activities involved in arranging and conducting joint meetings. The EEO Counselor should make sure the aggrieved person has consented to joint meetings with the agency before arranging a joint meeting.

1. Arranging a Joint EEO Counseling Session

- a. The EEO Counselor should select a location convenient for both parties.
- b. The EEO Counselor should arrange a date and time convenient to both parties, but as soon as possible.
- c. If there does not seem to be a mutually acceptable time for the parties to meet, consider the following questions:
 - (1) Is there a suitable and feasible alternative to the joint meeting? If so, the EEO Counselor should use it.
 - (2) Does the scheduling problem appear to be real, or does it appear to be a delaying tactic?

¹Under the Civil Rights Act of 1991, punitive damages are not available against a federal employer.

- (3) If the scheduling problem appears to be real, how do the parties feel about postponing the meeting? Would a request for an extension make resolution within 30 days impossible?
 - (4) If the scheduling problem is more of a delaying tactic and if there is no suitable alternative to a joint meeting, the EEO Counselor should terminate counseling.
- d. The EEO Counselor should determine who will be attending the meeting and let all parties know who will be present.
- e. The EEO Counselor should let the parties know the way the meeting will be run and suggest ways the parties can prepare for the meeting. Each party should understand that the EEO Counselor chairs the meeting but will not take a position on the merits of either party's position or the merits of any proposed solutions made by the parties, and that the EEO Counselor will not make decisions for the parties.
- f. The EEO Counselor should explain that the purpose of the meeting is to provide each party with an opportunity to present the facts and problems as each sees them, to clarify the issues, to establish points of agreement and disagreement, and to explore the possibility of some form of voluntary resolution acceptable to both parties.
- g. The EEO Counselor should suggest that the parties review the facts of the case as they know them and think about what it would take to resolve the problem as they see it.
- h. The EEO Counselor should point out the confidentiality of discussions to both parties.
- i. If, at the last minute, one of the parties calls to cancel, the EEO Counselor should try to determine if the reason is legitimate. If it appears it is, the EEO Counselor should reschedule the meeting as quickly as possible. If rescheduling becomes a problem, an alternative to the joint meeting **should** be explored. If there is a question about the reason for cancellation or if a party cancels more than one meeting, the EEO Counselor should decide whether informal resolution efforts should be terminated.

2. Conducting a Joint EEO Counseling Session

The EEO Counselor should:

- a. Start the meeting on time.

- b. Make sure everyone at the table knows everyone else and the reason each person is there.
- c. Set the tone and establish ground rules. This is the time to restate the purpose of the meeting, the EEO Counselor's role, and the role and responsibility of the parties.
- d. Work with the parties toward resolution.
- e. Prepare to handle the unexpected.
 - (1) If one party does not appear for the meeting, the EEO Counselor should find out why. Discuss the issues involved with the party who does appear. Try to get a sense of what it would take to resolve the dispute. See if the party is interested in continuing EEO counseling and is willing to reschedule the meeting.
 - (2) If one of the parties is about to break off discussions and leave in a huff, the EEO Counselor should try to calm the parties down and do the following:
 - Help both parties save face by getting them to put aside emotions and address the problem.
 - Talk to the parties separately, if necessary.
 - Not dwell on the incident if discussions resume, but remind the parties that a resolution does not have to be achieved and that it is okay to agree to disagree and to end informal resolution. The EEO Counselor can explain to the parties that a decision to end informal resolution efforts should be a conscious, deliberate one, not one simply made in a moment of anger.
- f. If one of the parties accuses the EEO Counselor of bias and asks the EEO Counselor to leave, the EEO Counselor should leave provided the other party is willing to continue the meeting without the EEO Counselor. If the other party is not willing to continue, the meeting should be adjourned.
 - (1) Later, if appropriate, the EEO Counselor can clarify what happened and try to regain acceptance.
 - (2) Apologize for any misconceptions that might have been created.
 - (3) Decide whether to terminate EEO counseling.

3. Ending the Joint EEO Counseling Session

A joint EEO counseling session can end in one of the following ways:

- a. With a resolution. The EEO Counselor should explain that s/he will draw up a written agreement to be signed by both parties.
- b. Without resolution but with an agreement to keep trying. The EEO Counselor should explain that she will arrange the next meeting. Keep in mind the requirement, pursuant to 29 C.F.R. § 1614.105(d), to conduct the final interview no later than the 30th day of initial contact by the aggrieved person, unless the aggrieved person and the EEO Director (or his delegate) agrees in writing to postpone the final interview. 29 C.F.R. § 1614.105(e).
- c. Without a resolution and with a decision to end EEO counseling. The EEO Counselor should explain to the aggrieved person that s/he will set up a final counseling session at which time the EEO Counselor will explain the next steps.

The EEO Counselor should make sure that each party agrees on the way the meeting is ending.

G. Attempting Resolution Using the Separate Meeting Technique

1. What Should Be Done Up Front

Separate EEO counseling sessions with each party can be used in place of or to supplement joint meetings. If separate meetings are to be used, the parties should know:

- a. That the EEO Counselor will be meeting separately with the parties.
- b. The purpose of the meetings.
- c. That what is said in the meetings is intended to be confidential.
- d. That the EEO Counselor will not serve as an advisor to the parties or comment directly on the substance of a proposal.

2. Handling Special Situations

The following paragraphs describe situations which may occur in separate meetings and suggest ways each situation might be handled.

- a. The agency concedes directly or indirectly that there may be some merit to what the aggrieved person sees as a problem.
 - (1) The EEO Counselor can explore alternative solutions to the problem, for example, suggesting that the agency consult with appropriate officials to review the dispute and merits with a view towards possible resolution. The EEO Counselor should consult with his/her EEO Director to discuss the dispute before a suggestion is made to the agency to consult with legal counsel.
 - (2) The EEO Counselor must be careful not to prejudge a case because a formal investigation may not find the situation to be as the parties described it.
 - (3) The EEO Counselor may assist the agency and the aggrieved person in reaching an acceptable resolution of the dispute.
- b. The aggrieved person concedes directly or indirectly that there may be no merit to the allegations. (S/he thinks that there was unfair treatment, but it may not have been in violation of the anti-discrimination laws and regulations.) In such a case, the EEO Counselor can examine alternative solutions to the problem.
- c. The parties may ask the EEO Counselor for his/her opinion regarding the strength of the allegation. The EEO Counselor should:
 - (1) Inform the parties that s/he cannot comment on the strength or weakness of a given situation.
 - (2) Let the parties judge the strength and weakness of an allegation.

H. Attempting Resolution Using Telephone Communication

The general procedures outlined for joint and separate meetings also apply to telephone conference calls and separate telephone calls to each party. However, at the start of the conversation the EEO Counselor should:

- 1. Ask if anyone else is on the line.
- 2. Remind parties that recording the conversation is prohibited.

APPENDIX C EEO-MD-110 EEO COUNSELOR CHECKLIST

At the initial counseling session, EEO Counselors must advise individuals in writing of their rights and responsibilities. At a minimum those rights include the following:

- a. The right to anonymity.
- b. The right to representation throughout the complaint process including the counseling stage. The EEO Counselor should make clear to the aggrieved person that the EEO Counselor is not an advocate for either the aggrieved person or the agency, but acts strictly as a neutral in the EEO process.
- c. The right to choose between the agency's EEO alternative dispute resolution (ADR) process or EEO counseling, where the agency agrees to offer EEO ADR in the particular case, and information about each procedure.
- d. The possible election requirement between a negotiated grievance procedure and the EEO complaint procedure. See Chapter 4, Section III of this Management Directive.
- e. The election requirement in the event that the claim at issue is appealable to the Merit Systems Protection Board (MSPB), i.e., the dispute is a mixed case. See Chapter 4, Section II of this Management Directive.
- f. The requirement that the aggrieved person file a complaint within 15 calendar days of receipt of the EEO Counselor's Notice of Right to File a Formal Complaint in the event s/he wishes to file a formal complaint at the conclusion of counseling or EEO ADR.
- g. The right to file a notice of intent to sue when age is alleged as a basis for discrimination and of the right to file a lawsuit under the ADEA instead of an administrative complaint of age discrimination, pursuant to § 1614.201(a).
- h. The right to go directly to a court of competent jurisdiction on claims of sex-based wage discrimination under the Equal Pay Act even though such claims are also cognizable under Title VII.¹

¹ Sex-based claims of wage discrimination may also be raised under Title VII; individuals so aggrieved may thus claim violations of both statutes simultaneously. Equal Pay Act complaints may be processed administratively under Part 1614. In the alternative, a complainant in the EPA claim may go directly to a court of competent jurisdiction.

- i. The right to request a hearing before a Commission Administrative Judge, except in a mixed case, after 180 calendar days from the filing of a formal complaint or after completion of the investigation, whichever comes first.
- j. The right to an immediate final decision after an investigation by the agency in accordance with § 1614.108(f).
- k. The right to go to U.S. District Court 180 calendar days after filing a formal complaint or 180 days after filing an appeal.
- l. The duty to mitigate damages, for example, that interim earnings or amounts that could be earned by the individual with reasonable diligence generally must be deducted from an award of back pay.
- m. The duty to keep the agency and the Commission informed of his/her current mailing address and to serve copies of appeal papers on the agency.
- n. Where counseling is selected, the right to receive in writing within 30 calendar days of the first counseling contact (unless the aggrieved person agrees in writing to an extension) a notice terminating counseling and informing the aggrieved of:
 - (1) the right to file a formal individual or class complaint within 15 calendar days of receipt of the notice,
 - (2) the appropriate official with whom to file a formal complaint, and
 - (3) the complainant's duty to immediately inform the agency if the complainant retains counsel or a representative. Any extension of the counseling period may not exceed an additional sixty (60) calendar days.
- o. Where the aggrieved person agrees to participate in an established EEO ADR program, the written notice terminating the counseling period will be issued upon completion of the dispute resolution process or within ninety (90) calendar days of the first contact with the EEO Counselor, whichever is earlier.
- p. That only those claims raised at the counseling stage or claims that are like or related to those that were raised may be the subject of a formal complaint, and how to amend a complaint after it has been filed.

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- q. The identity and address of the Commission field office to which a request for a hearing must be sent in the event that the aggrieved person files a formal complaint and requests a hearing pursuant to 29 C.F.R. § 1614.108(g).
- r. The name and address of the agency official to whom the aggrieved person must send a copy of the request for a hearing. The EEO Counselor should advise the aggrieved person of his/her duty to certify to the Administrative Judge that s/he provided the agency with a copy of a request for a hearing. See also Chapter 7, Section I of this Management Directive.
- s. The time frames in the complaint process.
- t. The class complaint procedures and the responsibilities of a class agent, if the aggrieved person informs the EEO Counselor that s/he wishes to file a class complaint. See Chapter 8, Section II of this Management Directive.
- u. That rejection of an agency's offer of resolution made pursuant to 29 C.F.R. § 1614.109(c) may result in the limitation of the agency's payment of attorney's fees or costs. See Chapter 6, Section XIII of this Management Directive.
- v. That the agency must consolidate two or more complaints filed by the same complainant after appropriate notice to the complainant. See 29 C.F.R. § 1614.606. The EEO Counselor should advise the complainant that when a complaint has been consolidated with one or more earlier complaints, the agency shall complete its investigation within the earlier of 180 days after the filing of the last complaint or 360 days of the filing of the first complaint and that the complainant may request a hearing before a Commission Administrative Judge at any time after 180 days of the filing of the first complaint.
- w. The proper contact to request any needed reasonable accommodations to navigate the EEO process.

APPENDIX D EEO-MD-110 INFORMATION ON OTHER PROCEDURES

A. Negotiated Grievance Procedures in Collective Bargaining Agreements

1. Aggrieved Person Makes Election

At the initial counseling session, the EEO Counselor must inform the aggrieved person of the possible applicability of the election of remedies provisions from the Civil Service Reform Act of 1978, 5 U.S.C. § 7121(d), concerning negotiated grievance procedures.

- a. In order for an aggrieved person to be covered under 5 U.S.C. § 7121(d), both of the following conditions must be met:
 - (1) S/he must be employed in a federal agency subject to the provisions of 5 U.S.C. § 7121(d); and
 - (2) S/he must be covered by a collective bargaining agreement at the agency where the grievance arises. The agreement must also permit allegations of discrimination to be raised in the negotiated grievance procedure.
- b. If these conditions are met, then the EEO Counselor must inform the aggrieved person that 5 U.S.C. § 7121(d) applies. This means that the aggrieved person must be informed of the requirement that s/he choose one (not both) of the following:
 - (1) a right to have his/her allegations of discrimination addressed in the negotiated grievance procedure of the collective bargaining agreement with a caution that the opportunity to raise allegations of discrimination will be lost if not raised in the grievance process; or
 - (2) a right to have his/her allegations of discrimination addressed under 29 C.F.R. Part 1614.
 - (3) An election to proceed under Part 1614 is indicated only by the filing of a formal complaint, in writing. Use of the pre-complaint process does not constitute an election to proceed under Part 1614.
 - (4) Allegations of discrimination that are raised by employees not covered by 5 U.S.C. § 7121(d) are to be processed as EEO complaints under Part 1614 regardless of whether they are also pursuing a grievance on the same claim (for example, a five-day

suspension from work) under a collective bargaining agreement not covered by 5 U.S.C. § 7121(d).¹

- (a) Under § 1614.301(c), the complaint may be held in abeyance while the grievance on the same claim is processed. The abeyance shall terminate without further notice upon the issuance of a final decision on the grievance. The complaint may be held in abeyance only if the aggrieved is provided written notice of the abeyance.
- (b) The notice of abeyance shall state that the abeyance is instituted pursuant to 29 C.F.R. § 1614.301(c) and that time limits for processing the complaint contained in 29 C.F.R. § 1614.106 and for appeal to the Commission contained in 29 C.F.R. § 1614.402 will also be held in abeyance until fifteen (15) days following the issuance of the final decision on the grievance.
- (c) If the EEO complaint is held in abeyance, the time limits for processing are tolled until a final decision is rendered in the grievance process.

2. Election Is Final

- a. Pursuant to 29 C.F.R. § 1614.301, EEO Counselors are required to inform an aggrieved person that once s/he decides which forum s/he will use the negotiated grievance procedure in a collective bargaining agreement covered by 5 U.S.C. § 7121(d) or Part 1614 the aggrieved person is precluded from using the other forum to address the same claim. This preclusion holds regardless of whether discrimination is actually raised. For example, if an aggrieved person elects to have a dispute involving a claim of discrimination addressed under the terms of a collective bargaining agreement by filing a grievance, s/he could not also file a formal complaint of discrimination under Part 1614 on the same claim. This bar to a subsequent formal EEO complaint would hold true even if the complainant failed to raise the discrimination claim in the grievance, as long as the grievance process could have addressed the discrimination allegations.
- b. If an agency issues a decision rejecting the grievance either because the individual is not covered by the collective bargaining agreement, the collective bargaining agreement does not contain a provision that allows allegations of discrimination to be raised in the grievance process, or the

¹Employees of the U.S. Postal Service, the Postal Regulatory Commission, and the Tennessee Valley Authority are not subject to 5 U.S.C. § 7121(d).

grievance was untimely filed, the agency shall include appeal rights to the Commission. The case shall be processed as a complaint under Part 1614. 29 C.F.R. § 1614.301(b).

3. Appeals

Unless the grievance is a mixed case, the complainant has the right to appeal a final decision on his/her grievance that contains a discrimination allegation to the Commission as provided in subpart D of 29 C.F.R. Part 1614. If the grievance is a mixed case, the complainant has the right to appeal to MSPB.

B. Mixed Cases

1. MSPB Mixed Case Complaints and Appeals

In addition to negotiated grievance procedures, an aggrieved person may present an allegation that constitutes a mixed case. A mixed case is one which alleges discrimination in connection with a claim which is also appealable to the MSPB. Two criteria determine whether a case is a mixed case.

- a. The employee has standing to file an appeal to the MSPB; and
- b. The allegations which form the basis of the discrimination complaint can be appealed to the MSPB.

For information on who can file and the actions that can be appealed to the MSPB, see 5 C.F.R. § 1201.3.

2. Choosing a Forum

If both criteria for a mixed case are met, the EEO Counselor must notify an aggrieved person that s/he must choose the forum in which s/he wishes to proceed. Where a negotiated grievance can also be filed, the EEO Counselor must explain that the aggrieved person must choose to proceed in one of three forums: the MSPB appeal process, the internal EEO process, or the negotiated grievance process (see Section A.1 above).

- a. The EEO Counselor is initially responsible for identifying mixed cases and for advising aggrieved persons of their right to pursue the claim as a mixed case complaint or as a mixed case appeal. The EEO Counselor must identify mixed cases early in order to ensure that aggrieved persons are fully informed of their complaint processing options.
- b. An aggrieved person may choose to raise allegations of discrimination in a mixed case either as an appeal to the MSPB (“mixed case appeal”) or as a discrimination complaint with the agency under 29 C.F.R. Part 1614

(“mixed case complaint”) but not both. Whichever action the employee files first is considered an election to proceed in that forum.

- c. An election to proceed under 29 C.F.R. Part 1614 is made when the aggrieved person files a formal complaint in writing. Use of the EEO counseling process is not an election to proceed under Part 1614.
- d. If an employee chooses to file an appeal with the MSPB on a mixed case, the agency must thereafter dismiss any subsequently filed complaint on the same claim, regardless of whether the allegations of discrimination are raised in the appeal to the MSPB. Upon dismissal, the agency must advise the employee to raise the allegations of discrimination in connection with his/her appeal to the MSPB.
- e. Where the agency disputes MSPB jurisdiction, (for timeliness, coverage, or any other reason), the agency shall notify the complainant that it is holding the mixed case complaint in abeyance until the MSPB Administrative Judge rules on the jurisdictional issue. During this period, all time limitations for processing or filing will be tolled. An agency decision to hold a mixed case complaint in abeyance is not appealable to the Commission.

If the MSPB Administrative Judge finds that the MSPB has jurisdiction over the claim, the agency shall dismiss the mixed case complaint under 29 C.F.R. § 1614.107(a)(4).

- f. If the employee elects to file a mixed case complaint under Part 1614, the agency must process the complaint in a manner substantially similar to any other discrimination complaint, except that the employee is not entitled to a hearing before a Commission Administrative Judge. An aggrieved person’s appeal rights will be to the MSPB, not the Commission. Following a final decision from the MSPB, an aggrieved person may petition the Commission to consider that decision as it pertains to the allegations of discrimination.

3. Constructive Discharge

A discriminatory constructive discharge occurs when the employer discriminatorily creates working conditions that are so difficult, unpleasant, or intolerable that a reasonable person in the aggrieved person’s position would feel compelled to resign. In other words, the aggrieved person is essentially forced to resign under circumstances where the resignation is tantamount to the employer’s termination or discharge of the employee.

Similarly, in coerced or involuntary retirement cases, the aggrieved person alleges that s/he was essentially forced to retire, for example, because of age, and the

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retirement decision was not voluntary. Discriminatory coercion or involuntary retirement allegations are, if supported, tantamount to the employer discharging the employee.

a. MSPB dismissal may “unmix” a case

An employee with MSPB appeal rights who alleges that s/he was constructively discharged or coerced into retirement because of discrimination should be advised to file a mixed case complaint or a mixed case appeal. Where the merits of the claim of discrimination cannot be reached for lack of jurisdiction, the case will be considered no longer mixed.

b. An unmixed appeal–referral to counseling

If an aggrieved person files a mixed case appeal with the MSPB and the MSPB dismisses the appeal for lack of jurisdiction, the agency shall promptly notify the individual in writing of the right to contact an EEO Counselor within forty-five (45) days of receipt of this notice and to file an EEO complaint, subject to 29 C.F.R. § 1614.107. The complaint will be processed as a non-mixed case. See 29 C.F.R. § 1614.302(b).

c. A complainant in a case that becomes an “unmixed” complaint after completion of the agency’s investigation and subject to the notice set forth at 29 C.F.R. § 1614.108(f) need not be referred back to EEO counseling and the 29 C.F.R. § 1614.108(f) notice should be issued.

d. When a mixed case complaint is “unmixed” by a finding by the MSPB of no jurisdiction, the individual has a right to elect between a hearing before a Commission Administrative Judge or an immediate final decision. See 29 C.F.R. § 1614.302(b).

C. **Age Discrimination in Employment Act Complaints**

When a person contacts an EEO Counselor with a complaint of age discrimination, the EEO Counselor must make the person aware of two important options:

1. The person may choose to file a formal complaint under 29 C.F.R. Part 1614; or
2. The person may bypass the administrative complaint process in Part 1614 and file a civil action directly in an appropriate U.S. District Court after first giving the Commission not less than thirty (30) days notice of intent to file such action. Such notice must be filed within 180 days after the date of the alleged discrimination. The notice may be mailed to the Commission Headquarters at the following address:

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Equal Employment Opportunity Commission
 Office of Federal Operations
 Federal Sector Programs
 P.O. Box 77960
 Washington, DC 20013

hand delivered to:

Equal Employment Opportunity Commission
 Office of Federal Operations
 Federal Sector Programs
 131 M Street N.E.
 Suite 5SW12G
 Washington, DC 20507

or sent by facsimile to:

(202) 663-7022

3. Because it is not clear which statute of limitations applies, an aggrieved person choosing to bypass the administrative process should initiate the civil action as soon as possible after the expiration of the 30-day waiting period that follows the notice of intent to sue.

D. Equal Pay Act

1. When a person contacts an EEO Counselor with a complaint of wage-based sex discrimination, the EEO Counselor should advise the person that s/he may file a civil action in a U.S. District Court within two years, or three years if the violation is willful, of the date of the alleged violation, regardless of whether s/he has pursued an administrative action against the agency. The EEO Counselor further should advise the person that the filing of an EEO complaint under Part 1614 alleging a violation of the EPA does not toll the time for filing a civil action.
2. The EEO Counselor further should advise the person that if s/he seeks to allege a violation of Title VII's prohibition against sex discrimination based on the same allegation, s/he must raise the Title VII allegation in the administrative process even if s/he files a civil action on the EPA allegation.
3. The EEO Counselor also should advise the person that notwithstanding the two/three-year limitations period applicable to the current action under the EPA, in order to present an administrative EPA claim, the aggrieved person must contact an EEO Counselor within forty-five (45) days of the date the aggrieved person becomes aware of or reasonably suspects a violation of the EPA.

E. Discrimination Based on Marital Status, Political Affiliation, Status as a Parent**1. Laws Enforced By the Commission -**

Discrimination based on an individual's status as a parent (prohibited under Executive Order 13152) is not a covered basis under the laws enforced by the Commission. However, there are circumstances where discrimination against caregivers may give rise to sex discrimination under Title VII or disability discrimination under the ADA. See [Enforcement Guidance: Unlawful Disparate Treatment of Workers with Caregiving Responsibilities](#).

Federal government employees may file claims of discrimination under the Part 1614 EEO process on any of the bases covered under the laws the Commission enforces, and/or may also utilize additional complaint procedures provided by their agency or described below.

2. **Civil Service Reform Act** - The Civil Service Reform Act of 1978 (CSRA), as amended, also protects federal government applicants and employees from discrimination in personnel actions (see [“Prohibited Personnel Practices”](#)) based on race, color, sex, religion, national origin, age, disability, marital status, political affiliation, or on conduct which does not adversely affect the performance of the applicant or employee -- which can include sexual orientation or transgender (gender identity) status. The [Office of Special Counsel \(OSC\)](#), and the [Merit Systems Protection Board \(MSPB\)](#), enforce the prohibitions against federal employment discrimination codified in the CSRA. For more information, see [Addressing Sexual Orientation and Gender Identity Discrimination in Federal Civilian Employment](#) and OPM’s [Guidance Regarding the Employment of Transgender Individuals in the Federal Workplace](#) and OSC’s [Prohibited Personnel Practices and How to File a Complaint](#).
3. **Executive Orders** - Additionally, federal agencies retain procedures for making complaints of discrimination on any bases prohibited by Executive Orders.

For Example,

Executive Order 13152 states that “status as a parent” refers to the status of an individual who, with respect to an individual who is under the age of 18 or who is 18 or older but is incapable of self-care because of a physical or mental disability, is: a biological parent, an adoptive parent, a foster parent, a stepparent, a custodian of a legal ward, in loco parentis over such individual, or actively seeking legal custody or adoption of such an individual. The Executive Order authorized OPM to develop guidance on the provisions of the Order.

APPENDIX E EEO-MD-110
(SAMPLE)
NOTICE OF POSSIBLE APPLICABILITY OF
5 U.S.C. § 7121(d) TO ALLEGED DISCRIMINATORY ACTION
(29 C.F.R. PART 1614)

Section 1614.105 of the regulations of the U.S. Equal Employment Opportunity Commission requires that upon an aggrieved person's initial contact with the Equal Employment Opportunity (EEO) Counselor, or as soon thereafter as possible, the EEO Counselor shall inform each aggrieved person of the possible applicability of 5 U.S.C. § 7121(d) to the alleged discriminatory action which caused the aggrieved person to seek EEO pre-complaint counseling. Further, the EEO Counselor must communicate to the aggrieved person the substance of 29 C.F.R. § 1614.301 concerning the election of remedies.

Section 1614.301 (Relationship to Negotiated Grievance Procedure) provides as follows:

- (a) When a person is employed by an agency subject to 5 U.S.C. § 7121(d) and is covered by a collective bargaining agreement that permits claims of discrimination to be raised in a negotiated grievance procedure, a person wishing to file a complaint or a grievance on a claim of alleged employment discrimination must elect to raise the claim under either Part 1614 or the negotiated grievance procedure, but not both. An election to proceed under this part is indicated only by the filing of a written complaint; use of the pre-complaint process as described in 29 C.F.R. § 1614.105 does not constitute an election for purposes of this section. An aggrieved employee who files a complaint under this part may not thereafter file a grievance on the same claim. An election to proceed under a negotiated grievance procedure is indicated by the filing of a timely written grievance. An aggrieved employee who files a grievance with an agency whose negotiated agreement permits the acceptance of grievances which allege discrimination may not thereafter file a complaint on the same claim under Part 1614 regardless of whether the agency has informed the individual of the need to elect or of whether the grievance has raised an issue of discrimination. Any such complaint filed after a grievance has been filed on the same claim shall be dismissed without prejudice to the complainant's right to proceed through the negotiated grievance procedure, including the right to appeal to the Commission from a final decision as provided in subpart D of this part. The notice of final action dismissing such a complaint shall advise the complainant of the obligation to raise discrimination in the grievance process and of the right to appeal the final grievance decision to the Commission.
- (b) When a person is not covered by a collective bargaining agreement that permits claims of discrimination to be raised in a negotiated grievance procedure, claims of discrimination shall be processed as complaints under this part.
- (c) When a person is employed by an agency not subject to 5 U.S.C. § 7121(d) and is covered by a negotiated grievance procedure, claims of discrimination shall be

Appendix E EEO-MD-110**August, 2015**

processed as complaints under this part, except that the time limits for processing the complaint contained in 29 C.F.R. § 1614.106 and for appeal to the Commission contained in § 1614.402 may be held in abeyance during processing of a grievance covering the same claim as the complaint if the agency notifies the complainant in writing that the complaint will be held in abeyance pursuant to this section.

Accordingly, if you are alleging discrimination on the grounds of race, color, religion, sex, national origin, age, disability, genetic information and/or reprisal and if you wish to pursue the claim, you must make an election to pursue it either as a complaint with your agency under 29 C.F.R. Part 1614 or in a negotiated grievance procedure, if the following conditions apply:

1. You are an employee of a federal agency subject to the provisions of 5 U.S.C. § 7121(d), and
2. You are covered by a collective bargaining agreement which permits claims of discrimination to be raised in a negotiated grievance procedure.

If those two conditions apply to you, then you must elect one or the other procedure but not both. An election is made as follows:

1. By filing a grievance in writing (whether or not the grievance has raised a claim of discrimination), or
2. By filing a written formal EEO complaint with your agency under Part 1614. Use of the pre-complaint process (counseling) under 29 C.F.R. § 1614.105 does not constitute an election.

If you have further questions concerning the possible applicability of 5 U.S.C. § 7121(d) to you, you should immediately contact a representative of the employee organization which has a negotiated agreement with your agency or ask the EEO Counselor for further information and assistance.

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APPENDIX F EEO-MD-110 SAMPLE RESOLUTION AGREEMENT

Aggrieved Person's Name
Aggrieved Person's Address

RE: Resolution of EEO Dispute

Dear [Aggrieved Person]:

This refers to the dispute which you first discussed with me on [DATE] when you alleged discrimination because of [IDENTIFY BASIS OF DISCRIMINATION] when on [IDENTIFY DATE OF ALLEGED DISCRIMINATORY EVENT] the following occurred: [IDENTIFY ALLEGED]_____.

_____ The purpose of this letter is to set out the terms of the informal resolution.

[INSERT TERMS OF RESOLUTION]_____
_____.

If you believe the agency has not complied with the terms of the informal resolution, you may, under 29 C.F.R. § 1614.504, notify the Director of Equal Employment Opportunity in writing within 30 days of the date of the alleged violation, requesting that the terms of the informal agreement be specifically implemented. Alternatively, you may request that the claim be reinstated for further processing from the point processing ceased.

The agency has signed the terms of the resolution as indicated by the signature of the agency official. Your signature and date below will verify your receipt of this letter and will signify your agreement with the terms of the informal resolution of this dispute as set out above. Enclosed is a duplicate copy of this letter. Please date and sign the original and the copy in the spaces provided and return the copy to me for inclusion in the counseling file. I will send a signed copy to the agency. You may keep the original.

Sincerely,

EEO Counselor

Date:

Agency Official

Date:

Aggrieved Person

Date:

Note: Be sure any agreement is put through the proper channels to ensure the agreement is enforceable and any other rights are also written in the agreement.

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APPENDIX G EEO-MD-110
NOTICE OF RIGHT TO FILE A DISCRIMINATION COMPLAINT
(SAMPLE)

SUBJECT: Notice of Right to File a Discrimination Complaint

FROM: EEO Counselor

DATE:

TO: (Name of Person Counseled)

This is to inform you that because the dispute you brought to my attention has not been resolved to your satisfaction, you are now entitled to file an individual or class-based discrimination complaint based on race, color, religion, sex, national origin, physical or mental disability, age, genetic information, and/or reprisal. If you file a complaint, it must be in writing, signed, and filed within fifteen (15) calendar days after receipt of this notice, with any of the following officials authorized to receive discrimination complaints:

- Field Installation Head
(Provide name and address)
- Agency Director of Equal Employment Opportunity
(Provide name and address)
- Agency Head
(Provide name, title, and address)
- Other Official(s) as designated by the Agency, for example, an agency Equal Employment Opportunity Officer, the Hispanic Program Coordinator, the Disability Program Coordinator, or the Federal Women's Program Coordinator
[Provide name(s) and address(es)]

A complaint shall be deemed timely if it is received or postmarked before the expiration of the 15-day filing period, or in the absence of a legible postmark, if it is received by mail within five days of the expiration of the filing period.

If you file your complaint with one of the officials listed above (other than the EEO Director), it will be sent to the activity's EEO Director for processing. Therefore, if you choose to file your complaint with any of the other officials listed above, be sure to provide a copy of your complaint to the EEO Director to ensure prompt processing of your complaint.

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The complaint must be specific and contain only those issues either specifically discussed with me or issues that are like or related to the issues that you discussed with me. It must also state whether you have filed a grievance under a negotiated grievance procedure or an appeal to the Merit Systems Protection Board on the same claims.

If you retain an attorney or any other person to represent you, you or your representative must immediately notify the EEO Director, in writing. You and/or your representative will receive a written acknowledgment of your discrimination complaint from the appropriate agency official.

If you file a complaint, you should name _____ (The EEO Counselor should provide the name and title of the agency head or department head. Agency or department means the national organization, and not just the local office, facility, or department in which the aggrieved person might work.)

(Signature Block)
EEO Counselor

NOTE:

A copy of this notice must be provided to the EEO Director with the EEO Counselor's Report and will be made a part of the complaint file.

You may contact _____ (provide name and contact information) if a reasonable accommodation is needed to navigate the EEO process.

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Appendix H EEO MD-110

**APPENDIX H EEO-MD-110
EEO COUNSELOR'S REPORT
29 C.F.R. § 1614.105**

I. REQUIRED ELEMENTS

A. AGGRIEVED PERSON

Name: _____

Job Title/Series/Grade: _____

Place of Employment: _____

Work Phone No.: _____

Home Phone No.: _____

Home Address: _____

B. CHRONOLOGY OF EEO COUNSELING

Date of Initial Contact: _____

Date of Initial Interview: _____

Date of Alleged Discriminatory Event: _____

45th Day after Event: _____

Reason for delayed contact beyond 45 days, if applicable:

Date Counseling Report Requested: _____

Date Counseling Report Submitted: _____

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Appendix H EEO MD-110**August, 2015****C. BASIS(ES) FOR ALLEGED DISCRIMINATION**

- 1) ☐ Race (Specify)_____
- 2) ☐ Color (Specify)_____
- 3) ☐ National Origin (Specify)_____
- 4) ☐ Sex (Male, Female, LGBT)_____
- 5) ☐ Pregnancy Discrimination_____
- 6) ☐ Age (Date of Birth)_____
- 7) ☐ Mental Disability (Specify)_____
- 8) ☐ Physical Disability (Specify)_____
- 9) ☐ Religion (Specify)_____
- 10) ☐ Equal Pay (Specify)_____
- 11) ☐ Genetic Information (Specify)_____
- 12) ☐ Reprisal (Identify earlier event and/or opposed
practice, give date)_____

D. PRECISE DESCRIPTION OF THE ISSUE(S) COUNSELED**E. REMEDY REQUESTED****F. EEO COUNSELOR'S CHECKLIST - THE EEO COUNSELOR ADVISED THE AGGRIEVED PERSON IN WRITING OF THE RIGHTS AND RESPONSIBILITIES CONTAINED IN THE EEO COUNSELOR CHECKLIST.****II. SUMMARY OF INFORMAL RESOLUTION ATTEMPTS****A. IF THE EEO COUNSELOR ATTEMPTED RESOLUTION**

1. Personal Contacts
2. Documents Reviewed

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3. Summary of Informal Resolution Attempt

- B. IF AGGRIEVED OPTED FOR EEO ADR, EEO COUNSELOR'S STATEMENT THAT THE EEO ADR PROCESS WAS FULLY EXPLAINED TO THE AGGRIEVED INDIVIDUAL/SUMMARY OF INFORMATION GIVEN TO THE AGGRIEVED INDIVIDUAL AND THE AGENCY BY THE EEO COUNSELOR

_____ Name of EEO Counselor	_____ Telephone Number
_____ Signature of EEO Counselor	_____ Office Address
_____ Date	

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EEOC APPENDIX I EEO-MD-110

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APPENDIX J EEO-MD-110

**MODEL FOR ANALYSIS
DISPARATE TREATMENT**

PRIMA FACIE CASE

- 1) Membership in protected group
- 2) Complainant treated differently from similarly situated employees not in protected group
 - a) Were compared employees in same chain of command as complainant?
 - b) Were compared employees in same work unit as complainant?

OR

In the absence of comparative evidence, is there other evidence that indicates that the agency's actions may have been motivated by discrimination?¹

OR

Is there direct evidence that shows discriminatory intent?

REBUTTAL

What did the agency say was the reason for its treatment of complainant and the compared employees/applicants? How did the agency respond to other evidence, if any, of discrimination?

PRETEXT

Is there direct or circumstantial evidence that the agency's reason for its treatment of complainant is pretextual?

¹In this model and in the models set forth below, keep in mind the Supreme Court's decision in O'Connor v. Consolidated Coin Caterer's Corp., 517 U.S. 308 (1996), in which the Court ruled that comparative evidence is not an essential element of a prima facie case of discrimination. In the absence of such evidence, the complainant must come forward with other evidence sufficient to create an inference of discrimination.

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APPENDIX J-2 EEO-MD-110

**MODEL FOR ANALYSIS
HIRING/PROMOTION**

PRIMA FACIE CASE

- 1) Complainant is a member of a protected group.
- 2) Was there a vacancy?
- 3) Did complainant apply?
- 4) Was complainant qualified; was complainant rejected?
- 5) Was the vacancy filled? If so, was the selectee a member of complainant's protected group?

OR

Is there direct evidence that shows discriminatory intent?

REBUTTAL

What did the agency say was the reason for rejecting complainant?

PRETEXT

Is there direct or circumstantial evidence that the agency's reason for rejecting complainant is pretextual?

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APPENDIX J-3 EEO-MD-110

**MODEL FOR ANALYSIS
DISCHARGE/DISCIPLINARY ACTION**

PRIMA FACIE CASE

- 1) Complainant is a member of a protected group.
- 2) Was complainant qualified for the position s/he was performing?
- 3) Was the complainant satisfying the normal requirements of the position?
- 4) Was the complainant discharged or otherwise disciplined?
- 5) Was the complainant replaced by an employee outside the protected group or was s/he singled out for discharge or discipline while similarly situated employees were retained or not comparably disciplined?

OR

Is there direct evidence that shows discriminatory intent?

REBUTTAL

What did the agency say was the reason for disciplining complainant?

PRETEXT

Is there direct or circumstantial evidence that the agency's reason for discipline or discharge of complainant is pretextual? For example, did the agency treat other individuals with similar performance problems more favorably than complainant?

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APPENDIX J-4 EEO-MD-110

**MODEL FOR ANALYSIS
RETALIATION**

PRIMA FACIE CASE

- 1) Had the complainant previously engaged in protected activity or opposed unlawful discrimination?
- 2) Was the agency aware of complainant's activity?
- 3) Was complainant contemporaneously or subsequently adversely affected by some action of the agency?
- 4) Does some connection exist between complainant's activity and the adverse employment decision (for example, the adverse employment decision occurred within such a period of time that a retaliatory inference arises)?

OR

Is there direct evidence that shows discriminatory intent?

REBUTTAL

What did the agency say was the reason for the adverse employment decision?

PRETEXT

Is there direct or circumstantial evidence that the agency's reason for the employment decision is pretextual?

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APPENDIX J-5 EEO-MD-110

**MODEL FOR ANALYSIS
DISABILITY--REASONABLE ACCOMMODATION**

PRIMA FACIE CASE -- Where Complainant Alleges a Failure to Provide a Reasonable Accommodation:

- 1) Does complainant have a physical or mental impairment (for example, deafness; blindness; partially or completely missing limbs or mobility impairments requiring the use of a wheel chair; intellectual disability (formerly termed mental retardation); autism; cerebral palsy; major depressive disorder; bipolar disorder; post-traumatic stress disorder; obsessive compulsive disorder; schizophrenia; cancer; diabetes; epilepsy; HIV infection; multiple sclerosis; and muscular dystrophy) that is readily observable or where there is medical documentation of the impairment?
- 2) Does this impairment, when active and not taking into account any mitigating measures employed by the complainant, substantially limit complainant's ability to perform a major life activity (for example, caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working) or substantially limits a major bodily function? If not readily observable then provide evidence on the activities affected, how they are affected, and the degree to which they are affected (can't do the activity at all, can only do the activity with assistive devices or equipment, can only do the activity for a limited period of time, *etc.*). The question of whether an individual meets the definition of disability under 29 C.F.R. § 1630.(c)(4) should not demand extensive analysis.
- 3) Does the agency know of the complainant's disability?
- 4) Is the complainant otherwise qualified (that is, does the complainant, with or without accommodation, meet the education, skills, and experience requirements of the job)?
- 5) What are the essential functions, (for example, the outcomes that must be achieved by a person in that position, not the methods by which those outcomes are typically achieved) of the complainant's job?
- 6) Did complainant request accommodation? What accommodation, if any, did the complainant suggest?
- 7) What action did the agency take to identify possible accommodation or attempt accommodation? Did the agency make an individualized assessment of the complainant,

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comparing his/her qualifications and limitations with the job requirements? What actions did the agency take to consider the complainant's suggested accommodations?

- 8) If an accommodation has been identified, will this accommodation enable complainant to perform the essential functions of the job, that is, is it effective?
- 9) Did the agency provide an accommodation?
- 10) If the agency did not provide an accommodation, what reason has the agency given for its refusal?
- 11) If the agency contends that a particular accommodation would impose an undue hardship on its operations, are these reasons sufficient to establish an undue hardship defense given:
 - a) the overall size of the agency's program (the number of employees, number and type of facilities and size of budget);
 - b) the type of agency operation (composition and structure of work force);
 - c) the nature and net cost of accommodation.

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APPENDIX J-6 EEO-MD-110

**MODEL FOR ANALYSIS
DISABILITY--DISPARATE TREATMENT**

PRIMA FACIE CASE -- Where Complainant Alleges Disparate Treatment

- 1) Does complainant have a physical or mental impairment (for example, deafness; blindness; partially or completely missing limbs or mobility impairments requiring the use of a wheel chair; intellectual disability (formerly termed mental retardation); autism; cerebral palsy; major depressive disorder; bipolar disorder; post-traumatic stress disorder; obsessive compulsive disorder; schizophrenia; cancer; diabetes; epilepsy; HIV infection; multiple sclerosis; and muscular dystrophy) that is readily observable or where there is medical documentation of the impairment?
- 2) Does this impairment, when active and not taking into account any mitigating measures employed by the complainant substantially limit complainant's ability to perform a major life activity (for example, caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working) or substantially limits a major bodily function? If not readily observable then provide evidence on the activities affected, how they are affected, and the degree to which they are affected (can't do the activity at all, can only do the activity with assistive devices or equipment, can only do the activity for a limited period of time, etc.). The question of whether an individual meets the definition of disability under 29 C.F.R. § 1630.(c)(4) should not demand extensive analysis.
- 3) Does complainant have a record or history of a substantially limiting impairment (from which complainant may have recovered in whole or in part)?

OR

Was complainant regarded as having such an impairment (whether or not the complainant has an impairment or a substantially limiting impairment)?

- 4) Does the agency know of complainant's disability?
- 5) Is complainant qualified to perform the essential functions of the job with or without reasonable accommodation:
 - a. Is complainant otherwise qualified (that is, does the complainant, with or without accommodation, meet the educational and experience requirements of the job)?

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- b. What are the essential functions, (for example, the outcomes that must be achieved by a person in that position, not the methods by which those outcomes are typically achieved) of complainant's job?
 - c. Can complainant perform the essential functions of the job with or without accommodation? If an accommodation is necessary, see Model for Analysis -- Disability -- Reasonable Accommodation, Attachment J-5.
- 6) Was complainant treated differently from similarly situated employees who were not disabled or who had different disabilities?
- a. Were compared employees in the same chain of command?
 - b. Were compared employees in the same work unit?

OR

Is there direct evidence which shows discriminatory intent?

REBUTTAL

What did the agency say was the reason for treating complainant differently than other similarly-situated employees who were not disabled or who had different disabilities?

PRETEXT

Is there direct or circumstantial evidence that the agency's reason for its treatment of complainant is pretextual?

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APPENDIX J-7 EEO-MD-110

**MODEL FOR ANALYSIS
RELIGIOUS ACCOMMODATION**

PRIMA FACIE CASE

- 1) Does complainant hold a religious belief which conflicts with employment requirements? (Note: only in the rarest of cases, where the evidence appears very clear that the complainant does not sincerely hold the religious belief or does not sincerely engage in the religious practices that may need an accommodation should an investigator challenge the sincerity of the belief or practice.)
- 2) Has complainant informed his/her superior of a conflict?
- 3) Has complainant been penalized for failing to comply with employment requirements?

REBUTTAL

- 1) Belief or practice not of religious nature.
- 2) Agency could not accommodate without undue hardship.

DUTY TO ACCOMMODATE -- RELIGIOUS COMPENSATORY TIME

To allow employees to work additional hours (overtime, compensatory time) to make up for the time required by their personal religious belief (Pub. L. No. 95-390, 5 U.S.C. § 5550a, “Compensatory Time Off for Religious Observances”).

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August, 2015**Appendix K EEO-MD-110**

APPENDIX K EEO-MD-110
NOTICE OF INCOMPLETE INVESTIGATION
(SAMPLE)

Subject: Notice of Incomplete Investigation

FROM: [EEO Director]

DATE: [Insert]

TO: [Complainant/Complainant's Representative]

This Notice is to inform you that the investigation of [Agency Complaint No(s)] has not been completed within the 180-day time frame. Therefore, at this time, you have the right to request a hearing before a Commission Administrative Judge or to file a civil action in an appropriate U.S. District Court. You should send your request for a hearing before a Commission Administrative Judge to [insert correct address for the Commission District Office]. If you choose to file a civil action, that action should be styled [Complainant v. Agency Head]. You may also petition the U.S. District Court to appoint an attorney and to authorize commencement of the civil action without payment of fees, costs, or security. Whether your request is granted or denied is within the sole discretion of the U. S. District Judge.

Should you elect to request a hearing or file a civil action, you may have the opportunity to engage in discovery. Discovery is a pre-hearing and pre-trial device you can use to obtain facts and information from the agency. Tools of discovery include, but are not limited to, depositions, interrogatories, requests for production of documents, and requests for admissions. You are required to prove your case by a preponderance of the evidence which means the evidence of discrimination must be of greater weight than the evidence of non-discrimination.

In the alternative, you may wait until the investigation is complete, at which time, you will receive notice of the right to request a hearing before a Commission Administrative Judge or to request an immediate final agency decision. The estimated date of completion for the investigation is [insert date]. If you choose to wait for the investigation to be completed, you need not take any action at this time. The issuance of this Notice does not operate to waive your right to seek sanctions against the Agency for failing to complete the investigation within the required regulatory time frame.

(Signature Block)
 EEO Director

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**APPENDIX L EEO-MD-110
COMPLAINT FILE FORMAT**

Title Page

(Agency Letterhead)

)

(COMPLAINANT):

(Complainant's Address):

(Complainant's City, State, ZIP):

)

Complainant:

)

)

and

)

)

AGENCY CASE NO.____:

(AGENCY HEAD):

(Title):

(Agency Name):

OTHER NUMBERS____:

(Agency Address)

(P.O. Box)

(City, State, ZIP)

Agency:

)

)

General Requirements

Adobe image over text (searchable portable document format (PDF) – To preserve document integrity while simultaneously providing additional functionality, the Commission requires that all agency submissions – whether for a hearing as directed from an EEOC Administrative Judge, or on appeal pursuant to 29 C.F.R. § 1614.403(g) – be in searchable PDF format. Searchable PDF documents still look like a copy of the scanned/converted document, but behind the image Adobe performs optical character recognition (OCR) to identify the letters, words, and numbers that are present in the image. This functionality allows someone to search for particular words or

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terms in the PDF document, and to copy and paste verbatim language from the PDF document into a word processing document.

Saving or converting word processing documents to PDF automatically results in a searchable PDF document. For those documents that are scanned, typically there is a setting on the scanner that changes the output to searchable PDF. An image-only PDF document can also be converted to searchable PDF. See http://blogs.adobe.com/acrobat/acrobat_ocr_make_your_scanned/.

Digital bookmarks – Digital submissions comprised of multiple documents (for example, Reports of Investigation, Administrative Complaint Files, briefs/motions containing exhibits, etc.) must contain hyperlinked bookmarks for relevant/important documents therein. The bookmarks must be named in a manner that describes what the document is (for example, “EEO Counselor’s Report,” “Formal Complaint,” “Exhibit A – 2014 Performance Evaluation,” etc.), rather than a generic tab or table of contents designation. While more detailed bookmarking is always appreciated, the following documents (if applicable) must be bookmarked:

- Formal Complaint
- EEO Counselor’s Report
- Notice of Right to File a Complaint
- Notice of Claims to be Investigated
- Agency’s Partial Dismissal of Claims
- Settlement Agreements
- Prior Appellate Activity
- Report of Investigation Summary
- Exhibits/Evidence in the Report of Investigation
- Notice of Incomplete Investigation
- Pre-Hearing Submissions (including motions, orders, exhibits, and transcripts)
- Hearing Submissions (including motions, orders, exhibits, and transcripts)
- Administrative Judge’s Decision
- Final Agency Decision or Final Order

For instructions on how to add bookmarks to a PDF document, see <https://acrobatusers.com/tutorials/how-do-i-add-bookmarks-to-a-pdf-document>.

Consolidated Submissions on Appeal – Submissions on appeal to the Office of Federal Operations should be consolidated into as few PDF files as possible, mindful of the size restrictions imposed by the Commission’s document submission portal. If a file exceeds the size limitation, it may be divided into multiple files, but there should be as few as possible.

For instructions on how to consolidate multiple PDF files, see <http://www.adobe.com/video/feature-detail/acrobat/axi/merge-pdf-files-into-one->

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[pdf.modaldisplay.s_content.s_dotcom.s_en.s_products.s_acrobat.s_merging-combining-pdf-files.html](#).

Sample Digital Complaint File

A sample digital complaint file will be posted on the FedSEP portal and the Commission's external web-site at a later date.

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August, 2015**Appendix M EEO-MD-110**

**APPENDIX M EEO-MD-110
REQUEST FOR A HEARING FORM**

To: The Commission Hearings Unit:

District/Field Office Name:	
Address:	
City, State, ZIP Code:	
Fax number (if applicable):	

Dear Sir/Madam:

I am requesting the appointment of an Equal Employment Opportunity Commission Administrative Judge pursuant to 29 C.F.R. § 1614.108(g). I hereby certify that either more than 180 days have passed from the date I filed my complaint or I have received a notice from the agency that I have thirty (30) days to elect a hearing or a final agency decision.

Complainant Information: (Please Print or Type)

Complainant's name (Last, First, M.I.):	
Home/mailling address:	
City, State, ZIP Code:	
Daytime Telephone # (with area code):	
Home or Mobile Phone # (with area code):	
E-mail address (if any):	
Agency Case Number:	

Attorney/Representative Information (if any):

Attorney name:	
Non-Attorney Representative name:	
Address:	
City, State, ZIP Code:	
Telephone number (if applicable):	
E-mail address (if any):	
Fax Number (if any)	

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I will require the following reasonable accommodation(s) to participate in the hearing process:

In accordance with Section 1614.108(g), I have sent a copy of this request for a hearing to the following person at the agency:

Agency EEO Office Representative Information:

Agency EEO Office Representative name:	
Address:	
City, State, ZIP Code:	
Fax number (if applicable):	
E-mail address (if any):	

Complainant's Signature:

Signature of complainant or complainant's attorney:	
Date:	

NOTE: Only Complainant or their attorney can sign the request for a hearing. Non-attorney representatives may not sign requests for a hearing. **HEARING REQUESTS MUST BE SIGNED.** **UNSIGNED HEARING REQUESTS WILL NOT BE ASSIGNED A HEARING NUMBER OR AN ADMINISTRATIVE JUDGE.**

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APPENDIX N EEO-MD-110
EQUAL EMPLOYMENT OPPORTUNITY COMMISSION
OFFICES AND GEOGRAPHIC JURISDICTIONS FOR
FEDERAL EMPLOYEE AND APPLICANT HEARING REQUESTS

Toll Free 1-800-669-4000

Toll Free TTY 1-800-669-6820

info@eeoc.gov

Atlanta District Office

EEOC

100 Alabama Street, S.W.

Suite 4R30

Atlanta, Georgia 30303-8704

Commercial No: 404/562-6930

Hearings Unit Phone No: 404/562-6928

Hearings Fax No: 404/562-6909

TTY No: 404/562-6801

Geographic Jurisdiction:

The **State of Georgia** and **State of South Carolina** counties of Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Charleston, Colleton, Dorchester, Georgetown, Hampton, Jasper, and Williamsburg.

Baltimore Field Office

EEOC

City Crescent Building

10 South Howard Street, 3rd Floor

Baltimore, Maryland 21201-2529

Commercial No: 410/962-3932

Hearings Unit Phone No: 410/209-2782

Hearings Fax No: 410/209-2777

TTY No: 410/962-6065

Geographic Jurisdiction: The State of Maryland.

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Appendix N EEO-MD-110**August, 2015****Birmingham District Office**

EEOC

Ridge Park Place, Suite 2000

1130 22nd St., South

Birmingham, Alabama 35205-2870

Commercial No: 205/212-2104

Hearings Unit Phone No: 205/212-2139

Hearings Fax No: 205/212-2105

TTY No: 205/212-2112

Geographic Jurisdiction:

The State of Alabama; the **State of Florida counties of** Bay, Calhoun, Escambia, Franklin, Gulf, Holmes, Jackson, Liberty, Okaloosa, Santa Rosa, Walton, and Washington; and the State of **Mississippi except for the counties of** Alcorn, Benton, Coahoma, DeSoto, Itawamba, Lafayette, Lee, Marshall, Panola, Pontotoc, Prentiss, Quitman, Tate, Tippah, Tishomingo, Tunica, and Union **which should be sent to the Memphis District office.**

Charlotte District Office

EEOC

129 W. Trade St., Suite 400

Charlotte, North Carolina 28202-5306

Commercial No: 704/344-6682

Hearings Unit Phone No: 704/954-6428

Hearings Fax No: 704/954.6573

TTY No: 704/344-6684

Geographic Jurisdiction:

The States of North Carolina and South Carolina except for the counties of Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Charleston, Colleton, Dorchester, Georgetown, Hampton, Jasper, and Williamsburg **which should be sent to the Atlanta District Office;** **The State of Virginia except for the counties of** Arlington, Clarke, Fairfax, Fauquier, Frederick, Loudoun, Prince William, Stafford, Warren, and the State of Virginia Independent Cities of Alexandria, Fairfax City, Falls Church, Manassas, Manassas Park, Winchester, Quantico, Dumfries, and Occoquan **which should be sent to the Washington Field Office.**

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August, 2015**Appendix N EEO-MD-110****Chicago District Office**

EEOC

500 West Madison Street, Suite 2000

Chicago, Illinois 60661-2506

Commercial No: 800-669-4000

Hearings Unit Phone No: 312/869-8114

Hearings Fax No: 312/869-8125

TTY No: 312/869-8001

Geographic Jurisdiction:

The State of Illinois except for the counties of Alexander, Bond, Calhoun, Clinton, Greene, Jackson, Jersey, Macoupin, Madison, Monroe, Perry, Pulaski, Randolph, St. Clair, Union, and Washington **which should be sent to the St. Louis District Office.**

Cleveland Field Office

EEOC

1240 E. Ninth Street, Room 3001

Cleveland, Ohio 44199

Commercial No: 216/522-2001

Hearings Unit Phone No: 216/522-7325

Hearings Fax No: 216/522-7430

TTY No: 216/522-8441

Geographic Jurisdiction:

The State of Ohio counties of Ashland, Ashtabula, Athens, Belmont, Carroll, Columbiana, Coshocton, Crawford, Cuyahoga, Delaware, Erie, Fairfield, Franklin, Geauga, Guernsey, Harrison, Hocking, Holmes, Huron, Jefferson, Knox, Lake, Licking, Lorain, Mahoning, Marion, Medina, Meigs, Monroe, Morgan, Morrow, Muskingum, Noble, Perry, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas, Vinton, Washington and Wayne.

Dallas District Office

EEOC

207 S. Houston Street, 3rd Floor

Dallas, Texas 75202-4726

Commercial No: 214/253-2700

Hearings Unit Phone No: 214/253-2763

Hearings Fax No: 214/253-2739

TTY No: 214/253-2710

Geographic Jurisdiction:

The State of Texas counties of Anderson, Andrews, Archer, Armstrong, Bailey, Baylor, Bell, Borden, Bosque, Bowie, Brewster, Briscoe, Brown, Callahan, Camp, Carson, Cass, Castro, Cherokee, Childress, Clay, Cochran, Coleman, Collin, Collingsworth, Comanche, Cooke, Coryell, Cottle, Crane, Crosby, Culberson, Dallam, Dallas, Dawson, Deaf Smith, Delta, Denton, Dickens, Donley, Eastland, Ector, Ellis, El Paso, Erath, Falls, Fannin, Fisher, Floyd, Foard, Franklin, Freestone, Gaines, Garza, Glasscock, Gray, Grayson, Gregg, Hale, Hall, Hamilton,

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Hansford, Hardeman, Harrison, Hartley, Haskell, Hemphill, Henderson, Hill, Hockley, Hood, Hopkins, Howard, Hudspeth, Hunt, Hutchinson, Jack, Jeff Davis, Johnson, Jones, Kaufman, Kent, King, Knox, Lamar, Lampasas, Lamb, Leon, Limestone, Lipscomb, Loving, Lubbock, Lynn, McLennan, Marion, Martin, Midland, Milam, Mills, Mitchell, Montague, Moore, Morris, Motley, Navarro, Nolan, Ochiltree, Oldham, Palo Pinto, Panola, Parker, Parmer, Pecos, Potter, Presidio, Rains, Randall, Reagan, Red River, Reeves, Roberts, Robertson, Rockwall, Runnels, Rusk, Scurry, Shackelford, Sherman, Smith, Somervell, Stephens, Sterling, Stonewall, Swisher, Tarrant, Taylor, Terry, Throckmorton, Titus, Upshur, Upton, Van Zandt, Ward, Wheeler, Wichita, Wilbarger, Winkler, Wise, Wood, Yoakum, and Young; and the **State of New Mexico counties of** Dona Ana, Eddy, Grant, Hidalgo, Lea, Luna, Otero, and Sierra.

Denver Field Office

EEOC

303 E. 17th Avenue, Suite 510

Denver, Colorado 80203-1258

Commercial No: 303/866-1300

Hearings Unit Phone No: 303/866-1356

Hearings Fax No: 303/866-1085

TTY No: 303-866-1950

Geographic Jurisdiction: The States of Colorado and Wyoming. Hearing requests should be sent to the Phoenix District Office.

Detroit Field Office

EEOC

477 Michigan Avenue, Room 865

Detroit, Michigan 48226-9704

Commercial No: 313/226-4600

Hearings Unit Phone No: 313/226-4641

Hearings Fax No: 313/226-4610

TTY No: 313-226-7599

Geographic Jurisdiction: The State of Michigan and the State of Ohio counties of Allen, Defiance, Fulton, Hancock, Henry, Lucas, Ottawa, Paulding, Putnam, Sandusky, Seneca, Van Wert, Williams, Wood, and Wyandot.

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Houston District Office	Commercial No:	713/651-4900
EEOC	Hearings Unit Phone No:	713/651-4967
1201 Louisiana Street, Suite 600	Hearings Fax No:	713-751-0675
Houston, Texas 77002-8094	TTY No:	713-651-4901

Geographic Jurisdiction: **The State of Texas counties of** Angelina, Austin, Brazoria, Brazos, Calhoun, Chambers, Colorado, Fayette, Fort Bend, Galveston, Grimes, Hardin, Harris, Houston, Jackson, Jasper, Jefferson, Lavaca, Liberty, Madison, Matagorda, Montgomery, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, Tyler, Victoria, Walker, Waller, Washington, and Wharton.

Indianapolis District Office	Commercial No:	317/226-7212
EEOC	Hearings Unit Phone No:	317/226-6430
101 West Ohio Street, Suite 1900	Hearings Fax No:	317-226-5571
Indianapolis, Indiana 46204-4203	TTY No:	317-226-5162

Geographic Jurisdiction: **The States of Indiana, Kentucky; the State of Ohio counties of** Adams, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Clinton, Darke, Fayette, Gallia, Greene, Hamilton, Hardin, Highland, Jackson, Lawrence, Logan, Madison, Mercer, Miami, Montgomery, Pickaway, Pike, Preble, Ross, Scioto, Shelby, Union, and Warren.

Los Angeles District Office	Commercial No:	213/894-1000
EEOC	Hearings Unit Phone No:	213/894-1064
255 E. Temple, 4th Floor	Hearings Fax No:	213-894-5482
Los Angeles, California 90012-3334	TTY No:	213-894-1121

Geographic Jurisdiction: **The State of California counties of** Fresno, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Mariposa, Merced, Mono, Orange, Riverside, San Benito, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Tulare, and Ventura; **The State of Hawaii and the State of Nevada counties of** Clark, Esmeralda, Lincoln, Mineral, and Nye; **The U.S. Possessions of American**

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**Samoa, Guam, Northern Mariana Islands, and Wake Island.
Federal civilian employees at military installations in Japan,
Korea, Okinawa and other Pacific Islands.**

Memphis District Office
EEOC
1407 Union Avenue, Suite 901
Memphis, Tennessee 38104-3629

Commercial No: 901/544-0116
Hearings Unit Phone No: 901/544-0073
Hearings Fax No: 901/544-0111
TTY No: 901/544-0112

Geographic Jurisdiction: **The States of Arkansas and Tennessee, and the State of Mississippi counties of** Alcorn, Benton, Coahoma, DeSoto, Itawamba, Lafayette, Lee, Marshall, Panola, Pontotoc, Prentiss, Quitman, Tate, Tippah, Tishomingo, Tunica, and Union.

Miami District Office
EEOC
100 SE 2nd Street, Suite 1500

Miami, Florida 33131

Commercial No: 305/808-1740
Hearings Unit Phone No: 305/808-1820
Hearings Fax No: 305/808-1835
TTY No: 305/808-1742

Geographic Jurisdiction: **The Commonwealth of Puerto Rico and the U.S. Virgin Islands. The State of Florida counties of** Alachua, Baker, Bradford, Brevard, Broward, Charlotte, Citrus, Clay, Collier, Columbia, Desoto, Dixie, Duval, Flagler, Gilchrist, Glades, Gadsden, Hamilton, Hardee, Hendry, Hernando, Highlands, Hillsborough, Indian River, Jefferson, Lafayette, Lake, Lee, Leon, Levy, Madison, Manatee, Marion, Martin, Miami Dade, Monroe, Nassau, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Sarasota, Seminole, St. Johns, St. Lucie, Sumter, Suwannee, Taylor, Union, Volusia, and Wakulla.

Milwaukee Area Office
EEOC
310 West Wisconsin Avenue, Suite 800
Milwaukee, Wisconsin 53203-2292

Commercial No: 414/297-1111
Hearings Unit Phone No: 414/297-1117
Hearings Fax No: 414/297-3146
TTY No: 414-297-1115

Geographic Jurisdiction: **The States of Iowa, Minnesota, North Dakota, South Dakota and Wisconsin.**

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New Orleans Field Office
 EEOC
 500 Poydras St., Suite 800
 New Orleans, Louisiana 70113

Commercial No: 504/595-2825
 Hearings Unit Phone No: 504/595-2329
 Hearings Fax No: 504/595-6861
 TTY No: 504/595-2958

Geographic Jurisdiction: The State of Louisiana.

New York District Office
 EEOC
 33 Whitehall Street
 New York, New York 10004-2112

Commercial No: 212/336-3620
 Hearings Unit Phone No: 212/336-3620
 Hearings Fax No: 212/336-3621
 TTY No: 212/336-3622

Geographic Jurisdiction: The States of Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont, and the State of New Jersey counties of Bergen, Essex, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex, Union, and Warren.

Philadelphia District Office
 EEOC
 801 Market St, Suite 1300

Commercial No: 215/440-2600
 Hearings Unit Phone No: 215/440-2800
 Hearings Fax No: 215/440-2805
 TTY No: 215/440-2610

Philadelphia, Pennsylvania 19107

Geographic Jurisdiction: The States of Delaware, Pennsylvania, and West Virginia. The State of New Jersey *except* for the State of New Jersey counties of Bergen, Essex, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex, Union, and Warren which should be sent to the New York District Office. The State of Ohio *except* for the State of Ohio counties under the jurisdiction of the Cincinnati Area Office (Adams, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Clinton, Darke, Fayette, Gallia, Greene, Hamilton, Hardin, Highland, Jackson, Lawrence, Logan, Madison, Mercer, Miami, Montgomery, Pickaway, Pike, Preble, Ross, Scioto, Shelby, Union, and Warren; and The State of Ohio counties of Allen, Defiance, Fulton, Hancock, Henry, Lucas, Ottawa, Paulding, Putnam, Sandusky, Seneca, Van Wert,

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Williams, Wood, and Wyandot. **and the State of Kentucky counties of** Bath, Boone, Bourbon, Boyd, Bracken, Breathitt, Campbell, Carter, Elliott, Fleming, Floyd, Gallatin, Grant, Greenup, Harrison, Johnson, Kenton, Knott, Lawrence, Letcher, Lewis, Magoffin, Martin, Mason, Menifee, Montgomery, Morgan, Nicholas, Pendleton, Perry, Pike, Powell, Robertson, Rowan, and Wolfe) **which should be sent to the Indianapolis District Office.**

Phoenix District Office
EEOC
3300 N. Central Avenue, Suite 690
Phoenix, Arizona 85012-2504

Commercial No: 602/640-5000
Hearings Unit Phone No: 602/640-5039
Hearings Fax No: 602/640-4729
TTY No: 602/640-5072

Geographic Jurisdiction: **The States of Arizona and Utah. The State of New Mexico *except for the State of New Mexico counties of* Dona Ana, Eddy, Grant, Hidalgo, Lea, Luna, Otero, and Sierra **which should be sent to the Dallas District Office.** Hearing requests for the states of **Colorado, and Wyoming should also be sent to the Phoenix District Office.****

St. Louis District Office
EEOC
The Robert A. Young Building
1222 Spruce Street, 8th Fl., Rm.100
St. Louis, Missouri 63103-2828

Commercial No: 314/539-7800
Hearings Unit Phone No: 314/539-7800
Hearings Fax No: 314/539-7894
TTY No: 314/539-7803

Geographic Jurisdiction: **The States of Kansas, Missouri, Nebraska, Oklahoma, and the State of Illinois counties of** Alexander, Bond, Calhoun, Clinton, Greene, Jackson, Jersey, Macoupin, Madison, Monroe, Perry, Pulaski, Randolph, St. Clair, Union, and Washington.

San Antonio Field Office
EEOC
5410 Fredericksburg Road, Suite 200
San Antonio, TX 78229-3555

Commercial No: 210/281-7600
Hearings Unit Phone No: 210/281-7676
Hearings Fax No: 210/281-2520
TTY No: 210/281-7610

Geographic Jurisdiction: **The State of Texas counties of** Aransas, Atascosa, Bandera, Bastrop, Bee, Bexar, Blanco, Brooks, Burleson, Burnet, Caldwell, Cameron, Coke, Comal, Concho, Crockett, De Witt,

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Dimmit, Duval, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Hays, Hidalgo, Irion, Jim Hogg, Jim Wells, Karnes, Kendall, Kennedy, Kerr, Kimble, Kinney, Kleberg, La Salle, Lee, Live Oak, Llano, McCulloch, McMullen, Mason, Maverick, Medina, Menard, Nueces, Real, Refugio, San Patricio, San Saba, Schleicher, Starr, Sutton, Terrell, Tom Green, Travis, Uvalde, Val Verde, Webb, Willacy, Williamson, Wilson, Zapata, and Zavala.

San Francisco District Office
EEOC

Phillip Burton Federal Building, Suite 5000
450 Golden Gate Avenue
5 West, P.O. Box 36025
San Francisco, California 94102-3661

Commercial No: 415/522-3000
Hearings Unit Phone No: 415/522-3023
Hearings Fax No: 415/522-3415
TTY No: 415/522-3152

Geographic Jurisdiction:

The State of California counties of Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba; **and the State of Nevada *except* for the State of Nevada counties of** Clark, Esmeralda, Lincoln, Mineral, and Nye **which should be sent to the Los Angeles District Office.**

Seattle Field Office

EEOC
Federal Office Building
909 First Avenue, Suite 400
Seattle, Washington 98104-1061

Commercial No: 206/220-6884
Hearings Unit Phone No: 206/220-6884
Hearings Fax No: 206/220-6911
TTY No: 206/220-6882

Geographic Jurisdiction:

The State of Montana; The States of Alaska, Idaho, Oregon, and Washington.

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Washington Field Office
EEOC
131 M Street, NE, 4th Floor
Washington, DC 20507

Commercial No: 202/419-0700
Hearings Unit Phone No: 202/419-0713
Hearings Fax No: 202/419-0740
TTY No: 202/419-0702

Geographic Jurisdiction:

The District of Columbia and the State of Virginia counties of Arlington, Clarke, Fairfax, Fauquier, Frederick, Loudoun, Prince William, Stafford, Warren, and the State of Virginia Independent Cities of Alexandria, Fairfax City, Falls Church, Manassas, Manassas Park, Winchester, Quantico, Dumfries, and Occoquan.

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**NOTICE OF APPEAL – AGENCY
TO THE EQUAL EMPLOYMENT OPPORTUNITY COMMISSION
OFFICE OF FEDERAL OPERATIONS**

1. Agency (please print or type):

2. Address:

3. Name of agency representative:

4. Telephone (including area code):

E-Mail address:

5. Name, address, telephone no. of complainant:

6. If the complainant is represented, name, address, and telephone no. of representative:

7. Agency complaint number:

8. Name of Administrative Judge, District/Field Office location, and the Commission Hearings Unit No.:

9. Date of agency final action (include a copy):

10. To your knowledge, does the complainant have any appeals pending at OFO? If so, please indicate the Commission Appeal Nos.:

11. Signature of agency representative:

Date:

NOTICE: Before mailing this appeal, please be sure to **attach a copy** of the final action and the Administrative Judge's decision from which you are appealing. Please serve a copy of this appeal form on the complainant, with a copy of your final action. **Any statement or brief in support of this appeal shall be submitted within twenty (20) days of the date this appeal is filed. Agencies must forward the complaint file to the Commission within thirty (30)**

FOR the Commission USE ONLY:**OFO DOCKET NO.:**

U.S. Government Printing Office 2000-462-842

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**NOTICE OF APPEAL/PETITION - COMPLAINANT
TO THE EQUAL EMPLOYMENT OPPORTUNITY COMMISSION
OFFICE OF FEDERAL OPERATIONS
P.O. Box 77960
Washington, DC 20013**

Complainant Information: (Please Print or Type)

Complainant's name (Last, First, M.I.):	
Home/mailling address:	
City, State, ZIP Code:	
Daytime Telephone # (with area code)	
E-mail address (if any):	

Attorney/Representative Information (if any):

Attorney name:	
Non-Attorney Representative name:	
Address:	
City, State, ZIP Code:	
Telephone number (if applicable):	
E-mail address (if any):	

General Information:

Name of the agency being charged with discrimination:	
Identify the Agency's complaint number:	
Location of the duty station or local facility in which the complaint arose:	
Has a final action been taken by the agency, an Arbitrator, FLRA, or MSPB on this complaint?	<input type="checkbox"/> Yes Date Received _____ (Remember to attach a copy) <input type="checkbox"/> No <input type="checkbox"/> This appeal alleges a breach of a settlement agreement
Has a complaint been filed on this same matter with the Commission, another agency, or through any other administrative or collective bargaining procedures?	<input type="checkbox"/> No <input type="checkbox"/> Yes (Indicate the agency or procedure, complaint/docket number, and attach a copy, if appropriate)
Has a civil action (lawsuit) been filed in connection with this complaint?	<input type="checkbox"/> No <input type="checkbox"/> Yes (Attach a copy of the civil action filed)

NOTICE: Please **attach a copy of the final decision or order** from which you are appealing. If a hearing was requested, please attach a copy of the agency's final order and a copy of the Commission Administrative Judge's decision. Any comments or brief in support of this appeal **MUST** be filed with the Commission and with the agency **within 30 days** of the date this appeal is filed. The date the appeal is filed is the date on which it is postmarked, hand delivered, submitted, or faxed to the Commission at the address above.

Please specify any reasonable accommodations you will require to participate in the appeal process:

Signature of complainant or complainant's representative:	
Date:	
Method of Service on Agency:	
Date of Service:	

PRIVACY ACT STATEMENT ON REVERSE SIDE.

EEOC Form 573 REV 2/09
PRIVACY ACT STATEMENT

(This form is covered by the Privacy Act of 1974. Public Law 93-597. Authority for requesting the personal data and the use thereof are given below)

- 1. FORM NUMBER/TITLE/DATE:** EEOC Form 573, Notice of Appeal/Petition, February 2009
- 2. AUTHORITY:** 42 U.S.C. § 2000e-16
- 3. PRINCIPAL PURPOSE:** The purpose of this questionnaire is to solicit information to enable the Commission to properly and effectively adjudicate appeals filed by federal employees, former federal employees, and applicants for federal employment.
- 4. ROUTINE USES:** Information provided on this form may be disclosed to: (a) appropriate federal, state, or local agencies when relevant to civil, criminal, or regulatory investigations or proceedings; (b) a Congressional office in response to an inquiry from that office at your request; and (c) a bar association or disciplinary board investigating complaints against attorneys representing parties before the Commission. Decisions of the Commission are final administrative decisions, and, as such, are available to the public under the provisions of the Freedom of Information Act. Some information may also be used in depersonalized form as a database for statistical purposes.
- 5. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL FOR NOT PROVIDING INFORMATION:** Since your appeal is a voluntary action, you are not required to provide any personal information in connection with it. However, failure to supply the Commission with the requested information could hinder timely processing of your case, or even result in the rejection or dismissal of your appeal.

You may send your appeal to:

The Equal Employment Opportunity Commission
Office of Federal Operations
P.O. Box 77960
Washington, DC 20013

Fax it to (202) 663-7022 or submit it through the Commission's electronic submission portal.

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Appendix Q EEO MD-110

APPENDIX Q EEO MD-110**QUICK REFERENCE CHART****DOCUMENTATION REQUIRED TO CLOSE COMPLIANCE WITH THE MOST COMMON OFO ORDERS**

TYPE OF ORDER OR EVENT	DOCUMENTATION REQUIRED
Attorney Fees Dollar amount is adjudicated and ordered. [Not general attorney fee entitlement]	<ol style="list-style-type: none"> 1. Copy of an agency payment order, print screen of electronic funds transfer or check issued to complainant (and attorney) for fees. 2. A narrative statement by an appropriate agency official - one to know with reasonable certainty that payment was made. 3. Documentation must include total monies paid, to whom, and when, or 4. A Final Agency Decision on contest of fees
Awards	<ol style="list-style-type: none"> 1. A narrative statement by an appropriate agency official, stating the dollar amount and the criteria used to calculate the award. An appropriate agency official must be one to know with reasonable certainty that the payment was made. 2. Documentation must include total monies paid, to whom, and when.
Back Pay 5 C.F.R. § 550.805 Interest 5 C.F.R. § 550.806	<ol style="list-style-type: none"> 1. Computer printouts or payroll documents delineating gross back pay before mitigation and interest, and 2. Copies of any cancelled checks issued; or a copy of a print screen showing an electronic funds transfer. 3. Narrative statement by an appropriate agency official of total monies paid. An appropriate agency official must be one to know with reasonable certainty that the payment was made. (Last resort) 4. Documentation must include total monies paid, to whom, and when.

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TYPE OF ORDER OR EVENT	DOCUMENTATION REQUIRED
Breach of Settlement or Noncompliance with a Final Agency Action (Remand – reinstatement / processing or specific performance of agreement/FAD)	For reinstatement at the point processing ceased - <u>see</u> documentation required for “ Remand [of a] previously dismissed complaint,” For an order of specific performance, submit proof that specific performance was completed.
Civil Action Terminations	A complete copy of the civil action complaint demonstrating that it was filed in a federal court and that it covers the same issues as the compliance matter.
Compensatory Damages (Remand for determination)	FAD determining complainant’s entitlement or non-entitlement to compensatory damages, with appeal rights to the Commission/OFO.
Compensatory Damages (Orders to pay)	Evidence of payment - Copies of any cancelled checks issued; a copy of a print screen showing an electronic funds transfer; or a narrative statement by an appropriate agency official of total monies paid. An appropriate agency official must be one to know with reasonable certainty that the payment was made. Documentation must include total monies paid, to whom, and when.
Disciplinary Action Consideration of	Documentation of oral or written counseling or a copy of any written notice of reprimand, suspension, or other action taken against any of the identified responsible management officials or statement of reason for not taking action. Note: The Commission does not consider training as a form of disciplinary action.
Final Agency Decision (FAD)	Copy of the FAD with appropriate appeal rights.
Personnel Actions (for example Reinstatement, Promotion, Hiring, Reassignment)	Copy of Standard Forms (SF) 50, or comparable notice of official action.
Petition for Enforcement (Terminating compliance)	A petition for enforcement may be requested by a complainant when s/he believes that the Commission’s Order has not been followed. The Compliance Officer will attempt to resolve the matter and may exercise appropriate discretion in having the matter docketed. Compliance will be suspended if the issue is critical to the remaining action(s) and the petition for enforcement is docketed.

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TYPE OF ORDER OR EVENT	DOCUMENTATION REQUIRED
Posting a Notice of Violation	The original signed and dated notice, reflecting the dates that the notice was posted. A copy may suffice, if the original is not available.
Remand (for example, Reinstatement of complaint – from dismissal or breach of settlement) (Reversal of Administrative Judge summary judgment)	<ol style="list-style-type: none"> 1. Copy of agency acknowledgment of remanded claims. 2. Copy of appropriate notice of rights to a hearing or FAD w/in 60days of receipt of notice and right to file a civil action w/in 90 days. A Final Agency Decision will be required to close compliance when no hearing elected. 3. Copy of letter transmitting the investigative file to an Administrative Judge where hearing is requested or on reversal of an Administrative Judge summary judgment.
Restoration of Leave	A printout or statement by an appropriate agency official, identifying the amount and type of leave restored.
Settlement Agreements (Which terminate compliance)	Written agreement signed and dated by both parties, containing specific dollar amounts and/or other applicable provisions. Should be followed up with documentation of relief provided. <u>Settlement agreements will not relieve an agency from a Commission Order to post a Notice of Violation.</u>
Supplemental Investigation	<ol style="list-style-type: none"> 1. Copy of the letter acknowledging to the complainant, receipt of their remanded case from OFO. 2. Signed copy of the letter transmitting the Investigative File and appropriate notice of rights to the complainant – may be order-specific. 3. Copy of the request for a hearing or a FAD. (Complainant's request for a hearing, agency transmittal of the complaint file to the appropriate Commission District/Field/Area Office, or a copy of the FAD.)

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Appendix Q EEO MD-110**August, 2015**

TYPE OF ORDER OR EVENT	DOCUMENTATION REQUIRED
Training	<ol style="list-style-type: none"> 1. Attendance roster at training session(s) or a narrative statement by an appropriate agency official confirming training hours, course titles and content, if necessary. 2. Course description providing some indication that the training was appropriate for the discrimination found or commensurate with the order.

NOTE: This appendix is not an exhaustive list of the documents that may be submitted to prove compliance.

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App. Q-4

Owner: ADA ADVOCATE (b) (6) (b) (6) gmail.com>
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**Department of Veterans Affairs
Washington, DC 20420**

**VA Directive 5977
Transmittal Sheet
May 5, 2011**

**EQUAL EMPLOYMENT OPPORTUNITY
DISCRIMINATION COMPLAINTS PROCESS**

- 1. REASON FOR ISSUE:** To revise the Department of Veterans Affairs (VA) Equal Employment Opportunity (EEO) Discrimination Complaints policy.
- 2. SUMMARY OF CONTENTS/MAJOR CHANGES:** 38 United States Code 516, as enacted in Title I, Public Law 105-114, 105th Congress, November 21, 1997, directs the Secretary to provide that the employment discrimination complaint resolution system be established and administered in a fair, objective manner that encourages timely and fair resolution. As a result in 1997 the Office of Resolution Management (ORM) was established. Since its establishment ORM's mission has expanded to a more proactive role in prevention and early resolution of workplace disputes. In 2007 the Secretary transferred management and oversight of the Department's Workplace Alternative Dispute Resolution program to ORM. In addition, ORM augmented its senior management structure and realigned its field operations to improve its organizational performance. Additionally, while Federal law and Equal Employment Opportunity Commission regulations do not cover sexual orientation as a protected basis, the VA has established new procedures for processing complaints of discrimination based on sexual orientation. This directive sets forth revised policies and responsibilities for the processing of EEO discrimination complaints.
- 3. RESPONSIBLE OFFICE:** The Office of the Deputy Assistant Secretary for Resolution Management (08) is responsible for this Directive.
- 4. RELATED HANDBOOKS:** VA Handbook 5977, EEO Discrimination Complaint Procedures.
- 5. RESCISSIONS:** VA Directive 5977, EEO Discrimination Complaints Process, February 7, 2007.

CERTIFIED BY:

**BY DIRECTION OF THE
SECRETARY OF VETERANS
AFFAIRS:**

/s/

/s/

Roger W. Baker
Assistant Secretary for
Information and Technology

John U. Sepúlveda
Assistant Secretary for
Human Resources and Administration

Distribution: Electronic

May 5, 2011

VA Directive 5977

DISCRIMINATION COMPLAINTS

1. PURPOSE. This directive revises Department of Veterans Affairs (VA) policy for processing Equal Employment Opportunity (EEO) complaints of discrimination. It implements Federal law and regulations of the Equal Employment Opportunity Commission (EEOC) at part 1614, title 29, Code of Federal Regulations (C.F.R.), which prohibits discrimination based on race, color, religion, gender (sex), national origin, age (40 years and over), physical or mental disability, and/or reprisal for filing a complaint of discrimination, participating in the EEO process or having opposed prohibited discrimination. Executive Order 13087 prohibits discrimination based upon sexual orientation in the competitive service of the civilian workforce. While Federal law and EEOC regulations do not cover sexual orientation as a protected basis, the VA has established new procedures for processing complaints of discrimination based on sexual orientation. In addition, on November 9, 2010, EEOC promulgated regulation 29 C.F.R. §1635, which implements Title II of the Genetic Information Nondiscrimination Act of 2008 (GINA). Title II of GINA prohibits the use of genetic information in making decisions related to any terms, conditions, or privileges of employment (e.g., hiring, firing, and opportunities for advancement); restricts employers and other entities from requesting, requiring, or purchasing genetic information, with limited exceptions; generally requires employers to keep any genetic information they have about applicants or employees confidential; and prohibits retaliation. Genetic information is a covered basis under the jurisdiction of EEOC. This policy applies to all VA employees, applicants for employment, and former employees.

2. POLICY

a. VA employees, applicants for employment, and former employees shall not be discriminated against based on race, color, religion, gender (sex), national origin, age (40 years and over), physical or mental disability, sexual orientation, genetic information, and/or reprisal for filing a complaint of discrimination, participating in the EEO process, or having opposed prohibited discrimination. Harassment based on the above categories is also prohibited.

b. VA employees, applicants for employment, and former employees will be afforded the right to file a complaint of discrimination under the provisions set out in 29 C.F.R. §1614 and §1615 as it relates to GINA.

c. VA employees, applicants for employment, and former employees will be afforded the right to file a complaint of discrimination based upon sexual orientation as set forth in the Secretary's Policy Statement dated May 13, 2010.

d. The Office of Resolution Management (ORM) will provide timely and quality EEO complaint processing services to all complainants. Complaints will be processed promptly with integrity, trust and impartiality throughout the counseling, investigation, and resolution of EEO complaints.

e. Complainants, their representatives, witnesses, and other participants in the EEO process shall be free from restraint, interference, coercion, discrimination, and reprisal at all stages in

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the presentation and processing of a discrimination complaint, including the pre-complaint counseling stage. Allegations of reprisal in discrimination complaints, like EEO complaints themselves, should be brought to the attention of a VA ORM EEO counselor. Retaliation for whistleblowing may be reported to the United States Office of Special Counsel (OSC). Refer to VA Handbook 5977, Discrimination Complaints for information regarding other grievance and administrative processes.

f. Complaints will be resolved at the earliest possible stage. Early resolution of complaints is encouraged to achieve better employee relations, cut administrative costs, and it avoids prolonged litigation. ORM will actively seek to assist in resolving EEO disputes at the lowest level possible by explaining and offering alternative dispute resolution (ADR). If the parties agree to ADR, they will be referred to the ADR coordinator.

g. This Directive does not affect the rights that are granted to unions that have exclusive recognition in the VA. Further, this Directive is not intended to affect the rights of an employee to file:

- (1) A discrimination complaint under this directive.
- (2) A grievance under a negotiated procedure.
- (3) An appeal under the appellate provisions of the Merit Systems Protection Board (MSPB) regulations.
- (4) A complaint with the OSC.
- (5) A complaint with the OIG.
- (6) An action under any other administrative procedure.

h. Sufficient resources in personnel and funds should be made available to ensure the success of VA's EEO Discrimination Complaint Program.

3. RESPONSIBILITIES

a. **Human Resources and Administration (HR&A).** The Assistant Secretary for HR&A (AS/HRA) is designated the Director EEO for VA, and is the principal advisor to the Secretary on EEO policies, programs, and plans. The AS/HRA reports directly to the Secretary.

b. **Office of Resolution Management (ORM).** The complaint resolution process is administered through the Veterans Affairs Central Office (VACO), Deputy Assistant Secretary for Resolution Management (DAS/RM), Associate Deputy Assistant Secretary for Resolution Management (ADAS/RM), District Directors (DD), Executive Operations Director and field offices throughout the country. Each field office has the following positions: Regional EEO Officer/Field Manager, administrative officer, case managers, team leaders, EEO investigators, EEO counselors, investigator/case managers (C2), and program assistants. This group of

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subject-matter-experts provides seamless and comprehensive EEO complaint processing services.

(1) **Mission.** The ORM's mission is to promote a discrimination-free work environment focused on serving veterans by preventing, resolving, and processing workplace disputes in a timely and effective manner.

(2) **Functional Independence.** Pursuant to 38 U.S.C. §§512 and 516 the DAS/RM has authority to implement and manage the EEOC regulatory requirements and procedures in this Directive and related Handbook 5977.

(3) **Functions.** ORM manages the informal and formal EEO complaint process. All functions performed by ORM are guided by EEOC regulatory requirements with the exception of sexual orientation complaints. Sexual orientation complaints are processed in accordance with the Secretary's Policy Statement dated May 13, 2010. These discrimination complaint processing services include:

(a) Conducting informal counseling during the informal complaint process to try and resolve allegations of discrimination.

(b) Acknowledging receipt of formal complaints of discrimination.

(c) Issuing procedural determinations concerning discrimination complaints.

(d) Managing the EEO investigation process including compensatory damages investigations.

(e) Releasing the investigative file and advisement of complainant's right to proceed in the administrative process. This may include forwarding the investigative files to EEOC for a hearing or to the Office of Employment Discrimination Complaint Adjudication (OEDCA) for a Final Agency Decision (FAD).

(f) Monitoring compliance with OEDCA's or EEOC's decisions. The DAS/RM will notify the appropriate Department official when facilities and/or organizational components resist or fail to comply with these decisions.

(g) Issuing decisions on allegations regarding breach of settlement agreements.

(h) Issuing decisions on claims of dissatisfaction with the processing of an individual's EEO complaint.

(i) Promoting early resolution through the ADR Program.

(j) Recommending to the Assistant Secretary for HR&A the need for a rapid response team on matters solely related to alleged egregious acts of discrimination in which a senior level manager is the responding management official.

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(k) Providing Congress with mandated quarterly and annual reports on discrimination complaints filed against senior VA managers. This report is required by 38 U.S.C. §516, which codifies Title I of Public Law 105-114, Veterans' Benefits Act of 1997, dated November 21, 1997.

(l) Posting quarterly statistical data as required by Title III, Section 202 of Public Law 107-174, Notification and Federal Employee Anti-discrimination and Retaliation Act of 2002, dated May 15, 2002 (the NO FEAR Act of 2002), codified at 5 U.S.C. §2301 note.

(m) Providing Congress a mandated Annual No Fear Act Report as required by Title II, Section 203 of the NO FEAR Act of 2002.

(4) **Commitment.** ORM will encourage employees, supervisors, and union officials to use ADR to help resolve workplace disputes as early as feasible, to the maximum extent practicable, in an appropriate and cost-effective manner, and at the lowest organizational level. ORM employees will explain the ADR process. If the parties agree to ADR, they will be referred to an ADR coordinator. ORM supports VA's goal of creating and maintaining a high-performing workforce.

(5) **Conflicts of Interest.** In order for ORM to ensure fairness, integrity, and trust in the processing of EEO complaints, the following procedures to address ex-parte communication and conflicts of interest must be followed. These procedures apply during and after the discrimination complaint process.

(a) When an ORM employee believes that he/she has, or may have, a conflict of interest in an assigned case(s), or otherwise believes that there are facts or circumstances that might create the appearance of a conflict, the employee will immediately report the matter to the Regional EEO Officer/Field Manager or their supervisor. The Regional EEO Officer/Field Manager or supervisor will inquire into the matter and determine whether the case(s) in question should be reassigned to another employee.

(b) If the aggrieved person identifies a perceived conflict of interest concerning the processing of the complaint or any alleged conflict of interest, this matter must be referred to the Regional EEO Officer/Field Manager or supervisor for appropriate disposition.

(c) If a conflict of interest is discovered after the issuance of a counselor's report, report of investigation, or procedural determination, the Regional EEO Officer/Field Manager will investigate the matter, and take appropriate action, which may include rescission of the report or determination. When appropriate, disciplinary action will be taken.

(d) If the complainant or agency representative creates a conflict of interest with his or her official or collateral duties, the Regional EEO Officer/Field Manager will give the representative notice of the possible conflict and afford the individual an opportunity to respond. The Regional EEO Officer/Field Manager will investigate the matter, including the arguments of interested parties, and forward all documentation to the jurisdictional (DD who will issue a decision on the matter.

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(e) If an ORM employee initiates a complaint of discrimination, OEDCA will assume responsibility for the complaint. Counseling and investigation will be conducted by a contractor.

(6) **Customer Service/Due Professional Care Standards.** ORM is committed to providing quality customer service. ORM employees will have a thorough knowledge of the applicable laws, regulations, directives, and handbooks related to the processing of EEO complaints. ORM employees will conduct themselves in a highly professional manner at all times and will avoid the appearance of compromising the integrity of the EEO complaint process. Employees shall avoid personal involvement with aggrieved persons, complainants, responsible management officials, witnesses, representatives, or any other participant in the EEO complaint process. Any conduct of an ORM employee that is believed to be inappropriate should be reported, in writing, to the ORM Regional EEO Officer/Field Manager or supervisor. They will investigate the matter and take corrective and/or disciplinary action where appropriate. ORM employees will provide the best possible service to VA and its employees. ORM employees will comply with all applicable Ethics in Government regulations and ensure that their conduct is consistent with ORM's Due Professional Care Standards. This requires high standards of honesty, objectivity, diligence, and loyalty. ORM employees will apply competent skills, exercise sound judgment and exhibit professional demeanor in performing their duties. The exercise of due professional care requires independence, professional proficiency, planning, and quality outcome. ORM's Customer Service/Professionalism Standards require that ORM staff will:

(a) Provide accurate and timely information to employees, applicants and former employees, witnesses, designated representatives, as well as responding management officials as to their rights and responsibilities in regard to the EEO process.

(b) Listen to, understand and document concerns of employment discrimination on the part of employees, applicants and former employees.

(c) Guarantee anonymity during the EEO counseling stage, unless a waiver of anonymity is secured.

(d) Provide timely notices to involved parties throughout the EEO complaint process.

(e) Process EEO complaints in a fair, objective and timely manner.

(f) Provide procedural determinations of all EEO complaints in accordance with 29 C.F.R. §1614.

(g) Conduct thorough and competent investigations of all EEO complaints.

(h) Treat all customers with dignity.

(i) Assist and try to resolve all complaints of employment discrimination at the lowest possible level.

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(j) Keep employees, applicants, former employees and designated representatives advised of the status of their complaint by adequately communicating with them.

(k) Maintain confidentiality of information in accordance with applicable privacy and security laws, regulations, directives, and handbooks.

(7) ORM Principal Roles.

(a) **Deputy Assistant Secretary for Resolution Management (DAS/RM).** The DAS/RM serves as the principal advisor to the Assistant Secretary for Human Resources and Administration (AS/HRA) regarding the EEO complaint process in the VA. The DAS/RM has been delegated authority to supervise and control the operation of the administrative EEO discrimination complaint processing system within the VA. Pursuant to 38 U.S.C. §516, 38 U.S.C. §512, and 38 C.F.R. Parts 2 and 15, the DAS/RM exercises exclusive authority to establish and modify discrimination complaint processing procedures. The DAS/RM's responsibilities are:

1. Administering the VA's discrimination complaint process in a manner that ensures prompt, equitable, and efficient processing of discrimination complaints.
2. Formulating and implementing department-wide policies and procedures to ensure the integrity, effectiveness, and impartiality of the complaint system.
3. Ensuring sufficient resources are allocated to achieve ORM's objectives.
4. Working closely with VA officials in resolving EEO complaint issues and raising awareness of management responsibility in this area.
5. Providing technical assistance and guidance to management and employees on all aspects of EEO complaint processing and recommending solutions to matters giving rise to discrimination complaints.
6. Utilizing departmental data to conduct special studies, research, and analysis to enhance the EEO complaint program.
7. Administering VA's Alternative Dispute Resolution program.
8. Formulating and implementing organizational wide ADR policies and procedures.
9. Providing executive leadership over ORM, its offices, and employees.

(b) **Associate Deputy Assistant Secretary for Resolution Management (ADAS/RM).** The ADAS/RM serves as the principal advisor to DAS/RM in formulating and implementing department-wide policies and procedures to ensure the integrity, effectiveness, and impartiality of the complaint processing system and the ADR program. Other responsibilities are:

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1. Developing VA's resolution management's programs initiatives in accordance with EEOC regulations and maintaining the control of administrative EEO discrimination complaint processing within the VA.

2. Providing direct oversight over the senior management team which is comprised of the Executive Operations Director, ADR Director, Eastern Operations Director and Western Operations Director.

3. Supervising the effectiveness of the complaint processing system, providing technical guidance and program management advice to the agency and to ORM management.

4. Overseeing the development and implementation of procedures, standards, and guidelines related to complaint processing.

5. Assuming all duties and authorities of the DAS in an acting capacity when necessary.

(c) **District Directors (DDs).** ORM has offices in various locations throughout the United States responsible for a full range of EEO services for the VA. To effectively manage field operations, two regions (east and west) are managed by the DDs. The Eastern DD provides leadership and technical guidance to the counselor, investigator and case manager national team leaders (NTL). The Western DD provides leadership and oversight to the Centralized Investigations Division (CID). Other responsibilities are:

1. Serving as the principal advisors to DAS/RM and ADAS/RM in formulating and implementing department-wide policies and procedures to ensure the integrity, effectiveness, and impartiality of EEO complaint processing.

2. Managing ORM's field operations and providing leadership, oversight and direction to ORM's Regional EEO Officers/Field Managers. The two regions have three field offices each and a host of satellite offices.

3. Determining ORM field operations program goals and objectives including identification of field program requirements and monitoring of accomplishments.

4. Monitoring the workload of field operations and advising the DAS and ADAS on staffing needs to assure the effectiveness of the complaint processing system.

5. Providing technical guidance and program management advice to the administrations and ORM management.

6. Assisting in the development and implementation of procedures, standards, and guidelines related to complaint processing and the development of training for EEO counselors, EEO investigators, and EEO case managers.

7. Providing direction based on ORM's mission and strategic plan.

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(d) **Regional EEO Officer/Field Manager.** The Regional EEO Officer/Field Manager is responsible for the full scope of EEO complaint processing and operations within the assigned geographical area and reports directly to the respective DD. The Regional EEO Officer/Field Manager is responsible for:

1. Formulating and directing organizational operations and serving as the principal ORM spokesperson in his/her service area.
2. Working closely with VA field facility management officials in raising awareness of their responsibilities and facilitating achievement of the objectives of the discrimination complaint program.
3. Ensuring sufficient resources are allocated to achieve ORM's objectives within his/her jurisdiction and supervising ORM personnel assigned to their geographical area.
4. Ensuring that all EEO complaints are processed in accordance with applicable laws, regulations, directives, and handbooks.
5. Reviewing and signing procedural determinations regarding the acceptability of EEO complaints for further processing.
6. Ensuring that all employees receive the appropriate level of training required by EEOC regulations.
7. Briefing employees on OPC's Annual and Semi-Annual Spin-Off Reports.
8. Taking prompt and appropriate corrective action to address any program or individual deficiencies that impact the processing of EEO complaints.
9. Creating and maintaining an effective work environment that supports teamwork, is free of discrimination, and promotes diversity.
10. Assigning EEO investigations to individual investigators after receiving notification of assignments from the CID.
11. Ensuring timely compliance with all EEOC and OEDCA remands.

(e) **Administrative Officer (AO).** AO serves as a non-supervisory assistant to the Regional EEO Officer/Field Manager with the exception that they supervise the duties and responsibilities of the Program Assistants. The AOs are responsible for:

1. Serving as a technical office advisor and quality control officer for complaint processing.
2. Providing daily oversight and direction to ensure the smooth processing and quality assurance of the field office operations.

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3. Assigning and reviewing work products, and providing technical assistance to field office staff.
4. Reviewing and evaluating procedural decisions and forwarding them to the Regional EEO Officer/Field Manager.
5. Serving as Acting Field Manager in the absence of the Regional EEO Officer/Field Manager.
6. Performing the duties of a case manager.

(f) **National Team Leaders (NTL).** The NTL for counselors, investigators, and case managers are key elements in ensuring standardization of the EEO complaint process. The NTLs are responsible for:

1. Maintaining consistent application of procedures.
2. Conducting regular meetings with their respective discipline team leads or designated representatives to discuss any procedural or policy changes that have or will take effect, any issues and/or areas of concern related to specific processes, and other items related to the effective and efficient processing of EEO complaints.
3. Interacting with the DDs, CID, Regional EEO Officers/Field Managers, AOs, team leaders and case managers, to ensure standardization of EEO complaint processing procedures.
4. Coordinating with the OPC Chief, Quality Assurance (QA) Manager, Learning Resources Chief, their respective DDs, and other key officials to develop policies, procedures, or guidelines for processing EEO complaints.
5. Ensuring a seamless transition of complaint processing responsibilities between each discipline.
6. Consulting with EEOC, OEDCA, and the VA Office of General Counsel (OGC) to ensure the VA is in compliance with established case law and regulations.
7. Serving on task forces and committees impacting the complaint process.

(a) **Counselor National Team Leader (NTL).** The Counselor NTL serves as the technical expert for EEO counseling and is responsible for the oversight of the quality and timeliness of the informal counseling process. Other responsibilities are:

(b) **Case Manager National Team Leader (NTL).** The Case Manager NTL serves as the technical expert and advisor for formal complaint processing and is responsible for oversight of the technical aspects of case manager activities.

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(c) **Investigator National Team Leader (NTL).** The Investigator NTL serves as the technical expert for EEO investigations and is responsible for oversight of the technical aspects of the investigative process.

(g) **Counselor Team Leader (TL).** The Counselor TL assigns work, provides technical assistance and guidance to the counselors under their jurisdiction. The Counselor TL is responsible for mentoring, coaching, facilitating, consensus-building and providing technical support to counselors. The Counselor TL is also responsible for reviewing each counseling report to insure it is prepared in accordance with standards and regulatory requirements.

(h) **EEO Counselor.** The EEO Counselor is responsible for providing counseling services. These services are:

1. Providing information to the complainant.
2. Collecting sufficient information to frame the claim(s) and basis(es).
3. Gathering information and affording both the aggrieved person and VA an opportunity to achieve an informal and mutually acceptable resolution of the complaint.
4. Conducting a limited inquiry for the purpose of jurisdictional questions.
5. Seeking resolution of disputes at the lowest possible level.
6. Educating and explaining the benefits of the ADR process.
7. Advising aggrieved individuals of other forums where they can pursue their concerns, i.e., OSC, the negotiated grievance process, MSPB, etc.
8. Preparing administrative files and counselor reports for every complaint counseled.

(i) **Case Manager.** The Case Manager has major oversight responsibilities for the processing of formal complaints of discrimination in a specified geographical location. The case manager is responsible for:

1. Acknowledging receipt of formal complaints, preparing procedural decisions, releasing investigation files, issuing the advisement of rights letter to complainants, and responding to correspondence and EEOC hearing requests.
2. Reviewing, researching, analyzing, and preparing complex, and technically sound procedural determinations, final agency decisions regarding the dismissal of EEO complaints.
3. Ensuring that procedural requirements are met and supported with relevant case law and precedents.
4. Serving as the principal point of contact for an assigned geographical area.

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5. Serving as back-up and handling overflow assignments from the counselor and investigator team leaders.

6. Providing technical assistance and mentoring to counselors, investigators, and other staff, in the absence of team leaders.

7. Ensuring the completeness and accuracy of all data entered into the Complaints Automated Tracking System (CATS).

8. Communicating regularly with management officials, EEO Managers and employees.

9. Resolving issues relating to processing complaints of discrimination.

(j) **Investigator Team Leader (TL).** The Investigator TL is responsible for providing support and guidance to the investigators under their jurisdiction. The Investigator TL is responsible for mentoring new investigators. The Investigator TL is responsible for reviewing each investigation prior to its release to insure the investigation has been completed according to standards and regulatory requirements.

(k) **EEO Investigator.** The EEO Investigator is responsible for investigating accepted claims of prohibited employment discrimination including:

1. Taking statements from witnesses under oath.

2. Gathering pertinent documents and records, and conducting whatever inquiry is necessary.

3. Collecting various data and information sources to obtain, analyze, and present facts.

4. Resolving discrepancies by conducting additional fact-finding, additional witness testimony, and reviewing additional documents.

5. Compiling an investigative file and preparing an investigative report, summarizing all relevant facts so a decision-maker can determine the relative likelihood that unlawful discrimination did or did not occur as alleged.

(l) **Investigator-Case Manager (C-2).** The Investigator-Case Manager (C-2) performs a combination of case manager and investigator duties as identified in paragraph (7)(i) and (7)(k) above. This position is designed to seamlessly adapt to workload fluctuations.

(m) **EEO Program Assistant.** The EEO program assistant provides administrative support to the Regional EEO Officer/Field Manager and field office staff. Duties include tracking and mailing correspondence, monitoring fund control points, and travel expenses, greeting visitors, answering the telephone and distributing mail. Program assistants are also responsible for

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distributing and monitoring correspondence to ensure appropriate distribution and timely action.

(n) **Centralized Investigations Division Manager (CID).** The CID manager facilitates timely assignment and completion of investigations. They work with ORM Regional EEO Officers/Field Managers in assigning cases pending investigation in ORM's national inventory to ORM investigators. The CID manager also reviews and approves contract investigations for release. The CID provides oversight to the Defense Logistics Agency, Document Services who reproduces, digitizes and distributes investigative files.

(o) **Document Management Specialists (DMS).** The DMS provides assistance to the CID Manager in the triaging and assigning of cases to investigators. The DMS monitors and tracks responses to initial document requests made by ORM case managers.

(p) **Alternative Dispute Resolution (ADR) Director.** The ADR Director advises the DAS/RM, the Deputy Dispute Resolution Specialist (DRS) for Workplace ADR, on VA's nation-wide Workplace ADR program. The ADR Director is responsible for:

1. Developing VA-wide policy and overseeing VA organizations' policy and efforts to manage conflict and resolve workplace disputes.
2. Collaborating with and advising VA organizations and stakeholders, such as Human Resources, OGC, and VA employee national and local labor unions, in designing, developing, and implementing ADR programs department-wide.
3. Representing VA on interagency work groups and committees.
4. Coordinating department-wide training on conflict management and ADR.
5. Tracking, monitoring, and reporting the quantity and quality of VA's Workplace ADR activities.
6. Identifying key issues affecting the use of ADR, assessing participation in ADR, cost savings, timeliness, satisfaction, and providing regular reports to the DAS/RM and appropriate VA officials on key ADR metrics.

(q) **Executive Operations (EO) Director.** The EO Director is responsible for oversight of five programs that provide support to ORM field offices to improve the organizational performance of ORM. The support programs include OPC, QA, External Affairs, Organizational Climate Assessment Program and Customer Service. The EO Director is responsible for:

1. Formulating and implementing organizational wide policies and procedures related to complaint processing.

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2. Issuing department-wide policies and procedures to ensure the integrity, effectiveness, and impartiality of the complaint processing system.
3. Overseeing of customer service satisfaction surveys.
4. Developing policy and procedural guidance related to the Privacy Act and the Freedom of Information Act.
5. Maintaining of the discrimination complaints tracking system.
6. Providing oversight of organizational climate assessment program activities which measures employee satisfaction in the workplace.

(r) **Organizational Climate Assessment Program (OCAP) Manager.** The OCAP Manager is responsible for ORM's Organizational Climate Assessment Program and assists the VA in early resolution and complaint prevention. The OCAP Manager measures employee satisfaction in the workplace by conducting surveys, focus groups, interviews, review of complaints, grievances, human resource and EEO data. The OCAP Manager identifies significant systemic patterns, trends and problems in the work environment and provides the DAS/RM an Assessment Report, which is distributed and used by appropriate VA officials to improve VA's work environment.

(s) **Office of Policy and Compliance (OPC) Chief.** The OPC Chief has responsibility for developing policies and procedures for processing complaints of discrimination. Other responsibilities are:

1. Issuing VA and ORM Directives, Handbooks, and Bulletins to ensure that policies and procedures for processing EEO complaints meet the requirements of the law and regulations. All policies, procedures, or guidelines for processing EEO complaints are coordinated with QA, Learning Resources Chief, the DDs, NTLs, and other key officials.
2. Providing technical guidance ORM-wide to preserve the integrity of the EEO complaint processing system.
3. Preparing mandated quarterly and annual Senior Manager Reports and the Annual No Fear Act Report.
4. Monitoring agency compliance with OEDCA, EEOC decisions and EEO settlement agreements.
5. Evaluating OEDCA and EEOC remand decisions to discern patterns or trends and providing guidance to ORM Field Offices.
6. Rendering decisions on breach of settlement agreement claims and claims of dissatisfaction with the processing of EEO complaints.

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- 7. Supervising compensatory damage investigations.
- 8. Conducting preliminary inquiries into age discrimination claims when a notice of intent to sue has been served on the agency.
- 9. Responding to all Congressional inquiries, Secretary inquiries and controlled correspondences related to EEO matters.

(t) **Directive Management Officer (DMO).** The DMO develops, controls, reviews, publishes, distributes and maintains ORM directives, handbooks and policies with oversight by the OPC Chief. The DMO provides advice and assistance to ORM personnel on developing, coordinating, reviewing, approving, and maintaining a Document Management System (DMS).

(u) **Internal Complaints EEO Manager.** The Internal Complaints EEO Manager serves as principal advisor to the ADAS/RM on all ORM EEO related matters. This includes managing the processing of complaints filed by ORM employees. Other responsibilities are:

- 1. Coordinating with the OEDCA Point of Contact to ensure that all ORM internal complaints are processed in accordance with EEOC regulations, the ORM Internal Complaints SOP, and the Memorandum of Understanding between ORM and OEDCA.
- 2. Receiving initial contact information from ORM employees, former employees and applicants for employment.
- 3. Forwarding initial contact information to the OEDCA POC for assignment to a contractor.
- 4. Entering internal complaint data into the applicable data fields and screens and scanning all relevant complaint documents into CATS.
- 5. Providing the ADAS/RM and DDs with a monthly status report of all ORM internal complaints.
- 6. Coordinating with the ADR Director, complainants, management officials, and other necessary parties to facilitate ADR participation.
- 7. Monitoring compliance with ORM settlement agreements and orders from OEDCA and the EEOC Office of Federal Operations.

(v) **Quality Assurance (QA) Manager.** The QA Manager is responsible for ORM's Quality Assurance Program, Data Management, and CATS. The QA Manager is responsible for:

- 1. Establishing assessment guidelines for reviewing and documenting compliance with applicable laws and regulations regarding the processing of EEO complaints.
- 2. Evaluating each field office to ensure complaints are processed in accordance with EEOC and ORM guidelines.

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3. Developing and reporting on key reporting mechanisms to the DAS/RM, ADAS, key management officials in ORM, internal VA customers, and EEOC.

4. Providing the EO Director with necessary reports, evaluations, and/or trend data regarding ORM compliance with applicable laws and regulations governing the processing of EEO complaints.

5. Overseeing CATS and its daily operation of the system which includes making modifications for improvement and maintaining quality control over operation of the system.

(w) **Customer Service Manager.** The Customer Service Manager is responsible for tracking, reviewing, analyzing, and monitoring internal and external customer satisfaction throughout ORM. The data collection process includes quantitative and qualitative data gathering processes and is utilized to gather information from VA employees that participate in the EEO complaints process, EEO Managers, VA Senior Managers, OEDCA, OGC (to include the Office of Regional Counsel), EEOC and other management officials who may provide responses during the EEO complaint process. Other responsibilities are:

1. Evaluating workload statistics, customer service surveys and focus group's outcomes to define ORM's internal and external customer service goals and performance standards. This evaluation may be targeted towards a specific region, field facility or situation.

2. Developing detailed plans, goals, and objectives for short and long-range implementation and administration of a complete, comprehensive, and consistent internal and external Customer Service Program.

3. Providing the DAS/RM a customer service assessment report, which is distributed to appropriate VA officials.

4. Providing EEO policy guidance, advisory assistance, and support to VA managers in the development of strategic planning for applying customer service principles to core business areas.

5. Ensuring reliability, creditability, and validity that improves job satisfaction for all ORM employees and improves customer satisfaction levels for all ORM stakeholders.

(x) **External Affairs Officer.** The External Affairs Officer serves as the agency liaison to the Department of Justice for external complaints filed with the agency under Title VI of the Civil Rights Act of 1964 and other similar statutes, such as Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and various Presidential Executive Orders. The External Affairs Officer is responsible for:

1. Serving as ORM's Freedom of Information Act and Privacy Act Officer.

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2. Advising the DAS and ADAS on public affairs issues relating to the media and special interest group contacts.

3. Providing guidance to ORM employees regarding The Freedom of Information Act under 5 U.S.C. §552, as amended by Public Law Number 104-231, 110 Statute 3048.

4. Assisting the DAS and ADAS/RM with presentation and development of speeches.

5. Coordinating the publication and dissemination of ORM's annual report and newsletter.

(y) **ORM Ombudsman.** Under charter by the DAS/RM, ORM's Ombudsman is responsible for:

1. Providing confidential advice and assistance to ORM managers and staff concerning workplace issues affecting employee productivity, job satisfaction or related processes or policies.

2. Formulating recommendations to ORM officials concerning workplace processes and policies affecting employee satisfaction and morale.

3. Providing, and collaborating with the ADR Director to provide, ADR services to VA organizations or employees requesting assistance with workplace issues and making recommendations on resolving such issues.

4. Providing, with the consent of the DAS/RM; ombudsman services under memorandum of understanding to VA organizations requesting such services.

5. Serving as a member of the ADR Council.

6. Performing other collateral duties in ORM not inconsistent with the Ombudsman's duties as requested.

(z) **Budget Officer.** The Budget Officer manages the budget operations for ORM in Headquarters and field operations areas. The primary responsibilities include budget formulation, execution, justification and presentation. The Budget Officer serves as ORM's Publications Control Officer. The Budget Officer will review, ensure adequate funding is available, approve, and order all printing and publications for ORM.

(aa) **Human Resource (HR) Manager.** The HR Manager serves as the principal advisor to the DAS/RM and ADAS/RM, and other ORM supervisors and managers on all human resources related matters, including employee relations matters. The HR Manager is the Position Management Coordinator for ORM. This includes coordinating with the Central Business Office, Workforce Management and VA Central Office in executing personnel actions and activities as it relates to position management, classification, and recruitment and placement activities. The HR Manager is responsible for ensuring policies and procedures are in place to ensure consistency in HR Programs.

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(bb) **Information and Technology (IT) Manager.** The IT Manager serves as technical advisor to the DAS on IT issues affecting ORM. The IT Manager plans, evaluates, develops, operates and maintains ORM's automated voice, video teleconferencing, and IT systems. The IT Manager provides technical oversight, formulates policy on IT systems and develops effective, timely, cost-efficient and innovative program plans and operating systems. The IT Manager evaluates the effectiveness of ORM's IT administrative policies, procedures, management practices, and recommends appropriate adjustments or alternative methods. The IT Manager keeps the DAS/RM, ADAS/RM, and other ORM supervisors and managers advised of significant IT activities impacting ORM and coordinates with Headquarters.

(cc) **Learning Resources Chief.** Learning Resources Chief serves as VA's and ORM's key official for all national EEO training programs that focus on the EEO complaint resolution process. The Learning Resources Chief responsibilities are:

1. Administering EEO training programs.
2. Developing project plans.
3. Analyzing learning needs of EEO professionals.
4. Designing course curriculum.
5. Developing training content and product marketing plans.
6. Implementing training initiatives to include, mandatory EEOC training.
7. Evaluating EEO training initiatives and programs.

c. Office of Employment Discrimination Complaints Adjudication (OEDCA)

(1) Issues FADs for individual, class action, and sexual orientation complaints, that do not go to EEOC for hearing.

(2) Issues FADs on compensatory damages and attorney fees, in consultation with OGC concerning the reasonableness of an attorney's hourly rate for the geographic location involved.

(3) Issues FADs, to include breach of settlement claims where the complainant is an ORM employee, and other cases where complaint processing efficiency will be best served by OEDCA.

(4) Issues final agency actions, within forty (40) calendar days of receipt of an EEOC hearing decision.

(5) Initiates follow-up reviews for possible disciplinary action in sustained intentional discrimination and retaliation complaints.

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(6) Remands complaints to ORM for supplemental investigation and, where administratively appropriate, remands complaints for procedural decisions.

(7) Issues the procedural decision on complaints of discrimination filed by ORM employees when bases for dismissal may exist in whole or in part.

d. Office of General Counsel (OGC). The OGC assists the Secretary and the AS/HRA in conducting reviews of cases where there has been a finding of discrimination. The OGC represents VA at EEOC hearings, in administrative appeals of final agency decisions or orders and requests for reconsideration of EEOC decisions. The OGC assists the United States Attorney in defending lawsuits filed against the VA and advises VA officials on EEO related matters and issues formal opinions relating to the VA's EEO program. The OGC consults with OEDCA concerning the reasonableness of an attorney's hourly rate for cases where there is a finding of discrimination and the payment of attorney fees has been granted.

e. Office of Inspector General (OIG). As specified in the Memorandum of Understanding dated August 22, 2006, with OGC, OIG may serve as the VA representative where an EEO complaint has been filed by an applicant for employment and current and former OIG employees. These responsibilities are:

(1) Assisting the Secretary and the AS/HRA in conducting reviews of cases where there has been a finding of discrimination.

(2) Representing the VA at EEOC hearings, administrative appeals of final agency decisions or final actions, and requests for reconsideration of EEOC decisions.

(3) Assisting the United States Attorney in defending lawsuits filed against the VA.

(4) Advising VA officials on EEO related matters.

(5) Consulting with OEDCA regarding award of attorney's fees.

f. Under Secretaries, Assistant Secretaries, and Other Key Officials. Under Secretaries, Assistant Secretaries, and Other Key Officials are responsible for eliminating discriminatory policies and practices, and maintaining a discrimination-free workplace. They are responsible for:

(1) Taking an active role to resolve EEO complaints and workplace disputes.

(2) Publicizing and permanently posting on official bulletin boards, the name, telephone number, and location of the regional ORM Field Office and the time limits for contacting an EEO counselor, Union, and MSPB with allegations of prohibited discrimination.

(3) Ensuring compliance with orders issued by the OEDCA, EEOC, and EEO related cases from the MSPB, Labor Arbitrators, and the Federal Labor Relations Authority (FLRA).

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(4) Appointing an EEO manager should be consistent with the needs and availability of resources. This could be on a full-time, part-time or collateral duty basis, as appropriate.

(5) Implementing an ADR program in accordance with VA Directive 5978, Alternative Dispute Resolution.

(6) Establishing policies that facilitate the appropriate use of ADR, especially mediation, to help resolve EEO complaints and workplace disputes and designate an ADR coordinator to manage the ADR program.

g. EEO Manager. The role of the EEO manager is vital in support of ORM's mission. It is important for a person to be designated to serve in this capacity. In any case where an EEO Manager believes that he/she has, or may have, a conflict of interest with, or otherwise believes that there are facts or circumstances that might create the appearance of a conflict, the employee will immediately report the matter to their supervisor. The EEO Manager is responsible for:

(1) Providing assistance in efforts to resolve claims during the informal stage, and after the filing of formal complaints of discrimination.

(2) Obtaining facility assistance to ORM during EEO complaint processing.

(3) Coordinate EEOC hearing activities with Regional Counsel.

(4) Monitoring compliance with all settlement agreements and orders issued by the OEDCA, EEOC, and EEO related cases from the MSPB, Labor Arbitrators, and the FLRA.

(5) Notifying management if compliance falters.

(6) Coordinating with ORM's OPC Chief and appropriate management officials to bring compliance actions to closure.

h. Alternative Dispute Resolution (ADR) Coordinator. ADR coordinators are located throughout the VA and are responsible for the daily operation of ADR programs under their jurisdiction and collaborating with affected offices in providing effective ADR services and processes.

i. Dispute Resolution Specialist (DRS). The AS/HRA is the DRS for VA. The DRS is appointed pursuant to the Administrative Dispute Resolution Act (ADRA), the VA DRS is the senior official within the VA responsible for the development and implementation of the VA's ADR program.

j. Management Officials and Supervisors. Managers and supervisors will provide equal opportunity to all employees within their operations by promoting an environment free of discrimination. They will not reprise against, coerce, restrain or interfere with an employee's

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rights to use the EEO complaint process; and will cooperate with EEO officials and administrative judges by providing, upon request, information in connection with the processing of an administrative complaint.

k. **Employees.** Employees at all levels are responsible for providing support to the overall equal employment program as appropriate in the performance of their official duties. They will treat all individuals in a fair and equitable manner without discrimination. They will cooperate with EEO officials and administrative judges by providing, upon request, information in connection with the administrative processing of an EEO complaint.

4. REFERENCES

- a. Age Discrimination in Employment Act of 1967, as amended, 29 U.S.C. §§621-634.
- b. The Administrative Dispute Resolution Act of 1996, (ADRA), 5 U.S.C. §§571-584.
- c. Americans with Disabilities Act of 1990, 42 U.S.C §12101 et seq.
- d. Architectural Barriers Act of 1968, as amended 42 U.S.C. §§ 4151 et seq.
- e. The Civil Rights Act of 1964, as amended, 42 U.S.C §2000e et seq.
- f. The Genetic Information Nondiscrimination Act of 2008, (GINA), 42 U.S.C. § 2000ff-1(b).
- g. Department of Justice (DOJ), The Freedom of Information Act 5 U.S.C. §552 , as amended by Public Law No. 104-231, 110 Stat. 3048.
- h. EEOC Regulation 29 C.F.R. §1614.
- i. EEOC Management Directive 110 (MD 110), November 9, 1999.
- j. EEOC Management Bulletin 100-1 (MB 100-1), October 24, 2003.
- k. EEOC Management Directive 715, October 1, 2003.
- l. EEOC Instructions to Federal Agencies for Equal Employment Opportunity Management Directive 715 (EEO-MD-715), March 31, 2004.
- m. EEOC, Equal Pay and Compensation Discrimination, September 20, 2001.
- n. EEOC Facts about Compensation Discrimination, May 11, 2000.
- o. Equal Pay Act of 1963, 29 U.S.C. §206(d).

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p. Executive Order 12067, Agency and EEOC Authority and Responsibility, transferred the functions of the EDO Coordinating Council to the EEOC and delineated the EEOC's responsibility for developing uniform standards, guidelines, and policies for promoting and furthering equal employment opportunity in the government.

q. Executive Order 12106, Transfer of Certain EEO Enforcement Functions, amends Executive Order 11478 to include in its coverage non-discrimination based on age and disability. The Order also transferred Federal equal employment opportunity enforcement authority to the EEOC and made the EEOC responsible for directing and furthering the implementation of equal employment opportunity policy.

r. Executive Order 13145, To Prohibit Discrimination in Federal Employment Based on Genetic Information, is self-descriptive.

s. Executive Order 13160, Nondiscrimination on the Basis of Race, Gender (Sex), Color, National Origin, Disability, Religion, Age (40 years and over), Sexual Orientation, and Status as a Parent in Federally Conducted Education and Training Programs.

t. Executive Order 13164, Requiring Federal Agencies to Establish Procedures to Facilitate the Provision of Reasonable Accommodation, is self-descriptive.

u. Merit Systems Protection Board (MSPB), Questions and Answers about Appeals.

v. Notification and Federal Employee Antidiscrimination and Retaliation (No Fear) Act of 2002.

w. Office of Personnel Management, Position Classification Appeals, June 1998.

x. Office of Special Counsel (OSC), Your Rights as a Federal Employee.

y. Office of Special Counsel (OSC), How to File a Complaint Alleging a Violation of the Hatch Act.

z. Pregnancy Discrimination Act of 1978, Public Law Number 95-955.

aa. Rehabilitation Act of 1973, as amended, 29 U.S.C. §791, §793, §794(a).

bb. Whistleblowers Protection Act of 1989, Public Law 101-12, as amended by Public Law 103-424, October 29, 1994.

cc. VA Authority and Duties of the Secretary, Equal Employment Responsibilities, 38 U.S.C §516.

dd. VA, Delegations of Authority, EEO Responsibilities, 38 C.F.R, §2 and §15.

ee. VA Directive 5975, Diversity Management and Equal Employment Opportunity.

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ff. VA Directive 5975.1 Processing Reasonable Accommodations by Employees and Applicants with Disabilities.

gg. VA Handbook 5975.1, Processing Reasonable Accommodations by Employees and Applicants with Disabilities.

hh. VA Directive 5978, Alternative Dispute Resolution.

ii. VA OEDCA, A Guide to Investigating Employment Discrimination Complaints, August 1999.

jj. VA Office of Resolution Management, A Plan for Transformation Guide, September 1997.

kk. VA Office of Resolution Management, EEO Counselors Manual, September 1997.

ll. VA Office of Resolution Management, Due Professionals Care Standards, 2002.

mm. VA Office of Resolution Management, Realignment Process, December 5, 2008.

nn. VA Office of Resolution Management, Standard Operating Procedures.

oo. VA 's Secretary's Delegations of Authority to Certain Officials, 38 U.S.C. §512.

pp. VA's Secretary's Policy Statement regarding processing EEO complaints based upon sexual orientation, May 13, 2010.

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**Department of Veterans Affairs
Washington, DC 20420**

**VA Handbook 5977
Transmittal Sheet
February 7, 2007**

**EQUAL EMPLOYMENT OPPORTUNITY
DISCRIMINATION COMPLAINTS PROCESS**

1. REASON FOR ISSUE: This handbook establishes the Department of Veterans Affairs (VA) Equal Employment Opportunity (EEO) discrimination complaint procedures as described in VA Directive 5977, EEO Discrimination Complaints.

2. SUMMARY OF CONTENTS/MAJOR CHANGES:

a. This handbook introduces procedures for carrying out the VA's EEO discrimination complaint processing requirements contained in various Federal laws and regulations of the Equal Employment Opportunity Commission (EEOC) at part 1614, title 29, Code of Federal Regulations (CFR), that prohibit discrimination based on race, color, religion, gender (sex), national origin, age (40 years and over), physical or mental disability, and/or reprisal. This handbook will be revised to reflect changes made by the EEOC in its regulations and/or through the issuance of new or revised directives. This handbook applies to processing discrimination complaints for VA employees, applicants for employment and former employees.

b. VA regulations, guides, bulletins and memoranda published over the years and used by VA to process EEO complaints of discrimination as required by Public Law 105-114.

c. This handbook identifies responsibilities for processing Equal Employment Opportunity (EEO) complaints of discrimination filed by VA employees, former employees and applicants for employment who believe that they have been subjected to employment discrimination.

d. Procedures for insuring that complaints of discrimination are either resolved at the earliest possible stage; or processed promptly and impartially, without restraint, interference, coercion, discrimination and/or reprisal is set forth in this handbook.

3. RESPONSIBLE OFFICE: The Office of Resolution Management (ORM), Deputy Assistant Secretary (DAS) is responsible for the material contained in this Handbook.

4. RELATED DIRECTIVE: VA Directive 5977, Discrimination Complaints.

5. RESCISSIONS: Portions of VA Manual MP-7, Equal Opportunity in the Department of Veterans Affairs, Part I, Internal Equal Employment Opportunity Program, Chapter 1, EEO General Provisions and Internal EEO Program and all of Chapter 3, Discrimination Complaints, December 14, 1984.

CERTIFIED BY:

**BY DIRECTION OF THE
SECRETARY OF VETERANS
AFFAIRS:**

/s/
Robert T. Howard
Assistant Secretary for
Information and Technology

/s/
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DISCRIMINATION COMPLAINT PROCESSING PROCEDURES

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CHAPTER 1 - INTRODUCTION

1. PURPOSE. This handbook establishes Department of Veterans Affairs (VA) procedures for processing Equal Employment Opportunity (EEO) complaints of discrimination. These procedures apply to all VA employees, applicants for employment and former VA employees.

2. BACKGROUND

a. Several anti-discrimination statutes prohibit workplace discrimination in the Federal government. They include Section 717 of Title VII of the Civil Rights Act of 1964, as amended, which prohibits discrimination based upon race, color, national origin, gender (sex), and religion; Section 501 of the Rehabilitation Act of 1973, which prohibits discrimination based upon disability; Section 15 of the Age Discrimination in Employment Act (ADEA), which prohibits discrimination based upon age (40 years and over); and the Equal Pay Act which prohibits gender (sex) based wage discrimination. These statutes provide the basis for the implementation of EEO programs designed to eliminate prohibited discrimination and to make whole, employees who have been victimized by discrimination.

b. The Equal Employment Opportunity Commission (EEOC) under Reorganization Plan No. 1 of 1978 was given responsibility for and supervision of EEO programs within the Federal government. Through regulations found at 29 CFR §1614, and Management Directive 110, the EEOC has published policy and the framework for an EEO complaint resolution process that provides a foundation upon which Federal agency programs must be based. EEOC directives establish requirements for all aspects of a complaint resolution process including EEO counseling, complaint acceptability activities, complaint investigation and ultimately through hearings and appellate decisions, the standards by which the existence or nonexistence of discrimination may be determined. While the substantive protections for applicants and Federal employees are the same as those for all other workers, the procedures differ from the procedures that govern the private sector.

c. Within the VA, the EEO complaint resolution process was established through a combination of administrative reorganization and statutory direction. 38 USC 516 directs the Secretary to provide that the employment discrimination complaint resolution system be established and administered in a fair, objective manner that encourages timely and fair resolution. To meet these objectives, a 1997 administrative reorganization produced the Office of Resolution Management (ORM), which is managed and directed by the Deputy Assistant Secretary (DAS) for Resolution Management (RM).

d. The following chapters of this handbook provide VA procedures for processing EEO complaints of discrimination. Appendix E contains a diagram of the EEO discrimination complaint process and the time-frames associated with various stages of the process.

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CHAPTER 2 – THE INFORMAL PRE-COMPLAINT EEO COUNSELING PROCESS

1. THE INFORMAL PRE-COMPLAINT EEO COUNSELING PROCESS. The discrimination complaint process is divided into two stages: the Pre-complaint (Informal EEO Counseling) Process, and the Formal Complaint Process. The purpose of the pre-complaint process is to gather information and afford both the aggrieved person and VA an opportunity to achieve an informal and mutually acceptable resolution of the matter. EEO counseling is a regulatory prerequisite to filing a formal complaint of discrimination and the employee, under any circumstances, cannot waive it.

2. INITIAL CONTACT. An aggrieved person who believes that he/she has been discriminated against on the basis of race, color, religion, gender (sex), national origin, age, disability or reprisal and intends to invoke the EEO complaint process, must consult an ORM EEO counselor prior to filing a complaint. The EEO counselor contact must be within 45 days of the date of occurrence of the alleged discriminatory event, or if a personnel action, within 45 days of the effective date of a personnel action. An aggrieved may contact an ORM EEO counselor in person at their local ORM office, or by calling ORM's toll free telephone number at: 1-888-RES-EEO1 (1-888-737-3361), or for the hearing impaired contact ORM via TTY/TDD – 1-888-626-9008. Counseling is a centralized ORM function; therefore, the aggrieved person is not allowed to select an EEO counselor of his/her choice. However, under certain circumstances, the aggrieved may request the appointment of another EEO counselor. The decision will be made at the discretion of the Regional EEO Officer/Field Manager. This usually occurs when there is, or appears to be, a conflict of interest.

a. Waiver of 45-day contact. EEOC regulations permit, under certain circumstances, the tolling or waiver of the 45-day contact requirement where untimely contact has occurred. Generally, forgiveness of the requirement will be granted where the VA cannot establish that it provided actual or constructive notice (e.g., via the posting of ORM posters throughout a facility) of the time limits to an individual; where the individual did not know or reasonably should not have known that discrimination occurred; where, despite due diligence, the individual was prevented from contacting a counselor due to circumstances beyond the individual's control, or for reasons considered sufficient by the agency.

b. Obtaining General Information. During initial contact, the following preliminary information is solicited from the aggrieved person to complete an Initial Referral Form: (a) date of contact; (b) name; (c) VA facility involved in the alleged discriminatory act and whether the caller is an employee, former employee of the facility, or an applicant for employment; (d) position title and grade; (e) telephone number where the individual can be reached; (f) home telephone number and address; (g) name, address, and telephone number of the individuals representative; (h) claim and basis(es) for the initial contact. The referral form is assigned to an EEO counselor for further processing. EEO counseling begins immediately or not later than two (2) business days from the initial contact. In emergency situations or if an EEO counselor is not available, an Intake Specialist will speak with the aggrieved person to secure the basic preliminary information. The date the aggrieved person contacts ORM, is considered the initial contact date.

3. RIGHTS AND RESPONSIBILITIES. The initial interview between an aggrieved person and the EEO counselor shall be arranged as soon as possible after initial contact. At the initial interview with the aggrieved person, the EEO counselor reviews all rights and responsibilities with the aggrieved verbally, and in writing. The EEO counselor will discuss the following information with the aggrieved:

a. **Anonymity.** The aggrieved person has a right to remain anonymous. If the aggrieved person elects to waive his/her right to anonymity, the counselor will obtain the waiver of anonymity in writing. The aggrieved person is informed that he/she can only remain anonymous during the informal counseling stage and that anonymity does not continue once a formal complaint has been filed.

b. **Representation.** The aggrieved person is entitled to representation during the EEO process. The aggrieved party may select anyone to represent them, as long as his/her representative's position with the VA does not present a conflict of interest. The EEO counselor may not be the complainant's representative. The aggrieved person must provide in writing the name, title, address and telephone number of any representative (attorney or non-attorney) he/she designates to represent him/her in this matter. If a representative or attorney is designated, all documents pertaining to the EEO complaint will be submitted directly to the representative or attorney with a copy to the aggrieved person.

c. **Alternative Dispute Resolution.** The aggrieved person is advised that the claim(s) may be addressed through the agency's Alternative Dispute Resolution (ADR) program or EEO counseling, but not both. The EEO counselor will explain that ADR is available during the informal and formal complaint process. The aggrieved person is informed that he/she, as well as the agency's participation in ADR is voluntary and if they agree to participate in mediation, the counseling period may be extended up to but not more than 90 calendar days from the initial contact date. The EEO counselor explains to the aggrieved that if they participate in ADR they will have to exercise an election option, and decide whether to continue pre-complaint resolution through the ADR process or through the traditional counseling process. The EEO counselor will explain the differences between the two options. If the aggrieved and management do not agree to ADR, the EEO counselor will assist the parties to facilitate resolution of the dispute as part of his or her counseling duties. If the aggrieved and management agree to participate in the ADR process, the EEO counselor will assist with the coordination of ADR. See item 13 for Information about the ADR process.

d. **Bargaining Unit Employee.** Bargaining unit employees have the right to file a grievance on issue(s) through a negotiated grievance procedure that accepts issues of discrimination. However, they may not file both an EEO complaint and a grievance on the same matter(s). Whichever the aggrieved person files first, a formal EEO complaint or step 1 grievance will be considered an election to proceed in that forum. A Bargaining unit employee may also seek redress through other administrative processes. Appendix C contains Other Grievance and Administrative Processes.

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e. Non-Bargaining Unit Employee. Non-Bargaining unit employees may not file a negotiated grievance, they may seek redress through other administrative processes. Appendix C contains Other Grievance and Administrative Processes.

f. Merit Systems Protection Board (MSPB). An aggrieved person may file an EEO complaint or an MSPB appeal, but not both on the same matter(s). Whichever is filed first (a formal EEO complaint or an MSPB appeal) will be considered an election to proceed in that forum.

g. Termination of Counseling. Within thirty (30) days of the aggrieved person's first contact with an EEO counselor, they have the right to receive a written notice terminating counseling and informing them of the right to file a formal complaint (unless prior written consent has extended the time period). The aggrieved person also has the right, at the conclusion of counseling, to file a formal complaint within fifteen (15) calendar days of receipt of the written Notice of Right to File a Discrimination Complaint.

h. Age Discrimination. An aggrieved person, who is age 40 years or older, may file an age based EEO discrimination complaint, or a civil lawsuit in Federal District Court. If the aggrieved person files a lawsuit in Federal District Court, without filing a formal EEO complaint, the lawsuit will terminate the processing of the EEO discrimination complaint. If, the complainant chooses to file an EEO discrimination complaint, he/she must complete the EEO discrimination process. If the complainant chooses to file a lawsuit he/she must first notify the EEOC of the intent to sue, at least 30 calendar days before the filing of the lawsuit at: 1801 L Street, NW, Washington, DC, 20507. Lawsuits must be filed within 180 calendar days of the date of the alleged discriminatory act.

i. Equal Pay Act/Sex-based Wage Discrimination. If an aggrieved person is complaining about sex-based wage discrimination (being paid less than a person of the opposite sex, even though they are doing equal work), they may file a formal EEO complaint under the discrimination complaint process, and/or a lawsuit in Federal District Court, pursuant to the Equal Pay Act. The civil action must be filed within a court of competent jurisdiction within two years, or, if the violation is willful, within three years of the date of the alleged violation of the Equal Pay Act. The filing of an EEO discrimination complaint does not toll the time for filing a civil action. Recovery on back wages is limited to two years prior to the date of filing suit, or to three years if the violation is willful; liquidated damages in an amount equal to lost back wages may also be awarded. An aggrieved individual may file an EEO discrimination complaint, and may file directly in a court of competent jurisdiction without first providing notice to the EEOC or exhausting the EEO discrimination complaint process. Filing of a lawsuit will terminate processing of the EEO discrimination complaint.

j. Right to Request Final Agency Decision (FAD) or a Hearing. If an aggrieved person files a formal EEO complaint and it is accepted, they have the right to request an immediate FAD from VA, or a hearing before an EEOC Administrative Judge, after 180 days has passed from the date they file a formal complaint, or after completion of the investigation, whichever comes first. If a complainant requests a FAD, their request should be addressed to the ORM Regional EEO Officer. If a complainant requests an EEOC hearing, their request should be

addressed to the local EEOC District Office, with a copy to the ORM Regional EEO Officer.

k. Right to File a Lawsuit in Federal District Court. A complainant has the right to file a lawsuit in Federal District Court at any time after 180 calendar days has passed from the date the formal complaint was filed or up to ninety (90) calendar days after receipt of a FAD from VA.

l. Right to File An Appeal. A complainant has the right to file an appeal of a FAD to EEOC within thirty (30) calendar days of receipt of the FAD. Even if a complainant chooses to appeal a FAD to EEOC, they will still have the right to file a lawsuit in Federal District Court at any time after 180 calendar days has passed from the date of filing of such an appeal, or up to ninety (90) calendar days after receiving an appellate decision from EEOC Office of Federal Operations. Special circumstances regarding the right to file a lawsuit in Federal District Court exist for Age and Equal Pay Act/Sex-based Wage Discrimination. Please refer to item 3(g) and 3 (h) of this chapter.

m. Class Action Complaint. If an aggrieved person believes that other individuals, similarly situated to them, have suffered from the same kind of discrimination, they may have the right to file a class action complaint. A class action complaint must allege that an individual has been individually harmed by a VA personnel management policy or practice that has similarly harmed numerous other class members. The aggrieved person must also allege that there are questions of fact that are common to, and typical of, the claims of the class. EEOC requires that a qualified class agent represent the class. The representative must be fair and adequately protect the interest of the class.

n. Cooperation. An aggrieved individual has the responsibility to cooperate with VA during the processing of a complaint. If an aggrieved person files a formal EEO complaint, he/she must keep the VA informed of a current address; retrieve certified and over night mail associated with the complaint, and cooperate with the investigator. If an aggrieved person files an appeal with EEOC, they must provide the ORM Regional EEO office copies of the appeal.

o. Back pay. If a complaint involves back pay, the complainant has a duty to mitigate damages by actively seeking and/or retaining employment. Interim earnings or amounts, which could be earned by a complainant with reasonable diligence, generally will be deducted from back pay.

p. Consolidation of Two or More Complaints. If a person has filed two or more complaints, and the Notice of Advisement of Rights was not issued, ORM is required to consolidate them after appropriate notice. When a complaint has been consolidated with one or more earlier complaints, ORM shall complete the investigation within 180 days after the filing of the last complaint or within 360 days of the filing of the first complaint. If the complainant requested a hearing, the EEOC Administrative Judge may consolidate multiple complaints.

q. Additional Issues. An aggrieved person must limit any formal EEO complaint to the matters discussed with the EEO counselor, or to like or related matters. If an individual wishes

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to amend a previously filed complaint, only matters that are like or related to the claim(s) in the pending complaint may be added. In order to protect an individual's rights, an aggrieved person should discuss all claims with the EEO counselor before they file a formal EEO complaint.

r. Agency Offer of Resolution. If an aggrieved person rejects an agency offer of resolution made pursuant to 29 CFR §1614.109(c), it may result in the limitation of the Agency's payment of attorney fees or costs.

s. Claims Outside the EEO Forum. For a complaint filed on the basis of sexual orientation, genetic information, parental status, political affiliation or any other forum falling outside of the EEO process, the aggrieved person should contact their local human resource department for guidance. Some of the alternative procedures for processing these types of complaints are as follows: an appeal to MSPB, a grievance under a negotiated grievance procedure, agency grievance procedures, a complaint filed with the Office of Special Counsel (OSC), or a complaint filed with the Office of the Inspector General (OIG). Appendix C contains Other Grievance and Administrative Processes.

4. NOTIFICATION TO UNDER SECRETARIES/FACILITY DIRECTORS. The EEO counselor forwards to the Under Secretary, Assistant Secretary, Facility Director, and Other Key Official the Notice of Counseling letter to inform him/her that an employee has contacted ORM for EEO counseling. This letter contains specific information concerning the claim(s) raised, the basis(es) of the claim(s), the organizational unit in which the complaint arose, the resolution sought, and the person named as the Responding Management Official (RMO). In cases where the aggrieved person does not waive anonymity, the information ORM will release is limited to protect this right. Under Secretaries/Facility Directors are responsible for notifying ORM if the aggrieved person has filed an MSPB appeal or a grievance through a negotiated grievance procedure on the same matter that has been brought to counseling. This information is crucial in determining acceptability should a formal complaint be filed on the matter or claim being counseled.

5. IDENTIFYING THE CLAIM(S). In an attempt to resolve the entire workplace dispute, the EEO counselor obtains relevant information regarding the claim(s), basis(es), and supporting evidence from the aggrieved person. When the claims and supporting evidence are identified, the sum total of that information may be helpful in the informal resolution of the matter by focusing the parties on the major areas of conflict or disagreement. In the event that informal resolution is not obtained, this information may be used during the formal complaint process to render a proper procedural decision to accept or dismiss the formal complaint in whole or in part.

6. IDENTIFYING THE REMEDY/CORRECTIVE ACTION. The EEO counselor identifies what remedy/corrective action the aggrieved person seeks.

7. IDENTIFYING RESPONDING MANAGEMENT OFFICIALS RMO(S) AND WITNESSES. When possible, the counselor will identify the Responding Management Official (RMO) as well as other witnesses to the events at issue.

8. CORRELATION OF DISCRIMINATION. The EEO counselor requests the aggrieved person to provide reason(s) he/she believes the action was motivated by prohibited employment discrimination.

9. RIGHTS SPECIFIC TO EEO BASIS(ES). In cases involving age and the Equal Pay Act, the EEO counselor provides the aggrieved person verbally and in writing of his/her rights related to these bases.

10. PROCEDURES FOR RELATED PROCESSES. During the EEO interview, the EEO counselor explains jurisdictional issues.

a. For claims that may also be filed through a negotiated grievance procedure or appealed to the Merit Systems Protection Board (MSPB), the counselor provides the aggrieved person verbally and in writing his/her rights related to these processes. For claims related to the various Executive Orders and other related processes, the counselor advises the aggrieved individual of the appropriate forum. Appendix C contains additional information regarding Other Grievance and Administrative Processes.

b. For claims that the agency has violated or has not performed a specific term(s) of a settlement agreement, the counselor does not initiate counseling on the breach allegation. The Regional EEO Officer or designee notifies the aggrieved person in writing, of the process to address his/her allegation that the agency breached the settlement agreement.

11. INFORMAL INTERVIEW. During the informal interview, the EEO counselor schedules interviews with the RMO, the aggrieved person, and the witnesses. This is necessary not only to develop information to aid in informal resolution or acceptability determinations, but also to provide valuable information for the investigator, if a formal complaint is filed. An EEO counselor will determine whether the case warrants an on-site interview by considering the type, number, and complexity of claims, in consultation with the ORM Regional EEO Officer or designee, after collecting the above information. If an on-site visit is appropriate, the counselor may contact the facility EEO/Diversity Program Manager/Liaison/Specialist for assistance with pertinent logistical arrangements, such as a private office with a telephone, to conduct the counseling. An EEO counselor will interview the aggrieved person, witnesses, and the RMO(s) and gather pertinent documentation and/or statistical data.

a. The counselor will interview witnesses and the RMO(s) that the aggrieved person identifies as having information about the alleged discrimination. The RMO's and witnesses are entitled to representation during the EEO process. An RMO or witness may select anyone to represent them, as long as his/her representative's position with the VA does not present a conflict of interest. Interviews will be limited to those individuals with relevant information concerning the claim(s) raised. Individuals identified by the aggrieved person and/or RMO who would provide unduly repetitious information may not be interviewed. However, the counselor will note their names in the counselor's report as having been named as witnesses and the reason(s) they were not interviewed.

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b. The counselor will inform the RMO of all claims against him/her; advise him/her of their rights and responsibilities; and allow the RMO to respond to each claim, suggest witnesses and documents, offer underlying reasons the aggrieved individual filed the complaint, and suggest possible resolution of the claim(s).

c. The counselor will obtain and review copies of all pertinent documentation and/or statistical data.

12. RESOLUTION. The primary focus of EEO counseling shall be informal resolution of the dispute. In this regard, all parties to the dispute shall cooperate with the EEO counselor in reaching an acceptable solution to the problem by considering all possible alternatives. If the matter cannot be resolved at the lower levels (i.e. first or second level supervisor), the EEO counselor is authorized to bring the matter to the attention of the Under Secretaries, Assistant Secretaries, and Other Key Officials and the local ORM Field Office Manager for appropriate assistance. If settlement is likely, the aggrieved person and the facility will negotiate and prepare a written settlement agreement. All resolutions must be in the form of a written settlement agreement, signed by the aggrieved person and the Under Secretaries, Assistant Secretaries, and Other Key Officials or designee and must identify the claim(s) being settled and the EEO case number. A copy of the settlement agreement must be provided to ORM for inclusion in the administrative file. It is advised that Regional Counsels review settlement agreements prior to the agency signing the agreement. Examples of Settlement Agreements and Settlement Agreement Tips can be found on ORM's website at <http://vaww.va.gov/orm>.

13. ELECTION OF ADR. If ADR is agreed upon, the EEO counselor must obtain and complete the information needed to determine the bases, claims, and timeliness before referring the dispute to ADR. If ADR is elected the pre-complaint processing period will be extended up to 90 calendar days. Upon agreement to ADR, the EEO counselor is responsible for the following information:

a. **Mediation Agreement.** The counselor obtains an agreement to mediate which is signed by both parties. After the agreement is signed, the election to proceed through ADR becomes the final election of choice. The counselor informs the complainant that since they elected ADR they will only gather enough information on the basis(es) and claim(s) to assist the agency in making a procedural decision in the event an ADR resolution is not reached. A prototype of a mediation agreement can be found on ORM's website at <http://vaww.va.gov/orm>.

b. **ADR Extensions.** If efforts to resolve the complaint extend beyond the 90-day period allowed by EEOC regulations, the EEO counselor will issue the required Notice of Right to File a Complaint by the 90th day. While mediation continues, the aggrieved may file a formal EEO complaint within 15 days of receipt of the notice.

c. **Resolution through ADR process.** If the dispute is resolved during ADR, the EEO counselor will document the resolution by including a copy of any written settlement agreement with the EEO Counselor's Report.

d. **Conclusion of ADR Process.** If resolution is not achieved during ADR, at the conclusion of ADR or by the 90th day, the counselor will schedule a final interview. During the final interview the counselor will review the claim(s) and basis(es) and issue a Notice of Right to File a Discrimination Complaint.

e. **Counselor's Report.** If resolution is not achieved during ADR, the EEO counselor will prepare an administrative file, which includes a counselor's report, pertinent correspondence, and documents obtained during informal counseling. This must be completed within 10 calendar days after the issuance of the Notice of Right to File a Discrimination Complaint.

14. EXTENSION DURING COUNSELING. Prior to the end of the 30-day counseling period, the aggrieved person may agree in writing to postpone the final interview and extend the counseling period for an additional period of no more than 60 calendar days. Extensions require approval of the ORM Regional EEO Officer or designee.

15. FINAL INTERVIEW. The EEO counselor conducts a final interview with the aggrieved person, in which he/she reviews all of the information obtained by the counselor during the pre-complaint phase. The counselor advises the aggrieved person that he/she must limit any resulting formal complaint to those matters discussed during counseling.

16. NOTICE OF RIGHT TO FILE A DISCRIMINATION COMPLAINT. Each EEO counseling contact shall be closed by the 30th day from initial contact with ORM, except where there is a signed, written extension, settlement agreement or agreement to participate in ADR. The EEO counselor will provide the aggrieved a Notice of Right to File a Discrimination Complaint along with a VA Form 4939, Complaint of Employment Discrimination. The aggrieved person must be asked to sign an acknowledgement of receipt at the bottom of a copy of the notice. The EEO counselor must send the notice to the aggrieved person by overnight or certified mail, return receipt requested. A return receipt or other evidence of receipt must be made part of the EEO counseling record. The EEO counselor may offer to assist the aggrieved person in filling out the VA Form 4939, Complaint of Discrimination. However, such assistance must be limited to the procedural aspects of how to fill out the form. The formal complaint must be filed within 15 calendar days of receipt of the Notice of Right to File a Discrimination Complaint. VA Form 4939 can be accessed electronically at <http://vaww.va.gov/orm/4939Rev11-99.pdf>

17. COUNSELOR'S REPORT AND ADMINISTRATIVE FILE. At the end of informal counseling, the counselor must prepare an administrative file which must include a counselor's report, pertinent correspondence and documents obtained during informal counseling. This must be completed for every contact within ten (10) calendar days after the issuance of the Notice of Right to File a Discrimination Complaint.

18. SUBSEQUENT AMENDMENT OF COMPLAINTS OF DISCRIMINATION. When it is determined during the initial interview that an aggrieved person has a pending related complaint in the process and the Notice of Advise of Rights has not been issued, the EEO counselor does not initiate counseling but follows these steps:

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a. Verifies the existence of an active complaint and its current status in the Web Based Tracking System.

b. Explains the process to amend an existing complaint and informs the aggrieved person that he/she will receive written guidance on how to request an amendment on an existing complaint.

c. Prepares a Subsequent Event and/or Instances letter for signature of the Regional EEO Officer. The letter instructs the aggrieved person to submit a written description of the new incident(s) and request to amend the existing complaint.

d. Upon receipt of the written description of the new incident(s), the intake specialist determines whether the new incident(s):

(1) Provide(s) additional evidence offered to support the existing claim(s), but does not raise a new claim in and of itself;

(2) Raise(s) a new claim that is *like* or related to the claim(s) raised in the pending complaint; or

(3) Raise(s) a new claim that is *not like* or related to the claim(s) raised in the pending complaint.

e. If the new claim is *like* or related to the claim(s) raised in the pending complaint, the new incident(s) will be amended into the existing complaint and EEO counseling is not required.

f. If the new claim is *not like* or related to the claim(s) raised in the pending complaint, an EEO counselor will contact the aggrieved person within two days of the intake specialist's decision and proceed with counseling the new claim. The date of the initial contact will be based on the original date the aggrieved person contacted ORM.

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CHAPTER 3 - THE FORMAL DISCRIMINATION COMPLAINT PROCESS

1. THE FORMAL DISCRIMINATION COMPLAINT PROCESS. VA employees, former employees, and applicants for employment are afforded the right to file a complaint of discrimination in accordance with the provisions of EEOC regulations on claims of discrimination. If the complainant chooses to file a formal complaint, the second phase of the complaint process begins. There are two types of formal complaints of discrimination that can be filed: an individual complaint and a class complaint. When a complainant files a formal complaint of discrimination, steps are initiated to advise the complainant of his/her rights and responsibilities during the formal complaint process. The individual formal complaint process includes the following major procedures: Acknowledgment, Procedural Decision, Investigation, Hearing or FAD, and EEOC Appeal. The following is a summary of the tasks that are performed in all cases:

2. ACKNOWLEDGMENT. Upon receipt of a formal EEO complaint, the following tasks are accomplished to acknowledge receipt:

a. Establish the official filing date. If mailed, the complaint shall be deemed filed on the date it is postmarked. In the absence of a legible postmark, the complaint will be deemed timely filed if received by an ORM official within 5-calendar days of the expiration of the filing period. If delivered in person or telefaxed, the complaint shall be deemed filed on the date it is received.

b. Issue a Notice of Receipt of Discrimination Complaint to the complainant, or the complainant's representative with a copy to the complainant, within 15 calendar days of being advised that the complainant has filed a formal complaint.

c. Issue a Notice of Receipt of Discrimination Complaint to the Under Secretary, Assistant Secretary, Facility Director, and other Key Official. Appended to the acknowledgment letter is a copy of the formal complaint. When the Under Secretary, Assistant Secretary, Facility Director, and other Key Official is named as the RMO, the notice will be sent to the next higher organizational element.

3. PROCEDURAL DECISION. The designated intake specialist reviews the formal complaint to determine if it is acceptable for investigation and makes a recommended procedural decision to the ORM Regional EEO Officer. The intake specialist will either accept or dismiss the complaint in whole or in part.

a. Acceptance Review.

(1) The intake specialist applies the following criteria in accordance with EEOC regulations to determine if the complaint is acceptable for further processing. If additional information is needed to answer these questions, the intake specialist requests the information from the complainant or the Under Secretary, Assistant Secretary, Facility Director, and other Key Official, as appropriate. Upon receipt the complainant/facility has 15 calendar days to provide the information. After the intake specialist receives the response, or after the allotted time has

expired, he or she proceed with the acceptability determination. The acceptance process is not the stage to determine whether there is any merit to the complaint. If all of the following questions are answered “yes”, then the complaint is acceptable for investigation.

(a) Did the complainant contact an EEO counselor within 45 calendar days of the event in dispute?

(b) Did the complainant file a formal complaint within 15 calendar days of receipt of the Notice of Right to File a Discrimination Complaint?

(c) Did the complaint specify each event in dispute and when it occurred?

(d) Does the complainant allege discrimination because of race, color, religion, gender (sex), national origin, age (40 years and over), disability, or reprisal?

(e) Does the complaint state a claim against VA for which a remedy is available?

(f) Is the complaint unique (i.e., not duplicative of another EEO complaint, an appeal to MSPB, or a negotiated grievance)?

(2) If the procedural decision results in the acceptance of the complaint, the ORM Regional EEO Officer transmits an Acceptance of EEO Complaint letter, which notifies the complainant that the complaint has been accepted for investigation and describes the specific claim(s) being accepted. This letter determines and controls what claims will be investigated. Therefore, it is critical that there be an agreement with the complainant on the formulation and statement of the accepted claims. If the complainant believes the accepted claims are improperly formulated, incomplete, or incorrect, they have 7-calendar days, after receipt of the acceptance letter, to notify the ORM Field Office in writing of the disagreement. Upon receipt of the written statement, the ORM Field Office will address the disagreement in writing and include the complainant's statement in the official record. This process is intended to reasonably assure that the proper claims are investigated to avoid the necessity of a supplemental investigation or the risk of sanctions imposed by an EEOC Administrative Judge. A copy of the acceptance letter is transmitted to the Under Secretary, Assistant Secretary, Facility Director, and Other Key Official, along with a Document List. The Document List details the evidentiary documents to be gathered and submitted for inclusion in the investigative file.

b. Dismissal resulting in a Final Agency Decision (FAD). If the procedural decision results in a FAD, dismissing the entire complaint, the complainant is notified of the reason for the dismissal and provided appeal rights. If, on appeal, the EEOC agrees with the ORM decision, there is no further processing of the complaint. If EEOC disagrees with the ORM decision to dismiss, the complaint will be accepted and processed in the same manner as other complaints. The EEOC has established a number of circumstances under which an agency may dismiss a complaint. A summary of the various reasons for dismissal follows:

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(1) **Failure to State a Claim.** A complainant must demonstrate that the matter regarded as discriminatory has resulted in harm. If the complainant cannot show some harm with regard to a term, condition, or privilege of employment, the complaint may be dismissed.

(2) **Same Claim Pending or Decided by the Agency or EEOC.** A complainant may not raise the same matter over and over. If the claim has been accepted in a prior complaint that is either pending or decided, the duplicate complaint may be dismissed. In order to dismiss, the claim must not be merely similar, it must be identical.

(3) **Failure to Comply with Applicable Time Limits.** If a complainant fails to raise a claim with an EEO counselor within the 45-day limitation, the claim is untimely raised and may be dismissed unless it is part of a pattern of harassing events, or there is a satisfactory explanation for the untimely contact. When counseling has been concluded and a complainant is issued a notice of right to file a complaint, the formal complaint must be filed within 15 calendar days of receipt of the notice. If it is filed beyond 15 calendar days, the complaint shall be dismissed unless there is an acceptable reason offered for the untimely filing.

(4) **Uncounseled Matters.** If the complaint contains matters not raised with the EEO counselor, they may be dismissed, unless they are like or related to matters that were raised. The test for being "like or related" is whether the uncounseled matter adds to, clarifies, or would reasonably arise in the investigation of the counseled matters. If the test is met, the uncounseled matters will be accepted.

(5) **A Matter Raised in Civil Litigation.** If a complainant chooses to file a judicial complaint over the same matter raised in the EEO discrimination complaint and more that 180 days have passed since the EEO discrimination complaint was filed and the complaint has not been adjudicated, the EEO discrimination complaint may be dismissed. Note: Complainants alleging a violation of the Equal Pay Act (EPA), sex-based wage discrimination may file a civil action in Federal District Court at any time. Please see Chapter 4, item 16 (d) of this document for additional information on EPA complaints.

(6) **Negotiated Grievance Procedure and MSPB Appeal.** If a complainant first files a grievance under the negotiated grievance procedure or MSPB Appeal, and later files a formal complaint, the complaint may be dismissed based upon the complainant's election of another forum. The underlying public policy for both the grievance and MSPB dismissal authority is based upon the premise that a person should not be permitted to adjudicate a matter in separate forums simultaneously, because of the added cost and risk of conflicting results. The matter should only be considered and adjudicated one time, in one forum or the other, but not both. [Also applies if person files an EEO complaint first, then a grievance, but carries the grievance all the way thru to the third step. In such cases, the EEOC has held that, though the EEO complaint was filed first, the fact that the person took the grievance all the way thru to the 3rd step shows the person elected to pursue the grievance.]

(a) **Negotiated Grievance Procedure.** If a grievance under a negotiated grievance procedure, which specifically permits the consideration of discrimination claims, is filed earlier than an EEO complaint on the same matter, the EEO complaint may be dismissed because

the complainant has elected a different forum to litigate the matter. The date the first stage of a negotiated grievance is filed is considered to be the filing date. However, if the grievance is subsequently dismissed for lack of jurisdiction, the filing of the grievance cannot be the reason the EEO complaint is dismissed.

(b) **MSPB Appeal.** If a complainant first files an MSPB appeal of a matter appealable to the MSPB, a later filed EEO complaint may be dismissed based upon the complainant's election of forums.

(7) **Mootness.** If a complaint demonstrates harm when filed, it states a claim to be adjudicated, however, if intervening events or relief have completely eradicated the harm, and there is no reasonable expectation that the alleged violation will recur, the matter is moot and may be dismissed. The difference between mootness and failure to state a claim is that under failure to state a claim, there never was any harm suffered by complainant, but in mootness, there was harm suffered which was subsequently rectified and is unlikely to recur. Therefore, there is no present claim to adjudicate.

(8) **Proposal to take Personnel Action.** The EEOC has determined that a person is not harmed when advised that an adverse action is proposed. The harm occurs only when the action is actually implemented. Prior to implementation of the proposal, the matter may be dropped, settled, or in another way resolved with no further action taken on the proposal. Consequently, a complaint based merely upon a proposal to take a personnel action may be dismissed.

(9) **Failure to locate the Complainant.** The complainant has a duty to cooperate in the processing of the complaint. If the complainant fails to keep the agency apprised as to his/her whereabouts, the agency may dismiss the complaint after reasonable efforts are made to locate the complainant. However, prior to dismissal the agency must send written notice to the last known address that a dismissal is proposed. If there is no response, the complaint may be dismissed.

(10) **Failure to respond to request for information.** If the complaint file lacks needed information to move the process forward, the agency may request the information from the complainant. The request is made in writing and contains a warning that failure to respond to the request may result in dismissal of the complaint. If the complainant fails to respond or responds but does not provide the requested information, the complaint may be dismissed.

(11) **Allegation of dissatisfaction with processing of a complaint.** If a complainant is dissatisfied with the processing of an earlier complaint ("spin-off" complaint), a new complaint expressing that dissatisfaction may not be filed and will be dismissed. An alternative procedure is established to consider and resolve such dissatisfaction in lieu of filing a complaint. In VA, the ORM Office of Policy and Compliance considers and responds to such claims.

(12) **Abuse of Process.** Where a complainant misuses the EEO process for a purpose other than prevention and elimination of discrimination and does so in a clear pattern of

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misuse, a complaint may be dismissed. While the regulatory authority to dismiss is clearly stated, the EEOC has construed such authority narrowly.

c. Partial Acceptance. If the complaint is dismissed in part, the intake specialist prepares the Partial Acceptance letter. The letter sets forth to the complainant the rationale for the determination and notifies him/her which claim(s) will not be investigated. A copy of the decision letter is placed in the administrative file for consideration when the case is adjudicated. If only a portion of the complaint is dismissed, there is no immediate right for the complainant to appeal that decision. The partial dismissal decision is made part of the file, and subsequent to the investigation, if the complainant requests an EEOC hearing, the Administrative Judge (AJ) will review that decision. If the AJ agrees with the decision, the matter dismissed will not be considered during the hearing phase, but at a later point can be raised in an appeal to EEOC. If the AJ disagrees with the ORM decision, the dismissed portions will be considered during the hearing process. If the complainant does not request a hearing but requests an immediate substantive decision from OEDCA, OEDCA will review the partial dismissal. If OEDCA agrees with the ORM decision, it will not substantively consider the dismissed matters. The complainant may appeal the dismissed matters to EEOC after OEDCA renders the substantive final agency decision. If OEDCA disagrees with the ORM partial dismissal, it may order the matter accepted and investigated.

4. INVESTIGATION. EEO complaints meeting acceptability requirements are assigned for investigation and generally investigated within 180 calendar days, unless the parties agree in writing to extend the time period. If the complaint is amended, the investigation shall be completed within the earlier of 180 days after the last amendment to the complaint or 360 calendar days after the original filing of the complaint. In addition, two or more accepted complaints, filed by the same complainant, must be consolidated for investigation. In cases where the complainant has requested an EEOC hearing, the Administrative Judge may decide to consolidate complaints for joint processing. Mixed cases (complaints on matters appealable to MSPB) and non-mixed cases filed by the same complainant are not consolidated for joint processing. The investigation process is as follows:

a. The ORM Regional EEO Officer/Field Manager assigns complaints for investigation, by letter, to the EEO investigator with concurrent notice to the complainant/representative and Under Secretary, Assistant Secretary, Facility Director, and Other Key Official. Investigations of EEO complaints will be conducted by full-time ORM investigators or contractors appointed by ORM. EEO investigators are required to complete their investigations within 30 or 60 days of assignment (depending on method of investigation). Extensions of that period will be granted only under extraordinary circumstances.

b. The EEO investigator reviews the administrative complaint file and completes the Pre-Investigative Planning Document to determine the appropriate theories of discrimination pertinent to the case and the most suitable method(s) of investigation. The method(s) is determined based on the complexity of the case, i.e., number and types of claims. Methods of investigations include: On-Site, Desk (by telephone), Written Affidavit, and Fact-Finding Conferences.

c. The EEO investigator will work with the EEO/Diversity Program Manager/Liaison/Specialist to schedule the investigation, schedule witnesses, acquire documents, and to make other arrangements necessary for the efficient conduct of the investigation. The investigator proceeds as follows:

(1) Determines the dates to conduct the actual investigation.

(2) Discuss with the EEO Manager/Liaison witness scheduling.

(3) Follows-up on request for evidentiary documents (Document List) transmitted to the Under Secretaries/Facility Director at the time the complaint was accepted.

(4) Obtains written affidavit, written interrogatory, or testimony related to the EEO complaint. When written affidavits are obtained the statements are made under penalty of perjury. When individuals are interviewed, the investigator obtains their testimony under oath. There are several ways to obtain testimony: by interrogatories, a court report or by transcription of the tape recording of the interview. All individuals that are interviewed are offered the opportunity to review and make corrections to their testimony. The procedures are outlined below:

(a) At the conclusion of each interview, while on the record, the investigator will obtain an affirmative or negative response whether the witness wants the opportunity to review, make minor changes, sign and be provided a copy of the transcript.

(b) If a witness requests a copy of the transcript the witness may not make any mark on the transcript itself, all revisions to the original transcript will be made on a correction sheet attached to the transcript. Witnesses may not make substantive changes to the transcript. Witnesses are required to return the signed transcript and correction sheet back to the investigator within seven (7) calendar days of receipt of the transcript. If the witness does not provide the signed transcript and correction sheet within the appropriate time limit, it will be deemed that the witness elected to waive his or her right to review, correct and sign the transcript.

(5) Upon completion of evidence gathering, the investigator develops an impartial and appropriate factual summary and analysis, which will evaluate the evidence in the investigative file but will not reach a conclusion as to whether discrimination did or did not occur. The investigator must be unbiased and objective and the investigation must be thorough.

(6) The investigator will submit the investigative summary and record to the ORM Regional EEO Officer or designee for technical review and release.

5. AMENDMENT OF COMPLAINTS DURING INVESTIGATION. When a complainant raises a new incident of alleged discrimination during the investigation, the EEO Investigator instructs the complainant to submit a letter to the ORM Regional EEO Officer describing the new incident(s) and stating that he/she requests to amend his/her complaint to include additional evidence or a claim like or related to the claim(s) accepted for investigation. If the request to amend is received during the investigation and the ORM Regional EEO Officer renders an

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acceptability decision, the EEO Investigator investigates the additional evidence or claim(s). The decision to accept, dismiss or refer amended claims back to counseling is also included in the investigative file. Additional guidance regarding this may be found in this chapter in paragraphs 10 through 12.

6. ADVISEMENT OF RIGHTS. Upon completion of the technical review of the investigative file and summary report, the intake specialist completes the following:

a. Forwards a copy of the investigative file to the complainant and his/her representative, when one has been identified. The file is forwarded with the Notice of Adverseness of Rights letter. This letter notifies the complainant that within 30 calendar days of receiving the investigative file he/she has the right to request a hearing before an Administrative Judge or a FAD by OEDCA, pursuant to 29 CFR §1614.108(f). Copies of the forms to request an EEOC hearing and instructions for requesting a FAD are attached to the Notice. A Request for an EEOC Hearing form can also be obtained through EEOC's website at <http://www.eeoc.gov>.

b. The following actions will follow receipt of the investigative file:

(1) If the complainant and his/her representative examines the investigative file and observes deficiencies, the complainant and/or representative should notify ORM, in writing, of the perceived deficiencies. A copy of the complainant's notification of perceived deficiencies will be included in the investigative file.

(2) If ORM agrees with the alleged deficiencies, ORM will take immediate action to correct them.

(3) If ORM does not agree with the complainant's claimed deficiencies, ORM will prepare a statement explaining the rationale for the disagreement and include it in the investigative file.

c. Transmits a copy of the investigative summary report to the appropriate Under Secretary, Assistant Secretary, Facility Director, and Other Key Official appended to the Notice of Completion of Investigation letter.

7. REQUEST FOR EQUAL EMPLOYMENT OPPORTUNITY COMMISSION (EEOC)

HEARING OR A FINAL AGENCY DECISION (FAD). The complainant has the right to request a hearing before an Administrative Judge or a FAD by OEDCA, pursuant to 29 CFR §1614.108(f). The complainant must request a hearing within 30 calendar days of receipt of the Adverseness of Rights letter, otherwise the intake specialist will send the complaint file to OEDCA for a FAD.

a. **REQUEST FOR EEOC HEARING.** EEOC regulations require that the complainant submit a hearing request directly to the EEOC District Office and a copy to the ORM Field Office having jurisdiction over the geographic area in which the complaint arose. The request for a hearing should be filed on EEOC's Request for a Hearing Form. However, if an appeal form is not available, a written request for a hearing will be acceptable. The hearing request form can be obtained through EEOC's website at <http://www.eeoc.gov>.

(1) Within 15 calendar days of receiving a copy of the complainant's request for a hearing, ORM will send a copy of the complaint file to the EEOC District Office, the Agency Representative and OEDCA. Once a hearing has been requested, all communications and/or matters related to the complaint will be conducted through the Agency Representative.

(2) The scheduling of an EEOC hearing rests with EEOC and the respondent facility. EEOC Administrative Judges are fully responsible for adjudicating the complaint, which means they may dismiss the complaint or issue a decision with or without a hearing.

(3) Where the complainant has requested an EEOC hearing, by EEOC regulation, the EEOC Administrative Judge (AJ) makes a substantive decision on the merits that is binding on the agency, unless OEDCA takes certain action within 40 days of receipt of the AJ's decision. The final action OEDCA must take within the 40-day period is to determine whether or not to implement the EEOC Administrative Judge's decision through the issuance of a final agency action. If OEDCA decides to fully implement the Administrative Judge's decision, the decision becomes the final action of the agency. If the OEDCA final order, which is the notice to complainant, does not fully implement the Administrative Judge's decision, then the agency must simultaneously appeal the matter to EEOC. Whether OEDCA renders a final agency decision or takes final agency action through a final order, the agency must advise the complainant of the right to appeal to EEOC, Office of Federal Operations (OFO) within 30 calendar days of receipt should they be dissatisfied with the decision or final action. The appeal should be filed on EEOC Form 573, Notice of Appeal/Petition to the EEOC. However, if an appeal form is not available a written request for a hearing will be acceptable. EEOC's Notice of Appeal/Petition can be obtained through EEOC's website at <http://www.eeoc.gov>.

b. REQUEST FOR FINAL AGENCY DECISION (FAD). OEDCA renders FADs addressing the merits of all claims in a complaint, including the rationale for their decision. A complainant can elect a FAD by submitting a written request or by failure to respond to the Advisement of Rights letter within 30 calendar days of receiving this notification. After ORM receives the complainant's election, ORM immediately transmits the investigative file to OEDCA upon receipt of the complainant's request for a FAD. In instances where the complainant does not respond to the Notice, ORM transmits the investigative file to OEDCA within 10 calendar days of the expiration of the 30-day period to make an election. OEDCA has 60 calendar days from receipt to render a decision.

(1) Non-Mixed Complaint Procedural Decisions. Where OEDCA issues a decision dismissing a complaint in its entirety, OEDCA will inform the complainant of his/her right to file an appeal with the EEOC. The agency informs the complainant that the appeal must be filed within 30 days of receipt of the FAD. A copy of EEOC Form 573, Notice of Appeal/Petition is attached to the FAD. EEOC's Notice of Appeal/Petition can also be obtained through EEOC's website at <http://www.eeoc.gov>.

(2) Mixed Complaint Procedural Decisions. Where OEDCA issues a decision dismissing a complaint in its entirety, OEDCA will inform the complainant of his/her right to file an appeal with the MSPB. Additional guidance regarding this may be found in this chapter under 16 (a).

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8. CIVIL COURT. If the complainant chooses not to appeal to the EEOC, he/she may file a civil action in United States District Court within 90 calendar days of receipt of the agency decision or final action. The right to file suit in US District Court is also available to any complainant if 180 days has elapsed after the complaint was filed and no final agency decision has been rendered or final action has been taken. Special circumstances exist for filing a civil action in United States District Court for Age discrimination and Equal Pay Act complaints. See item 16 (c) and 16 (d) of this chapter.

9. SPECIAL CIRCUMSTANCES DURING THE FORMAL COMPLAINT PROCESS. There are complaints that have slightly different procedures. This section will describe those complaints and the processing rights in accordance with EEOC Regulations.

a. Mixed Case Complaints. A mixed case complaint is a complaint of employment discrimination that may contain a claim of employment discrimination stemming from an action that can be appealed to the MSPB. The complaint may contain only a claim of employment discrimination or it may contain additional claims that the MSPB has jurisdiction to address. A list of actions that can be appealed to MSPB can be found on MSPB's website at <http://www.mspb.gov>. In a mixed case complaint situation, an aggrieved person may initially file a complaint of discrimination with the VA or an appeal on the same matter with MSPB, but not both. A mixed case complaint filed with the VA is processed as an individual complaint of discrimination with the following exceptions:

(1) Complainant is advised of the acceptance of a mixed case complaint and that if a final decision is not issued within 120 calendar days of the filing date of the complaint, he/she may appeal the matter to MSPB at any time thereafter.

(2) Upon completion of the investigation, the complainant is advised that a FAD will be issued by OEDCA within 45 calendar days without a hearing.

(3) If the complainant is dissatisfied with the FAD he/she may appeal the matter to MSPB (not EEOC) within 30 calendar days of receipt of the FAD.

b. Complaints of Class Discrimination. A "class" by definition, is a group of employees, former employees, or applicants for employment who allege they are adversely affected by a personnel management policy or practice. A class complaint is a written complaint of discrimination filed on behalf of the class by the agent of the class, alleging that the class is so numerous that a consolidated complaint by the members of the class is impractical, that there are questions of fact common to the class, that the claims of the agent of the class are typical of the claims of the class, and that the agent of the class or the representative will fairly and adequately protect the interests of the class.

(1) A class complaint must be signed by the agent or representative and must identify the policy or practice adversely affecting the class as well as the specific action or event affecting the class agent. The complaint must be filed with ORM no later than 15 calendar days after the agent's receipt of the Notice of the Right to File a Class Complaint.

(2) Once a formal complaint is filed on behalf of the “class,” the following actions occur:

(a) ORM notifies the Regional Counsel having jurisdiction to designate an Agency Representative.

(b) Within 30 calendar days of the receipt of a class complaint, ORM forwards the complaint, the name of the Agency Representative, a copy of the counselor’s report and other relevant information about the complaint to the EEOC District or Field Office having jurisdiction over the geographic area in which the complaint arose.

(c) The EEOC Supervisory Administrative Judge assigns an Administrative Judge to issue a decision on certification of the class. EEOC uses the following criteria in determining if the class complaint is subject to dismissal:

i. The complaint does not meet all the prerequisites of a class (i.e., numerosity, commonality, typicality, and adequacy of representation).

ii. The claim lacks specificity and detailed information.

iii. The complaint meets any of the criteria for Dismissal of Complaints under EEOC regulations (i.e., the questions posed under Procedural Decision of this Handbook).

iv. The complainant unduly delayed in moving for class certification.

(d) If it is the decision of the Administrative Judge not to certify the class complaint, within 30 calendar days of receipt of the decision, ORM will issue a letter acknowledging receipt of an individual complaint to the agent and individuals who filed formal complaints on the claim(s) and basis(es) identical to the class complaint. ORM will process each complaint as an individual complaint of discrimination. If it is the decision of the Administrative Judge to certify the class complaint, the VA’s organizational component where the complaint was filed is responsible for notifying all class members. All reasonable means will be used to notify all class members of the acceptance of the complaint within 15 calendar days of receipt of the Administrative Judge’s decision or within a time frame specified by the Administrative Judge. EEOC requires that a qualified class agent represent the class.

c. Age Discrimination Complaints. In order to pursue a formal complaint of age discrimination, the complainant must be at least 40 years of age at the time of the alleged discriminatory event at issue. Age discrimination complaints are processed in the same manner as all other complaints, with one exception. There is an alternate process that allows the age complainant to file a civil action without first filing an EEO complaint. A complainant may go directly to Federal District Court by filing a Notice of Intent to Sue with the EEOC. This notice should be filed at least 30-calendar days in advance of the civil suit. The civil suit must be filed within 180-calendar days of occurrence of the event believed to be discriminatory. The EEOC will immediately advise VA whenever such a notice is received. ORM will then have 30-calendar days to conduct an inquiry to discover whether there is any basis for believing that

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age discrimination has occurred. Responsibility to conduct an inquiry is delegated to the ORM Office of Policy and Compliance. A report of the inquiry, which briefly summarizes the information discovered, must be furnished to the DAS/ORM for transmittal to EEOC, within 30-calendar days. A summary of the charges of the complainant and the responses of management, along with employment statistics that may be relevant, is required. Filing of a private suit will terminate processing of the EEO discrimination complaint.

d. Equal Pay Act Complaints. An Equal Pay Act claim is raised when a complainant alleges that he or she is receiving less pay than an individual of the opposite sex for a job requiring equal skill, effort and responsibility and performed under similar working conditions. Each day the employee continues to receive less pay for equal work is considered to be a continuing violation by EEOC. A complainant may file an EEO discrimination complaint, and may file directly in a court of competent jurisdiction without first providing notice to the EEOC or exhausting the EEO discrimination complaint process. The civil action must be filed within a court of competent jurisdiction within two years, or, if the violation is willful, within three years of the date of the alleged violation of the Equal Pay Act. The filing of an EEO discrimination complaint does not waive the time for filing a civil action. Filing of a private suit will terminate the processing of the EEO discrimination complaint.

10. ADMINISTRATIVE PROCESS CASE AMENDMENT. At the conclusion of an investigation and any time prior to the agency's mailing of the Notice of Advisement of Rights, a complainant may amend a pending EEO complaint to add claim(s) that are like or related to those claim(s) raised in the pending complaint. If the new claim is accepted as like or related, the complainant cannot later seek EEO counseling on the same claim(s) being amended with the pending complaint.

a. When a complainant raises a new incident of alleged discrimination during the processing of an EEO complaint, the complainant must provide the ORM Regional EEO Officer a letter describing the new incident(s) and stating that he/she wishes to amend his/her complaint to include the new incident(s). Upon receipt of the complainant's request to amend an existing formal complaint, an acceptability determination is made to determine if the new incident:

(1) provides additional evidence offered to support the existing claim, but does not raise a new claim in and of itself;

(2) raises a new claim that is like or related to the claim(s) raised in the pending complaint;
or

(3) raises a new claim that is not like or related to the claim(s) raised in the pending complaint.

b. If the ORM Regional EEO Officer determines that the subsequent act(s) of alleged discrimination is like or related to the claim(s) raised in the pending complaint, an Amended Acceptance of EEO Complaint letter is transmitted to the complainant. This letter notifies the complainant that the subsequent act of alleged discrimination has been accepted for investigation and describes the specific claim(s) being accepted.

c. If the ORM Regional EEO Officer determines that the subsequent acts of alleged discrimination do not add to or clarify the original claim, and/or could not have been reasonably expected to grow out of the investigation of the original claim, the later incident will be treated as a new EEO complaint of discrimination. The EEO Officer will instruct the complainant to seek EEO counseling regarding the subsequent act(s).

11. CASE AMENDMENT AFTER AN EEOC HEARING IS REQUESTED. After the complainant has requested a hearing, he/she may file a motion with the Administrative Judge to amend the complaint to include claims that are like or related to those raised in a pending complaint.

12. CASE CONSOLIDATION

a. **Consolidation of Complaints by Two or More Complainants.** Complaints of discrimination filed by two or more complainants consisting of substantially similar allegations of discrimination or relating to the same matter may be consolidated by the agency or EEOC for joint processing after appropriate notification to the parties.

b. **Consolidation of Complaints by the Same Complainant.** Agencies are required to consolidate two or more complaints filed by the same complainant after appropriate notification to the complainant. When a complaint has been consolidated with an earlier filed complaint the agency will complete its investigation within the earlier of 180 days after the filing of the last complaint or 360 days after the filing of the original complaint. A complainant may request a hearing from an Administrative Judge on the consolidated complaints any time after 180 days from the date of the first filed complaint. If a complainant requests a hearing on consolidated complaints prior to the agency's completion of the investigation, the administrative judge will decide how best to insure an appropriate record. Administrative Judges may decide to place the complaint in abeyance until the agency can finish its investigation or by supplementation of the record through discovery or other methods ordered by the Administrative Judge.

c. **EEOC Case Consolidation.** When an Administrative Judge becomes aware that one or more complaints in the agency process should be consolidated with a complaint in the hearing process, the Administrative Judge may consolidate all claims at the hearing stage or hold the complaint in the hearing process until the others are ready for hearing.

13. ACCESS TO FILES. EEOC regulations and the Privacy Act govern access to EEO complaint files. Further guidance on the release of information of EEO files can be found on ORM's website at <http://vaww.va.gov/orm/ormpap.doc>.

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CHAPTER 4 - RESOLUTION OF COMPLAINTS

1. RESOLUTION OF COMPLAINTS. ORM is committed to assisting aggrieved individuals and management in resolving claims of employment discrimination and EEO complaints. EEOC encourages resolution of complaints at all times in the complaint process through a variety of settlement mechanisms: Mediation, Facilitation, Fact Finding, Early Neutral Evaluation, Ombudsmen, Settlement Conferences, Mini-trials and Peer Review. For more detailed information, refer to the Definition Section, Appendix B, of this Handbook or EEOC Management Directive (MD-110).

2. ALTERNATIVE DISPUTE RESOLUTION (ADR). Mediation through Alternative Dispute Resolution (ADR) is available during the informal and formal complaint process. ADR is a process that uses specially trained neutrals (third party mediators), to help individuals resolve disputes. Forms of ADR include, but are not limited to, conciliation, facilitation, mediation, fact-finding, mini-trials and arbitration, or any combination. VA has embraced mediation as its primary method of ADR.

3. OFFER OF RESOLUTION. EEOC regulations provide an incentive through its Offer of Resolution concept. The idea is for the facility and complainant to resolve complaints that will conserve agency resources where settlement reasonably should occur. If the complainant does not accept an Offer of Resolution made in accordance with the requirements of 29 CFR §1614.109(c) and subsequently obtains less relief than had been offered, the complainant's attorney fees will be limited.

4. SETTLEMENT AGREEMENTS AND WITHDRAWAL OF COMPLAINTS. EEOC's and VA's policy is to seek resolution of EEO disputes at the earliest opportunity; therefore, settlement on terms acceptable to both the complainant and the agency is encouraged. When agreement has been reached in principle, the terms should be incorporated into a written settlement agreement. Settlement agreements may include, where appropriate, promotions, back-pay, interest on back-pay, reasonable attorney fees, and compensatory damages as long as the terms do not violate laws, rules, or regulations. Prior to the execution of any settlement agreement, agency officials are advised to consult with the Office of General Counsel or Office of Regional Counsel as appropriate to assure that remedial relief is consistent with the nature of the claim and the terms of the agreement to assure that they are clear, unambiguous, and understandable to the parties. Withdrawal of the EEO complaint by case number and the claim being resolved should be clearly stated in the written settlement agreement. If the complaint is resolved, a copy of the settlement agreement must be provided to the ORM field office with jurisdiction over the case.

a. Settlement Agreement. When a complaint of discrimination is settled a written settlement agreement, signed by both parties is required. The agreement should identify the complaint(s), i.e., cases number(s), claim(s), and basis(es), and also provide that the complainant withdraws all causes of action, including all EEO complaints, grievances, unfair labor practices, civil actions, etc., arising prior to the execution of the agreement. Settlement Agreement Tips can be found on ORM's website at <http://vaww.va.gov/orm/opc/default.htm>.

(1) If both parties agree to settle a matter, ORM staff, upon request, can provide a sample format for a written settlement agreement.

(2) If the complaint is resolved, a copy of the settlement agreement must be provided to the ORM field office.

(3) All settlement agreements should include the following statement: The complainant acknowledges that if (he/she) believes VA has not complied with the terms of this Settlement Agreement, (he/she) may notify the Deputy Assistant Secretary for Resolution Management, in writing, within 30 days of the alleged violation and request the terms of this Settlement Agreement be specifically implemented. Alternatively, (he/she) may request that the EEO complaint be reinstated for further processing from the point processing ceased. Prior to asking the complainant which election he/she would like to make, the complainant should be advised that, if the complaint is reinstated, the parties will be returned to their respective status prior to the settlement and the complainant will be required to repay any money to the Agency paid to him or her as part of the vacated settlement agreement. Thereafter, the complainant may appeal to the Equal Employment Opportunity Commission pursuant to 29 CFR 1614.504 if (he/she) believes that VA has either not fully implemented the Settlement Agreement or improperly failed to reinstate the complaint. The Equal Employment Opportunity Commission states that allegations of subsequent acts of discrimination that violate a settlement agreement shall be processed as separate complaints under §1614.106 or §1614.204. If the complainant believes that (he/she) has experienced reprisal since signing the settlement agreement, (he/she) should bring the matter to the attention of an EEO counselor immediately.

(4) The Older Workers' Benefit Protection Act (OWBPA) sets out strict requirements if a settlement involves a claim of age (40 years and over), discrimination. At a minimum, an agreement to waive an ADEA claim must be clearly written from the employee's viewpoint, specifically referring to rights or claims under the ADEA, have no waivers of prospective rights under the ADEA, and give valuable consideration in exchange for the waiver. It must also specifically state that the complainant has twenty-one (21) calendar days to consider the agreement and seven (7) calendar days following the execution of the agreement to revoke it. In addition, the settlement agreement must also state, in writing, that the employee has the right to consult with an attorney prior to execution of the agreement. An example of a Settlement Agreement for ADEA claims can be found on ORM's website at <http://vawww.va.gov/orm/opc/default.htm>.

(5) The Under Secretary, Assistant Secretary, Facility Director, and Other Key Official or his/her designee must sign all settlement agreements. As it relates to Canteen Service, or the National Cemeteries, the National Canteen Director or the National Cemetery Area Directors must sign all settlement agreements, respectively.

(6) The agency representative will transmit a signed and dated copy of the settlement agreement obtained during an EEOC hearing for inclusion in the administrative file to the ORM's Regional EEO Officer.

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(7) The agency EEO/Diversity Program Manager/Liaison/Specialist will monitor local compliance with settlement agreements and orders issued by the Office of Employment Discrimination Complaints and Adjudication, EEOC, and EEO related cases from the Merit Systems Protection Board, labor arbitrators, and the Federal Labor Relations Authority, as well as ADR agreements. He/she will notify management if compliance falters.

b. **Withdrawal of Complaint.** Should a complainant unilaterally decide to withdraw a claim at any point in the EEO process, the withdrawal must be in writing describing the claims withdrawn, signed, and dated by the complainant. Complaint processing will cease upon receipt of the written withdrawal. Once claims are withdrawn, they cannot be raised again through subsequent contact with an EEO counselor. If the complaint is withdrawn, a copy of the withdrawal statement must be provided to the ORM field office.

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CHAPTER 5 - BREACH OF SETTLEMENT AGREEMENT

1. SETTLEMENT AGREEMENT. A settlement agreement is a contract signed by both parties. Any settlement agreement knowingly and voluntarily agreed to by the parties, reached at any stage of the complaint process, shall be binding on both parties.

2. BREACH OF SETTLEMENT AGREEMENT. Should a complainant believe that VA has breached any of the terms of a settlement agreement; the complainant must file a breach of settlement claim with the Deputy Assistant Secretary for Resolution Management, 810 Vermont Avenue NW, Washington, DC 20420. The breach of settlement claim must be filed within 30-calendar days of the date when the complainant knew or reasonably should have known of the alleged noncompliance. The complainant may request that the terms of the settlement agreement be specifically implemented or, alternatively, that the complaint be reinstated for further processing from the point processing ceased.

a. The DAS/RM has delegated the Chief of Policy and Compliance authority to decide Breach of Settlement Agreement Claims. The Chief of Policy and Compliance will issue decisions on all breach allegations within 35-calendar days of receipt.

b. ORM field offices should have the complainant complete the Breach of Settlement Agreement Allegation Form, (Appendix D)

c. A copy of the employee's Breach of Settlement Agreement Allegation Form and all supporting documentation, i.e., original EEO contact sheet, settlement agreement, EEO counselor's report, or background information obtained from the employee, should be forwarded to the Office of Policy and Compliance (OPC).

d. A copy of OPC's decision will be forwarded to the respective field facility and ORM field office.

e. The complainant is entitled to appeal that decision to EEOC within 30-calendar days from receipt or after 35-calendar days from the date the allegation of noncompliance was served on the DAS/RM, if there has been no decision in that time frame.

f. EEOC regulations at 29 CFR §1614.504, only provide for a complainant to seek enforcement of a settlement agreement. If the complainant breaches the terms of the settlement agreement, then the agency will be excused from performing the remaining obligations. There is no formal process for the agency to seek such relief. The agency will simply determine that the complainant stands in breach of the agreement and then refuse to implement the remaining terms.

3. SUBSEQUENT ACTS OF DISCRIMINATION. EEOC regulations 29 CFR §1614.106 and 1614.204 states that subsequent act of discrimination that violate a settlement agreement, or acts of reprisals, shall be processed as a separate complaint of discrimination. A subsequent act is defined as any allegation made by the complainant that involves an act or action by

management that occurred and is unrelated to the original settlement agreement or an allegation that management engaged in reprisal since signing the settlement agreement.

a. ORM Employees should help aggrieved individuals distinguish claims of reprisal, or subsequent acts of discrimination from breach claims. If after discussion, the employee nevertheless wishes to pursue the breach claim, the ORM field office should have the employee complete the Breach of Settlement Agreement Allegation Form, (Appendix D).

b. A copy of the employee's Breach of Settlement Agreement Allegation Form and all supporting documentation, i.e., original EEO contact sheet, EEO counselor's report, or background information obtained from the employee, should be forwarded to the Office of Policy and Compliance (OPC).

c. The Office of Policy and Compliance will issue a decision within 35-calendar days from receipt of the breach claim. A copy of the decision will be forwarded to the respective field facility and ORM field office.

d. If the complainant files a formal complaint of discrimination regarding the subsequent act, the new claim must be reviewed to determine if it meets the procedural requirements for further processing in accordance with 29 CFR §1614.

e. If the complainant files a formal complaint of discrimination regarding a breach claim, the breach claim should be dismissed and forwarded to OPC for processing.

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CHAPTER 6 - REMEDIES AND COMPLIANCE

1. REMEDIES (REMEDIAL RELIEF). When there has been a finding of discrimination, the remedies available to the complainant shall be those set forth in EEOC's regulations as 29 CFR §1614. The regulations require that when discrimination is found, the complainant is entitled to the appropriate remedy which, as nearly as possible, places him/her in the situation which he/she would have been had the discrimination not occurred, with all pay and benefits which would have accrued absent the discrimination. The following are the basic elements of remedial relief when there is a finding of discrimination.

a. Notification to all employees of the agency in the affected facility of their right to be free of unlawful discrimination and assurance that the particular types of discrimination found will not reoccur.

b. Commitment that corrective, curative or preventative action will be taken, or measures adopted, to ensure that violations of the law similar to those found will not recur.

c. A offer to each identified victim of discrimination of placement in the position the person would have occupied but for the discrimination suffered by that person, or a substantially equivalent position.

d. Payment to each identified victim of discrimination on a "make whole basis" for any loss of earnings the person may have suffered as a result of the discrimination.

e. Commitment that the agency shall cease from engaging in the specific unlawful employment practices found in the case.

2. PETITION FOR ENFORCEMENT. A complainant may petition the EEOC for enforcement of a decision issued under the EEOC's appellate jurisdiction. The petition shall be submitted to EEOC's Office of Federal Operations (OFO) and shall set forth the basis for the complainant's assertion that the agency is not complying with the decision. EEOC affords the VA and the complainant the opportunity to submit information and/or documentation regarding the issue in dispute. VA will respond to EEOC's notice to show cause and submit evidence of compliance or specify the compelling reasons for noncompliance. EEOC will inform the complainant of the petition for enforcement decision.

3. COMPLIANCE. All officials of VA are required to comply with the final agency decisions issued by OEDCA or the appeal decisions issued by EEOC, including timely implementation of any corrective action ordered. The decisions will specify the corrective actions required and the time limits for implementing those corrective actions.

a. The Office of Policy and Compliance monitors agency compliance with OEDCA and EEOC decisions. To show compliance with the decisions, the Office of Policy and Compliance will obtain the necessary documentation for completing compliance. The following is a list of acceptable documentation required to document OEDCA and EEOC compliance:

(1) Attorney Fees. A copy of the check issued or a payroll voucher for attorney fees and/or narrative statement by an appropriate agency official, or agency payment order stating the dollar amount and date attorney fees was paid.

(2) Awards. A copy of the check issued or a payroll voucher or a narrative statement by an appropriate agency official stating the dollar amount paid, date paid, and the criteria used to calculate the award amount. If the award is non-monetary, provide a copy of the award documentation.

(3) Back Pay and Interest. Computer print-outs or payroll documents outlining gross back pay and interest, copy of any checks issued, or a narrative statement by an appropriate agency official of total monies paid, and date of payment.

(4) Compensatory Damages. The final agency decision and evidence that payment has been made.

(5) Miscellaneous Expenses. A copy of the check issued or a payroll voucher.

(6) Training. Attendance roster of the training session(s) or a narrative statement by an appropriate official that confirms attendance and date of the training.

(7) Personnel Actions (e.g., Reinstatement, Promotion, Hiring, Reassignment), copies of SF-50's or agency service record cards. Provide a copy of the agency's letter to the complainant offering position as outlined in OEDCA or EEOC decision, and a copy of the employees' response accepting or declining the positions.

(8) Expungement of Records. Narrative statement by an appropriate agency official that confirms that the specific document identified in the order has been expunged.

(9) Posting of Notice of Violation for EEOC Decisions. After the expiration of the posted notice, mail the original signed and dated notice reflecting the dates that the notice was posted to EEOC OFO Compliance Officer. For OEDCA, a copy of the notice will suffice.

(10) Supplemental Investigation will include the following: (a) A copy of the letter to the complainant acknowledging receipt from EEOC of remanded case, or a copy of the acceptance letter including language to advise that the agency is in receipt of the EEOC remand. (b) A copy of the letter to the complainant to show that the Report of Investigation (ROI) was transmitted (not the ROI itself unless specified). (c) A copy of the complainant's request for an EEOC hearing or agency final decision.

(11) Restoration of Leave. Printout or statement identifying the amount of leave restored, if applicable. If not, an explanation or statement.

(12) Civil Actions. A complete copy of the civil action complaint demonstrating same issues raised as in compliance matter.

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(13) Settlement Agreements. Signed and dated agreement with specific dollar amounts, if applicable. Also appropriate documentation of relief is provided.

b. The EEO Diversity Program Manager/Liaison/Specialist will monitor local compliance with OEDCA and EEOC decisions and report compliance to the Office of Policy and Compliance. The EEO Diversity Program Manager/Liaison/Specialist will notify management of the non-compliance.

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CHAPTER 7 – OFFICIAL TIME

1. OFFICIAL TIME. If the complainant and/or their representative are employees of VA, they are entitled to a reasonable amount of official time to present the complaint and to respond to VA requests for information. The complainants, representatives, and witnesses, who are federal employees, regardless of whether they are employed by VA or some other Federal agency, shall be in duty status when their presence is authorized or required by EEOC or VA officials in connection with the complaint. “Duty Status” means normal hours of work.

a. To the extent practical, meetings, conferences, and hearings should be scheduled during normal working hours.

b. If meetings, conferences or hearings are scheduled outside of the normal work hour, the work schedule should be adjusted or rearranged to coincide with such meetings or hearings. Compensatory time, or official time should be granted to allow an approximately equivalent time off during the normal hours of work.

c. If a VA employee has already worked a full week and they are required to attend a meeting, conference or hearing on an off day, they are entitled to official time and the VA may be required to pay overtime.

2. Requesting Official Time. Official time should be requested in advance. Complainants, representatives, witnesses, and supervisors should arrive at a mutual understanding regarding the official time prior to the use of official time. VA employees are not entitled to simply take official time without first asking for it and having it approved by their supervisor.

a. Employees can request official time either orally or in writing.

b. Supervisors may require proof that the employee requires official time to engage in EEO complaint activity.

c. Employees may be required to justify the amount of official preparation time requested, where the request is for a substantial number of hours. Employees of VA are afforded a reasonable amount of official time, as defined above, to prepare for meetings, conferences, and hearings.

3. Denial of Official Time. If a request for official time, either in whole or in part, is denied, the supervisor should document the denial in writing.

a. The supervisor should provide a copy of the denied official time statement to the EEO/Diversity Program Manager/Liaison/Specialist.

b. The EEO/Diversity Program Manager/Liaison/Specialist should provide the ORM Field Office with a copy of the denied official time statement.

c. The ORM Field Office will include the denied official time statement in the pending complaint file, for which the official time was denied, noting the reason(s) for the denial.

d. If the complainant requests a hearing, EEOC will determine if the complainant was improperly denied official time. If the complainant requests a final agency decision, OEDCA will determine if the complainant was improperly denied official time. Where the complainant contends that an agency improperly denied him/her official time and EEOC or OEDCA finds in the complainant's favor, EEOC or OEDCA may order VA to restore such personal leave as the complainant may have used in lieu of official time.

e. Employees can only protest the official time denied for preparation of his/her own complaint and not for the complaints of others. Witnesses or representatives, who file complaints of discrimination because they were denied official time to work on another individual's EEO complaint, do not have standing and fail to state a claim. A complainant must challenge the denial of official time for their witness(es) or representative during the processing of the complaint for which the official time was denied. The right to raise such matters lies with the complainant and not with their witness or representative.

f. If a claim of denied official time is filed, it will be dismissed in accordance with EEOC Regulation 29 C.F.R. 1614.107(a) which states that an agency may dismiss a complaint which fails to state a claim pursuant to 29 C.F.R. 1614.103. A complainant must challenge the denial of official time during the processing of the underlying complaint.

4. Reasonable Amount of Official Time. "Reasonable" is defined as whatever is appropriate, under the particular circumstances of the complaint, in order to allow a complete presentation of the relevant information associated with the complaint and to respond to VA requests for information. The actual number of hours a complainant and their representative are entitled will vary, depending on the nature and complexity of the complaint and considering the mission of the VA and VA's need to have the employee available to perform their normal duties on a regular basis.

a. Complainants, representatives, and supervisors should arrive at a mutual understanding as to the amount of official time to be used prior to the use of official time.

b. Time spent commuting to and from home should not be included in official time computations.

5. Meetings and Hearing Time. Time spent in meetings and hearings with VA officials or EEOC Administrative Judges is automatically deemed reasonable.

6. Preparation Time. If complainants, representatives, and witnesses, are VA employees, they are also afforded a reasonable amount of official time, as defined above, to prepare for meetings, conferences, and hearings. They should be afforded a reasonable amount of official time to prepare the formal complaint and any appeals that may be filed with EEOC. "Reasonable," with respect to preparation time, is generally defined in terms of hours, not in terms of days, weeks or months.

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7. Representatives. Representatives who are employees of VA, should spend most of their time doing the work that they are employed to do. The overall hours of official time afforded to a representative, for both preparation purposes and for attendance at meetings and hearings, may be restricted to a certain percentage of the representative's duty hours in any given month, quarter, or year. The amount of official time to be afforded to a representative for representational activities will vary depending on the circumstances. The nature of the representative's position, the relationship of the position to VA's mission, and the degree the hardship imposes on VA's mission by the representative absence from his or her normal duties should be considered. The agency is not obligated to change work schedules, incur overtime wages, or pay travel expenses to facilitate the choice of a specific representative or to allow the complainant, and representative to meet.

a. When a VA employee serves as an EEO representative for an applicant seeking employment, the representative is not entitled to official time. Official time only applies to representatives of VA and federal employees.

b. Whether or not a representative is entitled to official time depends on the status of the complainant at the time of the alleged discriminatory action and not the status of the complainant at the time representation services are required. Where the challenged action is the complainant's removal, the complainant is an employee at the time of the action and the representative is entitled to official time.

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CHAPTER 8 - SPIN-OFF COMPLAINTS

1. DISSATISFACTION WITH THE PROCESSING OF AN EEO COMPLAINT/SPIN-OFF COMPLAINT.

If a complainant is dissatisfied with the processing of his/her pending complaint, he/she should notify the Office of Resolution Management before EEOC's Administrative Judge issues a decision on the complaint, OEDCA issues a final agency decision, or ORM dismisses the complaint. Allegations of dissatisfaction with the processing of an EEO complaint, otherwise known as a Spin-off complaint, should not be treated as a new complaint, but should be incorporated into the pending complaint for disposition. Such complaints usually involve dissatisfaction with matters such as delays, perceived bias, or misconduct by a counselor, investigator, intake specialist, or agency representative, or other similar matters relating to the underlying complaint. Dissatisfaction may be presented at the pre-complaint, informal counseling stage, or during the formal complaint process. A complainant may articulate dissatisfaction with the processing of their complaint by alleging that:

- a. their complaint is being processed in a manner different from that used for complaints filed by members not belonging to his or her protected group, or that
- b. their complaint is being adversely affected because of a specific policy or practice having a discriminatory effect on the processing of his or her complaint.

2. RECEIPT OF THE ALLEGATIONS OF DISSATISFACTION. EEOC regulations require the complainant to first raise their dissatisfaction claims with VA. This means the respective ORM Field Office, the DAS/RM, or the Office of Policy & Compliance. A complainant may raise allegations of dissatisfaction either verbally, or in writing.

3. ALLEGATIONS OF DISSATISFACTION RAISED WITH THE ORM FIELD OFFICE.

- a. When a complainant raises dissatisfaction with the process with the ORM Field Office, it should encourage the individual to put their concerns in writing.
- b. The ORM Field Office must attempt to informally resolve the dissatisfaction.
- c. The complainant's dissatisfaction and the ORM Field Manager's response should be made a part of the EEO administrative file.
- d. If the complainant files a formal complaint alleging improper processing, the claim of dissatisfaction with the processing of the complaint should be dismissed pursuant to 29 CFR §1614.107(a)(8). After the claim of dissatisfaction is dismissed, the ORM field office must send a copy of the dismissal and a referral letter to the Chief of Policy and Compliance for further processing along with the following:

- (1) A referral letter that addresses informal attempts to resolve the dissatisfaction.
- (2) A copy of the complainant's allegations.

(3) If applicable, a copy of the ORM field office's response to the complainant addressing the allegations.

(4) Any specific documentation relating to the complainant's allegations. A copy of the administrative file is not necessary, only specific documentation pertaining to the dissatisfaction should be provided.

4. ALLEGATIONS OF DISSATISFACTION INITIALLY RAISED WITH THE DEPUTY ASSISTANT SECRETARY FOR RESOLUTION MANAGEMENT. If the dissatisfaction is initially raised with the DAS/RM, the DAS/RM will forward the dissatisfaction/spin-off complaint to the Chief of Policy and Compliance. If the dissatisfaction complaint is not in writing, the DAS will encourage the individual to put their concerns in writing and request the individual to forward their concerns to the Chief of Policy and Compliance.

5. ALLEGATIONS OF DISSATISFACTION RECEIVED BY THE OFFICE OF POLICY AND COMPLIANCE. The DAS/RM has delegated the Chief of Policy and Compliance authority to consider and resolve all claims that allege dissatisfaction with the processing of an existing EEO complaint/spin-off complaint. If the dissatisfaction complaint is not in writing, the Policy and Compliance staff will encourage the individual to put their concerns in writing.

a. The Chief of Policy and Compliance will date stamp, log and assign the dissatisfaction/Spin-off complaints to a Policy and Compliance EEO Specialist.

b. The designated EEO Specialist will review and make an inquiry into the complainant's allegations of dissatisfaction. The inquiry may include the following steps:

(1) Determine if the ORM Field Office was aware of the complainant's dissatisfaction and if so, what action(s) were taken to resolve the dissatisfaction.

(2) Determine the stage of processing of the underlying EEO complaint.

(3) Request copies of relevant documents related to the dissatisfaction such as the counselor's report, investigative file, etc., if not available in the Web-based Tracking System.

c. The Office of Policy and Compliance will make the following determinations:

(1) If the processing was not compromised or impacted in any fashion, the individual will be notified that no further action will be taken and that the explanation will be incorporated into the complaint file. If the dissatisfaction is not resolved or the complainant does not agree with ORM's remedy, the individual is advised that they may present their concerns to the EEOC at either of the following stages outlined in item 6 of this chapter.

(2) If the determination concludes that the processing has been compromised, appropriate action(s) will be prepared by the Office of Policy and Compliance and the ORM Field Office will be directed to take appropriate action.

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d. A copy of the Chief of Policy and Compliance's response to the complainant's dissatisfaction/spin-off complaint will be mailed to the appropriate ORM Field Office with a cover letter instructing them to include a copy of response in the underlying complaint file.

e. The Office of Policy and Compliance will attach a copy of the response and enter all information relating to the dissatisfaction/spin-off complaint into the Web-Based Tracking System (WBTS).

6. UNRESOLVED/SPIN-OFF COMPLAINTS. If a dissatisfaction/spin-off complaint is not resolved, or the Complainant does not agree with the ORM's remedy, they may present their concerns to the EEOC at the following processing stages:

a. If the Complainant has requested a hearing and the complaint is under the jurisdiction of the EEOC, the complainant may present their dissatisfaction to the Administrative Judge (AJ) before the AJ issues a decision on that complaint.

b. If the Complainant has not requested a hearing, they may present their concerns to EEOC's Office of Federal Operations on appeal upon receiving a Final Agency Decision (FAD).

c. Where the AJ or OFO finds that ORM has improperly processed the original complaint and that such improper processing has had a material effect on the processing of the original complaint, the AJ or OFO may impose sanctions on ORM, as they deem appropriate.

d. If the AJ finds that ORM's actions were inconsistent with its requirements under the 29 CFR §1614 regulations, but had no material effect on the processing of the complaint, at the AJ's discretion, the AJ may suggest that the complainant submit a letter to EEOC's Federal Sector Programs Department for consideration regarding ORM's conduct.

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REFERENCES

- a. **Age Discrimination in Employment Act of 1967**, as amended, 29 USC 621-634, protects employees and job applicants who are 40 years of age or older from discrimination based on age with respect to any term, condition, or privilege of employment – including but not limited to hiring, firing, promotion, layoff, compensation, benefits, job assignments, and training.
- b. **The Administrative Dispute Resolution Act of 1996**, (ADRA), 5 U.S.C. 571-584.
- c. **Americans with Disabilities Act of 1990**, 42 USC 12101 et seq., prohibits private and public employers, employment agencies and labor unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training and other terms, conditions and privileges of employment.
- d. **Architectural Barriers Act**, 42 USC 4151 et seq. is enforced by the Architectural and Transportation Barriers Compliance Board and requires that buildings and facilities be accessible to people with disabilities if they were constructed or altered by or on behalf of the federal government or with certain federal funds, or leased to the government, after 1968.
- e. **The Civil Rights Act of 1964**, as amended, 42 USC 2000e et seq., is the major federal law prohibiting discrimination in employment. Title VII prohibits discrimination based on race, gender (sex), color, religion or national origin, and covers all areas of the employee-employer relationship, from advertising open positions through termination or retirement.
- f. **Department of Justice (DOJ), The Freedom of Information Act** 5 USC 552, as amended by Public Law No. 104-231, 110 Stat.3048.
- g. **Equal Employment Opportunity Commission (EEOC), 29 CFR Part §1614, Federal Sector Equal Employment Opportunity**, November 9, 1999. <http://www.eeoc.gov>
- h. **Equal Employment Opportunity Commission (EEOC), Equal Employment Opportunity Management Directive for 29 CFR Part §1614 (EEO-MD-110)**, November 9, 1999. <http://www.eeoc.gov>
- i. **Equal Employment Opportunity Commission (EEOC), Equal Employment Opportunity Management Directive 715**, October 1, 2003. <http://www.eeoc.gov>
- j. **Equal Employment Opportunity Commission (EEOC), Instructions to Federal Agencies for Equal Employment Opportunity Management Directive 715 (EEO-MD-715)**, March 31, 2004
- k. **Equal Employment Opportunity Commission (EEOC), Equal Pay and Compensation Discrimination**, September 20, 2001. <http://www.eeoc.gov>
- l. **Equal Employment Opportunity Commission (EEOC), Facts about Compensation Discrimination**, May 11, 2000. <http://www.eeoc.gov>

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m. **Equal Pay Act of 1963**, 29 USC 206(d), prohibits employers from discriminating on the basis of gender (sex) in the payment of wages where substantially equal work is performed under similar working conditions.

n. **Executive Order 12067, Agency and EEOC Authority and Responsibility**, transferred the functions of the Equal Employment Opportunity Coordinating Council to the Equal Employment Opportunity Commission and delineated the EEOC's responsibility for developing uniform standards, guidelines, and policies for promoting and furthering equal employment opportunity in the government.

o. **Executive Order 12106, Transfer of Certain Equal Employment Enforcement Functions**, amends Executive Order 11478 to include in its coverage non-discrimination based on age and disability. The Order also transferred Federal equal employment opportunity enforcement authority to the Equal Employment Opportunity Commission and made the EEOC responsible for directing and furthering the implementation of equal employment opportunity policy.

p. **Executive Order 13087, Sexual Orientation**, provides a uniform policy for the Federal Government to prohibit discrimination based on sexual orientation.

q. **Executive Order 13145, To Prohibit Discrimination in Federal Employment Based on Genetic Information**, is self-descriptive.

r. **Executive Order 13152, Addendum to E. O 11478 Equal Employment Opportunity in Federal Government, Status as a Parent**, provides a uniform policy for the Federal Government to prohibit discrimination based on status as a parent.

s. **Executive Order 13160, Nondiscrimination on the Basis of Race, Gender (Sex), Color, National Origin, Disability, Religion, Age (40 years and over), Sexual Orientation, and Status as a Parent in Federally Conducted Education and Training Programs**.

t. **Executive Order 13164, Requiring Federal Agencies to Establish Procedures to Facilitate the Provision of Reasonable Accommodation**, is self-descriptive.

u. **General Accounting Office (GAO), What is GAO, Where is GAO.** <http://www.gao.gov/>

v. **Merit Systems Protection Board (MSPB), Questions and Answers about Appeals.** www.mspb.gov

w. **Notification and Federal Employee Antidiscrimination and Retaliation (No Fear) Act of 2002**, 5 USC 2301 note, holds agencies fiscally responsible if they lose or settle EEO discrimination and whistleblower protection cases filed in U.S. District Court; requires a comprehensive study to determine the best Executive branch practices relating to disciplinary actions for employees who violate discrimination or whistleblower protection laws; requires

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yearly reporting of an analysis of discrimination and whistleblower cases; and requires that quarterly updates of this analysis be posted on the agency website.

x. **Office of Personnel Management, Position Classification Appeals**, June 1998.
<http://www.opm.gov/>

y. **Office of Special Counsel (OSC), Your Rights as a Federal Employee**.
<http://www.osc.gov>

z. **Office of Special Counsel (OSC), How to File a Complaint Alleging a Violation of the Hatch Act**. <http://www.osc.gov>

aa. **Pregnancy Discrimination Act of 1978, Public Law Number 95-955**

bb. **Rehabilitation Act of 1973**, as amended, 29 USC 791, 793, 794(a) in Section 503 and 504, prohibits discrimination against the disabled and requires institutions to take affirmative action to hire and promote qualified disabled persons. Institutions are required to recruit and consider disabled persons for vacant positions, and must make “reasonable accommodation” to the physical or mental limitations of otherwise qualified disabled employees, such as providing special equipment or modifying the job.

cc. **Whistleblowers Protection Act of 1989, Public Law 101-12, as amended by Public Law 103-424, October 29, 1994**

dd. **VA Directive 5975, Diversity Management and Equal Employment Opportunity**

ee. **VA Directive 5975.1 Processing Reasonable Accommodations by Employees and Applicants with Disabilities**

ff. **VA Handbook 5975.1, Processing Reasonable Accommodations by Employees and Applicants with Disabilities**

gg. **VA Directive 5978, Alternative Dispute Resolution**

hh. **VA FY 1998-2003 Strategic Plan, General Goal 10.**

ii. **VA, Office of Employment Discrimination Complaint Adjudication (OEDCA), A Guide to Investigating Employment Discrimination Complaints**, August 1999.

jj. **VA, Office of Resolution Management, A Plan for Transformation Guide**, September 1997.

kk. **VA, Office of Resolution Management, EEO Counselors Manual**, September 1997.

ll. **VA, Office of Resolution Management, Standard Operating Procedures**, November 2001.

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mm. **VA MP-4, Part V, Chapter 1**

nn. **VA, Office of Financial Policy Bulletin 03GA1.04**, June 9, 2003

oo. **38 CFR, Part 2, Section 2.6 (h), (i), (j), and (k), Secretary's delegations of authority to certain officials**, January 9, 2002.

pp. **38 CFR, Parts 2 and 15, Delegations of Authority, Equal Employment Opportunity (EEO) Responsibilities**, January 24, 2002.

qq. **38 USC 512, Secretary's Delegations of Authority to Certain Officials**

rr. **38 USC 516, Authority and Duties of the Secretary, Equal Employment Responsibilities**, as enacted in Title I, Public Law 105-114, 105th Congress, November 21, 1997.

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Appendix B**DEFINITIONS**

a. **Aggrieved.** An aggrieved is a Federal employee, a former employee, or an applicant for employment who requests resolution of a matter through the pre-complaint informal EEO counseling process. The aggrieved person must allege discrimination based on his or her race, color, religion, gender (sex), national origin, age (40 years and over), physical or mental disability, and/or reprisal. Sexual and non-sexual harassment based on the above categories is also prohibited.

b. **Allegation of Breach of Settlement Agreement.** A claim that the agency has violated or has not performed a specific term(s) of a settlement agreement.

c. **Alternative Dispute Resolution (ADR).** ADR refers to a process and approach designed to resolve disputes in a manner that avoids the cost, delay, and unpredictability of more traditional adversarial and adjudicatory processes, such as, litigation, hearings, and appeals. Numerous types of ADR techniques exist, including mediation, facilitation, fact-finding, early neutral evaluation, the use of an Ombudsman, settlement conferences, mini-trials, and peer review. Mediation is the preferred type of technique for resolving workplace disputes in VA.

d. **Basis.** Discrimination is prohibited because of race, color, religion, gender (sex), national origin, age (40 years and over), physical or mental disability, and/or reprisal. Sexual and non-sexual harassment based on the above categories is also prohibited.

e. **Claim.** A claim is the action(s) the agency has taken, is taking or has not taken that causes the aggrieved person to believe he/she is a victim of discrimination.

f. **Class Complaint.** A class complaint is a complaint brought forth by a group of employees, former employees, or applicants for employment who allege they are adversely affected by a personnel management policy or practice which discriminates against the group on the basis of their common race, color, religion, gender (sex), national origin, age (40 years and over), physical or mental disability, and/or reprisal.

g. **Complaint.** A complaint is an allegation of illegal discrimination that is handled through the EEO discrimination complaint process. A complaint may result when an employee believes he/she has been unfairly treated because of a protected class, i.e., race, color, religion, gender (sex), national origin, age (40 years and over), physical or mental disability, and/or reprisal. The allegation itself is not proof that illegal discrimination has taken place. The investigation that follows the filing of a formal complaint will determine if illegal discrimination has, in fact, occurred. A person who files a complaint is called a complainant.

h. **Complainant.** A complainant is a Federal employee, a former employee, or an applicant for employment who requests resolution of a matter through the EEO discrimination complaint process. The complainant must allege discrimination based on

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his/her race, color, religion, gender (sex), national origin, age (40 years and over), physical or mental disability, and/or reprisal.

i. **Discrimination.** The word discrimination is often used to mean illegal discriminatory acts. Discrimination simply means noticing the differences between things or people that are otherwise alike, and making decisions based on those differences. Illegal discrimination is unfair treatment of a person by category, class, or group rather than objective treatment on the basis of merit. Under EEO law, it is illegal to discriminate on the basis of race, color, religion, gender (sex), national origin, age (40 years and over), physical or mental disability, and/or reprisal or to engage in sexual or non-sexual harassment based on the above categories. Discrimination can be intentional or unintentional.

j. **Equal Employment Opportunity Commission (EEOC).** Within its headquarters in Washington, D.C., and through the operations of several offices nationwide, the EEOC coordinates all Federal equal employment opportunity regulations, practices, and policies. The Commission interprets employment discrimination laws, monitors the Federal sector employment discrimination program and oversees the development and implementation of Federal agencies' affirmative employment programs. The EEOC issues policy and regulations on the discrimination complaint system, holds hearings and makes findings on discrimination complaints, and makes final decisions on complaints that have been appealed. It also reviews, upon request, decisions of negotiated grievances and Merit Systems Protection Board appeals if they include issues of discrimination.

k. **Equal Employment Opportunity Commission (EEOC) Hearing.** A hearing is an adjudicatory proceeding that completes the process of developing a full and appropriate record. A hearing provides the parties with a fair and reasonable opportunity to explain and supplement the record and, in appropriate instances, to examine and cross-examine witnesses. Hearings are governed by 29 CFR §1614.109. An Administrative Judge from the EEOC conducts hearings to adjudicate claims of discrimination and issues decisions.

l. **Early Neutral Evaluation.** A process which involves the use of a neutral or impartial third party to provide an objective evaluation, sometimes in writing, of the strengths and weaknesses of a case. Under this method, the parties will usually make informal presentations to the neutral party to highlight their respective cases or positions.

m. **Facilitation.** A process that involves the use of techniques to improve the flow of information in a meeting between parties to a dispute. The techniques may also be applied to decision-making meetings where a specific outcome is desired (e.g., resolution of a conflict or dispute).

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n. **Fact-Finding.** A process that uses an impartial expert, in order to determine what the "facts" are in a dispute. The fact finder may be authorized only to investigate or evaluate the matter presented and file a report establishing the facts in the matter.

o. **Final Agency Decision (FAD) to Dismiss.** The agency decision to dismiss an entire EEO complaint or a substantive decision without a hearing on a formal complaint of discrimination.

p. **Mediation.** A form of ADR in which a specially trained neutral third party (mediator) assists individuals to find a mutually acceptable solution to their dispute. Mediation is a problem solving process; it is voluntary, unbiased, and confidential. Employees and management using mediation must agree to participate and agree to any solution that is generated through mediation. Mediation has comprehensive applicability for VA components seeking creative, mutually acceptable, and early resolution of conflicts, and it is the preferred type of ADR for resolving workplace disputes.

q. **Mini-trials.** A process which involves a structured settlement process in which each side to a dispute presents abbreviated summaries of their case before the parties and/or their representatives who have authority to settle the dispute. The summaries contain explicit data about the legal bases and the merits of a case.

r. **Ombudsmen.** An individual who rely on a number of techniques including counseling, mediating, conciliating, and fact finding in an effort to informally resolve disputes. Usually, when an ombudsman receives a complaint, he/she interviews parties, reviews files, and makes recommendations to the disputants. Typically, an ombudsman does not impose solutions.

s. **Peer Review.** A problem-solving process where an employee takes a dispute to a group or panel of fellow employees and managers for a decision. The decision is usually not binding on the employee, and he/she would be able to seek relief in traditional forums for dispute resolution if dissatisfied with the decision.

t. **Representative.** A person who is selected and designated by the aggrieved or the agency to accompany, represent, and advise the complainant, agency or witness during any stage of the complaint process. This individual may also serve as the class agent for class action complaints.

u. **Reprisal.** Actions taken against employees that include restraint, interference, or coercion because of their involvement in filing a charge of discrimination, participating in an investigation, or having opposed prohibited discrimination.

v. **Responding Management Official (RMO).** A management official who is alleged to have acted in a discriminatory manner while acting as an agent of the agency.

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w. **Settlement Agreement.** A written contract knowingly and voluntarily signed by the complainant or agent and the VA during the pre-complaint or formal complaint process that resolves an EEO complaint. The terms of the agreement are binding on both parties.

x. **Settlement Conferences.** A pre-hearing conference conducted by a settlement judge (for example an EEOC Administrative Judge) or referee and attended by representatives for the opposing parties and/or the parties themselves in order to reach a mutually acceptable settlement of the disputed matter.

y. **Spin-off Complaint.** A spin-off complaint is a complaint about the processing of an existing complaint.

z. **Whistleblowing.** Whistleblowing means disclosing information that you reasonably believe is evidence of a violation of any law, rule, or regulation, or gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety.

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Appendix C**Other Grievance and Administrative Processes**

1. Merit Systems Protection Board (MSPB). The MSPB is the proper appeal forum for a Title 5 employee if the employee has been the subject of an adverse action such as a suspension for more than 14 days, a demotion, or a removal. It is also the proper forum if the employee alleges an employment action was based on his/her whistle-blowing or other protected activity. Call 1-800-653-7200 to seek advice or visit MSPB's website at www.mspb.gov.

2. Office of Special Counsel (OSC). The OSC is the proper forum if a personnel action (appointment, promotion, adverse action, disciplinary or corrective action, detail, transfer, reassignment, reinstatement, restoration, reemployment, some performance evaluations, decision concerning pay or benefits, decision to order examination, or any other significant change in duties, responsibilities or working conditions) has been threatened, proposed, taken, or not taken allegedly because of the employee's whistle-blowing or other protected activity. Call 1-800-872-9855 to seek advice or visit OSC's website at <http://www.osc.gov/>.

3. Office of the Inspector General (OIG). This office deals with possible violation(s) of law, rules or regulations; mismanagement; gross waste of funds; abuse of authority; or danger to the public health and safety. The OIG normally does not act on matters for which there is another complaint process that handles the issue; however, investigations may be conducted on the basis of matters referred by OSC or MSPB. You may contact VA's OIG at 1-800-488-8244 or visit their website at <http://www.va.gov/oig>

4. The United States Government Accountability Office (GAO). The U.S. General Accounting Office (GAO) is an agency that works for Congress and the American people. Congress asks GAO to study the programs and expenditures of the Federal government. It studies how the Federal government spends taxpayer dollars. GAO evaluates Federal programs, audits Federal expenditures, and issues legal opinions. The GAO's Office of Special Investigations may be contacted at 202 512-7470, 1 800 424-5454 or visit their website at <http://www.gao.gov>

5. Negotiated Grievance. A bargaining unit employee may elect to pursue the union grievance procedure for any grievance covered by 5 U.S.C. 7103 (a) (9) in accordance with the process set forth in the collective bargaining agreement.

6. Administrative Grievance. The Administrative Grievance process covers matters of employee concerns or dissatisfaction for which personal relief is possible and which is subject to the control of VA management, that are not expressly excluded by the VA grievance policy. This includes any matter in which an employee alleges that coercion, reprisal, or retaliation occurred against him/her for using the grievance procedure.

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7. Office of Workers' Compensation Programs Claim. Work-related traumatic injury: Must be filed within three years of date of injury. (20 C.F.R. 10.100) Occupational disease caused by exposure to injurious work factors: Must be filed within three years of onset of illness. (20 C.F.R. 10.101)

8. Position Classification Appeal. Employees who are dissatisfied with the classification or grading of their positions have the right to appeal the decision. An appeal may be filed at any time and may involve the grade, series, title, or pay system coverage for the position. Employees under the General Schedule (5 U.S.C., chapter 51 and 5 CFR 511) have the option of (1) appealing to VA; (2) appealing to OPM through VA; or, (3) appealing directly to OPM. Employees covered under the Federal Wage System must first appeal to VA (unless the grading of their job has been certified by OPM; in that case, they must appeal to OPM). If they are dissatisfied with the VA's decision, they may appeal to OPM. For more information contact your local Human Resource Department or visit OPM's website at <http://www.opm.gov/fedclass>.

9. Veterans Alleging Service or Benefit Discrimination. Veterans alleging discrimination in service or benefits should contact in writing the Deputy Assistant Secretary for Resolution Management (08), 810 Vermont Avenue, NW, Washington, DC 20420.

10. Veteran Information. Veterans who want more information on VA Benefits can call 1-800 827-1000 or visit the VA's web site at <http://www.va.gov>.

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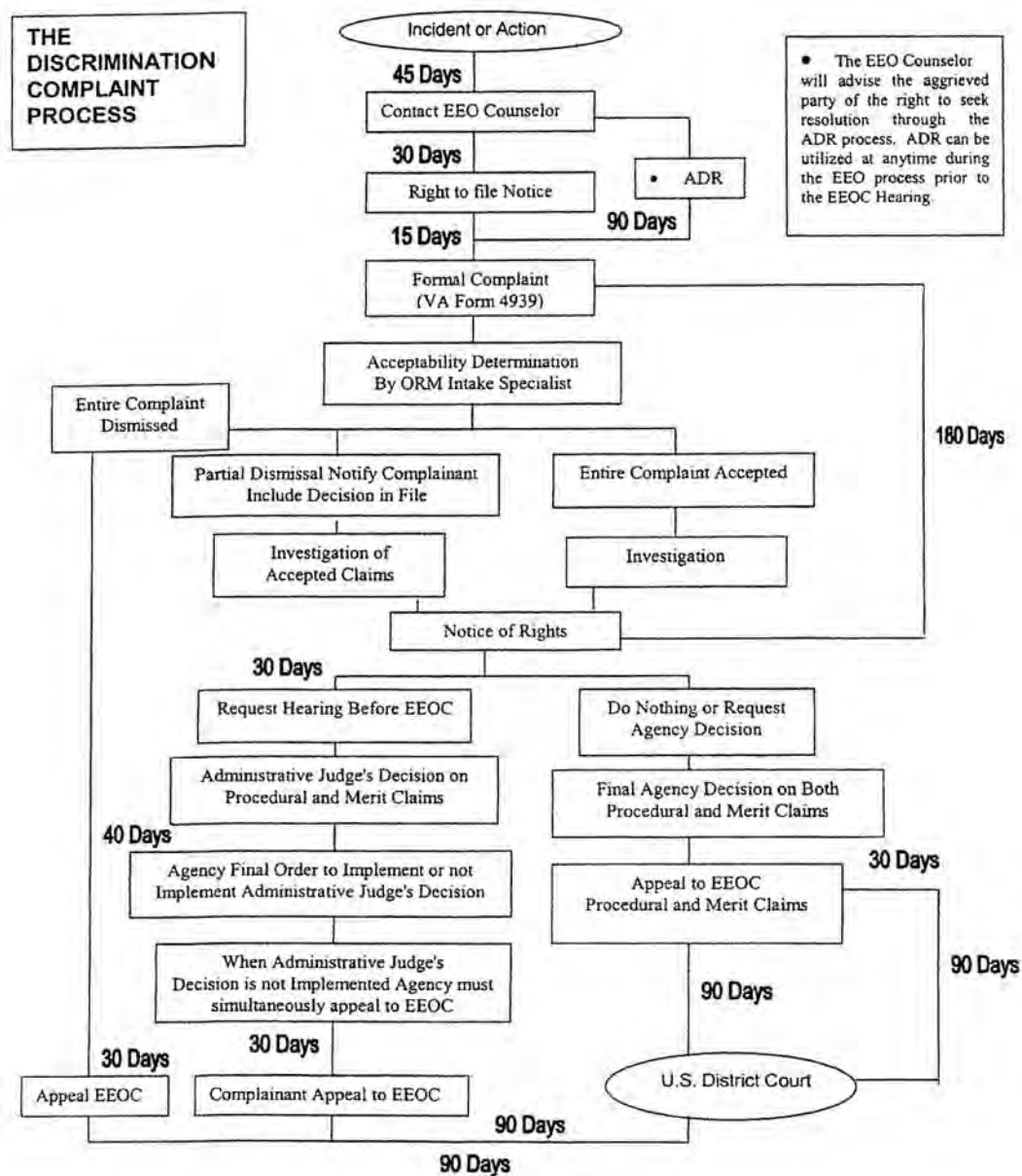
Department of Veterans Affairs		BREACH OF SETTLEMENT AGREEMENT ALLEGATION	
NOTE: Attach a copy of the settlement agreement. If additional space is needed continue on page 2, which is provided solely for extra space.		RETURN TO Department of Veterans Affairs Office of Resolution Management Office of Policy and Compliance (08B) 810 Vermont Avenue, NW Washington, DC 20420	
NAME OF EMPLOYEE John Doe		NAME OF VA FACILITY Any VA Facility	
HOME MAILING ADDRESS 123 Any Road Any Town, Any State 12345-1234		MAILING ADDRESS OF VA FACILITY 345 Any Road Any Town, Any State 12345-1234	
HOME TELEPHONE NUMBER (123) 123-1234		BUSINESS TELEPHONE NUMBER (345) 345-3456	
WHAT CLAIM(S) AND BASIS(ES) DID THE AGREEMENT SETTLE? The agreement settled my EEO complaint, case number 123-456-78910. My claim was that I was not selected for the GS-3030-05-06, Administrative Support Assistant position, Vacancy Announcement XX555-5555-XX, because of my sex (Male).			
DID YOU CONTACT THE EEO PROGRAM MANAGER WHEN YOU FIRST BECAME AWARE THAT A BREACH OCCURRED? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES (If "YES," provide approximate date and case number assigned.)		APPROXIMATE DATE N/A	NAME OF PERSON CONTACTED N/A
WHAT SPECIFIC PROVISION(S) OF THE SETTLEMENT AGREEMENT DO YOU BELIEVE WAS BREACHED? I believe that provision 3 (a) was breached. Provision 3 (a) states that I, John Doe, will be afforded the opportunity to attend Excel training conducted by Learning Resources on July 15, 2222.			
EXAMPLE			
HOW WAS THE SETTLEMENT AGREEMENT BREACHED? (Reference any actions that occurred that made you believe the settlement agreement was breached. Provide the names of the individuals you believe breached the settlement agreement. Please be specific, and if available, provide supporting documentation.) I believe that provision 3 (a) was breached by Ms. Jane Smith, my supervisor. Ms. Smith breached the agreement on July 15, 2222, when she failed to allow me to attend the Excel training in accordance with provision 3 (a) of the July 1, 2222, settlement agreement. On July 13, 2222, Ms. Smith notified me that she would not allow me to attend the training and that she would not reschedule me for the training. I asked Ms. Smith if I could attend Excel training at a later date and she said "no".			
PROVIDE DATE(S) AS TO WHEN YOU BELIEVE THE SETTLEMENT WAS BREACHED (Regulations require submission of breach claims to be submitted within 30 days of when you became aware, or should have been aware of the noncompliance with the agreement.) July 15, 2222			
IF YOU DO NOT MEET THE 30 DAY TIMEFRAME, EXPLAIN WHY THE DELAY N/A			
SIGNATURE OF EMPLOYEE Mr. John Doe		DATE 08/01/2222	

VA FORM
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AdobeFormsDesigner

VA-18-0457-D-000530
D-1
5084

February 7, 2007

VA Handbook 5977
Appendix E

Owner: ADA ADVOCATE (b) (6) (b) (6) gmail.com>
Filename: CFR Ref ORM Recuse and Delegation of Authority.pdf
Last Modified: Sun Nov 25 21:05:09 CST 2018

38 United States Code 516, as enacted in Title I, Public Law 105-114, 105th Congress, November 21, 1997, directs the **Secretary** to provide that the employment discrimination complaint resolution system be established and administered in a **fair**, objective manner that encourages **timely and fair resolution**

Title: Section Â§ 2.6 - Secretary's delegations of authority to certain officials (38 U.S.C. 512).Context:

Title 38 - Pensions, Bonuses, and Veterans' Relief. CHAPTER I - DEPARTMENT OF VETERANS AFFAIRS. PART 2 - DELEGATIONS OF AUTHORITY.

§ 2.6

Secretary's delegations of authority to certain officials (38 U.S.C. 512).

Employees occupying or acting in the positions designated below are delegated authority as indicated:

(a) Veterans Health Administration. The Under Secretary for Health is delegated authority:

(1) To act on all matters assigned to the Veterans Health Administration by statute (38 U.S.C. Ch. 73) and by regulation, except such matters as require the personal attention or action of the Secretary.

(2) To revise, exceed, delete, increase, or decrease fees contained in Department of Veterans Affairs Veterans Health Services and Research Administration Manual M-1, part I, appendix A (following agreement therefor as provided in the contract with the intermediary involved), in an approved State fee schedule, and to add additional fees when found to be necessary, provided such fees are not in excess of those customarily charged the general public, in the community concerned, for the same service.

(3) To designate the Deputy Under Secretary for Health, or other physician of the Veterans Health Administration, and authority is hereby delegated such designee to perform the functions prescribed in paragraph (a)(2) of this section.

(4) To revise, exceed, delete, increase or decrease dental fees established in Department of Veterans Affairs Veterans Health Services and Research Administration Manual M-4, chapter 6, and any amendments thereto, and to add additional fees when found to be necessary, provided: such fees are not in excess of those customarily charged the general public, in the community concerned, for the same service.

(5) To designate the Assistant Chief Medical Director for Dentistry, and authority is hereby delegated such designee, to perform the functions prescribed in paragraph (a)(4) of this section.

(6) To supervise programs for grants to the Republic of the Philippines and medical care for Commonwealth Army veterans and Philippine Scouts in Veterans Memorial Medical Center, Manila, pursuant to the provisions of 38 U.S.C. ch. 17, subch. IV.

(7) To designate the Deputy Under Secretary for Health of the Veterans Health Administration and authority is hereby delegated such designee to designate a Department of Veterans Affairs full-time physician or nonmedical Director to serve as an ex officio member on advisory bodies to State Comprehensive Health Planning agencies and to individual Regional Medical Programs in those areas in which there is located one or more Department of Veterans Affairs hospitals or other health facilities, who shall serve on such advisory group as the representative of the Department of Veterans Affairs health facilities located in that area.

(8) To authorize Directors of Department of Veterans Affairs property and facilities under the charge and control of the Department of Veterans Affairs to appoint police officers with the power to enforce Federal laws and Department of Veterans Affairs regulations, to investigate violations of those laws and to arrest for crimes committed on Department of Veterans Affairs property to the full extent provided by Department policies and procedures.

(Authority: 38 U.S.C. 501 and 512)

(9) To develop and establish minimum safety and quality standards for adaptive equipment provided under chapter 39 of title 38, United States Code, or to appoint a designee to perform these functions.

(b) Veterans Benefits Administration—(1) General. The Under Secretary for Benefits is delegated authority to act on all matters assigned to the Veterans Benefits Administration except as provided in § 1.771 of this chapter and to authorize supervisory or adjudicative personnel within his/her jurisdiction to perform such functions as may be assigned.

(2) Philippines. The Director, Department of Veterans Affairs Regional Office, Manila, Philippines, is delegated authority to exercise such authorities as are delegated to directors of regional offices in the United States, which are appropriate to the administration in the Republic of the Philippines of the laws administered by the Department of Veterans Affairs.

(c) Office of Management. (1) The Assistant Secretary for Management (Chief Financial Officer) is delegated authority to act on all matters assigned to his/her office, and to authorize supervisory personnel within his/her jurisdiction to perform such functions as may be assigned. Appropriate written notification will be furnished other Federal agencies concerning such authorizations.

(2) The Assistant Secretary for Management (Chief Financial Officer) is delegated authority under 31 U.S.C. 1553(c)(1), to approve, in a fixed appropriation account to which the period of availability for obligation has expired, obligational increases related to contract changes when such transaction will cause cumulative obligational increase for contract changes during a fiscal year to exceed \$4 million but not more than \$25 million; for this responsibility the Assistant Secretary for Management (Chief Financial Officer) shall act as a member of the Office of the Secretary and shall report to and consult with the Secretary on these matters.

(d) Assistant Secretary for Management (Chief Financial Officer); administration heads and staff office directors. The Assistant Secretary for Management (Chief Financial Officer) is delegated authority to take appropriate action (other than provided for in paragraphs (e)(3) and (e)(4) of this section) in connection with the collection of civil claims by VA for money or property, as authorized in § 1.900, et seq. The Assistant Secretary for Management (Chief Financial Officer) may redelegate such authority as he/she deems appropriate to administration heads and staff office directors.

(Authority: 38 U.S.C. 501, 512)

(e) General Counsel. (1) The General Counsel is delegated authority to serve as the Regulatory Policy Officer for the Department in accordance with Executive Order 12866. The General Counsel, the Principal Deputy General Counsel, the Deputy General Counsel, Central Office, and the Director of the Office of Regulation Policy and Management are delegated authority to manage, direct, and coordinate the Department's rulemaking activities, including the revision and reorganization of regulations, and to perform all functions necessary or appropriate under Executive Order 12866 and other rulemaking requirements.

(Authority: 38 U.S.C. 501, 512)

(2) Under the provisions of 38 U.S.C. 515(b), the General Counsel, Deputy General Counsel, Assistant General Counsel and Regional Counsel, or those authorized to act for them, are authorized to consider, ascertain, adjust, determine, and settle tort claims cognizable thereunder and to execute an appropriate voucher and other necessary instruments in connection with the final disposition of such claims.

(3) Under the provisions of “The Federal Medical Care Recovery Act,” 42 U.S.C. 2651, et seq. (as implemented by part 43, title 28, Code of Federal Regulations), authority is delegated to the General Counsel, Deputy General Counsel, Assistant General Counsel (Professional Staff Group I), Deputy Assistant General Counsel of said staff group, and Regional Counsels or those authorized to act for them, to collect in full, compromise, settle, or waive any claim and execute the release thereof; however, claims in excess of \$100,000 may be compromised, settled, or waived only with the prior approval of the Department of Justice.

(4) Under the Federal Claims Collection Act of 1966, 31 U.S.C. 3711, et seq., authority is delegated to the General Counsel, Deputy General Counsel, Assistant General Counsel, Deputy Assistant General Counsel and Regional Counsel, or those authorized to act for them, to:

(i) Make appropriate determinations with respect to the litigative probabilities of a claim (§ 1.932 of this chapter), the legal merits of a claim (§ 1.942(e) of this chapter), and any other legal considerations of a claim.

(ii) Collect in full a claim involving damage to or loss of government property under the jurisdiction of the Department of Veterans Affairs resulting from negligence or other legal wrong of a person (other than an employee of the Government while acting within the scope of his or her employment) and to compromise, suspend, or terminate any such claim not exceeding \$100,000.

(iii) Collect a claim in full from an individual or legal entity who is liable for the cost of hospital, medical, surgical, or dental care and treatment of a person, and to compromise, suspend, or terminate any such claim not exceeding \$100,000.

(Authority: 31 U.S.C. 3711(a)(2); 38 U.S.C. 501, 512)

(iv) The delegations of authority set forth in paragraphs (e)(4)(ii) and (iii) of this section do not apply to the handling of any claim as to which there is an indication of fraud, the presentation of a false claim or misrepresentation on the part of the debtor or any other party having an interest in the claim, or to any claim based in whole or in part on conduct in violation of the antitrust laws. Such cases will be considered by the General Counsel, who will make the determination in all instances as to whether the case warrants referral to the Department of Justice. The delegations of authority are applicable to those claims where the Department of Justice determines that action based upon the alleged fraud, false claim, or misrepresentation is not warranted.

(5) Pursuant to the provisions of the Military Personnel and Civilian Employees' Claim Act of 1964, 31 U.S.C. 3721, as amended, the General Counsel, Deputy General Counsel, Assistant General Counsel (Professional Staff Group III), Deputy Assistant General Counsel of said staff group, and Regional Counsel or those authorized to act for them, are authorized to settle and pay a claim for not more than \$40,000 made by a civilian officer or employee of the Department of Veterans Affairs for damage to, or loss of, personal property incident to his or her service. (Pub. L. 97-226)

(6) Under the provisions of 38 U.S.C. 7316(e), authority is delegated to the General Counsel, Deputy General Counsel, and the Assistant General Counsel (Professional Staff Group I) to hold harmless or provide liability insurance for any person to whom the immunity provisions of section 7316 apply, for damage for personal injury or death, or for property damage, negligently caused by such person while furnishing medical care or treatment in the exercise of his or her duties in or for the Veterans Health Administration, if such person is assigned to a foreign country, detailed to State or political division thereof, or is acting under any other circumstances which would preclude the remedies of an injured

third person against the United States, provided by sections 1346(b) and 2672 of title 28, United States Code, for such damage or injury.

(7) The General Counsel, Deputy General Counsel, and those authorized to act for them, are authorized to conduct investigations, examine witnesses, take affidavits, administer oaths and affirmations, and certify copies of public or private documents on all matters within the jurisdiction of the General Counsel. Pursuant to the provisions of § 2.2(c), the General Counsel, Deputy General Counsel, and those authorized to act for them, are authorized to countersign VA Form 4505.

(8) The General Counsel, or the Deputy General Counsel acting as or for the General Counsel, is authorized to designate, in accordance with established standards, those legal opinions of the General Counsel which will be considered precedent opinions involving veterans' benefits under laws administered by the Department of Veterans Affairs.

(Authority: 38 U.S.C. 501, 512)

(9) Under the provisions of 38 U.S.C. 1729(c)(1), authority is delegated to the General Counsel, Deputy General Counsel, Assistant General Counsel (Professional Staff Group I), Deputy Assistant General Counsel of said staff group, and Regional Counsel, or those authorized to act for them, to collect in full, compromise, settle, or waive any claim and execute the release thereof; however, claims in excess of \$100,000 may only be compromised, settled, or waived with the prior approval of the General Counsel, Deputy General Counsel, Assistant General Counsel (Professional Staff Group I), or Deputy Assistant General Counsel of said staff group, or those authorized to act for them.

(Authority: 31 U.S.C. 3711(a)(2); 38 U.S.C. 501, 512).

(10) Except as prescribed in paragraph (g)(3) of this section, the General Counsel, Deputy General Counsel, and the Assistant General Counsel for Professional Staff Group IV are authorized to make final Departmental decisions on appeals under the Freedom of Information Act, the Privacy Act, and 38 U.S.C. 5701, 5705 and 7332.

(Authority: 38 U.S.C. 512)

(11) All authority delegated in this paragraph to Regional Counsels will be exercised by them under the supervision of and in accordance with instructions issued by the General Counsel.

(f) National Cemetery Administration. Under Secretary for Memorial Affairs is delegated authority:

(1) To act on all matters assigned to the National Cemetery Administration by statute (38 U.S.C. chapter 24) and by regulation except where specifically requiring the personal attention or action of the Secretary and to authorize supervisory personnel within the jurisdiction of the Under Secretary for Memorial Affairs, to perform such functions as may be assigned.

(2) To designate, as deemed necessary, Superintendents of National Cemeteries as special investigators under 38 U.S.C. 901, however, such law enforcement authority is limited to enforcement of rules and regulations governing conduct on property under the charge and control of the Department of Veterans Affairs, as those rules and regulations apply to the cemetery over which the individual Superintendent exercises control and jurisdiction. Such designation will not authorize the carrying of firearms by any Superintendent.

(3) To accept donations, except offers of land, made in any manner, for the beautification or benefit of national cemeteries.

(4) To name features in national cemeteries, such as, roads, walks, and special structures.

(5) To establish policies and specifications for inscriptions on Government headstones, markers, and private monuments.

(Authority: 38 U.S.C. 501, 512, 2404)

(g) Inspector General. (1) The Secretary delegates to the Inspector General, the authority, as head of the Department of Veterans Affairs, to make written requests under the Privacy Act of 1974, 5 U.S.C. 552a(b)(7), for the transfer of records or copies of records maintained by other agencies which are necessary to carry out an authorized law enforcement activity of the Office of Inspector General. This delegation is made pursuant to 38 U.S.C. 512. The Inspector General may redelegate the foregoing authority within the Office of Inspector General, but the delegation may only be to an official of sufficient rank to ensure that the request for the records has been the subject of a high level evaluation of the need for the information.

(2) The Inspector General delegates the authority under the Inspector General Act of 1978, and redelegates the authority under paragraph (a) of this section, to request Privacy Act-protected records from Federal agencies pursuant to subsection (b)(7) of the Privacy Act to each of the following Office of Inspector General officials: (i) Deputy Inspector General, (ii) Assistant Inspector General for Investigations, (iii) Deputy Assistant Inspector General for Investigations, (iv) Chief of Operations, and (v) Special Agents in Charge of Field Offices of Investigations. These officials may not redelegate this authority.

(3) The Office of Inspector General is authorized to make final decisions on appeals submitted pursuant to the Freedom of Information Act concerning any Office of Inspector General records.

(Authority: 38 U.S.C. 512)

(h) Delegations to Office Resolution Management Officials (ORM). (1) The Deputy Assistant Secretary for Resolution Management is delegated authority to supervise and control the operation of the administrative EEO Discrimination Complaint Processing System within the Department.

(2) The Deputy Assistant Secretary for Resolution Management, the Chief Operating Officer, and all Regional EEO Officers/Field Managers are delegated authority to make procedural agency decisions to either accept or dismiss, in whole or in part, EEO discrimination complaints based upon race, color, national origin, sex, religion, age, disability, or reprisal filed by employees, former employees, or applicants for employment.

(3) The Deputy Assistant Secretary for Resolution Management, the Chief Operating Officer, and the Chief, Policy and Compliance are delegated authority to make agency decisions on all breach of settlement claims raised by employees, former employees, and applicants for employment.

(4) The Deputy Assistant Secretary for Resolution Management, the Chief Operating Officer, and the Chief, Policy and Compliance are delegated authority to consider and resolve all claims raised by employees, former employees, and applicants for employment that allege dissatisfaction with the processing of a previously filed EEO discrimination complaint.

(5) The Deputy Assistant Secretary for Resolution Management, the Chief Operating Officer, and the Chief, Policy and Compliance are delegated authority to monitor compliance by Department organizational components with orders and decisions of the OEDCA and the EEOC.

(i) Delegations to officials of the Office of Employment Discrimination Complaint Adjudication (OEDCA). (1) The Director and Associate Director, OEDCA, are delegated authority to make procedural decisions to dismiss, in whole or in part, any EEO discrimination complaint filed by any employee, former employee, or applicant for employment that may be pending before OEDCA, where administrative complaint processing efficiency may be best served by doing so.

(2) The Director and Associate Director, OEDCA, are delegated authority to dismiss, in whole or in part any EEO discrimination complaint based upon race, color, religion, sex, national origin, age, disability, or reprisal filed by any ORM employee, former employee, or applicant for employment.

(3) The Director and Associate Director, OEDCA, are delegated authority to make the agency decision on all breach of settlement claims raised by ORM employees, former employees, and applicants for employment.

(4) The Director and Associate Director, OEDCA, are delegated authority to consider and resolve all claims raised by ORM employees, former employees, and applicants for employment that allege dissatisfaction with the processing of a previously filed EEO discrimination complaint.

(5) The Director and Associate Director, OEDCA, are delegated authority to make procedural agency decisions to either accept or dismiss, in whole or in part, EEO discrimination complaints filed by employees, former employees, or applicants for employment where the **ORM must recuse itself from a case due to an actual, apparent, or potential conflict of interest.**

(j) Delegation to the Chairman, Board of Veterans' Appeals. In cases where OEDCA has recused itself from a case due to an actual, apparent, or potential conflict of interest, the Chairman, Board of Veterans' Appeals, is delegated authority to make procedural agency decisions to dismiss, in whole or in part, EEO discrimination complaints filed by agency employees, former employees, and applicants for employment; to make substantive final agency decisions where complainants do not request an EEOC hearing; to take final agency action following a decision by an EEOC Administrative Judge; and to make final agency decisions ordering appropriate remedies and relief where there is a finding of discrimination.

(k) Processing complaints involving certain officials. A complaint alleging that the Secretary or the Deputy Secretary personally made a decision directly related to matters in dispute, or are otherwise personally involved in such matters, will be **referred for procedural acceptability review, investigation, and substantive decision making to another Federal agency (e.g., The Department of Justice) pursuant to a cost reimbursement agreement.** Referral will not be made when the action complained of relates merely to ministerial involvement in such matters (e.g., ministerial approval of selection recommendations submitted to the Secretary by the Under Secretary for Health, the Under Secretary for Benefits, the Under Secretary for Memorial Affairs, assistant secretaries, or staff office heads).

(Authority: 38 U.S.C. 501, 512)

[25 FR 11095, Nov. 23, 1960]

Editorial Note:

For Federal Register citations affecting § 2.6, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.fdsys.gov.

From: (b) (6) @gmail.com>
To: (b) (6) <(b) (6)@va.gov>
Cc: (b) (6) <(b) (6)@va.gov>
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
>; (b) (6) @cox.net>; (b) (6)
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/(b) (6)
>
Bcc:
Subject: Fwd: [EXTERNAL] Seminole County Vet Center Service
Date: Thu Nov 15 2018 09:09:59 EST
Attachments:

Hey (b) (6)

I'm forwarding this email string between (b) (6) and myself so you can have her contact information. When I spoke with her at the Orlando Vet Center Open House, she is very much interested in initiating Vet Center Services to Seminole County. She stated she needs a location and I know you are the best to find that, as you have done so in the past. Hopefully, we can have better results this time and actually start the readjustment counseling process. I apologize for such a late response in responding to (b) (6) conversation. The plate has been full with mostly Veterans Treatment Court, Veterans Day, VA volunteering and election commitments. I know your plate is pretty full also, but I know you will do your best.

Thanks!

(b) (6)

----- Forwarded message -----

From: (b) (6) @gmail.com>
Date: Thu, Nov 15, 2018 at 8:57 AM
Subject: Re: [EXTERNAL] Seminole County Vet Center Service
To: (b) (6), PsyD. LCSW <(b) (6)@va.gov>

Hey (b) (6)

I'm going to carbon copy you on the emails I send to (b) (6) and all other contacts with Vet Center Services for Seminole County to keep you in the loop.

Later,

(b) (6)

On Thu, Nov 15, 2018 at 8:52 AM (b) (6) @va.gov> wrote:

Good morning (b) (6)

Thanks for speaking with me the other day. Please let me know if you have found a spot for an access point in your area.

Thanks

(b) (6)

(b) (6), Psy.D., LCSW

Readjustment Counselor

Retired USAF Veteran

Orlando Vet Center

(407) 857-(b) (6)

(b) (6)@va.gov

From: (b) (6) [mailto:(b) (6)@gmail.com]
Sent: Thursday, November 15, 2018 8:44 AM
To: (b) (6)@va.gov>
Subject: [EXTERNAL] Seminole County Vet Center Service

Hey (b) (6)

This is just a test email to see if I copied your contact information correctly. I will carbon copy you with any correspondence concerning Vet Center Services for Seminole County. I'm sorry I haven't responded until now. I've been very busy with various commitment to include Election Day, and Veterans Treatment Court on Thursday. I spoke with Ed (b) (6) and Judge (b) (6) this morning, and they are happy we talked. By the way, Happy Veterans Day!

Thanks!

(b) (6), MSW

From: (b) (6) D.
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6)
<(b) (6) gmail.com>; (b) (6) Adrienne F (OCEO/OCEO-FO)
<(b) (6) mcc.gov>
Cc:
Bcc:
Subject: FW: (b) (6) Financial Disclosure Report
Date: Tue Nov 13 2018 15:10:48 EST
Attachments:

HELP! lol

From: (b) (6) I. (OGC)" <(b) (6) va.gov>
Date: Tuesday, November 13, 2018 at 2:59 PM
To: (b) (6) D." <(b) (6) va.gov>
Subject: RE: (b) (6) Financial Disclosure Report

(b) (6)

I was trying to close out my last few remaining reports and noted that I had the following (b) (6)

(b) (6)

Thanks for the follow up..

(b) (6)

From: (b) (6) I. (OGC)
Sent: Monday, July 30, 2018 8:10 AM
To: (b) (6) D." <(b) (6) va.gov>
Subject: FW: (b) (6) Financial Disclosure Report

(b) (6)

I was reviewing my pending 2 78s and noted that you had

(b) (5)

(b) (5)

(b) (5)

(b) (5)

(b) (5)

(b) (5)

□ □ □ □ □

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(b) (5)

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From: (b) (6) I. (OGC)
Sent: Friday, July 20, 2018 3:47 PM
To: (b) (6) D. <(b) (6)@va.gov>
Cc: (b) (6) (OGC) <(b) (6)@va.gov>
Subject: RE: (b) (6) Financial Disclosure Report

(b) (6)

Thanks for the additional information on the (b) (6)

(b) (6)

From: (b) (6) D.
Sent: Friday, July 20, 2018 3:26 PM
To: (b) (6) I. (OGC) <(b) (6) va.gov>
Cc: (b) (6) (OGC) <(b) (6) va.gov>
Subject: Re: (b) (6) Financial Disclosure Report

Hi (b) (6)

I am making the (b) (6)

To be clear, I wasn't even (b) (6)

Thanks,

(b) (6)

From: (b) (6) I. (OGC)" <(b) (6) va.gov>
Date: Wednesday, July 18, 2018 at 3:23 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Cc: (b) (6) (OGC)" <(b) (6) va.gov>
Subject: RE: (b) (6) Financial Disclosure Report

(b) (6)

I have reviewed your annual report and have the following questions and comments.

Please include the

(b) (5)

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

(b) (5) [REDACTED]

(b) (5) [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

(b) (5) [Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

(b) (5) [Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

(b) (5)

(b) (5)

Thanks for the follow up.

(b) (5)

(b) (5)

Senior Ethics Attorney/

Deputy Ethics Official

(202) 461-

From: (b) (5) I. (OGC)
Sent: Wednesday, June 20, 2018 5:24 PM
To: (b) (5) D. <(b) (5) va.gov>
Cc: (b) (5) (OGC) <(b) (5) va.gov>
Subject: RE: (b) (5) Financial Disclosure Report

(b) (5)

I have certified your (b) (5)

(b) (5)

From: (b) (5) D.
Sent: Wednesday, June 20, 2018 4:57 PM

To: (b) (6) I. (OGC) <(b) (6) va.gov>
Cc: (b) (6) (OGC) <(b) (6) va.gov>
Subject: Re: Financial Disclosure Report

Thank you, my 2017 has been completed.

From: (b) (6) I. (OGC)" <(b) (6) va.gov>
Date: Wednesday, June 20, 2018 at 4:56 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Cc: (b) (6) (OGC)" <(b) (6) va.gov>
Subject: RE: Financial Disclosure Report

Correct.

From: (b) (6) D.
Sent: Wednesday, June 20, 2018 4:33 PM
To: (b) (6) I. (OGC) <(b) (6) va.gov>
Cc: (b) (6) (OGC) <(b) (6) va.gov>
Subject: Re: Financial Disclosure Report

After further review of the (b) (6)

From: (b) (6) I. (OGC)" <(b) (6) va.gov>
Date: Wednesday, June 20, 2018 at 4:08 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Cc: (b) (6) (OGC)" <(b) (6) va.gov>
Subject: RE: Financial Disclosure Report

Correct. Is your (b) (6) ?

(b) (6)

From: (b) (6) D.
Sent: Wednesday, June 20, 2018 3:20 PM

To: (b) (6) I. (OGC) <(b) (6) va.gov>
Cc: (b) (6) (OGC) <(b) (6) va.gov>
Subject: Re: Financial Disclosure Report

The (b) (5)

From: (b) (6) I. (OGC)" <(b) (6) va.gov>
Date: Wednesday, June 20, 2018 at 2:49 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Cc: (b) (6) (OGC)" <(b) (6) va.gov>
Subject: RE: Financial Disclosure Report

(b) (6)

Per the chart below, whether the (b) (5)

(b) (6)

(b) (5)

(b) (5) [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

(b) (5) [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

From: (b) (6) D.
Sent: Wednesday, June 20, 2018 2:10 PM
To: (b) (6) I. (OGC) <(b) (6) va.gov>
Cc: (b) (6) (OGC) <(b) (6) va.gov>
Subject: Re: (b) (6) Financial Disclosure Report

From (b) (6)

(b) (6)

Any guidance much appreciated.

Thanks,

(b) (6)

From: (b) (6) I. (OGC)" <(b) (6) va.gov>
Date: Wednesday, June 20, 2018 at 1:13 PM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (6) va.gov>
Cc: (b) (6) (OGC)" <(b) (6) va.gov>
Subject: RE: (b) (6) Financial Disclosure Report

(b) (6)

Thanks for the follow up.

Even though (b) (6)

(b) (6)

(b) (5)

(b) (5)

Senior Ethics Attorney/

Deputy Ethics Official

(202) 461- (b) (5)

From: (b) (5) D.
Sent: Wednesday, June 20, 2018 12:48 PM
To: (b) (5) I. (OGC) <(b) (5) va.gov>
Cc: (b) (5) (OGC) <(b) (5) va.gov>
Subject: Re: (b) (5) Financial Disclosure Report

(b) (5)

My account should be finishing this today.

On your other concerns, you are aware that (b) (5)

(b) (5)

If you would like to discuss further, please feel free to contact me.

Thank you,

(b) (5)

From: "(b) (5) I. (OGC)" <(b) (5) va.gov>
Date: Wednesday, May 2, 2018 at 9:41 AM
To: Department of Veterans Affairs Department of Veterans Affairs <(b) (5) va.gov>
Cc: "(b) (5) (OGC)" <(b) (5) va.gov>
Subject: (b) (5) Financial Disclosure Report

Mr. (b) (5)

I have reviewed your report and have the following questions and comments.

Please include a (b) (5)

(b) (5)

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(b) (5)

[REDACTED]

[REDACTED]

(b) (5)

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[REDACTED]

[REDACTED]

[REDACTED]

Senior Ethics Attorney/

Deputy Ethics Official

(202) 461- [REDACTED]

From: (b) (6) @gmail.com>
To: Hayes-Byrd, Jacquelyn
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
>
Cc:
Bcc:
Subject: [WARNING: ATTACHMENT UNSCANNED][EXTERNAL] Re: Helping One Veteran
Woman at a time. -
Date: Wed Nov 07 2018 11:54:03 EST
Attachments: Save the Date or get a space.pptx

Good morning Ms. hayes-byrd.

This is our flyer.

On Tue, Nov 6, 2018 at 11:34 PM (b) (6) @gmail.com> wrote:

Hello Ms. Byrd

I hope you will lend your support to our taking action to assist Veteran women through the National Association of Concern Veterans. Your participation in our Online and Silent Pop up Auction for our military women would be a welcome partnership. Please see attached.

Thank you for your support
(b) (6), Pop-up Auction Facilitator.

Owner: (b) (6) @gmail.com>
Filename: Save the Date or get a space.pptx
Last Modified: Wed Nov 07 10:54:03 CST 2018

SAVE THE DATE OR GET A SPACE

- COME JOIN US TO SUPPORT FEMALE VETERANS – WE ARE HELPING ONE WOMAN AT A TIME

THE POP-UP AUCTION

- DATE: SATURDAY, NOVEMBER 17TH & SUNDAY NOVEMBER 18TH
- PLACE: [REDACTED]
SILVER SPRING, MD 20910
- HOURS: 8:30AM – 4:00PM

Featuring: [REDACTED], Special Curator of Unique Coins

and

[REDACTED] – last living African-American fighter pilot who was one of the Tuskegee Airmen (pending)

For further information go to our website : www.ThePopUpAuction.com send us a message by the 15th if you want to get a space on



VA-18-0457-D-000562

From: (b) (6) @gmail.com>
To: Hayes-Byrd, Jacquelyn
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc: (b) (6) d,>
(b) (6) @aol.com>
Bcc:
Subject: [EXTERNAL] Helping One Veteran Woman at a time. -
Date: Tue Nov 06 2018 23:34:08 EST
Attachments: Selling booths for our indoor flea market style silent Auction.docx

Hello Ms. Byrd

I hope you will lend your support to our taking action to assist Veteran women through the National Association of Concern Veterans. Your participation in our Online and Silent Pop up Auction for our military women would be a welcome partnership. Please see attached.

Thank you for your support
(b) (6), Pop-up Auction Facilitator.

Owner: (b) (6) @gmail.com>
Filename: Selling booths for our indoor flea market style silent Auction.docx
Last Modified: Tue Nov 06 22:34:08 CST 2018

Help Us Help One Transitioning Veteran Woman At a Time



The Pop-Up Auction

Create Page @Username

Home

Services

Reviews

See more

Promote

Manage Promotions

Like Follow Share ...



The Pop-Up Auction added an event.

14 mins ·

"Thank You for Your Service Shero's" Please take this opportunity to put these words to practical use. The Pop-up Auction and the National Association of Concerned Veterans (NACV) are working together to help our sisters transitioning from military action to civilian life.

Female veterans are just as much a hero as her counterparts on the front lines. She is strong and rooted. She believes in our country's freedoms and will fight for its survival. She is our veteran hero and while she has asked for nothing in return we feel compelled to give her a place to lay her head when her military journey is done. A safe place to clear her head, consider her plans, and get back on her feet. We want to give her (our female veteran) hope for her future.

NACV is rehabilitating a house in the Mt. Rainer section of Washington, DC. It is a peaceful location in this Nations Capital, near transportation, healthcare, and jobs. The single family home is on a .25 acre lot with a porch and plenty of space to breath. We intend to house three veteran women and develop a plan for their successful transition to civilian life.

Instead of a GO Fund me account we went to a number of donors who have blessed us with some very nice Antique Road Show items we hope to turn into cash. These funds will support the NACV initiative to complete the Mt. Rainer house and provide residential safety to Female vets (our Shero's).

I look forward the online live auction as well as the concurrent Pop-up physical silent auction at 932 Philadelphia Ave in Silver Spring, Maryland. We have items like the 1st Wonder Woman magazine as it originally appeared in 1942; Marvel Group Comic Peter Parker the Spectacular Spider Man; Sport Magazine memorabilia like "The Ring" highlighting the Foreman-Norton fight; historic coins; 1920's Van Cleef similar jewelry and so much more.

Come Join The Pop-up Auction and NACV in saying "Thank you for your service" to women in the military. Bid on and purchase items with helping women transition in mind. Come out on Saturday, November 17th and Sunday November 18th and be prepared to support a good, transparent, and visible cause. [REDACTED] Silver Spring, MD 20904.



SAT, NOV 17 AT 8:30 AM

Charity Auction for Transitioning Female Veterans (host by NACV)

Causes

★ VA-18-0457-D-000565

Help Us Help One Transitioning Veteran Woman At a Time

We are selling booths for our indoor flea market style silent Auction. If you would like to use this platform for outreach or to sell/promote products and services please reach out to me.

Sharon Brown, Pop-up Auction Facilitator

Demographic: Multi-generational, Male, female, families, married, and single

Projected traffic

Online = 3 TO 8 MILLION viewers using live auctioneers

Foot traffic = Thanksgiving day parade goers, Veteran Day supporters, word of mouth from veteran groups and Montgomery County stakeholders.

If you are interested in getting a booth there is a nominal fee which goes to benefit this Pop-up Auction function. Please see the 2nd floor Floor plan below. Please contact me via phone (443) 305-(b) (6)

Individual Promotion
Space is 4x7

Space for your promotion /outreach is fifty (\$50.00) dollars per space. Please indicate where you would like to set up by placing an X on the 2nd Floor map below.

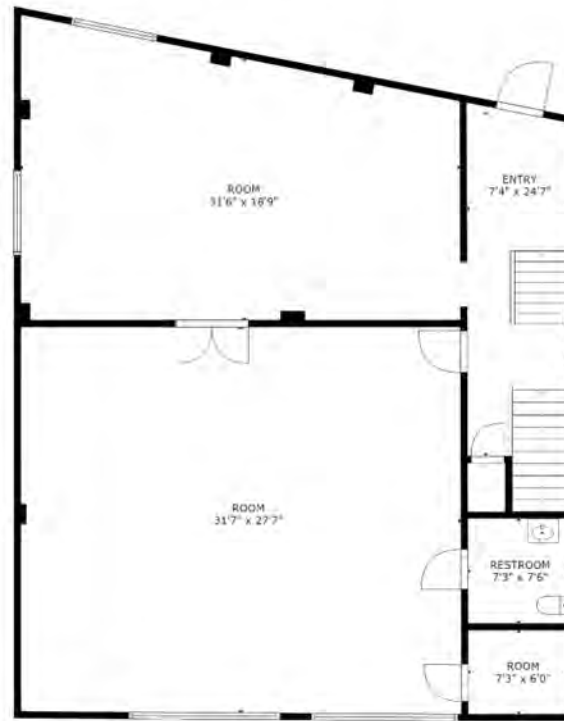
You are responsible for your own materials and tables. You are also responsible to clean your area.

Get a 3d view of the space:

<https://www.facebook.com/The-Pop-Up-Auction-326818524563995/>

Help Us Help One Transitioning Veteran Woman At a Time

2nd Floor Map



GROSS INTERNAL AREA
FLOOR 1: 16,318 sq ft, FLOOR 2: 18,114 sq ft
FLOOR 3: 18,112 sq ft
TOTAL: 52,544 sq ft

POWERED BY
matterport

From: (b) (6) [REDACTED]
To: [REDACTED]@aol.com>
Hayes-Byrd, Jacquelyn
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6) [REDACTED]>
Cc:
Bcc:
Subject: [EXTERNAL] Attn: Lady Hayes-Byrd / Draft Project Scope for (b) (6) [REDACTED]
Date: Tue Nov 06 2018 10:28:20 EST
Attachments: Project Scope AuctionPopup2.docx

Prestigious Lady Hayes-Byrd:

Our "Sister Veterans" thank you ever so dearly for your great Service, I'm therefore providing you with a preview peek at our up & coming pop-up auction project, to which you can let me know if you're interested.

(b) (6) [REDACTED]
Assistnt to the Founder
The (b) (6) [REDACTED]

Please see the November Pop-up event project scope attached.

Owner: (b) (6) @aol.com>
Filename: Project Scope AuctionPopup2.docx
Last Modified: Tue Nov 06 09:28:20 CST 2018



POP-UP AUCTION PROJECT SCOPE

Date: Saturday, November 17, 2018 and Sunday, November 18, 2018

Time: 08:00am to 4:00pm

Location: (b) (6)

Silver Spring, MD 20910

Presented by: "The (b) (6)

In association with: (b) (6) (Army), National Association of Concerned Vets; (b) (6) (Navy Veteran); Dr. (b) (6) (Private); and (b) (6) (Air Force), Luxury Homes International

OVERVIEW

1. Project Background and Description



This project is a mission for hope. It is intended to explore how a collaborating group can assist in addressing housing issues for transitioning female veterans in crisis. The plan was introduced by Mr. Rodger Robinson and Mr. Cecil Byrd. Cecil Byrd is an active member of the National Association of Concerned Veteran. He is currently renovating a residence located in Washington, DC intended for female veterans in crisis.

The vision is to rehabilitate available real estate to subsidize temporary housing opportunity for Female veterans transitioning, building, and adjusting to civilian life. This attempt is to connect and collaborate with organizations that provide steps to success for female veterans.

2. Project Scope



This is an exploratory pilot project to organize and define how a series of pop-up auctions can support a sustainable funding source intended to support transitioning veterans. Housed in a commercial establishment these Pop-up functions primary goal will be to establish agreements with various supporters and collect commissions from participating sellers. The project pilot will begin with the sale of 50 donated and consigned items. Each item will be auctioned silently via internet and in-person. A percentage equal to 25% of the winning bid price will go toward Mr. Byrd's program for veteran women. Only items committed by Mr. Byrd and Mr. Robinson will go toward this effort. Secondary seller(s) who wish to use space for sale of items such as movable art, jewelry, coins, collectable magazines, and minimal/portable furniture may be provided the opportunity to sell items in this festive environment. Each seller will donate \$50.00 to the primary organization in support of efforts to house women veterans. Sponsors are encouraged to provide financial donations.



Secondary Sellers are expected to register and are responsible for all aspects of transport, performance, and other applicable characteristics related to the commercial sale of their items and other property. No items shall remain on the premises after their sale-day.

Guests of the Pop-up will register at the front desk for accountability.

There will be a celebrity Guest who will assist in the live auction of 2 special items; 35% of the proceed will be donated to the specified female housing initiative.

There will be inventory of all auction items and a list of secondary Sellers. NO SAME DAY Seller registrants will be accepted.

3. High-Level Requirements

Systems will require are

Ability to sell and accept payments online.

Ability to access and update inventory list.

Physical Security

Connection and support for Social media on Twitter, YouTube, Facebook, Instagram, and LinkedIn.

Collaboration with Live Auction.com

Transportation to and from site for the (50) primary donations

Ability to incorporate automated routing and notifications based on business rules

4. Deliverables

Roundtrip Transportation for primary product

Event Insurance

Promotion

Volunteers [staging and design]

Basic Accounting: Square Services and dedicated bank account for closeout



Music

Food trucks

(10) Secondary Sellers

At least (1) \$500.00 Sponsor

5. Affected Parties/ Resources

Square.com

Dedicated bank account

Live Auction connection

Event Insurance:

Media/ Promotio

Volunteer(s): D

M

Ms

Ms.

Others to come.

Committed to provide Outreach:

Mr. (b) (6), Veteran's Franchise

Mr. (b) (6), MHS, CNC – Founder/President Human Service Senior Executive



6. Affected Business Systems and Other Access to Resources

Social Media

Electronic sales

7. Specific Exclusions from Scope

It will be clear to all that this is a Pilot event to determine whether these pop-up events are a good fit for the collaborative. All items in this sale are donated and shall be returned to the responsibility of its owner at the end of the Pop-up.

8. Implementation Plan

1	<p><i>Recommend to showcase all (50) auction items at the 932 Philadelphia Ave Silver Spring site.</i></p> <p><i>Roundtrip trip transportation is the responsibility of the donor.</i></p> <p><i>Items will be prepped and presented for sale to bidders</i></p> <p><i>A Bid sheet will be set in front of each of the 50 items. 36 will have a public final sale announcement every half hour; and until from start Saturday to closing Sunday. Two items may reach final sale on some half hours.</i></p> <p><i>Bidders will be responsible for transportation of the items sold [unless otherwise suggested]</i></p>
2	<p><i>Volunteers will be stationed at different posts and spread among the three floors</i></p> <p><i>A greeter volunteer will be present at front desk to register guest</i></p>
3	<p><i>Security will also be available to support the safety of our participants and guests.</i></p>
4	<p><i>Hours of operation will be from 8am to 4pm of Saturday and Sunday with a light breakfast provided for volunteers only. Doors will close promptly at 4pm.</i></p>
5	<p><i>Sellers are expected to set up their booths and breakdown during the hours operation. Sellers are expected to have registration fee paid in full prior to the event. If more than, 10 sellers become committed prior to the event date than the demand will change space pricing to \$50 per day.</i></p>

9. High-Level Timeline/Schedule



A Map and Design Plan will be available after the volunteers Saturday, October 19, 2019 site visit.

All activity for this project shall be concluded by Monday, November 18, 2018. Following the event closing an assessment to determine the continuation of similar pop-up projects will be made.

Describe the timeline/schedule plan, design, develop and deploy the project.

APPROVAL AND AUTHORITY TO PROCEED

We approve the project as described above, and authorize the team to proceed.

Name	Title	Date
(b) (6)	Principal	
	Principal	
(b) (6)	Owner of: (b) (6) Silver Spring, MD	

Approved By	Date	Approved By	Date
-------------	------	-------------	------



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

May 10, 2019

In Reply Refer To: 001B
FOIA Request: 18-11960-F

Daniel McGrath, Staff Attorney
Austin Evers, Executive Director
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005
foia@americanoversight.org; daniel.mcgrath@americanoversight.org

Dear Mr. McGrath:

This is the Fifth Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated and received August 23, 2018, and assigned FOIA tracking number **18-11960-F**. You requested: All records reflecting communications (including emails, email attachments, text messages, messages on messaging platforms (such as Slack, GChat or Google Hangouts, Lync, Skype, or WhatsApp), telephone call logs, calendar invitations/entries, meeting notices, meeting agendas, informational material, talking points, any handwritten or electronic notes taken during any oral communications, summaries of any oral communications, or other materials) between any of the individuals listed

- Veterans Affairs Officials
 - Darin Selnick, Senior Advisor to the Secretary
 - Casin Spero, Special Advisor
 - Individuals within the Offices of the Secretary and Deputy Secretary: David Shulkin, Former Secretary, and anyone acting on his behalf
 - Vivieca Wright Simpson, Former Chief of Staff
 - Pete O'Rourke, Former Chief of Staff, Former Acting Secretary, and Senior Advisor to the Secretary; and anyone acting on his behalf
 - Robert Wilkie, Secretary, and anyone acting on his behalf
 - Jacquelyn Hayes-Byrd, Acting Chief of Staff and Deputy Chief of Staff
 - Thomas Bowman, Deputy Secretary, and anyone acting on his behalf
 - Any political appointee* in the immediate Office of the Secretary or Deputy Secretary during the applicable time period not previously listed above
- Outside Recipients
 - Dan Caldwell
 - Nathan Anderson
 - Shannon Hough
 - Pete Hegseth
 - Any email address ending in @cv4a.org or @cvafoundation.org
 - Isaac "Ike" Perlmutter
 - Bruce Moskowitz
 - Marc Sherman
- All email communications between any of the individuals listed in Column A and any external individuals or organizations (i.e., emails with addresses ending in com/.org/.net/.mil/.edu) that mention one or more of the following search terms in the subject line, body of the email, or attachment:
 - a. "Concerned Veterans"
 - b. "Concerned Vets"
 - c. CVA

d. CV4A

Please provide all responsive records from January 20, 2017, through the date of the search.”

There is substantial overlap between FOIA request **18-11960-F** and your prior FOIA request **18-07426-F**, as there are responsive records responsive to both FOIA requests.

18-11960-F: 5th Partial IAD

After re-reconsidering OSVA’s FOIA Exemption 5 redactions to pages Bates-numbered 1003-1005 and 1124-1132, OSVA no longer redacts them per FOIA Exemption 5.

After re-considering OSVA’s FOIA Exemption 5 redactions to a briefing memorandum and talking points (Bates-numbered 1030-1031), OSVA still believes those redactions are warranted. Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts portions of talking points and a briefing memorandum prepared for Secretary Shulkin for his meeting with Rep. Cathy McMorris-Rodgers. The redacted information is both predecisional and deliberative because it reflects preliminary opinions and recommendations, which do not reflect VA’s final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials to discuss, opine, recommend or be forthcoming about the agency’s issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff’d in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996); Access Reports v. DOJ, 926 F.2d 1192, 1196-97 (D.C. Cir. 1991) (“talking points” memoranda are predecisional); ACLU v. DHS, 738 F. Supp. 2d 93, 112 (D.D.C. 2010) (“‘talking points’ are predecisional . . . the document itself suggests that a public statement was anticipated at the time of its creation, and given that no official statement has yet been made, the talking points remain ripe recommendations that are ready for adoption or rejection by the Department”); Sec. Fin. Life Ins. Co., No. 03-102-SBC, 2005 WL 839543, at *11 (D.D.C. Apr. 12, 2005) (“The undisputed evidence establishes that these [talking points] are deliberative”); Judicial Watch, Inc. v. U.S. Dep’t of Commerce, 337 F. Supp. 2d 146, 174 (D.D.C. 2004) (protecting “talking points” and recommendations on how to answer questions); St. Louis Sewer Dist., No. 10-2103, at *18 (E.D. Mo. Mar. 2, 2012) (protecting e-mail communications, “press releases, talking points and ‘Q & A,’” drafts, and briefing materials); Citizens for Responsibility & Ethics in Wash. v. DHS, 514 F. Supp. 2d 36, 44 (D.D.C. 2007) (protecting briefing materials concerning Hurricane Katrina response including proposed “solutions and approaches”); Judicial Watch, Inc. v. DOE, 310 F. Supp. 2d 271, 317 (D.D.C. 2004) (protecting briefing materials for Secretary of the Interior), aff’d in part, rev’d in part on other grounds & remanded, 412 F.3d 125, 133 (D.C. Cir. 2005); Klunzinger v. IRS, 27 F. Supp. 2d 1015, 1026 (W.D. 1998) (protecting paper to brief commissioner for meeting); Thompson v. Dep’t of the Navy, No. 95-347, 1997 WL 527344, at *4 (D.D.C. Aug. 18, 1997) (protecting materials to brief senior officials responding to media inquiries, as “disclosure of materials reflecting the process by which the Navy formulates its policy concerning statements to and interactions with the press” could stifle frank communication within the agency), aff’d, No. 97-5292, 1998 WL 202253, at *1 (D.C. Cir. Mar. 11, 1998) (per curiam); Williams v. DOJ, 556 F.

Supp. 63, 65 (D.D.C. 1982) (protecting "briefing papers prepared for the Attorney General prior to an appearance before a congressional committee").

Thus far, OSVA has released to you four thousand nine hundred seventy-six (4,976) pages for FOIA requests **18-07426-F** and **18-11960-F**. Please kindly consider whether "Concerned Vet" or "Concerned Veterans" are limiting enough search terms, which yield false positive emails from veterans claiming to be a "concerned vet" or "concerned veteran," as well as emails referencing the National Association of Concerned Veterans.

18-11960-F: 5/8/19, 4th Partial IAD & Reasonable Searches Dated 12/19/18 & 5/2/19

On December 19, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below twelve (12) custodians from January 20, 2017, to December 19, 2018:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) Shulkin, David, former VA Secretary;
- 3) O'Rourke, Peter M., former VA Acting Secretary;
- 4) Byrne, Jim, current VA Acting Deputy Secretary;
- 5) Bowman, Thomas, former VA Deputy Secretary;
- 6) Powers, Pam, current VA Chief of Staff;
- 7) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 8) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 9) Selnick, Darin, former VA White House Senior Advisor;
- 10) Lukach, Michael, former VA White House Senior Advisor;
- 11) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 12) Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches via the Clearwell e-discovery platform.

On May 2, 2019, using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms "Concerned Veterans of America," "CVA," "cv4a.org," "CV4A," "Concerned Vets," and "Concerned Veterans" to search through the email boxes of the aforementioned twelve (12) custodians. Excluding the previous Clearwell search results for the First through Third Partial Initial Agency Decisions, this May 2, 2019, Clearwell search yielded approximately two hundred twenty (220) emails and their attachments totaling approximately five thousand (5,000) pages.

On May 8, 2019, of the approximate two hundred twenty (220) emails and their attachments totaling approximately five thousand (5,000) pages, OSVA released fourteen (14) emails and their attachments totaling five hundred seventy-four (574) pages, Bates-numbered as 4555-5128. After reviewing the five hundred seventy-four (574) pages, OSVA redacted some information with FOIA Exemptions 5 and 6.

5 U.S.C. § 552(b)(5) exempts from required disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Under the attorney-client and work product privileges, the VA redacted portions of records, emails, and communications between VA employees and attorneys relating to federal lawsuits against the VA. The release of this information would impede the ability of VA employees and attorneys to speak openly and frankly about legal issues concerning lawsuits against the VA. The release of this information would also compromise the VA's legal positions for its lawsuits.

5 U.S.C. § 552(b)(6) exempts from required disclosure "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal employees and private citizens; we however release the names and VA email addresses of VA Senior Executives. Federal civilian employees and private citizens retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal civilian employees and private citizens whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, except names and VA email addresses of VA Senior Executives, we find that there is no public interest in knowing the names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal civilian employees and private citizens. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. Releasing even a single VA username reveals the pattern to ascertain VA usernames that VA employees use to log into VA Systems of Records; releasing VA usernames exposes the VA, its employees, and its contractors to potential hacking and information technology security liabilities and risks. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed." Long v. Immigration & Customs Enf't, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

18-11960-F: 5/2/19, 3rd Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

On September 6, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below ten (10) custodians from January 20, 2017, to September 6, 2018:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) Shulkin, David, former VA Secretary;
- 3) O'Rourke, Peter M., former VA Acting Secretary;
- 4) Bowman, Thomas, former VA Deputy Secretary;
- 5) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 6) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 7) Selnick, Darin, former VA White House Senior Advisor;
- 8) Lukach, Michael, former VA White House Senior Advisor;
- 9) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 10) Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches via the Clearwell e-discovery platform.

On September 11, 2018, using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms "Concerned Veterans of America," "CVA," and "cv4a.org" to search the email boxes of: former VA Secretary David Shulkin, Robert Wilkie, Peter O'Rourke, Thomas Bowman, Jacquelyn Hayes-Byrd, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero. This Clearwell search yielded one hundred eighty-two (182) documents totaling three thousand five hundred thirty-one (3,531) pages.

On November 30, 2018, OSVA released to you one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank), redacted with FOIA Exemptions 4, 5, 6, 7(C), and 7(E). On February 14, 2019, OSVA released three (3) documents and their attachments totaling seven (7) pages, Bates-numbered as 4548-4554, redacted with FOIA Exemptions 5 and 6.

18-11960-F: 2/14/19, 2nd Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

From the aforementioned searches dated September 6, 2018, and September 11, 2018, OSVA released three (3) documents and their attachments totaling seven (7) pages, Bates-numbered as 4548-4554, on February 14, 2019, redacted with FOIA Exemptions 5 and 6.

18-11960-F: 11/30/18, Initial Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

Of the searches dated September 6, 2018, and September 11, 2018, OSVA released seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages on November 30, 2018, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank), on November 30, 2018.

After reviewing the three thousand five hundred twenty-four (3,524) pages, OSVA redacted some information with FOIA Exemptions 4, 5, 6, 7(C), and 7(E). 5 U.S.C. § 552(b)(4) exempts from disclosure "trade secrets and commercial or financial information obtained from a person and privileged or confidential." Redacted information includes voluntary proposal submission verbiage, technical processes, technical approaches, and partnership or subcontracting agreements. The release of this information would likely lead to substantial competitive harm in reverse-engineering of the vendors' technical approaches, processes, partnership, subcontracting, and business and labor strategies. RMS Indus. v. DOD, No. C-92-1545, slip op. at 7 (N.D. Cal. Nov. 24, 1992) (protecting "descriptions of equipment and the names of contacts, customers, key employees, and subcontractors" because "bidders only submit such information if it will not be released to their competitors"); BDM Corp. v. SBA, 2 Gov't Disclosure Serv. (P-H) ¶ 81,189, at 81,495 (D.D.C. Mar. 20, 1981) (protecting names of consultants and subcontractors, performance, cost, and equipment information).

5 U.S.C. § 552(b)(7)(C) exempts from required disclosure information law enforcement information the disclosure of which "could reasonably be expected to constitute an unwarranted invasion of personal privacy." Redacted information includes names and email addresses of White House employees with security clearances, as well as Redacted information includes names, identities, email addresses, and VA usernames of VA law enforcement employees. The release of this information would risk impersonation of these White House employees with security clearances also working on national security and law enforcement matters, as well as jeopardizing their health and safety and those the White House employees are charged with protecting. The release of this information would risk impersonation of VA law enforcement

personnel and jeopardize the health and safety of not only law enforcement personnel, but those persons the VA law enforcement personnel protect including the VA Secretary.

5 U.S.C. § 552(b)(7)(E) exempts from required disclosure information that “would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law.” Redacted information includes VA usernames of VA law enforcement employees and shared VA email groups, for which VA law enforcement officials plan their law enforcement operations and protection of VA personnel. The release of this information would compromise the safety of VA law enforcement personnel and VA employees.

18-07426-F: 11/20/18, 2nd Partial IAD & Reasonable Searches Dated 5/8/18, 9/18/18, 10/12/18, 10/16/18, & 11/15/18

On October 12, 2018, and October 16, 2018, the OSVA FOIA office searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to June 22, 2018. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. These October 12, 2018, and October 16, 2018, searches yielded forty-four (44) pages, which the VA released redacted as pages Bates-numbered 243-286 on November 20, 2018.

On September 18, 2018, and October 16, 2018, the OSVA FOIA office searched through former VA Acting Chief of Staff Jacquelyn Hayes-Byrd's emails and calendars from November 8, 2016, to June 22, 2018. OSVA used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded two hundred fifty-five (255) pages, which OSVA released redacted as pages Bates-numbered 287-541 on November 20, 2018.

On October 18, 2018, the OSVA FOIA office searched through the email boxes and calendars, from January 20, 2017, to June 22, 2018, of: 1) Bowman, Thomas, former VA Deputy Secretary; 2) Wright-Simpson, Vivieca, former VA Chief of Staff; 3) Selnick, Darin, former VA White House Senior Advisor; 4) Lukach, Michael, former VA White House Senior Advisor; 5) Leinenkugel, Jake, former VA White House Senior Advisor; and 6) Spero, Casin D, former VA White House Liaison. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded two hundred seventy-two (272) pages, which OSVA released redacted as pages Bates-numbered 542-813 on November 20, 2018.

On November 15, 2018, the OSVA FOIA office searched through the email boxes and calendars from June 23, 2018, to September 6, 2018, including of:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) O'Rourke, Peter M., former VA Acting Secretary;
- 3) Bowman, Thomas, former VA Deputy Secretary;
- 4) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 5) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 6) Selnick, Darin, former VA White House Senior Advisor;
- 7) Lukach, Michael, former VA White House Senior Advisor;
- 8) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 9) Spero, Casin D, former VA White House Liaison.

The November 15, 2018, search yielded two pages, which OSVA release redacted as pages Bates-numbered 814-815 on November 20, 2018.

Our May 8, 2018 (our search cut-off date) search yielded fifty-six (56) pages of email communication to or from Jared Kushner. On November 20, 2018, OSVA released these fifty-six (56) pages redacted as pages Bates-numbered 816-871.

After reviewing six hundred twenty-nine (629) pages Bates-numbered 243-871, OSVA redacted some information with FOIA Exemptions 4, 5, 6, and 7(C). Pages bates-numbered 872-995 are intentionally left blank.

18-07426-F: 9/14/18, Partial IAD & Reasonable Searches Dated 5/8/18

On May 8, 2018, our search cut-off date, we searched through former VA Secretary David Shulkin's emails and calendars from February 14, 2017 (the date he became VA Secretary), to March 30, 2018 (the date he left VA). We searched through VA Secretary Robert Wilkie's emails and calendars from April 1, 2018 (the date he became VA Acting Secretary) to May 8, 2018.

We searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from February 15, 2018 (the date he became VA Acting Chief of Staff), to May 3, 2018. VA will conduct a follow-up search of former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to May 8, 2018.

OSVA searched for any emails to or from Mr. Perlmutter, Dr. Moskowitz, and Mr. Kushner. Our search thus far yielded two hundred ninety-eight (298) pages, of which fifty-six (56) pages require consultation with the White House FOIA Liaison. After reviewing two hundred forty-two (242) pages, OSVA redacted some information with FOIA Exemptions 5, 6, 7(C), and 7(E). Bates-numbered as 1-242 on September 14, 2018.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:

Name: John Buck

Email Address: vacofoiaservice@va.gov

Office of Government Information Services (OGIS)

Email Address: ogis@nara.gov

Fax: 202-741-5769

Mailing address:

National Archives and Records Administration

8601 Adelphi Road

College Park, MD 20740-6001

FOIA Appeal

This concludes OSVA's fifth partial IAD to request **18-11960-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)

Department of Veterans Affairs

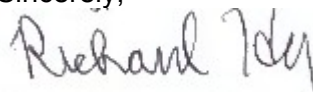
810 Vermont Avenue, NW

Mr. McGrath, Esq., & Mr. Evers
Page 8
May 10, 2019

Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,

A handwritten signature in dark ink, appearing to read "Richard Ha".

Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachment - Redacted pages Bates-numbered 1003-1005 and 1124-1132

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED]>
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED]>
Cc: Alaigh, Poonam, M.D. </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED]>
Bcc:
Subject: Former Senate Majority Leader Dr. Frist
Date: Thu Jun 01 2017 16:32:31 EDT
Attachments:

I had a long phone conversation with former Senate Majority Leader Dr. Bill Frist last week. Dr. Frist did part-time surgery for over 15 years at the VA Hospital in Nashville. He was also one of the co-chairs of the CVA Fixing Veterans Healthcare Taskforce.

As you know Dr. Frist is a board member for a lot of different types of Healthcare companies and wants to use his expertise and connections to help you and VA healthcare. Below is the follow up email he sent me on four areas he feels he can be helpful with.

One example is Valor Healthcare. VALOR is the biggest CBOC contract care provider for VA with 33 CBOCs that see 110,000 veterans each year. As a contract provider they have the flexibility we don't. I met with their president and they told me they can stand up a NEW CBOC, in 90 days after a contract is signed, at half the cost it takes VA. That would give us the ability to stand up new CBOCs quickly, at less cost, and without the need for legislation. We could also deal with our provider shortage by having more CBOC be contract and moving providers from there to more critical areas. By the way, the OIG did two studies in 2010 and 2011 comparing VA staff CBOC vs. contract CBOC in terms of quality, OIG found no difference.

I think Dr. Frist as past Majority leader could also help us with the Senate in passing legislation.

My recommendation is to set up a meeting with you, Poonam and myself, with Dr. Frist and [REDACTED] MD, President of Valor. [REDACTED] is an Army veteran who was also the Medical Director of the VA Denton, TX CBOC. Dr. Frist comes to DC every couple of weeks so it will be easy to schedule the meeting.

Let me know if you want to go forward with the meeting with Dr. Frist and I will set it up.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390- (b) (6)

From: Darin Selnick [mailto:(b) (6)@gmail.com]
Sent: Tuesday, May 30, 2017 12:11 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: issues discussed

Sent from my iPhone

Begin forwarded message:

From: Bill Frist <(b) (6)@wfrist.com>
Date: May 25, 2017 at 12:12:35 PM EDT
To: "(b) (6)@gmail.com" <(b) (6)@gmail.com>
Subject: issues discussed

Darin,

Great to catch up and excited about the opportunities to accelerate your and the Secretary's initiatives there.

- 1.Primary care and access. I have forwarded to you a memo on Valor and hopefully you can discuss innovation here which can be rapidly adopted.
- 2.Palliative health care. Aspire Health is the largest nonhospice, community based palliative care company in the country and is now in 20 states and on cutting edge with better outcomes and huge savings. They are aware of a pilot that the VA has done which apparently was successful and I would like to put CEO Brad Smith with your smartest person to, again on the innovation and on the service front, meet and discuss how the VA can incorporate this high quality patient and family centered service for advanced illness to our veterans – quickly.
- 3.Infrastructure: I am on the board of AECOM, the largest design and architecture firm in the country, . The VA is a very important client of AECOM as we are engaged with the agency through several contracts and through the Army Corps of Engineers, which now oversees the major construction projects for the VA. AECOM completed the design for the VA hospital in Orlando and has delivered more than a dozen renovation projects over the last couple of years. Would love to further this

relationship. Again quality and speed and expertise is primary.

4. Partnerships. I would suggest in the health IT world and mobile technology and communication world, that the VA meet (b) (6) who is the CEO of Accolade. Partnering with Accolade would potentially greatly accelerate VA entry into the patient navigation world. Their development team is very experienced, 100% health care, and is currently working with 10 of the largest employers in the country.

Thanks for taking time to discuss these opportunities. And thanks for helping me navigate through the VA to serve our veterans (which I had the privilege of doing every week in the operating room for 15 years!

From: Darin Selnick (b) (6) @gmail.com>
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: [EXTERNAL] Choice 2.0
Date: Mon Apr 17 2017 10:14:26 CDT
Attachments: CVA Matrix Taskforce Report to IA to Draft Leg.docx
VHCTF and Sec 201 Comparison Table.docx

Owner: Darin Selnick <d[REDACTED]@gmail.com>
Filename: CVA Matrix Taskforce Report to IA to Draft Leg.docx
Last Modified: Mon Apr 17 10:14:26 CDT 2017

Key Components/Independent Assessment/Draft Legislation

Key Components	VA Commissioned Independent Assessment	Draft Legislation
Separate the VA's payor and provider functions into separate institutions.	<p>Assessment C – Page 139 6.2.3.5 Separate VA's Payer and Provider Functions into Discrete Organizations The idea here is to reorganize the way that VA manages Veteran health care risk and pays for medical services, by standing up within VA a new, dedicated payer organization, which would become responsible for all health care funding and contracting/payment activity for VA. At the same time, VA's direct -provider network would be separated out as its own distinct organization, removed from the payer function, and solely dedicated to operating hospitals and providing medical services to Veterans.</p>	<p>Provider - Sec.101.Establishment of Veterans Accountable Care Organization Payor - Sec.102.Establishment of Veterans Health Insurance Program</p>
Establish the Veterans Health Insurance Program (VHIP) as a program office in the Veterans Health Administration.	<p>Assessment C – Page 139 6.2.3.5 Separate VA's Payer and Provider Functions into Discrete Organizations by standing up within VA a new, dedicated payer organization, which would become responsible for all health care funding and contracting/payment activity for VA. the VA payer entity would presumably also engage in contracts with other, outside provider networks, and would make decisions about how to allocate resources and pay providers to best implement VA health benefits. would manage VA health care funding in a manner similar to a traditional insurance entity.</p>	<p>Sec.102.Establishment of Veterans Health Insurance Program</p>
Establish the Veterans Accountable Care Organization (VACO) as a non-profit government corporation fully separate from Department of Veterans Affairs.	<p>Integrated Report – Page 26 Alternative governance models do exist. One was introduced by the Commission on the Future for America's Veterans, which proposed that Congress "establish a new entity with characteristics not unlike a federal government 'not for profit' corporation" that would be empowered with "unencumbered" authority to use all the assets of VHA to "maximize benefits to Veterans."</p>	<p>Sec.101.Establishment of Veterans Accountable Care Organization</p>

Key Components	VA Commissioned Independent Assessment	Draft Legislation
Institute a VA Medical Center realignment procedure (MRAC) modeled after the Defense Base Realignment and Closure Act of 1990 (BRAC).	Integrated Report – Page xiv, 26 Empower a board or commission to reshape geographic service areas and optimize facilities resourcing and lines of service (along the lines of the Defense Base Realignment and Closure Commission process used for military installations).	Sec.201. Realignment of medical centers.
Require the VHA to report publicly on all aspects of its operation, including quality, safety, patient experience, timeliness, and cost-effectiveness.	Integrated Report – Page 2 The Congressional Budget Office (CBO) has previously reported to Congress on the challenges of comparing the costs of VA and non-VA care, citing the scarcity of cost-accounting data for Veterans’ care and the complete absence of data on non-VA care received by Veterans who are also treated by VA. We do recognize that the value of Veterans’ health care, defined as health care outcomes relative to costs, should inform efforts for improvement.	Sec.106. Publication of health care information
<p>Preserve the VA health benefit for current enrollees who prefer it, while offering an option to seek coverage from the private sector.</p> <p>VetsCare Federal Veterans satisfied with VA health care would be able to maintain their existing coverage, with no changes. Veterans in this plan would have full access to the VA’s health care system, the VACO.</p> <p>VetsCare Choice Like VA employees, our veterans should be free to choose their own source of health insurance. This program would be called VetsCare Choice, and offers veterans the ability to purchase heavily discounted private health coverage.</p>	<p>Assessment C – Page 140 new VA payer entity would contract with the VA provider entity, with the latter becoming the primary provider network for delivering benefits. VA provider facilities might be shifted to specialized aspects of clinical service where they have greatest comparative advantage and value.</p> <p>Assessment C – Page 137 Incorporate All VA Purchased Care Initiatives into a Single Program within VA Assessment C – Page 133 One way to prioritize access to purchased care plausibly could involve making purchased care resources more readily available as a choice to Veterans in lower or higher-priority groups, with the aim of easing demand on VA’s direct-care system. any version of this step would involve tying the priority group scheme to purchased care so that Veterans in the highest priority groups would have enhanced access to outside services.</p>	<p>Sec.103.Designation of existing authorities for hospital care, medical services, and other health care.</p> <p>Sec.104.Health insurance support for new veterans and veterans electing health insurance support in lieu of eligibility for hospital care, medical services, and other health care under existing authorities. Subchapter I</p>

Key Components/Independent Assessment/Draft Legislation

Key Components	VA Commissioned Independent Assessment	Draft Legislation
<p><i>VetsCare Choice (Cont.)</i></p> <p>VetsCare Senior Enrolled veterans over the age of 65, and those who qualify for Medicare due to disability, would gain the option of using their VA funds to defray the costs of Medicare premiums and supplemental coverage (“Medigap”).</p>	<p>Assessment C – Page 134 6.2.2.4 Create a VA Subsidy for Veterans to Obtain Health Insurance Coverage Through ACA Exchanges or Other Sources Rather than directly providing or paying for care, VA under this step would pay a subsidy directly to Veterans, who would then use the money to purchase health insurance coverage, either through the health care exchanges established by the Affordable Care Act, or through traditional private health coverage</p> <p>6.2.2.4 Create a VA Subsidy for Veterans to Obtain Health Insurance Coverage Through ACA Exchanges or Other Sources VA under this step would pay a subsidy directly to Veterans, who would then use the money to purchase health insurance coverage, either through the health care exchanges established by the Affordable Care Act, or through traditional private health coverage, <i>or through other insurance mechanisms (including Medicare).</i></p>	<p>Sec.104. Health insurance support for new veterans and veterans electing health insurance support in lieu of eligibility for hospital care, medical services, and other health care under existing authorities. Subchapter II</p>
<p>Reform health insurance coverage for future veterans. Eligibility for sponsored health coverage would be based on the current Priority Group requirements. However, Priority Groups 1–3, would be even more highly prioritized. The program would also assist veterans in Priority Groups 4-6.</p>	<p>Assessment did not directly deal with this issue. However, the need to address this was stated in Integrated Report – Page 25 They must work to align VHA’s promise to provide comprehensive health care to Veterans with VHA’s capacity by defining the expected benefit—that is, the Veteran population to be served and the health care those Veterans will be provided. Who will VHA serve? Is it truly all Veterans, or a subset of Veterans whose care is mandated?</p>	<p>Sec.104. Subchapter I “2602. Eligibility. “(c) Exceptions</p> <p>Sec.104. Subchapter II “2611. “(c) “(2) EXCLUSION OF CERTAIN VETERANS</p>
<p>Offer veterans’ access to the Federal Long Term Care Insurance Program.</p>	<p>Assessment did not deal with this issue. However, at a Commission on Care open meeting, the issue was brought up as important.</p>	<p>Sec.401. Veterans’ eligibility for long-term care insurance.</p>
<p>Create a VetsCare Implementation Commission, a nonpartisan legislative branch agency, to implement the legislation</p>	<p>Integrated Report – Page xiv, 26 Establish a governance board to develop fundamental policy, define the strategic path, insulate VHA leadership from direct political interaction, and ensure accountability for the achievement of established performance measures. In the near term, several models could be tailored to address these policy issues in an objective and unbiased manner. Congress could charter a commission modeled after the 1955 U.S. President’s Commission on Veterans’ Pensions.</p>	<p>Sec.302.VetsCare Implementation Commission</p>

Owner: Darin Selnick [REDACTED]@gmail.com>
Filename: VHCTF and Sec 201 Comparison Table.docx
Last Modified: Mon Apr 17 10:14:26 CDT 2017



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Taskforce Report Recommendations Reflect on the Independent Assessment

Fixing Veterans Health Care Taskforce Report	VA Commissioned Independent Assessment
1. Separate the VA's payer and provider functions into separate institutions.	<p>Assessment C – Page 139</p> <p>6.2.3.5 Separate VA's Payer and Provider Functions into Discrete Organizations</p> <p>The idea here is to reorganize the way that VA manages Veteran health care risk and pays for medical services, by standing up within VA a new, dedicated payer organization, which would become responsible for all health care funding and contracting/payment activity for VA. At the same time, VA's direct -provider network would be separated out as its own distinct organization, removed from the payer function, and solely dedicated to operating hospitals and providing medical services to Veterans.</p>
2. Establish the Veterans Health Insurance Program (VHIP) as a program office in the Veterans Health Administration.	<p>Assessment C – Page 139</p> <p>6.2.3.5 Separate VA's Payer and Provider Functions into Discrete Organizations</p> <p>by standing up within VA a new, dedicated payer organization, which would become responsible for all health care funding and contracting/payment activity for VA.</p> <p>the VA payer entity would presumably also engage in contracts with other, outside provider networks, and would make decisions about how to allocate resources and pay providers to best implement VA health benefits.</p> <p>would manage VA health care funding in a manner similar to a traditional insurance entity.</p>
3. Establish the Veterans Accountable Care Organization (VACO) as a non-profit government corporation fully separate from Department of Veterans Affairs.	<p>Integrated Report – Page 26</p> <p>Alternative governance models do exist. One was introduced by the Commission on the Future for America's Veterans, which proposed that Congress "establish a new entity with characteristics not unlike a federal government 'not for profit' corporation" that would be empowered with "unencumbered" authority to use all the assets of VHA to "maximize benefits to Veterans."</p>
4. Institute a VA Medical Center realignment procedure (MRAC) modeled after the Defense Base Realignment and Closure Act of 1990 (BRAC).	<p>Integrated Report – Page xiv, 26</p> <p>Empower a board or commission to reshape geographic service areas and optimize facilities resourcing and lines of service (along the lines of the Defense Base Realignment and Closure Commission process used for military installations).</p>

CVA Member Briefing
October 7, 2015

VA-18-0457-E-000010

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<p>5. Require the VHA to report publicly on all aspects of its operation, including quality, safety, patient experience, timeliness, and cost-effectiveness.</p>	<p>Integrated Report – Page 2 The Congressional Budget Office (CBO) has previously reported to Congress on the challenges of comparing the costs of VA and non-VA care, citing the scarcity of cost-accounting data for Veterans' care and the complete absence of data on non-VA care received by Veterans who are also treated by VA. We do recognize that the value of Veterans' health care, defined as health care outcomes relative to costs, should inform efforts for improvement.</p>
<p>6. Preserve the traditional VA health benefit for current enrollees who prefer it, while offering an option to seek coverage from the private sector:</p> <p>VetsCare Federal Veterans who are satisfied with VA health care would be able to maintain their existing coverage, with no changes to benefits or cost-sharing. Veterans in this plan would have full access to the VA's integrated health care system, the Veterans Accountable Care Organization.</p> <p>VetsCare Choice Like VA employees, our veterans should be free to choose their own source of health insurance. This program would be called VetsCare Choice, and offers veterans the ability to purchase heavily discounted private health coverage.</p>	<p>Assessment C – Page 140 new VA payer entity would contract with the VA provider entity, with the latter becoming the primary provider network for delivering benefits. VA provider facilities might be shifted to specialized aspects of clinical service where they have greatest comparative advantage and value.</p> <p>Assessment C – Page 137 6.2.3.3 Incorporate All VA Purchased Care Initiatives into a Single Program Within VA</p> <p>Assessment C – Page 133 One way to prioritize access to purchased care plausibly could involve making purchased care resources more readily available as a choice to Veterans in lower or higher-priority groups, with the aim of easing demand on VA's direct-care system. any version of this step would involve tying the priority group scheme to purchased care so that Veterans in the highest priority groups would have enhanced access to outside services.</p> <p>Assessment C – Page 134 6.2.2.4 Create a VA Subsidy for Veterans to Obtain Health Insurance Coverage Through ACA Exchanges or Other Sources</p> <p>Rather than directly providing or paying for care, VA under this step would pay a subsidy directly to Veterans, who would then use the money to purchase health</p>



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<p>VetsCare Senior Enrolled veterans over the age of 65, and those who qualify for Medicare due to disability, would gain the option of using their VA funds to defray the costs of Medicare premiums and supplemental coverage (“Medigap”).</p>	<p>insurance coverage, either through the health care exchanges established by the Affordable Care Act, or through traditional private health coverage</p> <p>6.2.2.4 Create a VA Subsidy for Veterans to Obtain Health Insurance Coverage Through ACA Exchanges or Other Sources</p> <p>VA under this step would pay a subsidy directly to Veterans, who would then use the money to purchase health insurance coverage, either through the health care exchanges established by the Affordable Care Act, or through traditional private health coverage, or through other insurance mechanisms (including Medicare).</p>
<p>7. Reform health insurance coverage for future veterans. Eligibility for sponsored health coverage would be based on the current Priority Group requirements. However, veterans with service-connected disabilities—i.e., those in Priority Groups 1 through 3—would be even more highly prioritized The program would also assist disadvantaged veterans, such as those in Priority Groups 4 through 6.</p>	<p>Assessment did not directly deal with this issue. However, the need to address this was stated in Integrated Report – Page 25</p> <p>They must work to align VHA’s promise to provide comprehensive health care to Veterans with VHA’s capacity by defining the expected benefit—that is, the Veteran population to be served and the health care those Veterans will be provided. Who will VHA serve? Is it truly all Veterans, or a subset of Veterans whose care is mandated?</p>
<p>8. Offer veterans’ access to the Federal Long Term Care Insurance Program.</p>	<p>Assessment did not deal with this issue</p>
<p>9. Create a VetsCare Implementation Commission, a nonpartisan legislative branch agency, to implement the Veterans Independence Act.</p>	<p>Integrated Report – Page xiv, 26</p> <p>Establish a governance board to develop fundamental policy, define the strategic path, insulate VHA leadership from direct political interaction, and ensure accountability for the achievement of established performance measures. In the near term, several models could be tailored to address these policy issues in an objective and unbiased manner. Congress could charter a commission modeled after the 1955 U.S. President’s Commission on Veterans’ Pensions.</p>
<p>10. VHA needs accountability</p>	<p>Assessment I p. 43</p> <p>VHA employees want to move from a bureaucratic, political, and siloed organization to one defined by accountability, trust, and efficiency.</p>

“Dutchess has made significant progress with Hudson River Housing in driving down the total number of veterans who are struggling to find housing or are homeless, and the action by the VA to not continue the program — it’s absurd,” Molinaro said. “What is most egregious is to have received notice only three weeks before Hudson River Housing would have to fire their employees and shutter the program.”

He said there’s bipartisan support for continued funding from U.S. Sen. Charles Schumer, State Sen. Sue Serino, R-Hyde Park, and Reps. John Faso, R-Kinderhook, and Sean Patrick Maloney, D-Cold Spring, all of whom spoke out opposing the action.

Maloney called the decision “heartless” in a statement and said the organization has been a “lifeline for hundreds of men and women who wore our country’s uniform and needed some help when they got home.”

In a statement, Schumer spokesman Jason Kaplan said: “This is deeply concerning about the wrongheaded decision by the VA to discontinue this vital funding so that Hudson River Housing can continue to do the great work they do to keep our at-risk veterans from becoming homeless. They have done outstanding work so it makes little sense to hinder their ability to deliver top-notch service to our veterans. ...our office is working closely with Rep. Maloney’s office and local officials to bring our concerns to the highest levels of the VA.”

Faso sent a letter Wednesday to John Kuhn, national director of the VA’s Support Services for Veteran Families, imploring him to “use the full resources at your disposal to support HRH, and more importantly the veterans who are now at risk of homelessness, in order to deliver the services they require.

“Dutchess County simply does not have the capacity to deal with this issue without an adequate funding stream,” Faso said in the letter, “because HRH is the only program providing direct housing and support services to local veterans and their families.”

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3.8 - Press of Atlantic City: [Veterans push for better health care, experts fight to provide it](#) (14 September, Nicole Leonard, 320k online visitors/mo; Pleasantville, NJ)

NORTHFIELD — Dozens of men and women squeezed together in a small conference room at the VA Outpatient Clinic in Northfield on a hot summer afternoon.

The crowd, the majority veterans in their 60s, 70s and 80s, looked ready for battle as they stood shoulder to shoulder, arms crossed and some prepared with notes as they faced off with local, state and regional officials from the U.S. Department of Veterans Affairs.

It wasn’t nearly as dangerous as the situations these veterans faced while serving in the military, but it ranked high in priority as most of the South Jersey veterans voiced their demands for better localized health care while VA experts expressed their desire to give it to them.

“We believe community care is sufficient,” said Vince Kane, director at the Wilmington VA Medical Center. “We have to get out of the medical centers and get closer to where the veterans

live. They can't all go through Wilmington. As an example, we're working in Cape May to relocate services to those people."

An estimated 355,766 veterans live in New Jersey, according to the VA. Some areas of the state have more than others, including Cape May County, where veterans make up nearly 9 percent of the population, one of the highest rates in the state.

Many of the veterans who get health care through the VA said they are generally happy with the quality of care they receive, as the VA has some of the most advanced medical technology and experts in the country.

The issues lie in the access and delivery of it, veterans said.

"There have been attempts at the county level to make medical care more accessible and affordable to veterans," said Frank Formica, Atlantic County freeholder chairman and an Air Force veteran. "It seems like there's been a trend in the country to pay more attention to local communities, but we don't have enough resources to execute those services."

Many veterans continue to champion the federal Veterans Choice Program, which allows veterans to use private providers outside VA clinics and hospitals to get care if they live more than 40 miles from a VA center or have to wait more than 30 days for a consultation.

Funding for the program was set to run out this summer, but President Donald Trump signed a bill last month that allocated an additional \$2.7 billion to keep it going.

Instead of having to travel long distances, sometimes on VA shuttles, veterans are able to go to local providers, with approval, for injury treatment, procedures and specialty care, but the service is complicated.

Veterans' concerns included not getting choice approval, long wait times for paperwork to go through and gaps in communication between an outside provider and the VA.

"I needed emergency spine surgery and used the choice program, which was great because I got one of the best spine surgeons in the country at Penn (Medicine)," said one veteran at the Northfield meeting. "Then I needed therapy, and funding ran out. It took five weeks to get re-approved for services that I needed immediately."

Frustration was felt by both the veterans and those who provide services in the region, as many VA officials said they want nothing more than to increase access to health care, bring more services to South Jersey clinics and reduce issues that have prevented veterans from getting care in a timely manner.

Federal regulations, rules and policies often limit the way in which they can make changes at the county level, VA officials said.

Another issue VA officials found was a lack of eligible veterans enrolling and using VA services for their physical and behavioral health needs. Among the 6,000 eligible veterans in Cape May County, fewer than half are enrolled and only 1,824 are actively using services, Kane said.

Kane said he and other VA officials need to identify how to increase participation, adding he is optimistic that changes coming down the pipeline will lead to better outcomes and satisfaction with services in South Jersey.

At the Cape May community-based outpatient clinic, officials hope to expand the physical footprint and increase the number and range of health care services at that location.

Jackie Hinker, U.S. Veteran Affairs Veteran Community Outreach Specialist, said veterans have been looking forward to an expansion “for the longest of time.”

In addition to the brick and mortar clinics, the VA runs mobile clinics that visit several sites through New Jersey every month to provide basic health care checks and tests. One such clinic regularly stops at Stockton University where William Richmann, 68, of Galloway Township gets his annual health visits.

As far as the choice program, Kane said the VA has established relationships with Shore Medical Center, Cape Regional Medical Center and Inspira Health Network, and is talking about working more with others like AtlantiCare and Bacharach Institute for Rehabilitation.

David Hughes, Shore Medical Center Chief Financial Officer, said the hospital has the ability and willingness to treat more veterans than it is currently limited to because of strict agreement contracts under the choice program.

“One of the things we’re working on is a program specifically for vets so that they can go to their local doctor and for us to provide services so that they don’t need to get on a bus for hours,” he said. “We will do whatever we need to for the needs of veterans.”

At the end of the day, both veterans and VA officials agreed they want better streamlined services, shorter wait times, increased accessibility to local care and the resources to establish and improve more programs.

Current plans for improvement are just the beginning, VA officials said.

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3.9 - WKRG (CBS-5): [VA Offers Beds For Hurricane Irma Victims In Florida Nursing Homes](#) (14 September, 272k online visitors/mo; Mobile, AL)

In a press release sent out Thursday by the Department of Veterans Affairs, the U.S. Secretary of Veterans Affairs David Shulkin announced that the VA is making beds available to non-Veteran nursing home residents affected by Hurricane Irma.

This announcement comes after the new reports Wednesday that eight residents of a Florida nursing home died from what appeared to be heat exposure, likely caused by faulty air conditioning at their facility in Hollywood Hills.

Secretary Shulkin has been working with Florida Governor Rick Scott and Senator Bill Nelson and their staffs on this issue since Wednesday evening.

"We thank Governor Scott and Senator Nelson for involving VA and are grateful we can help our fellow citizens where we can in this time of need," said Shulkin. "All Americans are pulling together to help one another, and we must make a special effort for those most vulnerable to the conditions brought on by the storm."

VA has the ability to make its facilities available to non-Veterans as part of its fourth mission to support national, state and local emergency management, public health, safety and homeland security efforts and also through a mission agreement with FEMA under a Stafford Act Declaration.

Secretary Shulkin agreed to make more beds available to non-Veteran nursing home residents as needed and free, while ensuring they continue the primary mission of providing healthcare to Veterans.

The VA is also working closely with the U.S. Department of Health and Human Services and the Federal Emergency Management Agency on the overall response to Irma, in addition to this specific issue.

"We will continue to look for ways to relieve the hardship this powerful storm has caused," said Shulkin. "Much of the heavy-lifting to recover from the hurricane is still to come and our leaders and staff are determined to find as many ways as we can for VA to help in the response."

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3.10 - WUSF Public Media: [VA Secretary Offers Beds To Nursing Home Patients Affected By Irma](#) (14 September, Bobbie O'Brien, 197k online visitors/mo; Tampa, FL)

The tragic deaths of eight nursing home residents after Irma knocked out their air conditioning has prompted the U.S. Secretary of Veterans Affairs to offer up available beds at Florida's VA nursing homes.

The Florida Department of Veterans Affairs operates six nursing homes for veterans built with federal and state money.

Dr. David Shulkin, U.S. Secretary of Veterans Affairs, said that part of the VA's mission is to support emergency management and public health which allows them to open up to non-veterans impacted by Hurricane Irma.

In a news release, Shulkin said he was working with Gov. Rick Scott and U.S. Sen. Bill Nelson to help nursing home residents.

"All Americans are pulling together to help one another, and we must make a special effort for those most vulnerable to the conditions brought on by the storm," Shulkin said.

But Shulkin emphasized that veterans remain their primary mission and the circumstances will not change that.

Five of Florida's veterans' homes lost power during the hurricane, but a state spokesman said all the homes had backup generators and have since had power restored.

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3.11 - KSNT (NBC-27): [VA opening Veterans Crisis Line in Topeka – expected to hire 100 people](#) (14 September, Grant Stephens, 161k online visitors/mo; Topeka, KS)

The U.S. Veterans Administration is opening it's third Veterans Crisis Line call center in Topeka. It's expected to hire 100 employees.

"When it comes to preventing Veteran suicide, we will do everything we can to make it as easy as possible for Veterans to reach us," said VA secretary Dr. David J. Shulkin. "The new center in Topeka gives us more feet on the ground and an easier way for Veterans to connect with us when they need us most."

The VA already has two call centers, one in upstate New York, and one in Atlanta, Georgia. The VA says the Topeka call center will be located on the VA campus and is expected to open in the fall.

The new center will bring the total number of crisis line responders to 610.

The agency says that since its launch in 2007, the VCL has answered more than 3 million calls. Since launching chat in 2009 and text services in November 2011, the VCL has answered nearly 359,000 and nearly 78,000 requests for chat and text services.

Veterans in crisis can call the Veterans Crisis Line for confidential support 24 hours a day, seven days a week, 365 days a year at 800-273-8255 and Press 1, chat online at VeteransCrisisLine.net/Chat or text to 838255.

For more information or to apply for openings at the new call center, visit www.usajobs.gov/GetJob/ViewDetails/478700400 or www.usajobs.gov and search for announcement No. 10046052.

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3.12 - Florida Politics: [VA hospitals to take in nursing home residents, Bill Nelson says](#) (14 September, Scott Powers, 161k online visitors/mo; Saint Petersburg, FL)

The U.S. Department of Veterans Affairs will make beds in VA facilities available to residents of Florida nursing homes that have no power, Sen. Bill Nelson said Thursday.

Nelson said he saw that the VA had done so with refugees from the U.S. Virgin Islands, accepting them into the VA hospital at Puerto Rico, and asked them Wednesday, before news of the horrific six-death incident in Hollywood, if the same could be done in Florida.

"I called the VA secretary [David Shulkin] yesterday," Nelson said. "He said, 'Absolutely!' He said, 'You have my authority to make that happen.'"

Nelson said he's now working with an assistant secretary to get it done.

Nelson said he is not certain how many beds might be available in Florida's VA facilities.

The VA issued a release Thursday saying that Shulkin has been working with both Florida Gov. Rick Scott and Nelson and their staffs on this issue beginning yesterday evening.

"We thank Governor Scott and Senator Nelson for involving VA and are grateful we can help our fellow citizens where we can in this time of need," Shulkin stated in the release. "All Americans are pulling together to help one another, and we must make a special effort for those most vulnerable to the conditions brought on by the storm."

The VA has the ability to make its facilities available to non-veterans as part of its fourth mission, to support national, state and local emergency management, public health, safety and homeland security efforts and also through a mission agreement with FEMA under a Stafford Act Declaration.

Shulkin agreed to make more beds available to non-veteran nursing home residents as needed and free, while ensuring we continue our primary mission of providing healthcare to Veterans, the release stated.

The VA is also working closely with the U.S. Department of Health and Human Services and the Federal Emergency Management Agency on the overall response to Irma, in addition to this specific issue.

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3.13 - ideastream.org (Audio): [Cleveland VA Gets National Recognition](#) (13 September, Stephanie Jarvis, 145k online visitors/mo; Cleveland, OH)

As the battle against the opioid epidemic rages on, a local program to manage opioid addiction among some of our region's most at-risk patients is gaining national recognition.

Of all the veteran's hospitals in the country, the Northeast Ohio VA Healthcare System is being recognized for its innovative program to cut down on opioid prescriptions and addiction among the veterans it serves – at a time Ohio sits at the epicenter of the opioid crisis. Thursday, the Secretary of Veterans Affairs, along with New Jersey Governor Chris Christie - who heads up the White House Opioid Task Force, will travel to Cleveland to learn more about the VA's program.

To help us understand how the program is helping our region's veterans steer clear of pain pills -- and how it may be a model for other health systems, ideastream's Kay Colby spoke with Dr. Ali Mchaourab, the head of the pain management program at the Cleveland VA.

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3.14 - ideastream.org (Video/Audio): [President's Opioid Task Force Learns Best Practices from Cleveland VA](#) (14 September, Annie Wu, 145k online visitors/mo; Cleveland, OH)

The U.S. Secretary of Veterans Affairs joined President Trump's opioid task force at the Cleveland VA Medical Center on Thursday. They were in town to hear from VA doctors on their best practices for pain management and opioid use including guidelines for prescribing opioids, alternative medicine for dealing with pain, and a continuum of care for opioid addiction.

Nationally, the VA has been using these practices since 2013. Locally, the VA began even earlier and Secretary of Veterans Affairs Dr. David Shulkin says Cleveland is showing strong results.

"Just 4 percent of the patient population they serve are using and being prescribed opioids, which is well, well below what you would find across the country."

At a roundtable discussion that included President Trump's advisor Kellyanne Conway, the VA shared some of its practices to address pain, including the use of alternative treatments such as acupuncture, yoga and meditation.

"In not all cases must pain management mean pain medicine. There are opioids and there are other modalities. And we saw that first hand here. To read about it is one thing. To intuit as a lay person is quite another. But to see it in practice is quite remarkable and something I will take back to the White House and really never forget."

The opioid task force will issue its report on November first.

The group's chairman—New Jersey Governor Chris Christie says his group is working with the White House to designate the opioid epidemic a national emergency.

"The president is getting advice from his staff and from lawyers on the best way to do that, and I'm confident that in the very near future he will execute the documents that need to be executed for us to be able to do that. But the biggest problem would be is if we did it in a way that was haphazard and less effective and have to go back and redo it."

President Trump said in August he intended to make the national emergency declaration—opening up federal funds to address the problem—but he has yet to do so.

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3.15 - KIII (ABC-3, Video): [VA Outpatient Clinic closed due to damage from Harvey](#) (14 September, 65k online visitors/mo; Corpus Christi, TX)

Among the facilities that suffered significant damage in Hurricane Harvey was the Corpus Christi Veteran's Affairs Outpatient Clinic.

The building suffered water damage and beginning Monday, veterans who normally receive primary care services at the clinic will be treated at the Corpus Christi Specialty Outpatient Clinic on Enterprize Parkway or the Patient Aligned Care Team Annex Building, which is near the VA's outpatient clinic.

It is expected to take about 130 days to make repairs to the VA building.

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3.16 - KXXV (ABC-25, Video): [Reminding veterans of local services this Suicide Prevention Week](#) (13 September, Holly Stouffer, 54k online visitors/mo; Waco, TX)

It's Suicide Prevention Week and a local veterans affairs center is making sure the veteran community knows of the resources available to them.

According to the Department of Veterans Affairs, an average of 20 veterans die by suicide each day.

The Waco VA offers a number of resources to help those struggling with their mental health, including its Center of Excellence, which focuses on researching the events that lead up to suicidal thoughts.

"The classic one certainly is a major depressive disorder, but even minor feelings of depression," said Dr. Richard Seim, a clinical psychologist at the Center of Excellence. "PTSD, traumatic brain injury, symptoms of military sexual trauma or even just kind of life issues like marital problems or family functioning issues."

Dr. Seim said this type of research allows them to better serve veterans who could use additional treatment after going through traditional therapy.

"One of the studies we've been running for the last seven years now is tracking veterans as they come back from recent wars in Iraq and Afghanistan and looking at those symptoms of PTSD, traumatic brain injury and so forth to see how they change over time," said Dr. Seim.

Dr. Seim said the Center of Excellence is also about to open a new clinic. It will involve using magnetic waves to stimulate the brain, which will help to alleviate symptoms of depression.

If you know a veteran struggling with depression, call the Veterans Crisis Line at 1-800-273-8255.

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3.17 - WEWS (ABC-5, Video): [White House Opioid Task Force looks for answers to crisis in Cleveland](#) (13 September, Mona Kosar, 17k online visitors/mo; Cleveland, OH)

With the opioid epidemic considered a national emergency, News 5 has learned the answer to this scourge may be here in Cleveland. The president's opioid task force is coming here to look for some answers.

Behind the wall of the Louis Stokes Cleveland VA Medical Center lies a possible solution to a national crisis. “I think the lessons we have learned can be duplicated in the private sector,” said Medical Director Susan Fuehrer.

Those lessons started a decade ago when the center began addressing the over-prescription of addictive opioids with other alternatives such as yoga and physical therapy.

“Rather than just prescribe opioids to manage pain they have been working on evidence based management and alternative therapy,” Fuehrer said.

From 2008 to 2015, the center saw a 50% reduction in the prescription of opioids. Even at the height of the epidemic, the center was recognized for its reduction. “There have been lots of ways that we have been identified as a best practice within the VA health care system,” said Fuehrer.

Their practices haven’t gone unnoticed in Washington either. When it came time for the newly formed white house opioid task force to seek a solution, they pinpointed The Louis Stokes Center.

“They will be meeting with multi disciplinary people and they are going to speak to a veteran or two who have recovered from opioid addiction,” said Fuehrer.

Fuehrer says this is an opportunity for their work to have a national impact.

“If one or two things make a difference for one or two people outside the VA community, then we will call tomorrow a success,” Fuehrer said.

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3.18 - Missoula Current: [Tester urges VA to move quicker in opening new Missoula health clinic](#) (14 September, Martin Kidston, 17k online visitors/mo; Missoula, MT)

President Donald Trump signed Sen. Jon Tester’s bill securing a lease for a larger Veterans Affairs clinic in Missoula on the first day of August, marking a positive step for a facility that’s long been in need of expansion.

Now, the state’s senior senator is asking the VA to expedite the process.

Tester this week sent a letter to VA Secretary David Shulkin asking the agency to move the process forward, saying the region’s demand for VA care is projected to increase 43 percent over the next 20 years.

While it traditionally takes the VA as long as five years to open a new clinic once authorization is given, Tester said the Missoula facility is needed sooner rather than later.

“To the greatest extent possible, I urge the department to expedite the process for leasing the recently authorized replacement of the outpatient clinic in Missoula in order to better meet current and future patient demand,” Tester wrote. “I urge the VA to move with all due speed to procure this facility.”

Trump signed Tester's VA Choice and Quality Employment Act in August, which included the leasing authority allowing the VA to secure a larger facility in Missoula.

The authorization will nearly triple the clinic's size, providing additional parking, clinical space and the medical services needed to meet the growing demand for VA care in Missoula, the state's second largest city.

Tester's communications director, Marnee Banks, said the VA was authorized to pursue 28 major medical leases under the latest bill, including one in Missoula. The lease allows for a 60,000-square-foot facility with an estimated rent just under \$2 million a year.

"It will provide primary care, mental health, specialty care and some outpatient surgeries," Banks said. "The VA intends for the clinic to be located in the same general area as the existing clinic."

Banks said it often takes the VA about two years to develop the specific facility requirements once it begins working on the lease. Another year is needed to negotiate with developers prior to issuing a construction award.

That's followed by an additional two years to build the facility.

"The former Deputy (VA) Secretary (Sloan) Gibson had been working to bring this timeline down," Banks said. "The VA will need to obtain a delegation of authority from GSA to award the Missoula clinic lease."

The effort to secure a larger Missoula clinic dates back to at least 2014 when Tester began pushing the VA to expand the facility. Back then, a VA consulting team had toured the small clinic and recommended a modest expansion.

Nearly a year later, the General Services Administration began studying the possibility of converting the vacant Federal Building in downtown Missoula to a new outpatient clinic. That effort was later deemed cost prohibitive, leaving the clinic's future in limbo.

At the same time, the VA fell into controversy, resulting in the resignation of then-VA Secretary Erick Shinkseki, who was replaced by Robert McDonald and later by Shulkin, who now heads the agency under the Trump administration.

The Montana Department of Veterans Affairs and its own health care system has also seen a parade of new leaders, including Christine Gregory, Johnny Ginnity and Kathy Berger, who took the agency's helm in late 2016 and pledged changes to the system.

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4. Women Veterans

5. Appeals Modernization

6. Strategic Partnerships

7. Supply Chain Modernization

8. Other

8.1 - Dayton Daily News: [Lawmakers pushing for Columbus to get national veterans museum \(14 September, Jessica Wehrman, 1.1M online visitors/mo; Dayton, OH\)](#)

WASHINGTON - To hear Reps. Joyce Beatty and Steve Stivers tell it, Columbus is an ideal place to host the National Veterans Memorial and Museum.

The state, they said hosts the 6th largest veterans population in the U.S. If that's not enough, it's within an eight-hour car ride of almost half of the nation's veterans.

Speaking before a House panel Wednesday, Stivers and Beatty argued that a memorial to the nation's veterans was long overdue — and that Columbus was all too happy to change that. The site, argued Stivers, “will serve as a civic landmark to honor, inspire and educate all Americans about the service and sacrifice of more than 22 million veterans in this country.”

Under construction and scheduled to open next summer, the site started as a replacement for Columbus' previous veterans memorial and then blossomed into something far more sweeping and ambitious, said Stivers. Now, he, Beatty and Rep. Pat Tiberi, R-Genoa Township are pushing a bill that would designate it a national museum.

It wouldn't be the state's only museum honoring the armed services or those who have served: Roughly an hour's drive away, Dayton hosts the National Museum of the United States Air Force.

During a hearing on the bill Wednesday, Matthew Sullivan, deputy undersecretary for finance and planning and CFO for the National Cemetery Administration for the Department of Veterans Affairs, said the department neither supported nor opposed locating the museum in Columbus. “VA respectfully expresses no view on the proposed bill, which does not apply to VA or to VA's core mission,” he testified.

But Alex Zhang, assistant director of National Veterans Affairs and Rehabilitation for the American Legion, said his organization backs the bill. He said the bill would “represent American veterans with profound respect, connecting them with the civilian population, possibly inspiring others to serve and most importantly, educating youth about what these fine men and women have done for America.”

The organization, he said, “wholeheartedly supports” the “beautiful, thoughtful” memorial's designation, he said.

Veterans of Foreign Wars also backed the legislation, with John Towles, deputy director of national legislative service for the organization, telling the House Veterans Affairs Committee's subcommittee on Disability Assistance and Memorial Affairs "our country currently lacks a museum specifically dedicated to honoring and preserving the collective sacrifices made by this nation's veterans."

"This museum would serve to fill that gap," he said.

Groundbreaking for the 50,000 square foot museum and memorial began in 2015, and more than \$75 million was raised for design and construction. It's located at 300 West Broad St. in Columbus, site of the former Franklin County Veterans Memorial.

The entire Ohio congressional delegation is cosponsoring the bill, and Stivers said he hopes to tuck it into a larger legislative package in the months ahead. Sens. Sherrod Brown, D-Ohio, and Rob Portman, R-Ohio, are working on a similar measure in the Senate.

Beatty said the museum was in part the brainchild of former Ohio Sen. John Glenn, who died last year.

"If he were here today, he would highlight this museum and memorial," she said. "He would talk about the 300 foot reflecting pool. He would talk about the memorial wall. He would talk about the sanctuary where veterans families and others could go.

"It's a tremendous idea," she told the panel. "And we ask for your support."

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Veterans Affairs Media Summary and News Clips

15 September 2017

1. Top Stories

1.1 - Military.com: [Obamacare Repeal Would Increase Uninsured Veterans: Report](#) (14 September, Amy Bushatz, 9M online visitors/mo; San Francisco, CA)

Repealing Obamacare would leave more than nine percent of all veterans under 65 without health insurance, likely causing an increased strain on the Department of Veterans Affairs, researchers caution in a new report released Thursday. As of 2015, about 5.8 percent of America's 10.8 million estimated veterans under age 65 were without health insurance, the report found.

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1.2 - Miami Herald: [Veteran Affairs offers beds to nursing home residents in need after Irma](#) (14 September, David J. Neal, 8.9M online visitors/mo; Doral, FL)

After Wednesday's death of eight residents of a Hollywood nursing home steaming without air conditioning, U.S. Secretary of Veteran Affairs David Shulkin announced Thursday that the agency will open available beds to non-Veteran nursing home residents affected by Hurricane Irma. "We will continue to look for ways to relieve the hardship this powerful storm has caused," Shulkin said.

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1.3 - The Tennessean (Video): [Meet the man picked to fix the Memphis VA, one of the most troubled in the nation](#) (14 September, Jake Lowary, 2.1M online visitors/mo; Nashville, TN)

There's a symbolic line at the Memphis Veterans Affairs Medical Center that new director David Dunning says sums up the daunting task ahead of him. On one side, in the brand-new emergency room, there's new floors, cutting-edge technology and other modern amenities. On the other, there is decades-old wallpaper, mismatched tile and almost cliché decor.

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1.4 - The Republican: [Ginnie Mae launches task force to investigate VA-backed lenders; US Sen. Elizabeth Warren praises move](#) (14 September, Shannon Young, 2.1M online visitors/mo; Springfield, MA)

Ginnie Mae, the principal financing arm for government loans, will look into potentially misleading marketing practices involving U.S. Department of Veterans Affairs-backed lenders, officials announced Thursday. Acknowledging concerns U.S. Sen. Elizabeth Warren raised in a recent letter, Ginnie Mae Acting President and Chief Operating Officer Michael Bright said the Massachusetts Democrat is right to be bothered by the potential impacts aggressive mortgage marketing practices could have on veteran borrowers.

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1.5 - Military Times: [New ad campaign reopens fight over VA privatization claims](#) (14 September, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

A left-leaning veterans advocacy group today is reopening the fight over privatization of Veterans Affairs services with a multi-state ad campaign imploring lawmakers to "save VA." The nearly \$400,000 effort comes as top VA officials and congressional leaders are preparing to

unveil their long-term plans for the department's controversial Choice program, which allows veterans to seek private-sector care using federal dollars.

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1.6 - Military Times: [Ashford University gets OK to keep GI Bill students](#) (14 September, Natalie Gross, 2.1M online visitors/mo; Springfield, VA)

Ashford University has received the Department of Veterans Affairs' stamp of approval to continue enrolling GI Bill students long-term. The announcement comes after a tumultuous summer for the online for-profit school, which was, at one time, scheduled to lose its eligibility to receive VA funds in August after losing its state-level approval in Iowa. Ashford then sought approval in Arizona and was permitted to continue enrolling veteran students for the new school year, pending approval from VA.

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1.7 - Stars and Stripes: [Veterans crisis line to open third call center](#) (14 September, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

The Department of Veterans Affairs will open a third call center in the fall to handle an anticipated increase in calls to the veterans crisis hotline. The call center will be located on the VA campus in Topeka, Kansas, the VA said late Wednesday. The announcement comes just nine months after a second call center was opened in Atlanta.

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[2. Veteran and Employee Experience](#)

2.1 - WRAL (NBC-5, Video): [Long waits lead to good news for vets seeking resolution to VA problems](#) (14 September, Cullen Browder, 3.1M online visitors/mo; Raleigh, NC)

Hundreds of veterans walked into the Herb Young Community Center in Cary on Thursday with complaints and problems and walked out with resolution and, many times, money. The American Legion and the VFW sponsored the Veterans' Experience Action Center to help veterans who are having trouble with the U.S. Department of Veterans Affairs. Because North Carolina is the only state hosting such events, veterans came from across the country.

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2.2 - Inside Higher Ed: [VA seeks broad waiver of rule barring payments from for-profit colleges](#) (15 September, Andrew Kreighbaum, 1.6M online visitors/mo; Washington, DC)

The Department of Veterans Affairs intends to grant employees a waiver of a rule barring receipt of salary or other benefits from for-profit colleges. The proposed regulation was published in the federal register Thursday and would take effect next month without "adverse comment." A recent VA inspector general report found that two employees had violated the rule by working as adjunct instructors at for-profit colleges receiving VA benefits.

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2.3 - Commercial Appeal (Video): [How we're fixing a broken VA care system](#) (14 September, Phil Roe and David Kustoff, 1.1M online visitors/mo; Memphis, TN)

As the Chairman of the House Committee on Veterans Affairs and the Congressman representing West Tennessee veterans who seek care at the Memphis VA Medical Center, we are concerned and outraged by the recent abysmal failures at the Memphis facility. We are encouraged to see swift action from the Department of Veterans Affairs (VA) to get the Memphis facility on track — and will continue to closely monitor progress...

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2.4 - WTVD (ABC-11, Video): [Cary event brings veterans face-to-face with VA representatives](#) (14 September, Julie Wilson, 880k online visitors/mo; Durham, NC)

The American Legion and the Town of Cary are hosting a three-day event focused on answering questions for veterans. The Veterans Experience Action Center will put veterans face-to-face with a representative from the U.S. Department of Veteran Affairs. Meetings will allow for explanations, assistance facilitating, expediting existing claims and appeals, filing new claims, and accepting all claim related evidence.

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2.5 - La Crosse Tribune (Jackson County Chronicle): [Jackson County hosts benefits fair for veterans](#) (14 September, Jordan Simonson, 818k online visitors/mo; La Crosse, WI)

The Jackson County Veterans Service Office and Tomah VA Medical Center hosted a Homeless/At Risk Veterans Stand Down and Benefits Fair Thursday at the Black River Falls American Legion Post 200, providing information for veterans about many of the services available to them via federal, state and local programs. "It is a two-fold event, it is a homeless or an at-risk stand down for veterans in the area that can come and get assets and services.

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2.6 - KTVI (FOX-2, Video): [Government workers hold union rally outside VA Medical Center on Grand](#) (14 September, 663k online visitors/mo; Saint Louis, MO)

Workers at the John Cochran VA Medical Center will hold a rally Thursday, September 14 outside the hospital. Members of the American Federation of Government Workers want to raise awareness of what they call dangerously low staffing levels at facilities around the country. The union claims the shortages are depriving veterans of the health care they deserve. They say it's also creating risks to patient safety and a hazardous work environment.

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2.7 - WNCN (CBS-17, Video): [3-day push will help NC veterans connect with benefits](#) (14 September, Bearshelle Edme, 607k online visitors/mo; Raleigh, NC)

— A three-day event for veterans launched Thursday to help former military members access benefits, among other services. But many veterans told CBS North Carolina's Bearshelle Edmé they're frustrated with all these processes, applications, and long waits. 61 years could separate some of the veterans who have served in the Korean War from those who were sent to the Iraq War.

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2.8 - Post-Tribune: [Column: Vietnam documentary should take a balanced look](#) (14 September, Tom Bellino, 261k online visitors/mo; Crown Point, IN)

The PBS special series, "The Vietnam War," by Ken Burns and Lynn Novick, which begins Sunday, no doubt will evoke emotions for both the veterans of that war as well as the observers, resisters and opponents of it. Various Veterans Affairs facilities are offering a Monday morning debriefing after the first episode of the series, because "it may bring up stressful memories for combat veterans."

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2.9 - WUSF Public Media (Audio): [VA Prepares for PBS Vietnam Documentary; It May Trigger Some Vets' PTSD](#) (15 September, Steve Walsh, 197k online visitors/mo; Tampa, FL)
The ten-part documentary by filmmakers Ken Burns and Lynn Novick is at times graphic, and people who work with veterans say it may trigger traumatic memories for those who fought in Vietnam. For two weeks, PBS stations will relive one of the most divisive eras in American history. "The Vietnam War" documentary - produced by Ken Burns and Lynn Novick - is being billed as a rare cultural milestone.

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2.10 - Tribune-Democrat: [UPJ summit seeks ways to help veterans](#) (15 September, Dave Sutor, 155k online visitors/mo; Johnstown, PA)
Issues that afflict active military personnel and veterans, including thoughts of suicide, physical pain and moral injury, also impact the general population, albeit in different ways. So, when advancements are made to help men and women who serve the United States deal with those challenges, the nation benefits. That lesson was understood well by U.S. Rep. John Murtha, whose work helping military personnel and their families deal with traumatic brain injury...

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2.11 - New Hampshire Public Radio: [Makeup of N.H. VA Task Force Announced, Some Whistleblowers Say They Were Shut Out of Process](#) (14 September, Peter Biello, 148k online visitors/mo; Concord, NH)
The Department of Veterans Affairs has released a list of the twelve people who will serve on a task force looking at the future of health care for New Hampshire veterans. Since July, a dozen whistleblowers have come forward with allegations of substandard care at the Manchester VA. One of those whistleblowers, cardiologist Erik Funk, will serve on the task force. The list also includes four people who are not VA employees and five who are not New Hampshire residents.

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2.12 - Hudson Valley News Network: [Maloney, Local Officials Slam VA Decision to Cut Funding](#) (14 September, Kathy Welsh, 54k online visitors/mo; Hyde Park, NY)
— Representative Sean Patrick Maloney (NY-18) and local officials condemned a decision by the Department of Veterans Affairs to deny an anticipated annual federal investment of over \$500,000 to Hudson River Housing. If no action is taken, funding will run out and the program will be terminated after Sept. 30.

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2.13 - DS News: [Ginnie Mae Responds to Senator Warren on VA Lenders](#) (14 September, Brianna Gilpin, 54k online visitors/mo; Dallas, TX)

Thursday, in a letter to Senator Elizabeth Warren (D-MA), Ginnie Mae explained how it is curbing VA refinance speeds and aggressive marketing by some VA approved lenders. The letter was in response to Sen. Warren, who initially addressed the aggressive practices in a letter to Ginnie Mae on September 6, 2017. Warren warned that the marketing practices are negatively impacting Ginnie Mae securities without necessarily benefiting veteran borrowers.

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2.14 - Reveal: [White House seeks to legalize payoffs to VA officials by for-profit schools](#)

(14 September, Aaron Glantz, 39k online visitors/mo; Emeryville, CA)

The Trump administration is seeking to waive a 50-year-old anti-corruption law that prevents officials who administer the GI Bill from accepting money from for-profit schools backed by taxpayer subsidies. The proposed regulation, published Thursday in the Federal Register, would allow employees of the Department of Veterans Affairs to receive "wages, salary, dividends, profits, gratuities" and services from for-profit schools that receive GI Bill funds.

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2.15 - WBOY (NBC-12, Video): [VA Hospital Hosts Town Hall to Hear Concerns from Veterans](#)

(14 September, Elayna Conard, 21k online visitors/mo; Clarksburg, WV)

The VA Hospital held a town hall to hear the concerns of veterans Thursday afternoon. The VA holds these town halls every few months as a way to keep open communication with veterans. The director of the hospital, Dr. Glenn Snider, said that he was glad to hear compliments from veterans about their recent services.

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2.16 - Bloomberg Politics: [U.S. Probes High-Pressure Mortgage Sales Targeting Veterans](#)

(14 September, Joe Light, 18k online visitors/mo; New York, NY)

The U.S. is investigating lenders for allegedly pressuring veterans and members of the military into unneeded mortgage refinances -- unsavory conduct that not only leads to higher consumer costs but has consequences for one of the world's largest bond markets. The probe is being conducted by Ginnie Mae, a government-owned corporation whose purpose is to make mortgages more affordable.

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2.17 - KUPR (NPR-89.3): [Landmark Vietnam War Series May Trigger Unwanted Memories For Some Vets](#)

(14 September, Steve Walsh, 17k online visitors/mo; Fresno, CA)

Almost anything can trigger the vivid and aggressive thoughts associated with PTSD. It might be a door slam or the smell of diesel, according to Tina Mayes, a staff psychologist at VA San Diego Healthcare. Most common triggers: "It can be something someone says. The way they say it," she said.

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2.18 - Law Firm Newswire: [VA Fires Head of DC Facility Amid Confidentiality Breach, Leadership Concerns Says Veterans Attorney Jim Fausone](#)

(14 September, 900 online visitors/day; Tampa, FL)

Northville, MI (Law Firm Newswire) September 14, 2017 - The Department of Veterans Affairs (VA) fired the longtime director of its main veterans medical center in Washington, D.C. Brian

Hawkins was dismissed due to growing concerns about his leadership of the VA facility. The VA released a statement saying "he failed to provide effective leadership." Hawkins was reassigned to a different post within the agency in April pending further review.

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3. Access to Healthcare

3.1 - ABC News (AP): [The Latest: Hurricane cleanup crew finds body near hotel](#) (14 September, 24.1M online visitors/mo; New York, NY)

Federal officials say that nursing homes normally reserved for veterans will be opened up to non-veteran nursing home residents if space is available, in the aftermath of Hurricane Irma. U.S. Sen. Bill Nelson announced Thursday that the U.S. Department of Veterans Affairs had agreed to open its nursing homes following eight deaths at Florida nursing home. Florida has seven nursing homes throughout the state that are available to residents who were veterans.

[Hyperlink to Above](#)

3.2 - The Huffington Post: [VA Broken Promise Harms Veteran and Costs Jobs](#) (14 September, Hal Donahue, 22.9M online visitors/mo; New York, NY)

A technical expert, Joe possessed little knowledge concerning how to actually start a business. He visited his local VA Veterans Rehabilitation Counselor and received a wealth of information and assistance to create a Service-Disabled Veteran-Owned Small Business(SDVOSB).

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3.3 - Palm Beach Post: [VA offers beds to Florida nursing home residents affected by Irma](#) (14 September, Joe Capozzi, 3.8M online visitors/mo; West Palm Beach, FL)

The U.S. Department of Veterans Affairs is making beds available to non-veteran nursing home residents affected by Hurricane Irma. U.S. Secretary of Veterans Affairs David Shulkin announced the plan after talking with Gov. Rick Scott and Sen. Bill Nelson late Wednesday. Those discussions took place after eight residents of a Florida nursing home died from what appears to be heat exposure likely caused by a power outage at their facility in Hollywood.

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3.4 - WJW (FOX-8, Video): [Presidential Opioid Commission praises, learns from Cleveland VA](#) (14 September, Bill Sheil, 665k online visitors/mo; Cleveland, OH)

Gov. Chris Christie of New Jersey, head of a Presidential Commission on opioids, summed it up well when addressing doctors and patients gathered at the Louis Stokes VA Center in Cleveland. "We didn't come here by accident," he said. Christie, and several prominent national figures, toured the VA Center on Thursday to learn more about a remarkable contradiction.

[Hyperlink to Above](#)

3.5 - WOIO (CBS-19): [White House opioid commission turns to Cleveland VA for solutions](#) (14 September, Sara Goldenberg, 610k online visitors/mo; Cleveland, OH)

Northeast Ohio continues to struggle with opioid addiction and overdose deaths. But there's a treatment program in our own backyard that's bucking the trend. The VA Secretary and White

House officials came to Cleveland on Thursday to learn more. The Northeast Ohio VA Healthcare System has the lowest addiction rates across the VA.

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3.6 - WIBW (CBS-13): [VA opening new Veterans Crisis Line in Topeka: expects to hire 100](#)

(14 September, Nick Viviani, 485k online visitors/mo; Topeka, KS)

Topeka will be the home of the Dept. of Veterans Affairs' newest Veterans Crisis Line call center. On Wednesday, the VA officially announced it would open the new crisis line, its third one nationwide, in the Capital City. The new call center is expected to employ 100 people and will be housed in the VA Eastern Kansas Health Care System.

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3.7 - Poughkeepsie Journal (Video): [Hudson River Housing lose federal funding for homeless veteran program](#)

(14 September, Jack Howland, 440k online visitors/mo; Poughkeepsie, NY)

Homeless veterans and their families might be losing support in a few weeks, if Hudson River Housing is forced to shut down a key program. Hudson River Housing is facing losing its program serving homeless veteran families in Dutchess County by the end of September in the wake of the U.S. Department of Veteran Affairs denying the group an annual grant, the nonprofit said Thursday.

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3.8 - Press of Atlantic City: [Veterans push for better health care, experts fight to provide it](#)

(14 September, Nicole Leonard, 320k online visitors/mo; Pleasantville, NJ)

Dozens of men and women squeezed together in a small conference room at the VA Outpatient Clinic in Northfield on a hot summer afternoon. The crowd, the majority veterans in their 60s, 70s and 80s, looked ready for battle as they stood shoulder to shoulder, arms crossed and some prepared with notes as they faced off with local, state and regional officials from the U.S. Department of Veterans Affairs.

[Hyperlink to Above](#)

3.9 - WKRG (CBS-5): [VA Offers Beds For Hurricane Irma Victims In Florida Nursing Homes](#)

(14 September, 272k online visitors/mo; Mobile, AL)

In a press release sent out Thursday by the Department of Veterans Affairs, the U.S. Secretary of Veterans Affairs David Shulkin announced that the VA is making beds available to non-Veteran nursing home residents affected by Hurricane Irma. This announcement comes after the new reports Wednesday that eight residents of a Florida nursing home died from what appeared to be heat exposure, likely caused by faulty air conditioning at their facility in Hollywood Hills.

[Hyperlink to Above](#)

3.10 - WUSF Public Media: [VA Secretary Offers Beds To Nursing Home Patients Affected By Irma](#)

(14 September, Bobbie O'Brien, 197k online visitors/mo; Tampa, FL)

The tragic deaths of eight nursing home residents after Irma knocked out their air conditioning has prompted the U.S. Secretary of Veterans Affairs to offer up available beds at Florida's VA

nursing homes. The Florida Department of Veterans Affairs operates six nursing homes for veterans built with federal and state money.

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3.11 - KSNT (NBC-27): [VA opening Veterans Crisis Line in Topeka – expected to hire 100 people](#) (14 September, Grant Stephens, 161k online visitors/mo; Topeka, KS)

The U.S. Veterans Administration is opening its third Veterans Crisis Line call center in Topeka. It's expected to hire 100 employees. "When it comes to preventing Veteran suicide, we will do everything we can to make it as easy as possible for Veterans to reach us," said VA secretary Dr. David J. Shulkin.

[Hyperlink to Above](#)

3.12 - Florida Politics: [VA hospitals to take in nursing home residents, Bill Nelson says](#) (14 September, Scott Powers, 161k online visitors/mo; Saint Petersburg, FL)

The U.S. Department of Veterans Affairs will make beds in VA facilities available to residents of Florida nursing homes that have no power, Sen. Bill Nelson said Thursday. Nelson said he saw that the VA had done so with refugees from the U.S. Virgin Islands, accepting them into the VA hospital at Puerto Rico, and asked them Wednesday, before news of the horrific six-death incident in Hollywood, if the same could be done in Florida.

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3.13 - ideastream.org (Video/Audio): [Cleveland VA Gets National Recognition](#) (13 September, Stephanie Jarvis, 145k online visitors/mo; Cleveland, OH)

As the battle against the opioid epidemic rages on, a local program to manage opioid addiction among some of our region's most at-risk patients is gaining national recognition. Of all the veteran's hospitals in the country, the Northeast Ohio VA Healthcare System is being recognized for its innovative program to cut down on opioid prescriptions and addiction among the veterans it serves – at a time Ohio sits at the epicenter of the opioid crisis.

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3.14 - ideastream.org (Video/Audio): [President's Opioid Task Force Learns Best Practices from Cleveland VA](#) (14 September, Annie Wu, 145k online visitors/mo; Cleveland, OH)

The U.S. Secretary of Veterans Affairs joined President Trump's opioid task force at the Cleveland VA Medical Center on Thursday. They were in town to hear from VA doctors on their best practices for pain management and opioid use including guidelines for prescribing opioids, alternative medicine for dealing with pain, and a continuum of care for opioid addiction.

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3.15 - KIII (ABC-3, Video): [VA Outpatient Clinic closed due to damage from Harvey](#) (14 September, 65k online visitors/mo; Corpus Christi, TX)

Among the facilities that suffered significant damage in Hurricane Harvey was the Corpus Christi Veteran's Affairs Outpatient Clinic. The building suffered water damage and beginning Monday, veterans who normally receive primary care services at the clinic will be treated at the Corpus Christi Specialty Outpatient Clinic on Enterprize Parkway or the Patient Aligned Care Team Annex Building, which is near the VA's outpatient clinic.

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3.16 - KXXV (ABC-25, Video): [Reminding veterans of local services this Suicide Prevention Week](#)

(13 September, Holly Stouffer, 54k online visitors/mo; Waco, TX)
It's Suicide Prevention Week and a local veterans affairs center is making sure the veteran community knows of the resources available to them. According to the Department of Veterans Affairs, an average of 20 veterans die by suicide each day. The Waco VA offers a number of resources to help those struggling with their mental health, including its Center of Excellence, which focuses on researching the events that lead up to suicidal thoughts.

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3.17 - WEWS (ABC-5, Video): [White House Opioid Task Force looks for answers to crisis in Cleveland](#)

(13 September, Mona Kosar, 17k online visitors/mo; Cleveland, OH)
With the opioid epidemic considered a national emergency, News 5 has learned the answer to this scourge may be here in Cleveland. The president's opioid task force is coming here to look for some answers. Behind the wall of the Louis Stokes Cleveland VA Medical Center lies a possible solution to a national crisis.

[Hyperlink to Above](#)

3.18 - Missoula Current: [Tester urges VA to move quicker in opening new Missoula health clinic](#)

(14 September, Martin Kidston, 17k online visitors/mo; Missoula, MT)
President Donald Trump signed Sen. Jon Tester's bill securing a lease for a larger Veterans Affairs clinic in Missoula on the first day of August, marking a positive step for a facility that's long been in need of expansion. Now, the state's senior senator is asking the VA to expedite the process. Tester this week sent a letter to VA Secretary David Shulkin asking the agency to move the process forward...

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[4. Women Veterans](#) – No Coverage

[5. Appeals Modernization](#) – No Coverage

[6. Strategic Partnerships](#) – No Coverage

[7. Supply Chain Modernization](#) – No Coverage

[8. Other](#)

8.1 - Dayton Daily News: [Lawmakers pushing for Columbus to get national veterans museum](#)

(14 September, Jessica Wehrman, 1.1M online visitors/mo; Dayton, OH)
During a hearing on the bill Wednesday, Matthew Sullivan, deputy undersecretary for finance and planning and CFO for the National Cemetery Administration for the Department of Veterans Affairs, said the department neither supported nor opposed locating the museum in Columbus.

“VA respectfully expresses no view on the proposed bill, which does not apply to VA or to VA’s core mission,” he testified.

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1. Top Stories

1.1 - Military.com: [Obamacare Repeal Would Increase Uninsured Veterans: Report](#) (14 September, Amy Bushatz, 9M online visitors/mo; San Francisco, CA)

Repealing Obamacare would leave more than nine percent of all veterans under 65 without health insurance, likely causing an increased strain on the Department of Veterans Affairs, researchers caution in a new report released Thursday.

As of 2015, about 5.8 percent of America's 10.8 million estimated veterans under age 65 were without health insurance, the report found.

Eliminating the Affordable Care Act (ACA), it says, would push that number up to 9.1 percent, while subsequently increasing the number of veterans who rely on the VA for some or all of their health care needs.

The report, compiled by the nonpartisan Rand Corp. and released Thursday, examines demographics and health care data for non-elderly veterans under age 65 between 2013 and 2015.

The report was commissioned by the non-profit Robert Wood Johnson Foundation and the New York State Health Foundation, which promote expanding health insurance coverages as part of their mission.

Among the report's big-picture findings, said researcher Michael Dworsky, is the major impact Obamacare had on how veterans get their health care.

Rather than turning to the VA exclusively, most veterans carry some kind of dual coverage.

Thanks to the ACA, he said, the number of dual-covered veterans increased -- and the demand on the VA's health system went down.

"First of all, the ACA did change coverage for veterans," Dworsky said. "The VA health system is not an island. It's connected to what's happening in the rest of the health care system and the rest of federal health policy.

"What we're trying to get people to pay more attention to, is if you think about a change as significant as repealing the ACA, it could be very important to think through how other federal programs ... might be impacted," he said.

More than six million non-elderly veterans were eligible for VA health care in 2015, the report estimates, a figure not tracked by federal officials, Rand officials said.

About six million veterans total, the majority of whom were over 65, used VA health care in 2015, according to VA statistics.

The VA has been plagued by scandals stemming from a substantial claims backlog, mishandled or lost paperwork, long appointment wait times, mismanaged facilities and a provider shortage.

The VA Choice system attempts to remedy some of those problems by pushing some veterans to community-based providers for care.

Lawmakers have ordered ongoing program overhauls and increased congressional oversight as a means of addressing the system's woes.

Without the ACA, the report found, veterans under 65 would have turned to the VA for about 1 percent more health care in 2015. That's about 125,000 more office visits, 1,500 more inpatient surgeries and 375,000 more prescriptions, it says.

Additionally, if an effort known as "repeal and replace" had been made law, the number of uninsured veterans would likely have gone even higher -- up to 10.4 percent, the reports says.

That estimate is based on a 2024 plan for health care policy included in replacement language known as the American Health Care Act (AHCA), which would have changed how the federal government funds Medicaid.

The AHCA was ultimately rejected by lawmakers earlier this year.

Dworsky said the researchers hope the report will inspire policymakers to broaden their view of how an Obamacare repeal would impact other portions of the U.S. health care system.

"The goal of the report really was to try and broaden the debate over ACA appeal and make sure the potential spillover effect on the VA health system and insurance coverage would be taken in account," he said.

"We didn't really see that as part of the conversation, and we think it still might be a little bit neglected," Dworsky said.

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1.2 - Miami Herald: [Veteran Affairs offers beds to nursing home residents in need after Irma](#) (14 September, David J. Neal, 8.9M online visitors/mo; Doral, FL)

After Wednesday's death of eight residents of a Hollywood nursing home steaming without air conditioning, U.S. Secretary of Veteran Affairs David Shulkin announced Thursday that the agency will open available beds to non-Veteran nursing home residents affected by Hurricane Irma.

"We will continue to look for ways to relieve the hardship this powerful storm has caused," Shulkin said. "Much of the heavy-lifting to recover from the hurricane is still to come and our leaders and staff are determined to find as many ways as we can for VA to help in the response."

After delivering withering statements about the tragic deaths at The Rehabilitation Center at Hollywood Hills, the VA announcement said, Florida Gov. Rick Scott and U.S. Sen. Bill Nelson, D-Fla., began talking with Shulkin Wednesday night about inadequately cooled nursing homes. The Florida Health Care Association said as of Thursday morning, 64 of the state's 683 nursing homes remained without power after Irma's rampage across the state.

Many nursing homes have generators, but generators doesn't equal air conditioning. The Rehabilitation Center had a generator.

Hollywood police, now going over the center with a search warrant, said Thursday morning, "The initial investigation has determined the facility had some power; however the building's air conditioning system was not fully functional."

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1.3 - The Tennessean (Video): [Meet the man picked to fix the Memphis VA, one of the most troubled in the nation](#) (14 September, Jake Lowary, 2.1M online visitors/mo; Nashville, TN)

There's a symbolic line at the Memphis Veterans Affairs Medical Center that new director David Dunning says sums up the daunting task ahead of him.

On one side, in the brand-new emergency room, there's new floors, cutting-edge technology and other modern amenities.

On the other, there is decades-old wallpaper, mismatched tile and almost cliché decor.

Dunning calls it "very clean, but it's just tired" and says the divide represents where they are and where he intends to take the hospital in the future.

"We're on a trip to L.A. and we've made it to Little Rock," he told the USA TODAY NETWORK - Tennessee during an exclusive interview this summer.

The Memphis VA serves hundreds of thousands of veterans in three states but is among the most troubled in the entire nation. It has received just one star in the agency's internal rankings — one of 14 nationwide and three in Tennessee with the rating.

New documents obtained by the USA TODAY NETWORK detailed a litany of patient safety issues at the hospital in recent years, including how VA providers mistakenly left plastic packaging embedded in a veteran's artery, leading to an amputation.

Reports of threats to patient safety jumped from 700 in 2015 to more than 1,000 in 2016, the newly obtained documents show.

Dunning, 52, a twice-deployed career Army officer, now finds himself tasked with turning around the hospital and improving patient care. The job comes amid several ongoing congressional investigations and as the hospital is one of just four nationwide reporting weekly to the VA's top health official in Washington.

The problems leading to the one-star ranking and detailed in the newly obtained documents pre-date Dunning's arrival. VA Secretary David Shulkin tapped Dunning in May to pull the hospital from the bottom. Four interim directors preceded him.

"We acknowledge it, but we don't accept it," Dunning said of the one-star ranking and history of poor care.

Dunning said he was "given the whole truth" about the hospital before accepting the director's position

"I chose to come to the Memphis VA with the expectation that I would be required to make tough decisions on behalf of my fellow veterans," Dunning said.

In June, Shulkin mentioned the hospital during a White House briefing on a push to pass accountability legislation that allows problem employees to be fired more easily.

Shulkin used the hospital as an example just days after the USA TODAY NETWORK reported that an employee returned to work after serving a 60-day jail sentence for a third DUI conviction and used donated leave to continue being paid.

The hospital denied the woman, Brittney Lowe, used donated leave, but sent a memo to all hospital employees about the leave policy, which generally only applies to long absences related to health conditions.
whistleblowers

Dunning declined to respond to those statements, but noted that Shulkin also referenced the hospital's one-star rating.

"There are very few people that believe they're a one star and they're offended (at the rating)," he said.

Dunning the Memphian, combat vet

Dunning was born in the now-razed Baptist Hospital just blocks from where the current VA hospital sits today. His grandmother retired from the VA when it was located on Getwell Road, before it moved to its current home in the Medical District.

His father was a Baptist preacher, an upbringing that meant spending time in lots of different places.

"We skipped everywhere when I was a kid, and I literally skipped everywhere in the military," he said.

But now he's back in what he calls his "forever home," a place he and his wife both have craved after more than a dozen moves during his military career.

"I'm committed to Memphis. Hopefully Memphis is committed to me."

David Dunning, Memphis VA director

"I'm committed to Memphis," he said. "Hopefully Memphis is committed to me."

Dunning's grandparents grew up on Summer Avenue in Memphis, and his life and career as a soldier has taken him all over the world and Tennessee, from Somerville to Columbia to Clarksville and Nashville.

He still has family in Bartlett and his two brothers went to the University of Memphis.

"I could have gone somewhere and probably made more money, but this is where I belong," he said, noting that he had a choice of director positions to choose from, one in Memphis and one in the Northeast.

Dunning's Army career was almost entirely in the Medical Command section, and took him all over the world, the last stop for two years at Tripler Army Medical Center in Hawaii, a facility slightly larger than the Memphis VA.

Dunning deployed twice, and was among the first soldiers to take part in the Iraq surge ordered by then-President George W. Bush.

He also served in the 101st Airborne Division early in his career and remembers eating at Nashville's San Antonio Taco Company, a popular eatery on 21st Avenue near Vanderbilt University.

"There wasn't much to do in Clarksville back then," he said of his time with the 101st some 25 years ago.

The 5-point plan

Dunning said the increase in patient safety reports is a sign of improvement, and a sign of greater comfort disclosing issues.

And when Dunning talks about his vision and goals, he cites his five-point focusing on primary care, mental health, hospital-patient flow, infrastructure modernization, and the hospital's culture.

It's a plan he developed over his first 60 days on the job, and is "directly in line" with higher initiatives laid out by Shulkin, he said.

Dunning has made quick progress on some of the initiatives. The hospital will see a renovated and reorganized main entry atrium complete at the end of the year and a new parking garage begin around the same time that will add about 180 spots in a three-story parking garage.

He's also had the help of regional oversight to expedite the hiring of 182 critical but vacant positions he sees as necessary to improve the hospital's care and culture, mainly for the patients.

In just 30 days between June and July, the hospital hired 30 medical support assistants, who are among the first people to interact with veterans when they call for an appointment or visit the hospital.

Each of those could yield immediate gains, but also bring frustration with some patients.

The crave for stability

Dunning's arrival has brought a sense of stability to the hospital, which has been under control of interim directors for more than 18 months since the last permanent director left in February 2016.

"The culture war is really the biggest issue we have to fight here," Dunning said.

Some within the facility are already on Dunning's side. Willie Logan, the communications director, said the hospital has craved a stable presence at the helm.

"You (have to) get a leader people want to follow, we haven't had one," she said.

David Spencer, the executive officer for the Memphis Combat Vets Motorcycle Association, said though he doesn't get medical care at the Memphis VA, he knows many who do, and those experiences are mixed.

Dunning spoke to a recent chapter meeting, where Spencer said he was "firm" about improving the hospital's performance and reputation, and afterward personally met with many of the members, with an assistant taking notes and contact information.

"I think he's got the right idea," Spencer said.

Spencer said Dunning, if given the opportunity to succeed by both the community and the VA, he's confident he will achieve his goal.

Dunning has placed establishing healthy relationships with other area hospitals — "community affiliates," he calls them — around Memphis at the top of his priority list.

"My big thing is we just need to get moving," he said.

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1.4 - The Republican: [Ginnie Mae launches task force to investigate VA-backed lenders; US Sen. Elizabeth Warren praises move](#) (14 September, Shannon Young, 2.1M online visitors/mo; Springfield, MA)

Ginnie Mae, the principal financing arm for government loans, will look into potentially misleading marketing practices involving U.S. Department of Veterans Affairs-backed lenders, officials announced Thursday.

Acknowledging concerns U.S. Sen. Elizabeth Warren raised in a recent letter, Ginnie Mae Acting President and Chief Operating Officer Michael Bright said the Massachusetts Democrat is right to be bothered by the potential impacts aggressive mortgage marketing practices could have on veteran borrowers.

Bright, who noted that Ginnie Mae has already taken some steps to address these issues, further announced the creation of a joint "Lender Abuse Task Force," which will work with the VA to crack down on such practices.

Contending that some Ginnie Mae-approved issuer companies seem to be taking advantage of the VA program to aggressively market and "churn" loans, or successfully solicit an existing VA borrower to refinance a mortgage, Bright said his agency is working to analyze data and better understand what net economic benefit such refinances could offer borrowers.

Bright said the agency further believes it has found some patterns of suspicious behavior it will work to curtail, adding that "this churning is having a negative impact on Ginnie Mae securities."

For example, he argued that some VA borrowers may pay a higher mortgage rate than they otherwise would due to such churning.

Bright noted that Ginnie Mae took steps to respond to these issues, as well as those raised in a November 2016 Consumer Financial Protection Bureau report, which offered a snapshot of complaints service members have filed related to VA mortgage refinancing.

However, he noted that some issuers "seem determined to evade the intent of our program guidelines" and employ practices that "appear designed to market products that evade Ginnie Mae and VA program rules, and, in our view, may not be designed to help veteran homeowners."

The new task force, Bright said, will help the agency "continue and intensify (its) work in analyzing monthly data and developing additional policy steps" and be responsible for keeping members of Congress and industry officials aware of program changes and enforcement actions.

"Ginnie Mae, in its sole discretion, reserves the right to remove any lender from its program for violations and we have not finished our work to solve this issue," he wrote in a letter to Warren. "We are analyzing every option, from large scale program changes to working lender-by-lender, to understand how individual marketing practices may be impacting the overall health of Ginnie Mae's program."

Bright added that he's committed to working with Warren "and partner federal agencies to put an end to these practices."

Warren lauded Ginnie Mae's response to her recent inquiry into these refinance mortgage marketing practices.

"I am glad that Ginnie Mae and the VA have created the Lender Abuse Task Force and have committed to work with me to crack down on lenders who are exploiting veterans in order to line their own pockets," she said in a statement. "These abusive practices are wrong, and lenders who engage in them shouldn't benefit from any taxpayer backing."

Warren, in her early September letter to Bright, raised concerns that Ginnie Mae-approved companies could be forcefully marketing VA-backed refinance mortgages that hurt veterans and American taxpayers.

She pointed to CFPB report, which found that of the more than 12,500 mortgage complaints service members, veterans and their dependents filed with the bureau, about 14 percent -- or 1,800 -- were related to refinance.

Market analysts, meanwhile, have noted that some VA mortgage service providers are more likely to "churn" loans, or successfully solicit an existing VA borrower to refinance a mortgage -- something that may reflect aggressive marketing tactics, Warren argued.

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1.5 - Military Times: [New ad campaign reopens fight over VA privatization claims](#) (14 September, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

WASHINGTON — A left-leaning veterans advocacy group today is reopening the fight over privatization of Veterans Affairs services with a multi-state ad campaign imploring lawmakers to “save VA.”

The nearly \$400,000 effort comes as top VA officials and congressional leaders are preparing to unveil their long-term plans for the department’s controversial Choice program, which allows veterans to seek private-sector care using federal dollars.

The program has been a frequent target of critics who accuse conservatives of working to undermine VA funding and services, by outsourcing core government responsibilities to provide health care to veterans.

But supporters — including President Donald Trump, who has repeatedly promised to expand current Choice offerings — say the outside care options are critical to providing faster, less cumbersome medical access for veterans, and avoiding long wait times at VA facilities.

The ad campaign by VoteVets Action Fund does not mention the Choice program by name but warns watchers “don’t let Trump privatize my VA.” The group, which has worked closely with a number of Democratic outreach and election efforts, argues that moving more veterans outside the federally-funded health care system will erode its effectiveness and value.

“We’re doing this because we want to make sure people know the true story at VA,” said Will Fischer, VoteVets director of government relations and an Iraq War veteran. “The other side is interested in making money off of veterans and privatizing anything and everything.”

That’s a charge that VA Secretary David Shulkin has repeatedly denied, in congressional testimony and numerous media interviews.

Currently, about one-third of veterans medical appointments paid for by VA are conducted by physicians outside the department. White House officials have requested \$13.2 billion in outside care spending for fiscal 2018, about one-fifth of the total funding requested for veterans health services.

Shulkin has pushed for significant changes to the Choice program, including changing eligibility criteria to open the program to more veterans. Choice funding is expected to run out early next year, and Shulkin has promised the replacement — the Coordinated Access and Rewarding Experiences program, or Veterans CARE — will be “a program that’s easy to understand, simple to administer and meets (veterans) needs.”

The criteria, cost and potential impacts on other programs have not yet been released.

Republican leaders on Capitol Hill have also repeatedly promised not to look at “privatizing VA,” but have taken criticism from Democratic colleagues for a host of policy suggestions that some fear could be the first steps towards eroding department resources.

Fischer said he hopes viewers of the ads help push for improvements to the VA system instead of moving more outside it.

Just extending the Choice program another six months became a contentious debate earlier this summer, with several prominent veterans groups lobbying for additional funds for VA facilities in conjunction with \$2.1 billion in Choice money. That fight is likely to resume again this fall if groups see plans to pull money from existing VA programs for private-sector payments.

Meanwhile, supporters of outside care expansion have also been increasing their outreach in recent weeks.

Officials from Concerned Veterans for America, which has ties to conservative groups and have been among the most vocal supporters of reforming and broadening the Choice program, has released a series of op-eds and policy positions arguing that too many veterans face significant waits for basic health needs within VA.

“Every veteran should have the choice to use their health care benefits in the private sector, especially if the VA is unable to provide them with quality care in a timely manner,” CVA Policy Director Dan Caldwell said in a statement late last month.

The VoteVets ads will be airing in Alaska, Florida, Kansas, Louisiana, Maine, Minnesota, Montana, Nevada, Ohio, South Dakota, Tennessee, Texas and West Virginia. They’re also available online.

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1.6 - Military Times: [Ashford University gets OK to keep GI Bill students](#) (14 September, Natalie Gross, 2.1M online visitors/mo; Springfield, VA)

Ashford University has received the Department of Veterans Affairs’ stamp of approval to continue enrolling GI Bill students long-term.

The announcement comes after a tumultuous summer for the online for-profit school, which was, at one time, scheduled to lose its eligibility to receive VA funds in August after losing its state-level approval in Iowa. Ashford then sought approval in Arizona and was permitted to continue enrolling veteran students for the new school year, pending approval from VA.

It got that Wednesday, according to a letter to students from Ashford President Craig Swenson. A VA spokesman confirmed this was the final step to certify students’ use of GI Bill funds through the school’s Arizona location.

“We appreciate the VA and Arizona (State Approving Agency) for working to complete this process and ensuring there was no disruption to students’ GI Bill education benefits,” Swenson said in a statement. “We look forward to continuing to serve these students and assisting them in achieving their educational goals.”

In July, an Iowa court ruled against Ashford’s request to retain state eligibility for its online programs, more than a year after the school closed its only campus in the state. The school of

more than 40,000 students, which is the 15th most popular college destination for GI Bill users, turned to Arizona, opening an administrative and student service center in Phoenix.

Federal approval of the move wasn't guaranteed; the VA did not accept the Arizona State Approving Agency's initial notice of approval and had requested additional information. But Thursday, a VA spokesman said the department had acknowledged the state's approval of the university and that there would be no immediate impact to Ashford students using GI Bill benefits.

He said in an email, "VA continues to review adherence to statutory and regulatory requirements relating to this approval. In all cases, we urge G.I. Bill recipients to make informed decisions regarding the use of their education benefits."

Loss of VA approval could have also impacted the school's eligibility to enroll active-duty military students using tuition assistance, since schools must have VA approval in order to receive funds from the Department of Defense.

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1.7 - Stars and Stripes: [Veterans crisis line to open third call center](#) (14 September, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

The Department of Veterans Affairs will open a third call center in the fall to handle an anticipated increase in calls to the veterans crisis hotline.

The call center will be located on the VA campus in Topeka, Kansas, the VA said late Wednesday. The announcement comes just nine months after a second call center was opened in Atlanta.

"The new center in Topeka gives us more feet on the ground and an easier way for veterans to connect with us when they need us most," VA Secretary David Shulkin said in a written statement.

The VA has previously been criticized for allowing calls to the veterans crisis line to roll to voicemail. Last year, the VA inspector general reported instances of veterans waiting on hold for long periods and calls being dropped.

The opening of the Atlanta facility improved the situation, the VA said. In December, it reported the crisis line was answering 44 percent more calls than it was months earlier, but some calls were still rolling to a backup center. When phone lines are busy, calls are routed to another contracted call center. The inspector found responders in those centers were ill-equipped to handle crises.

About 200 responders work at the Atlanta facility, and 310 work at the VA's original call center in upstate New York. The Topeka facility will bring the number of employees staffing the veterans crisis line to 610. The call centers answer phone calls, texts and online messages from veterans, servicemembers and their families.

The VA is also expecting an increase in calls once it expands a function to automatically transfer veterans to the veterans crisis line from any VA facility. At VA hospitals, veterans can press "7" from a phone and be sent to the hotline. The VA is rolling the option out to its 300 veterans centers and more than 1,000 outpatient clinics.

The expansion is expected in the next few months. The VA said the Topeka call center would open in the fall, but didn't give a date of when it would be operational.

"Expanding the [veterans crisis line] to additional locations and increasing crisis responders is critical to providing veterans with support they need, when they need it," Sen. Jerry Moran, R-Kan., said in a written statement. Moran is a member of the Senate Veterans' Affairs Committee.

To reach the hotline, veterans, servicemembers or their families can call 1-800-273-8255 and press 1, text 838255 or open an online chat at veteranscrisisline.net.

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2. Veteran and Employee Experience

2.1 - WRAL (NBC-5, Video): [Long waits lead to good news for vets seeking resolution to VA problems](#) (14 September, Cullen Browder, 3.1M online visitors/mo; Raleigh, NC)

CARY, N.C. — Hundreds of veterans walked into the Herb Young Community Center in Cary on Thursday with complaints and problems and walked out with resolution and, many times, money.

The American Legion and the VFW sponsored the Veterans' Experience Action Center to help veterans who are having trouble with the U.S. Department of Veterans Affairs. Because North Carolina is the only state hosting such events, veterans came from across the country.

"Nothing could be finer than to be in Carolina this morning," said Army veteran Marc Stratton, who flew to the Triangle from Arizona. "I got more done today in less than an hour than I've done in years."

Veterans started lining up for the event Wednesday night, and the line wrapped around the building by the time the doors opened at 9 a.m.

"The word got out, and the need is there," said Richard Spyrisson, the service officer for the American Legion post in Cary. "The biggest thing is that the veteran can tell that [volunteer] his story, his problem, why he needs this."

Army veteran Robert Jones of Greenville stood in line for hours to erase years of VA paperwork problems.

"They made a mistake, and they acknowledged that themselves and corrected it and took a lot of pressure off," Jones said. "Today was a very good day. I thank God for the folks here."

Struggling with PTSD, Marine veteran Dustin Glidewell of Carthage finally got the disability he'd been fighting for.

"I got 100 percent today," Glidewell said. "That means my kids get fed. I mean, it means I have a home now."

Not every veteran got what they wanted, but they got answers and personal attention.

"Today's been amazing. They spent three hours with me, and it's been ultimately validating," said Evangeline Moore, a homeless Navy veteran who drove from Washington, D.C., in search of education assistance.

"It feels like I just dropped my rucksack for the last time. I can breathe again," Glidewell said.

The Veterans' Experience Action Center continues 9 a.m. to 4 p.m. Friday and 9 a.m. to 3 p.m. Saturday. Veterans are advised to bring their medical records with them.

About 500 veterans were served in a similar event last year, and organizers said they hope to double that by the end of Saturday.

"This is needed, and we're going to try and increase this format," North Carolina Secretary of Military and Veterans Affairs Larry Hall said. "We do it several times across the state already, and we have these kinds of turnouts. The second thing is we have to have better follow up and make sure they get into the system."

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2.2 - Inside Higher Ed: [VA seeks broad waiver of rule barring payments from for-profit colleges](#) (15 September, Andrew Kreighbaum, 1.6M online visitors/mo; Washington, DC)

The Department of Veterans Affairs intends to grant employees a waiver of a rule barring receipt of salary or other benefits from for-profit colleges.

The proposed regulation was published in the federal register Thursday and would take effect next month without "adverse comment."

A recent VA inspector general report found that two employees had violated the rule by working as adjunct instructors at for-profit colleges receiving VA benefits. The report recommended issuing waivers where no specific conflict of interest exists.

The proposal goes further, granting a waiver to all VA employees as long as they abide by certain other federal conflict-of-interest laws. Asked for comment, the VA's press office referred to language in the agency's notice of intent stating that the "statute has illogical and unintended consequences."

Carrie Wofford, president of Veterans Education Success, a group that's frequently been critical of for-profit colleges, called the proposal "crazy." She argued it would allow employees at VA, which acts as a regulator of institutions receiving veterans' education benefits, to hold stock or receive gifts from those entities.

Will Hubbard, vice president of government affairs at Student Veterans of America, said he wasn't sure the proposal had a nefarious intent. But he said the timing was interesting considering recent changes the Department of Education has made to rules protecting students and certain personnel decisions at the department.

"We remain very committed to ensuring that student veterans continue to be the top priority of the Department of Veterans Affairs," he said.

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2.3 - Commercial Appeal (Video): [How we're fixing a broken VA care system](#) (14 September, Phil Roe and David Kustoff, 1.1M online visitors/mo; Memphis, TN)

As the Chairman of the House Committee on Veterans Affairs and the Congressman representing West Tennessee veterans who seek care at the Memphis VA Medical Center, we are concerned and outraged by the recent abysmal failures at the Memphis facility.

We are encouraged to see swift action from the Department of Veterans Affairs (VA) to get the Memphis facility on track — and will continue to closely monitor progress — but these examples underscore the serious and urgent need to reform VA. As the representatives of Tennessee veterans, we have a duty to ensure they have timely access to quality health care, and it's a duty we take very seriously.

This is simple: the men and women who put on a uniform and fought for this country made a promise to serve; a promise to defend the United States against all enemies foreign and domestic. In return, this country made a promise to care for the men and women who have borne the battle and to provide for their families.

Over the past several years, we've seen numerous instances of VA failing veterans, and it's long past time Congress act in a bipartisan way to make things right. We've made some progress, but as ongoing congressional investigations and recent media reports show, there is still much work to do.

We're fortunate to have partners in the Trump administration. President Trump has repeatedly expressed his desire to reform VA, and VA Secretary Shulkin has worked to build trust with members of Congress on both sides of the aisle. Secretary Shulkin called both of us individually to hear our concerns about the Memphis VA facility and to discuss ways to improve care for West Tennessee veterans.

The secretary has always been honest about the challenges the department faces and what VA needs from Congress to be successful. That's why we championed and supported accountability legislation the administration explicitly asked for. The Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 was signed into law by President Trump on June 23 after passing the House and Senate with bipartisan support.

This law gives the secretary more authority to fire or discipline bad employees while protecting VA employees' due process rights. The vast majority of VA employees are good, hardworking

men and women who want to serve veterans honorably, but the bad actions of a few have tainted the reputations of many.

Still, as any employer will tell you, you cannot fire your way to success. That's why the accountability law includes provisions that provide VA with direct-hiring authority to fill medical center positions throughout the country. According to a VA Fact Sheet released in March 2015, "since June 2014, ninety one percent of [VA] medical facilities have new leaders or leadership teams..." That percentage is inclusive of both newly placed, permanent leaders and those who have been detailed to an acting director role.

How can we expect to change the direction of VA without steady leadership? After having numerous interim directors at the Memphis VA in 2016 alone, we applaud VA for hiring Memphis VA Medical Center Director David Dunning. We thank Director Dunning for his commitment to bringing much-needed stability to the Memphis facility.

Congress has also sent legislation to the president's desk, which was signed into law on Aug. 12, 2017, that will give the department the tools it needs to recruit, train and retain a high-quality workforce. These are two strong steps in the right direction. Another, and perhaps the most important step, is giving veterans options for care just like any other patient. If a patient receiving care in the private sector isn't happy with the quality of care, they can find another provider to meet their needs. Veterans should have that same option.

This fall, Congress will work to reauthorize the Choice Program, a program we realize needs improvements and reform. Providing veterans with options for care is another important part of making things right on behalf of our nation's veterans. Our priority will continue to be making good on the promise we made to veterans in Tennessee and across the nation. It's a promise worth keeping, and a promise that has been broken for far too long.

U.S. Rep. David Kustoff of Memphis represents the Eighth Congressional District. U.S. Rep. Phil Roe of Johnson City, Tenn., is chairman of the House Committee on Veterans Affairs.

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2.4 - WTVD (ABC-11, Video): [Cary event brings veterans face-to-face with VA representatives](#) (14 September, Julie Wilson, 880k online visitors/mo; Durham, NC)

CARY (WTVD) -- The American Legion and the Town of Cary are hosting a three-day event focused on answering questions for veterans.

The Veterans Experience Action Center will put veterans face-to-face with a representative from the U.S. Department of Veteran Affairs.

Meetings will allow for explanations, assistance facilitating, expediting existing claims and appeals, filing new claims, and accepting all claim related evidence.

The event runs from 9 a.m. to 4 p.m. Thursday and Friday. On Saturday, doors will be open from 9 a.m. to 3 p.m.

Veterans in attendance are asked to bring their DD214, all medical records about their disability both military and civilian, along with any dependency documentation.

The location for the event is Herbert Young Community Center in Cary, 101 Wilkinson Ave., Cary, NC, 27513.

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2.5 - La Crosse Tribune (Jackson County Chronicle): [Jackson County hosts benefits fair for veterans](#) (14 September, Jordan Simonson, 818k online visitors/mo; La Crosse, WI)

The Jackson County Veterans Service Office and Tomah VA Medical Center hosted a Homeless/At Risk Veterans Stand Down and Benefits Fair Thursday at the Black River Falls American Legion Post 200, providing information for veterans about many of the services available to them via federal, state and local programs.

"It is a two-fold event, it is a homeless or an at-risk stand down for veterans in the area that can come and get assets and services. It is also a benefits fair for any other veteran. They can come in and as you can see there are many different points of contact here, they can actually find out a lot of information," Jackson County veterans service officer Randy Bjerke said.

This fair was aimed at getting more veterans in Jackson County connected with the many services that they qualify for, including the Tomah VA Medical Center.

"We could identify that the veteran population in all of our counties is higher than the population of veterans that are actually registered with the VA. That means that there's a lot of veterans within our counties that just don't know what their benefits are. They don't know that they qualify for things. They may not know that we have a homeless program. They may not know that there are other programs that might help them both within the community and the VA," Tomah VA Medical Center homeless outreach coordinator Amanda Steinhoff said.

The first-time event for Jackson County had more than 20 vendors including several local, state and federal programs.

"We have never had a veterans homeless stand down in Jackson County, so being the first of its kind we have a lot of resources here, a lot of community programs here, a lot of state and federal resources here to help veterans identify if they need any help," Steinhoff said.

One of those local programs on hand was the local VFW Post 1959 that was helping serve a light meal during the event.

"Since we feel fervent about helping veterans, I shouldn't say more so than anyone, just as much as anyone else, we want to do a couple of things. First, we want to facilitate this for all of the entities that are here. The American Red Cross, the VA, but we also want to assist with our own personal recruiting drive because there are not very many VFW members," VFW Post 1959 chaplain Mario Garcia said.

Garcia spoke passionately about the many benefits of the VFW for its members, highlighting the importance of programs for veterans.

“It is that little brotherhood, or that cohesive mindset that we bring to other veterans that could be possibly stumbling a little bit, that could use a helping hand. So what the VFW does in their position, we have an emergency fund,” Garcia said explaining that they recently used the fund to help a veteran replace his roof.

It is connecting even one veteran with programs like the Tomah VA Medical Center and the local VFW that made the event a success for Bjerke.

“Every time that we get a new veteran to come in and find out what is available to them, that is a benefit just in itself because we have one more educated veteran. I don’t like it when they are in the woodwork, so to speak,” Bjerke said. “No matter how many veterans you have, you always wish you had more show up. Because you want to be able to get that word out and be able to inform the veterans that need it.”

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2.6 - KTVI (FOX-2, Video): [Government workers hold union rally outside VA Medical Center on Grand](#) (14 September, 663k online visitors/mo; Saint Louis, MO)

Workers at the John Cochran VA Medical Center will hold a rally Thursday, September 14 outside the hospital. Members of the American Federation of Government Workers want to raise awareness of what they call dangerously low staffing levels at facilities around the country.

The union claims the shortages are depriving veterans of the health care they deserve. They say it’s also creating risks to patient safety and a hazardous work environment.

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2.7 - WNCN (CBS-17, Video): [3-day push will help NC veterans connect with benefits](#) (14 September, Bearshelle Edme, 607k online visitors/mo; Raleigh, NC)

CARY, N.C. (WNCN) – A three-day event for veterans launched Thursday to help former military members access benefits, among other services.

But many veterans told CBS North Carolina’s Bearshelle Edmé they’re frustrated with all these processes, applications, and long waits.

61 years could separate some of the veterans who have served in the Korean War from those who were sent to the Iraq War. But as they formed a perimeter around the Cary Herbert Young Community Center, their mission was the same: access to veteran benefits.

“You start out at the VA. They put you in the system, then you meet with the veteran services officer to fill out the paperwork,” explained Larry Kall, a Army veteran of Vietnam. “They say it’s six to nine months to a year before you hear anything. I’m hoping this will escalate it.”

The Veterans Experience Action Center, VEAC, brings in former military member from across the nation.

It's the third year for the event where agents help fill out applications for benefit claims and direct veterans to health services, including for mental illness.

Derwood Bobbitt is a Marine veteran, who like others, has doubts about the process.

"Yes, I volunteered to serve my country; however, I was perfectly fine then," Bobbitt said. "Now, all of a sudden I have an injury or mental illness or whatever the case may be. You know, 'Hey let's fix this problem. Instead of putting a Band-Aid on something that needs surgery, hey, let's do surgery.'"

The Department of Veteran Affairs, along with several other veteran organizations, sponsor the event.

Asked how to make veterans feel less frustrated and more valued, Megan Miller, an assistant veterans services manager at the Winston-Salem VBA answered: "Part of the way we're trying to make it better is by being here face-to-face, because I think a lot of the frustration results from confusion. Veterans don't understand the process to file a claim or they don't understand why their claim may not be entitled to service connection for example."

VA officials say regional and congressional offices as well as online resources are all available.

They hope the three-day event starts or continues the process to honoring their service.

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2.8 - Post-Tribune: [Column: Vietnam documentary should take a balanced look](#) (14 September, Tom Bellino, 261k online visitors/mo; Crown Point, IN)

The PBS special series, "The Vietnam War," by Ken Burns and Lynn Novick, which begins Sunday, no doubt will evoke emotions for both the veterans of that war as well as the observers, resisters and opponents of it. Various Veterans Affairs facilities are offering a Monday morning debriefing after the first episode of the series, because "it may bring up stressful memories for combat veterans."

Clearly the Vietnam experience is so unique that extraordinary responses are expected to the impact of this series, as it was to the actual war.

Vietnam, the time and place, was in fact extraordinary, and was and still is difficult to describe. Former United States Senator and Secretary of the Navy James Webb, who also was a highly decorated combat Marine in Vietnam, summed it up on a CBS Sunday Morning show in 2014: "If you were there, I don't need to explain. If you weren't, I can't explain."

I would suspect that most veterans of Vietnam would echo that statement. It has become became a common mantra of many veterans of that war. Many thought (and still think) the greatest problem many of the returning Vietnam veterans was that if in fact your body came back, so did your mind.

Some veterans are discussing whether they will watch the series. Some say that since it no doubt was developed by what they perceive as a left-leaning type, it merely will rehash the anti-war sentiment of the era, and they simply do not want to hear that again. Some of the more hardened veterans go on to say this will no doubt portray the enemy as the good guy and the American soldier as the bad guy, resurrecting the way they were treated upon the return home following their tours of duty in Southeast Asia.

The stories of being spat upon at airports, with chants of "Baby Killer," and "Hey Hey, Ho Ho, how many kids did you kill today?" are ubiquitous in the Vietnam veteran community.

Even if half of these stories are embellished memories, then the other half are tragic, and perhaps even more tragic because they were heaped on young men, often 17 to 27 years old. They answered the call of their country and were sent to a foreign land to fight a war that was not a declared war, one not supported by most of their peers, and even most of their government.

Other warriors are referred to as "The Greatest Generation," as is the case of the World War II veterans, and "American Heroes" in the case of the Iraq and Afghanistan veterans. These accolades are right and just.

No such positive descriptors, however, have been applied to the Vietnam veteran. Perhaps the relatively recent greeting of "Welcome Home" is America's newfound acknowledgment of the veteran from 1965 to 1975, the war of which the writer Myra MacPherson described in 1984, "Above all, Vietnam was a war that asked everything of a few and nothing of most of America."

Michael Herr, who helped write the screenplay for "Full Metal Jacket" and "Apocalypse Now," wrote, "All the wrong people remember Vietnam. I think all the people who remember it should forget it, and all the people who forget it should remember it."

There is no doubt that all war is hell, but without the support of the people who send you into that war however, it is an even greater hell.

Hopefully, Ken Burns and Lynn Novick in their series, treat the Vietnam veteran with the honor deserved, and that the warrior of that war, albeit not declared, can in some way put away some of the demons that often come at night. Let's hope so.

Dr. Tom Bellino is the author of *Bac Si: A Novel*, a saga of the Vietnam War. He was a Navy psychologist during the Vietnam War.

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2.9 - WUSF Public Media (Audio): [VA Prepares for PBS Vietnam Documentary; It May Trigger Some Vets' PTSD](#) (15 September, Steve Walsh, 197k online visitors/mo; Tampa, FL)

The ten-part documentary by filmmakers Ken Burns and Lynn Novick is at times graphic, and people who work with veterans say it may trigger traumatic memories for those who fought in Vietnam.

For two weeks, PBS stations will relive one of the most divisive eras in American history.

"The Vietnam War" documentary - produced by Ken Burns and Lynn Novick - is being billed as a rare cultural milestone. The filmmakers have been planning the series since 2006, meaning their production process was about as long as America's involvement in the war.

The series is designed to be intense. Each episode is preceded by a warning about strong language and graphic violence.

But people who work with veterans say the documentary may be too intense for some of those who fought in Vietnam.

"Some are going to watch it. Few will," said Henry Peterson, a chaplain at the Department of Veterans Affairs in San Diego. He counsels people with PTSD.

"It could bring up some memories they don't want to deal with," Patterson said. "It could bring up some memories they may need to deal with."

Tina Mayes, a VA staff psychologist, said almost anything can trigger the vivid and aggressive thoughts associated with PTSD. A door slam. Smell of diesel.

"It can be something someone says. The way they say it," Mayes said.

News, movies, and documentaries are among the most common triggers.

"I would say the majority of veterans that I work with, when their symptoms are high, they're actively avoiding any media," Mayes said.

While PTSD is an issue among veterans of all eras, as well as certain populations of non-veterans, Mayes said people who served in Vietnam are particularly vulnerable.

"Honestly we don't know why, but some of the research suggests that it was because of the way they were received when they came back," she said.

In the 1970s, the VA was often unwelcoming. Society in general appeared, at best, uninterested in the plight of returning vets, and in some places was openly hostile.

Decades later, some vets still live with the symptoms of untreated PTSD, like the aggression that feels like it comes out of nowhere.

"It affects everyone," said Vietnam combat veteran Larry Taylor. "I would say my own wife experienced PTSD just from her relationship with me and the war I fought in."

Before he was treated, Taylor coped by avoiding his triggers. He didn't see *Apocalypse Now*, *The Deer Hunter*, or other popular movies about Vietnam. But when the first Gulf War broke out in 1990, he couldn't avoid the constant media coverage.

"Basically after the Gulf War, my PTSD kicked in," Taylor said. "I would wake up screaming. My wife would wonder what's going on. I was having nightmares all the time, during the daytime."

Still, Taylor wouldn't seek treatment for another decade. He's now the lead mental health chaplain at the VA in San Diego. He plans to watch the 18 hour long PBS documentary.

"I think today I know the difference between a bad memory and reliving a situation," Taylor said. "Fortunately I'm not reliving things the way I once did."

His guidance for vets is: Don't feel obligated to watch. If you do watch, find a loved one to watch with you. Taylor is enlisting his wife of 46 years.

In the past, the VA provided outreach around movies like Saving Private Ryan for vets who were triggered by what they saw. But the agency said it didn't experience a major increase in calls.

This time, the VA is partnering with PBS, preparing to provide counseling to any vets who feel it's time to start working through their own experience with the war.

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2.10 - Tribune-Democrat: [UPJ summit seeks ways to help veterans](#) (15 September, Dave Sutor, 155k online visitors/mo; Johnstown, PA)

Issues that afflict active military personnel and veterans, including thoughts of suicide, physical pain and moral injury, also impact the general population, albeit in different ways.

So, when advancements are made to help men and women who serve the United States deal with those challenges, the nation benefits.

That lesson was understood well by U.S. Rep. John Murtha, whose work helping military personnel and their families deal with traumatic brain injury and breast cancer ended up positively impacting Johnstown, Pennsylvania and the entire country.

Carrying on his mission was part of the reason for holding the James E. Van Zandt VAMC Health and Wellness Community Summit on Thursday at the University of Pittsburgh at Johnstown's John P. Murtha Center for Public Service and National Competitiveness.

"He made taking care of veterans a benefit to the whole community," state Rep. Bryan Barbin said. "What we learned in taking care of veterans was also a benefit to the population as a whole. And that should continue."

The summit was the first symposium-type event hosted by the newly opened center.

"I can't think of any organization that's more appropriate for this center than one dealing with veterans and their problems and concerns because, as all of you know, that, for Jack, was our No. 1 program and problem that he worked on," said Joyce Murtha, the late congressman's widow. "And he just felt like that veterans didn't always get all they deserved."

UPJ President Jem Spectar explained how the gathering brought together representatives from different fields to share ideas, which was a way Murtha worked when trying to find solutions to difficult issues.

"One of the most important things this center can do is to bring people from different sectors," Spectar said. "We have here representatives from the medical community, from the military community, leaders, community service agencies, volunteers to talk about issues of concern to our community and to bring insights, new ideas, the latest research to try to find solutions to the pressing and vexing issues that affect our community."

The summit included a presentation about suicide among military personnel and veterans.

Russell L. Crupe, Sr., whose son committed suicide after serving in Iraq, discussed the need to eliminate the "stigma" that exists surrounding mental issues that can lead to suicide.

"It's a story I'm trying to tell," Crupe said. "Maybe I can save a veteran's life."

Ronald Poropatich, executive director for the University of Pittsburgh Center for Military Medicine Research, discussed advancements that are being made in eye transplants, regenerative medicine, and other areas. He went into detail about work being done to better map nerves in the human brain.

"It's high-definition fiber tracking," Poropatich said. "It's neuroimaging, imaging of the brain. It's taking a MRI of the brain and developing a stronger way to interpret the signals from the MRI machine in such a way that we can see the actual nerve fiber, where we don't see that now."

The research is supported by the Department of Defense.

"Military funding that we're receiving to do research for military-specific medical problems has a direct translation to the civilian sector," Poropatich said.

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2.11 - New Hampshire Public Radio: [Makeup of N.H. VA Task Force Announced, Some Whistleblowers Say They Were Shut Out of Process](#) (14 September, Peter Biello, 148k online visitors/mo; Concord, NH)

The Department of Veterans Affairs has released a list of the twelve people who will serve on a task force looking at the future of health care for New Hampshire veterans.

Since July, a dozen whistleblowers have come forward with allegations of substandard care at the Manchester VA. One of those whistleblowers, cardiologist Erik Funk, will serve on the task force.

The list also includes four people who are not VA employees and five who are not New Hampshire residents.

Ed Kois, a VA doctor and leader of the whistleblowers, said that's a problem.

"We have people deciding the fate of the Manchester VA who don't have any skin in New Hampshire," Kois said.

VA Secretary David Shulkin ordered the creation of this task force in a visit to New Hampshire last month.

One of the more outspoken whistleblowers, Stewart Levenson, was turned away when he offered to join. Levenson worked at the Manchester VA for nearly two decades before leaving the VA earlier this summer.

Dr. Michael Mayo-Smith, network director for the New England VA system and co-chair of the task force, said at the time in an email obtained by NHPR that Levenson could not join the task force because "government work needs to be done by government employees - others are not bound by the same ethical and regulatory guidance."

He went on to say that "the Task Force will be VA staff."

Mayo-Smith was unavailable to comment Thursday.

Dave Kenney is co-chair of the committee, and chair of the New Hampshire State Veterans Advisory Committee. He is also not a VA employee. Kenney says through his work on this task force, he will be looking for ways to bring "full-service" healthcare to New Hampshire veterans.

"Full-service" means a broader range of treatment options for New Hampshire veterans, including in-patient care. Kenney says that's what most veterans want.

"They want full service, however that manifests itself," Kenney said. "Whether it's a combination of VAMC [VA Medical Center] and Choice [The Veterans Choice Program], which I believe is the way it will be."

New Hampshire is one of three states in the country without a full-service VA Medical Center, along with Alaska and Hawaii.

The task force's next meeting is scheduled for September 25th, with recommendations due by January 2018.

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2.12 - Hudson Valley News Network: [Maloney, Local Officials Slam VA Decision to Cut Funding](#) (14 September, Kathy Welsh, 54k online visitors/mo; Hyde Park, NY)

NEWBURGH – Representative Sean Patrick Maloney (NY-18) and local officials condemned a decision by the Department of Veterans Affairs to deny an anticipated annual federal investment of over \$500,000 to Hudson River Housing.

If no action is taken, funding will run out and the program will be terminated after Sept. 30.

"Hudson River Housing has been an absolute lifeline for hundreds of men and women who wore our country's uniform and needed some help when they got home. This heartless decision would leave them out in the cold," said Rep. Maloney. "This breaks our sacred promise to our veterans and turns our back on them when they need us most."

“Veterans should have every expectation we will continue to support them and will not give up on them,” said Dutchess County Executive Marcus J. Molinaro. “These brave men and women put their lives at risk to ensure our safety and the security of our nation. Though Supportive Services for Veteran Families (SSVF) and our partnership with Hudson River Housing has led to a dramatic decrease in homelessness among veterans, the issue remains. We do not want to see even one veteran struggling to find safe shelter and secure housing. With little notice the Department of Veterans Affairs’ decision to deny another year of SSVF support in our community is shortsighted and illogical. We are grateful to Congressmen John Faso and Sean Maloney and Senator Chuck Schumer for speaking up for Dutchess County’s and America’s veterans. We cannot allow any veteran to be left out in the cold, to struggle on their own. Dutchess County stands with our veterans and will keep fighting for every one of them.”

“Since 2012, Hudson River Housing has been able to assist over 500 families who would have otherwise been homeless without this funding,” said New York State Senator Sue Serino. “This harmful decision to eliminate this grant, which has effectively reached so many veterans in need, illustrates either a lack of understanding of the critical need it fills or a callous disregard for our veterans. I implore the Division of Veterans Affairs to reconsider and provide this critical funding to ensure that our homeless veterans and their families are not abandoned by the nation they have courageously served.”

“On behalf of the homeless Veteran families that Hudson River Housing proudly serves, we are devastated by the news of the defunding of our Support Services for Veteran Families (SSVF) grant,” said Hudson River Housing Executive Director Christa Hines. “The possible closure of the SSVF program will cause an immediate and serious impact on the at-risk and homeless Veteran community that we serve and potentially reverse all of the progress that Hudson River Housing and our partners have made to address Veteran homelessness in Dutchess County. The manner in which we received notification that funding we have relied upon since 2012 would be completely eliminated in 2 weeks just furthers our disappointment and magnifies the impact this will have on the Veterans we serve. We appreciate the willingness of our Congressional representatives, John Faso and Sean Patrick Maloney, our Senator Charles Schumer and State Senator Sue Serino as well as Dutchess County Executive Marcus Molinaro who joined with us in questioning why this funding was cut and their advocacy on our behalf with the Administration.”

Hudson River Housing will apply for an emergency one month extension to allow the organization to finish its existing cases. Local leaders are working together to appeal the decision or secure an extension. Rep. Maloney sent a letter directly to the President, asking him to intervene on behalf of local veterans. Dutchess County Executive Molinaro wrote an additional letter to the VA.

Hudson River Housing in the City of Poughkeepsie has received an investment of \$511,000 every year for the past five years from the Supportive Services for Veteran Families (SSVF) program. The investment has allowed the organization to employ five full-time staff who provide wraparound services to homeless veterans. Two staff members are veterans themselves. Since starting the program in 2012, HRH has helped over 450 homeless or at-risk veteran families and are currently providing services to thirty veterans. The U.S. Interagency Council on Homelessness recently confirmed that Dutchess County had effectively ended homelessness among veterans. However, this status is reliant on local organizations which have the capacity to assist individual veterans who are at-risk or have recently become homeless.

Since taking office in 2013, Rep. Maloney has worked to secure nearly \$2 million to assist homeless veterans in the Hudson Valley. In July, he introduced the Housing Our Heroes Act, which would create a three-year \$25 million pilot program within the VA to provide grants to VSOs and other non-governmental organizations to acquire and update blighted properties for the purpose of housing homeless veterans.

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2.13 - DS News: [Ginnie Mae Responds to Senator Warren on VA Lenders](#) (14 September, Brianna Gilpin, 54k online visitors/mo; Dallas, TX)

Thursday, in a letter to Senator Elizabeth Warren (D-MA), Ginnie Mae explained how it is curbing VA refinance speeds and aggressive marketing by some VA approved lenders.

The letter was in response to Sen. Warren, who initially addressed the aggressive practices in a letter to Ginnie Mae on September 6, 2017. Warren warned that the marketing practices are negatively impacting Ginnie Mae securities without necessarily benefiting veteran borrowers.

After researching the unusually fast prepayment speeds Ginnie Mae was noticing in its securities, as well as conducting conversations with its partners at the VA, with Ginnie Mae issuers, and the investor community, in 2016 Ginnie Mae decided to change a few program standards.

“The APM put in place a limitation on the delivery of so-called “streamline refinance” loans into standard Ginnie mortgage-backed-securities until six consecutive monthly payments were made on the initial mortgage loans,” Michael Bright, President and CEO of Ginnie Mae said in the letter.

According to Bright, this means that an originator cannot do a quick refinance of a loan and deliver it into a standard Ginnie Mae security until the borrower has made six months of payments. This restriction went into effect in February of this year, but after a successful six months, Ginnie Mae noticed more streamlined refinancing appearing in their pools. Some VA loan issuers are now using other “evasive mechanisms.”

“Ginnie Mae’s efforts, along with its partners in government, industry, Congress, and other stakeholders, seek to fully root out these questionable lending practices that harm veterans and harm the Ginnie Mae security, which also notably means harm to FHA and other government backed loan program borrowers,” Bright said.

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2.14 - Reveal: [White House seeks to legalize payoffs to VA officials by for-profit schools](#) (14 September, Aaron Glantz, 39k online visitors/mo; Emeryville, CA)

The Trump administration is seeking to waive a 50-year-old anti-corruption law that prevents officials who administer the GI Bill from accepting money from for-profit schools backed by taxpayer subsidies.

The proposed regulation, published Thursday in the Federal Register, would allow employees of the Department of Veterans Affairs to receive “wages, salary, dividends, profits, gratuities” and services from for-profit schools that receive GI Bill funds.

VA employees would also be allowed to own stock in those colleges, the waiver says, as “the Secretary (of Veterans Affairs) has determined that no detriment will result to the United States, veterans or eligible persons from such activities.”

News of the proposed rule blindsided veterans’ advocates who have battled for years against predatory colleges, many of which have used aggressive marketing techniques to become leading recipients of GI Bill money.

“Bizarre and very likely illegal,” said Carrie Wofford, president of Veterans Education Success, a nonprofit group that has bailed out veterans who found themselves unemployed and deep in debt after attending for-profit schools.

“There are federal laws – including federal criminal laws – that prohibit federal employees from engaging in this exact behavior,” she said.

At VA headquarters in Washington, press secretary Curt Cashour said the agency remained “committed to protecting veterans from predatory behavior from for-profit educational institutions.”

But he said the Vietnam-era law that prohibited employees from receiving payments from for-profit schools was so sweeping that it could have “illogical and unintended consequences.” He cited supplementary materials attached to the regulation that said current law could cover VA lab technicians who take a class, on their own time and using their own money, at a for-profit educational institution that is also attended by veterans using the GI Bill.

The rule change sought by the Trump administration is far more sweeping, however. It would create a situation where VA officials, who are charged with ensuring GI Bill funds are well spent, could accept payments from colleges that are facing civil suits or probes from law enforcement.

Under this rule change, VA employees could even own or run a for-profit college that profits from the GI Bill.

It’s the latest example of the Trump administration apparently embracing conflicts of interest when it comes to for-profit colleges.

Earlier this week, the VA angered many consumer advocates by allowing for-profit Ashford University to continue receiving GI Bill money even after regulators in California and Iowa revoked its certification from the program. The online college had responded to the crackdown by moving its official address from Iowa to Arizona. On Wednesday, the VA sent Ashford a letter saying it would be able to continue to accept taxpayer money to educate veterans, using the Arizona address.

On Aug. 31, the Trump administration announced it had picked Julian Schmoke Jr., a former official at for-profit DeVry University, to head an Education Department unit that polices colleges for student aid fraud. Last year, DeVry paid \$100 million to settle federal claims it misled students.

And, shortly after last November's election, Donald Trump agreed to pay \$25 million to settle multiple lawsuits claiming fraud at Trump University, his own now-defunct for-profit real estate school. The school, which lacked any academic accreditation, did not receive GI Bill funds.

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2.15 - WBOY (NBC-12, Video): [VA Hospital Hosts Town Hall to Hear Concerns from Veterans](#) (14 September, Elayna Conard, 21k online visitors/mo; Clarksburg, WV)

The VA Hospital held a town hall to hear the concerns of veterans Thursday afternoon.

The VA holds these town halls every few months as a way to keep open communication with veterans. The director of the hospital, Dr. Glenn Snider, said that he was glad to hear compliments from veterans about their recent services.

Dr. Snider said that most questions from veterans tend to be about benefits and the best people to contact so at every town hall are representatives to directly talk to veterans.

Many veterans had concerns and questions about food service and accommodating religious preferences like kosher.

"We not only provide food for our in-patients, we also provide food for some of our out-patients and we are the food preparer for the state veterans home next door. Our space is constrained and that is one of the reasons we can't expand as quickly the food services as we would like to," said Dr. Snider, director.

Dr. Snider went on to add that food service staff and nutritionists work to accommodate both religious and dietary needs for every veteran.

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2.16 - Bloomberg Politics: [U.S. Probes High-Pressure Mortgage Sales Targeting Veterans](#) (14 September, Joe Light, 18k online visitors/mo; New York, NY)

The U.S. is investigating lenders for allegedly pressuring veterans and members of the military into unneeded mortgage refinances -- unsavory conduct that not only leads to higher consumer costs but has consequences for one of the world's largest bond markets.

The probe is being conducted by Ginnie Mae, a government-owned corporation whose purpose is to make mortgages more affordable. It does so by guaranteeing repayment on \$2 trillion of mortgage bonds even if borrowers default on the underlying loans. Ginnie-backed securities support several federal housing initiatives, including programs in which loans are made through the Department of Veterans Affairs.

The concern is that some lenders are improperly pushing veterans and servicemembers to refinance loans that have been wrapped into Ginnie securities. Lenders are hounding

consumers to refinance loans over and over again in a short period of time, according to Ginnie Acting President Michael Bright. The practice, known as churning, generates high fees for lenders but can leave servicemembers with larger loan balances.

The issue is starting to resonate on Capitol Hill, where it has drawn the attention of Senator Elizabeth Warren, one of the finance industry's most relentless critics. Last week, the Massachusetts Democrat sent Bright a letter, asking whether some lenders were abusing Ginnie's program by engaging in aggressive marketing tactics.

Task Force

In a response to Warren dated Thursday, Bright said Ginnie and Veterans Affairs had created a task force to address churning and other abusive practices by lenders approved to issue Ginnie-backed bonds. The agencies could impose restrictions on refinances and ban lenders from their programs. Bright's letter didn't identify any specific companies engaging in churning.

"There are clearly some Ginnie Mae-approved issuer companies who appear to be taking advantage of the VA program to aggressively market and churn loans in our securities," Bright wrote to Warren in his letter, which Ginnie provided to Bloomberg News.

When banks make loans through Veterans Affairs they offer terms that aren't available to most borrowers. These include no requirement for a down payment and adding closing costs to loan balances so borrowers don't have to pay them at the time of the sale.

But the loans are also prime targets for churning, Bright said in an interview. Unlike financing provided through other government programs, lenders issuing loans through Veterans Affairs don't have a strong obligation to ensure that borrowers experience a real benefit when they refinance. Some lenders are persuading servicemembers to refinance loans at rates that barely reduce their mortgage payment, while misleading them about potential consequences, Bright said.

"I am glad that Ginnie Mae and the VA have created the Lender Abuse Task Force and have committed to working with me to crack down on lenders who are exploiting veterans in order to line their own pockets," Warren said in a statement Thursday. "These abusive practices are wrong, and lenders who engage in them shouldn't benefit from any taxpayer backing."

'Predatory Lending'

Ted Tozer, who helmed Ginnie under President Barack Obama's administration, said that his agency found some lenders who called veterans and offered a refinance that would allow them to draw cash out of their homes and pay off other debts such as credit-card balances. However the rate given could be a half percentage point above the current market price. Then several months later, the lender or a competitor would call the veteran back and offer another refinance at the market rate, earning another round of fees for the refinance.

"It's starting to smell like predatory lending," said Tozer, comparing the recent practices to those used by subprime lenders before the last housing bust.

In a report released last November, the Consumer Financial Protection Bureau said it had received 1,800 complaints from servicemembers, veterans or their families about mortgage refinances. In one such complaint, a veteran continued to get calls from their mortgage

company, even though they had told the lender multiple times that they had recently refinanced their mortgage.

Bonds Slump

Serial refinances have become enough of a problem that they are driving down prices of Ginnie bonds, JPMorgan Chase & Co. analysts said in a research report issued last week.

When investors buy Ginnie securities, they make assumptions about how quickly borrowers will refinance. If refinances happen more quickly than expected, investors risk losing their expected bond yield and income stream. Such factors make Ginnie bonds less attractive, and when demand wanes, prices fall.

That's what seems to be happening, and it doesn't just affect Veterans Affairs mortgages, the JPMorgan analysts wrote. Veterans Affairs mortgages are wrapped into the same Ginnie-securities as mortgages backed by the Federal Housing Administration, which are popular among first-time home buyers. Falling securities prices lead to higher interest rates for mortgage borrowers.

Ginnie has tried to slow down the refinancing rush in the past year, putting a six-month moratorium between new mortgages and a refinance.

However, there were enough exceptions to the moratorium that serial refinances didn't stop, and once the six-month mark passed, Bright said Ginnie saw a new blitz of lenders preying on servicemembers. In the letter to Warren, Bright said that some lenders apparently targeted veterans for a refinance at "six months and one day."

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2.17 - KUPR (NPR-89.3): [Landmark Vietnam War Series May Trigger Unwanted Memories For Some Vets](#) (14 September, Steve Walsh, 17k online visitors/mo; Fresno, CA)

Starting Sunday, PBS stations around the country begin airing a 10-part series on the Vietnam War produced by Ken Burns and Lynn Novick. Many veterans will be watching. Others say they definitely will not watch because they want to avoid the traumatic memories that could be triggered.

"The Vietnam War" is being billed as a rare cultural milestone, at least for veterans of the war. The filmmakers have been planning the documentary series since 2006 -- meaning their production process has been about as long as the war itself, from the Gulf of Tonkin Resolution in 1964 to the Fall of Saigon in 1975.

The series may be too intense for some Vietnam vets, according to Henry Peterson, a chaplain with the Veterans Affairs hospital in San Diego. He counsels veterans with post traumatic stress disorder, PTSD, and he surveyed some of them to find out who will be watching. He said many of his clients will not.

"It could bring up some memories that they don't want to deal with," Peterson said. "It could bring up some memories they may need to deal with."

Almost anything can trigger the vivid and aggressive thoughts associated with PTSD. It might be a door slam or the smell of diesel, according to Tina Mayes, a staff psychologist at VA San Diego Healthcare.

Most common triggers

"It can be something someone says. The way they say it," she said.

News, films and documentaries are among the most common triggers.

"I would say the majority of veterans that I work with when their symptoms are high, they're actively avoiding any media," she said.

Vietnam vets are particularly vulnerable. Most of them were not treated early. The PTSD treatment evolved after this group of vets had returned from the war. In the 1970s, the VA was often unwelcoming. Society in general appeared, at best, uninterested in the plight of returning vets. Older Vietnam vets, in particular, have among the highest rate of suicide.

"Honestly, we don't know why, but some of the research suggests that it was because of the way they were received when they came back," Mayes said.

'It affects everyone'

This group of vets can end up living for decades with the symptoms of untreated PTSD, including feelings of aggression that seem to emerge from nowhere, said Larry Taylor, a combat veteran of Vietnam.

"It affects everyone," Taylor said. "I would say my own wife experienced PTSD just from her relationship with me and the war I fought in."

Before Taylor was treated, he coped by avoiding his triggers. He did not watch movies like "Apocalypse Now" or "The Deer Hunter," but he ran into trouble when news coverage of the original Gulf War blanketed TV. As the war raged, so did Taylor's symptoms.

"Basically, after the Gulf War, my PTSD kicked in," Taylor said. "I would wake up screaming. My wife would wonder what's going on. I was having nightmares all the time, during the daytime."

Find a loved one to watch it with you

Still, Taylor did not seek treatment for another decade. He is now the lead mental health chaplain at VA San Diego. He plans to watch the 18-hour-long documentary.

"I think today I know the difference between a bad memory and reliving a situation," he said. "Fortunately, I'm not reliving things the way I once did."

Taylor is counseling other Vietnam veterans that they should not feel obligated to watch the documentary. If they do watch, he advises them to find a loved one to watch it with you. Taylor is enlisting his wife of 46 years.

In the past, the VA has provided outreach around movies like "Saving Private Ryan" for vets who may be triggered by what they are seeing. This time the VA is partnering with PBS, preparing to provide counseling to any vets who feel it is time to start working through their own experience with the war.

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2.18 - Law Firm Newswire: [VA Fires Head of DC Facility Amid Confidentiality Breach, Leadership Concerns Says Veterans Attorney Jim Fausone](#) (14 September, 900 online visitors/day; Tampa, FL)

Northville, MI (Law Firm Newswire) September 14, 2017 - The Department of Veterans Affairs (VA) fired the longtime director of its main veterans medical center in Washington, D.C.

Brian Hawkins was dismissed due to growing concerns about his leadership of the VA facility. The VA released a statement saying "he failed to provide effective leadership." Hawkins was reassigned to a different post within the agency in April pending further review. Retired Army Col. Lawrence Connell has served as the hospital's acting director since then.

"The disciplinary action taken against Brian Hawkins reiterates the fact that the VA is now more committed to enhancing accountability in the department," commented Jim Fausone, a Michigan veterans attorney. "Both VA employees and leaders should face the appropriate consequences if they put veterans at the risk of harm and are not aligned with the VA's mission."

Hawkins' departure followed several months of investigations by the VA Office of Inspector General. Audits found evidence of mismanagement at the facility. The hospital's patients were endangered by poor inventory practices and organizational dysfunction.

The VA Inspector General Michael J. Missal released the findings of an internal probe in April. His report documented "the highest levels of chaos" at the Washington, D.C. medical center, including large-scale medical supply shortages and unsanitary conditions in equipment storage areas.

The VA had an even bigger cause for concern when its internal watchdog made public another report in June. It revealed that Hawkins had emailed "sensitive" information about administrative decisions and VA staff to his wife's personal account. She is not a VA employee. According to the report, the emails were a breach of the department's rules on data confidentiality.

Hawkins was fired after the inspector general's office recommended new disciplinary action be taken against him. Missal was unable to prove separate accusations of Hawkins trying to obstruct an investigation into staff bonuses that he authorized "without proper justification." The report, however, said his employees delayed providing certain documents related to the probe.

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3. Access to Healthcare

3.1 - ABC News (AP): [The Latest: Hurricane cleanup crew finds body near hotel](#) (14 September, 24.1M online visitors/mo; New York, NY)

The Latest on Hurricane Irma (all times local):

[...]

2:50 p.m.

Federal officials say that nursing homes normally reserved for veterans will be opened up to non-veteran nursing home residents if space is available, in the aftermath of Hurricane Irma.

U.S. Sen. Bill Nelson announced Thursday that the U.S. Department of Veterans Affairs had agreed to open its nursing homes following eight deaths at Florida nursing home. Florida has seven nursing homes throughout the state that are available to residents who were veterans.

Multiple nursing homes and assisted living centers in Florida have evacuated their residents after losing electric power.

U.S. Secretary of Veterans Affairs David Shulkin said in a statement that available beds will be offered to non-veterans, although the agency would continue to focus on its primary mission of assisting veterans.

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3.2 - The Huffington Post: [VA Broken Promise Harms Veteran and Costs Jobs](#) (14 September, Hal Donahue, 22.9M online visitors/mo; New York, NY)

Trusting the Department of Veterans Affairs and not seeking outside assistance can hurt veterans.

Meet Joe Stahurski. Experts like Joe made aviators like me miserable. Red Flag, the huge international aerial combat training exercises held by the Air Force, is deadly serious business. One of Joe's jobs was to ready aircrews for war. Just as Red Flag training became intense, radars maintained by Joe would come on line posing the latest enemy anti-aircraft threats. Our detection and threat systems were tones and lights. The threats Joe helped simulate lit up what we called 'oh sh*t' lights. Dire warnings at the best of times.

We cannot thank these people enough. Joe, and people like him, help US military aviators and aircrew of allied nations survive their first critical hours and days of combat. Mr. Stahurski is a disabled Army veteran who continues to serve. Following six years of military service, Joe's critical skills were put to use working for a military contractor both in Florida and then for 15 years at Tobyhanna Army Depot where his duties went far beyond Red Flag.

"Tobyhanna Army Depot is a recognized leader in providing World-Class Logistics Support for Command, Control, Communications, Computers, Intelligence, Surveillance and Reconnaissance (C4ISR) Systems across the Department of Defense..."

As this century's wars began to wind down, Mr. Stahurski expected that his job as a defense contractor would come to an end. Joe saved for that eventuality and when laid off last year, he sought help starting a disabled veteran owned business. A technical expert, Joe possessed little knowledge concerning how to actually start a business. He visited his local VA Veterans Rehabilitation Counselor and received a wealth of information and assistance to create a Service-Disabled Veteran-Owned Small Business(SDVOSB).

Mr. Stahurski was referred to the University of Scranton Small Business Development Center where he met Nicholas DeAntonio from the Defense Transition Partnership, a program designed specifically to help people just like Mr. Stahurski. Mr. DeAntonio provided expert guidance concerning the myriad requirements, applications and planning necessary to become a disabled veteran owned business. Everyone Joe contacted was eager to assist him from former fellow workers to potential clients eager to use his services.

Under the expert tutelage of Mr. DeAntonio, Joe spent countless hours developing business plans, sourcing equipment and identifying labor sources. By August, 2016, Mr. Stahurski was the proud owner of a fully certified Disabled Veteran Business, STS Delta Aerospace Corporation , and he was fielding calls from potential clients wanting his services. There was one snag. Joe was still waiting for his equipment. Stahurski had identified the equipment required and submitted the order to the VA for his promised equipment valued at approximately \$16,000.

Mr. Stahurski patiently waited, accepting delays while losing potential business on a steady basis. The promised equipment never arrived and by November, the VA was no longer returning his calls. Finally, in 2017, Joe received word that he could not be approved to receive his equipment until he completed additional paperwork. Seeking advice from local official and unofficial veteran resources, Mr. Stahurski appealed to Congressman Matt Cartwright, his local congressman, who summed up the Mr. Stahurski situation precisely:

"...Mr. Stahurski was approved for the program in August 2016 after presenting a well-developed 3-year business plan. However, after a February 2017 change in regulations, a 5-year business plan became a requirement. As a result of this change, Mr. Stahurski was unable to move forward with his business despite being previously approved under the program. Mr. Stahurski has not benefitted from the program as promised and has suffered significant financial harm. I firmly believe this is an egregious oversight on the part of the VA as Mr. Stahurski was previously approved prior to the rule change adopted earlier this year."

When asked what occurred, Mr. DeAntonio praised all the local people involved especially Mr. Stahurski but then said; "The VA moved the goal post". The VA agrees in a July letter to Congressman Cartwright:

"...The veteran's case at this time is still pending Self-Employment approval, because in 2017 VR&E guidelines have been updated for any case pending which has caused the Veterans' case to require new updated information for a business plan to be approved."

If taken to nearly any financial institution when complete, Mr. Stahurski's business plan would almost certainly have won a solid loan under favorable terms. Joe Stahurski met every requirement and was eagerly awaiting delivery of his equipment to begin hiring employees. Concern only developed when the VA stopped responding to his telephone calls toward the end

of 2016. If Mr. Stahurski made any mistake, it was trusting the VA and delaying to seek outside assistance. He is now receiving assistance.

Congressman Cartwright requested a meeting with VA officials in Washington to further discuss the program and Mr. Stahurski's situation. Following a request from Mr. Stahurski, Senator Robert Casey is now aggressively pursuing his complaint. While local veteran advocates have connected Mr. Stahurski to other disabled veteran businesses who may be able to assist him.

Mr. Stahurski wants to protect fellow veterans:

"No other veteran should have to go through what I have. Be aware of the challenges dealing with the VA and seek help when difficulties cannot be resolved. Your members of Congress are there for you; use them."

Mr. Stahurski deserves both to be made whole and to receive our thanks for speaking out.

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3.3 - Palm Beach Post: [VA offers beds to Florida nursing home residents affected by Irma](#) (14 September, Joe Capozzi, 3.8M online visitors/mo; West Palm Beach, FL)

The U.S. Department of Veterans Affairs is making beds available to non-veteran nursing home residents affected by Hurricane Irma.

U.S. Secretary of Veterans Affairs David Shulkin announced the plan after talking with Gov. Rick Scott and Sen. Bill Nelson late Wednesday. Those discussions took place after eight residents of a Florida nursing home died from what appears to be heat exposure likely caused by a power outage at their facility in Hollywood.

"We thank Governor Scott and Senator Nelson for involving VA and are grateful we can help our fellow citizens where we can in this time of need," Shulkin said.

VA can make its facilities available to non-veterans as part of its mission to support national, state and local emergency management, public health, safety and homeland security efforts.

Shulkin agreed to make more beds available to non-veteran nursing home residents as needed and free.

The VA also is working with the U.S. Department of Health and Human Services and the Federal Emergency Management Agency on the overall response to Irma.

"We will continue to look for ways to relieve the hardship this powerful storm has caused," Shulkin said. "Much of the heavy-lifting to recover from the hurricane is still to come and our leaders and staff are determined to find as many ways as we can for VA to help in the response."

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3.4 - WJW (FOX-8, Video): [Presidential Opioid Commission praises, learns from Cleveland VA](#) (14 September, Bill Sheil, 665k online visitors/mo; Cleveland, OH)

Gov. Chris Christie of New Jersey, head of a Presidential Commission on opioids, summed it up well when addressing doctors and patients gathered at the Louis Stokes VA Center in Cleveland.

"We didn't come here by accident," he said.

Christie, and several prominent national figures, toured the VA Center on Thursday to learn more about a remarkable contradiction.

Even though the state of Ohio has the highest addiction rate in the nation, the Stokes Center in Cleveland has the lowest addiction rate across the nation in terms of VA hospitals treating patients.

So, how is that possible?

It started several years ago, when caregivers at the Stokes VA starting tackling the explosion in opiate addiction.

Basically, they looked for innovative ways to treat pain that involved fewer opiates, and they looked to monitor patients closely for signs of addiction, along with additional training for doctors about prescribing painkillers.

The Cleveland model has now been incorporated into a system-wide effort at the VA called

"STOP PAIN."

"One of my personal goals in working with the President...is to de-stigmatize the opiate addiction," said Kellyanne Conway, a counselor to President Trump.

Former Congressman Patrick Kennedy, a recovering addict, said the VA is on the forefront in treating mental illness and addiction together in their efforts to help many patients.

He also said addiction needs to be treated, and covered by insurance, like any other disease. The Secretary of Veterans Affairs, David Shulkin, also traveled to Cleveland with the group to see first-hand what has worked so well at the Stokes VA Center.

VA doctors here have reduced opioid prescribing by 25 percent in the past seven years. That's more than double the reduction seen nationwide, or elsewhere in the region at other health systems.

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3.5 - WOIO (CBS-19): [White House opioid commission turns to Cleveland VA for solutions](#) (14 September, Sara Goldenberg, 610k online visitors/mo; Cleveland, OH)

CLEVELAND HEIGHTS, OH (WOIO) - Northeast Ohio continues to struggle with opioid addiction and overdose deaths.

But there's a treatment program in our own backyard that's bucking the trend.

The VA Secretary and White House officials came to Cleveland on Thursday to learn more.

The Northeast Ohio VA Healthcare System has the lowest addiction rates across the VA.

They're creating alternatives to pain management, and officials hope some of what they're doing could become a national model to fight the opioid epidemic.

Governor Chris Christie of New Jersey heads President Trump's opioid commission.

Christie toured the Louis Stokes Cleveland VA Medical Center along with VA Secretary David Shulkin, Kellyanne Conway and former Congressman Patrick Kennedy Thursday morning.

"We didn't come here by accident, we didn't pick you out of a hat. We came here because this facility has the reputation for being a model," Christie said.

"The only way we're going to stop the suffering and death is to change the culture around the way we manage pain in this country. And the model here is extraordinary, both in terms of its breadth and its effectiveness," Christie said.

Only four percent of veterans who receive care at this VA are prescribed opioids.

The VA says that's well below the national average.

The VA healthcare system in Cleveland has reduced opioid prescriptions by nearly 25 percent since 2010.

The VA says other healthcare providers in the area have reduced prescriptions by only 10 percent.

Officials are looking at the best practices used here, focusing on pain treatment alternatives like physical therapy, even acupuncture and yoga.

Patrick Kennedy, the son of Ted Kennedy, is a recovering opioid addict himself.

"We want the same urgency of care that you would provide for any other disease someone could be afflicted with, end of story," Kennedy said.

Kennedy hopes what they're doing here can be used everywhere.

"We can save people. I've been able to get access to continuity of care, I shouldn't be the only one in this country," Kennedy said.

The opioid commission plans to have a final report with recommendations ready for the President on November 1st.

Officials say they need to take more steps before declaring a national emergency to fight the epidemic.

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3.6 - WIBW (CBS-13): [VA opening new Veterans Crisis Line in Topeka; expects to hire 100](#)
(14 September, Nick Viviani, 485k online visitors/mo; Topeka, KS)

Topeka will be the home of the Dept. of Veterans Affairs' newest Veterans Crisis Line call center.

On Wednesday, the VA officially announced it would open the new crisis line, its third one nationwide, in the Capital City. The new call center is expected to employ 100 people and will be housed in the VA Eastern Kansas Health Care System.

"When it comes to preventing Veteran suicide, we will do everything we can to make it as easy as possible for Veterans to reach us," said VA Secretary Dr. David J. Shulkin. "The new center in Topeka gives us more feet on the ground and an easier way for Veterans to connect with us when they need us most."

The VA says the call center should open this fall. VCL currently operates two centers in Canandaigua, New York, and Atlanta, Georgia.

More information about the openings and how to apply are available here. The VA says the positions are open to applicants with prior comparable experience or a master's degree in a health science, such as mental health, social work, or psychology. The agency held a job fair as well last Friday prior to the announcement of the new facility.

Having a third location will offer the VA more capacity as it expands the "Press 7" automatic transfer function for its Community-based Outpatient Clinics (CBOCs) and Vet Centers. Press 7 offers callers to VA Medical Centers immediate access to the crisis line from a main phone tree.

Right now, the CBOC and Vet Center do not have that option and veterans have to take the extra steps of calling 800-273-8255 and pressing 1, the VA explained.

According to numbers from the agency, the VCL has answered more than three million calls since it launched in 2007 and dispatched emergency services for callers in imminent crisis more than 84,000 times. Chat was launched two years later, in 2009, and text services came two years after that and, in that time, the VCL had answered nearly 359,000 and nearly 78,000 requests for chat and text services respectively.

Veterans in crisis can call the Veterans Crisis Line for confidential support 24 hours a day, seven days a week, 365 days a year at 800-273-8255 and Press 1, chat online at VeteransCrisisLine.net/Chat or text to 838255.

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3.7 - Poughkeepsie Journal (Video): [Hudson River Housing lose federal funding for homeless veteran program](#) (14 September, Jack Howland, 440k online visitors/mo; Poughkeepsie, NY)

Homeless veterans and their families might be losing support in a few weeks, if Hudson River Housing is forced to shut down a key program.

Hudson River Housing is facing losing its program serving homeless veteran families in Dutchess County by the end of September in the wake of the U.S. Department of Veteran Affairs denying the group an annual grant, the nonprofit said Thursday.

The Support Services for Veteran Families grant - about \$500,000 - has been awarded to Hudson River Housing since 2012, and has been the sole source of funding its program for those who are homeless or lack secure housing and their families. Hudson River Housing Executive Director Christa Hines said the VA informed the organization that its funding renewal application was rejected in a letter received Sept. 7.

The 2017 funding of \$516,145 provided by the VA is set to run out Sept. 30.

This annual federal grant, Hines said, has been the organization's second-largest source of funding and it's only funding specifically for veterans.

"We have 30 open cases of homeless veteran families we're currently servicing, and in two weeks we could not be able to serve them," she said. "We're beyond concerned."

A spokesperson for the VA could not be reached by deadline.

Hudson River Housing, which began in 1984, has provided outreach services for Dutchess County's homeless population and those who are at-risk, but the SSVF specifically targets veterans.

Since 2012, the program has served more than 458 homeless or at-risk veteran families, providing services like housing location, rental assistance, financial planning, employment assistance and transportation. The organization takes on roughly 10 new cases each month.

Hines said the SSVF grant funds five-full time employees, two of them veterans, as well as an office space on North Clinton Street.

Hudson River Housing President Dan Hubbel said the organization is working on a plan as to "how we can continue that funding and continue the service.

"If the VA wants to renege on our commitment on veterans, Hudson River Housing isn't doing that," he said. "We made a commitment in 2012 and we want to continue that commitment."

Dutchess County Executive Marc Molinaro said the county, with Hudson River Housing, will send a request to the VA to extend the funding for 12 more months. This, he said, would keep the program running and allow the organization to eventually "transition to perhaps some other federally funded program or something that allows us to continue to make the progress we've been making.

“Dutchess has made significant progress with Hudson River Housing in driving down the total number of veterans who are struggling to find housing or are homeless, and the action by the VA to not continue the program — it’s absurd,” Molinaro said. “What is most egregious is to have received notice only three weeks before Hudson River Housing would have to fire their employees and shutter the program.”

He said there’s bipartisan support for continued funding from U.S. Sen. Charles Schumer, State Sen. Sue Serino, R-Hyde Park, and Reps. John Faso, R-Kinderhook, and Sean Patrick Maloney, D-Cold Spring, all of whom spoke out opposing the action.

Maloney called the decision “heartless” in a statement and said the organization has been a “lifeline for hundreds of men and women who wore our country’s uniform and needed some help when they got home.”

In a statement, Schumer spokesman Jason Kaplan said: “This is deeply concerning about the wrongheaded decision by the VA to discontinue this vital funding so that Hudson River Housing can continue to do the great work they do to keep our at-risk veterans from becoming homeless. They have done outstanding work so it makes little sense to hinder their ability to deliver top-notch service to our veterans. ...our office is working closely with Rep. Maloney’s office and local officials to bring our concerns to the highest levels of the VA.”

Faso sent a letter Wednesday to John Kuhn, national director of the VA’s Support Services for Veteran Families, imploring him to “use the full resources at your disposal to support HRH, and more importantly the veterans who are now at risk of homelessness, in order to deliver the services they require.

“Dutchess County simply does not have the capacity to deal with this issue without an adequate funding stream,” Faso said in the letter, “because HRH is the only program providing direct housing and support services to local veterans and their families.”

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3.8 - Press of Atlantic City: [Veterans push for better health care, experts fight to provide it](#) (14 September, Nicole Leonard, 320k online visitors/mo; Pleasantville, NJ)

NORTHFIELD — Dozens of men and women squeezed together in a small conference room at the VA Outpatient Clinic in Northfield on a hot summer afternoon.

The crowd, the majority veterans in their 60s, 70s and 80s, looked ready for battle as they stood shoulder to shoulder, arms crossed and some prepared with notes as they faced off with local, state and regional officials from the U.S. Department of Veterans Affairs.

It wasn’t nearly as dangerous as the situations these veterans faced while serving in the military, but it ranked high in priority as most of the South Jersey veterans voiced their demands for better localized health care while VA experts expressed their desire to give it to them.

“We believe community care is sufficient,” said Vince Kane, director at the Wilmington VA Medical Center. “We have to get out of the medical centers and get closer to where the veterans

live. They can't all go through Wilmington. As an example, we're working in Cape May to relocate services to those people."

An estimated 355,766 veterans live in New Jersey, according to the VA. Some areas of the state have more than others, including Cape May County, where veterans make up nearly 9 percent of the population, one of the highest rates in the state.

Many of the veterans who get health care through the VA said they are generally happy with the quality of care they receive, as the VA has some of the most advanced medical technology and experts in the country.

The issues lie in the access and delivery of it, veterans said.

"There have been attempts at the county level to make medical care more accessible and affordable to veterans," said Frank Formica, Atlantic County freeholder chairman and an Air Force veteran. "It seems like there's been a trend in the country to pay more attention to local communities, but we don't have enough resources to execute those services."

Many veterans continue to champion the federal Veterans Choice Program, which allows veterans to use private providers outside VA clinics and hospitals to get care if they live more than 40 miles from a VA center or have to wait more than 30 days for a consultation.

Funding for the program was set to run out this summer, but President Donald Trump signed a bill last month that allocated an additional \$2.7 billion to keep it going.

Instead of having to travel long distances, sometimes on VA shuttles, veterans are able to go to local providers, with approval, for injury treatment, procedures and specialty care, but the service is complicated.

Veterans' concerns included not getting choice approval, long wait times for paperwork to go through and gaps in communication between an outside provider and the VA.

"I needed emergency spine surgery and used the choice program, which was great because I got one of the best spine surgeons in the country at Penn (Medicine)," said one veteran at the Northfield meeting. "Then I needed therapy, and funding ran out. It took five weeks to get re-approved for services that I needed immediately."

Frustration was felt by both the veterans and those who provide services in the region, as many VA officials said they want nothing more than to increase access to health care, bring more services to South Jersey clinics and reduce issues that have prevented veterans from getting care in a timely manner.

Federal regulations, rules and policies often limit the way in which they can make changes at the county level, VA officials said.

Another issue VA officials found was a lack of eligible veterans enrolling and using VA services for their physical and behavioral health needs. Among the 6,000 eligible veterans in Cape May County, fewer than half are enrolled and only 1,824 are actively using services, Kane said.

Kane said he and other VA officials need to identify how to increase participation, adding he is optimistic that changes coming down the pipeline will lead to better outcomes and satisfaction with services in South Jersey.

At the Cape May community-based outpatient clinic, officials hope to expand the physical footprint and increase the number and range of health care services at that location.

Jackie Hinker, U.S. Veteran Affairs Veteran Community Outreach Specialist, said veterans have been looking forward to an expansion “for the longest of time.”

In addition to the brick and mortar clinics, the VA runs mobile clinics that visit several sites through New Jersey every month to provide basic health care checks and tests. One such clinic regularly stops at Stockton University where William Richmann, 68, of Galloway Township gets his annual health visits.

As far as the choice program, Kane said the VA has established relationships with Shore Medical Center, Cape Regional Medical Center and Inspira Health Network, and is talking about working more with others like AtlantiCare and Bacharach Institute for Rehabilitation.

David Hughes, Shore Medical Center Chief Financial Officer, said the hospital has the ability and willingness to treat more veterans than it is currently limited to because of strict agreement contracts under the choice program.

“One of the things we’re working on is a program specifically for vets so that they can go to their local doctor and for us to provide services so that they don’t need to get on a bus for hours,” he said. “We will do whatever we need to for the needs of veterans.”

At the end of the day, both veterans and VA officials agreed they want better streamlined services, shorter wait times, increased accessibility to local care and the resources to establish and improve more programs.

Current plans for improvement are just the beginning, VA officials said.

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3.9 - WKRG (CBS-5): [VA Offers Beds For Hurricane Irma Victims In Florida Nursing Homes](#) (14 September, 272k online visitors/mo; Mobile, AL)

In a press release sent out Thursday by the Department of Veterans Affairs, the U.S. Secretary of Veterans Affairs David Shulkin announced that the VA is making beds available to non-Veteran nursing home residents affected by Hurricane Irma.

This announcement comes after the new reports Wednesday that eight residents of a Florida nursing home died from what appeared to be heat exposure, likely caused by faulty air conditioning at their facility in Hollywood Hills.

Secretary Shulkin has been working with Florida Governor Rick Scott and Senator Bill Nelson and their staffs on this issue since Wednesday evening.

"We thank Governor Scott and Senator Nelson for involving VA and are grateful we can help our fellow citizens where we can in this time of need," said Shulkin. "All Americans are pulling together to help one another, and we must make a special effort for those most vulnerable to the conditions brought on by the storm."

VA has the ability to make its facilities available to non-Veterans as part of its fourth mission to support national, state and local emergency management, public health, safety and homeland security efforts and also through a mission agreement with FEMA under a Stafford Act Declaration.

Secretary Shulkin agreed to make more beds available to non-Veteran nursing home residents as needed and free, while ensuring they continue the primary mission of providing healthcare to Veterans.

The VA is also working closely with the U.S. Department of Health and Human Services and the Federal Emergency Management Agency on the overall response to Irma, in addition to this specific issue.

"We will continue to look for ways to relieve the hardship this powerful storm has caused," said Shulkin. "Much of the heavy-lifting to recover from the hurricane is still to come and our leaders and staff are determined to find as many ways as we can for VA to help in the response."

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3.10 - WUSF Public Media: [VA Secretary Offers Beds To Nursing Home Patients Affected By Irma](#) (14 September, Bobbie O'Brien, 197k online visitors/mo; Tampa, FL)

The tragic deaths of eight nursing home residents after Irma knocked out their air conditioning has prompted the U.S. Secretary of Veterans Affairs to offer up available beds at Florida's VA nursing homes.

The Florida Department of Veterans Affairs operates six nursing homes for veterans built with federal and state money.

Dr. David Shulkin, U.S. Secretary of Veterans Affairs, said that part of the VA's mission is to support emergency management and public health which allows them to open up to non-veterans impacted by Hurricane Irma.

In a news release, Shulkin said he was working with Gov. Rick Scott and U.S. Sen. Bill Nelson to help nursing home residents.

"All Americans are pulling together to help one another, and we must make a special effort for those most vulnerable to the conditions brought on by the storm," Shulkin said.

But Shulkin emphasized that veterans remain their primary mission and the circumstances will not change that.

Five of Florida's veterans' homes lost power during the hurricane, but a state spokesman said all the homes had backup generators and have since had power restored.

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3.11 - KSNT (NBC-27): [VA opening Veterans Crisis Line in Topeka – expected to hire 100 people](#) (14 September, Grant Stephens, 161k online visitors/mo; Topeka, KS)

The U.S. Veterans Administration is opening it's third Veterans Crisis Line call center in Topeka. It's expected to hire 100 employees.

"When it comes to preventing Veteran suicide, we will do everything we can to make it as easy as possible for Veterans to reach us," said VA secretary Dr. David J. Shulkin. "The new center in Topeka gives us more feet on the ground and an easier way for Veterans to connect with us when they need us most."

The VA already has two call centers, one in upstate New York, and one in Atlanta, Georgia. The VA says the Topeka call center will be located on the VA campus and is expected to open in the fall.

The new center will bring the total number of crisis line responders to 610.

The agency says that since its launch in 2007, the VCL has answered more than 3 million calls. Since launching chat in 2009 and text services in November 2011, the VCL has answered nearly 359,000 and nearly 78,000 requests for chat and text services.

Veterans in crisis can call the Veterans Crisis Line for confidential support 24 hours a day, seven days a week, 365 days a year at 800-273-8255 and Press 1, chat online at VeteransCrisisLine.net/Chat or text to 838255.

For more information or to apply for openings at the new call center, visit www.usajobs.gov/GetJob/ViewDetails/478700400 or www.usajobs.gov and search for announcement No. 10046052.

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3.12 - Florida Politics: [VA hospitals to take in nursing home residents, Bill Nelson says](#) (14 September, Scott Powers, 161k online visitors/mo; Saint Petersburg, FL)

The U.S. Department of Veterans Affairs will make beds in VA facilities available to residents of Florida nursing homes that have no power, Sen. Bill Nelson said Thursday.

Nelson said he saw that the VA had done so with refugees from the U.S. Virgin Islands, accepting them into the VA hospital at Puerto Rico, and asked them Wednesday, before news of the horrific six-death incident in Hollywood, if the same could be done in Florida.

"I called the VA secretary [David Shulkin] yesterday," Nelson said. "He said, 'Absolutely!' He said, 'You have my authority to make that happen.'"

Nelson said he's now working with an assistant secretary to get it done.

Nelson said he is not certain how many beds might be available in Florida's VA facilities.

The VA issued a release Thursday saying that Shulkin has been working with both Florida Gov. Rick Scott and Nelson and their staffs on this issue beginning yesterday evening.

"We thank Governor Scott and Senator Nelson for involving VA and are grateful we can help our fellow citizens where we can in this time of need," Shulkin stated in the release. "All Americans are pulling together to help one another, and we must make a special effort for those most vulnerable to the conditions brought on by the storm."

The VA has the ability to make its facilities available to non-veterans as part of its fourth mission, to support national, state and local emergency management, public health, safety and homeland security efforts and also through a mission agreement with FEMA under a Stafford Act Declaration.

Shulkin agreed to make more beds available to non-veteran nursing home residents as needed and free, while ensuring we continue our primary mission of providing healthcare to Veterans, the release stated.

The VA is also working closely with the U.S. Department of Health and Human Services and the Federal Emergency Management Agency on the overall response to Irma, in addition to this specific issue.

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3.13 - ideastream.org (Audio): [Cleveland VA Gets National Recognition](#) (13 September, Stephanie Jarvis, 145k online visitors/mo; Cleveland, OH)

As the battle against the opioid epidemic rages on, a local program to manage opioid addiction among some of our region's most at-risk patients is gaining national recognition.

Of all the veteran's hospitals in the country, the Northeast Ohio VA Healthcare System is being recognized for its innovative program to cut down on opioid prescriptions and addiction among the veterans it serves – at a time Ohio sits at the epicenter of the opioid crisis. Thursday, the Secretary of Veterans Affairs, along with New Jersey Governor Chris Christie - who heads up the White House Opioid Task Force, will travel to Cleveland to learn more about the VA's program.

To help us understand how the program is helping our region's veterans steer clear of pain pills -- and how it may be a model for other health systems, ideastream's Kay Colby spoke with Dr. Ali Mchaourab, the head of the pain management program at the Cleveland VA.

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3.14 - ideastream.org (Video/Audio): [President's Opioid Task Force Learns Best Practices from Cleveland VA](#) (14 September, Annie Wu, 145k online visitors/mo; Cleveland, OH)

The U.S. Secretary of Veterans Affairs joined President Trump's opioid task force at the Cleveland VA Medical Center on Thursday. They were in town to hear from VA doctors on their best practices for pain management and opioid use including guidelines for prescribing opioids, alternative medicine for dealing with pain, and a continuum of care for opioid addiction.

Nationally, the VA has been using these practices since 2013. Locally, the VA began even earlier and Secretary of Veterans Affairs Dr. David Shulkin says Cleveland is showing strong results.

"Just 4 percent of the patient population they serve are using and being prescribed opioids, which is well, well below what you would find across the country."

At a roundtable discussion that included President Trump's advisor Kellyanne Conway, the VA shared some of its practices to address pain, including the use of alternative treatments such as acupuncture, yoga and meditation.

"In not all cases must pain management mean pain medicine. There are opioids and there are other modalities. And we saw that first hand here. To read about it is one thing. To intuit as a lay person is quite another. But to see it in practice is quite remarkable and something I will take back to the White House and really never forget."

The opioid task force will issue its report on November first.

The group's chairman—New Jersey Governor Chris Christie says his group is working with the White House to designate the opioid epidemic a national emergency.

"The president is getting advice from his staff and from lawyers on the best way to do that, and I'm confident that in the very near future he will execute the documents that need to be executed for us to be able to do that. But the biggest problem would be is if we did it in a way that was haphazard and less effective and have to go back and redo it."

President Trump said in August he intended to make the national emergency declaration—opening up federal funds to address the problem—but he has yet to do so.

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3.15 - KIII (ABC-3, Video): [VA Outpatient Clinic closed due to damage from Harvey](#) (14 September, 65k online visitors/mo; Corpus Christi, TX)

Among the facilities that suffered significant damage in Hurricane Harvey was the Corpus Christi Veteran's Affairs Outpatient Clinic.

The building suffered water damage and beginning Monday, veterans who normally receive primary care services at the clinic will be treated at the Corpus Christi Specialty Outpatient Clinic on Enterprise Parkway or the Patient Aligned Care Team Annex Building, which is near the VA's outpatient clinic.

It is expected to take about 130 days to make repairs to the VA building.

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3.16 - KXXV (ABC-25, Video): [Reminding veterans of local services this Suicide Prevention Week](#) (13 September, Holly Stouffer, 54k online visitors/mo; Waco, TX)

It's Suicide Prevention Week and a local veterans affairs center is making sure the veteran community knows of the resources available to them.

According to the Department of Veterans Affairs, an average of 20 veterans die by suicide each day.

The Waco VA offers a number of resources to help those struggling with their mental health, including its Center of Excellence, which focuses on researching the events that lead up to suicidal thoughts.

"The classic one certainly is a major depressive disorder, but even minor feelings of depression," said Dr. Richard Seim, a clinical psychologist at the Center of Excellence. "PTSD, traumatic brain injury, symptoms of military sexual trauma or even just kind of life issues like marital problems or family functioning issues."

Dr. Seim said this type of research allows them to better serve veterans who could use additional treatment after going through traditional therapy.

"One of the studies we've been running for the last seven years now is tracking veterans as they come back from recent wars in Iraq and Afghanistan and looking at those symptoms of PTSD, traumatic brain injury and so forth to see how they change over time," said Dr. Seim.

Dr. Seim said the Center of Excellence is also about to open a new clinic. It will involve using magnetic waves to stimulate the brain, which will help to alleviate symptoms of depression.

If you know a veteran struggling with depression, call the Veterans Crisis Line at 1-800-273-8255.

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3.17 - WEWS (ABC-5, Video): [White House Opioid Task Force looks for answers to crisis in Cleveland](#) (13 September, Mona Kosar, 17k online visitors/mo; Cleveland, OH)

With the opioid epidemic considered a national emergency, News 5 has learned the answer to this scourge may be here in Cleveland. The president's opioid task force is coming here to look for some answers.

Behind the wall of the Louis Stokes Cleveland VA Medical Center lies a possible solution to a national crisis. “I think the lessons we have learned can be duplicated in the private sector,” said Medical Director Susan Fuehrer.

Those lessons started a decade ago when the center began addressing the over-prescription of addictive opioids with other alternatives such as yoga and physical therapy.

“Rather than just prescribe opioids to manage pain they have been working on evidence based management and alternative therapy,” Fuehrer said.

From 2008 to 2015, the center saw a 50% reduction in the prescription of opioids. Even at the height of the epidemic, the center was recognized for its reduction. “There have been lots of ways that we have been identified as a best practice within the VA health care system,” said Fuehrer.

Their practices haven’t gone unnoticed in Washington either. When it came time for the newly formed white house opioid task force to seek a solution, they pinpointed The Louis Stokes Center.

“They will be meeting with multi disciplinary people and they are going to speak to a veteran or two who have recovered from opioid addiction,” said Fuehrer.

Fuehrer says this is an opportunity for their work to have a national impact.

“If one or two things make a difference for one or two people outside the VA community, then we will call tomorrow a success,” Fuehrer said.

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3.18 - Missoula Current: [Tester urges VA to move quicker in opening new Missoula health clinic](#) (14 September, Martin Kidston, 17k online visitors/mo; Missoula, MT)

President Donald Trump signed Sen. Jon Tester’s bill securing a lease for a larger Veterans Affairs clinic in Missoula on the first day of August, marking a positive step for a facility that’s long been in need of expansion.

Now, the state’s senior senator is asking the VA to expedite the process.

Tester this week sent a letter to VA Secretary David Shulkin asking the agency to move the process forward, saying the region’s demand for VA care is projected to increase 43 percent over the next 20 years.

While it traditionally takes the VA as long as five years to open a new clinic once authorization is given, Tester said the Missoula facility is needed sooner rather than later.

“To the greatest extent possible, I urge the department to expedite the process for leasing the recently authorized replacement of the outpatient clinic in Missoula in order to better meet current and future patient demand,” Tester wrote. “I urge the VA to move with all due speed to procure this facility.”

Trump signed Tester's VA Choice and Quality Employment Act in August, which included the leasing authority allowing the VA to secure a larger facility in Missoula.

The authorization will nearly triple the clinic's size, providing additional parking, clinical space and the medical services needed to meet the growing demand for VA care in Missoula, the state's second largest city.

Tester's communications director, Marnee Banks, said the VA was authorized to pursue 28 major medical leases under the latest bill, including one in Missoula. The lease allows for a 60,000-square-foot facility with an estimated rent just under \$2 million a year.

"It will provide primary care, mental health, specialty care and some outpatient surgeries," Banks said. "The VA intends for the clinic to be located in the same general area as the existing clinic."

Banks said it often takes the VA about two years to develop the specific facility requirements once it begins working on the lease. Another year is needed to negotiate with developers prior to issuing a construction award.

That's followed by an additional two years to build the facility.

"The former Deputy (VA) Secretary (Sloan) Gibson had been working to bring this timeline down," Banks said. "The VA will need to obtain a delegation of authority from GSA to award the Missoula clinic lease."

The effort to secure a larger Missoula clinic dates back to at least 2014 when Tester began pushing the VA to expand the facility. Back then, a VA consulting team had toured the small clinic and recommended a modest expansion.

Nearly a year later, the General Services Administration began studying the possibility of converting the vacant Federal Building in downtown Missoula to a new outpatient clinic. That effort was later deemed cost prohibitive, leaving the clinic's future in limbo.

At the same time, the VA fell into controversy, resulting in the resignation of then-VA Secretary Erick Shinkseki, who was replaced by Robert McDonald and later by Shulkin, who now heads the agency under the Trump administration.

The Montana Department of Veterans Affairs and its own health care system has also seen a parade of new leaders, including Christine Gregory, Johnny Ginnity and Kathy Berger, who took the agency's helm in late 2016 and pledged changes to the system.

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8.1 - Dayton Daily News: [Lawmakers pushing for Columbus to get national veterans museum \(14 September, Jessica Wehrman, 1.1M online visitors/mo; Dayton, OH\)](#)

WASHINGTON - To hear Reps. Joyce Beatty and Steve Stivers tell it, Columbus is an ideal place to host the National Veterans Memorial and Museum.

The state, they said hosts the 6th largest veterans population in the U.S. If that's not enough, it's within an eight-hour car ride of almost half of the nation's veterans.

Speaking before a House panel Wednesday, Stivers and Beatty argued that a memorial to the nation's veterans was long overdue — and that Columbus was all too happy to change that. The site, argued Stivers, “will serve as a civic landmark to honor, inspire and educate all Americans about the service and sacrifice of more than 22 million veterans in this country.”

Under construction and scheduled to open next summer, the site started as a replacement for Columbus' previous veterans memorial and then blossomed into something far more sweeping and ambitious, said Stivers. Now, he, Beatty and Rep. Pat Tiberi, R-Genoa Township are pushing a bill that would designate it a national museum.

It wouldn't be the state's only museum honoring the armed services or those who have served: Roughly an hour's drive away, Dayton hosts the National Museum of the United States Air Force.

During a hearing on the bill Wednesday, Matthew Sullivan, deputy undersecretary for finance and planning and CFO for the National Cemetery Administration for the Department of Veterans Affairs, said the department neither supported nor opposed locating the museum in Columbus. “VA respectfully expresses no view on the proposed bill, which does not apply to VA or to VA's core mission,” he testified.

But Alex Zhang, assistant director of National Veterans Affairs and Rehabilitation for the American Legion, said his organization backs the bill. He said the bill would “represent American veterans with profound respect, connecting them with the civilian population, possibly inspiring others to serve and most importantly, educating youth about what these fine men and women have done for America.”

The organization, he said, “wholeheartedly supports” the “beautiful, thoughtful” memorial's designation, he said.

Veterans of Foreign Wars also backed the legislation, with John Towles, deputy director of national legislative service for the organization, telling the House Veterans Affairs Committee's subcommittee on Disability Assistance and Memorial Affairs "our country currently lacks a museum specifically dedicated to honoring and preserving the collective sacrifices made by this nation's veterans."

"This museum would serve to fill that gap," he said.

Groundbreaking for the 50,000 square foot museum and memorial began in 2015, and more than \$75 million was raised for design and construction. It's located at 300 West Broad St. in Columbus, site of the former Franklin County Veterans Memorial.

The entire Ohio congressional delegation is cosponsoring the bill, and Stivers said he hopes to tuck it into a larger legislative package in the months ahead. Sens. Sherrod Brown, D-Ohio, and Rob Portman, R-Ohio, are working on a similar measure in the Senate.

Beatty said the museum was in part the brainchild of former Ohio Sen. John Glenn, who died last year.

"If he were here today, he would highlight this museum and memorial," she said. "He would talk about the 300 foot reflecting pool. He would talk about the memorial wall. He would talk about the sanctuary where veterans families and others could go.

"It's a tremendous idea," she told the panel. "And we ask for your support."

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From: (b) (6)

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Subject: [EXTERNAL] 4 October Veterans Affairs Media Summary and News Clips

Date: Wed Oct 04 2017 04:16:11 CDT

Attachments: 171004_Veterans Affairs Media Summary and News Clips.docx
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Good morning,

Please find the attached Veterans Affairs Media Summary and News Clips.

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Veterans Affairs Media Summary and News Clips

4 October 2017

[1. Top Stories](#)

1.1 - The Washington Post (AP): [VA watchdog reviewing Shulkin's 10-day trip to Europe](#)

(3 October, Hope Yen, 43.9M online visitors/mo; Washington, DC)

The Veterans Affairs Department's watchdog said Tuesday it is reviewing Secretary David Shulkin's 10-day trip to Europe with his wife that mixed business meetings with sightseeing. Shulkin disclosed last week he traveled to Denmark and England to discuss veterans' health issues. Travel records released by VA show four days of the trip were spent on personal activities, including attending a Wimbledon tennis match and a cruise on the Thames River.

[Hyperlink to Above](#)

1.2 - FOX News: [Hurricane Maria: VA in Puerto Rico still trying to reach more than 500 homebound vets](#)

(3 October, Tori Richards, 32.5M online visitors/mo; New York, NY)

Nearly two weeks after Hurricane Maria roared through Puerto Rico, destroying much of the island's infrastructure, more than 500 homebound at-risk veterans still haven't been reached by doctors, nurses and social workers, Fox News has learned. There are 1,687 homebound vets in Puerto Rico who require ongoing treatment such as dialysis, chemotherapy and insulin to survive.

[Hyperlink to Above](#)

1.3 - CNN (Video): [VA Secretary David Shulkin under review for work trip to Europe](#)

(3 October, Miranda Green, Rene March, and Gregory Wallace, 29.7M online visitors/mo; Atlanta, GA)

The VA's inspector general is reviewing Veterans Affairs Secretary David Shulkin's July business trip to London and Denmark, which included meetings with Danish and UK officials as well as a stop at Wimbledon. It's now the fifth investigation into a member of the Trump administration's travel by a department inspector general.

[Hyperlink to Above](#)

1.4 - CBS News: [Veterans Affairs inspector general is reviewing David Shulkin's Europe trip](#)

(3 October, Jacqueline Alemany, 26.1M online visitors/mo; New York, NY)

The Department of Veterans Affairs inspector general is reviewing Secretary David Shulkin's 10-day taxpayer-funded trip to Europe in July, during which Shulkin and his wife spent time shopping and sightseeing in Denmark and the U.K. A spokesman for the VA's Office of Inspector General told CBS News on Tuesday that it is "gathering information and reviewing the recent trip."

[Hyperlink to Above](#)

1.5 - Military Times: [VA names Elizabeth Dole to head caregivers advisory group](#)

(3 October, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

Veterans Affairs officials on Monday announced former North Carolina Sen. Elizabeth Dole will chair the department's new family and caregiver advisory committee, formed in response to problems with support programs earlier this year. The committee, which features a mix of veterans and military caregivers, is charged with advocating for improvements to VA care and benefits services. In a statement, Dole called the work "critical" for the veterans community.

[Hyperlink to Above](#)

1.6 - KARE (NBC-11, Video): [VA apologizes to Vietnam vet for ER denial - The Department Of Veterans Affairs has apologized to a Vietnam veteran for repeatedly denying his claim for medical care after KARE 11 reported his story as part of its continuing investigation – a pattern of denial.](#) (3 October, A.J. Lagoe and Steven Eckert, 1.5M online visitors/mo; Golden Valley, MN)

Rocky's story of wrongful denial began this past July when he needed emergency surgery to remove a large kidney stone. "The pain just got to be excruciating," Rocky said. "So, I called VA nurses hotline and asked them what I should do, and they said to go to the nearest facility which was St. John's Hospital in Maplewood."

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1.7 - WFED (AM-1500, Audio): [Advancing the VA's Community Care Mission: A conversation with Baligh Yehia, Deputy Under Secretary for Health](#) (3 October, 831k online visitors/mo; Washington, DC)

What is the mission of VA's Office of Community Care? How is VA enhancing how it provides Community Care? What can VA do better? Join host Michael Keegan as he explores these questions & more with Baligh Yehia, Deputy Under Secretary for Health for Community Care at the US Department of Veterans Affairs.

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[2. Veteran and Employee Experience](#)

2.1 - The Hill: [VA chief under investigation over European trip: report](#) (3 October, Jacqueline Thomsen, 11.8M online visitors/mo; Washington, DC)

The Department of Veteran Affairs inspector general is investigating Veteran Affairs Secretary David Shulkin over his trip to Europe, CNN reported Tuesday. Shulkin traveled to London and Denmark in July, where he met with officials from both countries. Michael Nacincik, spokesman for the VA inspector general's office, told CNN that he couldn't say what triggered the probe or if the office was investigating any other instances of Shulkin's travel.

[Hyperlink to Above](#)

2.2 - Fortune: [Trump's VA Secretary Is the Fourth Cabinet Member to be Caught in a Travel Expense Scandal](#) (3 October, John Patrick Pullen, 7.7M online visitors/mo; New York, NY)

Overshadowed by Health and Human Services Secretary Tom Price's resignation Friday afternoon, Veterans Affairs chief David Shulkin is the latest Trump cabinet member to be found mixing personal trips and expenses with government travel. The VA secretary cruised the Thames, took in sight-seeing at Westminster Abbey, and watched a Wimbledon tennis match during a 10-day European trip with his wife, according to an itinerary obtained by The Washington Post.

[Hyperlink to Above](#)

2.3 - Washington Examiner: [VA watchdog launches probe of David Shulkin's 10-day European trip](#) (3 October, Gabby Morrongiello, 4.8M online visitors/mo; Washington, DC)

The Department of Veterans Affairs' internal watchdog has launched an investigation into a 10-day, taxpayer-funded trip taken by Secretary David Shulkin and his wife earlier this summer. Shulkin came under fire last week for the July vacation to Denmark and the U.K., during which he and his wife attended a Wimbledon tennis match, and went shopping and sightseeing.

[Hyperlink to Above](#)

2.4 - WXIN (FOX-59, Video): [Veterans voice concerns, outline legislative agenda items at town hall](#) (3 October, Haley Bull, 1.5M online visitors/mo; Indianapolis, IN)

Veterans are making sure their voices are heard by state lawmakers and local government officials during a series of town hall meetings across the state. Tuesday, veterans at a meeting in Carmel raised their concerns and outlined their legislative agenda items for the upcoming legislative session. "It's really important for the legislators to hear our concerns we have many healthcare being right at the top of the list..."

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2.5 - Fayetteville Observer: [NC congressmen, VA leaders meet in Washington](#) (3 October, Drew Brooks, 439k online visitors/mo; Fayetteville, NC)

Congress members from North Carolina met with Veterans Affairs leaders in Washington on Tuesday, hoping for better communication on problems in the VA system. Eight House members met with top officials from the VA's Mid-Atlantic Health Care Network, also known as Veterans Integrated Service Network 6, and the leaders from at least three VA medical centers, including Fayetteville's.

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2.6 - Michigan Radio Network: [Ann Arbor VA Hospital employees and vets protest staffing shortage](#) (3 October, Tracy Samilton, 385k online visitors/mo; Ann Arbor, MI)

Ann Arbor VA Hospital employees rallied Tuesday to ask Congress for enough money to eliminate the 49,000 VA job vacancies nationwide. Similar rallies have been held at other VA hospitals nationally in recent weeks. Ozzie James, Jr. is president of American Federation of Government Employees Local 2092. He says veterans need the expertise of VA doctors, nurses and other staff, because outside health care professionals don't fully understand veterans' needs.

[Hyperlink to Above](#)

2.7 - Outer Banks Sentinel: [VETERANS POST Will bad employees still linger at VA?](#) (4 October, 23k online visitors/mo; Nags Head, NC)

The Department of Veterans Affairs' new authority to get rid of bad employees is getting a test in Memphis. An employee at the Memphis VA Medical Center was arrested for aggravated assault with a deadly weapon and criminal impersonation of a police officer. Specifically, she pulled a revolver on a grandmother and a toddler, waving the gun and saying she was the police.

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2.8 - WSAW (CBS-7, Video): [Free benefits expo offered for area veterans](#) (3 October, 196k online visitors/mo; Wausau, WI)

In an effort to serve area veterans, a Wausau expo will offer free service members or dependents of veterans who want to gather information. The U.S. Department of Veterans

Affairs along with the Wausau Veterans Service Office are organizing the event on Thursday, October 5. To explain what will be offered, Veteran Service Officer, Scott Berger joined the Sunrise 7 team.

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3. Access to Healthcare

3.1 - The Hill: Congress can use the power of pets to help women and vets (3 October, Rep Steve Cohen (D-Tenn.) and Mike Bober, 11.8M online visitors/mo; Washington, DC)
Each year, Congress works hard to pass bills that will help the American people. While acrimony and partisanship have made this more difficult, lawmakers are considering two bills that have bipartisan support on Capitol Hill and among the American people: H.R. 2327 and H.R. 909, the Puppies Assisting Wounded Servicemembers (PAWS), and the Pets And Women Safety (PAWS) Acts of 2017.

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3.2 - Dayton Business Journal: Dayton VA moving clinic to new location (3 October, John Bush, 885k online visitors/mo; Dayton, OH)
The Dayton VA Medical Center is moving its Lima clinic to a larger location this spring. The Lima Community Based Outpatient Clinic, currently located at 1303 Bellefontaine Ave., will move to 750 W. High St. following renovations. The project will allow the VA to treat more veterans. The new clinic will be housed in a professional building on the campus of St. Rita's Medical Center. It is owned by Lima IV Medical Properties LLC...

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3.3 - Government Executive: How the VA Is Blocking Marijuana Research Veterans Say Could Save Lives (3 October, Eric Katz, 852k online visitors/mo; Washington, DC)
In 2010, Boone Cutler was taking 30 milligrams of morphine, 70 milligrams of oxycodone and other opioids each day. He regularly went three to four days without sleep. The Army veteran had survived a blast injury while deployed in Sadr City, Iraq, and has since endured seven knee surgeries, five shoulder surgeries and back surgery. He also suffers from Parkinson's Disease.

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3.4 - WSLs (NBC-10, Video): Salem VA Medical Center offering free drive-thru flu vaccines, The medical center has opened a drive-thru flu shot clinic on campus. (3 October, Alison Wickline, 815k online visitors/mo; Roanoke, VA)
The Salem VA Medical Center is making it easier for veterans to get their flu shots. The medical center has opened a drive-thru flu shot clinic on campus. During the whole month of October, between 8 a.m. and 4 p.m., from Monday to Friday, veterans enrolled in the VA system and Salem VA Medical Center employees can receive the vaccine for free.

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3.5 - JD Supra: Department of Veterans Affairs Releases Long-Awaited Proposed Rule to Allow Telehealth Services Across State Lines (3 October, Faegre Baker Daniels, 701k online visitors/mo; Sausalito, CA)

On Friday, September 29, the Department of Veterans Affairs (VA) released its long-awaited proposed rule amending medical regulations to improve access to care for beneficiaries regardless of patient or provider locations. Specifically, the rule enables health care providers to provide telehealth services to beneficiaries across state lines in an effort to increase patient access to care. This “modern, beneficiary- and family-centered health care delivery model” – 38 CFR 17.417...

[Hyperlink to Above](#)

3.6 - KRGV (ABC-5, Video): [Local VA Records Show Improvements in Veterans' Wait Times](#) (3 October, Matt Rist and Valerie Gonzalez, 275k online visitors/mo; Weslaco, TX) CHANNEL 5 NEWS' investigative team looked closer at data behind wait times at the VA Texas Valley Coastal Bend Health Care System clinics. After scouring through records, we found a downward trend in wait times for returning patients. However, if you're a new patient, you can expect to wait as long as 70 days for care.

[Hyperlink to Above](#)

3.7 - South Bend Tribune: [Our Opinion: A long journey's end for local veterans](#) (3 October, Editorial Board, 273k online visitors/mo; South Bend, IN) The recent opening of the new St. Joseph County VA Clinic in Mishawaka marked the beginning of a new era for veterans' care locally. It's been a long journey. Veterans from South Bend, Mishawaka, Elkhart and other local communities have often had to travel to VA facilities in Chicago or Fort Wayne for more extensive medical procedures.

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3.8 - KRTV (CBS-3): [VA gearing up for Drive Thru-Flu Clinic and Health Fair](#) (3 October, Eric Jochim, 195k online visitors/mo; Black Eagle, MT) Staff at the VA are gearing up for their Annual Drive Thru-Flu Clinic and Health Fair. Tomorrow from 7 am to 5 pm free Flu shots will be available for to all enrolled Veterans and VA employees. If a veteran isn't enrolled with the VA staff will be on hand to assist with the process. Last year at the event the clinic administered over 500 flu shots.

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3.9 - Healthcare-Informatics: [VA Issues Proposed Rule to Allow Home-Based Telemedicine for Veterans](#) (3 October, Heather Landi, 158k online visitors/mo; New York, NY) The U.S. Department of Veterans Affairs (VA) issued a proposed rule this week that would allow VA healthcare providers to provide medical care via telehealth across state lines and regardless of the location of the provider of the beneficiary. The VA says the proposed rule would increase the availability of mental health, specialty and general clinical care for all VA beneficiaries.

[Hyperlink to Above](#)

3.10 - Gatehouse Media: [VA's chief surgeon envisions center of excellence in Fayetteville](#) (3 October, Amanda Dolasinski, 74k online visitors/mo; Fayetteville, NC) Dr. Lynn Weaver was a part of integration in Knoxville, Tennessee, but bullies were no match. His distinguished career now comes to Fayetteville's VA Medical Center. Fifty-three years ago, a young Lynn Weaver walked into his new classroom at West High School in Knoxville,

Tennessee, ready for lessons, but honestly more interested in the football field. He and a dozen other black students were the first to integrate into the school.

[Hyperlink to Above](#)

3.11 - Salem News: [Walgreens to offer flu shots for vets](#) (3 October, Larry Shields, 68k online visitors/mo; Salem, OH)

The shots will be given from 11 a.m. to 5 p.m. Oct. 14 at the AMVETS Post 45, 750 S. Broadway Ave., in Salem. "The VA teamed up with Walgreens this year so we are providing a place for flu shots for all vets in the VA," Hughes said, adding that, "their spouses are also able to get shots that day with current insurance."

[Hyperlink to Above](#)

3.12 - KGVO (CMN-1290, Audio): [Montana Veteran Affairs Talks With Veteran's Heartbeat About Recent Suicide Numbers](#) (3 October, Nick Chrestenson, 20k online visitors/mo; Missoula, MT)

On the Pulse of the Veteran is a weekly half hour talk show devoted to issues of hope, health, opportunity and well-being of veterans. Join us on KGVO 98.3 FM every Saturday morning at 8:30 a.m. The show is brought to you by the Rural Institute for Veteran's Education and Research and they are on a mission.

[Hyperlink to Above](#)

3.13 - KTVH (NBC-12): [Drive-thru flu shot clinic offers vets and others convenient option](#) (3 October, John Riley, 2.3k online visitors/day; Helena, MT)

Over 550 Veterans received their Flu immunization on Tuesday at the Fort Harrison along with community members and VA staff. VA Montana staff braved the cold temperatures outside to kick off the flu season with the annual Fall Health Festival and Drive-Thru Flu Clinic. The shots were free for enrolled veterans and VA employees. County Health Department were on hand to supply flu shots for a fee for everyone else.

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3.14 - Interlochen Public Radio: [In Michigan, veterans commit suicide at high rate](#) (3 October, David Cassleman, 900 online visitors/day; Interlochen, MI)

The suicide rate for Michigan veterans is more than twice as high as the state's overall rate, according to data released by the U.S. Department of Veterans Affairs last month. The analysis shows more than 200 veterans killed themselves in Michigan in 2014 – the most recent year covered by the study. Michigan's rate of 35.5 suicides per 100,000 veterans is slightly less than the national rate of 38.4. The rate for all Michigan residents is 16.9.

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[4. Women Veterans](#) – No Coverage

[5. Appeals Modernization](#) – No Coverage

[6. Strategic Partnerships](#)

6.1 - WXIN (FOX-59, Video): [Researchers at IUPUI using dogs to sniff out prostate cancer](#) (3 October, Nick McGill, 1.5M online visitors/mo; Indianapolis, IN)

Scientists at IUPUI are hoping man's best friend can help solve one of man's biggest problems. Recently, a study in Italy found that dogs have the ability to smell and detect certain odors in urine that are associated with prostate cancer with 98% accuracy. A team at IUPUI, led by Dr. Mangilal Argawal, is hoping to replicate that process and develop an early screening method.

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[7. Supply Chain Modernization](#)

7.1 - Forbes: [Use It Or Lose It -- Trump's Agencies Spent \\$11 Billion Last Week In Year-End Spending Spree](#) (3 October, Adam Andrzejewski, 29.8M online visitors/mo; Jersey City, NJ)

For the new fiscal year, many federal agencies decided to redecorate. In one week, the government spent \$83.4 million on furniture plus another \$23 million on office supplies and equipment. The Department of Veterans Affairs spent \$15.6 million on new office furniture including \$4.7 million to a veteran-owned company, American Veteran Office Furniture, LLC.

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7.2 - EHR Intelligence: [VA to Award Cerner EHR Implementation Contract Within 30 Days, The federal agency will migrate or abandon 240 of its 299 other IT projects to allocate funding toward the Cerner EHR implementation.](#) (3 October, Kate Monica, 50k online visitors/mo; Danvers, MA)

VA Secretary David Shulkin announced the federal agency will award its EHR implementation contract to Cerner Corporation in the next thirty days. The announcement came during the recent Senate Veterans Affairs Committee hearing last week. The new VA EHR system will operate on a similar platform as the Department of Defense (DoD) EHR system—MHS Genesis—in an effort to improve interoperability between agencies.

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7.3 - ExecutiveGov: [Report: VA Inches Closer to Cerner EHR Devt Contract Award](#) (3 October, Jane Edwards, 20k online visitors/mo; Tysons Corner, VA)

The Department of Veterans Affairs expects to award Cerner a contract to build a new electronic health record system for VA as early as this month, Federal News Radio reported Friday. VA Secretary David Shulkin told members of the Senate Veterans Affairs Committee at a hearing Wednesday that the department issued to Congress a 30-day notice of contract award for the new EHR platform.

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[8. Other](#)

8.1 - The Washington Post (AP): [Tennessee mail carrier sentenced for stealing opioids](#) (3 October, 43.9M online visitors/mo; Washington, DC)

A Tennessee mail carrier who pleaded guilty to stealing at least 33 packages of medications intended for veterans has been sentenced to probation. The Kingsport Times-News reports that Bronson Cobble was sentenced last week to three years' probation and ordered to pay \$1,154 in restitution following his June plea to one count of theft of mail.

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8.2 - The Buffalo News: [Alden companies accused in fraud case agree to pay \\$3 million](#) (3 October, Phil Fairbanks, 1.6M online visitors/mo; Buffalo, NY)

"The contracting companies and principals allowed greed to corrupt a federal process intended to benefit service-disabled, veteran-owned small businesses," said Special Agent in Charge Adam S. Cohen of FBI Buffalo Field Office. The settlement is the result of investigation by the FBI, Assistant U.S. Attorney Kathleen A. Lynch, the VA Office of Inspector General and the Small Business Administration's Office of Inspector General.

[Hyperlink to Above](#)

1. Top Stories

1.1 - The Washington Post (AP): [VA watchdog reviewing Shulkin's 10-day trip to Europe](#) (3 October, Hope Yen, 43.9M online visitors/mo; Washington, DC)

WASHINGTON — The Veterans Affairs Department's watchdog said Tuesday it is reviewing Secretary David Shulkin's 10-day trip to Europe with his wife that mixed business meetings with sightseeing.

Shulkin disclosed last week he traveled to Denmark and England to discuss veterans' health issues. Travel records released by VA show four days of the trip were spent on personal activities, including attending a Wimbledon tennis match and a cruise on the Thames River. The VA said Shulkin traveled on a commercial airline, and that his wife's airfare and meals were paid for by the government as part of "temporary duty" expenses.

A spokesman for VA inspector general Michael Missal described the review as "preliminary."

Shulkin is one of several Cabinet members who have faced questions about travel after Tom Price resigned as health chief.

Curt Cashour, a VA spokesman, said the travel activities had been approved as part of an ethics review.

"The secretary welcomes the IG looking into his travel, and a good place to start would be VA's website where VA posted his full foreign travel itineraries, along with any travel on government or private aircraft," Cashour said.

The site lists Shulkin's travel itineraries but does not detail costs to the government.

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1.2 - FOX News: [Hurricane Maria: VA in Puerto Rico still trying to reach more than 500 homebound vets](#) (3 October, Tori Richards, 32.5M online visitors/mo; New York, NY)

Nearly two weeks after Hurricane Maria roared through Puerto Rico, destroying much of the island's infrastructure, more than 500 homebound at-risk veterans still haven't been reached by doctors, nurses and social workers, Fox News has learned.

There are 1,687 homebound vets in Puerto Rico who require ongoing treatment such as dialysis, chemotherapy and insulin to survive. Since Maria struck Sept. 20, the San Juan VA Medical Center has dispatched special teams consisting of a doctor, nurse and social worker to visit the homes of each one of these vets.

It has been a tough task. Most of the island still lacks power because of damage to the electric grid and intermittent phone service because of downed lines and cell towers. Many rural areas have been rendered inaccessible by damage to roads and the scarcity of gasoline for vehicles.

As of Tuesday, VA officials said visits have taken place at the homes of 1,147 homebound vets. That leaves 540 more to be seen. The VA is vowing to reach the rest but isn't sure how long it will take.

"The safety of all our patients is a top priority," VA spokesperson Mary Kay Rutan told Fox News Tuesday. "We have been going out in the communities where it is safe to do so. Additionally, we are engaged with local shelter operations and other agencies to assist in helping us locate veterans."

One of the visits resulted in a homebound vet who needed more treatment being transported by military helicopter to the San Juan VA, Rutan said.

Another visit brought more insulin to 75-year-old Vietnam vet Miguel Olivera in the hard-hit mountain town of Aguas Buenas, north of San Juan. The Veterans of Foreign Wars in Washington had asked the VA to check on Olivera after learning that he was in danger of losing his last vial of insulin because he had no electricity to keep it refrigerated.

"I'm just happy to hear one veteran is being taken care of," VFW spokesman Joe Davis told Fox News. "I wish there was more that all of us could do for Puerto Rico, it's just terrible down there."

VA whistleblower Joseph Colon, a credentialing official at the San Juan VA Medical Center, said more needed to be done for the island's homebound vets.

"If you are truly in the business of caring for veterans it should not take two weeks to check on all high-risk patients," Colon told Fox News.

Colon also complained that the majority of staff at the San Juan VA had to be sent home last week because the hospital was running out of food, water and diesel fuel for generators.

He also accused hospital leaders of not having a contingency plan to deal with the storm and said the hospital's acting director, Dr. Antonio Sanchez, wasn't around when Maria struck.

"If you know you are going to have problems with water and possibly the electrical grid, why wouldn't you stock up on supplies?" he said. "There is a big new concrete garage next door, they could've put it in there."

As of Monday, the hospital was back at full strength, according to officials.

Rutan defended the hospital's plans for dealing with Maria and the previous one that passed through, Hurricane Irma.

"The San Juan VA Medical Center has comprehensive and well-tested emergency management and operations plans where they have successfully managed numerous hurricanes and other events, including most recently Hurricane Irma," she said.

Rutan also said that Sanchez was at a VA meeting in the U.S. the day of the hurricane and returned as fast as he could three days later.

"He was on the very first available flight to the island on Saturday after the storm," Rutan said. "In his absence, the deputy medical center director and the full incident management team

conducted necessary operations ensuring the safety of more than 300 patients and 800 staff during the height of the storm.”

But Colon said he still questioned why Sanchez wouldn't skip the meeting knowing that a Category 4 storm was bearing down on Puerto Rico.

“He had plenty of time to get back here – was that conference so important?” he said.

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1.3 - CNN (Video): [VA Secretary David Shulkin under review for work trip to Europe](#) (3 October, Miranda Green, Rene March, and Gregory Wallace, 29.7M online visitors/mo; Atlanta, GA)

Washington (CNN) - The VA's inspector general is reviewing Veterans Affairs Secretary David Shulkin's July business trip to London and Denmark, which included meetings with Danish and UK officials as well as a stop at Wimbledon.

It's now the fifth investigation into a member of the Trump administration's travel by a department inspector general.

Shulkin joins Environmental Protection Agency Administrator Scott Pruitt, Interior Secretary Ryan Zinke, Treasury Secretary Steven Mnuchin and recently resigned Health and Human Services Secretary Tom Price under scrutiny for the use of private planes, first class travel, military air or flights for possible personal reasons.

Michael Nacincik, spokesman for the VA inspector general's office, told CNN he could not specify who requested the investigation, nor whether the inspector general's office was investigating any other travel by the secretary.

News of Shulkin's July trip abroad, which included a Thames River cruise, was first reported by The Washington Post last week.

Following the report, the Veterans Affairs department posted the trip itinerary online, which showed that Shulkin traveled with his wife and three members of the department, one of whom also brought a spouse. The US government paid for the travel expenses and a per diem for Shulkin's wife, Merle Bari, the Post reported.

Last Friday, HHS Secretary Price resigned after coming under fire for his use of chartered planes for business purposes. Price's departure came as he's being investigated by the department's inspector general for using private jets for multiple government business trips, even to fly distances often as short as from Washington to Philadelphia. The total cost for the trips ran into the hundreds of thousands of dollars.

Interior's Zinke is also being investigated over his travel.

In a statement he gave before giving his policy speech at the Heritage Foundation Friday, Zinke confirmed that he's used private jet travel on three occasions and has flown military aircraft at other times as well.

"Using tax dollars wisely and ethically is a greatest responsibility and is at the heart of good government," he said. "Unfortunately there are some times when Interior has to utilize charter services because we often travel to areas that don't have a lot of flight options."

He called the recent criticism about his use of private jets "a little BS."

CNN's Kevin Liptak contributed to this report.

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1.4 - CBS News: [Veterans Affairs inspector general is reviewing David Shulkin's Europe trip](#) (3 October, Jacqueline Alemany, 26.1M online visitors/mo; New York, NY)

The Department of Veterans Affairs inspector general is reviewing Secretary David Shulkin's 10-day taxpayer-funded trip to Europe in July, during which Shulkin and his wife spent time shopping and sightseeing in Denmark and the U.K.

A spokesman for the VA's Office of Inspector General told CBS News on Tuesday that it is "gathering information and reviewing the recent trip."

Details of the trip, which included visits to Westminster Abbey and Wimbledon, were first reported by The Washington Post. While the trip to Denmark and the United Kingdom was focused on veterans issues, Shulkin and his wife also devoted significant time to leisure activities paid for by U.S. government dollars.

Shulkin joins the list of cabinet members under investigation for travel. Tom Price resigned as Secretary of Human and Health Services last week after coming under fire for extensive use of expensive private jets footed by taxpayers. EPA Administrator Scott Pruitt, Treasury Secretary Steven Mnuchin and Interior Secretary Ryan Zinke are also currently under investigation by their respective agency's inspector generals for travel spending.

Shulkin announced in a statement last week that the VA would be posting all official travel taken since January 20th on the VA website.

"Under this administration, VA is committed to becoming the most transparent organization in government, and I'm pleased to take another step in that direction with this move," Shulkin said in a statement. "Veterans and taxpayers have a right to know about my official travel as secretary, and posting this information online for all to see will do just that."

The itinerary uploaded to the website details conferences on veterans policy and meetings with various government officials but also time carved out of his schedule for extracurricular activities. In London, Shulkin and his wife Dr. Merle Bari attended Wimbledon and visited Buckingham Palace and Westminster Abbey. They also took a cruise down the Thames River followed by "dinner/ evening in Piccadilly Circus" and spent their first day in Denmark visiting various castles throughout Copenhagen.

The website also notes that Shulkin has not utilized private aircraft to date. Curt Cashour, VA Press Secretary told CBS News in a statement, "The Secretary welcomes the IG looking into his

travel, and a good place to start would be VA's website where the VA posted his full foreign travel itineraries, along with any travel on government or private aircraft."

"As the posted information shows, the Secretary has taken no trips on private aircraft," Cashour continued, "and the only government aircraft trips he has taken has been as a guest on the planes of the President, Vice President, or First Lady."

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1.5 - Military Times: [VA names Elizabeth Dole to head caregivers advisory group](#) (3 October, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

WASHINGTON — Veterans Affairs officials on Monday announced former North Carolina Sen. Elizabeth Dole will chair the department's new family and caregiver advisory committee, formed in response to problems with support programs earlier this year.

The committee, which features a mix of veterans and military caregivers, is charged with advocating for improvements to VA care and benefits services. In a statement, Dole called the work "critical" for the veterans community.

"Military families, caregivers, and survivors are truly our nation's hidden heroes, and make great sacrifices each and every day on behalf of their loved ones, so we must do more to support them on their journey," she said.

Last spring, VA conducted a nine-week review of the department's caregiver program after an NPR report revealed dozens of regional medical centers were cutting back on the number of families receiving caregiver benefits, possibly against program rules.

More than 20,000 individuals are currently enrolled in the department's caregivers stipend program, which awards payouts of several thousand dollars a month to family members of severely injured post-9/11 veterans providing full-time caregiving duties.

In July, VA officials ended the review promising better communication and outreach to families involved. Shulkin has also publicly discussed the possibility of extending the caregiver stipend to veterans of other war generations, but doing so will likely require congressional action.

In a statement Monday, Shulkin said his department "is committed to the delivery of highest quality care and support to our veterans, and recognizes the essential role their families, caregivers, and survivors have every day."

Dole, herself a caregiver to husband Bob Dole, the former U.S. Senate majority leader and a veteran injured in World War II, has been an advocate for military and veteran caregivers in recent years through the Elizabeth Dole Foundation.

Sherman Gillums, executive director at Paralyzed Veterans of America, will serve as vice chair of the committee. The group also includes Lolita Zinke, wife of Interior Secretary Ryan Zinke, who served as a Navy SEAL.

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1.6 - KARE (NBC-11, Video): [VA apologizes to Vietnam vet for ER denial - The Department Of Veterans Affairs has apologized to a Vietnam veteran for repeatedly denying his claim for medical care after KARE 11 reported his story as part of its continuing investigation – a pattern of denial.](#) (3 October, A.J. Lagoe and Steven Eckert, 1.5M online visitors/mo; Golden Valley, MN)

LITTLE CANADA, Minn. - Rockne “Rocky” Waite of Little Canada, Minnesota sat in his living room on September 26th watching his television in disbelief.

“It was like watching my own story,” the 71-year-old former Army Medic recalled.

He was watching a KARE 11 investigative report exposing how veterans are being saddled with medical debt they should not owe – some of it even turned over to collection agencies – after trips to the emergency room.

“It was exactly what happened to me!” Rocky said.

Rocky’s story of wrongful denial began this past July when he needed emergency surgery to remove a large kidney stone.

“The pain just got to be excruciating,” Rocky said. “So, I called VA nurses hotline and asked them what I should do, and they said to go to the nearest facility which was St. John’s Hospital in Maplewood.”

Following his emergency operation in the private hospital, the surgeon told Rocky a stent had been inserted and he needed to get it removed in 10 days.

Following VA protocol, Rocky again called the nurses hotline at the Minneapolis VA to ask if he should go back to the private hospital where he had the surgery, or if he should come into the VA for the procedure?

His VA medical file shows Rocky spoke with a registered nurse who, after consulting with his regular VA physician, instructed him to go back to St. John’s to have the stent removed.

“I took their advice, went, had the procedure done,” Rocky said.

Despite doing exactly what the VA instructed, Rocky received a denial letter in the mail. The VA was refusing to pay for the stent removal, leaving the 100% service connected disabled veteran with the \$1,200 bill.

“What more could I have done?” Rocky asked while throwing his hands in the air. “I did as I was told, I don’t know how else you could do it!”

Rocky’s is not an isolated case.

Current and former VA staffers tell KARE 11 that medical claim processors at the VA are pressured to review complicated files in just minutes.

To meet performance goals, they say it's quicker to deny claims than to take the additional steps needed to approve payments.

"We are accountable for speed," one VA insider told KARE 11 in an exclusive interview. "We were told to pick-n-click and get them moving."

When he appealed his bill rejection, Rocky said he quickly received another denial letter.

Fast forward a few weeks and the frustrated veteran watched as KARE 11's investigation aired.

Rocky emailed his denial records to KARE 11. Investigative Reporter A.J. Lagoe told about Rocky's case during a follow-up broadcast and emailed the Department of Veterans Affairs asking what the veteran, who appeared to have followed all the rules, should have done differently?

VA Press Secretary Curt Cashour responded, "While strict rules and federal law govern when VA can pay for emergency care, we always want to work with veterans on their particular claim(s) to see what VA can do in their case. We will do that in this case."

The next day, Rocky received a voicemail from a VA official apologizing for the hassle he'd been through and stating, "So we'll get that paid for you, probably today."

"What bothers me about this is it is not just one incident," Senator Amy Klobuchar (D-MN) said.

Klobuchar says her office has received a number of similar constituent complaints.

"There are many incidents and usually when a member of Congress starts getting called over and over again it's like the canary in the coal mine. It means there is one, and then there's 10, and then there's 20. It means there's probably thousands across the country, and this means they are having a rule problem, a protocol problem, that has to be fixed!"

The Senator said she would be speaking directly to VA Secretary David J. Shulkin this week about the ER denials uncovered in the KARE 11 investigation.

KARE 11 analyzed two and a half years of VA data and found in the VA MidWest Network, which includes Minnesota, 52% of all ER claims were denied.

As a result, \$65,772,205 in medical bills were forced back onto veterans to pay.

There is no way to determine how many of those veterans got stuck with bills – like Rocky – because of improper VA denials.

"If it hadn't been for KARE 11, I would still have been fighting this battle," Rocky said. "And it could go on for years with these people."

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1.7 - WFED (AM-1500, Audio): [Advancing the VA's Community Care Mission: A conversation with Baligh Yehia, Deputy Under Secretary for Health](#) (3 October, 831k online visitors/mo; Washington, DC)

This content is provided by the IBM Center for the Business of Government.

Mondays at 11:00 a.m. & Fridays at 1:00 p.m.

The Business of Government Radio Hour, hosted by Michael J. Keegan, features a conversation with a federal executive who is changing the way government does business. The executives discuss their careers and the management challenges facing their organizations. Guests include administrators, chief financial officers, chief information officers, chief operating officers, commissioners, controllers, directors, and undersecretaries.

SPECIAL REBROADCAST:

What is the mission of VA's Office of Community Care? How is VA enhancing how it provides Community Care? What can VA do better? Join host Michael Keegan as he explores these questions & more with Baligh Yehia, Deputy Under Secretary for Health for Community Care at the US Department of Veterans Affairs.

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2. Veteran and Employee Experience

2.1 - The Hill: [VA chief under investigation over European trip: report](#) (3 October, Jacqueline Thomsen, 11.8M online visitors/mo; Washington, DC)

The Department of Veteran Affairs inspector general is investigating Veteran Affairs Secretary David Shulkin over his trip to Europe, CNN reported Tuesday.

Shulkin traveled to London and Demark in July, where he met with officials from both counties.

Michael Nacincik, spokesman for the VA inspector general's office, told CNN that he couldn't say what triggered the probe or if the office was investigating any other instances of Shulkin's travel.

The Washington Post first reported last week that Shulkin spent half of the trip sightseeing and shopping with his wife.

The VA chief was there to attend a conference in London on veterans' health issues and then held a series of meetings in Denmark.

Shulkin reportedly attended a Wimbledon tennis tournament match, toured multiple palaces in London and Denmark and took a cruise on the River Thames in London while on the trip.

The VA head took commercial flights for the trip and reportedly sat in coach on at least one of them, The Post reported.

The investigation into Shulkin is the fifth inspector-general investigation into a member of the Trump administration.

Environmental Protection Agency Administrator Scott Pruitt, Interior Secretary Ryan Zinke, Treasury Secretary Steven Mnuchin and former Heath Secretary Tom Price were each probed over their use of private, military or chartered planes.

Price resigned last week over his use of private jets.

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2.2 - Fortune: [Trump's VA Secretary Is the Fourth Cabinet Member to be Caught in a Travel Expense Scandal](#) (3 October, John Patrick Pullen, 7.7M online visitors/mo; New York, NY)

Overshadowed by Health and Human Services Secretary Tom Price's resignation Friday afternoon, Veterans Affairs chief David Shulkin is the latest Trump cabinet member to be found mixing personal trips and expenses with government travel. The VA secretary cruised the Thames, took in sight-seeing at Westminster Abbey, and watched a Wimbledon tennis match during a 10-day European trip with his wife, according to an itinerary obtained by The Washington Post.

The VA secretary's 10-day trip—which also included the department's undersecretary and her husband, Shulkin's chief of staff, an aide, and six security people—was approximately half business, half pleasure, the itinerary reportedly details. The government paid for Shulkin's wife airfare and provided a per diem for her meals because she was traveling on “approved invitational orders,” reports the Post.

The Shulkins' July trip was revealed as the personal travel and government expenses of other cabinet officials have also come under scrutiny. In his first three months in office, Environmental Protection Agency chief Scott Pruitt reportedly travelled home to Oklahoma at least 10 times, according to records acquired by a watchdog group. In addition, the EPA is building a \$25,000 soundproof booth for Pruitt, the first agency head to have an around-the-clock security detail.

In August, U.S. Treasury Secretary Steve Mnuchin and his wife reportedly used a government plane to travel to Lexington, Ky. to watch the solar eclipse, a trip that came to light after Mnuchin's wife, Louise Linton boasted on Instagram about traveling with her husband on a government plane. Mnuchin has denied that he took the trip to view the eclipse. He has also said claims about him requesting the use of a government jet during his honeymoon with Linton earlier this year were about national security.

HHS secretary Price's spending has been the most audacious of the cabinet so far. The former Georgia congressman may have taken more than \$1 million in chartered, private jets, according to reporting by the Post. The revelation ultimately led to his resignation on Friday.

As for Shulkin, the VA Secretary is likely hoping Price's exit helps his own spending to fly under the radar. One of few Obama administration holdovers, Shulkin was most recently the VA's undersecretary before being promoted by President Trump. Considering his previous boss and

the current president's unfavorable views of how the VA has been run, Shulkin may now be on thin ice—if he wasn't already.

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2.3 - Washington Examiner: [VA watchdog launches probe of David Shulkin's 10-day European trip](#) (3 October, Gabby Morrongiello, 4.8M online visitors/mo; Washington, DC)

The Department of Veterans Affairs' internal watchdog has launched an investigation into a 10-day, taxpayer-funded trip taken by Secretary David Shulkin and his wife earlier this summer.

Shulkin came under fire last week for the July vacation to Denmark and the U.K., during which he and his wife attended a Wimbledon tennis match, and went shopping and sightseeing.

Though a conference on veterans policy and meetings with foreign officials were included in the trip, much of the secretary's time was spent touring castles in Copenhagen and enjoying a cruise with his wife.

Michael Nacincik, a spokesperson for the VA's Inspector General, told the Washington Examiner on Tuesday the internal watchdog is "gathering information and reviewing the secretary's recent trip." CBS News first reported the investigation.

Nacincik could not say how long the investigation is estimated to take or when it began.

"It really depends on what they find or what they don't find," he said.

Shulkin denied any wrongdoing in a statement last week, and announced that he would make the itinerary from his trip for the public.

"Veterans and taxpayers have a right to know about my official travel as secretary, and posting this information online for all to see will do just that," he said.

"The secretary welcomes the IG looking into his travel, and a good place to start would be VA's website where the VA posted his full foreign travel itineraries, along with any travel on a government or private aircraft," VA press secretary Curt Cashour later told CBS.

News of the IG investigation comes days after Health and Human Services Secretary Tom Price was fired for chartering several private flights on the taxpayer dime.

The Interior Department's internal watchdog also launched an investigation this week into Secretary Zinke's travel, bring the total number of Cabinet officials under investigation by their own agencies to four, including Treasury Secretary Steve Mnuchin and EPA administrator Scott Pruitt.

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2.4 - WXIN (FOX-59, Video): [Veterans voice concerns, outline legislative agenda items at town hall](#) (3 October, Haley Bull, 1.5M online visitors/mo; Indianapolis, IN)

CARMEL, Ind. – Veterans are making sure their voices are heard by state lawmakers and local government officials during a series of town hall meetings across the state.

Tuesday, veterans at a meeting in Carmel raised their concerns and outlined their legislative agenda items for the upcoming legislative session.

"It's really important for the legislators to hear our concerns we have many healthcare being right at the top of the list, also treatment of PTSD as our returning veterans from the global war on terror suicide rates among veterans are at an all-time high," said Steven McDaniel, commander of VFW Post 10003.

Some of the issues veterans raised include support for medical marijuana and ways to help veterans find employment.

But before the town hall, a group of Indiana veterans groups called the Big Four, including the VFW, AMVETS, Disabled American Veterans and the American legion, met to approve a list of their legislative agenda items for the next session.

"We've come a long way veterans contribute a lot to the state of Indiana we're not asking for a handout," said Richard Leirer, the commander for dist. 6 of the VFW in Indiana and legislative chairman.

"We want to make sure we clean up some legislation that was passed this last year in the budget bill with some wording to extend the program for our homeless veterans and for our hyperbaric oxygen therapy treatment for traumatic brain injury," said Lisa Wilken, the legislative director for Indiana AMVETS.

Wilken said they also want to make another run at a bill creating a lottery scratch off ticket to help fund veterans' programs.

"We think we have the support now to get it passed this year," Leirer said.

The next town hall will be held Oct. 17 in Indianapolis.

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2.5 - Fayetteville Observer: [NC congressmen, VA leaders meet in Washington](#) (3 October, Drew Brooks, 439k online visitors/mo; Fayetteville, NC)

Congress members from North Carolina met with Veterans Affairs leaders in Washington on Tuesday, hoping for better communication on problems in the VA system.

Eight House members met with top officials from the VA's Mid-Atlantic Health Care Network, also known as Veterans Integrated Service Network 6, and the leaders from at least three VA medical centers, including Fayetteville's.

The meeting was an introduction of sorts for DeAnne Seekins, who became director of VISN 6 in July. The network includes seven VA medical centers, 27 community-based outpatient clinics and four health care centers, and it is the fastest-growing region within the VA.

Republican Rep. Richard Hudson, whose district includes parts of Fayetteville, said he was impressed by Seekins and other VA leaders.

The discussion was “very candid, very open,” and addressed concerns about delays in VA care, problems within the VA Choice Program and late payments to vendors working with the VA, Hudson said.

“Hopefully it’s the beginning of better communication,” said Hudson, who helped organize the meeting.

Seekins was appointed director of VISN 6 after leading the Durham VA Health Care System for five years. Directors of VA medical centers in Asheville and Durham also attended the meeting.

Fayetteville has the fastest growing patient population in the VA, Hudson said, and it was important for VA leaders and Congress to be on the same page to help address issues that arise with that growth.

“I take very seriously my responsibilities as a voice for veterans in North Carolina,” he said. “I wanted to open better lines of communications.”

The meeting was co-chaired by Democratic Rep. David Price. It included Republican Reps. Robert Pittenger, Virginia Foxx, David Rouzer, Walter Jones and Mark Meadows, and Democratic Rep. Alma Adams.

In the past, members of Congress have had to “start at the bottom and work up” when it comes to VA issues, Hudson said. After the meeting, he hopes there will be a direct line of dialogue at the highest levels of the local VA network.

He said he would like VA leaders to notify the congressional delegation of potential issues or when problems arise. The delegation can be more proactive in helping the VA fix issues that continue to plague the system.

“We both have the same mission — taking care of our veterans,” he said.

VISN 6 officials said the meeting was important to Seekins, who wants to develop relationships with the delegation and learn their concerns.

A spokesman, Stephen Wilkins, said the meeting was not meant to address specific issues, but instead more of a meet and greet.

But Hudson said the delegation was able to ask questions, paying particular attention to access to VA care, the opioid epidemic among veterans, and the Choice program that allows some veterans to seek care outside the VA system.

Several representatives also brought up VA payments. They said veterans are being harassed by collection agencies because the VA is not paying its bills.

Hudson said that while he praises the network's efforts to cut down on wait times, he is lobbying for an expanded Choice program that gives more veterans the ability to go outside the VA.

The Fayetteville VA previously had one of the nation's longest waits for veteran care. In recent months, officials have said those numbers have drastically improved.

"I think we're making progress, but I personally would like to see veterans having more access to private care as an alternative," Hudson said.

Hudson has introduced legislation that would allow any veteran who is at least 50 percent disabled to see whatever doctor they would like.

"I'm just not convinced we can build enough VA facilities to keep up with the growth," Hudson said.

He said that expanded Choice would never destroy the VA. But giving veterans the ability to "vote with their feet" may force the VA to improve its practices.

"Competition will make the VA better," he said. "They care about our veterans but they work within a system that is just strangled with bureaucracy."

The congressional delegation last met with VA leaders earlier this year, after a VA audit found that the network underreported the length of wait times for new patients, and that those seeking care outside of the Department of Veterans Affairs often had long waits or were unable to receive care.

Hudson said the delegation wants to meet regularly with VA leaders.

"I think we all agreed we'd like to have something," he said. He urged veterans in North Carolina who have problems with the VA to contact their Congress representative.

"We'll be their advocate," he said.

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2.6 - Michigan Radio Network: [Ann Arbor VA Hospital employees and vets protest staffing shortage](#) (3 October, Tracy Samilton, 385k online visitors/mo; Ann Arbor, MI)

Ann Arbor VA Hospital employees rallied Tuesday to ask Congress for enough money to eliminate the 49,000 VA job vacancies nationwide. Similar rallies have been held at other VA hospitals nationally in recent weeks.

Ozzie James, Jr. is president of American Federation of Government Employees Local 2092. He says veterans need the expertise of VA doctors, nurses and other staff, because outside health care professionals don't fully understand veterans' needs.

"The promise to take care of the veterans who go fight the war, you're not keeping that promise," says James. "Because you fail to have the staffing that's needed to take care of the veteran when he or she comes home. It's a disgrace to us."

James says the shortage is particularly acute for VA nurses; many cannot take the vacations to which they're entitled because there is no one to fill in for them.

He says the staffing problem predates the Trump administration but has gotten worse under it.

Darcy Guyton-Hanna is a dental hygienist at the Ann Arbor VA. She says the staffing shortage means some veterans have to wait a year for a comprehensive dental exam.

"We are short two dental assistants and one administrative assistant, so they have a lot of the dentists doing paperwork and administrative jobs instead of seeing patients," says Guyton-Hanna.

She says administrators told her there is a hiring freeze so nothing can be done about the situation.

But according to recent comments by VA Secretary David Shulkin, the prospect for more federal money for the VA to boost hiring seems dim. At a press conference in late May, he said, "the problems in VA are not largely going to be solved through additional money. These are going to be solved through management practices, focus, and some legislation changes."

Shulkin said the VA will have a position management system in place by December, so it can track which jobs are open. And the agency plans to expand graduate medical education training opportunities to be able to train more health professionals to stay in the VA system.

He said the VA also plans to work with the Unified Services University -- the medical school of the military -- to train more medical students who then would serve in the VA for 10 years after their education.

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2.7 - Outer Banks Sentinel: [VETERANS POST Will bad employees still linger at VA?](#) (4 October, 23k online visitors/mo; Nags Head, NC)

The Department of Veterans Affairs' new authority to get rid of bad employees is getting a test in Memphis.

An employee at the Memphis VA Medical Center was arrested for aggravated assault with a deadly weapon and criminal impersonation of a police officer. Specifically, she pulled a revolver on a grandmother and a toddler, waving the gun and saying she was the police.

According to the VA, the employee was being processed for removal and has been suspended. What, exactly, does that mean. Taking steps to terminate the employee? Barred from the facility? Told to stay home with pay?

Inquiring minds want to know: Will the Merit Systems Protection Board jump in on this one, too? Long ago the VA tried twice to remove an employee because the hospital kept running out of crucial surgical inventory. The Office of the Inspector General got involved and came up with yet one more reason to get rid of the guy: He'd been sending sensitive VA personnel information

to his personal email account and his wife. The guy was fired, but after the Board got involved, the VA had to rehire him. It took quite a while, but finally he is gone.

This is the same place where a veteran getting care had his vehicle stolen from the parking lot by a VA employee. The veteran had to turn over all his personal belongings when he was admitted ... including his car keys. Within hours, before his wife could retrieve the car, it was gone. Six months later, the veteran saw his car in the parking lot, called police, and they arrested a VA employee when he came out.

So now we watch and wait. Will pulling a handgun on a little girl and her grandmother be serious enough to get rid of the employee? Does the Accountability Act truly have enough teeth to get the job done?

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2.8 - WSAW (CBS-7, Video): [Free benefits expo offered for area veterans](#) (3 October, 196k online visitors/mo; Wausau, WI)

In an effort to serve area veterans, a Wausau expo will offer free service members or dependents of veterans who want to gather information.

The U.S. Department of Veterans Affairs along with the Wausau Veterans Service Office are organizing the event on Thursday, October 5.

To explain what will be offered, Veteran Service Officer, Scott Berger joined the Sunrise 7 team.

From 10 a.m. to 2 p.m. at the East Gate Hall of Marathon Park in Wausau area veterans are encouraged to visit the Wausau Area Veterans Benefits Expo.

Vets can expect to gather information and learn about VA and other community services that they may want to avail themselves to. Also, eligible veterans will be able to get their flu shot.

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3. Access to Healthcare

3.1 - The Hill: [Congress can use the power of pets to help women and vets](#) (3 October, Rep Steve Cohen (D-Tenn.) and Mike Bober, 11.8M online visitors/mo; Washington, DC)

Each year, Congress works hard to pass bills that will help the American people. While acrimony and partisanship have made this more difficult, lawmakers are considering two bills that have bipartisan support on Capitol Hill and among the American people: H.R. 2327 and H.R. 909, the Puppies Assisting Wounded Servicemembers (PAWS), and the Pets And Women Safety (PAWS) Acts of 2017.

Each of these bills involves man's best friend, and both provide for an underserved segment of America. In the case of H.R. 2327, veterans with PTSD and traumatic brain injuries are provided

opportunities for healing through grant-funded service dogs. H.R. 909 expands the number of domestic abuse shelters that can accept pets, in order to help abused women escape domestic violence.

Rep. Cohen is a sponsor of both bills, and PIJAC supports them on behalf of the professional pet care community. Passing these bills now would be a powerful symbol to a public eager for Congress to lead, as National Suicide Prevention Month ends and National Domestic Violence Awareness Month begins.

The House is already taking important steps to help veterans get the companions they need. On Sept. 26, the House Veterans Affairs Committee held a hearing about several bills, including H.R. 2327, that can help servicemembers adjust back to non-combat life. H.R. 2327 has support among myriad veterans' groups, and 200 House co-sponsors. With about 20 veterans committing suicide each day, the PAWS Act is just one way that Congress can improve assistance to America's military servicemembers who return from war with physical and mental scars.

H.R. 909 is likewise an important bill with enormous support. It has 230 co-sponsors in the House and 20 in the Senate. It will provide assistance to many of the approximately one in four women, and one in seven men, who are domestically abused each year.

Studies are clear that in a home where human abuse is taking place, a pet is also often a target. With nearly half of women saying they have returned to an abusive home out of concern for a pet's safety, H.R. 909 is clearly necessary to save lives and prevent more harm to innocent human and animal victims.

The bill provides funds so that abuse shelters can accommodate pets, and extends domestic abuse laws so that courts may require abusers to provide restitution for veterinary costs a victim may incur.

These bills recognize the strength of the human-animal bond. Fully 65 percent of U.S. households have a pet; 88 percent of House and Senate offices allow pets in their offices.

Not only is connecting people and pets good business – with 1.3 million jobs, mostly small business, supported in 2015 alone – it is also great for human health. Just owning a pet saves over \$11 billion in health care dollars each year, according to a conservative study by George Mason University. Other studies show direct links to less stress, better educational results, and improved health for senior citizens.

Whether in Washington, D.C. or Tennessee, pets are everyone's best friend. Congress should use the power of pets to bring people together by passing H.R. 2327 and H.R. 909.

Representative Steve Cohen represents the 9th District of Tennessee. Mike Bober is President of the Pet Industry Joint Advisory Council (PIJAC), which is the legislative and advocacy voice of the responsible pet industry.

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3.2 - Dayton Business Journal: [Dayton VA moving clinic to new location](#) (3 October, John Bush, 885k online visitors/mo; Dayton, OH)

The Dayton VA Medical Center is moving its Lima clinic to a larger location this spring.

The Lima Community Based Outpatient Clinic, currently located at 1303 Bellefontaine Ave., will move to 750 W. High St. following renovations.

The project will allow the VA to treat more veterans.

The new clinic will be housed in a professional building on the campus of St. Rita's Medical Center. It is owned by Lima IV Medical Properties LLC, which will hire a contractor to perform renovations after a bidding process.

The clinic will offer more than 1,400 additional square feet compared to the old location — 9,750 square feet versus 8,341. The increase in space will allow for additional nursing clinics, dedicated exam rooms for tele-health and other specialty services, and more parking (about 100 spaces).

It is also located near major roadways such as U.S. 30, state Route 501, Hume Road and Thayer Road.

The new clinic will be designed "to best serve the needs of veterans" by improving access to care, efficiency of facility operations, infrastructure layout, parking and care coordination between all services, according to a press release from the Dayton VA.

The VA stated the relocation was a necessary move, as the number of veterans served at the current Lima CBOC has expanded by 10.5 percent over the past two years.

The Bellefontaine Avenue site will remain open for all existing services until the new location is ready in spring 2018. At that time, veterans' medical information and appointment schedules will be transferred to the new CBOC.

The Lima clinic served more than 4,200 veterans in the last year, with more than 22,000 outpatient visits.

The Dayton VA Medical Center is the third-largest hospital in the Dayton region with \$382 million in net revenue for 2015, according to DBJ research. The hospital has 371 beds and saw about 5,500 admissions that year.

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3.3 - Government Executive: [How the VA Is Blocking Marijuana Research Veterans Say Could Save Lives](#) (3 October, Eric Katz, 852k online visitors/mo; Washington, DC)

In 2010, Boone Cutler was taking 30 milligrams of morphine, 70 milligrams of oxycodone and other opioids each day. He regularly went three to four days without sleep. The Army veteran had survived a blast injury while deployed in Sadr City, Iraq, and has since endured seven knee surgeries, five shoulder surgeries and back surgery. He also suffers from Parkinson's Disease.

"I did my time," Cutler says. "I've been beat up a few times."

That year, however, Cutler abandoned his treatment through the Veterans Affairs Department and checked himself into a psychiatric ward at a private hospital, where he quit his prescribed cocktail of opioid painkillers cold turkey. Upon leaving the hospital, a coworker convinced him to try something new for his physical and psychological symptoms: marijuana. He was reluctant, telling his colleague, "I'm not one of those pot heads."

The more he thought about it, the more he realized he had nothing left to lose: "I tried everything," he says. "Nothing worked."

But after trying cannabis, Cutler experienced something for the first time since he returned from Iraq: He slept for five hours.

"I thought it was a fluke. I tried it again, and it happened again," he says. "That was an absolute, 100 percent, 180-degree life changing event for me."

Cutler is part of a growing community of veterans who depend on cannabis to treat post-traumatic stress and pain from service-connected injuries. Some vets returning from combat tours of duty have reported that the drug has reduced nightmares and flashbacks, eased pain and helped eliminate their dependency on opioids. The drug nonetheless remains classified as "schedule one" by the federal government, which it defines as "drugs with no currently accepted medical use and a high potential for abuse." While some studies have examined the potential medicinal benefits of cannabis and a growing number of states have legalized medical and even recreational marijuana, there has never been a federally-approved study of its impact on post-traumatic stress disorder with the potential to change the federal government's scheduling.

Dr. Sue Sisley and the Multidisciplinary Association for Psychedelic Studies are trying to change that. Sisley and the group have worked for 10 years to get their triple-blind study with a placebo on the impact of marijuana on veterans with PTSD off the ground. Sisley's research now has approval from the Food and Drug Administration, the Drug Enforcement Administration and the Health and Human Services Department's National Institute on Drug Abuse, which is supplying the marijuana for the study. The research has finally commenced, and Sisley now has 28 participants in treatment. She will need 76 to complete the study, but she is facing a significant barrier: she is running out of veterans who qualify to participate, and the Veterans Affairs Department is refusing to help her identify more.

Taking Risks

Unlike Cutler's state of Nevada, where marijuana is now legal, Thomas Brennan lives in North Carolina, where the drug remains outlawed in all forms. The Marine Corps veteran who completed tours in Fallujah, Iraq, in 2004 and the Helmand Province in Afghanistan in 2010 felt he had no choice but to set up a cannabis distribution network with a handful of other veterans. While they had the marijuana shipped from Marines they trusted located in other parts of the country, they knew they were putting themselves in jeopardy.

"Veterans know this is better than the alternative and were willing to take the risks to deal with this," says Brennan, who suffers from PTSD.

Brennan also tried to use VA as his primary care provider, but felt shunned after informing his doctors there he used marijuana.

“They treated me like a drug addict when I told them about my cannabis use,” says Brennan, who considers himself lucky because he is now entitled to TRICARE by virtue of being medically retired. “They weren’t willing to help me wean off narcotics.” Brennan, before he started using marijuana, took a mixture of antidepressants, sedatives, amphetamines and mood stabilizers that VA sent him through the mail.

Brennan credits marijuana with saving his life, saying without it, he would have committed suicide.

Blocking Research

VA says it is willing to examine research on medical marijuana.

“There may be some evidence that this is beginning to be helpful,” VA Secretary David Shulkin said in May. “And we’re interested in looking at that and learning from that.”

To veterans like Cutler and Brennan, and service organizations like the American Legion, which is pushing VA to adopt a more lenient position on medical marijuana, the department is standing directly in the way of researchers trying to collect that evidence. The researchers will continue their work even if they cannot sign up a sufficient number of veterans, according to MAPS’ Brad Burge, by opening up the study to anyone with PTSD. Burge said it is unclear if such a study would still be generalizable to the veteran community.

VA, for its part, said it is bound by federal law that prohibits its clinicians from recommending patients for studies involving marijuana. A spokesman blamed Sisley and MAPS for not finding other means to recruit veterans for their research.

“Federal law restricts VA’s ability to conduct research involving medical marijuana, or to refer veterans to such research projects,” said Curt Cashour, the VA spokesman. “If the researcher is truly interested in finding veterans for her study, she should spend more time recruiting candidates and less time protesting to the media.”

Sisley says VA is poorly informed, noting she and her team have been “pounding the pavement” to recruit participants. She has screened more than 4,000 veterans over the last two years, but most of them are not qualified to participate. Veterans enrolled in VA health care are uniquely qualified subjects, she explains, as they are likely to have already attempted other treatment and are less likely to already depend on marijuana.

“If you’re in the VA system, that means you’ve already raised your hand and said ‘I need help,’” Sisley says. She adds the department is being disingenuous when it says it wants to examine more research: “It’s very negligent for VA to be begging for more data, and then refuse to cooperate with the federally legal, FDA-approved study that is happening right in the backyard of a VA facility. They should be ashamed.”

Sisley’s study is not receiving any federal funds. She has a \$2.1 million grant awarded from the state of Colorado, and received the marijuana from a National Institute on Drug Abuse contracted facility at the University of Mississippi (all federally approved research on marijuana

comes from plants grown at that facility). To advocates, VA already has the authority to refer its patients to the study.

"We've been, to no avail, trying to work locally with the hospital director and the [Veterans Integrated Service Networks] director to try to get them to build some kind of bridge, some kind of information bridge between the [researchers] and the VA, and they've just been really resistant to doing that," said Lou Celli, American Legion's VA director. He noted VA's laudable history in research, with its clinicians winning three Nobel prizes.

"The time is ripe for this administration to take the lead on this issue and really come out looking like superheroes," Celli said. "It's not a controversial topic. It's only controversial in their own minds."

The American Legion is hopeful if Sisley's study is completed, and its results are accepted by the FDA, it would just be the tip of the iceberg into researching the possibilities of medical marijuana. Like Brennan and Cutler, he acknowledges cannabis will not cure PTSD for any veteran. The alleviation it does provide, however, enables them to seek further help.

"The most common term I hear is, 'It helps keep the visitors away,' meaning the nightmares, the flashbacks," Celli says. "We don't believe there is any study that will prove cannabis cures PTSD. But what it does do is it relaxes them enough, and it lowers their inhibitions enough to be able to receive counseling and to be able to work through whatever issues that they have."

Sisley says marijuana could help address the epidemic of veteran suicides, and if the plant can save even one life, her research is worth pursuing.

"Please allow science to stop being shackled by VA politics," she says in a plea to the department. Absent such action, the American Legion plans to mobilize its 2 million members to lobby VA and members of Congress to help the study move forward.

Getting Out of Bed

Cutler describes the period of his life in which he was taking an ever-growing opioid cocktail as a "never-ending blackout." He went through cycles in which his tolerance would soar, he would detox, the pain would continue and he would repeat the process all over again. He now takes cannabidiol tablets during the day, which he says have no psychoactive effect, and smokes marijuana at night before going to sleep. Cutler calls the VA "hypocritical" for prescribing addictive opioids, but refusing to even research marijuana.

"You send us to war," he says, "and you deny us medication."

Brennan knows marijuana is not a cure-all. He still takes some prescription drugs. He still has migraines. He is, however, sleeping more easily and for longer. He has seen gradual improvements to his depression, mood and relationships. He no longer feels numb.

"Sometimes," Brennan explains, "the smallest reasons for getting out of bed in the morning are what can make a difference for mental health."

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3.4 - WSLs (NBC-10, Video): [Salem VA Medical Center offering free drive-thru flu vaccines, The medical center has opened a drive-thru flu shot clinic on campus.](#) (3 October, Alison Wickline, 815k online visitors/mo; Roanoke, VA)

SALEM, Va. - The Salem VA Medical Center is making it easier for veterans to get their flu shots.

The medical center has opened a drive-thru flu shot clinic on campus. During the whole month of October, between 8 a.m. and 4 p.m., from Monday to Friday, veterans enrolled in the VA system and Salem VA Medical Center employees can receive the vaccine for free.

"For them, it's just a quick and easy process. It's less time-consuming for them because it's a hassle to go into primary care and have a wait time," said Jody Duke, assistant nurse manager for the Salem VA Medical Center.

Veterans are asked to bring their ID card when they visit the flu shot clinic. The clinic is set up in front of Building 1. Staff members say they have given more than 200 vaccines since Monday.

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3.5 - JD Supra: [Department of Veterans Affairs Releases Long-Awaited Proposed Rule to Allow Telehealth Services Across State Lines](#) (3 October, Faegre Baker Daniels, 701k online visitors/mo; Sausalito, CA)

On Friday, September 29, the Department of Veterans Affairs (VA) released its long-awaited proposed rule amending medical regulations to improve access to care for beneficiaries regardless of patient or provider locations. Specifically, the rule enables health care providers to provide telehealth services to beneficiaries across state lines in an effort to increase patient access to care. This "modern, beneficiary- and family-centered health care delivery model" – 38 CFR 17.417 – will leverage novel information and telecommunication technologies, such as apps on a patient's phone or computer, to connect patients and providers throughout the country.

The proposed rule provides a concrete outline for how the Trump Administration intends to utilize the increasingly popular telehealth technology to care for veterans. In fiscal year (FY) 2016, VA providers had 2.17 million telehealth episodes serving over 700,000 beneficiaries. While this accounted for only 12 percent of all beneficiaries that sought care from the Veterans Health Administration (VHA), 45 percent of these patients were from rural communities. Telehealth technology is incredibly effective at expanding access to care for patients in remote locations.

As a national health care provider, the VHA must ensure that its beneficiaries all receive an adequate level of care regardless of location at the time which health care services are provided. As the proposed rule notes, a focused effort to ensure beneficiaries in remote, rural or medically underserved areas is necessary to level accessibility to those with on-site services available. Telehealth will improve the ability of the VHA to take these clinical services to beneficiaries in a convenient, cost-effective and institutionally efficient matter. Congressional and Administration-based efforts to date have demonstrated the desire to make this transition,

evidenced by authorization of department-wide initiatives, copayment waivers and pilot programs.

Today, all VHA providers are licensed in at least one state, but are restricted from practicing in states in which they are not licensed. The proposed rule would exercise federal preemption of state licensure and allow licensed providers to provide services, regardless of the patient's location. Previously, VA medical centers have held off on expansion of telehealth services outside of federal property, such as a beneficiary or provider's home, for fear of repercussions. To date, issues arising from disparities between state law and the VA health care practice have impeded the integration of these services. While some states have already begun to regulate the practice of interstate telehealth, the VA would exercise the federal preemption of state licensure, registration, and certification laws, rules and regulations for all VA providers offering telehealth services within the scope of their employment. Furthering the VA's capabilities to provide telehealth services across state lines would allow these providers to treat more patients in a more timely fashion.

The proposed rule is in stark contrast to Medicare rules, which still require patients to reside in certain locations to receive covered telehealth services. VHA could be paving the way for changes to the Medicare program as the benefits to increased access to care, as well as cost-effective care, are demonstrated.

At a time where the country faces the perils of a deadly prescription opioid epidemic, however, the proposed rule is absent of any language around prescribing practices. The rulemaking does not affect the VA's existing requirement for compliance with state regulations on prescribing and administering controlled substances. Health care providers are still required to abide by limitations put forth in the Controlled Substances Act alongside any additional federal regulations that apply to the VA.

Advancing access to health care services for individuals in remote, rural or medically underserved areas will also benefit those dealing with serious mental illnesses, such as anxiety, depression or agoraphobia. Research conducted by the VA in 2016 clearly demonstrates the improvement that telehealth provides in terms of outcomes, especially in the instance of mental health. VA beneficiaries receiving mental health services through synchronous video telehealth saw a 39 percent reduction in acute psychiatric intakes. Data also supports the use of telehealth for the treatment of general or chronic condition management. For those with limited mobility, telehealth offers an alternative to receiving care without the stress of traveling to receive care. For many, receiving care in the comfort of their home may also lead them to take a more proactive role in their health care, thus improving outcomes.

As a part of the proposed rulemaking, VA solicited comments and input from a variety of stakeholders, including the National Governors Association, Association of State and Provincial Psychology, National Council of State Boards of Nursing, Federation of State Medical Boards, Association of Social Work Boards, and National Association of State Directors of Veterans Affairs. Each of these stakeholders, among others, responded favorably to the inquiries and noted their support of the proposed rulemaking.

The proposed rule will be published in the Federal Register on Monday, October 2, with an open comment period lasting 30 days.

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3.6 - KRGV (ABC-5, Video): [Local VA Records Show Improvements in Veterans' Wait Times](#) (3 October, Matt Rist and Valerie Gonzalez, 275k online visitors/mo; Weslaco, TX)

CHANNEL 5 NEWS' investigative team looked closer at data behind wait times at the VA Texas Valley Coastal Bend Health Care System clinics.

After scouring through records, we found a downward trend in wait times for returning patients. However, if you're a new patient, you can expect to wait as long as 70 days for care.

The Texas Valley Coastal Bend Veteran's administration booked more than 235,000 appointments for the fiscal year 2017 alone.

That works out to just shy of 30,000 patients churning through the system.

"We have radically changed the access to our patients," said Dr. Jorge Ortegon, Chief of Medicine at the Texas Valley Coastal Bend VA.

He shared what happens if patients face high wait times.

"The health of the patient will deteriorate," said Dr. Ortegon.

CHANNEL 5 NEWS wanted to find out exactly how long VATVCBHCS patients are waiting, so we pulled data from the VA's government website.

As of Sept. 1st, patients waited an average of five days for primary care, five days for specialists and 2.5 days for mental health care in the Rio Grande Valley region.

"Fortunately, we've done a really good job of gaining trust and credibility back with our patients," said VA Texas Valley Coastal Bend Health Care System VA director Joe Perez.

The data showed it's difficult for veterans to get certain types of care in some places.

In July, veterans at a Harlingen clinic waited an average of 13.5 days to see a specialist. The Sept. 1st numbers show improvement; veterans now wait at that clinic just more than 10 days.

Several Corpus Christi and Laredo veterans also faced waits longer than overall averages.

In July, veterans from Corpus Christi waited 10 days to get primary care. In Laredo, it took eight days to see a specialist.

"Our challenge here is having some of these specialties on board," Perez said.

Perez said they streamlined many processes to reduce wait times. He said veterans can directly opt into the Choice Program and choose an outside provider if wait times are clocking over a certain number of days.

If you're a new patient, expect to wait as many as 70 days to get specialty care at the VA.

The following is a breakdown of new patient wait times as of late September:

In McAllen, for primary care, you'll wait an average of 24 days, compared to 16 in the Harlingen clinic and just 12 at its other Treasure Hills location.

According to the records, when it comes to specialized care like gastroenterology, it takes 27 days. To see an Audiologist, you'll have to take a 70-day wait.

Perez said that number is an exception.

"These are really good compared to what I've experienced out in the community," Perez said. "From my own personal experience, if I could have something at 24 days that would be awesome."

Perez said wait times rise when patients miss or forget to cancel appointments. He also said wait times can be a testament to the quality of care they provide.

"We have a number of patients who choose to wait a little bit longer to be seen by us," Perez said. "We do know their background, we can relate to them. A lot of it is by veteran's choice."

Veterans like Hilario Diaz make that choice every day. Diaz said he's satisfied with his experiences at local regional VA clinics.

"Where in the Valley can you go to and you don't have to wait to see a doctor?" Diaz said.

He did not wait long for care.

"It's free. I haven't researched, but I would venture to say there's no other country in the world that does for veterans what the United States of America does," Diaz said.

Army veteran Robert Grandstaff shared a different experience with the VA. He was injured while deployed.

"I need a lot of care, I have a lot of physical injuries, PTSD, chronic back pain," Grandstaff said.

He said he waited long for his first VA appointment in 2013.

"When I first moved here, I asked for an appointment and they told me to wait three to four months," Grandstaff said.

Grandstaff said his injuries force him to seek specialty care.

"Just like other veterans, I'm going to have to find other care," Grandstaff said. "There needs to be some sort of better system, better accountability."

Back in 2016, the local VA was scrutinized after an allegation of altering data to make it look like veterans were waiting less time for appointments.

Perez said it happened at clinics across the country, but it's no longer an issue.

"It was a national initiative to do training and re-training of everybody that had the ability to schedule within our system and that continues annually," Perez said.

The director admits wait times will constantly change. A new patient survey will be a crucial measuring stick to find out how satisfied or dissatisfied veterans are with their care.

If you want to learn more about wait times at VA clinics across the region, you can log on to the VA's website: <https://www.accesstopwt.va.gov/>

There are bi-monthly published reports on government websites which outline wait times and show conflicting information. Perez said the data online is always changing and it can make monthly published reports quickly outdated.

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3.7 - South Bend Tribune: [Our Opinion: A long journey's end for local veterans](#) (3 October, Editorial Board, 273k online visitors/mo; South Bend, IN)

The recent opening of the new St. Joseph County VA Clinic in Mishawaka marked the beginning of a new era for veterans' care locally.

It's been a long journey. Veterans from South Bend, Mishawaka, Elkhart and other local communities have often had to travel to VA facilities in Chicago or Fort Wayne for more extensive medical procedures. Now, patients will be able to receive more services here. As many as 8,000 patients will be receiving services here initially and the VA hopes to grow that number to 13,000 in the next two years.

Work on the clinic began nearly a decade ago when, as a U.S. representative, Joe Donnelly began work on improving veterans' services here with the possible goal of building a new facility. Credit, too, should be given to Jackie Walorski, who has made veterans' issues a priority during her time as Indiana's 2nd District congressional representative.

The VA approved a clinic for the South Bend area and in 2011 Congress appropriated \$6.7 million to build it.

Nearly two years ago, ground was broken for a new 89,000-square-foot clinic. Now, the dream has become a reality.

Veterans will be able to receive a range of offerings at the new clinic that the current clinic on South Bend's Western Avenue doesn't provide: eye and hearing clinics, foot and skin doctors, a cardiologist for consulting (no procedures), prosthetics, physical and occupational therapy and CT scans. Women will have a space for primary care and procedures.

More services will gradually be added.

"It's the culmination of the dedication and determination of the entire community," Donnelly wrote in a Tribune Viewpoint last week, "and it's an example of what we can accomplish when we work together."

Hoosier veterans in northern Indiana now are getting the care they need and a clinic they deserve.

...

Leaders at the South Bend Police Department, who are finding it difficult to recruit and retain officers in this day and age, are trying something different to address the problem.

The Common Council approved a plan by Police Chief Scott Ruskowski to begin a part-time program using retired officers to staff certain positions.

Rather than working patrol beats, retired officers would be assigned to more administrative and less confrontational tasks.

Ruskowski envisions part-time officers handling jobs such as traffic control at Notre Dame football games, taking vandalism and shoplifting reports, traffic enforcement and other "quality of life issues."

The officers would be paid a bit less, but would carry the same weapons and have the same arrest powers as full-time officers. Pending approval by the city's Board of Public Safety, the program could be launched by spring.

Statewide, the only other known city department to operate such a program is Danville, a small community west of Indianapolis.

South Bend's plan to use retired officers is a creative way to address its personnel shortage. That kind of resourcefulness is what's needed to attract new officers to the city, retain current ones and maintain the level of public safety this community deserves.

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3.8 - KRTV (CBS-3): [VA gearing up for Drive Thru-Flu Clinic and Health Fair](#) (3 October, Eric Jochim, 195k online visitors/mo; Black Eagle, MT)

Staff at the VA are gearing up for their Annual Drive Thru-Flu Clinic and Health Fair.

Tomorrow from 7 am to 5 pm free Flu shots will be available for to all enrolled Veterans and VA employees.

If a veteran isn't enrolled with the VA staff will be on hand to assist with the process.

Last year at the event the clinic administered over 500 flu shots.

Registered Nurse Katie Temple urges the public to get their flu shot sooner than later.

"Up to 20% of the population actually gets influenza every year and the elderly and the young are really prone to get hospitalized from influenza," said Temple.

The clinic will also offer health promotions, disease prevention, suicide awareness, and hepatitis C screenings.

According to VA staff baby boomers are 5 times more likely to test positive for hepatitis C than any other age group.

The county health office will also be in attendance from 8:30am to 3 pm, to provide flu shots to family members for a small fee.

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3.9 - Healthcare-Informatics: [VA Issues Proposed Rule to Allow Home-Based Telemedicine for Veterans](#) (3 October, Heather Landi, 158k online visitors/mo; New York, NY)

The U.S. Department of Veterans Affairs (VA) issued a proposed rule this week that would allow VA healthcare providers to provide medical care via telehealth across state lines and regardless of the location of the provider of the beneficiary.

The VA says the proposed rule would increase the availability of mental health, specialty and general clinical care for all VA beneficiaries. “Just as it is critical to ensure there are qualified health care providers on-site at all VA medical facilities, VA must ensure that all beneficiaries, specifically including beneficiaries in remote, rural or medically underserved areas, have the greatest possible access to mental health care, specialty care and general clinical care,” the proposed rule states. “Thus, VA has developed a telehealth program as a modern, beneficiary- and family-centered health care delivery model that leverages information and telecommunication technologies to connect beneficiaries with health care providers, irrespective of the state or location within a state where the health care provider or the beneficiary is physically located at the time the health care is provided.”

Further, VA officials stated, “By providing health care services by telehealth from one state to a beneficiary located in another state or within the same state, whether that beneficiary is located at a VA medical facility or in his or her own home, VA can use its limited health care resources most efficiently.”

VA will accept comments on the proposed rule through Nov. 1.

For fiscal year (FY) 2016, VA health care providers had 2.17 million telehealth episodes of health care (meaning a clinical encounter or a period of time in which care was monitored), which served over 702,000 veterans (approximately 12 percent of the total patient population), with 45 percent of those veterans living in rural communities. By increasing VA’s capabilities to provide telehealth services, VA would be able to expand these services, the agency said in the proposed rule.

While telehealth enhances VA’s capacity to deliver health care services to beneficiaries located in areas where health care providers may be unavailable or to beneficiaries who may be unable to travel to the nearest VA medical facility for care because of their medical conditions, the agency states that in order to protect VA health care providers from potential adverse actions by states, many VA medical centers (VAMC) are currently not expanding some critical telehealth services if the health care service is provided outside federal property, or across state lines.

In addition, many individual VA health care providers refuse to practice telehealth because of concerns over states taking action against the health care provider’s state license, state laws, or

the shifting regulatory landscape that creates legal ambiguity and unacceptable state licensing risk, the VA stated in the proposed rule. “The current disparities between VA health care practice in telehealth and state laws have effectively stopped or inhibited VA’s expansion of telehealth services to certain locations, thereby reducing the availability and accessibility of care for beneficiaries,” the VA stated.

This proposed rulemaking would clarify that VA health care providers may exercise their authority to provide care through the use of telehealth, notwithstanding any state laws, rules, or licensure, registration, or certification requirements to the contrary. In so doing, VA would exercise federal preemption of state licensure, registration, and certification laws, rules, regulations, or requirements to the extent such state laws conflict with the ability of VA health care providers to engage in the practice of telehealth while acting within the scope of their VA employment.

The VA notes in the proposed rule that the changes would improve VA’s ability to provide mental health services to veterans. Veterans who received mental health services through synchronous video telehealth in fiscal year 2016 saw a reduction in the number of acute psychiatric VA bed days of care by 39 percent, the VA reports.

Another benefit of expanding VA telehealth includes serving a recruitment incentive for VA healthcare providers and allowing VA to address recruitment shortages, the agency states. In Charleston, South Carolina, the South Carolina VAMC serves as one of the VA’s National TeleMental Health Hubs and provides mental health services to veterans across eight states with a team of 30 full-time healthcare provides. The VA notes there are currently multiple vacancies for TeleMental Health psychiatrists at the Charleston Hub, and “in the past six months, applicants have only expressed interest in telework positions.”

The American Medical Association (AMA) released a statement supporting the expansion of clinically validated telehealth services within the VA, and stated that “this decision ensures that important patient protections are in place for the delivery of high quality and reliable care.

“The VA has a unique federally controlled healthcare system with essential safeguards to help ensure that both in-person and virtual beneficiary care meet and exceed the standard of care. The AMA strongly supports that the proposed rule explicitly provides that this program’s multi-state licensure exception applies only to VA-employed providers and would not be expanded to contracted physicians or providers who are not directly controlled and supervised by the VA and would not necessarily have the same training, staff support, shared access to a beneficiary’s EHR and infrastructure capabilities. We applaud the VA’s expansion of telehealth services in a manner that promotes quality and access,” the AMA stated.

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3.10 - Gatehouse Media: [VA’s chief surgeon envisions center of excellence in Fayetteville](#)
(3 October, Amanda Dolasinski, 74k online visitors/mo; Fayetteville, NC)

Dr. Lynn Weaver was a part of integration in Knoxville, Tennessee, but bullies were no match. His distinguished career now comes to Fayetteville’s VA Medical Center.

Fifty-three years ago, a young Lynn Weaver walked into his new classroom at West High School in Knoxville, Tennessee, ready for lessons, but honestly more interested in the football field.

He and a dozen other black students were the first to integrate into the school.

"I got stomach cramps every morning just thinking about going to school," Weaver said. "I stopped eating breakfast."

The daring move led Weaver to second-guess his abilities. But the 14-year-old student who was constantly targeted by racist teachers and bullies would not only ace his classes, he also became one of the top Veterans Affairs surgeons.

In February, Weaver was named the chief of surgery at the Fayetteville Veterans Affairs Medical Center. Weaver, who completed his residency while serving 13 years in the Army, most recently worked as the senior associate dean and chairman of surgery at Ross University School of Medicine in Dominica.

Gregory Antoine, the medical center's chief of staff and a longtime friend, enticed him to take over the surgery department in Fayetteville, Weaver said. The men were stationed together at Fort Campbell, Kentucky.

The VA has been finding ways to work with Womack Army Medical Center on Fort Bragg, and is looking into ways to work with Wake Forest University and the University of North Carolina at Chapel Hill, he said.

"I liked the picture he envisioned for patients," Weaver said. "You can put together a center of excellence right here in Fayetteville."

Weaver's career began to take shape when he was a high school student in Knoxville. That's when learning became a spiteful act, and he learned as much as he could, he said.

Weaver was a constant target of racist teachers, who put his desk in the back corner of their classrooms, he said. And of the students and parents who crowded him on the football team, intimidating him.

With failing grades in all of his seventh grade classes, Weaver questioned if he was smart enough to be in the school.

"I started to think I am dumb," Weaver said. "Maybe I don't belong."

Then Edward Hill, his science teacher, knocked on the door at his family's home.

"He said, 'I heard you're having problems,' " Weaver recalled. "I said, 'Yeah, they're trying to run me away.' "

Hill, a black teacher, set up private tutoring lessons for Weaver after school and on Saturdays.

"I was able to pass the semester," Weaver said. "After they got through tutoring me, learning became a spiteful activity. I needed to show I belong and I was as smart as everyone else."

Hill encouraged Weaver to compete in the Southern Appalachian Science Fair that year. Weaver, not thrilled about yet another activity that would cut away at his time practicing football, conceded when Hill paid another visit to his home and spoke with his parents.

For three days, Weaver dressed up in a jacket and tie and stood next to his project at the science fair. The other contestants, mostly white students, ignored him and didn't speak to him, Weaver said.

His project was simple compared to the other students. He set out to prove why asbestos was a good insulator; it is now a known carcinogen.

A group of men stopped at his project and Weaver was so excited someone wanted to talk to him. He rattled off all the details of his experiment.

Unbeknownst to him, they were the judges — and they would later name him grand champion.

"I was the first black student to win," Weaver said, smiling at the memory. "It was a huge deal in Knoxville."

His win caught the attention of bullies, Weaver said. He had a brief brush with being a "bigger thug than they were," Weaver said.

Then he decided to get back on track, dedicating his life to making his father and Hill proud.

He hadn't given college much thought, but didn't question when he received a scholarship to Howard University. Years later he learned he received that scholarship because Hill applied for it on his behalf.

Weaver would go on to complete his residency training in general surgery at Fitzsimmons Army Medical Center in Denver, Colorado, and residency at Madigan Army Medical Center in Tacoma, Washington. He served in the Army from 1974 to 1987, when he was a major.

"As far as being a surgeon in the Army, you're not trying to make money," Weaver said. "You're there to take care of the soldiers. I really enjoyed my time in the Army."

As Weaver winds down his busy career, he said he's happy to be in Fayetteville, taking care of soldiers.

"I thought it'd be great to end my career in a place with a lot of soldiers and veterans," he said. "I've made a difference, I hope."

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3.11 - Salem News: [Walgreens to offer flu shots for vets](#) (3 October, Larry Shields, 68k online visitors/mo; Salem, OH)

For the first time, the Veterans Administration is partnering with the Walgreens drug store chain to provide flu shots for all veterans, Rod Hughes, commander of AMVETS Post 45, said.

The shots will be given from 11 a.m. to 5 p.m. Oct. 14 at the AMVETS Post 45, 750 S. Broadway Ave., in Salem.

“The VA teamed up with Walgreens this year so we are providing a place for flu shots for all vets in the VA,” Hughes said, adding that, “their spouses are also able to get shots that day with current insurance.”

The Columbiana County Veterans Service Commission will also have representatives available for veterans who are not registered and veterans can speak with them about what services and benefits are available to them.

Any veteran who is unsure if they are registered should bring their DD-214 form. The shots will be at no cost to veterans with proof of registration.

Hughes said Walgreens will provide pharmacists and the necessary personnel to fill out paperwork to the post.

Privacy laws under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be followed Hughes said.

“Our members are aware of the flu shot program this year,” Hughes said, “but possibly not all veterans.”

AMVETS Post 45 has a combined membership of 800 regular, auxiliary and Sons of AMVETS members.

The VA system includes the Youngstown and Calcutta outpatient clinics along with Brecksville and Wade Park hospitals.

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3.12 - KGVO (CMN-1290, Audio): [Montana Veteran Affairs Talks With Veteran's Heartbeat About Recent Suicide Numbers](#) (3 October, Nick Chrestenson, 20k online visitors/mo; Missoula, MT)

Veteran's Heartbeat – On the Pulse of the Veteran is a weekly half hour talk show devoted to issues of hope, health, opportunity and well-being of veterans. Join us on KGVO 98.3 FM every Saturday morning at 8:30 a.m. The show is brought to you by the Rural Institute for Veteran's Education and Research and they are on a mission. When veterans encounter obstacles to health and well-being, RIVER is there to help. RIVER provides training to the veteran's community for outdoor recreational therapists and emergency medical technicians, plus medical services and cutting edge research projects. If you are a veteran or veteran's family, contact RIVER at riverofchange.org.

For episode 32 of Veteran's Heartbeat, we spoke with Juliana Hallows and she is the Suicide Prevention Coordinator with Veteran Affairs Montana.

Read More: Montana Veteran Affairs Talks With Veteran's Heartbeat About Recent Suicide Numbers | <http://newstalkkgvo.com/montana-veteran-affairs-talks-with-veterans-heartbeat-about-recent-suicide-numbers/?trackback=tsmclip>

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3.13 - KTVH (NBC-12): [Drive-thru flu shot clinic offers vets and others convenient option](#) (3 October, John Riley, 2.3k online visitors/day; Helena, MT)

Over 550 Veterans received their Flu immunization on Tuesday at the Fort Harrison along with community members and VA staff.

VA Montana staff braved the cold temperatures outside to kick off the flu season with the annual Fall Health Festival and Drive-Thru Flu Clinic.

The shots were free for enrolled veterans and VA employees. County Health Department were on hand to supply flu shots for a fee for everyone else.

People 65 years and older, young children and people with certain health conditions are at higher risk for serious flu complications.

Each year around 200,000 people are hospitalized and around 32,000 people die from Influenza. Health experts say best way to prevent the flu is by getting vaccinated each year.

Veterans attending the event said that they love the ease of the clinic considering they didn't even have to leave their vehicles.

"I've never had to wait long," said veteran Louie Stiles, "When I was doing it privately getting these private shots they'd just take a lot of time, this doesn't. "

If you are an enrolled veteran and missed the clinic you can still get your shot at the VA Medical Center.

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3.14 - Interlochen Public Radio: [In Michigan, veterans commit suicide at high rate](#) (3 October, David Cassleman, 900 online visitors/day; Interlochen, MI)

The suicide rate for Michigan veterans is more than twice as high as the state's overall rate, according to data released by the U.S. Department of Veterans Affairs last month.

The analysis shows more than 200 veterans killed themselves in Michigan in 2014 – the most recent year covered by the study.

Michigan's rate of 35.5 suicides per 100,000 veterans is slightly less than the national rate of 38.4. The rate for all Michigan residents is 16.9.

Dr. Nazzareno Liegghio, the chief of mental health at the Saginaw VA medical center, says it can be difficult for veterans to travel to get mental health treatment.

“In Michigan I think the biggest challenge is just our huge space and area,” Liegghio says, “and the location of veterans between the upper part of lower Michigan and Upper Peninsula.”

The suicide rate is especially high among young Michigan veterans. Only Oklahoma had a higher rate than Michigan for veterans aged 18-34.

Liegghio says young veterans are at risk when they transition out of the military.

“Usually they enlist around 18, 19, so they get out, they’re 23, 24,” Liegghio says. “They come home. They have a little time to adjust. And then all of a sudden they find themselves, ‘okay, now what do I do?’”

Nationwide more than two-thirds of veterans who commit suicide are aged 50 or older.

The analysis shows 20 veterans commit suicide each day in the United States.

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4. Women Veterans

5. Appeals Modernization

6. Strategic Partnerships

6.1 - WXIN (FOX-59, Video): [Researchers at IUPUI using dogs to sniff out prostate cancer](#)
(3 October, Nick McGill, 1.5M online visitors/mo; Indianapolis, IN)

Scientists at IUPUI are hoping man’s best friend can help solve one of man’s biggest problems.

Recently, a study in Italy found that dogs have the ability to smell and detect certain odors in urine that are associated with prostate cancer with 98% accuracy. A team at IUPUI, led by Dr. Mangilal Argawal, is hoping to replicate that process and develop an early screening method.

“If we can find that smell in prostate cancer from urine, it can really change the way we diagnose prostate cancer right now,” Argawal said.

Partnering with the Roudebush VA Medical Center, Argawal says his team has potentially identified molecules that could be the key to the “odor test.”

The team is working with dog training service “Medical Mutts” to verify their work. The hope is then to create a sensor that can detect the odors. Argawal says it would work similar to a “pregnancy test for prostate cancer.”

“So if you can make a sensor that is as accurate as a trained dog that can sniff prostate cancer from urine at 98% accuracy, then you are completely changing the field,” he said.

Argawal says current tests for prostate cancer screening can be inaccurate and lead to unnecessary and painful biopsies, a fact that can deter many men from seeking the tests. Argawal says if his team is successful, it would eliminate those problems.

“You can do the test in a clinic, you could do the test at home, same day results, and same day discussion with you doctor. So there are a lot of advantages to having accurate tests that avoid biopsies,” he said.

Argawal says so far the results of his team’s work are promising. He says they may be about four years away from finishing their study, developing a sensor and clearing clinical trials. However, he added that four years in “medical time” is relatively quick.

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7. Supply Chain Modernization

7.1 - Forbes: [Use It Or Lose It -- Trump's Agencies Spent \\$11 Billion Last Week In Year-End Spending Spree](#) (3 October, Adam Andrzejewski, 29.8M online visitors/mo; Jersey City, NJ)

Every September, the end of the fiscal year sparks a “use it or lose it” spending frenzy as federal agencies race to use up what’s left in their annual budgets. It’s a phenomenon that should drive taxpayers crazy. Agencies are afraid that if they spend less than their budget allows, Congress might send them less money in the next year. Agencies often try to spend everything that’s left instead of admitting they can operate on less.

Here are the top ten ways the government wasted taxpayer money in the last week of FY2017:

[...]

5. Insect and Rodent Control at the VA – The federal government did some end-of-the-year cleaning, paying \$152.5 million in “housekeeping” bills. While agencies paid \$114 million to guards and facilities operations support, they also signed for custodial janitorial (\$24.3 million); laundry and dry cleaning (\$2.9 million); surveillance (\$2.7 million); trash and garbage collection (\$1 million); carpet cleaning (\$630,943); interior landscaping (\$154,458); and snow removal/salt (\$127,373). “Housekeeping” contracts included insect and rodent control, which cost \$111,000 at the Department of Veterans Affairs.

6. Redecorating Allowance – For the new fiscal year, many federal agencies decided to redecorate. In one week, the government spent \$83.4 million on furniture plus another \$23 million on office supplies and equipment. The Department of Veterans Affairs spent \$15.6 million on new office furniture including \$4.7 million to a veteran-owned company, American Veteran Office Furniture, LLC. The largest furniture contractor across all agencies, however, was Knoll, Inc. (\$6.2 million) – a luxury furniture company that has 40 pieces permanently displayed in the American Museum of Modern Art in New York City.

7. Self-Promotion (PR) Machine – The government spent tens of millions of dollars on last-minute self-promotion. Agencies spent \$18.6 million on public relations, \$11.7 million on market research and public opinion, and \$5.5 million on communications. Further, \$28.8 million went to advertising efforts – the Department of Homeland Security spent \$15 million on advertising, including a \$6.7 million deal with Lempugh, Inc., and a \$4 million contract with the Ogilvy Group. Further, the Department of Veterans Affairs spent \$3.2 million on signs and advertising displays with S2 Ventures, LLC.

[...]

In the midst of the government's year-end spending spree, Senator Rand Paul (R-KY) introduced the Bonuses for Cost-Cutters Act to curb "use it or lose it" spending. Paul's bill would expand current law to pay bonus happy bureaucrats who identify unneeded or surplus funds and redirect 90 percent of those savings to deficit reduction.

The private-sector uses zero-based budgeting - where all expenses need to be justified from the ground up and every function within an organization is audited for cost. As a businessman, the president should know this.

Whether it's passing legislation or finding another way to address this taxpayer abuse, Congress needs to crack down on "use it lose it" spending. When agencies engage in this wasteful practice, we all lose.

Adam Andrzejewski (say: Angie-eff-ski) is the Founder and CEO of OpenTheBooks.com – a national transparency organization with a database of 4 billion federal, state and local expenditures.

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7.2 - EHR Intelligence: [VA to Award Cerner EHR Implementation Contract Within 30 Days, The federal agency will migrate or abandon 240 of its 299 other IT projects to allocate funding toward the Cerner EHR implementation.](#) (3 October, Kate Monica, 50k online visitors/mo; Danvers, MA)

VA Secretary David Shulkin announced the federal agency will award its EHR implementation contract to Cerner Corporation in the next thirty days.

The announcement came during the recent Senate Veterans Affairs Committee hearing last week. The new VA EHR system will operate on a similar platform as the Department of Defense (DoD) EHR system—MHS Genesis—in an effort to improve interoperability between agencies.

"We released to Congress—to you—30-day notice of award of a contract," said Shulkin. "We are keeping on the timeline that we talked about. We're marching forward. We have the principles. I have some updates to share with you on the strategic IT plan, because I think we are making a lot of progress with that."

In June, three senators submitted a letter to Shulkin and DoD Secretary James Mattis requesting more information about the Cerner EHR replacement, as well as a projected timeline.

Senators John McCain (R-AZ), Johnny Isakson (R-GA), and Jerry Moran (R-KS) emphasized the importance of an efficient integrated health system.

In this most recent discussion of the upcoming project, Shulkin stated part of VA's strategic plan will involve phasing out 80 percent of VA's other projects currently in development. The federal department will migrate or cease work on 240 of its 299 projects.

"By concentrating on some specific IT modernization initiatives, like [electronic health record modernization, financial management business transformation], etc., and leveraging cloud and digital platforms, the 80 percent reduction of ongoing development projects is expected to occur within 18 months, which is part of the overall IT modernization roadmap," VA Press Secretary Curt Cashour told Federal News Radio in an email.

VA has not stated how much the Cerner EHR implementation will cost. However, the VA IT office must contend with the \$215 million budget cut in the President's fiscal 2018 proposal. An appropriations bill for 2018 designated \$78.6 billion in discretionary funding for VA healthcare modernization and improvements.

In an effort to better utilize funds, a source close to the department stated VA is ceasing development on less pressing projects and instead allocating those funds to the new Cerner system.

While VA has not released any information about how much the system will cost, the federal department has outlined its priorities for the new Cerner EHR and indicated other tools necessary to optimize the system.

"We haven't gotten to defining which specific tools they are yet, and how we're going to meet those needs," Shulkin said. "We've talked about the days of VA being a software developer are over, and we're going to be looking at off the shelf, current technologies. There's going to be a lot more definition on that."

Shulkin also emphasized the need for experienced political leadership and assistance from the private sector to offer guidance during the implementation process.

"This is a big, complex organization," Shulkin told reporters following the hearing. "I need the best team possible. I need my nominees, all my political appointments to clear through the vetting process and then to go through their confirmation if it's required. And I need additional people from the private sector who want to come and serve their country to get in touch, because we need the A team on this."

Toward this end, Cerner created an Advisory Group last month to offer insights and recommendations during the EHR modernization that includes former government, military, and private sector leaders.

"Our Veterans deserve continuous access to their medical records while in the service and afterward, whether they are seen in VA or a private health care system," said former Nebraska Senator and Governor Bob Kerrey, who will chair the group. "I received years of treatment from VA and have firsthand experience with the challenges veterans often face when receiving care."

Other members of the group include Former VA CEO and Assistant Secretary of Information and Technology Roger Baker and former National Coordinator and Acting Assistant Secretary for Health Karen DeSalvo, MD.

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7.3 - ExecutiveGov: [Report: VA Inches Closer to Cerner EHR Devt Contract Award](#) (3 October, Jane Edwards, 20k online visitors/mo; Tysons Corner, VA)

The Department of Veterans Affairs expects to award Cerner a contract to build a new electronic health record system for VA as early as this month, Federal News Radio reported Friday.

VA Secretary David Shulkin told members of the Senate Veterans Affairs Committee at a hearing Wednesday that the department issued to Congress a 30-day notice of contract award for the new EHR platform.

His statement came months after he announced plans in June to issue a direct solicitation to Cerner to implement the same EHR system – MHS Genesis – that the Defense Department currently deploys.

VA Press Secretary Curt Cashour told the station in an email that the department will end 80 percent of its ongoing information technology development projects over the next 18 months as part of VA's IT strategic plan.

A source said the agency's move to reduce its current projects seeks to help fund the implementation of the new EHR system, the report added.

Cerner collaborates with Leidos and Accenture as part an industry team that won a potential 10-year, \$4.3 billion contract in 2015 to help DoD integrate a commercial EHR platform across the Military Health System.

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8. Other

8.1 - The Washington Post (AP): [Tennessee mail carrier sentenced for stealing opioids](#) (3 October, 43.9M online visitors/mo; Washington, DC)

GREENEVILLE, Tenn. — A Tennessee mail carrier who pleaded guilty to stealing at least 33 packages of medications intended for veterans has been sentenced to probation.

The Kingsport Times-News reports that Bronson Cobble was sentenced last week to three years' probation and ordered to pay \$1,154 in restitution following his June plea to one count of theft of mail.

Prosecutors in a sentencing memorandum recommended a bottom-range sentence, saying his admission of guilt and request for court-appointed counsel makes him unlike most defendants and suggests a low risk of recidivism.

Court records state that between August 2016 and March, Cobble stole the packages mailed from the U.S. Department of Veterans Affairs to patients in East Tennessee and used the narcotics himself because of a severe opioid addiction.

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8.2 - The Buffalo News: [Alden companies accused in fraud case agree to pay \\$3 million](#) (3 October, Phil Fairbanks, 1.6M online visitors/mo; Buffalo, NY)

An Alden company used a figurehead to qualify for contracts set aside for disabled veteran-owned small businesses and on Tuesday agreed to pay \$3 million to settle a whistleblower's lawsuit, according to federal prosecutors.

The monetary settlement ends a civil suit that accused Zoladz Construction Company, Arsenal Contracting LLC and Alliance Contracting, all of Alden, of recruiting a service-disabled veteran to serve as a front for Arsenal, a sham company controlled by two other individuals.

Those two men, John Zoladz of Darien and David Lyons of Grand Island, also were named in the suit and in the agreement settling allegations that they violated the federal False Claims Act. Neither Zoladz nor Lyons is a service-disabled veteran.

The government, in its suit, claimed Arsenal was a front company that had few employees of its own and relied almost exclusively on Zoladz Construction and Alliance to operate.

"Every time an ineligible contractor knowingly pursues and obtains such set-aside contracts, they are cheating American taxpayers at the expense of service-disabled veterans," said acting Assistant Attorney General Chad A. Readler in a statement.

A woman answering the phone at Zoladz said the company would not comment.

The scheme that Zoladz and Lyons carried out included false statements regarding Arsenal's qualifications for the small business program to the U.S. Department of Veterans' Affairs.

"The multi-million dollar civil judgment ensures that those involved pay a heavy price for their decision to divert to themselves resources intended for the benefit of those who have made supreme sacrifices on behalf of all," said acting U.S. Attorney James P. Kennedy.

The settlement also resolves a whistleblower lawsuit filed in 2011 by the Western New York Foundation for Fair Contracting, a labor-management group acting as watchdog on public contracts.

Under the settlement, the foundation will receive \$450,000.

“The contracting companies and principals allowed greed to corrupt a federal process intended to benefit service-disabled, veteran-owned small businesses,” said Special Agent in Charge Adam S. Cohen of FBI Buffalo Field Office.

The settlement is the result of investigation by the FBI, Assistant U.S. Attorney Kathleen A. Lynch, the VA Office of Inspector General and the Small Business Administrations's Office of Inspector General.

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Veterans Affairs Media Summary and News Clips

4 October 2017

1. Top Stories

1.1 - The Washington Post (AP): [VA watchdog reviewing Shulkin's 10-day trip to Europe](#)

(3 October, Hope Yen, 43.9M online visitors/mo; Washington, DC)

The Veterans Affairs Department's watchdog said Tuesday it is reviewing Secretary David Shulkin's 10-day trip to Europe with his wife that mixed business meetings with sightseeing. Shulkin disclosed last week he traveled to Denmark and England to discuss veterans' health issues. Travel records released by VA show four days of the trip were spent on personal activities, including attending a Wimbledon tennis match and a cruise on the Thames River.

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1.2 - FOX News: [Hurricane Maria: VA in Puerto Rico still trying to reach more than 500 homebound vets](#)

(3 October, Tori Richards, 32.5M online visitors/mo; New York, NY)

Nearly two weeks after Hurricane Maria roared through Puerto Rico, destroying much of the island's infrastructure, more than 500 homebound at-risk veterans still haven't been reached by doctors, nurses and social workers, Fox News has learned. There are 1,687 homebound vets in Puerto Rico who require ongoing treatment such as dialysis, chemotherapy and insulin to survive.

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1.3 - CNN (Video): [VA Secretary David Shulkin under review for work trip to Europe](#)

(3 October, Miranda Green, Rene March, and Gregory Wallace, 29.7M online visitors/mo; Atlanta, GA)

The VA's inspector general is reviewing Veterans Affairs Secretary David Shulkin's July business trip to London and Denmark, which included meetings with Danish and UK officials as well as a stop at Wimbledon. It's now the fifth investigation into a member of the Trump administration's travel by a department inspector general.

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1.4 - CBS News: [Veterans Affairs inspector general is reviewing David Shulkin's Europe trip](#)

(3 October, Jacqueline Alemany, 26.1M online visitors/mo; New York, NY)

The Department of Veterans Affairs inspector general is reviewing Secretary David Shulkin's 10-day taxpayer-funded trip to Europe in July, during which Shulkin and his wife spent time shopping and sightseeing in Denmark and the U.K. A spokesman for the VA's Office of Inspector General told CBS News on Tuesday that it is "gathering information and reviewing the recent trip."

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1.5 - Military Times: [VA names Elizabeth Dole to head caregivers advisory group](#)

(3 October, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

Veterans Affairs officials on Monday announced former North Carolina Sen. Elizabeth Dole will chair the department's new family and caregiver advisory committee, formed in response to problems with support programs earlier this year. The committee, which features a mix of veterans and military caregivers, is charged with advocating for improvements to VA care and benefits services. In a statement, Dole called the work "critical" for the veterans community.

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1.6 - KARE (NBC-11, Video): [VA apologizes to Vietnam vet for ER denial - The Department Of Veterans Affairs has apologized to a Vietnam veteran for repeatedly denying his claim for medical care after KARE 11 reported his story as part of its continuing investigation – a pattern of denial.](#) (3 October, A.J. Lagoe and Steven Eckert, 1.5M online visitors/mo; Golden Valley, MN)

Rocky's story of wrongful denial began this past July when he needed emergency surgery to remove a large kidney stone. "The pain just got to be excruciating," Rocky said. "So, I called VA nurses hotline and asked them what I should do, and they said to go to the nearest facility which was St. John's Hospital in Maplewood."

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1.7 - WFED (AM-1500, Audio): [Advancing the VA's Community Care Mission: A conversation with Baligh Yehia, Deputy Under Secretary for Health](#) (3 October, 831k online visitors/mo; Washington, DC)

What is the mission of VA's Office of Community Care? How is VA enhancing how it provides Community Care? What can VA do better? Join host Michael Keegan as he explores these questions & more with Baligh Yehia, Deputy Under Secretary for Health for Community Care at the US Department of Veterans Affairs.

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[2. Veteran and Employee Experience](#)

2.1 - The Hill: [VA chief under investigation over European trip: report](#) (3 October, Jacqueline Thomsen, 11.8M online visitors/mo; Washington, DC)

The Department of Veteran Affairs inspector general is investigating Veteran Affairs Secretary David Shulkin over his trip to Europe, CNN reported Tuesday. Shulkin traveled to London and Demark in July, where he met with officials from both counties. Michael Nacincik, spokesman for the VA inspector general's office, told CNN that he couldn't say what triggered the probe or if the office was investigating any other instances of Shulkin's travel.

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2.2 - Fortune: [Trump's VA Secretary Is the Fourth Cabinet Member to be Caught in a Travel Expense Scandal](#) (3 October, John Patrick Pullen, 7.7M online visitors/mo; New York, NY)

Overshadowed by Health and Human Services Secretary Tom Price's resignation Friday afternoon, Veterans Affairs chief David Shulkin is the latest Trump cabinet member to be found mixing personal trips and expenses with government travel. The VA secretary cruised the Thames, took in sight-seeing at Westminster Abbey, and watched a Wimbledon tennis match during a 10-day European trip with his wife, according to an itinerary obtained by The Washington Post.

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2.3 - Washington Examiner: [VA watchdog launches probe of David Shulkin's 10-day European trip](#) (3 October, Gabby Morrongiello, 4.8M online visitors/mo; Washington, DC)

The Department of Veterans Affairs' internal watchdog has launched an investigation into a 10-day, taxpayer-funded trip taken by Secretary David Shulkin and his wife earlier this summer. Shulkin came under fire last week for the July vacation to Denmark and the U.K., during which he and his wife attended a Wimbledon tennis match, and went shopping and sightseeing.

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2.4 - WXIN (FOX-59, Video): [Veterans voice concerns, outline legislative agenda items at town hall](#) (3 October, Haley Bull, 1.5M online visitors/mo; Indianapolis, IN)

Veterans are making sure their voices are heard by state lawmakers and local government officials during a series of town hall meetings across the state. Tuesday, veterans at a meeting in Carmel raised their concerns and outlined their legislative agenda items for the upcoming legislative session. "It's really important for the legislators to hear our concerns we have many healthcare being right at the top of the list..."

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2.5 - Fayetteville Observer: [NC congressmen, VA leaders meet in Washington](#) (3 October, Drew Brooks, 439k online visitors/mo; Fayetteville, NC)

Congress members from North Carolina met with Veterans Affairs leaders in Washington on Tuesday, hoping for better communication on problems in the VA system. Eight House members met with top officials from the VA's Mid-Atlantic Health Care Network, also known as Veterans Integrated Service Network 6, and the leaders from at least three VA medical centers, including Fayetteville's.

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2.6 - Michigan Radio Network: [Ann Arbor VA Hospital employees and vets protest staffing shortage](#) (3 October, Tracy Samilton, 385k online visitors/mo; Ann Arbor, MI)

Ann Arbor VA Hospital employees rallied Tuesday to ask Congress for enough money to eliminate the 49,000 VA job vacancies nationwide. Similar rallies have been held at other VA hospitals nationally in recent weeks. Ozzie James, Jr. is president of American Federation of Government Employees Local 2092. He says veterans need the expertise of VA doctors, nurses and other staff, because outside health care professionals don't fully understand veterans' needs.

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2.7 - Outer Banks Sentinel: [VETERANS POST Will bad employees still linger at VA?](#) (4 October, 23k online visitors/mo; Nags Head, NC)

The Department of Veterans Affairs' new authority to get rid of bad employees is getting a test in Memphis. An employee at the Memphis VA Medical Center was arrested for aggravated assault with a deadly weapon and criminal impersonation of a police officer. Specifically, she pulled a revolver on a grandmother and a toddler, waving the gun and saying she was the police.

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2.8 - WSAW (CBS-7, Video): [Free benefits expo offered for area veterans](#) (3 October, 196k online visitors/mo; Wausau, WI)

In an effort to serve area veterans, a Wausau expo will offer free service members or dependents of veterans who want to gather information. The U.S. Department of Veterans Affairs along with the Wausau Veterans Service Office are organizing the event on Thursday, October 5. To explain what will be offered, Veteran Service Officer, Scott Berger joined the Sunrise 7 team.

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3. Access to Healthcare

3.1 - The Hill: [Congress can use the power of pets to help women and vets](#) (3 October, Rep Steve Cohen (D-Tenn.) and Mike Bober, 11.8M online visitors/mo; Washington, DC) Each year, Congress works hard to pass bills that will help the American people. While acrimony and partisanship have made this more difficult, lawmakers are considering two bills that have bipartisan support on Capitol Hill and among the American people: H.R. 2327 and H.R. 909, the Puppies Assisting Wounded Servicemembers (PAWS), and the Pets And Women Safety (PAWS) Acts of 2017.

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3.2 - Dayton Business Journal: [Dayton VA moving clinic to new location](#) (3 October, John Bush, 885k online visitors/mo; Dayton, OH)

The Dayton VA Medical Center is moving its Lima clinic to a larger location this spring. The Lima Community Based Outpatient Clinic, currently located at 1303 Bellefontaine Ave., will move to 750 W. High St. following renovations. The project will allow the VA to treat more veterans. The new clinic will be housed in a professional building on the campus of St. Rita's Medical Center. It is owned by Lima IV Medical Properties LLC...

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3.3 - Government Executive: [How the VA Is Blocking Marijuana Research Veterans Say Could Save Lives](#) (3 October, Eric Katz, 852k online visitors/mo; Washington, DC)

In 2010, Boone Cutler was taking 30 milligrams of morphine, 70 milligrams of oxycodone and other opioids each day. He regularly went three to four days without sleep. The Army veteran had survived a blast injury while deployed in Sadr City, Iraq, and has since endured seven knee surgeries, five shoulder surgeries and back surgery. He also suffers from Parkinson's Disease.

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3.4 - WSLs (NBC-10, Video): [Salem VA Medical Center offering free drive-thru flu vaccines. The medical center has opened a drive-thru flu shot clinic on campus.](#) (3 October, Alison Wickline, 815k online visitors/mo; Roanoke, VA)

The Salem VA Medical Center is making it easier for veterans to get their flu shots. The medical center has opened a drive-thru flu shot clinic on campus. During the whole month of October, between 8 a.m. and 4 p.m., from Monday to Friday, veterans enrolled in the VA system and Salem VA Medical Center employees can receive the vaccine for free.

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3.5 - JD Supra: [Department of Veterans Affairs Releases Long-Awaited Proposed Rule to Allow Telehealth Services Across State Lines](#) (3 October, Faegre Baker Daniels, 701k online visitors/mo; Sausalito, CA)

On Friday, September 29, the Department of Veterans Affairs (VA) released its long-awaited proposed rule amending medical regulations to improve access to care for beneficiaries regardless of patient or provider locations. Specifically, the rule enables health care providers to provide telehealth services to beneficiaries across state lines in an effort to increase patient access to care. This “modern, beneficiary- and family-centered health care delivery model” – 38 CFR 17.417...

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3.6 - KRGV (ABC-5, Video): [Local VA Records Show Improvements in Veterans' Wait Times](#) (3 October, Matt Rist and Valerie Gonzalez, 275k online visitors/mo; Weslaco, TX) CHANNEL 5 NEWS' investigative team looked closer at data behind wait times at the VA Texas Valley Coastal Bend Health Care System clinics. After scouring through records, we found a downward trend in wait times for returning patients. However, if you're a new patient, you can expect to wait as long as 70 days for care.

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3.7 - South Bend Tribune: [Our Opinion: A long journey's end for local veterans](#) (3 October, Editorial Board, 273k online visitors/mo; South Bend, IN) The recent opening of the new St. Joseph County VA Clinic in Mishawaka marked the beginning of a new era for veterans' care locally. It's been a long journey. Veterans from South Bend, Mishawaka, Elkhart and other local communities have often had to travel to VA facilities in Chicago or Fort Wayne for more extensive medical procedures.

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3.8 - KRTV (CBS-3): [VA gearing up for Drive Thru-Flu Clinic and Health Fair](#) (3 October, Eric Jochim, 195k online visitors/mo; Black Eagle, MT) Staff at the VA are gearing up for their Annual Drive Thru-Flu Clinic and Health Fair. Tomorrow from 7 am to 5 pm free Flu shots will be available for to all enrolled Veterans and VA employees. If a veteran isn't enrolled with the VA staff will be on hand to assist with the process. Last year at the event the clinic administered over 500 flu shots.

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3.9 - Healthcare-Informatics: [VA Issues Proposed Rule to Allow Home-Based Telemedicine for Veterans](#) (3 October, Heather Landi, 158k online visitors/mo; New York, NY) The U.S. Department of Veterans Affairs (VA) issued a proposed rule this week that would allow VA healthcare providers to provide medical care via telehealth across state lines and regardless of the location of the provider of the beneficiary. The VA says the proposed rule would increase the availability of mental health, specialty and general clinical care for all VA beneficiaries.

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3.10 - Gatehouse Media: [VA's chief surgeon envisions center of excellence in Fayetteville](#) (3 October, Amanda Dolasinski, 74k online visitors/mo; Fayetteville, NC)

Dr. Lynn Weaver was a part of integration in Knoxville, Tennessee, but bullies were no match. His distinguished career now comes to Fayetteville's VA Medical Center. Fifty-three years ago, a young Lynn Weaver walked into his new classroom at West High School in Knoxville, Tennessee, ready for lessons, but honestly more interested in the football field. He and a dozen other black students were the first to integrate into the school.

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3.11 - Salem News: [Walgreens to offer flu shots for vets](#) (3 October, Larry Shields, 68k online visitors/mo; Salem, OH)

The shots will be given from 11 a.m. to 5 p.m. Oct. 14 at the AMVETS Post 45, 750 S. Broadway Ave., in Salem. "The VA teamed up with Walgreens this year so we are providing a place for flu shots for all vets in the VA," Hughes said, adding that, "their spouses are also able to get shots that day with current insurance."

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3.12 - KGVO (CMN-1290, Audio): [Montana Veteran Affairs Talks With Veteran's Heartbeat About Recent Suicide Numbers](#) (3 October, Nick Chrestenson, 20k online visitors/mo; Missoula, MT)

On the Pulse of the Veteran is a weekly half hour talk show devoted to issues of hope, health, opportunity and well-being of veterans. Join us on KGVO 98.3 FM every Saturday morning at 8:30 a.m. The show is brought to you by the Rural Institute for Veteran's Education and Research and they are on a mission.

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3.13 - KTVH (NBC-12): [Drive-thru flu shot clinic offers vets and others convenient option](#) (3 October, John Riley, 2.3k online visitors/day; Helena, MT)

Over 550 Veterans received their Flu immunization on Tuesday at the Fort Harrison along with community members and VA staff. VA Montana staff braved the cold temperatures outside to kick off the flu season with the annual Fall Health Festival and Drive-Thru Flu Clinic. The shots were free for enrolled veterans and VA employees. County Health Department were on hand to supply flu shots for a fee for everyone else.

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3.14 - Interlochen Public Radio: [In Michigan, veterans commit suicide at high rate](#) (3 October, David Cassleman, 900 online visitors/day; Interlochen, MI)

The suicide rate for Michigan veterans is more than twice as high as the state's overall rate, according to data released by the U.S. Department of Veterans Affairs last month. The analysis shows more than 200 veterans killed themselves in Michigan in 2014 – the most recent year covered by the study. Michigan's rate of 35.5 suicides per 100,000 veterans is slightly less than the national rate of 38.4. The rate for all Michigan residents is 16.9.

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4. Women Veterans – No Coverage

5. Appeals Modernization – No Coverage

6. Strategic Partnerships

6.1 - WXIN (FOX-59, Video): Researchers at IUPUI using dogs to sniff out prostate cancer

(3 October, Nick McGill, 1.5M online visitors/mo; Indianapolis, IN)

Scientists at IUPUI are hoping man's best friend can help solve one of man's biggest problems. Recently, a study in Italy found that dogs have the ability to smell and detect certain odors in urine that are associated with prostate cancer with 98% accuracy. A team at IUPUI, led by Dr. Mangilal Argawal, is hoping to replicate that process and develop an early screening method.

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7. Supply Chain Modernization

7.1 - Forbes: Use It Or Lose It -- Trump's Agencies Spent \$11 Billion Last Week In Year-End Spending Spree (3 October, Adam Andrzejewski, 29.8M online visitors/mo; Jersey City, NJ)

For the new fiscal year, many federal agencies decided to redecorate. In one week, the government spent \$83.4 million on furniture plus another \$23 million on office supplies and equipment. The Department of Veterans Affairs spent \$15.6 million on new office furniture including \$4.7 million to a veteran-owned company, American Veteran Office Furniture, LLC.

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7.2 - EHR Intelligence: VA to Award Cerner EHR Implementation Contract Within 30 Days. The federal agency will migrate or abandon 240 of its 299 other IT projects to allocate funding toward the Cerner EHR implementation. (3 October, Kate Monica, 50k online visitors/mo; Danvers, MA)

VA Secretary David Shulkin announced the federal agency will award its EHR implementation contract to Cerner Corporation in the next thirty days. The announcement came during the recent Senate Veterans Affairs Committee hearing last week. The new VA EHR system will operate on a similar platform as the Department of Defense (DoD) EHR system—MHS Genesis—in an effort to improve interoperability between agencies.

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7.3 - ExecutiveGov: Report: VA Inches Closer to Cerner EHR Devt Contract Award (3 October, Jane Edwards, 20k online visitors/mo; Tysons Corner, VA)

The Department of Veterans Affairs expects to award Cerner a contract to build a new electronic health record system for VA as early as this month, Federal News Radio reported Friday. VA Secretary David Shulkin told members of the Senate Veterans Affairs Committee at a hearing Wednesday that the department issued to Congress a 30-day notice of contract award for the new EHR platform.

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8. Other

8.1 - The Washington Post (AP): [Tennessee mail carrier sentenced for stealing opioids](#) (3 October, 43.9M online visitors/mo; Washington, DC)

A Tennessee mail carrier who pleaded guilty to stealing at least 33 packages of medications intended for veterans has been sentenced to probation. The Kingsport Times-News reports that Bronson Cobble was sentenced last week to three years' probation and ordered to pay \$1,154 in restitution following his June plea to one count of theft of mail.

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8.2 - The Buffalo News: [Alden companies accused in fraud case agree to pay \\$3 million](#) (3 October, Phil Fairbanks, 1.6M online visitors/mo; Buffalo, NY)

"The contracting companies and principals allowed greed to corrupt a federal process intended to benefit service-disabled, veteran-owned small businesses," said Special Agent in Charge Adam S. Cohen of FBI Buffalo Field Office. The settlement is the result of investigation by the FBI, Assistant U.S. Attorney Kathleen A. Lynch, the VA Office of Inspector General and the Small Business Administration's Office of Inspector General.

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1. Top Stories

1.1 - The Washington Post (AP): [VA watchdog reviewing Shulkin's 10-day trip to Europe](#) (3 October, Hope Yen, 43.9M online visitors/mo; Washington, DC)

WASHINGTON — The Veterans Affairs Department's watchdog said Tuesday it is reviewing Secretary David Shulkin's 10-day trip to Europe with his wife that mixed business meetings with sightseeing.

Shulkin disclosed last week he traveled to Denmark and England to discuss veterans' health issues. Travel records released by VA show four days of the trip were spent on personal activities, including attending a Wimbledon tennis match and a cruise on the Thames River. The VA said Shulkin traveled on a commercial airline, and that his wife's airfare and meals were paid for by the government as part of "temporary duty" expenses.

A spokesman for VA inspector general Michael Missal described the review as "preliminary."

Shulkin is one of several Cabinet members who have faced questions about travel after Tom Price resigned as health chief.

Curt Cashour, a VA spokesman, said the travel activities had been approved as part of an ethics review.

"The secretary welcomes the IG looking into his travel, and a good place to start would be VA's website where VA posted his full foreign travel itineraries, along with any travel on government or private aircraft," Cashour said.

The site lists Shulkin's travel itineraries but does not detail costs to the government.

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1.2 - FOX News: [Hurricane Maria: VA in Puerto Rico still trying to reach more than 500 homebound vets](#) (3 October, Tori Richards, 32.5M online visitors/mo; New York, NY)

Nearly two weeks after Hurricane Maria roared through Puerto Rico, destroying much of the island's infrastructure, more than 500 homebound at-risk veterans still haven't been reached by doctors, nurses and social workers, Fox News has learned.

There are 1,687 homebound vets in Puerto Rico who require ongoing treatment such as dialysis, chemotherapy and insulin to survive. Since Maria struck Sept. 20, the San Juan VA Medical Center has dispatched special teams consisting of a doctor, nurse and social worker to visit the homes of each one of these vets.

It has been a tough task. Most of the island still lacks power because of damage to the electric grid and intermittent phone service because of downed lines and cell towers. Many rural areas have been rendered inaccessible by damage to roads and the scarcity of gasoline for vehicles.

As of Tuesday, VA officials said visits have taken place at the homes of 1,147 homebound vets. That leaves 540 more to be seen. The VA is vowing to reach the rest but isn't sure how long it will take.

"The safety of all our patients is a top priority," VA spokesperson Mary Kay Rutan told Fox News Tuesday. "We have been going out in the communities where it is safe to do so. Additionally, we are engaged with local shelter operations and other agencies to assist in helping us locate veterans."

One of the visits resulted in a homebound vet who needed more treatment being transported by military helicopter to the San Juan VA, Rutan said.

Another visit brought more insulin to 75-year-old Vietnam vet Miguel Olivera in the hard-hit mountain town of Aguas Buenas, north of San Juan. The Veterans of Foreign Wars in Washington had asked the VA to check on Olivera after learning that he was in danger of losing his last vial of insulin because he had no electricity to keep it refrigerated.

"I'm just happy to hear one veteran is being taken care of." VFW spokesman Joe Davis told Fox News. "I wish there was more that all of us could do for Puerto Rico, it's just terrible down there."

VA whistleblower Joseph Colon, a credentialing official at the San Juan VA Medical Center, said more needed to be done for the island's homebound vets.

"If you are truly in the business of caring for veterans it should not take two weeks to check on all high-risk patients," Colon told Fox News.

Colon also complained that the majority of staff at the San Juan VA had to be sent home last week because the hospital was running out of food, water and diesel fuel for generators.

He also accused hospital leaders of not having a contingency plan to deal with the storm and said the hospital's acting director, Dr. Antonio Sanchez, wasn't around when Maria struck.

"If you know you are going to have problems with water and possibly the electrical grid, why wouldn't you stock up on supplies?" he said. "There is a big new concrete garage next door, they could've put it in there."

As of Monday, the hospital was back at full strength, according to officials.

Rutan defended the hospital's plans for dealing with Maria and the previous one that passed through, Hurricane Irma.

"The San Juan VA Medical Center has comprehensive and well-tested emergency management and operations plans where they have successfully managed numerous hurricanes and other events, including most recently Hurricane Irma," she said.

Rutan also said that Sanchez was at a VA meeting in the U.S. the day of the hurricane and returned as fast as he could three days later.

"He was on the very first available flight to the island on Saturday after the storm," Rutan said. "In his absence, the deputy medical center director and the full incident management team

conducted necessary operations ensuring the safety of more than 300 patients and 800 staff during the height of the storm.”

But Colon said he still questioned why Sanchez wouldn't skip the meeting knowing that a Category 4 storm was bearing down on Puerto Rico.

“He had plenty of time to get back here – was that conference so important?” he said.

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1.3 - CNN (Video): [VA Secretary David Shulkin under review for work trip to Europe](#) (3 October, Miranda Green, Rene March, and Gregory Wallace, 29.7M online visitors/mo; Atlanta, GA)

Washington (CNN) - The VA's inspector general is reviewing Veterans Affairs Secretary David Shulkin's July business trip to London and Denmark, which included meetings with Danish and UK officials as well as a stop at Wimbledon.

It's now the fifth investigation into a member of the Trump administration's travel by a department inspector general.

Shulkin joins Environmental Protection Agency Administrator Scott Pruitt, Interior Secretary Ryan Zinke, Treasury Secretary Steven Mnuchin and recently resigned Health and Human Services Secretary Tom Price under scrutiny for the use of private planes, first class travel, military air or flights for possible personal reasons.

Michael Nacincik, spokesman for the VA inspector general's office, told CNN he could not specify who requested the investigation, nor whether the inspector general's office was investigating any other travel by the secretary.

News of Shulkin's July trip abroad, which included a Thames River cruise, was first reported by The Washington Post last week.

Following the report, the Veterans Affairs department posted the trip itinerary online, which showed that Shulkin traveled with his wife and three members of the department, one of whom also brought a spouse. The US government paid for the travel expenses and a per diem for Shulkin's wife, Merle Bari, the Post reported.

Last Friday, HHS Secretary Price resigned after coming under fire for his use of chartered planes for business purposes. Price's departure came as he's being investigated by the department's inspector general for using private jets for multiple government business trips, even to fly distances often as short as from Washington to Philadelphia. The total cost for the trips ran into the hundreds of thousands of dollars.

Interior's Zinke is also being investigated over his travel.

In a statement he gave before giving his policy speech at the Heritage Foundation Friday, Zinke confirmed that he's used private jet travel on three occasions and has flown military aircraft at other times as well.

"Using tax dollars wisely and ethically is a greatest responsibility and is at the heart of good government," he said. "Unfortunately there are some times when Interior has to utilize charter services because we often travel to areas that don't have a lot of flight options."

He called the recent criticism about his use of private jets "a little BS."

CNN's Kevin Liptak contributed to this report.

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1.4 - CBS News: [Veterans Affairs inspector general is reviewing David Shulkin's Europe trip](#) (3 October, Jacqueline Alemany, 26.1M online visitors/mo; New York, NY)

The Department of Veterans Affairs inspector general is reviewing Secretary David Shulkin's 10-day taxpayer-funded trip to Europe in July, during which Shulkin and his wife spent time shopping and sightseeing in Denmark and the U.K.

A spokesman for the VA's Office of Inspector General told CBS News on Tuesday that it is "gathering information and reviewing the recent trip."

Details of the trip, which included visits to Westminster Abbey and Wimbledon, were first reported by The Washington Post. While the trip to Denmark and the United Kingdom was focused on veterans issues, Shulkin and his wife also devoted significant time to leisure activities paid for by U.S. government dollars.

Shulkin joins the list of cabinet members under investigation for travel. Tom Price resigned as Secretary of Human and Health Services last week after coming under fire for extensive use of expensive private jets footed by taxpayers. EPA Administrator Scott Pruitt, Treasury Secretary Steven Mnuchin and Interior Secretary Ryan Zinke are also currently under investigation by their respective agency's inspector generals for travel spending.

Shulkin announced in a statement last week that the VA would be posting all official travel taken since January 20th on the VA website.

"Under this administration, VA is committed to becoming the most transparent organization in government, and I'm pleased to take another step in that direction with this move," Shulkin said in a statement. "Veterans and taxpayers have a right to know about my official travel as secretary, and posting this information online for all to see will do just that."

The itinerary uploaded to the website details conferences on veterans policy and meetings with various government officials but also time carved out of his schedule for extracurricular activities. In London, Shulkin and his wife Dr. Merle Bari attended Wimbledon and visited Buckingham Palace and Westminster Abbey. They also took a cruise down the Thames River followed by "dinner/ evening in Piccadilly Circus" and spent their first day in Denmark visiting various castles throughout Copenhagen.

The website also notes that Shulkin has not utilized private aircraft to date. Curt Cashour, VA Press Secretary told CBS News in a statement, "The Secretary welcomes the IG looking into his

travel, and a good place to start would be VA's website where the VA posted his full foreign travel itineraries, along with any travel on government or private aircraft."

"As the posted information shows, the Secretary has taken no trips on private aircraft," Cashour continued, "and the only government aircraft trips he has taken has been as a guest on the planes of the President, Vice President, or First Lady."

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1.5 - Military Times: [VA names Elizabeth Dole to head caregivers advisory group](#) (3 October, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

WASHINGTON — Veterans Affairs officials on Monday announced former North Carolina Sen. Elizabeth Dole will chair the department's new family and caregiver advisory committee, formed in response to problems with support programs earlier this year.

The committee, which features a mix of veterans and military caregivers, is charged with advocating for improvements to VA care and benefits services. In a statement, Dole called the work "critical" for the veterans community.

"Military families, caregivers, and survivors are truly our nation's hidden heroes, and make great sacrifices each and every day on behalf of their loved ones, so we must do more to support them on their journey," she said.

Last spring, VA conducted a nine-week review of the department's caregiver program after an NPR report revealed dozens of regional medical centers were cutting back on the number of families receiving caregiver benefits, possibly against program rules.

More than 20,000 individuals are currently enrolled in the department's caregivers stipend program, which awards payouts of several thousand dollars a month to family members of severely injured post-9/11 veterans providing full-time caregiving duties.

In July, VA officials ended the review promising better communication and outreach to families involved. Shulkin has also publicly discussed the possibility of extending the caregiver stipend to veterans of other war generations, but doing so will likely require congressional action.

In a statement Monday, Shulkin said his department "is committed to the delivery of highest quality care and support to our veterans, and recognizes the essential role their families, caregivers, and survivors have every day."

Dole, herself a caregiver to husband Bob Dole, the former U.S. Senate majority leader and a veteran injured in World War II, has been an advocate for military and veteran caregivers in recent years through the Elizabeth Dole Foundation.

Sherman Gillums, executive director at Paralyzed Veterans of America, will serve as vice chair of the committee. The group also includes Lolita Zinke, wife of Interior Secretary Ryan Zinke, who served as a Navy SEAL.

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1.6 - KARE (NBC-11, Video): [VA apologizes to Vietnam vet for ER denial - The Department Of Veterans Affairs has apologized to a Vietnam veteran for repeatedly denying his claim for medical care after KARE 11 reported his story as part of its continuing investigation – a pattern of denial.](#) (3 October, A.J. Lagoe and Steven Eckert, 1.5M online visitors/mo; Golden Valley, MN)

LITTLE CANADA, Minn. - Rockne “Rocky” Waite of Little Canada, Minnesota sat in his living room on September 26th watching his television in disbelief.

“It was like watching my own story,” the 71-year-old former Army Medic recalled.

He was watching a KARE 11 investigative report exposing how veterans are being saddled with medical debt they should not owe – some of it even turned over to collection agencies – after trips to the emergency room.

“It was exactly what happened to me!” Rocky said.

Rocky’s story of wrongful denial began this past July when he needed emergency surgery to remove a large kidney stone.

“The pain just got to be excruciating,” Rocky said. “So, I called VA nurses hotline and asked them what I should do, and they said to go to the nearest facility which was St. John’s Hospital in Maplewood.”

Following his emergency operation in the private hospital, the surgeon told Rocky a stent had been inserted and he needed to get it removed in 10 days.

Following VA protocol, Rocky again called the nurses hotline at the Minneapolis VA to ask if he should go back to the private hospital where he had the surgery, or if he should come into the VA for the procedure?

His VA medical file shows Rocky spoke with a registered nurse who, after consulting with his regular VA physician, instructed him to go back to St. John’s to have the stent removed.

“I took their advice, went, had the procedure done,” Rocky said.

Despite doing exactly what the VA instructed, Rocky received a denial letter in the mail. The VA was refusing to pay for the stent removal, leaving the 100% service connected disabled veteran with the \$1,200 bill.

“What more could I have done?” Rocky asked while throwing his hands in the air. “I did as I was told, I don’t know how else you could do it!”

Rocky’s is not an isolated case.

Current and former VA staffers tell KARE 11 that medical claim processors at the VA are pressured to review complicated files in just minutes.

To meet performance goals, they say it's quicker to deny claims than to take the additional steps needed to approve payments.

"We are accountable for speed," one VA insider told KARE 11 in an exclusive interview. "We were told to pick-n-click and get them moving."

When he appealed his bill rejection, Rocky said he quickly received another denial letter.

Fast forward a few weeks and the frustrated veteran watched as KARE 11's investigation aired.

Rocky emailed his denial records to KARE 11. Investigative Reporter A.J. Lagoe told about Rocky's case during a follow-up broadcast and emailed the Department of Veterans Affairs asking what the veteran, who appeared to have followed all the rules, should have done differently?

VA Press Secretary Curt Cashour responded, "While strict rules and federal law govern when VA can pay for emergency care, we always want to work with veterans on their particular claim(s) to see what VA can do in their case. We will do that in this case."

The next day, Rocky received a voicemail from a VA official apologizing for the hassle he'd been through and stating, "So we'll get that paid for you, probably today."

"What bothers me about this is it is not just one incident," Senator Amy Klobuchar (D-MN) said.

Klobuchar says her office has received a number of similar constituent complaints.

"There are many incidents and usually when a member of Congress starts getting called over and over again it's like the canary in the coal mine. It means there is one, and then there's 10, and then there's 20. It means there's probably thousands across the country, and this means they are having a rule problem, a protocol problem, that has to be fixed!"

The Senator said she would be speaking directly to VA Secretary David J. Shulkin this week about the ER denials uncovered in the KARE 11 investigation.

KARE 11 analyzed two and a half years of VA data and found in the VA MidWest Network, which includes Minnesota, 52% of all ER claims were denied.

As a result, \$65,772,205 in medical bills were forced back onto veterans to pay.

There is no way to determine how many of those veterans got stuck with bills – like Rocky – because of improper VA denials.

"If it hadn't been for KARE 11, I would still have been fighting this battle," Rocky said. "And it could go on for years with these people."

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1.7 - WFED (AM-1500, Audio): [Advancing the VA's Community Care Mission: A conversation with Baligh Yehia, Deputy Under Secretary for Health](#) (3 October, 831k online visitors/mo; Washington, DC)

This content is provided by the IBM Center for the Business of Government.

Mondays at 11:00 a.m. & Fridays at 1:00 p.m.

The Business of Government Radio Hour, hosted by Michael J. Keegan, features a conversation with a federal executive who is changing the way government does business. The executives discuss their careers and the management challenges facing their organizations. Guests include administrators, chief financial officers, chief information officers, chief operating officers, commissioners, controllers, directors, and undersecretaries.

SPECIAL REBROADCAST:

What is the mission of VA's Office of Community Care? How is VA enhancing how it provides Community Care? What can VA do better? Join host Michael Keegan as he explores these questions & more with Baligh Yehia, Deputy Under Secretary for Health for Community Care at the US Department of Veterans Affairs.

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2. Veteran and Employee Experience

2.1 - The Hill: [VA chief under investigation over European trip: report](#) (3 October, Jacqueline Thomsen, 11.8M online visitors/mo; Washington, DC)

The Department of Veteran Affairs inspector general is investigating Veteran Affairs Secretary David Shulkin over his trip to Europe, CNN reported Tuesday.

Shulkin traveled to London and Demark in July, where he met with officials from both counties.

Michael Nacincik, spokesman for the VA inspector general's office, told CNN that he couldn't say what triggered the probe or if the office was investigating any other instances of Shulkin's travel.

The Washington Post first reported last week that Shulkin spent half of the trip sightseeing and shopping with his wife.

The VA chief was there to attended a conference in London on veterans' health issues and then held a series of meetings in Denmark.

Shulkin reportedly attended a Wimbledon tennis tournament match, toured multiple palaces in London and Denmark and took a cruise on the River Thames in London while on the trip.

The VA head took commercial flights for the trip and reportedly sat in coach on at least one of them, The Post reported.

The investigation into Shulkin is the fifth inspector-general investigation into a member of the Trump administration.

Environmental Protection Agency Administrator Scott Pruitt, Interior Secretary Ryan Zinke, Treasury Secretary Steven Mnuchin and former Health Secretary Tom Price were each probed over their use of private, military or chartered planes.

Price resigned last week over his use of private jets.

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2.2 - Fortune: [Trump's VA Secretary Is the Fourth Cabinet Member to be Caught in a Travel Expense Scandal](#) (3 October, John Patrick Pullen, 7.7M online visitors/mo; New York, NY)

Overshadowed by Health and Human Services Secretary Tom Price's resignation Friday afternoon, Veterans Affairs chief David Shulkin is the latest Trump cabinet member to be found mixing personal trips and expenses with government travel. The VA secretary cruised the Thames, took in sight-seeing at Westminster Abbey, and watched a Wimbledon tennis match during a 10-day European trip with his wife, according to an itinerary obtained by The Washington Post.

The VA secretary's 10-day trip—which also included the department's undersecretary and her husband, Shulkin's chief of staff, an aide, and six security people—was approximately half business, half pleasure, the itinerary reportedly details. The government paid for Shulkin's wife airfare and provided a per diem for her meals because she was traveling on "approved invitational orders," reports the Post.

The Shulkins' July trip was revealed as the personal travel and government expenses of other cabinet officials have also come under scrutiny. In his first three months in office, Environmental Protection Agency chief Scott Pruitt reportedly travelled home to Oklahoma at least 10 times, according to records acquired by a watchdog group. In addition, the EPA is building a \$25,000 soundproof booth for Pruitt, the first agency head to have an around-the-clock security detail.

In August, U.S. Treasury Secretary Steve Mnuchin and his wife reportedly used a government plane to travel to Lexington, Ky. to watch the solar eclipse, a trip that came to light after Mnuchin's wife, Louise Linton boasted on Instagram about traveling with her husband on a government plane. Mnuchin has denied that he took the trip to view the eclipse. He has also said claims about him requesting the use of a government jet during his honeymoon with Linton earlier this year were about national security.

HHS secretary Price's spending has been the most audacious of the cabinet so far. The former Georgia congressman may have taken more than \$1 million in chartered, private jets, according to reporting by the Post. The revelation ultimately led to his resignation on Friday.

As for Shulkin, the VA Secretary is likely hoping Price's exit helps his own spending to fly under the radar. One of few Obama administration holdovers, Shulkin was most recently the VA's undersecretary before being promoted by President Trump. Considering his previous boss and

the current president's unfavorable views of how the VA has been run, Shulkin may now be on thin ice—if he wasn't already.

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2.3 - Washington Examiner: [VA watchdog launches probe of David Shulkin's 10-day European trip](#) (3 October, Gabby Morrongiello, 4.8M online visitors/mo; Washington, DC)

The Department of Veterans Affairs' internal watchdog has launched an investigation into a 10-day, taxpayer-funded trip taken by Secretary David Shulkin and his wife earlier this summer.

Shulkin came under fire last week for the July vacation to Denmark and the U.K., during which he and his wife attended a Wimbledon tennis match, and went shopping and sightseeing.

Though a conference on veterans policy and meetings with foreign officials were included in the trip, much of the secretary's time was spent touring castles in Copenhagen and enjoying a cruise with his wife.

Michael Nacincik, a spokesperson for the VA's Inspector General, told the Washington Examiner on Tuesday the internal watchdog is "gathering information and reviewing the secretary's recent trip." CBS News first reported the investigation.

Nacincik could not say how long the investigation is estimated to take or when it began.

"It really depends on what they find or what they don't find," he said.

Shulkin denied any wrongdoing in a statement last week, and announced that he would make the itinerary from his trip for the public.

"Veterans and taxpayers have a right to know about my official travel as secretary, and posting this information online for all to see will do just that," he said.

"The secretary welcomes the IG looking into his travel, and a good place to start would be VA's website where the VA posted his full foreign travel itineraries, along with any travel on a government or private aircraft," VA press secretary Curt Cashour later told CBS.

News of the IG investigation comes days after Health and Human Services Secretary Tom Price was fired for chartering several private flights on the taxpayer dime.

The Interior Department's internal watchdog also launched an investigation this week into Secretary Zinke's travel, bring the total number of Cabinet officials under investigation by their own agencies to four, including Treasury Secretary Steve Mnuchin and EPA administrator Scott Pruitt.

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2.4 - WXIN (FOX-59, Video): [Veterans voice concerns, outline legislative agenda items at town hall](#) (3 October, Haley Bull, 1.5M online visitors/mo; Indianapolis, IN)

CARMEL, Ind. – Veterans are making sure their voices are heard by state lawmakers and local government officials during a series of town hall meetings across the state.

Tuesday, veterans at a meeting in Carmel raised their concerns and outlined their legislative agenda items for the upcoming legislative session.

"It's really important for the legislators to hear our concerns we have many healthcare being right at the top of the list, also treatment of PTSD as our returning veterans from the global war on terror suicide rates among veterans are at an all-time high," said Steven McDaniel, commander of VFW Post 10003.

Some of the issues veterans raised include support for medical marijuana and ways to help veterans find employment.

But before the town hall, a group of Indiana veterans groups called the Big Four, including the VFW, AMVETS, Disabled American Veterans and the American legion, met to approve a list of their legislative agenda items for the next session.

"We've come a long way veterans contribute a lot to the state of Indiana we're not asking for a handout," said Richard Leirer, the commander for dist. 6 of the VFW in Indiana and legislative chairman.

"We want to make sure we clean up some legislation that was passed this last year in the budget bill with some wording to extend the program for our homeless veterans and for our hyperbaric oxygen therapy treatment for traumatic brain injury," said Lisa Wilken, the legislative director for Indiana AMVETS.

Wilken said they also want to make another run at a bill creating a lottery scratch off ticket to help fund veterans' programs.

"We think we have the support now to get it passed this year," Leirer said.

The next town hall will be held Oct. 17 in Indianapolis.

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2.5 - Fayetteville Observer: [NC congressmen, VA leaders meet in Washington](#) (3 October, Drew Brooks, 439k online visitors/mo; Fayetteville, NC)

Congress members from North Carolina met with Veterans Affairs leaders in Washington on Tuesday, hoping for better communication on problems in the VA system.

Eight House members met with top officials from the VA's Mid-Atlantic Health Care Network, also known as Veterans Integrated Service Network 6, and the leaders from at least three VA medical centers, including Fayetteville's.

The meeting was an introduction of sorts for DeAnne Seekins, who became director of VISN 6 in July. The network includes seven VA medical centers, 27 community-based outpatient clinics and four health care centers, and it is the fastest-growing region within the VA.

Republican Rep. Richard Hudson, whose district includes parts of Fayetteville, said he was impressed by Seekins and other VA leaders.

The discussion was “very candid, very open,” and addressed concerns about delays in VA care, problems within the VA Choice Program and late payments to vendors working with the VA, Hudson said.

“Hopefully it’s the beginning of better communication,” said Hudson, who helped organize the meeting.

Seekins was appointed director of VISN 6 after leading the Durham VA Health Care System for five years. Directors of VA medical centers in Asheville and Durham also attended the meeting.

Fayetteville has the fastest growing patient population in the VA, Hudson said, and it was important for VA leaders and Congress to be on the same page to help address issues that arise with that growth.

“I take very seriously my responsibilities as a voice for veterans in North Carolina,” he said. “I wanted to open better lines of communications.”

The meeting was co-chaired by Democratic Rep. David Price. It included Republican Reps. Robert Pittenger, Virginia Foxx, David Rouzer, Walter Jones and Mark Meadows, and Democratic Rep. Alma Adams.

In the past, members of Congress have had to “start at the bottom and work up” when it comes to VA issues, Hudson said. After the meeting, he hopes there will be a direct line of dialogue at the highest levels of the local VA network.

He said he would like VA leaders to notify the congressional delegation of potential issues or when problems arise. The delegation can be more proactive in helping the VA fix issues that continue to plague the system.

“We both have the same mission — taking care of our veterans,” he said.

VISN 6 officials said the meeting was important to Seekins, who wants to develop relationships with the delegation and learn their concerns.

A spokesman, Stephen Wilkins, said the meeting was not meant to address specific issues, but instead more of a meet and greet.

But Hudson said the delegation was able to ask questions, paying particular attention to access to VA care, the opioid epidemic among veterans, and the Choice program that allows some veterans to seek care outside the VA system.

Several representatives also brought up VA payments. They said veterans are being harassed by collection agencies because the VA is not paying its bills.

Hudson said that while he praises the network's efforts to cut down on wait times, he is lobbying for an expanded Choice program that gives more veterans the ability to go outside the VA.

The Fayetteville VA previously had one of the nation's longest waits for veteran care. In recent months, officials have said those numbers have drastically improved.

"I think we're making progress, but I personally would like to see veterans having more access to private care as an alternative," Hudson said.

Hudson has introduced legislation that would allow any veteran who is at least 50 percent disabled to see whatever doctor they would like.

"I'm just not convinced we can build enough VA facilities to keep up with the growth," Hudson said.

He said that expanded Choice would never destroy the VA. But giving veterans the ability to "vote with their feet" may force the VA to improve its practices.

"Competition will make the VA better," he said. "They care about our veterans but they work within a system that is just strangled with bureaucracy."

The congressional delegation last met with VA leaders earlier this year, after a VA audit found that the network underreported the length of wait times for new patients, and that those seeking care outside of the Department of Veterans Affairs often had long waits or were unable to receive care.

Hudson said the delegation wants to meet regularly with VA leaders.

"I think we all agreed we'd like to have something," he said. He urged veterans in North Carolina who have problems with the VA to contact their Congress representative.

"We'll be their advocate," he said.

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2.6 - Michigan Radio Network: [Ann Arbor VA Hospital employees and vets protest staffing shortage](#) (3 October, Tracy Samilton, 385k online visitors/mo; Ann Arbor, MI)

Ann Arbor VA Hospital employees rallied Tuesday to ask Congress for enough money to eliminate the 49,000 VA job vacancies nationwide. Similar rallies have been held at other VA hospitals nationally in recent weeks.

Ozzie James, Jr. is president of American Federation of Government Employees Local 2092. He says veterans need the expertise of VA doctors, nurses and other staff, because outside health care professionals don't fully understand veterans' needs.

"The promise to take care of the veterans who go fight the war, you're not keeping that promise," says James. "Because you fail to have the staffing that's needed to take care of the veteran when he or she comes home. It's a disgrace to us."

James says the shortage is particularly acute for VA nurses; many cannot take the vacations to which they're entitled because there is no one to fill in for them.

He says the staffing problem predates the Trump administration but has gotten worse under it.

Darcy Guyton-Hanna is a dental hygienist at the Ann Arbor VA. She says the staffing shortage means some veterans have to wait a year for a comprehensive dental exam.

"We are short two dental assistants and one administrative assistant, so they have a lot of the dentists doing paperwork and administrative jobs instead of seeing patients," says Guyton-Hanna.

She says administrators told her there is a hiring freeze so nothing can be done about the situation.

But according to recent comments by VA Secretary David Shulkin, the prospect for more federal money for the VA to boost hiring seems dim. At a press conference in late May, he said, "the problems in VA are not largely going to be solved through additional money. These are going to be solved through management practices, focus, and some legislation changes."

Shulkin said the VA will have a position management system in place by December, so it can track which jobs are open. And the agency plans to expand graduate medical education training opportunities to be able to train more health professionals to stay in the VA system.

He said the VA also plans to work with the Unified Services University -- the medical school of the military -- to train more medical students who then would serve in the VA for 10 years after their education.

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2.7 - Outer Banks Sentinel: [VETERANS POST Will bad employees still linger at VA?](#) (4 October, 23k online visitors/mo; Nags Head, NC)

The Department of Veterans Affairs' new authority to get rid of bad employees is getting a test in Memphis.

An employee at the Memphis VA Medical Center was arrested for aggravated assault with a deadly weapon and criminal impersonation of a police officer. Specifically, she pulled a revolver on a grandmother and a toddler, waving the gun and saying she was the police.

According to the VA, the employee was being processed for removal and has been suspended. What, exactly, does that mean. Taking steps to terminate the employee? Barred from the facility? Told to stay home with pay?

Inquiring minds want to know: Will the Merit Systems Protection Board jump in on this one, too? Long ago the VA tried twice to remove an employee because the hospital kept running out of crucial surgical inventory. The Office of the Inspector General got involved and came up with yet one more reason to get rid of the guy: He'd been sending sensitive VA personnel

information to his personal email account and his wife. The guy was fired, but after the Board got involved, the VA had to rehire him. It took quite a while, but finally he is gone.

This is the same place where a veteran getting care had his vehicle stolen from the parking lot by a VA employee. The veteran had to turn over all his personal belongings when he was admitted ... including his car keys. Within hours, before his wife could retrieve the car, it was gone. Six months later, the veteran saw his car in the parking lot, called police, and they arrested a VA employee when he came out.

So now we watch and wait. Will pulling a handgun on a little girl and her grandmother be serious enough to get rid of the employee? Does the Accountability Act truly have enough teeth to get the job done?

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2.8 - WSAW (CBS-7, Video): [Free benefits expo offered for area veterans](#) (3 October, 196k online visitors/mo; Wausau, WI)

In an effort to serve area veterans, a Wausau expo will offer free service members or dependents of veterans who want to gather information.

The U.S. Department of Veterans Affairs along with the Wausau Veterans Service Office are organizing the event on Thursday, October 5.

To explain what will be offered, Veteran Service Officer, Scott Berger joined the Sunrise 7 team.

From 10 a.m. to 2 p.m. at the East Gate Hall of Marathon Park in Wausau area veterans are encouraged to visit the Wausau Area Veterans Benefits Expo.

Vets can expect to gather information and learn about VA and other community services that they may want to avail themselves to. Also, eligible veterans will be able to get their flu shot.

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3. Access to Healthcare

3.1 - The Hill: [Congress can use the power of pets to help women and vets](#) (3 October, Rep Steve Cohen (D-Tenn.) and Mike Bober, 11.8M online visitors/mo; Washington, DC)

Each year, Congress works hard to pass bills that will help the American people. While acrimony and partisanship have made this more difficult, lawmakers are considering two bills that have bipartisan support on Capitol Hill and among the American people: H.R. 2327 and H.R. 909, the Puppies Assisting Wounded Servicemembers (PAWS), and the Pets And Women Safety (PAWS) Acts of 2017.

Each of these bills involves man's best friend, and both provide for an underserved segment of America. In the case of H.R. 2327, veterans with PTSD and traumatic brain injuries are provided

opportunities for healing through grant-funded service dogs. H.R. 909 expands the number of domestic abuse shelters that can accept pets, in order to help abused women escape domestic violence.

Rep. Cohen is a sponsor of both bills, and PIJAC supports them on behalf of the professional pet care community. Passing these bills now would be a powerful symbol to a public eager for Congress to lead, as National Suicide Prevention Month ends and National Domestic Violence Awareness Month begins.

The House is already taking important steps to help veterans get the companions they need. On Sept. 26, the House Veterans Affairs Committee held a hearing about several bills, including H.R. 2327, that can help servicemembers adjust back to non-combat life. H.R. 2327 has support among myriad veterans' groups, and 200 House co-sponsors. With about 20 veterans committing suicide each day, the PAWS Act is just one way that Congress can improve assistance to America's military servicemembers who return from war with physical and mental scars.

H.R. 909 is likewise an important bill with enormous support. It has 230 co-sponsors in the House and 20 in the Senate. It will provide assistance to many of the approximately one in four women, and one in seven men, who are domestically abused each year.

Studies are clear that in a home where human abuse is taking place, a pet is also often a target. With nearly half of women saying they have returned to an abusive home out of concern for a pet's safety, H.R. 909 is clearly necessary to save lives and prevent more harm to innocent human and animal victims.

The bill provides funds so that abuse shelters can accommodate pets, and extends domestic abuse laws so that courts may require abusers to provide restitution for veterinary costs a victim may incur.

These bills recognize the strength of the human-animal bond. Fully 65 percent of U.S. households have a pet; 88 percent of House and Senate offices allow pets in their offices.

Not only is connecting people and pets good business – with 1.3 million jobs, mostly small business, supported in 2015 alone – it is also great for human health. Just owning a pet saves over \$11 billion in health care dollars each year, according to a conservative study by George Mason University. Other studies show direct links to less stress, better educational results, and improved health for senior citizens.

Whether in Washington, D.C. or Tennessee, pets are everyone's best friend. Congress should use the power of pets to bring people together by passing H.R. 2327 and H.R. 909.

Representative Steve Cohen represents the 9th District of Tennessee. Mike Bober is President of the Pet Industry Joint Advisory Council (PIJAC), which is the legislative and advocacy voice of the responsible pet industry.

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3.2 - Dayton Business Journal: [Dayton VA moving clinic to new location](#) (3 October, John Bush, 885k online visitors/mo; Dayton, OH)

The Dayton VA Medical Center is moving its Lima clinic to a larger location this spring.

The Lima Community Based Outpatient Clinic, currently located at 1303 Bellefontaine Ave., will move to 750 W. High St. following renovations.

The project will allow the VA to treat more veterans.

The new clinic will be housed in a professional building on the campus of St. Rita's Medical Center. It is owned by Lima IV Medical Properties LLC, which will hire a contractor to perform renovations after a bidding process.

The clinic will offer more than 1,400 additional square feet compared to the old location — 9,750 square feet versus 8,341. The increase in space will allow for additional nursing clinics, dedicated exam rooms for tele-health and other specialty services, and more parking (about 100 spaces).

It is also located near major roadways such as U.S. 30, state Route 501, Hume Road and Thayer Road.

The new clinic will be designed "to best serve the needs of veterans" by improving access to care, efficiency of facility operations, infrastructure layout, parking and care coordination between all services, according to a press release from the Dayton VA.

The VA stated the relocation was a necessary move, as the number of veterans served at the current Lima CBOC has expanded by 10.5 percent over the past two years.

The Bellefontaine Avenue site will remain open for all existing services until the new location is ready in spring 2018. At that time, veterans' medical information and appointment schedules will be transferred to the new CBOC.

The Lima clinic served more than 4,200 veterans in the last year, with more than 22,000 outpatient visits.

The Dayton VA Medical Center is the third-largest hospital in the Dayton region with \$382 million in net revenue for 2015, according to DBJ research. The hospital has 371 beds and saw about 5,500 admissions that year.

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3.3 - Government Executive: [How the VA Is Blocking Marijuana Research Veterans Say Could Save Lives](#) (3 October, Eric Katz, 852k online visitors/mo; Washington, DC)

In 2010, Boone Cutler was taking 30 milligrams of morphine, 70 milligrams of oxycodone and other opioids each day. He regularly went three to four days without sleep. The Army veteran had survived a blast injury while deployed in Sadr City, Iraq, and has since endured seven knee surgeries, five shoulder surgeries and back surgery. He also suffers from Parkinson's Disease.

"I did my time," Cutler says. "I've been beat up a few times."

That year, however, Cutler abandoned his treatment through the Veterans Affairs Department and checked himself into a psychiatric ward at a private hospital, where he quit his prescribed cocktail of opioid painkillers cold turkey. Upon leaving the hospital, a coworker convinced him to try something new for his physical and psychological symptoms: marijuana. He was reluctant, telling his colleague, "I'm not one of those pot heads."

The more he thought about it, the more he realized he had nothing left to lose: "I tried everything," he says. "Nothing worked."

But after trying cannabis, Cutler experienced something for the first time since he returned from Iraq: He slept for five hours.

"I thought it was a fluke. I tried it again, and it happened again," he says. "That was an absolute, 100 percent, 180-degree life changing event for me."

Cutler is part of a growing community of veterans who depend on cannabis to treat post-traumatic stress and pain from service-connected injuries. Some vets returning from combat tours of duty have reported that the drug has reduced nightmares and flashbacks, eased pain and helped eliminate their dependency on opioids. The drug nonetheless remains classified as "schedule one" by the federal government, which it defines as "drugs with no currently accepted medical use and a high potential for abuse." While some studies have examined the potential medicinal benefits of cannabis and a growing number of states have legalized medical and even recreational marijuana, there has never been a federally-approved study of its impact on post-traumatic stress disorder with the potential to change the federal government's scheduling.

Dr. Sue Sisley and the Multidisciplinary Association for Psychedelic Studies are trying to change that. Sisley and the group have worked for 10 years to get their triple-blind study with a placebo on the impact of marijuana on veterans with PTSD off the ground. Sisley's research now has approval from the Food and Drug Administration, the Drug Enforcement Administration and the Health and Human Services Department's National Institute on Drug Abuse, which is supplying the marijuana for the study. The research has finally commenced, and Sisley now has 28 participants in treatment. She will need 76 to complete the study, but she is facing a significant barrier: she is running out of veterans who qualify to participate, and the Veterans Affairs Department is refusing to help her identify more.

Taking Risks

Unlike Cutler's state of Nevada, where marijuana is now legal, Thomas Brennan lives in North Carolina, where the drug remains outlawed in all forms. The Marine Corps veteran who completed tours in Fallujah, Iraq, in 2004 and the Helmand Province in Afghanistan in 2010 felt he had no choice but to set up a cannabis distribution network with a handful of other veterans. While they had the marijuana shipped from Marines they trusted located in other parts of the country, they knew they were putting themselves in jeopardy.

"Veterans know this is better than the alternative and were willing to take the risks to deal with this," says Brennan, who suffers from PTSD.

Brennan also tried to use VA as his primary care provider, but felt shunned after informing his doctors there he used marijuana.

“They treated me like a drug addict when I told them about my cannabis use,” says Brennan, who considers himself lucky because he is now entitled to TRICARE by virtue of being medically retired. “They weren’t willing to help me wean off narcotics.” Brennan, before he started using marijuana, took a mixture of antidepressants, sedatives, amphetamines and mood stabilizers that VA sent him through the mail.

Brennan credits marijuana with saving his life, saying without it, he would have committed suicide.

Blocking Research

VA says it is willing to examine research on medical marijuana.

“There may be some evidence that this is beginning to be helpful,” VA Secretary David Shulkin said in May. “And we’re interested in looking at that and learning from that.”

To veterans like Cutler and Brennan, and service organizations like the American Legion, which is pushing VA to adopt a more lenient position on medical marijuana, the department is standing directly in the way of researchers trying to collect that evidence. The researchers will continue their work even if they cannot sign up a sufficient number of veterans, according to MAPS’ Brad Burge, by opening up the study to anyone with PTSD. Burge said it is unclear if such a study would still be generalizable to the veteran community.

VA, for its part, said it is bound by federal law that prohibits its clinicians from recommending patients for studies involving marijuana. A spokesman blamed Sisley and MAPS for not finding other means to recruit veterans for their research.

“Federal law restricts VA’s ability to conduct research involving medical marijuana, or to refer veterans to such research projects,” said Curt Cashour, the VA spokesman. “If the researcher is truly interested in finding veterans for her study, she should spend more time recruiting candidates and less time protesting to the media.”

Sisley says VA is poorly informed, noting she and her team have been “pounding the pavement” to recruit participants. She has screened more than 4,000 veterans over the last two years, but most of them are not qualified to participate. Veterans enrolled in VA health care are uniquely qualified subjects, she explains, as they are likely to have already attempted other treatment and are less likely to already depend on marijuana.

“If you’re in the VA system, that means you’ve already raised your hand and said ‘I need help,’” Sisley says. She adds the department is being disingenuous when it says it wants to examine more research: “It’s very negligent for VA to be begging for more data, and then refuse to cooperate with the federally legal, FDA-approved study that is happening right in the backyard of a VA facility. They should be ashamed.”

Sisley’s study is not receiving any federal funds. She has a \$2.1 million grant awarded from the state of Colorado, and received the marijuana from a National Institute on Drug Abuse contracted facility at the University of Mississippi (all federally approved research on marijuana

comes from plants grown at that facility). To advocates, VA already has the authority to refer its patients to the study.

"We've been, to no avail, trying to work locally with the hospital director and the [Veterans Integrated Service Networks] director to try to get them to build some kind of bridge, some kind of information bridge between the [researchers] and the VA, and they've just been really resistant to doing that," said Lou Celli, American Legion's VA director. He noted VA's laudable history in research, with its clinicians winning three Nobel prizes.

"The time is ripe for this administration to take the lead on this issue and really come out looking like superheroes," Celli said. "It's not a controversial topic. It's only controversial in their own minds."

The American Legion is hopeful if Sisley's study is completed, and its results are accepted by the FDA, it would just be the tip of the iceberg into researching the possibilities of medical marijuana. Like Brennan and Cutler, he acknowledges cannabis will not cure PTSD for any veteran. The alleviation it does provide, however, enables them to seek further help.

"The most common term I hear is, 'It helps keep the visitors away,' meaning the nightmares, the flashbacks," Celli says. "We don't believe there is any study that will prove cannabis cures PTSD. But what it does do is it relaxes them enough, and it lowers their inhibitions enough to be able to receive counseling and to be able to work through whatever issues that they have."

Sisley says marijuana could help address the epidemic of veteran suicides, and if the plant can save even one life, her research is worth pursuing.

"Please allow science to stop being shackled by VA politics," she says in a plea to the department. Absent such action, the American Legion plans to mobilize its 2 million members to lobby VA and members of Congress to help the study move forward.

Getting Out of Bed

Cutler describes the period of his life in which he was taking an ever-growing opioid cocktail as a "never-ending blackout." He went through cycles in which his tolerance would soar, he would detox, the pain would continue and he would repeat the process all over again. He now takes cannabidiol tablets during the day, which he says have no psychoactive effect, and smokes marijuana at night before going to sleep. Cutler calls the VA "hypocritical" for prescribing addictive opioids, but refusing to even research marijuana.

"You send us to war," he says, "and you deny us medication."

Brennan knows marijuana is not a cure-all. He still takes some prescription drugs. He still has migraines. He is, however, sleeping more easily and for longer. He has seen gradual improvements to his depression, mood and relationships. He no longer feels numb.

"Sometimes," Brennan explains, "the smallest reasons for getting out of bed in the morning are what can make a difference for mental health."

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3.4 - WSLs (NBC-10, Video): [Salem VA Medical Center offering free drive-thru flu vaccines, The medical center has opened a drive-thru flu shot clinic on campus.](#) (3 October, Alison Wickline, 815k online visitors/mo; Roanoke, VA)

SALEM, Va. - The Salem VA Medical Center is making it easier for veterans to get their flu shots.

The medical center has opened a drive-thru flu shot clinic on campus. During the whole month of October, between 8 a.m. and 4 p.m., from Monday to Friday, veterans enrolled in the VA system and Salem VA Medical Center employees can receive the vaccine for free.

"For them, it's just a quick and easy process. It's less time-consuming for them because it's a hassle to go into primary care and have a wait time," said Jody Duke, assistant nurse manager for the Salem VA Medical Center.

Veterans are asked to bring their ID card when they visit the flu shot clinic. The clinic is set up in front of Building 1. Staff members say they have given more than 200 vaccines since Monday.

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3.5 - JD Supra: [Department of Veterans Affairs Releases Long-Awaited Proposed Rule to Allow Telehealth Services Across State Lines](#) (3 October, Faegre Baker Daniels, 701k online visitors/mo; Sausalito, CA)

On Friday, September 29, the Department of Veterans Affairs (VA) released its long-awaited proposed rule amending medical regulations to improve access to care for beneficiaries regardless of patient or provider locations. Specifically, the rule enables health care providers to provide telehealth services to beneficiaries across state lines in an effort to increase patient access to care. This "modern, beneficiary- and family-centered health care delivery model" – 38 CFR 17.417 – will leverage novel information and telecommunication technologies, such as apps on a patient's phone or computer, to connect patients and providers throughout the country.

The proposed rule provides a concrete outline for how the Trump Administration intends to utilize the increasingly popular telehealth technology to care for veterans. In fiscal year (FY) 2016, VA providers had 2.17 million telehealth episodes serving over 700,000 beneficiaries. While this accounted for only 12 percent of all beneficiaries that sought care from the Veterans Health Administration (VHA), 45 percent of these patients were from rural communities. Telehealth technology is incredibly effective at expanding access to care for patients in remote locations.

As a national health care provider, the VHA must ensure that its beneficiaries all receive an adequate level of care regardless of location at the time which health care services are provided. As the proposed rule notes, a focused effort to ensure beneficiaries in remote, rural or medically underserved areas is necessary to level accessibility to those with on-site services available. Telehealth will improve the ability of the VHA to take these clinical services to beneficiaries in a convenient, cost-effective and institutionally efficient matter. Congressional and Administration-based efforts to date have demonstrated the desire to make this transition,

evidenced by authorization of department-wide initiatives, copayment waivers and pilot programs.

Today, all VHA providers are licensed in at least one state, but are restricted from practicing in states in which they are not licensed. The proposed rule would exercise federal preemption of state licensure and allow licensed providers to provide services, regardless of the patient's location. Previously, VA medical centers have held off on expansion of telehealth services outside of federal property, such as a beneficiary or provider's home, for fear of repercussions. To date, issues arising from disparities between state law and the VA health care practice have impeded the integration of these services. While some states have already begun to regulate the practice of interstate telehealth, the VA would exercise the federal preemption of state licensure, registration, and certification laws, rules and regulations for all VA providers offering telehealth services within the scope of their employment. Furthering the VA's capabilities to provide telehealth services across state lines would allow these providers to treat more patients in a more timely fashion.

The proposed rule is in stark contrast to Medicare rules, which still require patients to reside in certain locations to receive covered telehealth services. VHA could be paving the way for changes to the Medicare program as the benefits to increased access to care, as well as cost-effective care, are demonstrated.

At a time where the country faces the perils of a deadly prescription opioid epidemic, however, the proposed rule is absent of any language around prescribing practices. The rulemaking does not affect the VA's existing requirement for compliance with state regulations on prescribing and administering controlled substances. Health care providers are still required to abide by limitations put forth in the Controlled Substances Act alongside any additional federal regulations that apply to the VA.

Advancing access to health care services for individuals in remote, rural or medically underserved areas will also benefit those dealing with serious mental illnesses, such as anxiety, depression or agoraphobia. Research conducted by the VA in 2016 clearly demonstrates the improvement that telehealth provides in terms of outcomes, especially in the instance of mental health. VA beneficiaries receiving mental health services through synchronous video telehealth saw a 39 percent reduction in acute psychiatric intakes. Data also supports the use of telehealth for the treatment of general or chronic condition management. For those with limited mobility, telehealth offers an alternative to receiving care without the stress of traveling to receive care. For many, receiving care in the comfort of their home may also lead them to take a more proactive role in their health care, thus improving outcomes.

As a part of the proposed rulemaking, VA solicited comments and input from a variety of stakeholders, including the National Governors Association, Association of State and Provincial Psychology, National Council of State Boards of Nursing, Federation of State Medical Boards, Association of Social Work Boards, and National Association of State Directors of Veterans Affairs. Each of these stakeholders, among others, responded favorably to the inquiries and noted their support of the proposed rulemaking.

The proposed rule will be published in the Federal Register on Monday, October 2, with an open comment period lasting 30 days.

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3.6 - KRGV (ABC-5, Video): [Local VA Records Show Improvements in Veterans' Wait Times](#) (3 October, Matt Rist and Valerie Gonzalez, 275k online visitors/mo; Weslaco, TX)

CHANNEL 5 NEWS' investigative team looked closer at data behind wait times at the VA Texas Valley Coastal Bend Health Care System clinics.

After scouring through records, we found a downward trend in wait times for returning patients. However, if you're a new patient, you can expect to wait as long as 70 days for care.

The Texas Valley Coastal Bend Veteran's administration booked more than 235,000 appointments for the fiscal year 2017 alone.

That works out to just shy of 30,000 patients churning through the system.

"We have radically changed the access to our patients," said Dr. Jorge Ortegon, Chief of Medicine at the Texas Valley Coastal Bend VA.

He shared what happens if patients face high wait times.

"The health of the patient will deteriorate," said Dr. Ortegon.

CHANNEL 5 NEWS wanted to find out exactly how long VATVCBHCS patients are waiting, so we pulled data from the VA's government website.

As of Sept. 1st, patients waited an average of five days for primary care, five days for specialists and 2.5 days for mental health care in the Rio Grande Valley region.

"Fortunately, we've done a really good job of gaining trust and credibility back with our patients," said VA Texas Valley Coastal Bend Health Care System VA director Joe Perez.

The data showed it's difficult for veterans to get certain types of care in some places.

In July, veterans at a Harlingen clinic waited an average of 13.5 days to see a specialist. The Sept. 1st numbers show improvement; veterans now wait at that clinic just more than 10 days.

Several Corpus Christi and Laredo veterans also faced waits longer than overall averages.

In July, veterans from Corpus Christi waited 10 days to get primary care. In Laredo, it took eight days to see a specialist.

"Our challenge here is having some of these specialties on board," Perez said.

Perez said they streamlined many processes to reduce wait times. He said veterans can directly opt into the Choice Program and choose an outside provider if wait times are clocking over a certain number of days.

If you're a new patient, expect to wait as many as 70 days to get specialty care at the VA.

The following is a breakdown of new patient wait times as of late September:

In McAllen, for primary care, you'll wait an average of 24 days, compared to 16 in the Harlingen clinic and just 12 at its other Treasure Hills location.

According to the records, when it comes to specialized care like gastroenterology, it takes 27 days. To see an Audiologist, you'll have to take a 70-day wait.

Perez said that number is an exception.

"These are really good compared to what I've experienced out in the community," Perez said. "From my own personal experience, if I could have something at 24 days that would be awesome."

Perez said wait times rise when patients miss or forget to cancel appointments. He also said wait times can be a testament to the quality of care they provide.

"We have a number of patients who choose to wait a little bit longer to be seen by us," Perez said. "We do know their background, we can relate to them. A lot of it is by veteran's choice."

Veterans like Hilario Diaz make that choice every day. Diaz said he's satisfied with his experiences at local regional VA clinics.

"Where in the Valley can you go to and you don't have to wait to see a doctor?" Diaz said.

He did not wait long for care.

"It's free. I haven't researched, but I would venture to say there's no other country in the world that does for veterans what the United States of America does," Diaz said.

Army veteran Robert Grandstaff shared a different experience with the VA. He was injured while deployed.

"I need a lot of care, I have a lot of physical injuries, PTSD, chronic back pain," Grandstaff said.

He said he waited long for his first VA appointment in 2013.

"When I first moved here, I asked for an appointment and they told me to wait three to four months," Grandstaff said.

Grandstaff said his injuries force him to seek specialty care.

"Just like other veterans, I'm going to have to find other care," Grandstaff said. "There needs to be some sort of better system, better accountability."

Back in 2016, the local VA was scrutinized after an allegation of altering data to make it look like veterans were waiting less time for appointments.

Perez said it happened at clinics across the country, but it's no longer an issue.

"It was a national initiative to do training and re-training of everybody that had the ability to schedule within our system and that continues annually," Perez said.

The director admits wait times will constantly change. A new patient survey will be a crucial measuring stick to find out how satisfied or dissatisfied veterans are with their care.

If you want to learn more about wait times at VA clinics across the region, you can log on to the VA's website: <https://www.accesstopwt.va.gov/>

There are bi-monthly published reports on government websites which outline wait times and show conflicting information. Perez said the data online is always changing and it can make monthly published reports quickly outdated.

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3.7 - South Bend Tribune: [Our Opinion: A long journey's end for local veterans](#) (3 October, Editorial Board, 273k online visitors/mo; South Bend, IN)

The recent opening of the new St. Joseph County VA Clinic in Mishawaka marked the beginning of a new era for veterans' care locally.

It's been a long journey. Veterans from South Bend, Mishawaka, Elkhart and other local communities have often had to travel to VA facilities in Chicago or Fort Wayne for more extensive medical procedures. Now, patients will be able to receive more services here. As many as 8,000 patients will be receiving services here initially and the VA hopes to grow that number to 13,000 in the next two years.

Work on the clinic began nearly a decade ago when, as a U.S. representative, Joe Donnelly began work on improving veterans' services here with the possible goal of building a new facility. Credit, too, should be given to Jackie Walorski, who has made veterans' issues a priority during her time as Indiana's 2nd District congressional representative.

The VA approved a clinic for the South Bend area and in 2011 Congress appropriated \$6.7 million to build it.

Nearly two years ago, ground was broken for a new 89,000-square-foot clinic. Now, the dream has become a reality.

Veterans will be able to receive a range of offerings at the new clinic that the current clinic on South Bend's Western Avenue doesn't provide: eye and hearing clinics, foot and skin doctors, a cardiologist for consulting (no procedures), prosthetics, physical and occupational therapy and CT scans. Women will have a space for primary care and procedures.

More services will gradually be added.

"It's the culmination of the dedication and determination of the entire community," Donnelly wrote in a Tribune Viewpoint last week, "and it's an example of what we can accomplish when we work together."

Hoosier veterans in northern Indiana now are getting the care they need and a clinic they deserve.

...

Leaders at the South Bend Police Department, who are finding it difficult to recruit and retain officers in this day and age, are trying something different to address the problem.

The Common Council approved a plan by Police Chief Scott Ruskowski to begin a part-time program using retired officers to staff certain positions.

Rather than working patrol beats, retired officers would be assigned to more administrative and less confrontational tasks.

Ruskowski envisions part-time officers handling jobs such as traffic control at Notre Dame football games, taking vandalism and shoplifting reports, traffic enforcement and other "quality of life issues."

The officers would be paid a bit less, but would carry the same weapons and have the same arrest powers as full-time officers. Pending approval by the city's Board of Public Safety, the program could be launched by spring.

Statewide, the only other known city department to operate such a program is Danville, a small community west of Indianapolis.

South Bend's plan to use retired officers is a creative way to address its personnel shortage. That kind of resourcefulness is what's needed to attract new officers to the city, retain current ones and maintain the level of public safety this community deserves.

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3.8 - KRTV (CBS-3): [VA gearing up for Drive Thru-Flu Clinic and Health Fair](#) (3 October, Eric Jochim, 195k online visitors/mo; Black Eagle, MT)

Staff at the VA are gearing up for their Annual Drive Thru-Flu Clinic and Health Fair.

Tomorrow from 7 am to 5 pm free Flu shots will be available for to all enrolled Veterans and VA employees.

If a veteran isn't enrolled with the VA staff will be on hand to assist with the process.

Last year at the event the clinic administered over 500 flu shots.

Registered Nurse Katie Temple urges the public to get their flu shot sooner than later.

"Up to 20% of the population actually gets influenza every year and the elderly and the young are really prone to get hospitalized from influenza," said Temple.

The clinic will also offer health promotions, disease prevention, suicide awareness, and hepatitis C screenings.

According to VA staff baby boomers are 5 times more likely to test positive for hepatitis C than any other age group.

The county health office will also be in attendance from 8:30am to 3 pm, to provide flu shots to family members for a small fee.

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3.9 - Healthcare-Informatics: [VA Issues Proposed Rule to Allow Home-Based Telemedicine for Veterans](#) (3 October, Heather Landi, 158k online visitors/mo; New York, NY)

The U.S. Department of Veterans Affairs (VA) issued a proposed rule this week that would allow VA healthcare providers to provide medical care via telehealth across state lines and regardless of the location of the provider of the beneficiary.

The VA says the proposed rule would increase the availability of mental health, specialty and general clinical care for all VA beneficiaries. “Just as it is critical to ensure there are qualified health care providers on-site at all VA medical facilities, VA must ensure that all beneficiaries, specifically including beneficiaries in remote, rural or medically underserved areas, have the greatest possible access to mental health care, specialty care and general clinical care,” the proposed rule states. “Thus, VA has developed a telehealth program as a modern, beneficiary- and family-centered health care delivery model that leverages information and telecommunication technologies to connect beneficiaries with health care providers, irrespective of the state or location within a state where the health care provider or the beneficiary is physically located at the time the health care is provided.”

Further, VA officials stated, “By providing health care services by telehealth from one state to a beneficiary located in another state or within the same state, whether that beneficiary is located at a VA medical facility or in his or her own home, VA can use its limited health care resources most efficiently.”

VA will accept comments on the proposed rule through Nov. 1.

For fiscal year (FY) 2016, VA health care providers had 2.17 million telehealth episodes of health care (meaning a clinical encounter or a period of time in which care was monitored), which served over 702,000 veterans (approximately 12 percent of the total patient population), with 45 percent of those veterans living in rural communities. By increasing VA’s capabilities to provide telehealth services, VA would be able to expand these services, the agency said in the proposed rule.

While telehealth enhances VA’s capacity to deliver health care services to beneficiaries located in areas where health care providers may be unavailable or to beneficiaries who may be unable to travel to the nearest VA medical facility for care because of their medical conditions, the agency states that in order to protect VA health care providers from potential adverse actions by states, many VA medical centers (VAMC) are currently not expanding some critical telehealth services if the health care service is provided outside federal property, or across state lines.

In addition, many individual VA health care providers refuse to practice telehealth because of concerns over states taking action against the health care provider’s state license, state laws, or

the shifting regulatory landscape that creates legal ambiguity and unacceptable state licensing risk, the VA stated in the proposed rule. “The current disparities between VA health care practice in telehealth and state laws have effectively stopped or inhibited VA’s expansion of telehealth services to certain locations, thereby reducing the availability and accessibility of care for beneficiaries,” the VA stated.

This proposed rulemaking would clarify that VA health care providers may exercise their authority to provide care through the use of telehealth, notwithstanding any state laws, rules, or licensure, registration, or certification requirements to the contrary. In so doing, VA would exercise federal preemption of state licensure, registration, and certification laws, rules, regulations, or requirements to the extent such state laws conflict with the ability of VA health care providers to engage in the practice of telehealth while acting within the scope of their VA employment.

The VA notes in the proposed rule that the changes would improve VA’s ability to provide mental health services to veterans. Veterans who received mental health services through synchronous video telehealth in fiscal year 2016 saw a reduction in the number of acute psychiatric VA bed days of care by 39 percent, the VA reports.

Another benefit of expanding VA telehealth includes serving a recruitment incentive for VA healthcare providers and allowing VA to address recruitment shortages, the agency states. In Charleston, South Carolina, the South Carolina VAMC serves as one of the VA’s National TeleMental Health Hubs and provides mental health services to veterans across eight states with a team of 30 full-time healthcare provides. The VA notes there are currently multiple vacancies for TeleMental Health psychiatrists at the Charleston Hub, and “in the past six months, applicants have only expressed interest in telework positions.”

The American Medical Association (AMA) released a statement supporting the expansion of clinically validated telehealth services within the VA, and stated that “this decision ensures that important patient protections are in place for the delivery of high quality and reliable care.

“The VA has a unique federally controlled healthcare system with essential safeguards to help ensure that both in-person and virtual beneficiary care meet and exceed the standard of care. The AMA strongly supports that the proposed rule explicitly provides that this program’s multi-state licensure exception applies only to VA-employed providers and would not be expanded to contracted physicians or providers who are not directly controlled and supervised by the VA and would not necessarily have the same training, staff support, shared access to a beneficiary’s EHR and infrastructure capabilities. We applaud the VA’s expansion of telehealth services in a manner that promotes quality and access,” the AMA stated.

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3.10 - Gatehouse Media: [VA’s chief surgeon envisions center of excellence in Fayetteville](#)
(3 October, Amanda Dolasinski, 74k online visitors/mo; Fayetteville, NC)

Dr. Lynn Weaver was a part of integration in Knoxville, Tennessee, but bullies were no match. His distinguished career now comes to Fayetteville’s VA Medical Center.

Fifty-three years ago, a young Lynn Weaver walked into his new classroom at West High School in Knoxville, Tennessee, ready for lessons, but honestly more interested in the football field.

He and a dozen other black students were the first to integrate into the school.

"I got stomach cramps every morning just thinking about going to school," Weaver said. "I stopped eating breakfast."

The daring move led Weaver to second-guess his abilities. But the 14-year-old student who was constantly targeted by racist teachers and bullies would not only ace his classes, he also became one of the top Veterans Affairs surgeons.

In February, Weaver was named the chief of surgery at the Fayetteville Veterans Affairs Medical Center. Weaver, who completed his residency while serving 13 years in the Army, most recently worked as the senior associate dean and chairman of surgery at Ross University School of Medicine in Dominica.

Gregory Antoine, the medical center's chief of staff and a longtime friend, enticed him to take over the surgery department in Fayetteville, Weaver said. The men were stationed together at Fort Campbell, Kentucky.

The VA has been finding ways to work with Womack Army Medical Center on Fort Bragg, and is looking into ways to work with Wake Forest University and the University of North Carolina at Chapel Hill, he said.

"I liked the picture he envisioned for patients," Weaver said. "You can put together a center of excellence right here in Fayetteville."

Weaver's career began to take shape when he was a high school student in Knoxville. That's when learning became a spiteful act, and he learned as much as he could, he said.

Weaver was a constant target of racist teachers, who put his desk in the back corner of their classrooms, he said. And of the students and parents who crowded him on the football team, intimidating him.

With failing grades in all of his seventh grade classes, Weaver questioned if he was smart enough to be in the school.

"I started to think I am dumb," Weaver said. "Maybe I don't belong."

Then Edward Hill, his science teacher, knocked on the door at his family's home.

"He said, 'I heard you're having problems,' " Weaver recalled. "I said, 'Yeah, they're trying to run me away.' "

Hill, a black teacher, set up private tutoring lessons for Weaver after school and on Saturdays.

"I was able to pass the semester," Weaver said. "After they got through tutoring me, learning became a spiteful activity. I needed to show I belong and I was as smart as everyone else."

Hill encouraged Weaver to compete in the Southern Appalachian Science Fair that year. Weaver, not thrilled about yet another activity that would cut away at his time practicing football, conceded when Hill paid another visit to his home and spoke with his parents.

For three days, Weaver dressed up in a jacket and tie and stood next to his project at the science fair. The other contestants, mostly white students, ignored him and didn't speak to him, Weaver said.

His project was simple compared to the other students. He set out to prove why asbestos was a good insulator; it is now a known carcinogen.

A group of men stopped at his project and Weaver was so excited someone wanted to talk to him. He rattled off all the details of his experiment.

Unbeknownst to him, they were the judges — and they would later name him grand champion.

"I was the first black student to win," Weaver said, smiling at the memory. "It was a huge deal in Knoxville."

His win caught the attention of bullies, Weaver said. He had a brief brush with being a "bigger thug than they were," Weaver said.

Then he decided to get back on track, dedicating his life to making his father and Hill proud.

He hadn't given college much thought, but didn't question when he received a scholarship to Howard University. Years later he learned he received that scholarship because Hill applied for it on his behalf.

Weaver would go on to complete his residency training in general surgery at Fitzsimmons Army Medical Center in Denver, Colorado, and residency at Madigan Army Medical Center in Tacoma, Washington. He served in the Army from 1974 to 1987, when he was a major.

"As far as being a surgeon in the Army, you're not trying to make money," Weaver said. "You're there to take care of the soldiers. I really enjoyed my time in the Army."

As Weaver winds down his busy career, he said he's happy to be in Fayetteville, taking care of soldiers.

"I thought it'd be great to end my career in a place with a lot of soldiers and veterans," he said. "I've made a difference, I hope."

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3.11 - Salem News: [Walgreens to offer flu shots for vets](#) (3 October, Larry Shields, 68k online visitors/mo; Salem, OH)

For the first time, the Veterans Administration is partnering with the Walgreens drug store chain to provide flu shots for all veterans, Rod Hughes, commander of AMVETS Post 45, said.

The shots will be given from 11 a.m. to 5 p.m. Oct. 14 at the AMVETS Post 45, 750 S. Broadway Ave., in Salem.

“The VA teamed up with Walgreens this year so we are providing a place for flu shots for all vets in the VA,” Hughes said, adding that, “their spouses are also able to get shots that day with current insurance.”

The Columbiana County Veterans Service Commission will also have representatives available for veterans who are not registered and veterans can speak with them about what services and benefits are available to them.

Any veteran who is unsure if they are registered should bring their DD-214 form. The shots will be at no cost to veterans with proof of registration.

Hughes said Walgreens will provide pharmacists and the necessary personnel to fill out paperwork to the post.

Privacy laws under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be followed Hughes said.

“Our members are aware of the flu shot program this year,” Hughes said, “but possibly not all veterans.”

AMVETS Post 45 has a combined membership of 800 regular, auxiliary and Sons of AMVETS members.

The VA system includes the Youngstown and Calcutta outpatient clinics along with Brecksville and Wade Park hospitals.

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3.12 - KGVO (CMN-1290, Audio): [Montana Veteran Affairs Talks With Veteran's Heartbeat About Recent Suicide Numbers](#) (3 October, Nick Chrestenson, 20k online visitors/mo; Missoula, MT)

Veteran's Heartbeat – On the Pulse of the Veteran is a weekly half hour talk show devoted to issues of hope, health, opportunity and well-being of veterans. Join us on KGVO 98.3 FM every Saturday morning at 8:30 a.m. The show is brought to you by the Rural Institute for Veteran's Education and Research and they are on a mission. When veterans encounter obstacles to health and well-being, RIVER is there to help. RIVER provides training to the veteran's community for outdoor recreational therapists and emergency medical technicians, plus medical services and cutting edge research projects. If you are a veteran or veteran's family, contact RIVER at riverofchange.org.

For episode 32 of Veteran's Heartbeat, we spoke with Juliana Hallows and she is the Suicide Prevention Coordinator with Veteran Affairs Montana.

Read More: Montana Veteran Affairs Talks With Veteran's Heartbeat About Recent Suicide Numbers | <http://newstalkkgvo.com/montana-veteran-affairs-talks-with-veterans-heartbeat-about-recent-suicide-numbers/?trackback=tsmclip>

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3.13 - KTVH (NBC-12): [Drive-thru flu shot clinic offers vets and others convenient option](#) (3 October, John Riley, 2.3k online visitors/day; Helena, MT)

Over 550 Veterans received their Flu immunization on Tuesday at the Fort Harrison along with community members and VA staff.

VA Montana staff braved the cold temperatures outside to kick off the flu season with the annual Fall Health Festival and Drive-Thru Flu Clinic.

The shots were free for enrolled veterans and VA employees. County Health Department were on hand to supply flu shots for a fee for everyone else.

People 65 years and older, young children and people with certain health conditions are at higher risk for serious flu complications.

Each year around 200,000 people are hospitalized and around 32,000 people die from Influenza. Health experts say best way to prevent the flu is by getting vaccinated each year.

Veterans attending the event said that they love the ease of the clinic considering they didn't even have to leave their vehicles.

"I've never had to wait long," said veteran Louie Stiles, "When I was doing it privately getting these private shots they'd just take a lot of time, this doesn't."

If you are an enrolled veteran and missed the clinic you can still get your shot at the VA Medical Center.

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3.14 - Interlochen Public Radio: [In Michigan, veterans commit suicide at high rate](#) (3 October, David Cassleman, 900 online visitors/day; Interlochen, MI)

The suicide rate for Michigan veterans is more than twice as high as the state's overall rate, according to data released by the U.S. Department of Veterans Affairs last month.

The analysis shows more than 200 veterans killed themselves in Michigan in 2014 – the most recent year covered by the study.

Michigan's rate of 35.5 suicides per 100,000 veterans is slightly less than the national rate of 38.4. The rate for all Michigan residents is 16.9.

Dr. Nazzareno Liegghio, the chief of mental health at the Saginaw VA medical center, says it can be difficult for veterans to travel to get mental health treatment.

“In Michigan I think the biggest challenge is just our huge space and area,” Liegghio says, “and the location of veterans between the upper part of lower Michigan and Upper Peninsula.”

The suicide rate is especially high among young Michigan veterans. Only Oklahoma had a higher rate than Michigan for veterans aged 18-34.

Liegghio says young veterans are at risk when they transition out of the military.

“Usually they enlist around 18, 19, so they get out, they’re 23, 24,” Liegghio says. “They come home. They have a little time to adjust. And then all of a sudden they find themselves, ‘okay, now what do I do?’”

Nationwide more than two-thirds of veterans who commit suicide are aged 50 or older.

The analysis shows 20 veterans commit suicide each day in the United States.

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4. Women Veterans

5. Appeals Modernization

6. Strategic Partnerships

6.1 - WXIN (FOX-59, Video): [Researchers at IUPUI using dogs to sniff out prostate cancer](#)
(3 October, Nick McGill, 1.5M online visitors/mo; Indianapolis, IN)

Scientists at IUPUI are hoping man’s best friend can help solve one of man’s biggest problems.

Recently, a study in Italy found that dogs have the ability to smell and detect certain odors in urine that are associated with prostate cancer with 98% accuracy. A team at IUPUI, led by Dr. Mangilal Argawal, is hoping to replicate that process and develop an early screening method.

“If we can find that smell in prostate cancer from urine, it can really change the way we diagnose prostate cancer right now,” Argawal said.

Partnering with the Roudebush VA Medical Center, Argawal says his team has potentially identified molecules that could be the key to the “odor test.”

The team is working with dog training service “Medical Mutts” to verify their work. The hope is then to create a sensor that can detect the odors. Argawal says it would work similar to a “pregnancy test for prostate cancer.”

“So if you can make a sensor that is as accurate as a trained dog that can sniff prostate cancer from urine at 98% accuracy, then you are completely changing the field,” he said.

Argawal says current tests for prostate cancer screening can be inaccurate and lead to unnecessary and painful biopsies, a fact that can deter many men from seeking the tests. Argawal says if his team is successful, it would eliminate those problems.

“You can do the test in a clinic, you could do the test at home, same day results, and same day discussion with you doctor. So there are a lot of advantages to having accurate tests that avoid biopsies,” he said.

Argawal says so far the results of his team’s work are promising. He says they may be about four years away from finishing their study, developing a sensor and clearing clinical trials. However, he added that four years in “medical time” is relatively quick.

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7. Supply Chain Modernization

7.1 - Forbes: [Use It Or Lose It -- Trump's Agencies Spent \\$11 Billion Last Week In Year-End Spending Spree](#) (3 October, Adam Andrzejewski, 29.8M online visitors/mo; Jersey City, NJ)

Every September, the end of the fiscal year sparks a “use it or lose it” spending frenzy as federal agencies race to use up what’s left in their annual budgets. It’s a phenomenon that should drive taxpayers crazy. Agencies are afraid that if they spend less than their budget allows, Congress might send them less money in the next year. Agencies often try to spend everything that’s left instead of admitting they can operate on less.

Here are the top ten ways the government wasted taxpayer money in the last week of FY2017:

[...]

5. Insect and Rodent Control at the VA – The federal government did some end-of-the-year cleaning, paying \$152.5 million in “housekeeping” bills. While agencies paid \$114 million to guards and facilities operations support, they also signed for custodial janitorial (\$24.3 million); laundry and dry cleaning (\$2.9 million); surveillance (\$2.7 million); trash and garbage collection (\$1 million); carpet cleaning (\$630,943); interior plantscaping (\$154,458); and snow removal/salt (\$127,373). “Housekeeping” contracts included insect and rodent control, which cost \$111,000 at the Department of Veterans Affairs.

6. Redecorating Allowance – For the new fiscal year, many federal agencies decided to redecorate. In one week, the government spent \$83.4 million on furniture plus another \$23 million on office supplies and equipment. The Department of Veterans Affairs spent \$15.6 million on new office furniture including \$4.7 million to a veteran-owned company, American Veteran Office Furniture, LLC. The largest furniture contractor across all agencies, however, was Knoll, Inc. (\$6.2 million) – a luxury furniture company that has 40 pieces permanently displayed in the American Museum of Modern Art in New York City.

7. Self-Promotion (PR) Machine – The government spent tens of millions of dollars on last-minute self-promotion. Agencies spent \$18.6 million on public relations, \$11.7 million on market research and public opinion, and \$5.5 million on communications. Further, \$28.8 million went to advertising efforts – the Department of Homeland Security spent \$15 million on advertising, including a \$6.7 million deal with Lempugh, Inc., and a \$4 million contract with the Ogilvy Group. Further, the Department of Veterans Affairs spent \$3.2 million on signs and advertising displays with S2 Ventures, LLC.

[...]

In the midst of the government's year-end spending spree, Senator Rand Paul (R-KY) introduced the Bonuses for Cost-Cutters Act to curb "use it or lose it" spending. Paul's bill would expand current law to pay bonus happy bureaucrats who identify unneeded or surplus funds and redirect 90 percent of those savings to deficit reduction.

The private-sector uses zero-based budgeting - where all expenses need to be justified from the ground up and every function within an organization is audited for cost. As a businessman, the president should know this.

Whether it's passing legislation or finding another way to address this taxpayer abuse, Congress needs to crack down on "use it lose it" spending. When agencies engage in this wasteful practice, we all lose.

Adam Andrzejewski (say: Angie-eff-ski) is the Founder and CEO of OpenTheBooks.com – a national transparency organization with a database of 4 billion federal, state and local expenditures.

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7.2 - EHR Intelligence: [VA to Award Cerner EHR Implementation Contract Within 30 Days, The federal agency will migrate or abandon 240 of its 299 other IT projects to allocate funding toward the Cerner EHR implementation.](#) (3 October, Kate Monica, 50k online visitors/mo; Danvers, MA)

VA Secretary David Shulkin announced the federal agency will award its EHR implementation contract to Cerner Corporation in the next thirty days.

The announcement came during the recent Senate Veterans Affairs Committee hearing last week. The new VA EHR system will operate on a similar platform as the Department of Defense (DoD) EHR system—MHS Genesis—in an effort to improve interoperability between agencies.

"We released to Congress—to you—30-day notice of award of a contract," said Shulkin. "We are keeping on the timeline that we talked about. We're marching forward. We have the principles. I have some updates to share with you on the strategic IT plan, because I think we are making a lot of progress with that."

In June, three senators submitted a letter to Shulkin and DoD Secretary James Mattis requesting more information about the Cerner EHR replacement, as well as a projected timeline.

Senators John McCain (R-AZ), Johnny Isakson (R-GA), and Jerry Moran (R-KS) emphasized the importance of an efficient integrated health system.

In this most recent discussion of the upcoming project, Shulkin stated part of VA's strategic plan will involve phasing out 80 percent of VA's other projects currently in development. The federal department will migrate or cease work on 240 of its 299 projects.

"By concentrating on some specific IT modernization initiatives, like [electronic health record modernization, financial management business transformation], etc., and leveraging cloud and digital platforms, the 80 percent reduction of ongoing development projects is expected to occur within 18 months, which is part of the overall IT modernization roadmap," VA Press Secretary Curt Cashour told Federal News Radio in an email.

VA has not stated how much the Cerner EHR implementation will cost. However, the VA IT office must contend with the \$215 million budget cut in the President's fiscal 2018 proposal. An appropriations bill for 2018 designated \$78.6 billion in discretionary funding for VA healthcare modernization and improvements.

In an effort to better utilize funds, a source close to the department stated VA is ceasing development on less pressing projects and instead allocating those funds to the new Cerner system.

While VA has not released any information about how much the system will cost, the federal department has outlined its priorities for the new Cerner EHR and indicated other tools necessary to optimize the system.

"We haven't gotten to defining which specific tools they are yet, and how we're going to meet those needs," Shulkin said. "We've talked about the days of VA being a software developer are over, and we're going to be looking at off the shelf, current technologies. There's going to be a lot more definition on that."

Shulkin also emphasized the need for experienced political leadership and assistance from the private sector to offer guidance during the implementation process.

"This is a big, complex organization," Shulkin told reporters following the hearing. "I need the best team possible. I need my nominees, all my political appointments to clear through the vetting process and then to go through their confirmation if it's required. And I need additional people from the private sector who want to come and serve their country to get in touch, because we need the A team on this."

Toward this end, Cerner created an Advisory Group last month to offer insights and recommendations during the EHR modernization that includes former government, military, and private sector leaders.

"Our Veterans deserve continuous access to their medical records while in the service and afterward, whether they are seen in VA or a private health care system," said former Nebraska

Senator and Governor Bob Kerrey, who will chair the group. “I received years of treatment from VA and have firsthand experience with the challenges veterans often face when receiving care.”

Other members of the group include Former VA CEO and Assistant Secretary of Information and Technology Roger Baker and former National Coordinator and Acting Assistant Secretary for Health Karen DeSalvo, MD.

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7.3 - ExecutiveGov: [Report: VA Inches Closer to Cerner EHR Devt Contract Award](#) (3 October, Jane Edwards, 20k online visitors/mo; Tysons Corner, VA)

The Department of Veterans Affairs expects to award Cerner a contract to build a new electronic health record system for VA as early as this month, Federal News Radio reported Friday.

VA Secretary David Shulkin told members of the Senate Veterans Affairs Committee at a hearing Wednesday that the department issued to Congress a 30-day notice of contract award for the new EHR platform.

His statement came months after he announced plans in June to issue a direct solicitation to Cerner to implement the same EHR system – MHS Genesis – that the Defense Department currently deploys.

VA Press Secretary Curt Cashour told the station in an email that the department will end 80 percent of its ongoing information technology development projects over the next 18 months as part of VA’s IT strategic plan.

A source said the agency’s move to reduce its current projects seeks to help fund the implementation of the new EHR system, the report added.

Cerner collaborates with Leidos and Accenture as part an industry team that won a potential 10-year, \$4.3 billion contract in 2015 to help DoD integrate a commercial EHR platform across the Military Health System.

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8. Other

8.1 - The Washington Post (AP): [Tennessee mail carrier sentenced for stealing opioids](#) (3 October, 43.9M online visitors/mo; Washington, DC)

GREENEVILLE, Tenn. — A Tennessee mail carrier who pleaded guilty to stealing at least 33 packages of medications intended for veterans has been sentenced to probation.

The Kingsport Times-News reports that Bronson Cobble was sentenced last week to three years' probation and ordered to pay \$1,154 in restitution following his June plea to one count of theft of mail.

Prosecutors in a sentencing memorandum recommended a bottom-range sentence, saying his admission of guilt and request for court-appointed counsel makes him unlike most defendants and suggests a low risk of recidivism.

Court records state that between August 2016 and March, Cobble stole the packages mailed from the U.S. Department of Veterans Affairs to patients in East Tennessee and used the narcotics himself because of a severe opioid addiction.

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8.2 - The Buffalo News: [Alden companies accused in fraud case agree to pay \\$3 million](#) (3 October, Phil Fairbanks, 1.6M online visitors/mo; Buffalo, NY)

An Alden company used a figurehead to qualify for contracts set aside for disabled veteran-owned small businesses and on Tuesday agreed to pay \$3 million to settle a whistleblower's lawsuit, according to federal prosecutors.

The monetary settlement ends a civil suit that accused Zoladz Construction Company, Arsenal Contracting LLC and Alliance Contracting, all of Alden, of recruiting a service-disabled veteran to serve as a front for Arsenal, a sham company controlled by two other individuals.

Those two men, John Zoladz of Darien and David Lyons of Grand Island, also were named in the suit and in the agreement settling allegations that they violated the federal False Claims Act. Neither Zoladz nor Lyons is a service-disabled veteran.

The government, in its suit, claimed Arsenal was a front company that had few employees of its own and relied almost exclusively on Zoladz Construction and Alliance to operate.

"Every time an ineligible contractor knowingly pursues and obtains such set-aside contracts, they are cheating American taxpayers at the expense of service-disabled veterans," said acting Assistant Attorney General Chad A. Readler in a statement.

A woman answering the phone at Zoladz said the company would not comment.

The scheme that Zoladz and Lyons carried out included false statements regarding Arsenal's qualifications for the small business program to the U.S. Department of Veterans' Affairs.

"The multi-million dollar civil judgment ensures that those involved pay a heavy price for their decision to divert to themselves resources intended for the benefit of those who have made supreme sacrifices on behalf of all," said acting U.S. Attorney James P. Kennedy.

The settlement also resolves a whistleblower lawsuit filed in 2011 by the Western New York Foundation for Fair Contracting, a labor-management group acting as watchdog on public contracts.

Under the settlement, the foundation will receive \$450,000.

“The contracting companies and principals allowed greed to corrupt a federal process intended to benefit service-disabled, veteran-owned small businesses,” said Special Agent in Charge Adam S. Cohen of FBI Buffalo Field Office.

The settlement is the result of investigation by the FBI, Assistant U.S. Attorney Kathleen A. Lynch, the VA Office of Inspector General and the Small Business Administrations's Office of Inspector General.

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From: (b) (6)

Cc:

Bcc:

Subject: [EXTERNAL] 1 October Veterans Affairs Media Summary and News Clips

Date: Sun Oct 01 2017 04:15:07 CDT

Attachments: 171001_Veterans Affairs Media Summary and News Clips.docx
171001_Veterans Affairs Media Summary and News Clips.pdf

Good morning,

Please find the attached Veterans Affairs Media Summary and News Clips.

Document ID: 0.7.10678.164582-000001

Owner: (b) (6) >

Filename: 171001_Veterans Affairs Media Summary and News Clips.docx

Last Modified: Sun Oct 01 04:15:07 CDT 2017



Veterans Affairs Media Summary and News Clips

1 October 2017

[1. Top Stories](#)

1.1 - Washington Times (AP): [Prosecutors: Veteran Threatened to Kill Congressman, Staff](#) (30 September, 24M online visitors/mo; Washington, DC)

Federal prosecutors say a New Jersey veteran who suffers from post-traumatic stress disorder threatened to assault and kill a congressman and the lawmaker's staff. Joseph Brodie allegedly made the threats via telephone and email on Sept. 15 and 19.

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1.2 - Portland Press Herald: [Maine veterans given substandard care are told it's too late to sue](#) (1 October, Edward D. Murphy, 2.1M online visitors/mo; Portland, ME)

After crushing her ankle in a fall during ropes training at Fort Leonard Wood in Missouri, April Wood for years sought relief from the pain she endured after leaving the Army in 2004. Doctors with the Department of Veterans Affairs ultimately determined that the only way to get rid of her pain was to amputate her leg a few inches below the knee.

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1.3 - The Day: [VA groups, services tackle high suicide rates among female veterans](#) (30 September, Julia Bergman, 440k online visitors/mo; New London, CT)

Female veterans are committing suicide at 250 percent the rate of female civilians, according to the Department of Veterans Affairs. In Connecticut, at least 10 of the 50 veterans who committed suicide in 2014, the most recent data available, were women. And that's only counting veterans receiving care at the VA.

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1.4 - ESPN: [Sean Doolittle on Bruce Maxwell, respecting veterans and defining patriotism in a polarized America](#) (30 September, Jerry Crasnick, 429k online visitors/mo; Bristol, CT)

Long before Oakland Athletics catcher Bruce Maxwell took a knee in protest during the playing of the national anthem last weekend, Sean Doolittle was giving sincere thought to patriotic displays at baseball games and the surrounding symbolism.

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[2. Veteran and Employee Experience](#)

2.1 - FOX News: [Creators of lifesaving body armor, artificial pancreas among federal workers honored](#) (30 September, Joseph Weber, 32.5M online visitors/mo; New York, NY)

Rory Cooper, a Department of Veterans Affairs researcher, received a Sammie for designing wheelchairs and other assistive technology equipment that has improved the mobility and quality of life for hundreds of thousands of disabled veterans and other Americans.

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2.2 - The Hill: [Trump's Cabinet and charter flights: What we know and don't know](#) (30 September, Nathaniel Weixel, 11.8M online visitors/mo; Washington, DC)

Health and Human Services Secretary Tom Price resigned Friday following a series of public rebukes from President Trump and GOP lawmakers over his repeated use of charter and military aircraft, at public expense, for official travel. Price is far from the only Cabinet member to take private flights however, so his resignation isn't likely to stem the controversy.

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2.3 - Sun Herald: [Cruise-in to salute veterans goes back to its roots with return to Centennial Plaza](#) (30 September, Scott Hawkins, 858k online visitors/mo; Gulfport, MS)
One of the most meaningful and memorable events at Cruisin' The Coast each year is the Salute To Our Veterans cruise-ins. "The whole purpose is to have the vets enjoy the cars," said Woody Bailey, executive director of Cruisin' The Coast.

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2.4 - Herald-Mail Media: [Cruise-in unites community, veterans in common passion](#) (30 September, Richard Belisle, 158k online visitors/mo; Hagerstown, MD)
The main parking lot at the VA Medical Center shined bright in paint and chrome from a hundred sport and muscle cars, street rods, vintage Detroit autos and trucks lined up for Saturday's annual Country Roads Car Club Cruise-in. This was the third year for the event.

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2.5 - Little India: [Undersecretary Poonam Alaigh Caught Up in Veterans Affairs Travel Scandal](#) (30 September, 44k online visitors/mo; Torrington, CT)
Acting Undersecretary Poonam Alaigh and her husband accompanied Veterans Affairs chief David Shulkin and his wife on a 10-day trip to Europe in July this year, which is being criticized as a taxpayer paid holiday junket. Shuklin and his entourage attended a Wimbledon tennis match, toured Westminster Abbey and took a cruise on the Thames, all while on an official visit for meetings with Danish and British officials.

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2.6 - WOAY (ABC-50): [Beckley's Inaugural VAMC Veterans Art Show](#) (30 September, Daniella Hankey, Oak Hill, WV)
The Beckley VA Medical Center hosted its inaugural art show this Saturday at the Medical Center auditorium. The Veteran's Council planned the art show as one of its projects. Using the tag line "healing through creativity", the art show features projects that have helped Veterans to heal. Nationwide, VA medical facilities use the creative arts as one form of rehabilitative treatment to help Veterans recover from and cope with physical and emotional disabilities.

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[3. Access to Healthcare](#)

3.1 - Times Union: [What's the point of jailing this veteran?](#) (30 September, Chris Churchill, 1.5M online visitors/mo; Albany, NY)
Scott Gilligan had just turned 26. He was a guy from Cohoes and a Navy petty officer stationed in Puerto Rico. One day, he took a drive that would change his life. Gilligan was stopped at a

light when a man walked up to his car and stuck a gun in his face. A second armed man climbed into the back seat.

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3.2 - The Olympian: [How we can help improve the quality of life for military veterans](#) (30 September, Dr. Rachel Wood, 851k online visitors/mo; Olympia, WA)

There are many things that contribute to our quality of life here in Thurston County: where you live or work, what you eat for breakfast, or how much stress you have in your day-to-day life. It's common sense that your health affects your quality of life, but it's also true that your quality of life can affect your health.

[Hyperlink to Above](#)

3.3 - Los Angeles Daily News: [L.A. veterans' health care has room to improve](#) (29 September, Editorial Board, 883k online visitors/mo; Woodland Hills, CA)

A Veterans Administration regional health care system is more than a corner of the federal bureaucracy. It's a promise to the men and women who served this country in the military. It's part of Americans' bargain with young people who sign up for duty.

[Hyperlink to Above](#)

3.4 - La Crosse Tribune: [Thanks to VA for great service](#) (30 September, Eugene Smithart, 823k online visitors/mo; La Crosse, WI)

I recently retired from Trane after more than 40 years. As a former U.S. Marine who served in Vietnam, I was able to get coverage from the Veterans Administration to replace the health coverage Trane had provided for all those years. With all I had heard about the Tomah VA, I didn't know what to expect in the way of quality of service I would receive.

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3.5 - WHAM (ABC-13): [Groundwork underway for new VA clinic in Henrietta](#) (29 September, 817k online visitors/mo; Rochester, NY)

There will soon be a new location for local veterans to go for services and healthcare. A ceremonial groundbreaking took place Friday afternoon in the drizzle for the new VA clinic on Calkins Road in Henrietta. The 84,000-square-foot building will expand primary care services, along with mental health assessments and social work support.

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3.6 - WSBT (CBS-22): [Local veterans say they're glad to see new VA clinic in Mishawaka officially open](#) (30 September, Cassidy Williams, 449k online visitors/day; Mishawaka, IN)

The new St. Joseph County VA Clinic in Mishawaka is officially open. The 90,000 square foot facility offers a variety of services. The \$38 million dollar project finished on time and on budget. Senator Joe Donnelly and Congresswoman Jackie Walorski were there to get a tour of the new facility.

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3.7 - The Post and Courier: [South Carolina veterans react sharply to Ken Burns Vietnam documentary](#) (30 September, Bo Petersen, 319k online visitors/mo; Charleston, SC)

Jerry Davis won't watch the Ken Burns' documentary on the Vietnam War, he tells you. The bayonet scar still plainly shows on his eye. "I saw it 'real time' and I don't want to see what someone else thinks," said the 76-year-old Marine Corps veteran from West Ashley, who set up communications under fire on hilltops in Vietnam.

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3.8 - South Bend Tribune: [Viewpoint: St. Joseph County clinic's grand opening fulfills a promise to our veterans](#) (29 September, Sen. Joe Donnelly (D-Ind.), 274k online visitors/mo; South Bend, IN)

When we care for our veterans, we both honor their service, and we reinforce our values. Yet for too long, it was a struggle to provide veterans in our community convenient access to quality health care. Veterans from South Bend, Mishawaka, Elkhart, LaPorte and Plymouth have regularly had to make a two-hour trip to VA facilities in Chicago or Fort Wayne to see a doctor.

[Hyperlink to Above](#)

3.9 - The Herald-Dispatch: [Look for these warning signs to help prevent suicide](#) (1 October, Debbie Brammer, 192k online visitors/mo; Huntington, WV)

Thirty-nine stones lay scattered beneath the leafy branches of a young maple tree. Each stone bears the name of a loved one who was lost to suicide. Billy, Rita, Scott are among the names painted on the stones, representing both male and female, young and old, because suicide has no respect for gender or age.

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3.10 - FierceHealthcare: [VA proposed rule would override state licensing restrictions to expand access to telehealth](#) (29 September, Evan Sweeney, 140k online visitors/mo; Washington, DC)

The Department of Veterans Affairs has issued a proposed rule that would allow VA providers to treat patients in any state via telehealth, regardless of where they are licensed to practice. The proposed rule would override state licensing restrictions that the agency says are limiting its telehealth program and allow VA physicians to treat patients anywhere in the country using the VA's telehealth technology.

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3.11 - The Sun News: [VA hospitals must be fixed - now](#) (30 September, Stephen Sherwood, 140k online visitors/mo; Myrtle Beach, SC)

I have written all my senators and one congressman, and yet nothing changes with the VA hospital. I had major neck surgery in July and was prescribed four different opiates for pain. Now I cannot get anyone to prescribe any of these opiates, so along with being in pain, I am withdrawing from the opiates cold turkey.

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3.12 - The Joplin Globe: [Missouri's U.S. senators note bipartisan efforts](#) (29 September, Susan Redden, 76k online visitors/mo; Joplin, MO)

On the federal front, Missouri's U.S. Sen. Roy Blunt this week announced he and Sen. Richard Blumenthal had introduced bipartisan legislation to expand veterans' access to peer counseling specialists to better combat the risks of suicide and treat associated mental health conditions.

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3.13 - Daily Messenger: [Improvements reported at Veterans Crisis Line](#) (29 September, Julie Sherwood, 74k online visitors/mo; Canandaigua, NY)

The Veterans Crisis Line — which has been criticized for calls rolling to voicemail, dropped calls and veterans put on hold for long periods — received a glowing report Friday. U.S. Reps. Chris Collins, R-Clarence and Phil Roe, a Republican from Tennessee who chairs the House Committee on Veterans Affairs, discussed improvements following a tour of the crisis center at the Canandaigua VA Medical Center.

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3.14 - KXRM (FOX-21, Video, Updated): [VFW raises concerns over VA care](#) (30 September, Carly Moore, 60k online visitors/mo; Colorado Springs, CO)

A fallen service member has a group from the Veterans of Foreign Wars organization speaking out. Some members of the VFW are attributing his death to lack of care from the Colorado Springs Veterans Affairs hospital. The widow of the service member was left overwhelmed and unprepared. She was concerned about her financial situation and was worried she would lose her house.

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3.15 - KXRM (FOX-21, Video): [Colorado Springs widow gives final salute to veteran husband who died suddenly](#) (30 September, Sarah Ferguson, 60k online visitors/mo; Colorado Springs, CO)

The widow of a fallen Service Member left overwhelmed after he suddenly died, is able to give her husband, a Vietnam Veteran, the honorary send-off he deserves. His wife, Ute was shocked when her husband Ray Belasco suddenly passed away at 65-year's-old. Recently a local Veterans of Foreign Wars group heard the widow's story, with Members attributing his death to a lack of care from the Colorado Springs Veterans Affairs hospital.

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3.16 - Finger Lakes Daily News: [VA Crisis Line Reports Improvements in Call Handling](#) (30 September, Joe Lasky, 53k online visitors/mo; Geneva, NY)

The Daily Messenger reports Congressman Chris Collins and Tennessee Representative Phil Roe toured the facility Friday, and reported that only 1.3% of calls are now rolling over to a backup center, with 99% of calls answered within 8 seconds.

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3.17 - Inquirer.net: [US lawmaker files bill for full benefits for Filipino WWII veterans](#) (29 September, 14k online visitors/mo; Daly City, CA)

Congresswoman Jackie Speier (CA-14) introduced H.R. 3865, the Filipino Veterans Fairness Act of 2017 on Thursday, September 28. During World War II, about 250,000 Filipinos volunteered to fight alongside U.S. troops. As citizens of a commonwealth of the United States before and during the war, Filipinos were legally American nationals.

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3.18 - Montgomery Herald: [VA awards grants to help at-risk Southern W.Va. vets, families](#)
(29 September, 7k online visitors/mo; Montgomery, WV)

Earlier this month, the Department of Veterans Affairs (VA) announced it has awarded \$343 million in grants to 288 nonprofit organizations to help low-income veterans and their families. More than \$2 million will go towards a community partner that assists veterans across the state, including southern West Virginia. The grants were awarded under VA's Supportive Services for Veteran Families (SSVF) program.

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[4. Women Veterans](#) – No Coverage

[5. Appeals Modernization](#) – No Coverage

[6. Strategic Partnerships](#)

6.1 - WFED (AM-1500): [Major changes coming to DoD's TRICARE system Jan. 1](#) (29 September, Jared Serbu, 831k online visitors/mo; Washington, DC)

The Defense Department published new rules Friday that will make significant changes to the health insurance system that serves military family members and retirees on Jan. 1, altering the structure and fees of benefit plans, and, according to Defense health officials, making care more accessible.

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[7. Supply Chain Modernization](#) – No Coverage

[8. Other](#) – No Coverage

1. Top Stories

1.1 - Washington Times (AP): [Prosecutors: Veteran Threatened to Kill Congressman, Staff](#) (30 September, 10.8M online visitors/mo; Washington, DC)

CAMDEN, N.J. — Federal prosecutors say a New Jersey veteran who suffers from post-traumatic stress disorder threatened to assault and kill a congressman and the lawmaker's staff.

Joseph Brodie allegedly made the threats via telephone and email on Sept. 15 and 19.

Prosecutors say the 38-year-old Millville man was initially arrested on weapons charges Sept. 20 after state police went to his home to do a welfare check. They say Brodie fled out the front door with an assault rifle and tried unsuccessfully to fire it.

Brodie was charged Friday with threatening to assault a U.S. official. But the name of the congressman has not been disclosed.

Authorities say Brodie contacted the lawmaker to complain about a Department of Veterans Affairs clinic

It wasn't known Saturday if Brodie has retained an attorney.

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1.2 - Portland Press Herald: [Maine veterans given substandard care are told it's too late to sue](#) (1 October, Edward D. Murphy, 2.1M online visitors/mo; Portland, ME)

After crushing her ankle in a fall during ropes training at Fort Leonard Wood in Missouri, April Wood for years sought relief from the pain she endured after leaving the Army in 2004.

Doctors with the Department of Veterans Affairs ultimately determined that the only way to get rid of her pain was to amputate her leg a few inches below the knee.

But less than a year after the amputation, officials at the VA hospital in Togus, where she was initially treated, called her in to admit that her care there was substandard and the reason for her amputation was, at least in part, due to the poor care she had received at the Maine VA hospital, which has 230 doctors and serves 42,000 veterans annually.

"I was sitting there crying because, up to that point, I thought maybe my bones just cracked and there was something wrong with me," said Wood, who is no longer able to work because of her disability. "They said, 'No, your doctor sucked.' "

Now, Wood and five other Maine veterans are suing, claiming that the VA fraudulently concealed that a podiatrist at the VA hospital in Togus gave them substandard care, subjecting them to years of pain that hospital officials now say could have been avoided. Their case is currently before U.S. District Judge Jon D. Levy in Portland, who will decide whether the lawsuits can move forward.

Federal lawyers, however, have moved to dismiss the cases, arguing that the veterans waited too long to file the suits, even though the VA has admitted that the podiatrist, Dr. Thomas Franchini, provided poor care and the VA took years to notify the veterans that there were problems in their treatment.

The suits come against a backdrop of sharp criticism of the Department of Veterans Affairs over the standards of care given to veterans, including issues such as monthslong wait lists for care and mismanagement that led to veteran deaths.

The first suit was filed by Wood, now 42, a Maine native now living in Missouri, who was in Army basic training in early 2004 when she fell about 20 feet from the ropes course, smashing her ankle. Franchini, who treated her after her honorable discharge and is now in private practice in New York, performed surgery on Wood twice. Neither surgery provided any relief from the pain, and she eventually underwent the amputation, performed by other surgeons in 2012.

VETS CITE PAIN, LACK OF MOBILITY

The suits filed by the five other veterans have since been combined with Wood's and allege the same lack of effective treatment by Franchini, although no one else was subject to such a drastic remedy as Wood's amputation. Franchini's treatment of the other vets included plates and screws inserted into their feet and ankles – with some of the hardware allegedly incorrectly placed – joints fused improperly and bones from other parts of their bodies implanted poorly, the suits say.

All of the vets said they have limited mobility, and pain in their feet, ankles and legs. In some cases, doctors outside the VA system have recommended additional procedures, but the vets fear those operations will only worsen their conditions.

Jack Downs, 77, of Fairfield said doctors have told him further surgery would worsen the osteoarthritis in the foot that Franchini operated on in 2008.

The Marine Corps veteran said he can feel one of the screws that Franchini inserted during that surgery. He still suffers numbness in his foot, and pain that shoots up his leg to his hip when he walks or drives.

But, he said, "I'm afraid if they take the screw out, my foot will collapse."

Franchini began working at Togus, the oldest veterans' facility in the country, in 2004 after a career as a Navy doctor – in fact, one of the people suing him was treated for a different ailment by Franchini in Rhode Island while both were in the Navy. Franchini is still a licensed podiatrist, even though he resigned from the VA after the agency told him to step down or he would be fired in early 2010, according to Chris Cashour, a spokesman for the VA.

In addition to substandard care, a VA investigation said it appeared that Franchini was "falsifying some medical records," according to an affidavit filed in the veterans' suits by Yuri Walker, the VA's director of risk management.

Franchini is now listed as one of three doctors in a private podiatry practice on Fifth Avenue in New York City. His Maine podiatrist's license lapsed in 2011, but he has an active New York license. Records in both states show that there have been no complaints filed against him, although Cashour said the VA has "broad authority" to report doctors in cases where care was

substandard or caused injuries. Cashour would not say whether the VA reported Franchini to medical boards, citing privacy laws.

DOCTOR DEFENDS HIS TECHNIQUE

In most cases in Maine and New York, complaints that have not been validated are not recorded in state licensing records available to the public.

Through a representative of his office in New York, Franchini said he would not comment on the suits, and the government, not Franchini, is named as the defendant.

However, in a 2016 post on his personal blog, he complained that the review of his performance at Togus came about after one patient complained, although the VA said it was an official with the hospital who raised concerns about the doctor's care. That complaint, Franchini said, led to a "second wave" in which VA officials reviewed the care for more than 100 of his patients. He alleged the VA review only found that his record-keeping was deficient, not his surgical techniques or patient care, although the VA called in dozens of patients in January 2013 to admit that the care provided by Franchini was subpar.

Letters were sent at that time to Franchini's patients in what the VA terms a "large-scale disclosure event," but Franchini described the complaints as unfounded.

"Now the true fact (is) that my notes were brief, but not my care," Franchini wrote in his blog, in which he also complains about the difficulty of finding a new job. "They could not find something that was wrong other than (sic) brief note-taking."

In an affidavit filed in one of the suits last week, Franchini again denied that his care was subpar and said he tried to give his patients "accurate and truthful information" about their conditions and the results of his surgical procedures.

Vets and politicians have been critical of the quality of the care provided by the VA nationwide. The criticisms include allegations of mismanagement that led to veteran deaths, wait times as long as six months for VA hospital care, and VA officials' attempts to hide substandard care. In 2014, auditors discovered that employees at 110 VA facilities kept secret waiting lists to hide the delays veterans faced when seeking care. In July, Veterans Affairs Secretary David J. Shulkin fired two top officials at the Manchester, New Hampshire, VA Medical Center and ordered a review of the hospital.

Legislators and advocates have since pushed to reform the VA medical system, including changes that would make it easier for vets to see doctors outside the VA system or go to hospitals nearer to their homes.

The VA began examining the care it provided in recent years and rated the hospitals it ran on the quality of care offered.

TOGUS WAS RATED 2 ON A 5 SCALE

A critical report in 2015 commissioned by the Office of the Inspector General in the U.S. Department of Veterans Affairs found scheduling problems at Togus mirroring those at veterans hospitals nationwide, saying employees didn't enter appointment requests for some patients who weren't willing to be seen within 14 days, the VA benchmark for a comprehensive

examination for first-time patients. Employees were directed at times not to log referrals in their computerized system.

In 2016, care at Togus was rated a 2 on a 5-point scale, with 1 the lowest rank and 5 the highest. The rankings used some of the same variables used to evaluate other hospitals, such as surveys of patient experiences and outcomes, complications, readmissions and deaths, as well as some measures more geared toward VA hospitals, such as access to care and the quality of mental health care.

The VA rankings said Togus has made a “large improvement” from 2015, the baseline year for the rankings.

“We are proud of our improvements in all of our care programs, including podiatry,” said Ryan Lilly, director of the VA Maine Healthcare system.

The suits, however, allege that Franchini provided substandard care from early on in his tenure at the hospital.

Andy Korsiak, 58, who settled in Maine after he was assigned to Brunswick Naval Air Station, said he suffered for years from a bone spur that was pressing into his Achilles tendon. He went to Togus, where Franchini recommended surgery. The day of the operation, Korsiak said, Franchini decided at the last second to also remove a second bone spur lower on his heel that had not been causing any problems.

“We’re going to be in there, why don’t we do that as well?” Korsiak said he was told by Franchini.

He never saw Franchini again after the surgery in 2007, Korsiak said. A nurse removed his stitches and essentially sent him on his way.

Korsiak, who lives in Troy, said he still deals with pain and problems resulting from the surgery. A VA doctor in Massachusetts found bone fragments left behind in his ankle and heel, Korsiak said, but “there was absolute silence from the VA” until six years later, when the VA wrote to say there may have been problems with his care by Franchini and asked him to return to Togus to discuss his case.

The other cases contain similar accusations, but the most egregious appears to be Wood’s.

Wood said joining the Army was a lifelong dream. But she reluctantly accepted an honorable discharge in September 2004 when the Army determined that her effectiveness as a soldier would be reduced because of the injuries she suffered in the fall. After her discharge, she went to Togus to deal with continuing problems in her ankle and was assigned to Franchini for care.

“He said he could fix it,” she said of her ankle, and she believed him.

Franchini operated to fuse the ankle joint to reduce the movement of the joint, surgery that took four hours instead of the two she had been told to expect. A metal plate and eight screws were inserted into her ankle, she said, but after the surgery, Franchini told Wood and her family said that he wasn’t sure of a good outcome because she had “mushy bones,” Wood said.

When the pain didn't subside, Franchini operated again to insert more screws to immobilize the joint. When that failed to provide relief, Wood consulted VA doctors in Massachusetts, who decided to remove all the hardware Franchini had inserted and put in a piece of bone from a cadaver and more screws.

But in 2012, another VA doctor performed the amputation after the determination was made that it was the only way to alleviate the constant pain Wood was experiencing.

In early 2013, she was called back to Togus to discuss her case, where officials told her that Franchini's care was substandard.

Ultimately, the VA determined that her care had resulted in a full disability. Wood said she no longer works outside her home, but makes a few hundred dollars a year writing adult romance books.

BETRAYED BY THE SYSTEM

Timothy Mansir, now 36, injured his foot after falling while in Iraq with the Marine Corps. After he was discharged in 2007, he went to the VA, where Franchini diagnosed an unstable ankle and performed an ankle reconstruction in 2008.

Finally, he saw a podiatrist who lived down the street from him in Oxford. A surgical procedure that doctor performed helped some, Mansir said, but "my ankle was severely messed up."

Finally he was called in to Togus in 2013, where VA officials told him that Franchini's initial care was to blame and the ankle reconstruction was "overly aggressive."

Mansir has since had additional surgeries by doctors outside the VA system, but still experiences pain and said he feels "hurt and betrayed" by the system. Mansir said he worked as a commercial electrician and then a testing technician, but he lost both jobs when the pain interfered with his work. He still has a severe limp, has to take frequent breaks when he walks and lives with his wife on Social Security and military disability.

"I held up my end of the bargain and went and served my country, and I expected to be taken care of," he said. Being told that his care was substandard "was like a huge slap in the face."

Mark Prescott said pain that developed in his regular runs led him to seek help, initially while on active duty in the Navy and later as a veteran.

He said he had always been a runner, which continued after he joined the Navy out of high school in 1983. But in the late 1990s, Prescott started experiencing pain in his ankle and learned he had broken a bone in the joint years earlier and never had it treated. He had surgery twice while still on active duty and then was treated at Togus after retiring.

"He had a very good bedside manner," Prescott said of Franchini. "He was always available to talk to and seemed like a guy you wanted to hang out with." Prescott noted, however, that Franchini never seemed to write anything down.

Franchini operated on Prescott twice, transplanting a piece of bone taken from his foot into his ankle to stabilize it, but Prescott only experienced more pain. Franchini gave him a brace,

Prescott said, but he was unable to use it because he had to tighten it on the inside of his ankle, which caused too much pain.

Still, Franchini told him he was “progressing normally,” the suit alleges. Prescott said he never suspected anything might be amiss until VA officials told him that he might not have been treated well.

A doctor from the VA in Boston showed him an X-ray that, he said, indicated that Franchini had overly tightened the piece of transplanted bone, creating a ridge that caused his pain, Prescott said.

KICKED WHEN YOU'RE DOWN

Like the others, Prescott was told he could file a claim with the VA that might result in a finding of a greater disability with an increased pension and guarantee of care going forward. That claim was rejected.

“They admitted that they had harmed me, but the other office said, ‘Well, there’s nothing we’re going to do for you,’ ” Prescott said. “That’s sort of like kicking you when you’re down. To listen to the government, they should have known that we were improperly treated.”

In his suit, veteran Kenneth Myrick of South Portland said Franchini operated on his ankle at Togus in 2005 but he continued to experience “severe pain” in his left leg after the procedure despite additional surgeries at the VA in Boston. The VA told him in 2013 that the original surgery by Franchini resulted in “nerve entrapment,” which Franchini and other doctors failed to see in examinations after the original surgery. Franchini’s original surgery was “substandard,” the VA told Myrick.

Both Myrick and his lawyer, David Kreisler, have declined to comment on the suit.

Downs, the Marine from Fairfield, said his issues with the care provided by the VA go beyond the surgery Franchini performed on his foot in 2008.

Downs, who served in the Marine Corps for two years in the late 1950s, said the top of his foot had collapsed. Franchini told him it could be fixed by fusing a bone and operated in 2008.

Downs had follow-up appointments during which X-rays and scans were taken, but when Downs and his wife moved to Florida, Franchini didn’t contact him and never got in touch with VA doctors in Florida. According to his suit, the X-rays and scans indicated that the fusion had not succeeded and that a screw might have been improperly placed, but Downs was never told about those findings.

After the couple moved back to Maine, Togus officials told Downs that his care may have been inadequate and an outside doctor told him that the metal plate Franchini put in was too small to allow the bones to fuse.

Now, Downs – who used to walk 5 miles a day – suffers numbness in his foot when he tries to walk. If he drives, the pain starts in his foot and then travels up his leg to his hip.

Downs said he thinks Franchini never ordered physical therapy for him because he knew the therapists would discover that the surgery wasn’t right.

After the surgery, Downs said, he believes the VA dragged its feet on informing him and other Franchini patients that their care might have been substandard in order to run out the clock on time limits for filing a suit.

"I truthfully feel they stalled me," he said. "I was being stalled by the VA."

WHEN DOES THE TIMER START?

Levy, the judge over the ongoing cases, ruled in February 2016 that Maine's three-year time on malpractice suits is a "statute of repose," meaning the window of time on when the plaintiffs can file suit starts from when the alleged malpractice occurred. For most of the vets, their surgeries were performed in the mid- or late-2000s.

Attorneys for the veterans argued that the VA should be tried under a federal malpractice law with a two-year limit, but a clock that begins to run when the patients discover they may have received substandard care. The six vets were told by Togus officials in January 2013 that their care might have been substandard and most filed their suits within a year.

In his ruling in early 2016, however, Levy allowed the veterans' lawyers to pursue a claim that the VA had "fraudulently concealed" the findings of poor care, which would allow the suits to move ahead, regardless of the time limits. He's expected to rule in October or November.

Togus officials have admitted that they took a long time to disclose the findings of their investigation into Franchini's cases, but deny that they did so on purpose to limit the veterans' ability to sue.

Dr. Timothy Richardson, the former chief of staff at Togus, said he ordered another doctor to review Franchini's cases after a compensation and pension examiner raised concerns in early 2010. In an affidavit filed in the case, Richardson – who was demoted as chief of staff over the length of time it took to review the Franchini cases – said the pace of the review and notification of patients was "admittedly slow" and said he should have devoted more resources to investigating Franchini's cases.

But it wasn't a ruse, he said.

"At no time during the process did I ever deliberately delay the reviews to minimize or avoid potential legal liability from any claims that patients might assert against the Togus VAMC," Richardson said. "In fact, I never once considered the applicability of any statute of limitations to those claims, and had never even heard of the 'statute of repose' until the government raised the issue in the pending lawsuits. Based on my own personal experience, the issue of 'timing' or 'time limits' for potential tort claims was never discussed by anyone at the Togus VAMC. Nor did anyone say or even suggest that we should 'conceal' the results of our reviews from patients."

Walker, the VA's director of risk management who was involved in the Franchini investigation, also denied that the review was deliberately delayed.

U.S. attorneys in Portland who are defending the government in the suit said they had no comment because the case is in active litigation.

David Lipman, who represents Wood and Prescott, said the VA's argument, boiled down, is "we didn't fraudulently conceal it, we incompetently concealed it."

"That's just so frustrating and ridiculous," said Celine Boyle, of the Shaheen and Gordon law firm, who represents Korsiak, Downs and Mansir.

Both Lipman and Boyle indicated that they will likely file appeals if Levy's next ruling, on the fraudulent concealment claims, goes against them. In that case, they would likely appeal the ruling that the time limit is a statute of repose and that the state law, rather than the federal statute, should be followed in determining filing deadlines.

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1.3 - The Day: [VA groups, services tackle high suicide rates among female veterans](#) (30 September, Julia Bergman, 440k online visitors/mo; New London, CT)

Female veterans are committing suicide at 250 percent the rate of female civilians, according to the Department of Veterans Affairs.

In Connecticut, at least 10 of the 50 veterans who committed suicide in 2014, the most recent data available, were women. And that's only counting veterans receiving care at the VA.

Nationally, the suicide rate for female veterans from 2001 to 2014 increased by a greater degree than the suicide rate among male veterans.

The data was part of an update to a 2016 VA report that analyzed more than 55 million records from 1979 to 2014, the most comprehensive look at veteran suicides in the U.S.

Women are one of the fastest growing groups of veterans. Of Connecticut's 200,000-plus veterans, more than 16,500 are female. The number of female veterans in the state has grown by 10 percent in the past five years.

A 2016 survey of active-duty women and female veterans by the Service Women's Action Network found that they view gender bias as a major obstacle to success, and feel underappreciated by society. They listed their top community challenge as access to women-specific health care.

"I often hear from women 'I just wish I could meet other women veterans. I don't know how to meet other women veterans,'" said Lynette Adams, women veterans program manager at VA Connecticut. "Social support is a really large protective factor for people at risk of suicide."

As more women are entering the military, there may be an increase in the number of women accessing care at the VA. That, in turn, allows the VA to continue to build more programs geared toward women, Adams said.

From 2001 to 2014, the suicide rate for female veterans overall increased, but the rate decreased by 2.6 percent for those accessing services at the VA.

About 25 percent of female veterans in Connecticut are enrolled at the VA. This number has increased steadily over time, according to Adams, but there's still a large percentage of female veterans who are not going to the VA in Connecticut.

The VA, on a national level, has stepped up its outreach to women, letting them know about resources and programs specific to them. And it has "greatly expanded" its women-specific programming in the past five to 10 years, according to Adams.

"So I hope one of the reasons for those (VA enrollment) numbers going up is that women are realizing 'the VA can provide me with the gender-specific services that I need,'" she said.

There's a women veterans liaison at each of the VA's veterans centers in Connecticut, for example. And there's a number of mental health programs for women, such as support groups.

A few years ago, there was one only one group at the Connecticut VA for women who've experienced sexual assault or sexual harassment during their military service, commonly referred to as military sexual trauma or MST. A recent VA study found the rate of suicide to be higher among women who've experienced military sexual trauma.

Today, there are three such support groups.

"We find that women who are able to engage in these gender-specific programs are happier with their care," Adams said.

These programs can also provide female veterans with the social support that they might otherwise feel that they don't have, she added.

While the VA has expanded its offerings for women, veteran organizations are lacking in this regard, an op-ed written recently by two female veterans points out. The SWAN survey found that 71 percent of female veterans don't belong to a veterans service organization, and 30 percent said they don't feel welcome in existing veterans organizations.

A 2015 law directed the Connecticut's Department of Veterans Affairs, within existing resources, to create a women veterans program to let them know about federal and state benefits and services and to study their unique needs. A group meet twice that year, but hasn't met since, according to Emily Hein, spokeswoman for the state's Department of Veterans Affairs.

As was the case back then, the department's Office of Advocacy and Assistance has three female veteran services offices who act as liaisons for female vets, Hein said.

The national Women Veterans Hotline is 1 (855) VA-WOMEN (829-6636). The website is www.va.gov/WOMENVET.

For free, confidential support for veterans in crisis, call the Veterans Crisis Line at 1 (800) 273-8255 and press 1, or text to 838255, or chat online 24 hours a day at www.veteranscrisisline.net.

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1.4 - ESPN: [Sean Doolittle on Bruce Maxwell, respecting veterans and defining patriotism in a polarized America](#) (30 September, Jerry Crasnick, 429k online visitors/mo; Bristol, CT)

Long before Oakland Athletics catcher Bruce Maxwell took a knee in protest during the playing of the national anthem last weekend, Sean Doolittle was giving sincere thought to patriotic displays at baseball games and the surrounding symbolism.

Doolittle, who played with Maxwell in Oakland before being traded to the Washington Nationals in July, is the product of a military family. His father, Rory, served in the Air Force for 26 years and currently teaches aerospace science to high school ROTC students in New Jersey.

During his time in the majors, Doolittle has become a strong advocate for veterans and used his visibility to help them with everything from housing and employment to substance abuse-related issues. In May, Doolittle and his fiancée, Eireann Dolan, wrote a Sports Illustrated op-ed piece to raise awareness of the plight of veterans with "bad paper"-- those who've fallen through the cracks and failed to receive care after less-than-honorable discharges from the military because of alleged misconduct.

Doolittle and Dolan have also taken an interest in lesbian, gay, bisexual and transgender issues, and in November 2015 they hosted 17 Syrian refugee families for Thanksgiving dinner in Chicago. The Athletics nominated Doolittle for the Branch Rickey Award in 2013-2014 and the Roberto Clemente Award in 2016.

During a stop in Philadelphia this week, Doolittle shared his thoughts on the furor swirling around athletes and the national anthem in a conversation with ESPN.com.

Were you surprised when you saw Bruce Maxwell take a knee in Oakland?

Sean Doolittle: "I was a little bit surprised, mainly because it was a young guy that did it -- a guy that still has so much to prove in this league and so much to lose at the same time. [It's harder] for a guy like that to put himself out there. I hope we get to a point whether people agree with him or not, or wherever they fall on the issue, they can respect somebody for standing up for what they believe in."

What did you learn about Maxwell during your time in Oakland?

SD: "He's a very thoughtful guy. He's really matured a lot as a person and a player over his last couple of years. He had some big league time and got to be around some really good veteran guys in that clubhouse who really helped his development. He has talent, and he's starting to mature and work really well with that pitching staff.

"Bruce is a super nuanced guy. We want to put people in boxes. Words like 'conservative' or 'liberal' or 'Republican' or 'Democrat' have become pejoratives that people use to define and use against other people now. We want to label them before we even get to know them."

There has been a lot of conversation about how NFL and NBA players have jumped into the political fray while baseball players have remained largely silent. Some people point to the racial makeup of MLB rosters or the game's established clubhouse culture. What do you think?

SD: "I have theories, but I don't know. It's touchy."

Does it strike you that the national anthem is becoming such a flash point for debate?

SD: "A lot of these questions are being posed to people for the first time, like, 'What does it mean to you to stand for the anthem?' I think if you asked 10 people, you might get 10 different answers. You might see one guy standing at attention and other people walking around the concourse buying food or whatever."

What does the playing of the national anthem mean to you personally?

SD: "I came from a military family, so there are a lot of things I think about when the anthem is playing. One thing that bothers me is the way that people use veterans and troops almost as a shield. They say that's the reason they stand and that veterans deserve to be honored and respected during the anthem. But where is that outrage in taking better care of veterans? The most recent statistics say that we still lose 20 veterans to suicide every day.

"If you want to have that conversation, if that's your reason for standing, then let's talk. Let's have a conversation about putting that into action, because they deserve a heck of a lot more than people standing at attention during the flag or giving them discounts on food or hotels.

"It's really nice that we honor them at games sometimes. They'll bring a veteran on the field and he'll get a standing ovation, and that's important. We're in the 16th or 17th year of this war [in Afghanistan], and it keeps a reminder that we are still a country at war. But we need to follow through on those thoughts and actions."

How are you involved personally?

SD: "My fiancée and I do a lot of work with veterans' issues. Earlier this year, we wrote an op-ed that ran in Sports Illustrated about some of the things we found regarding veterans being wrongly excluded from VA care at a time when they're experiencing a mental health crisis and a suicide epidemic the way they are now. We need to be figuring out ways to expand VA care to take better care of veterans.

"We've worked very closely with three big organizations. We've also gotten closely connected with people in and around D.C. When we were writing the op-ed, we talked to policy makers and policy groups about it. We've learned a lot about veterans' issues and we stay super informed about it. Anytime people use vets and the military as a political football or a prop, it's kind of bothersome.

"The VA works, it really does. For some of the negative press they've gotten in the past few years, when the veterans are able to access it, it really works and saves lives, because they're the ones that are really equipped to handle the unique needs that veterans have."

Do you think there's a distinction to be made between symbolism and action here?

SD: "I don't want it to be a hollow gesture. I think it's a very valid reason to stand for the anthem. But if people are going to point to veterans and use them as the reason, then let's follow through on that.

"There are a lot of veterans being left out. It takes more than standing for the anthem or 'God Bless America' to stand up for them in a [real] sense. As long as we have a volunteer-only military, a lot of the responsibility falls on the general public to make sure they're getting the care

they need when they're done with their service. The veterans raise these questions with Congress and policymakers, but it's going to take the general public to raise their voices in order to really move the needle."

Some people say that athletes who kneel are disrespecting veterans and their service. Others maintain that veterans have fought to give people the right to peacefully protest in such a manner. Can you understand both arguments?

SD: "I worry sometimes in this country that we conflate patriotism exclusively with love of the military and militarism and the strength of our armed forces. That's not the only way that you can be patriotic."

"People draw a direct line between the national anthem and the military, or patriotism and the military. But there are a lot of things that we're not doing for veterans."

Have you seen any positive changes since you've been doing advocacy work for veterans?

SD: "It's getting better. [Veterans Affairs] Secretary [David] Shulkin, who was appointed last year, is doing a good job. But it's almost like we have to capture some of the momentum so that we don't lose any of that progress. He said his priority is bringing down the suicide numbers and reducing that rate."

Can the current debate be a "teachable moment"?

SD: "I think it's important to realize that the players who are protesting aren't protesting the anthem. They're not protesting the flag. People kind of move the goalposts on them and try to tell them what they're protesting. But as they keep saying, that's not what they're protesting."

As someone who stands for the anthem, what's your response to athletes who kneel?

SD: "I think American democracy is strong enough to have that conversation. I think my patriotism is strong enough to not be offended when somebody takes a knee during the anthem. That's not something I take personally. It's something that makes me want to reach out to that person and have a conversation with them and say, 'Let's talk about some of these issues. Tell me about certain things that have caused you to take such a stand.'

"I want to have these conversations with guys like Bruce Maxwell and guys in other leagues, and maybe someday we can get to a point where we give them a reason to stand, and they're proud to stand along the other guys that are standing."

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2. Veteran and Employee Experience

2.1 - FOX News: [Creators of lifesaving body armor, artificial pancreas among federal workers honored](#) (30 September, Joseph Weber, 32.5M online visitors/mo; New York, NY)

Marine Corps engineer Flora Jordan was honored this week at a Washington, black-tie gala for creating body armor that's nearly half the weight of older models yet equally protective.

While humbled for winning the 2017 Service to America Medal, Jordan admitted that her mind was already focused on next-generation armor that will better help soldiers in combat and keep them healthier.

"This is so humbling, especially among all the accomplishments being recognized here," Jordan, the youngest recipient of the award, formally known as the Samuel J. Heyman Service to America Medal, said Wednesday at the awards ceremony, inside the neoclassic Andrew W. Mellon Auditorium on Constitution Avenue.

The 28-year-old Jordan said she and others at Marine Corps Systems Command in Quantico, Va., are now working on integrating the award-winning vests with other soldier-gear like helmets and hydration packs "in a more holistic way," which she said will also help with back and shoulder problems.

The annual gala, in which hundreds of not-so-famous federal employees pay tribute to coworkers' vital-yet-frequently-unheralded efforts, was not without star power and laughter this year.

Award-winning writer Michael Lewis -- who's had several books turned into movies -- was among those who spoke at the ceremonies, known around the nation's capital as the "Sammies."

"This is way more efficient" than the Oscars, Lewis said in a nod to federal workers' pride in no-waste efficiency.

Joshua Van Eaton, a Justice Department attorney honored with EPA investigators Phillip Brooks and Bryon Bunker for their lead work in the 2016 Volkswagen emission case, thanked Robert Muller for his efforts in negotiating the landmark, \$17.4 billion settlement with the German automaker.

The case, in which the company rigged more than a half-million vehicles to evade pollution regulations, also led to billions more in civil and criminal penalties.

"It should be obvious why I'd want to stay in (former FBI Director) Mueller's good graces," Eaton said about Mueller, who now leads a Justice probe into whether Trump campaign officials colluded with Russia in the 2016 White House race.

"Our nation relies on dedicated public servants like those we honor here tonight," Max Stier, president and CEO of the nonprofit, nonpartisan Partnership for Public Service, which runs the awards program, said in joint statement with Tom Bernstein, the partnership's chairman.

This year's lifetime achievement award went to Dr. Tedd Ellerbrock from the Centers for Disease Control and Prevention.

Ellerbrock played a vital role in building, expanding and improving the U.S.-led program that provides medicine and assistance to 11 million people worldwide living with HIV/AIDS.

Like many who won awards, Ellerbrock thanked his wife and family for their support and acknowledge how their work forced them to miss so many dance recitals and youth soccer games.

Ellerbrock said about his wife, "Without Pamela, I wouldn't be here today. Thank you for your love and support."

The other 2017 winners were the FDA's Courtney Lias and Stayce Beck who paved the way for the first artificial pancreas device to receive agency approval, three years faster than expected, which has helped those living with Type 1 diabetes.

Timothy Camus, a Treasury Department inspector general, and the IRS Impersonation Scam Team won for leading a multi-agency investigation and public awareness campaign to stop a massive fraud that conned thousands of Americans into paying millions of dollars in bogus tax bills.

Alex Mahoney and the Middle East Crisis Humanitarian Response Team for leading the U.S. humanitarian relief effort in war-torn Syria and parts of Iraq -- delivering food, medicine, safe drinking water and other assistance to millions of victims.

Rory Cooper, a Department of Veterans Affairs researcher, received a Sammie for designing wheelchairs and other assistive technology equipment that has improved the mobility and quality of life for hundreds of thousands of disabled veterans and other Americans.

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2.2 - The Hill: [Trump's Cabinet and charter flights: What we know and don't know](#) (30 September, Nathaniel Weixel, 11.8M online visitors/mo; Washington, DC)

Health and Human Services Secretary Tom Price resigned Friday following a series of public rebukes from President Trump and GOP lawmakers over his repeated use of charter and military aircraft, at public expense, for official travel.

Price is far from the only Cabinet member to take private flights however, so his resignation isn't likely to stem the controversy.

Here's what we know, and what we don't know.

Who is involved?

There are at least four Cabinet secretaries under fire for their use of charter or military flights.

Price was the most extreme case, as his flights cost taxpayers about \$1 million, according to estimates by Politico.

The Treasury Department inspector general is reviewing department head Steven Mnuchin's use of a private jet in August, as well as why he requested a government plane to take him and his wife, Louise Linton, on their European honeymoon.

Environmental Protection Agency Administrator Scott Pruitt has also been using private planes for government duties. The Washington Post reported on Wednesday that Pruitt's private flights have cost taxpayers more than \$58,000.

On Thursday, Politico and The Washington Post reported Interior Secretary Ryan Zinke took a \$12,000 charter flight aboard a plane owned by oil-and-gas executives.

They also reported on at least three other occasions of private jet travel since Zinke was confirmed, including to the Virgin Islands, before hurricanes Irma and Maria hit.

Veterans Affairs Secretary David Shulkin is also coming under scrutiny for combining personal travel in Europe with an official trip, all paid for with taxpayer money. While Shulkin flew commercial, the government paid for both he and his wife's flight and a per-diem for both their meals.

The trip also came less than two weeks after he signed a memo instructing top VA staffers to determine whether "employee travel in their organization is essential."

Apologizing might not be enough

Price apologized for his decision and offered to pay back tax payers for the cost of his seat on his private flights.

That wasn't enough to stem the controversy or the president's ire.

Zinke on Friday was more combative, telling an audience at the Heritage Foundation that the outrage was "a little B.S."

Mnuchin hasn't apologized either, and on Thursday he declined to promise that he would only ever fly commercial.

"I can promise the American taxpayer that the only time that I will be using mil air is when there are issues either for national security or we have to get to various different things where there's no other means," Mnuchin said on CBS "This Morning."

Price's pledge to pay back "his share of the travel" amounts to \$51,887.31. According to Politico, which broke the stories about his private flights, Price took at least 26 flights on private jets at an estimated cost to the taxpayers of over \$400,000.

On Thursday night, Politico reported that the White House approved flights on U.S. military aircraft to travel to Europe, Asia and Africa for official events, at a cost of more than \$500,000.

Congressional Republicans are taking notice.

Price's trips managed to earn bipartisan outrage.

Democrats were fuming, but Republicans also gave him a dressing down.

"[Everything] that happens around here is based on appearances. And if it just appears wrong, don't do it," Sen. Lisa Murkowski (R-Alaska) told reporters this week.

Sen. John Kennedy (R-La.) had harsher words.

“Taking these charter flights, playing the big shot on the taxpayer's dime when you can go by bus or train or regular commercial air, can't put lipstick on this pig,” Kennedy said Thursday on Fox News Channel's “America's Newsroom.”

More broadly, the charter flights by Cabinet members are also the subject of an investigation by the House Oversight Committee.

Judiciary Committee Chairman Chuck Grassley (R-Iowa) on Thursday urged Trump to curb the spending of Cabinet secretaries.

He called on Trump to “emphasize to cabinet secretaries the necessity of using reasonable and cost-effective modes of travel,” especially “considering the many travel options to and from Washington, D.C.”

Will the flights cost anyone else their jobs?

Trump was reportedly incensed at Price for being a distraction, and was annoyed the reports about Price's air travel have undercut his “swamp draining” image.

But there was also speculation that Trump blamed Price for the failure of Congress to repeal ObamaCare.

If tax reform suffers a similar fate, one couldn't blame Mnuchin for being worried.

On the other hand, Mnuchin is a confidante and friend to Trump. Price was seen as a loyalist to Vice President Pence, and lacked a more personal connection to Trump.

Trump has also been cleaning house at the VA, firing more than 500 employees since he took office. It's not clear yet how the latest scandal will impact Shulkin.

Zinke has already come under fire from Democrats, and his initial defense shows he may be painting the issue as a partisan attack, which doesn't necessarily reflect poorly on Trump.

Trump has also been trying to combat the image of a White House in chaos, and while the scandals have not gotten positive cable news coverage, more staff resignations or firings could be even worse.

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2.3 - Sun Herald: [Cruise-in to salute veterans goes back to its roots with return to Centennial Plaza](#) (30 September, Scott Hawkins, 858k online visitors/mo; Gulfport, MS)

One of the most meaningful and memorable events at Cruisin' The Coast each year is the Salute To Our Veterans cruise-ins.

“The whole purpose is to have the vets enjoy the cars,” said Woody Bailey, executive director of Cruisin' The Coast.

This year, the event, which features Cruisers converging on the location to honor veterans, will be held 10 a.m. to 2 p.m. Tuesday, Oct. 3, at Centennial Plaza, 200 E. Beach Blvd., Gulfport. In recent years, it has been held at the Biloxi VA facility.

“The change of venue is going back to its original roots,” Bailey said.

Prior to Hurricane Katrina, the event was held under the oaks at the old Veterans Affairs facility at Centennial Plaza, which is now Cruise Central, but after the storm damaged the property, organizers moved the veterans cruise-in to the Biloxi VA facility.

In the following years, construction and other issues forced the event to move around for a few years.

“The vets event started at the Gulfport VA property a number of years ago,” Bailey said, “to have the vets at the VA home in Gulfport enjoy Cruisin’ The Coast.”

Now the veterans are living in Gulfport’s new VA retirement facility near Centennial Plaza, so moving the event back to the original location makes sense. Bailey said veterans from both the Gulfport and Biloxi VA facilities will be bused to Cruise Central for the Tuesday, Oct. 3, Salute to Veterans event.

“The vets have served their country,” he said. “We want to honor that service and feel like this is a way Cruisin’ The Coast can help do that.”

This year’s Salute to Our Veterans event also will feature a celebrity appearance by Cristy Lee and the Crusin’ The Coast Feature car.

SALUTE TO OUR VETERANS

Where: Cruise Central, Centennial Plaza, 200 E. Beach Blvd., Gulfport

When: 10 a.m.-2 p.m. Tuesday, Oct. 3

The event will feature a celebrity appearance by Cristy Lee and an appearance of the Cruisin’ The Coast Feature Car

Cruisin’ The Coast

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2.4 - Herald-Mail Media: [Cruise-in unites community, veterans in common passion](#) (30 September, Richard Belisle, 158k online visitors/mo; Hagerstown, MD)

MARTINSBURG, W.Va. — The main parking lot at the VA Medical Center shined bright in paint and chrome from a hundred sport and muscle cars, street rods, vintage Detroit autos and trucks lined up for Saturday’s annual Country Roads Car Club Cruise-in.

This was the third year for the event.

It's stated goal, VA and club organizers said, is to bring the community and military veterans together in a common passion — the love of things automotive.

Veterans themselves judged the vehicles and chose the winners in about a dozen categories. The biggest trophy, the Director's Choice, was a 1978 Corvette, picked by Timothy J. Cooke, the medical center's director. He once owned a 1978 Corvette, according Mike McAleer, public affairs officer.

The cruise-in is hosted every year by the Jefferson County, W.Va., car club. Member Bill Crawford said the club has its headquarters in Harpers Ferry, W.Va. It hosts two shows a year — the one at the VA and one in Ranson, W.Va.

Among the vehicles getting attention from veterans and visitors was a vintage 1959 British-made Turner MK 1 sports racing car. It was brought to the cruise-in by David Thomas, president of High Performance Heroes of Clarksburg, W.Va.

Heroes is a group of race fans who help combat-wounded veterans become active in motorsports.

Thomas's wife, Ashley Thomas, said the organization restores and modifies vintage sports cars, including a 1962 Austin Healey Sprite and 1972 MG Midget. Two combat-wounded veterans, Liam Dwyer of Litchfield, Conn., and Patrick Brown of Chesapeake, Va., have benefitted from the group's help.

Dwyer lost his left leg from an improvised explosive device in Afghanistan in 2011. In 2013, through the efforts of High Performance Heroes, he won the Pittsburgh Vintage Grand Prix Group 2 in the Austin Healey Sprite.

Brown was able to drive the MG Midget because the mechanics at High Performance Heroes were able to convert a window crank from a Ford F-150 into an automatic clutch for the MG's manual transmission, Ashley Thomas said.

"We are the only ones doing vintage sports car racing with combat-wounded veterans," she said.

Jim Boyer of Kearneysville, W.Va., who was wounded in action in Korea, was at the VA showing off his 1959 Plymouth Fury. He said he had bought a brand new iceberg-white Fury with a yellow roof in 1959. He drove the car for years before he sold it. The one on display Saturday was purchased in Franklin, W.Va. It's owner had died and his widow was trying to sell it.

"It was just like my first one. It had the same color, same 318-cubic-inch motor and it only had 28,000 miles on it," he said. "I bought it for \$23,000. My first one cost, new, less than \$3,000. I didn't have to do anything to it. I only get it out for occasions like this."

Steve Hummer of Star Tannery, Va., has a similar story, but with an "all original" 1929 Ford Model A pickup truck. An Army Ranger, he was seriously wounded in 1968 during the Tet Offensive in Vietnam. Today, Hummer is a certified peer recovery specialist in a veteran-to-veteran program at the Hope Center at the Martinsburg VA.

Jocelyn Doyle of Boonsboro is a dental assistant at the VA. On Saturday she was one of a cadre of volunteers who transported veterans in wheelchairs from their rooms to the cruise-in to see the cars up close.

"I transported six of them today," she said. "I do this so I can give something back."

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2.5 - Little India: [Undersecretary Poonam Alaigh Caught Up in Veterans Affairs Travel Scandal](#) (30 September, 44k online visitors/mo; Torrington, CT)

Acting Undersecretary Poonam Alaigh and her husband accompanied Veterans Affairs chief David Shulkin and his wife on a 10-day trip to Europe in July this year, which is being criticized as a taxpayer paid holiday junket.

Shuklin and his entourage attended a Wimbledon tennis match, toured Westminster Abbey and took a cruise on the Thames, all while on an official visit for meetings with Danish and British officials.

Besides the Alaighs, Shulkin's travel team included his chief of staff, and another aide. They were accompanied by a team of six security personnel.

Controversial Europe Trip

Shulkin was visiting the continent for meetings on veterans' health issues, but he spent more than half the time in sightseeing and shopping, the Washington Post reported.

The report comes on the heels of the resignation of Tom Price, the Health and Human Services Secretary, who was forced to resign on Sept. 29 following allegations of taxpayer-funded air travel.

VA revealed on Sept. 29 that the federal government paid for the flights for Shulkin and his wife, Merle Bari. The government also provided per-diem reimbursement for their meals and other expenses.

The VA representative did not respond to the Washington Post on how Bari became eligible for reimbursements and taxpayer-funded airfare, saying that she was traveling on "approved invitational orders." The spokesperson also refused to reveal the flight fare and the total reimbursement amount. Under federal guidelines, Bari could have been eligible for per diem reimbursement of \$3,600.

Alaigh defended the trip, telling the newspaper it enabled valuable exchange of ideas with their British and Danish counterparts.

"Were there some breaks we got? Sure. But they were reasonable. They were not at the expense of what we had committed to do: representing our country and showing our commitment to veterans," Alaigh told the Washington Post.

A travel itinerary released by the Department of Veterans Affairs shows that Alaigh and her husband accompanied the secretary on a separate flight.

The Indian American physician is reported to have submitted her resignation for family reasons on Sept. 25, effective Oct 7, according to the Military Times . It reported that Alaigh, who assumed the post in February, said in a letter to staff: "I want you to know that it has been my greatest honor to serve (VA) Secretary (David) Shulkin, each one of you and all of our veterans.

"As I prepare to now leave Washington, I thank you sincerely for what you have helped us to accomplish, moving from being the country's largest integrated healthcare system into, truly, America's greatest healthcare system."

Her resignation, however, has not been publicly announced, and Alaigh made no reference to it in her interview with the Washington Post.

Alaigh is an internist, who completed her residency at the State University of New York in Stony Brook. She earlier served as national medical director for GlaxoSmithKline, was cofounder of the Atlantic Accountable Care Organization in New Jersey, and a senior advisor to the Under Secretary for Health.

The Military Times reported that Carolyn Clancy, the deputy undersecretary of health for organizational excellence, will assume her post next month.

VA Press Secretary Curt Cashour defended the trip, saying that the visit, including the trip to the Wimbledon game, was reviewed and approved by the ethics counsel. He added that Alaigh's husband paid his expenses for the trip.

"These were important trips with our allies to discuss best practices for taking care of veterans. The secretary has been transparent on his down-time activities that were similar to what he would have done with his family over a weekend in the U.S.," Cashour said.

Shulkin attended a conference in London on July 19 to discuss mental health issues with representatives of Britain, Canada, Australia and New Zealand, following meetings in Denmark from July 12-14.

During the trip, Shulkin and his team also visited Copenhagen's Christiansborg and Amalienborg, and London's Buckingham and Kensington.

Travel Scandals in Trump Administration

Many senior members of Congress, including two key Republicans, have expressed concerns over the travel scandals involving members of the Trump administration. House Oversight Committee Chairman Trey Gowdy and Democrat Rep. Elijah E. Cummings wrote to the White House that official travel should not be connected to personal use.

Sen. Charles E. Grassley, the Chairman of the Senate Judiciary Committee, wrote to Trump asking what steps the government has taken to "ensure Cabinet secretaries use the most fiscally responsible travel in accordance with the public trust they hold."

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2.6 - WOAY (ABC-50): [Beckley's Inaugural VAMC Veterans Art Show](#) (30 September, Daniella Hankey, Oak Hill, WV)

The Beckley VA Medical Center hosted its inaugural art show this Saturday at the Medical Center auditorium.

The Veteran's Council planned the art show as one of its projects. Using the tag line "healing through creativity", the art show features projects that have helped Veterans to heal. Nationwide, VA medical facilities use the creative arts as one form of rehabilitative treatment to help Veterans recover from and cope with physical and emotional disabilities.

"It helps our veterans heal through our PTSD, military trauma and whatever else we have gone through and we're having an art show displaying it," said Melissa Burnett, Vice President of the Veteran's Council.

Veterans submitted their pieces including paintings, models, wood crafts, needlework and more. The art submissions will be judged by fellow veterans who will vote for their favorite piece of art.

Vern Hughes, a Navy Veteran and volunteer at the Beckley VA, submitted five of his pieces for the show.

"I'm trying to help people through their healing a little bit and give them a place to display their artwork and hopefully this will become an annual event," said Vern Hughes, a Navy Veteran.

In the past, Hughes has given his handmade cards to patients, employees and visitors at the VA.

"One veteran that use to be upstairs, his roommate got a card from his granddaughter and he said, I've never gotten a home made card, so his birthday came around and I made him one and he was just so excited. I make about 150 cards and hand them out to veterans, visitors and patients," said Hughes.

Awards were presented for first, second and third place. Veterans were able to submit up to five pieces. Additionally, all winners of the show were encouraged to submit their pieces to the 2017 National Veterans Creative Arts Festival to be held later this year.

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3. Access to Healthcare

3.1 - Times Union: [What's the point of jailing this veteran?](#) (30 September, Chris Churchill, 1.5M online visitors/mo; Albany, NY)

Scott Gilligan had just turned 26. He was a guy from Cohoes and a Navy petty officer stationed in Puerto Rico. One day, he took a drive that would change his life.

Gilligan was stopped at a light when a man walked up to his car and stuck a gun in his face. A second armed man climbed into the back seat.

As Gilligan thought of his pregnant wife, the men ordered him to drive to an isolated section of rain forest. There, they savagely beat the soldier and left him for dead. He walked six hours to call for help.

That was on Good Friday in 1995.

Gilligan returned to civilian life in Cohoes soon after, but struggled despite keeping steady jobs. He drank too much. He got divorced. His two sons became men. He was often anxious or depressed, but he held it together.

Then, two years ago, everything fell apart.

He lost his job at the Von Roll factory in Rotterdam, which meant he lost his health insurance. He couldn't afford the prescriptions that made his life bearable.

So he drank more. He started smoking crack. He slid into addiction.

"It was the only way I could make it through the day," Gilligan told me. "I wasn't in my right mind."

Gilligan hit bottom on Jan. 22, 2016.

That was the day he broke into a friend's house and stole a TV, two iPads and a laptop. He was arrested within hours and immediately confessed to the crime.

The arrest was a blessing — the jolt that turned Gilligan around.

He devoted himself to treatment and got clean. Doctors at the VA hospital in Albany told him he had post-traumatic stress disorder from the attack in Puerto Rico. It was like a revelation, an explanation for so much of what he'd been feeling.

Gilligan has been sober for 17 months now. He works at Saratoga National Cemetery, where he digs and maintains the graves of veterans.

"We make sure they get the respect they deserve," he said. "It's like therapy to me."

Gilligan typically attends seven Alcoholics Anonymous meetings a week. When he rises to speak, the 48-year-old hopes he's a role model, especially for veterans. That's what he wants his life to be now. He wants to help.

But there's a problem.

Gilligan still faces a second-degree burglary charge. His trial starts Monday. If convicted, he could face at least three-and-a-half years in prison.

But why? What good will that really do? Doesn't the veteran deserve a break?

"None of this would have happened to him, nor would he be suffering the effects, but for volunteering to serve his country," Gary Horton, director of the Veterans Defense Program at the New York State Defenders Association, wrote in a letter supporting Gilligan.

"He deserves the consideration and leniency of the justice system."

That seems obvious. And hardly groundbreaking. Some New York counties have Veterans Courts to deal with precisely these scenarios — to recognize the special difficulties faced by military veterans and to give them the understanding they deserve.

Albany County doesn't have a veterans court, but Gilligan would seem an ideal candidate for its drug court. There, he could avoid prison time and continue his treatment under supervision.

A lesser burglary charge would also keep him out of prison.

But District Attorney David Soares has refused to cut Gilligan any slack. As of Friday afternoon, he had offered no deals that don't involve prison time. He has insisted on criminal charges that mandate a prison sentence if Gilligan is convicted.

That led Gilligan's exasperated attorney, Michael Feit, to take an unusual step: He asked the court to remove Soares' office from the case, arguing the district attorney has no valid reason to oppose treatment as an alternative to prison.

"Everything Mr. Gilligan has done shows that he should not be locked in a cage," Feit said.

Gilligan has no criminal record, save for a drunken-driving conviction in 1996. He was an exemplary soldier.

Albany County Judge William Carter was sympathetic.

"I'm very well aware of Mr. Gilligan's plight," he said during a recent hearing on Feit's request. "I'm very well aware about how hard he has worked in treatment. And I don't disagree that he is the poster child for a veterans court."

But Carter found no legal reason to remove Soares' office from the case.

"I can't do that any more than I can make them actually care about the things they profess to care about and put into action some of the words that they speak," said the judge, who has tangled with Soares before.

Soares' office declined to comment, so I can't say why the district attorney is taking so harsh a position. I can't comprehend why he would.

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3.2 - The Olympian: [How we can help improve the quality of life for military veterans](#) (30 September, Dr. Rachel Wood, 851k online visitors/mo; Olympia, WA)

There are many things that contribute to our quality of life here in Thurston County: where you live or work, what you eat for breakfast, or how much stress you have in your day-to-day life.

It's common sense that your health affects your quality of life, but it's also true that your quality of life can affect your health. To improve our quality of life, we can change what we're eating, where we're living, or even where we work. But for many, those changes are difficult; for others, such as our military veterans, there are unique hurdles that can be holding them back.

According to the National Homeless Veteran Coalition, nearly 200,000 American veterans face this reality every year. Military service members may have been away from home for long stretches of time. They may be dealing with Post-Traumatic Stress Disorder, pain or depression. There may be injuries (visible or not visible) they have to overcome. This is all on top of the stress of navigating health care, finances and family life.

But there are tools and programs in Thurston County that are designed to help veterans address these issues, and get the support they need.

Finding work can be a major hurdle for veterans, and one that affects all areas of their lives, including their health. Service members entering the job market after serving with distinction and honor and carrying out their missions regardless of the circumstances often find it difficult to translate their skillset into the civilian equivalent. Many feel they have to re-invent themselves. Their skills, although sharp, are hard to define to a new employer. They may need to find a new industry, learn new jargon, or even move to a new place. Worse, they may have to start at a near entry-level positions.

Transitioning out of the military can be the hardest mission that a service member will have to endure. In those circumstances, stress and depression may become issues, and veterans may feel alone and isolated. The stress it causes resonates through the entire family, straining relationships.

But there are numerous programs to help veterans make this transition as smooth as possible while maintaining their dignity in the process. While it's true that the civilian world lacks machine gunners and nuclear weapons technicians, many managers are seeking leadership, initiative and motivation in their workers. Luckily for us, there is a deluge of veterans with these intangible qualities seeking employment each day. Both veterans and civilian managers can benefit greatly by simply learning to speak a similar language.

There are tools, and people, that can help. Veterans looking to find a new job can use a "skills translator tool" to help reframe their experience in a way civilian employers will understand. Titles such as "Squad Leader" and "Section Chief" can be retooled to highlight leadership qualities, for example, and provide an understanding of the responsibilities that are embedded in those unfamiliar titles.

Among the resources:

National Center for PTSD: <https://www.ptsd.va.gov/public/types/war/index.asp>

U.S. Department of Veterans Affairs resource locator: <https://maketheconnection.net/resources>

Veterans Administration military skills translator: <https://www.vets.gov/employment/job-seekers/skills-translator>

Lacey Veterans Services Hub: <https://www.laceyveteranshub.org/>

Veterans have worked diligently for their country around the globe. With the right tools and resources, we can support veterans re-integrating to civilian society and help them attain the quality of life they are seeking.

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3.3 - Los Angeles Daily News: [L.A. veterans' health care has room to improve](#) (29 September, Editorial Board, 883k online visitors/mo; Woodland Hills, CA)

A Veterans Administration regional health care system is more than a corner of the federal bureaucracy. It's a promise to the men and women who served this country in the military. It's part of Americans' bargain with young people who sign up for duty.

You take care of us; we'll take care of you.

That's why it causes more than the usual disappointment in government to learn the VA health-care system in our area isn't as good as it could be.

The VA has released results from the rating system it uses to assess medical service delivery at its 140 service centers. The system assigns regional systems scores from 1 to a glistening 5. So, what score did the VA Greater Los Angeles Healthcare System receive?

That puts the L.A. VA in the bottom 10 percent of the nation's VA systems.

VA officials emphasize that a relatively low score like L.A.'s doesn't mean veterans don't get good care. Regions' scores are meant to compare one to the other. The goal is for low scorers to learn from high scorers — and improve.

Evidently, there's a considerable range of quality within one rating. According to the list on the VA website, although L.A. got a "1" this year, it actually has shown "large improvement" from the last time scores were assigned under the VA's Strategic Analytics for Improvement and Learning (SAIL) rating formula, which rates the systems on metrics used by the private sector and special metrics measuring access and quality of care.

Still, people in Greater L.A. should be sorry to see that medical service delivery isn't as good as it is in other places. Next door, the Long Beach Veterans Healthcare System rated a 3, while San Diego, San Francisco and Sacramento also got 3s. Among the nation's other big cities earning top-shelf 5s were Boston, Cleveland and Pittsburgh.

All American remember the scandal a few years ago when long delays for VA care were revealed.

That scandal led to Congress infusing the VA with funding, including billions for hires. An NPR report last January showed staffing additions have come inconsistently, and L.A. was among the systems getting less than needed.

VA officials here vow to continue their progress. We can see there's room for improvement.

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3.4 - La Crosse Tribune: [Thanks to VA for great service](#) (30 September, Eugene Smithart, 823k online visitors/mo; La Crosse, WI)

I recently retired from Trane after more than 40 years. As a former U.S. Marine who served in Vietnam, I was able to get coverage from the Veterans Administration to replace the health coverage Trane had provided for all those years.

With all I had heard about the Tomah VA, I didn't know what to expect in the way of quality of service I would receive.

Well, I am pleased to report that the service I have received has been nothing short of amazing from both the Tomah and La Crosse VA personnel.

In talking to a number of people, this reflects a remarkable turnaround in the past nine months and I want to thank everyone involved.

To everyone at the VA, thank you. Keep up your wonderful efforts.

Eugene Smithart, Onalaska

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3.5 - WHAM (ABC-13): [Groundwork underway for new VA clinic in Henrietta](#) (29 September, 817k online visitors/mo; Rochester, NY)

Henrietta, N.Y. - There will soon be a new location for local veterans to go for services and healthcare.

A ceremonial groundbreaking took place Friday afternoon in the drizzle for the new VA clinic on Calkins Road in Henrietta.

The 84,000-square-foot building will expand primary care services, along with mental health assessments and social work support.

The bigger facility will also have room for an eye clinic, women's healthcare and diagnostic imaging.

Carnegie Management and Development Corporation will construct the new facility and lease it to the VA for 20 years.

The new clinic should be fully constructed in the spring of 2019.

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3.6 - WSBT (CBS-22): [Local veterans say they're glad to see new VA clinic in Mishawaka officially open](#) (30 September, Cassidy Williams, 449k online visitors/day; Mishawaka, IN)

The new St. Joseph County VA Clinic in Mishawaka is officially open.

The 90,000 square foot facility offers a variety of services.

The \$38 million dollar project finished on time and on budget

Senator Joe Donnelly and Congresswoman Jackie Walorski were there to get a tour of the new facility.

They both see this is as just the start.

"This is just the beginning," said Walorski. "You know this isn't the end of taking care of veterans. This is the beginning of taking care of veterans in our district and throughout Michigan as well."

Dozens of veterans also came out to see it. The facility will serve almost 9,000.

Each veteran will save travel time for some procedures and exams.

The new Mishawaka facility offers more services than the old clinic in South Bend. Meaning they won't always need to leave this area.

George Proctor spent a large portion of his life serving in both the Marines and the Army.

"23 years, 9 months, and 18 days. I say 24 because that's close enough."

Despite his decades of service, George says he rarely used the benefits provided by the VA.

Living in Mishawaka, the services in Indianapolis or Fort Wayne were just too far away.

"I'm what you call a busted wing," Proctor said. "I broke up my back on third jump at Fort Bragg. It's just too far for me to drive and be comfortable." "

Now that is no longer a problem.

Proctor got his first look at the new facility in Mishawaka. Not only is it closer, but the city has added a bus stop to serve the clinic.

Mishawaka's Mayor also says plowing the road will be a priority in the winter.

Proctor already has ideas for how to use it.

"probably for prosthetics, orthopedics, dermatology, my eyes, whatever."

The facility can also be used as a place to socialize.

A coffee shop inside hopes to bring veterans together, and the socializing has already begun.

The veterans say they are happy to have it for themselves, and for the veterans yet to serve.

"I'm very glad to see it, because it is in my backyard."

Half of the services offered at the facility have already begun.

The final part -- urology and podiatry services -- are expected to open on Decemeber 11.

Address: 1540 Trinity Pl, Mishawaka, IN 46545

Phone: (574) 272-9000

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3.7 - The Post and Courier: [South Carolina veterans react sharply to Ken Burns Vietnam documentary](#) (30 September, Bo Petersen, 319k online visitors/mo; Charleston, SC)

Jerry Davis won't watch the Ken Burns' documentary on the Vietnam War, he tells you. The bayonet scar still plainly shows on his eye.

"I saw it 'real time' and I don't want to see what someone else thinks," said the 76-year-old Marine Corps veteran from West Ashley, who set up communications under fire on hilltops in Vietnam.

Chuck Blankin did watch.

"I just want to see somebody held accountable for what they turned their back on," said the 65-year-old Navy veteran from James Island, his gregarious smile gone grim. He had a river patrol boat blown out from under him.

Emotions flared and nightmares re-awoke for veterans across South Carolina as the 10-episode, public television special "The Vietnam War" finished last week.

Among the more than 130,000 veterans of the era still living in the state, many opted to ignore it. For the others who did watch, the broadcast was more than a documentation. It was an affirmation — reassuring or not — of what happened in front of their eyes.

"The vets have wanted to talk about it," said Sonya Campbell, director of the Columbia Vet Center, about the uptick in sessions in the show's aftermath.

The centers are an outreach, counseling and referral service for troubled veterans. The Charleston Vet Center put together round table sessions at some veterans' request so they could talk it out.

"It has brought up a lot of issues for them," said Director Emily Shannon.

"They're saying, 'This has validated a lot of what I've been saying and believing for years,'" said Curtis Lucas, a psychologist with the Myrtle Beach Vet Center.

But it's been difficult, Lucas acknowledged. A lot of the vets he works with bought the video set or taped the show, wanting to watch only as much as they could handle at a time.

Some veterans who watched came away with new insights about the divisive conflict. Much of the thrust of the PBS documentary is how U.S. leaders across multiple presidential administrations knew there was little chance of U.S. victory in Southeast Asia but kept pouring men and materials into the conflict.

"Why you were there, it made sense at the time," said Eugene E. Coakley, 72, of North Charleston, an Air Force veteran who did maintenance work on F-4 fighter jets launching from a base in Thailand.

"I learned some things I never heard about before," said Craig Burnette, 71, of Inman in the Upstate. He led an Army platoon into firefights against the Viet Cong and North Vietnam army.

"I was very angry. I was sad. I was frustrated. I saw all these people making political decisions (in contradiction to what people on the ground were telling them)," he said.

Burnette stopped watching episodes when American troops like his began to be featured. He had trouble falling asleep.

"I'm worried for the (reactions of) other vets and their families, plus the families with names on the Wall," he said, referring to the Vietnam Veterans Memorial on the National Mall in Washington, D.C., which lists the names of some 58,220 U.S. service people who died in the war.

An estimated 895 South Carolinians died in Vietnam.

During a recent interview, Davis and Blankin sat at a table in the American Legion Post 147 on James Island. The bar chatter quieted as they talk. Like a lot of combat veterans, they don't go to fireworks shows. Seemingly mundane things can set off memories that, as Davis said, many thought had been buried. Davis recoils from the smell of coconut. For Blankin, it's burning rubber.

When Davis' eight-man crew was attacked on a hilltop, he was gashed in the face as an enemy fighter leaped over him. He thought he had been butted by a rifle until it started to bleed.

"I pulled out my .45 pistol and shot him," he said.

Blankin commanded a "river rat" patrol boat through the jungle when a rocket-propelled grenade blew the hull apart under him, killing one of his seven-man crew.

"You don't know what's around the next bend. The banks are sprayed bare by Agent Orange. You know, you go into the Navy, you just don't think you're going to be doing things like that," he said.

Like a lot of others, both men struggled with post-traumatic stress disorder but have come to their own acceptances.

"Some things are just right there. They will always be right there," Davis said. "The only thing, you can't dwell on it. That was then. This is now. When we came back, we didn't call it going home. We called it going back to the real world."

At times, the television special irritated Blankin, he said. Jane Fonda (featured protesting in North Vietnam in support of the enemy during the war) and John Kerry (featured testifying to Congress about American atrocities after he returned from combat), "They just stick in my craw," he said.

Both veterans returned home on transports also carrying the caskets of other service people — Davis on a boat "with a hull full of bodies," Blankin on a C-130 plane with caskets set in the cargo hold the soldiers' seats lined.

"Everything that left had bodies on it," he said. "When I felt that plane come off the ground (in Vietnam), that was the best I'd felt in a long time."

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3.8 - South Bend Tribune: [Viewpoint: St. Joseph County clinic's grand opening fulfills a promise to our veterans](#) (29 September, Sen. Joe Donnelly (D-Ind.), 274k online visitors/mo; South Bend, IN)

When we care for our veterans, we both honor their service, and we reinforce our values.

Yet for too long, it was a struggle to provide veterans in our community convenient access to quality health care. Veterans from South Bend, Mishawaka, Elkhart, LaPorte and Plymouth have regularly had to make a two-hour trip to VA facilities in Chicago or Fort Wayne to see a doctor. Veterans, family members and their caregivers often have to fight traffic and bad weather to get the health care they earned through their service to our nation. For those veterans unable to drive themselves, making the trip often involved taking a Disabled Americans Veterans van all the way to Fort Wayne, possibly spending an entire day in transit, receiving care, and waiting hours for other DAV passengers to receive their care too.

For the last 10 years — in the U.S. House of Representatives and in the U.S. Senate — it has been my mission to work alongside veterans in north central Indiana to provide the finest VA care possible, and I am proud that today we will officially open the St. Joseph County VA Clinic.

And while the promise we are fulfilling today seems simple, the process was long and full of challenges. Alongside our local veterans, we began working on the clinic in 2007, holding roundtables and meetings to understand the specific needs of Hoosiers. Through each step of the decade-long process — gathering the facts necessary to make our case for a new VA clinic; securing VA approval, congressional authorizations, as well as funding; cutting through red tape to contract, permit, and build the new clinic; and even locating a Transpo bus stop at the clinic to accommodate local veterans and employees — our community stood up, answering the call to make good on our promise to provide access to quality health.

I want to recognize our entire community, the VA, veterans service officers and other veterans advocates, and local elected officials, for their persistence and tireless work that made the St. Joseph County VA Clinic a reality.

Today we officially open a new 89,000-square foot, state-of-the-art St. Joseph County VA Clinic that is expected to serve up to 13,000 area veterans. Our veterans will be able to receive a range of services from primary medical care, mental health care, audiology, radiology, physical therapy, podiatry, care for post-traumatic stress disorder, substance abuse counseling, traumatic brain injury care, tele-health, and many other services. Perhaps, more importantly, they will receive these services right here in north central Indiana.

Today's grand opening is a significant milestone. It's the culmination of the dedication and determination of the entire community, and it's an example of what we can accomplish when we work together. More importantly, it fulfills an important part of our promise to our veterans.

Joe Donnelly, D-Indiana, is a U.S. senator.

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3.9 - The Herald-Dispatch: [Look for these warning signs to help prevent suicide](#) (1 October, Debbie Brammer, 192k online visitors/mo; Huntington, WV)

Thirty-nine stones lay scattered beneath the leafy branches of a young maple tree. Each stone bears the name of a loved one who was lost to suicide. Billy, Rita, Scott are among the names painted on the stones, representing both male and female, young and old, because suicide has no respect for gender or age.

This Tree of Remembrance, planted on the lawn of the Huntington VA Medical Center (VAMC), stands as a solemn reminder of lives cut short and the families and friends who were left behind to grieve. The tree is not only a memorial, but it also supports the healing of the families and friends.

Suicide prevention is a top priority of the Department of Veterans Affairs. In a recent message to employees, Huntington VAMC Director Brian Nimmo pointed out that suicide is preventable. September was designated Suicide Prevention Month and now is a perfect opportunity to change the way the public thinks about suicide through education about warning signs

"The statistics are startling," Nimmo said. "An average of 20 veterans die from suicide each day, and 67 percent of those deaths were a result of firearm injuries. But, did you know only six of the 20 were users of VA health services." He encouraged staff, who encounter hundreds of veterans and their friends and family members each day, to not only reach out to educate the public but to make sure they know the warning signs, too.

The warning signs include significant changes in behavior or mood such as:

>> sleeping a lot more or a lot less.

>> quick to anger, more withdrawn.

>> drinking more or using drugs.

>> engaging in high risk behavior.

>> expressing feeling of hopelessness or saying loved ones would be better off without them around.

If these changes are noticed, encourage the veteran to contact the Veterans Crisis Line or make the contact yourself. The toll- free number is 1-800-273-8255, and press 1, or chat online at VeteransCrisisLine.net, or send a text to 838255.

The Huntington VA has two suicide prevention coordinators, Deanna Stump and Julie Brawn, who work to raise awareness of VA's resources and foster communication and education among veterans, community organizations and the public at large. They provide intensive case management for those identified as being at risk.

Unfortunately, VA and our suicide prevention coordinators cannot do it alone, we need the help of our communities. To learn more about suicide awareness and prevention go online to <http://www.VeteransCrisisLine.net/BeThere>, or <http://maketheconnection.net>.

Debbie Brammer is public affairs officer at the Huntington VA Medical Center.

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3.10 - FierceHealthcare: [VA proposed rule would override state licensing restrictions to expand access to telehealth](#) (29 September, Evan Sweeney, 140k online visitors/mo; Washington, DC)

The Department of Veterans Affairs has issued a proposed rule that would allow VA providers to treat patients in any state via telehealth, regardless of where they are licensed to practice.

The proposed rule would override state licensing restrictions that the agency says are limiting its telehealth program and allow VA physicians to treat patients anywhere in the country using the VA's telehealth technology.

That change is a critical part of the VA's "Anywhere to Anywhere VA Health Care" program, unveiled by VA Secretary David Shulkin, M.D., and President Donald Trump last month. During that announcement, Shulkin said he was working with the White House's Office of American Innovation and the Department of Justice to issue a new medical practice regulation to support telehealth initiatives.

According to the proposal, "many VA medical centers" have not expanded telehealth programs because of state laws, and "many physicians" refuse to practice telehealth out of fear they will jeopardize their medical license.

"As VA's telehealth program expands and successfully provides increased access to high quality healthcare to all beneficiaries, it is increasingly important for VA health care providers to be able to practice telehealth across State lines and within states free of restrictions imposed by State law or regulations, including conditions attached to their State licenses," the rule states.

Rather than lobby each state to remove licensure restrictions, the VA argues that preempting state law would allow the agency to quickly expand telehealth services.

“By allowing VA telehealth providers to more easily treat patients across state lines, we can ensure that recent advances in technology-enabled care reach the most deserved among us and spur better outcomes for the 20 million veterans in the VA system today,” Health IT Now Executive Director Joel White said in a statement supporting the regulatory change.

Currently, VA providers can waive state licensing requirements if both the physician and the patient are in a federally owned facility. But with the development of a new mobile app, the VA wants to reach veterans in their homes to expand access to mental health services and make it easier for those with limited mobility to get necessary medical care.

This week, behavioral health advocates came out in support of the VETS Act of 2017, which proposes similar regulatory changes. But the VA’s rulemaking process could move faster. The proposed rule will be open for comments for 30 days.

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3.11 - The Sun News: [VA hospitals must be fixed - now](#) (30 September, Stephen Sherwood, 140k online visitors/mo; Myrtle Beach, SC)

I have written all my senators and one congressman, and yet nothing changes with the VA hospital.

I had major neck surgery in July and was prescribed four different opiates for pain. Now I cannot get anyone to prescribe any of these opiates, so along with being in pain, I am withdrawing from the opiates cold turkey. I would be willing to bet that if you and all your staff looked into this situation, you would find that there are countless other veterans who are also receiving this unethical and immoral treatment from VA hospitals nationwide.

Please do something other than what you haven't been doing. I am begging you as a proud veteran and a resident of the great state of South Carolina that you immediately do more than send them a letter or a phone call - that you actually look into this terrible treatment that myself and countless other veterans continue to receive at the hands of the VA.

STEPHEN SHERWOOD, MYRTLE BEACH

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3.12 - The Joplin Globe: [Missouri's U.S. senators note bipartisan efforts](#) (29 September, Susan Redden, 76k online visitors/mo; Joplin, MO)

On the federal front, Missouri's U.S. Sen. Roy Blunt this week announced he and Sen. Richard Blumenthal had introduced bipartisan legislation to expand veterans' access to peer counseling specialists to better combat the risks of suicide and treat associated mental health conditions.

"Our nation has a responsibility to ensure our veterans have access to quality behavioral and mental health treatment," Blunt said. "Given their shared experiences, peer specialists are uniquely positioned to provide veterans the support they need in their recovery."

The Veteran Peer Act would establish peer specialists in patient aligned-care teams within the Veterans Affairs medical system to undertake veteran outreach, according to Blumenthal, a Democrat from Connecticut.

The Department of Veterans Affairs employs peer specialists to assist veterans in treatment for mental health and substance abuse disorders. The specialists support their fellow veterans and encourage recovery by helping them access veterans' health services and navigate the VA health care system and by teaching coping and positive behavior.

The VA was instructed by a 2012 executive order to hire and train 800 peer specialists by the end of 2013 to treat the estimated 1.5 million veterans needing mental health services.

Blunt's bill would expand veterans' access to the services by addressing current shortcomings that restrict specialists' participation in primary care services, along with the persistent stigma attached to seeking mental health treatment.

The measure would implement the program in 50 locations across the nation over a two-year period. It would also require consideration of rural and underserved areas when seeking locations.

Missouri's U.S. Sen. Claire McCaskill, a Democrat, on Thursday announced she had joined a GOP colleague to introduce what she described as "commonsense fixes" aimed at providing relief to some regional banks affected by burdensome requirements of the Dodd-Frank financial reform bill.

In a release, McCaskill said the proposed rules are aimed at small, regional banks to modify Dodd-Frank regulations that were never intended for banks that engage in ordinary consumer banking practices.

David Perdue, a Republican from Georgia, is co-sponsor of the measure. It serves as the Senate companion to a measure sponsored by U.S. Rep. Blaine Leutkemeyer, of Missouri, and passed in the House last year.

"When even some of the architects of Dodd-Frank agree the law is overly burdensome on regional banks, you know we've got a problem on our hands," McCaskill said. "This commonsense fix will untie the hands of our small regional banks and return to them to the flexibility to lend to Missouri customers who want to buy a house or start a business. I'm glad to join Congressman Leutkemeyer's efforts to help get this bill across the finish line in the Senate."

Perdue pointed out that Dodd-Frank overregulated regional banks by placing them in the same category as huge banks with a global reach, increasing their costs and limiting their ability to support their communities.

The legislation would lower the regulatory burden on regional banks by giving the Federal Reserve the flexibility to exempt them from certain Dodd-Frank rules that limit their lending

ability. Under the measure passed in the wake of the 2008 financial crisis, banks with assets over \$50 billion are subject to stronger regulations.

The proposed measure would relax rules for banks over the \$50 billion threshold if they are not designated as a Global Systemically Important Bank that, according to the Federal Reserve, could have an impact on international financial systems.

McCaskill said the threshold being applied to regional banks had been criticized by everyone from governors for the Federal Reserve to Barney Frank, the former lawmaker who authorized the legislation.

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3.13 - Daily Messenger: [Improvements reported at Veterans Crisis Line](#) (29 September, Julie Sherwood, 74k online visitors/mo; Canandaigua, NY)

The Veterans Crisis Line — which has been criticized for calls rolling to voicemail, dropped calls and veterans put on hold for long periods — received a glowing report Friday.

U.S. Reps. Chris Collins, R-Clarence and Phil Roe, a Republican from Tennessee who chairs the House Committee on Veterans Affairs, discussed improvements following a tour of the crisis center at the Canandaigua VA Medical Center.

“The biggest problem we’ve had is timely access to care, so this is basically the front porch to that,” said Roe, after seeing the crisis center that opened in 2007 and is now one of two centers at the forefront of the VA’s efforts to address the alarming rate of veteran suicide. The call centers, in Canandaigua and Atlanta, Georgia, answer phone calls, texts and online messages from veterans, military members and their families.

“It’s very disturbing to me, the number of veterans we are losing to suicide, and not just veterans but Americans,” said Roe, a Vietnam veteran and physician. “When you lose more men and women to suicide than combat, something needs to be done.”

Roe and Collins were pleased with what they saw and heard. A panel of VA staff involved with the Crisis Line in Building 37, where dispatchers work the center, discussed improvements with the congressmen. Among those: the Veterans Crisis Line averaged 2,300 calls in the month of September at both call centers. Of those, an average of 1.3 percent of calls (about 30 calls) rolled over to a backup center. When phone lines are busy, calls are routed to another contracted call center. In the past few days that percentage dropped to less than half a percent.

The crisis line is now answering calls, on average, in 7.5 seconds, with 99 percent of calls answered within 20 seconds.

“I am very impressed, it was a great tour,” said Collins, whose district covers much of Western New York and part of the Finger Lakes including Canandaigua. “Folks here care about our veterans, their dedication is clear,” he said.

The VA plans to open a third call center this fall on the VA campus in Topeka, Kansas.

About 200 responders work at the Atlanta facility, and 310 work at the Canandaigua center, according to a Sept. 14 report by the military publication Stars and Stripes. The Topeka facility will bring the number of employees staffing the veterans crisis line to 610.

During the press conference, the congressmen were also asked about a federal funding cut of millions of dollars for the Veterans Outreach Center in Rochester. At issue is a \$2.1 million grant that the VOC has received annually for the last six years that was not renewed for 2018. The VOC of Rochester was one of 36 previous recipients of the funds through the VA's Supportive Services for Veteran Families program that did not get renewed.

The center in Rochester helps veterans in seven local counties and their families find reliable housing. The lack of funds would scale back services, and a satellite office at the Veteran's Outreach Center in Buffalo could close with staff losing jobs or being reassigned.

Roe said he couldn't say why the funds were cut. Collins mentioned a possible "paperwork snafu." Collins said this is not a partisan issue and he was going to fix the problem, beginning that afternoon, working with others in Congress.

Need help?

— Call Veterans Crisis Line at 1-800-273-8255 and press 1 to talk to someone now.

— Text 838255 to get help now.

— Chat online at www.veteranscrisisline.net.

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3.14 - KXRM (FOX-21, Video, Updated): [VFW raises concerns over VA care](#) (30 September, Carly Moore, 60k online visitors/mo; Colorado Springs, CO)

A fallen service member has a group from the Veterans of Foreign Wars organization speaking out. Some members of the VFW are attributing his death to lack of care from the Colorado Springs Veterans Affairs hospital.

The widow of the service member was left overwhelmed and unprepared. She was concerned about her financial situation and was worried she would lose her house.

The VFW said it's extremely common for people to not have plans, to not know their benefits, and to not have documents on hand.

A small group of commanders at VFW Post 3917 turned it around.

Ray Belasco was a 20-year Vietnam veteran. He passed away at age 65, and some VFW members believe his death could have been avoided.

"It sound to me, people didn't really take him serious, didn't feel that he was really sick," said VFW Sr. Vice Commander Steve Kjonaas.

He went to the VA in Colorado Springs over the Labor Day holiday and was sent to an emergency room.

“Veterans have very unique diseases, illness and problems,” said Kjonaas. “That’s the difference between the Department of Veterans Affairs and any other civilian healthcare that you see.”

The VA facility in Colorado Springs doesn’t have an emergency room specifically for veterans. For that, they must go to Denver or to a local civilian emergency room.

“As with other outpatient clinics in the community, emergency services are not available at the PFC Floyd K Lindstrom VA Clinic in Colorado Springs,” the VA said in a statement. “We encourage anyone in an emergency situation to seek immediate treatment and care at their nearest emergency department, where appropriate services are available.”

After the emergency room released him, hospice care he was searching for wasn’t enough. He died just days later.

Belasco’s widow, Ute, was left with nothing: no money or plans for her husband’s funeral. She tried to sort things out, but was shut down without documentation.

“Once a service member dies, they cut off his pay,” said VFW Jr. Vice Commander Cindy Galvin. “If you don’t have the paperwork to go in and say, ‘Hey, I’m a spouse,’ then you don’t get the survivors pay.”

VFW members helped expedite the process. Something that could take one to three months was done in about two weeks.

“As a veteran myself, it makes me very happy to help,” said Galvin.

When Galvin was asked why she is also helping plan a funeral this Saturday, she said, “He’s a comrade and we never leave a vet behind.”

The American Legion Post 38 at 6685 Southmoor Drive in Fountain is hosting a memorial service starting at 11 a.m. Saturday. They want other former service members to come out and help support this fallen veteran.

Those close to Ute have released the following statement on her behalf:

Ute would like them to know about her being misquoted. She never said she was afraid nobody would show up for Ray’s funeral. Not a funeral, but to attend a memorial. She only reached out for help with this process, not for anything for her. She also wanted help with the way Ray was treated at Cheyenne Mountain Care Facility (Center) hospice provider. They showed extreme lack of care, compassion and dignity with his care. Ute wants to thank the Veterans of Foreign Wars for their help and all who have supported her and helped during this time.”

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3.15 - KXRM (FOX-21, Video): [Colorado Springs widow gives final salute to veteran husband who died suddenly](#) (30 September, Sarah Ferguson, 60k online visitors/mo; Colorado Springs, CO)

The widow of a fallen Service Member left overwhelmed after he suddenly died, is able to give her husband, a Vietnam Veteran, the honorary send-off he deserves.

His wife, Ute was shocked when her husband Ray Belasco suddenly passed away at 65-year's-old.

Recently a local Veterans of Foreign Wars group heard the widow's story, with Members attributing his death to a lack of care from the Colorado Springs Veterans Affairs hospital.

"When we found out that the funeral home wanted to hold the funeral in the parking lot we couldn't have that," said VFW Jr. Vice Commander Cindy Galvin.

Saying because Ute didn't have the proper documentation complete after Ray's death, she was turned away from any funeral plans.

Fortunately, VFW Post 3917 took matters into their own hands and set-up a memorial at the American Legion Post 38 in Fountain.

"So many valued people; so many honorable people from different walks of life, from different organizations, different motivations who come here to honor the veterans," said VFW Sr. Vice Commander Steve Kjonaas.

Prior to the memorial, VFW Post 3917 also helped Ute collect the benefits her husband deserves, while assisting her with filling out the proper documentation.

"They weren't asking for anything; they weren't expecting anything, they didn't beg for anything, they just are very grateful, they didn't realize we were going to do all of this," said Galvin.

If you'd like to read more about Ute's story and her concern with the Colorado Springs Veterans Affairs hospital, click here.

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3.16 - Finger Lakes Daily News: [VA Crisis Line Reports Improvements in Call Handling](#) (30 September, Joe Lasky, 53k online visitors/mo; Geneva, NY)

The Daily Messenger reports Congressman Chris Collins and Tennessee Representative Phil Roe toured the facility Friday, and reported that only 1.3% of calls are now rolling over to a backup center, with 99% of calls answered within 8 seconds.

The Crisis Line had come under fire in recent years for allowing as many as 30% of calls to go to backup centers.

The suicide hotline employs 310 at the Canandaigua center, with an additional 200 workers out of Atlanta, and an additional center in Topeka, Kansas set to go online later this fall.

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3.17 - Inquirer.net: [US lawmaker files bill for full benefits for Filipino WWII veterans](#) (29 September, 14k online visitors/mo; Daly City, CA)

WASHINGTON, DC – Congresswoman Jackie Speier (CA-14) introduced H.R. 3865, the Filipino Veterans Fairness Act of 2017 on Thursday, September 28.

During World War II, about 250,000 Filipinos volunteered to fight alongside U.S. troops. As citizens of a commonwealth of the United States before and during the war, Filipinos were legally American nationals.

With American nationality, they were promised all the benefits afforded to those serving in the U.S. Armed Forces. But in 1946, Congress stripped many Filipinos of the benefits that had been promised by President Franklin D. Roosevelt. Of veterans of the 66 countries allied with the United States during World War II, only Filipinos were denied benefits.

Speier's legislation eliminates the distinction between the Regular or "Old" Philippine Scouts and the other three groups of veterans—Commonwealth Army of the Philippines, Recognized Guerrilla Forces, and New Philippine Scouts. Widows and children of Filipino veterans would be eligible for Dependency and Indemnity Compensation just like any other veteran.

"This bill rights a shameful wrong created when Congress rescinded a promise to Filipino veterans of World War II over 70 years ago," Speier said. "I will not rest until these heroes, and their families, receive the benefits they need and deserve. If America won't live up to its honor and duty to our allies and friends we may find ourselves alone in our next hour of need."

The 2009 American Recovery and Reinvestment Act contained a provision that provided a lump sum payment of \$15,000 for Filipino veterans who are now U.S. citizens and \$9,000 for non-citizens. But there have been problems with the implementation of this payment program. To be eligible, a veteran has to be on the so-called "Missouri List," an Army roster of eligible veterans.

The Missouri List is incomplete. A 1973 fire destroyed 80 percent of the records for Army personnel from 1912 to 1960. As a result, over 17,000 Filipino veterans have had their claims denied. The Filipino Veterans Fairness Act directs the VA to take into account alternative military documentation to determine eligibility.

"The Recovery Act payments were a start, but our nation must bestow the full status it promised these veterans in wartime," Speier concluded. "Their average age is 90. Fewer than 15,000 are still alive today, and they are dying at a rate of over 10 a day. For these veterans and their loved ones the time to act is now."

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3.18 - Montgomery Herald: [VA awards grants to help at-risk Southern W.Va. vets, families](#) (29 September, 7k online visitors/mo; Montgomery, WV)

BECKLEY — Earlier this month, the Department of Veterans Affairs (VA) announced it has awarded \$343 million in grants to 288 nonprofit organizations to help low-income veterans and their families. More than \$2 million will go towards a community partner that assists veterans across the state, including southern West Virginia.

The grants were awarded under VA's Supportive Services for Veteran Families (SSVF) program.

In West Virginia, three SSVF programs received money from the \$343 million grants. One of them, West Virginia Community Action Partnerships, supports the entire state.

SSVF funding, which supports outreach, case management and other flexible assistance to rapidly re-house veterans who become homeless or to prevent veterans from becoming homeless. The funding helps the most economically vulnerable veterans avoid or exit homelessness.

In 2016, SSVF funding through WVCAP supported 589 veterans who were homeless or at-risk in West Virginia. As of July 31, 461 veterans had been helped, according to Leah Willis, SSVF coordinator for WVCAP.

"We are projecting to assist 600 veterans during the 2018 program year," Willis said.

"No veteran that served our country should be without a home or be facing that reality," said Stacy Vasquez, Beckley VAMC director and Army veteran. "Our homeless, health care and social work teams, along with community partners, successfully reduced the overall homeless Veteran rate in this region by more than 51 percent in 2016."

This year's recipients competed successfully for grants under a Dec. 7, 2016, Notice of Fund Availability. The funding will support SSVF services in fiscal 2018.

For additional information, please contact Public Affairs Officer Sara Yoke at 1-304-255-2121, ext. 4883 (office) or sara.yoke@va.gov

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4. Women Veterans

5. Appeals Modernization

6. Strategic Partnerships

6.1 - WFED (AM-1500): [Major changes coming to DoD's TRICARE system Jan. 1](#) (29 September, Jared Serbu, 831k online visitors/mo; Washington, DC)

The Defense Department published new rules Friday that will make significant changes to the health insurance system that serves military family members and retirees on Jan. 1, altering the structure and fees of benefit plans, and, according to Defense health officials, making care more accessible.

Most significantly, new beneficiaries will have to make an affirmative decision to enroll in the TRICARE system and will only be able to do so during an annual open enrollment period. The open enrollment schedule will be the same as the one used by the Federal Employee Health Benefits Program that serves civilian DoD employees: November and December of each year.

The policy differs substantially from the one in place today, in which TRICARE-eligible beneficiaries receive health benefits automatically. With a few exceptions, family members and retirees who do not sign up during the open enrollment period will lose coverage in TRICARE's "purchased care" market for the following year. They would still be able to seek care in military-run hospitals and clinics, but only on a space-available basis.

The change was one of several Defense health reforms Congress ordered as part of the 2017 Defense authorization bill. But Vice Adm. Raquel Bono, the director of the Defense Health Agency, said the move to open enrollment made sense from DHA's perspective as well.

"We need to make sure that we have as much information as possible in order to design our provider network," she told reporters on a conference call. "We wanted to also come as close as we could to what's happening in the commercial sector, and we're intent on being able to create some efficiencies in the administration of our health plans. We see this as one of the mechanisms to do that."

But officials said the open enrollment change will not have any meaningful effect on beneficiaries for another year; 2018 will be treated as a "transition year," and anyone who's covered by TRICARE as of Jan. 1, 2018 will be automatically enrolled in the plan that most closely matches the one that serves them today.

The plans are changing as well, effective Jan. 1. Also at the direction of Congress, DoD is merging the existing TRICARE Standard and Extra benefits — the department's fee-for-service options — into a single plan called TRICARE Select.

Like Standard and Extra, Select will let patients use any authorized medical provider, but cost shares are lower when beneficiaries see in-network providers. In most ways, it will operate like the plans it's replacing, but with changes to the ways in which patients pay out-of-pocket costs.

Currently, the cost shares are based on a percentage of TRICARE's negotiated costs with a network provider (or of that provider's "allowable costs" if they're out-of-network). Starting next year, patients will pay a fixed, per-visit rate for in-network providers that varies according to the type of medical care they're receiving.

For example, under Standard and Extra, a family member of an active-duty service member is responsible for 15 percent of the bill for an outpatient visit from an in-network doctor and 20 percent for an out-of-network doctor. The new Standard plan would charge a flat \$27 fee for an in-network provider. The fees for TRICARE-covered retirees are higher: the same visit would cost \$35.

“We thought this was something that would be a little more predictable and a little more patient-friendly, and we also thought it was an easier construct for our providers to use,” Bono said. “What we tried to do was take an average, so it should be close to what people are currently paying.”

Another change: The rules set a new requirement that TRICARE Select’s provider network cover enough geographic territory to provide services to at least 85 percent of its beneficiaries, up from just over 60 percent under the existing Standard and Extra plans.

The fee structure for TRICARE’s Prime plan, the managed care option that primarily serves areas with large concentrations of military members, remains largely unchanged, but the rule makes several changes that officials said were designed to improve access to care.

For instance, if TRICARE’s contractors don’t offer an appointment with a managed care provider within a timeframe that meets DoD’s access standards, the patient will be allowed to see an out-of-network provider without paying additional fees. The department says it will also waive some of its previous requirements that patients get referrals or pre-authorizations before patients visit specialty care providers or urgent care clinics, and treatments for obesity are specifically called out in the rule as covered care.

None of the changes are applicable to currently-serving military members, whose medical care remains a government obligation for as long as they continue to serve on active duty, but the fees for family members whose sponsors join the military after 2018 will be different from those that are currently serving, depending on which TRICARE plan they enroll in.

The changes to TRICARE’s health plans were only a few of the tweaks Congress made to the military health system as part of the 2017 Defense bill.

The rules DoD published on Friday nominally implement some of them, but Bono said the department will have to undertake more careful study before the other changes take effect.

Among those changes, Congress ordered DoD to treat expenses for telehealth in the same way it covers in-person visits, adjust the staffing in its military treatment facilities so that the health specialists the military employs more closely matches the medical expertise the military is likely to need in wartime environments, and to start creating “high-performance” treatment networks in pockets of the country that are underserved by DoD’s system by partnering with the Department of Veterans Affairs and private-sector hospital networks.

“The rule gives us an opportunity to implement some of these things, but it’s going to be an iterative process,” Bono said. “We will be looking specifically at where it makes the most sense to partner with the civilian health care systems that are in the particular areas where we have our beneficiaries. It’s part of our network development and it’s an opportunity to build partnerships. We’ll be evaluating it, and this is one of the things that the open enrollment requirement if going to help us with in terms of understanding where those opportunities might exist.”

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7. Supply Chain Modernization

8. Other

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Veterans Affairs Media Summary and News Clips

1 October 2017

1. Top Stories

1.1 - Washington Times (AP): Prosecutors: Veteran Threatened to Kill Congressman, Staff (30 September, 24M online visitors/mo; Washington, DC)

Federal prosecutors say a New Jersey veteran who suffers from post-traumatic stress disorder threatened to assault and kill a congressman and the lawmaker's staff. Joseph Brodie allegedly made the threats via telephone and email on Sept. 15 and 19.

[Hyperlink to Above](#)

1.2 - Portland Press Herald: Maine veterans given substandard care are told it's too late to sue (1 October, Edward D. Murphy, 2.1M online visitors/mo; Portland, ME)

After crushing her ankle in a fall during ropes training at Fort Leonard Wood in Missouri, April Wood for years sought relief from the pain she endured after leaving the Army in 2004. Doctors with the Department of Veterans Affairs ultimately determined that the only way to get rid of her pain was to amputate her leg a few inches below the knee.

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1.3 - The Day: VA groups, services tackle high suicide rates among female veterans (30 September, Julia Bergman, 440k online visitors/mo; New London, CT)

Female veterans are committing suicide at 250 percent the rate of female civilians, according to the Department of Veterans Affairs. In Connecticut, at least 10 of the 50 veterans who committed suicide in 2014, the most recent data available, were women. And that's only counting veterans receiving care at the VA.

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1.4 - ESPN: Sean Doolittle on Bruce Maxwell, respecting veterans and defining patriotism in a polarized America (30 September, Jerry Crasnick, 429k online visitors/mo; Bristol, CT)

Long before Oakland Athletics catcher Bruce Maxwell took a knee in protest during the playing of the national anthem last weekend, Sean Doolittle was giving sincere thought to patriotic displays at baseball games and the surrounding symbolism.

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2. Veteran and Employee Experience

2.1 - FOX News: Creators of lifesaving body armor, artificial pancreas among federal workers honored (30 September, Joseph Weber, 32.5M online visitors/mo; New York, NY)

Rory Cooper, a Department of Veterans Affairs researcher, received a Sammie for designing wheelchairs and other assistive technology equipment that has improved the mobility and quality of life for hundreds of thousands of disabled veterans and other Americans.

[Hyperlink to Above](#)

2.2 - The Hill: Trump's Cabinet and charter flights: What we know and don't know (30 September, Nathaniel Weixel, 11.8M online visitors/mo; Washington, DC)

Health and Human Services Secretary Tom Price resigned Friday following a series of public rebukes from President Trump and GOP lawmakers over his repeated use of charter and military aircraft, at public expense, for official travel. Price is far from the only Cabinet member to take private flights however, so his resignation isn't likely to stem the controversy.

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2.3 - Sun Herald: [Cruise-in to salute veterans goes back to its roots with return to Centennial Plaza](#) (30 September, Scott Hawkins, 858k online visitors/mo; Gulfport, MS)
One of the most meaningful and memorable events at Cruisin' The Coast each year is the Salute To Our Veterans cruise-ins. "The whole purpose is to have the vets enjoy the cars," said Woody Bailey, executive director of Cruisin' The Coast.

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2.4 - Herald-Mail Media: [Cruise-in unites community, veterans in common passion](#) (30 September, Richard Belisle, 158k online visitors/mo; Hagerstown, MD)
The main parking lot at the VA Medical Center shined bright in paint and chrome from a hundred sport and muscle cars, street rods, vintage Detroit autos and trucks lined up for Saturday's annual Country Roads Car Club Cruise-in. This was the third year for the event.

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2.5 - Little India: [Undersecretary Poonam Alaigh Caught Up in Veterans Affairs Travel Scandal](#) (30 September, 44k online visitors/mo; Torrington, CT)
Acting Undersecretary Poonam Alaigh and her husband accompanied Veterans Affairs chief David Shulkin and his wife on a 10-day trip to Europe in July this year, which is being criticized as a taxpayer paid holiday junket. Shuklin and his entourage attended a Wimbledon tennis match, toured Westminster Abbey and took a cruise on the Thames, all while on an official visit for meetings with Danish and British officials.

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2.6 - WOAY (ABC-50): [Beckley's Inaugural VAMC Veterans Art Show](#) (30 September, Daniella Hankey, Oak Hill, WV)
The Beckley VA Medical Center hosted its inaugural art show this Saturday at the Medical Center auditorium. The Veteran's Council planned the art show as one of its projects. Using the tag line "healing through creativity", the art show features projects that have helped Veterans to heal. Nationwide, VA medical facilities use the creative arts as one form of rehabilitative treatment to help Veterans recover from and cope with physical and emotional disabilities.

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[3. Access to Healthcare](#)

3.1 - Times Union: [What's the point of jailing this veteran?](#) (30 September, Chris Churchill, 1.5M online visitors/mo; Albany, NY)
Scott Gilligan had just turned 26. He was a guy from Cohoes and a Navy petty officer stationed in Puerto Rico. One day, he took a drive that would change his life. Gilligan was stopped at a

light when a man walked up to his car and stuck a gun in his face. A second armed man climbed into the back seat.

[Hyperlink to Above](#)

3.2 - The Olympian: [How we can help improve the quality of life for military veterans](#) (30 September, Dr. Rachel Wood, 851k online visitors/mo; Olympia, WA)

There are many things that contribute to our quality of life here in Thurston County: where you live or work, what you eat for breakfast, or how much stress you have in your day-to-day life. It's common sense that your health affects your quality of life, but it's also true that your quality of life can affect your health.

[Hyperlink to Above](#)

3.3 - Los Angeles Daily News: [L.A. veterans' health care has room to improve](#) (29 September, Editorial Board, 883k online visitors/mo; Woodland Hills, CA)

A Veterans Administration regional health care system is more than a corner of the federal bureaucracy. It's a promise to the men and women who served this country in the military. It's part of Americans' bargain with young people who sign up for duty.

[Hyperlink to Above](#)

3.4 - La Crosse Tribune: [Thanks to VA for great service](#) (30 September, Eugene Smithart, 823k online visitors/mo; La Crosse, WI)

I recently retired from Trane after more than 40 years. As a former U.S. Marine who served in Vietnam, I was able to get coverage from the Veterans Administration to replace the health coverage Trane had provided for all those years. With all I had heard about the Tomah VA, I didn't know what to expect in the way of quality of service I would receive.

[Hyperlink to Above](#)

3.5 - WHAM (ABC-13): [Groundwork underway for new VA clinic in Henrietta](#) (29 September, 817k online visitors/mo; Rochester, NY)

There will soon be a new location for local veterans to go for services and healthcare. A ceremonial groundbreaking took place Friday afternoon in the drizzle for the new VA clinic on Calkins Road in Henrietta. The 84,000-square-foot building will expand primary care services, along with mental health assessments and social work support.

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3.6 - WSBT (CBS-22): [Local veterans say they're glad to see new VA clinic in Mishawaka officially open](#) (30 September, Cassidy Williams, 449k online visitors/day; Mishawaka, IN)

The new St. Joseph County VA Clinic in Mishawaka is officially open. The 90,000 square foot facility offers a variety of services. The \$38 million dollar project finished on time and on budget. Senator Joe Donnelly and Congresswoman Jackie Walorski were there to get a tour of the new facility.

[Hyperlink to Above](#)

3.7 - The Post and Courier: [South Carolina veterans react sharply to Ken Burns Vietnam documentary](#) (30 September, Bo Petersen, 319k online visitors/mo; Charleston, SC)

Jerry Davis won't watch the Ken Burns' documentary on the Vietnam War, he tells you. The bayonet scar still plainly shows on his eye. "I saw it 'real time' and I don't want to see what someone else thinks," said the 76-year-old Marine Corps veteran from West Ashley, who set up communications under fire on hilltops in Vietnam.

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3.8 - South Bend Tribune: [Viewpoint: St. Joseph County clinic's grand opening fulfills a promise to our veterans](#) (29 September, Sen. Joe Donnelly (D-Ind.), 274k online visitors/mo; South Bend, IN)

When we care for our veterans, we both honor their service, and we reinforce our values. Yet for too long, it was a struggle to provide veterans in our community convenient access to quality health care. Veterans from South Bend, Mishawaka, Elkhart, LaPorte and Plymouth have regularly had to make a two-hour trip to VA facilities in Chicago or Fort Wayne to see a doctor.

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3.9 - The Herald-Dispatch: [Look for these warning signs to help prevent suicide](#) (1 October, Debbie Brammer, 192k online visitors/mo; Huntington, WV)

Thirty-nine stones lay scattered beneath the leafy branches of a young maple tree. Each stone bears the name of a loved one who was lost to suicide. Billy, Rita, Scott are among the names painted on the stones, representing both male and female, young and old, because suicide has no respect for gender or age.

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3.10 - FierceHealthcare: [VA proposed rule would override state licensing restrictions to expand access to telehealth](#) (29 September, Evan Sweeney, 140k online visitors/mo; Washington, DC)

The Department of Veterans Affairs has issued a proposed rule that would allow VA providers to treat patients in any state via telehealth, regardless of where they are licensed to practice. The proposed rule would override state licensing restrictions that the agency says are limiting its telehealth program and allow VA physicians to treat patients anywhere in the country using the VA's telehealth technology.

[Hyperlink to Above](#)

3.11 - The Sun News: [VA hospitals must be fixed - now](#) (30 September, Stephen Sherwood, 140k online visitors/mo; Myrtle Beach, SC)

I have written all my senators and one congressman, and yet nothing changes with the VA hospital. I had major neck surgery in July and was prescribed four different opiates for pain. Now I cannot get anyone to prescribe any of these opiates, so along with being in pain, I am withdrawing from the opiates cold turkey.

[Hyperlink to Above](#)

3.12 - The Joplin Globe: [Missouri's U.S. senators note bipartisan efforts](#) (29 September, Susan Redden, 76k online visitors/mo; Joplin, MO)

On the federal front, Missouri's U.S. Sen. Roy Blunt this week announced he and Sen. Richard Blumenthal had introduced bipartisan legislation to expand veterans' access to peer counseling specialists to better combat the risks of suicide and treat associated mental health conditions.

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3.13 - Daily Messenger: [Improvements reported at Veterans Crisis Line](#) (29 September, Julie Sherwood, 74k online visitors/mo; Canandaigua, NY)

The Veterans Crisis Line — which has been criticized for calls rolling to voicemail, dropped calls and veterans put on hold for long periods — received a glowing report Friday. U.S. Reps. Chris Collins, R-Clarence and Phil Roe, a Republican from Tennessee who chairs the House Committee on Veterans Affairs, discussed improvements following a tour of the crisis center at the Canandaigua VA Medical Center.

[Hyperlink to Above](#)

3.14 - KXRM (FOX-21, Video, Updated): [VFW raises concerns over VA care](#) (30 September, Carly Moore, 60k online visitors/mo; Colorado Springs, CO)

A fallen service member has a group from the Veterans of Foreign Wars organization speaking out. Some members of the VFW are attributing his death to lack of care from the Colorado Springs Veterans Affairs hospital. The widow of the service member was left overwhelmed and unprepared. She was concerned about her financial situation and was worried she would lose her house.

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3.15 - KXRM (FOX-21, Video): [Colorado Springs widow gives final salute to veteran husband who died suddenly](#) (30 September, Sarah Ferguson, 60k online visitors/mo; Colorado Springs, CO)

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[4. Women Veterans](#) – No Coverage

[5. Appeals Modernization](#) – No Coverage

[6. Strategic Partnerships](#)

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[Hyperlink to Above](#)

[7. Supply Chain Modernization](#) – No Coverage

[8. Other](#) – No Coverage

1. Top Stories

1.1 - Washington Times (AP): [Prosecutors: Veteran Threatened to Kill Congressman, Staff](#) (30 September, 10.8M online visitors/mo; Washington, DC)

CAMDEN, N.J. — Federal prosecutors say a New Jersey veteran who suffers from post-traumatic stress disorder threatened to assault and kill a congressman and the lawmaker's staff.

Joseph Brodie allegedly made the threats via telephone and email on Sept. 15 and 19.

Prosecutors say the 38-year-old Millville man was initially arrested on weapons charges Sept. 20 after state police went to his home to do a welfare check. They say Brodie fled out the front door with an assault rifle and tried unsuccessfully to fire it.

Brodie was charged Friday with threatening to assault a U.S. official. But the name of the congressman has not been disclosed.

Authorities say Brodie contacted the lawmaker to complain about a Department of Veterans Affairs clinic

It wasn't known Saturday if Brodie has retained an attorney.

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1.2 - Portland Press Herald: [Maine veterans given substandard care are told it's too late to sue](#) (1 October, Edward D. Murphy, 2.1M online visitors/mo; Portland, ME)

After crushing her ankle in a fall during ropes training at Fort Leonard Wood in Missouri, April Wood for years sought relief from the pain she endured after leaving the Army in 2004.

Doctors with the Department of Veterans Affairs ultimately determined that the only way to get rid of her pain was to amputate her leg a few inches below the knee.

But less than a year after the amputation, officials at the VA hospital in Togus, where she was initially treated, called her in to admit that her care there was substandard and the reason for her amputation was, at least in part, due to the poor care she had received at the Maine VA hospital, which has 230 doctors and serves 42,000 veterans annually.

"I was sitting there crying because, up to that point, I thought maybe my bones just cracked and there was something wrong with me," said Wood, who is no longer able to work because of her disability. "They said, 'No, your doctor sucked.' "

Now, Wood and five other Maine veterans are suing, claiming that the VA fraudulently concealed that a podiatrist at the VA hospital in Togus gave them substandard care, subjecting them to years of pain that hospital officials now say could have been avoided. Their case is currently before U.S. District Judge Jon D. Levy in Portland, who will decide whether the lawsuits can move forward.

Federal lawyers, however, have moved to dismiss the cases, arguing that the veterans waited too long to file the suits, even though the VA has admitted that the podiatrist, Dr. Thomas Franchini, provided poor care and the VA took years to notify the veterans that there were problems in their treatment.

The suits come against a backdrop of sharp criticism of the Department of Veterans Affairs over the standards of care given to veterans, including issues such as monthslong wait lists for care and mismanagement that led to veteran deaths.

The first suit was filed by Wood, now 42, a Maine native now living in Missouri, who was in Army basic training in early 2004 when she fell about 20 feet from the ropes course, smashing her ankle. Franchini, who treated her after her honorable discharge and is now in private practice in New York, performed surgery on Wood twice. Neither surgery provided any relief from the pain, and she eventually underwent the amputation, performed by other surgeons in 2012.

VETS CITE PAIN, LACK OF MOBILITY

The suits filed by the five other veterans have since been combined with Wood's and allege the same lack of effective treatment by Franchini, although no one else was subject to such a drastic remedy as Wood's amputation. Franchini's treatment of the other vets included plates and screws inserted into their feet and ankles – with some of the hardware allegedly incorrectly placed – joints fused improperly and bones from other parts of their bodies implanted poorly, the suits say.

All of the vets said they have limited mobility, and pain in their feet, ankles and legs. In some cases, doctors outside the VA system have recommended additional procedures, but the vets fear those operations will only worsen their conditions.

Jack Downs, 77, of Fairfield said doctors have told him further surgery would worsen the osteoarthritis in the foot that Franchini operated on in 2008.

The Marine Corps veteran said he can feel one of the screws that Franchini inserted during that surgery. He still suffers numbness in his foot, and pain that shoots up his leg to his hip when he walks or drives.

But, he said, "I'm afraid if they take the screw out, my foot will collapse."

Franchini began working at Togus, the oldest veterans' facility in the country, in 2004 after a career as a Navy doctor – in fact, one of the people suing him was treated for a different ailment by Franchini in Rhode Island while both were in the Navy. Franchini is still a licensed podiatrist, even though he resigned from the VA after the agency told him to step down or he would be fired in early 2010, according to Chris Cashour, a spokesman for the VA.

In addition to substandard care, a VA investigation said it appeared that Franchini was "falsifying some medical records," according to an affidavit filed in the veterans' suits by Yuri Walker, the VA's director of risk management.

Franchini is now listed as one of three doctors in a private podiatry practice on Fifth Avenue in New York City. His Maine podiatrist's license lapsed in 2011, but he has an active New York license. Records in both states show that there have been no complaints filed against him, although Cashour said the VA has "broad authority" to report doctors in cases where care was

substandard or caused injuries. Cashour would not say whether the VA reported Franchini to medical boards, citing privacy laws.

DOCTOR DEFENDS HIS TECHNIQUE

In most cases in Maine and New York, complaints that have not been validated are not recorded in state licensing records available to the public.

Through a representative of his office in New York, Franchini said he would not comment on the suits, and the government, not Franchini, is named as the defendant.

However, in a 2016 post on his personal blog, he complained that the review of his performance at Togus came about after one patient complained, although the VA said it was an official with the hospital who raised concerns about the doctor's care. That complaint, Franchini said, led to a "second wave" in which VA officials reviewed the care for more than 100 of his patients. He alleged the VA review only found that his record-keeping was deficient, not his surgical techniques or patient care, although the VA called in dozens of patients in January 2013 to admit that the care provided by Franchini was subpar.

Letters were sent at that time to Franchini's patients in what the VA terms a "large-scale disclosure event," but Franchini described the complaints as unfounded.

"Now the true fact (is) that my notes were brief, but not my care," Franchini wrote in his blog, in which he also complains about the difficulty of finding a new job. "They could not find something that was wrong other than (sic) brief note-taking."

In an affidavit filed in one of the suits last week, Franchini again denied that his care was subpar and said he tried to give his patients "accurate and truthful information" about their conditions and the results of his surgical procedures.

Vets and politicians have been critical of the quality of the care provided by the VA nationwide. The criticisms include allegations of mismanagement that led to veteran deaths, wait times as long as six months for VA hospital care, and VA officials' attempts to hide substandard care. In 2014, auditors discovered that employees at 110 VA facilities kept secret waiting lists to hide the delays veterans faced when seeking care. In July, Veterans Affairs Secretary David J. Shulkin fired two top officials at the Manchester, New Hampshire, VA Medical Center and ordered a review of the hospital.

Legislators and advocates have since pushed to reform the VA medical system, including changes that would make it easier for vets to see doctors outside the VA system or go to hospitals nearer to their homes.

The VA began examining the care it provided in recent years and rated the hospitals it ran on the quality of care offered.

TOGUS WAS RATED 2 ON A 5 SCALE

A critical report in 2015 commissioned by the Office of the Inspector General in the U.S. Department of Veterans Affairs found scheduling problems at Togus mirroring those at veterans hospitals nationwide, saying employees didn't enter appointment requests for some patients who weren't willing to be seen within 14 days, the VA benchmark for a comprehensive

examination for first-time patients. Employees were directed at times not to log referrals in their computerized system.

In 2016, care at Togus was rated a 2 on a 5-point scale, with 1 the lowest rank and 5 the highest. The rankings used some of the same variables used to evaluate other hospitals, such as surveys of patient experiences and outcomes, complications, readmissions and deaths, as well as some measures more geared toward VA hospitals, such as access to care and the quality of mental health care.

The VA rankings said Togus has made a “large improvement” from 2015, the baseline year for the rankings.

“We are proud of our improvements in all of our care programs, including podiatry,” said Ryan Lilly, director of the VA Maine Healthcare system.

The suits, however, allege that Franchini provided substandard care from early on in his tenure at the hospital.

Andy Korsiak, 58, who settled in Maine after he was assigned to Brunswick Naval Air Station, said he suffered for years from a bone spur that was pressing into his Achilles tendon. He went to Togus, where Franchini recommended surgery. The day of the operation, Korsiak said, Franchini decided at the last second to also remove a second bone spur lower on his heel that had not been causing any problems.

“We’re going to be in there, why don’t we do that as well?” Korsiak said he was told by Franchini.

He never saw Franchini again after the surgery in 2007, Korsiak said. A nurse removed his stitches and essentially sent him on his way.

Korsiak, who lives in Troy, said he still deals with pain and problems resulting from the surgery. A VA doctor in Massachusetts found bone fragments left behind in his ankle and heel, Korsiak said, but “there was absolute silence from the VA” until six years later, when the VA wrote to say there may have been problems with his care by Franchini and asked him to return to Togus to discuss his case.

The other cases contain similar accusations, but the most egregious appears to be Wood’s.

Wood said joining the Army was a lifelong dream. But she reluctantly accepted an honorable discharge in September 2004 when the Army determined that her effectiveness as a soldier would be reduced because of the injuries she suffered in the fall. After her discharge, she went to Togus to deal with continuing problems in her ankle and was assigned to Franchini for care.

“He said he could fix it,” she said of her ankle, and she believed him.

Franchini operated to fuse the ankle joint to reduce the movement of the joint, surgery that took four hours instead of the two she had been told to expect. A metal plate and eight screws were inserted into her ankle, she said, but after the surgery, Franchini told Wood and her family said that he wasn’t sure of a good outcome because she had “mushy bones,” Wood said.

When the pain didn't subside, Franchini operated again to insert more screws to immobilize the joint. When that failed to provide relief, Wood consulted VA doctors in Massachusetts, who decided to remove all the hardware Franchini had inserted and put in a piece of bone from a cadaver and more screws.

But in 2012, another VA doctor performed the amputation after the determination was made that it was the only way to alleviate the constant pain Wood was experiencing.

In early 2013, she was called back to Togus to discuss her case, where officials told her that Franchini's care was substandard.

Ultimately, the VA determined that her care had resulted in a full disability. Wood said she no longer works outside her home, but makes a few hundred dollars a year writing adult romance books.

BETRAYED BY THE SYSTEM

Timothy Mansir, now 36, injured his foot after falling while in Iraq with the Marine Corps. After he was discharged in 2007, he went to the VA, where Franchini diagnosed an unstable ankle and performed an ankle reconstruction in 2008.

Finally, he saw a podiatrist who lived down the street from him in Oxford. A surgical procedure that doctor performed helped some, Mansir said, but "my ankle was severely messed up."

Finally he was called in to Togus in 2013, where VA officials told him that Franchini's initial care was to blame and the ankle reconstruction was "overly aggressive."

Mansir has since had additional surgeries by doctors outside the VA system, but still experiences pain and said he feels "hurt and betrayed" by the system. Mansir said he worked as a commercial electrician and then a testing technician, but he lost both jobs when the pain interfered with his work. He still has a severe limp, has to take frequent breaks when he walks and lives with his wife on Social Security and military disability.

"I held up my end of the bargain and went and served my country, and I expected to be taken care of," he said. Being told that his care was substandard "was like a huge slap in the face."

Mark Prescott said pain that developed in his regular runs led him to seek help, initially while on active duty in the Navy and later as a veteran.

He said he had always been a runner, which continued after he joined the Navy out of high school in 1983. But in the late 1990s, Prescott started experiencing pain in his ankle and learned he had broken a bone in the joint years earlier and never had it treated. He had surgery twice while still on active duty and then was treated at Togus after retiring.

"He had a very good bedside manner," Prescott said of Franchini. "He was always available to talk to and seemed like a guy you wanted to hang out with." Prescott noted, however, that Franchini never seemed to write anything down.

Franchini operated on Prescott twice, transplanting a piece of bone taken from his foot into his ankle to stabilize it, but Prescott only experienced more pain. Franchini gave him a brace,

Prescott said, but he was unable to use it because he had to tighten it on the inside of his ankle, which caused too much pain.

Still, Franchini told him he was “progressing normally,” the suit alleges. Prescott said he never suspected anything might be amiss until VA officials told him that he might not have been treated well.

A doctor from the VA in Boston showed him an X-ray that, he said, indicated that Franchini had overly tightened the piece of transplanted bone, creating a ridge that caused his pain, Prescott said.

KICKED WHEN YOU'RE DOWN

Like the others, Prescott was told he could file a claim with the VA that might result in a finding of a greater disability with an increased pension and guarantee of care going forward. That claim was rejected.

“They admitted that they had harmed me, but the other office said, ‘Well, there’s nothing we’re going to do for you,’ ” Prescott said. “That’s sort of like kicking you when you’re down. To listen to the government, they should have known that we were improperly treated.”

In his suit, veteran Kenneth Myrick of South Portland said Franchini operated on his ankle at Togus in 2005 but he continued to experience “severe pain” in his left leg after the procedure despite additional surgeries at the VA in Boston. The VA told him in 2013 that the original surgery by Franchini resulted in “nerve entrapment,” which Franchini and other doctors failed to see in examinations after the original surgery. Franchini’s original surgery was “substandard,” the VA told Myrick.

Both Myrick and his lawyer, David Kreisler, have declined to comment on the suit.

Downs, the Marine from Fairfield, said his issues with the care provided by the VA go beyond the surgery Franchini performed on his foot in 2008.

Downs, who served in the Marine Corps for two years in the late 1950s, said the top of his foot had collapsed. Franchini told him it could be fixed by fusing a bone and operated in 2008.

Downs had follow-up appointments during which X-rays and scans were taken, but when Downs and his wife moved to Florida, Franchini didn’t contact him and never got in touch with VA doctors in Florida. According to his suit, the X-rays and scans indicated that the fusion had not succeeded and that a screw might have been improperly placed, but Downs was never told about those findings.

After the couple moved back to Maine, Togus officials told Downs that his care may have been inadequate and an outside doctor told him that the metal plate Franchini put in was too small to allow the bones to fuse.

Now, Downs – who used to walk 5 miles a day – suffers numbness in his foot when he tries to walk. If he drives, the pain starts in his foot and then travels up his leg to his hip.

Downs said he thinks Franchini never ordered physical therapy for him because he knew the therapists would discover that the surgery wasn’t right.

After the surgery, Downs said, he believes the VA dragged its feet on informing him and other Franchini patients that their care might have been substandard in order to run out the clock on time limits for filing a suit.

"I truthfully feel they stalled me," he said. "I was being stalled by the VA."

WHEN DOES THE TIMER START?

Levy, the judge over the ongoing cases, ruled in February 2016 that Maine's three-year time on malpractice suits is a "statute of repose," meaning the window of time on when the plaintiffs can file suit starts from when the alleged malpractice occurred. For most of the vets, their surgeries were performed in the mid- or late-2000s.

Attorneys for the veterans argued that the VA should be tried under a federal malpractice law with a two-year limit, but a clock that begins to run when the patients discover they may have received substandard care. The six vets were told by Togus officials in January 2013 that their care might have been substandard and most filed their suits within a year.

In his ruling in early 2016, however, Levy allowed the veterans' lawyers to pursue a claim that the VA had "fraudulently concealed" the findings of poor care, which would allow the suits to move ahead, regardless of the time limits. He's expected to rule in October or November.

Togus officials have admitted that they took a long time to disclose the findings of their investigation into Franchini's cases, but deny that they did so on purpose to limit the veterans' ability to sue.

Dr. Timothy Richardson, the former chief of staff at Togus, said he ordered another doctor to review Franchini's cases after a compensation and pension examiner raised concerns in early 2010. In an affidavit filed in the case, Richardson – who was demoted as chief of staff over the length of time it took to review the Franchini cases – said the pace of the review and notification of patients was "admittedly slow" and said he should have devoted more resources to investigating Franchini's cases.

But it wasn't a ruse, he said.

"At no time during the process did I ever deliberately delay the reviews to minimize or avoid potential legal liability from any claims that patients might assert against the Togus VAMC," Richardson said. "In fact, I never once considered the applicability of any statute of limitations to those claims, and had never even heard of the 'statute of repose' until the government raised the issue in the pending lawsuits. Based on my own personal experience, the issue of 'timing' or 'time limits' for potential tort claims was never discussed by anyone at the Togus VAMC. Nor did anyone say or even suggest that we should 'conceal' the results of our reviews from patients."

Walker, the VA's director of risk management who was involved in the Franchini investigation, also denied that the review was deliberately delayed.

U.S. attorneys in Portland who are defending the government in the suit said they had no comment because the case is in active litigation.

David Lipman, who represents Wood and Prescott, said the VA's argument, boiled down, is "we didn't fraudulently conceal it, we incompetently concealed it."

"That's just so frustrating and ridiculous," said Celine Boyle, of the Shaheen and Gordon law firm, who represents Korsiak, Downs and Mansir.

Both Lipman and Boyle indicated that they will likely file appeals if Levy's next ruling, on the fraudulent concealment claims, goes against them. In that case, they would likely appeal the ruling that the time limit is a statute of repose and that the state law, rather than the federal statute, should be followed in determining filing deadlines.

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1.3 - The Day: [VA groups, services tackle high suicide rates among female veterans](#) (30 September, Julia Bergman, 440k online visitors/mo; New London, CT)

Female veterans are committing suicide at 250 percent the rate of female civilians, according to the Department of Veterans Affairs.

In Connecticut, at least 10 of the 50 veterans who committed suicide in 2014, the most recent data available, were women. And that's only counting veterans receiving care at the VA.

Nationally, the suicide rate for female veterans from 2001 to 2014 increased by a greater degree than the suicide rate among male veterans.

The data was part of an update to a 2016 VA report that analyzed more than 55 million records from 1979 to 2014, the most comprehensive look at veteran suicides in the U.S.

Women are one of the fastest growing groups of veterans. Of Connecticut's 200,000-plus veterans, more than 16,500 are female. The number of female veterans in the state has grown by 10 percent in the past five years.

A 2016 survey of active-duty women and female veterans by the Service Women's Action Network found that they view gender bias as a major obstacle to success, and feel underappreciated by society. They listed their top community challenge as access to women-specific health care.

"I often hear from women 'I just wish I could meet other women veterans. I don't know how to meet other women veterans,'" said Lynette Adams, women veterans program manager at VA Connecticut. "Social support is a really large protective factor for people at risk of suicide."

As more women are entering the military, there may be an increase in the number of women accessing care at the VA. That, in turn, allows the VA to continue to build more programs geared toward women, Adams said.

From 2001 to 2014, the suicide rate for female veterans overall increased, but the rate decreased by 2.6 percent for those accessing services at the VA.

About 25 percent of female veterans in Connecticut are enrolled at the VA. This number has increased steadily over time, according to Adams, but there's still a large percentage of female veterans who are not going to the VA in Connecticut.

The VA, on a national level, has stepped up its outreach to women, letting them know about resources and programs specific to them. And it has "greatly expanded" its women-specific programming in the past five to 10 years, according to Adams.

"So I hope one of the reasons for those (VA enrollment) numbers going up is that women are realizing 'the VA can provide me with the gender-specific services that I need,'" she said.

There's a women veterans liaison at each of the VA's veterans centers in Connecticut, for example. And there's a number of mental health programs for women, such as support groups.

A few years ago, there was one only one group at the Connecticut VA for women who've experienced sexual assault or sexual harassment during their military service, commonly referred to as military sexual trauma or MST. A recent VA study found the rate of suicide to be higher among women who've experienced military sexual trauma.

Today, there are three such support groups.

"We find that women who are able to engage in these gender-specific programs are happier with their care," Adams said.

These programs can also provide female veterans with the social support that they might otherwise feel that they don't have, she added.

While the VA has expanded its offerings for women, veteran organizations are lacking in this regard, an op-ed written recently by two female veterans points out. The SWAN survey found that 71 percent of female veterans don't belong to a veterans service organization, and 30 percent said they don't feel welcome in existing veterans organizations.

A 2015 law directed the Connecticut's Department of Veterans Affairs, within existing resources, to create a women veterans program to let them know about federal and state benefits and services and to study their unique needs. A group meet twice that year, but hasn't met since, according to Emily Hein, spokeswoman for the state's Department of Veterans Affairs.

As was the case back then, the department's Office of Advocacy and Assistance has three female veteran services offices who act as liaisons for female vets, Hein said.

The national Women Veterans Hotline is 1 (855) VA-WOMEN (829-6636). The website is www.va.gov/WOMENVET.

For free, confidential support for veterans in crisis, call the Veterans Crisis Line at 1 (800) 273-8255 and press 1, or text to 838255, or chat online 24 hours a day at www.veteranscrisisline.net.

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1.4 - ESPN: [Sean Doolittle on Bruce Maxwell, respecting veterans and defining patriotism in a polarized America](#) (30 September, Jerry Crasnick, 429k online visitors/mo; Bristol, CT)

Long before Oakland Athletics catcher Bruce Maxwell took a knee in protest during the playing of the national anthem last weekend, Sean Doolittle was giving sincere thought to patriotic displays at baseball games and the surrounding symbolism.

Doolittle, who played with Maxwell in Oakland before being traded to the Washington Nationals in July, is the product of a military family. His father, Rory, served in the Air Force for 26 years and currently teaches aerospace science to high school ROTC students in New Jersey.

During his time in the majors, Doolittle has become a strong advocate for veterans and used his visibility to help them with everything from housing and employment to substance abuse-related issues. In May, Doolittle and his fiancée, Eireann Dolan, wrote a Sports Illustrated op-ed piece to raise awareness of the plight of veterans with "bad paper"-- those who've fallen through the cracks and failed to receive care after less-than-honorable discharges from the military because of alleged misconduct.

Doolittle and Dolan have also taken an interest in lesbian, gay, bisexual and transgender issues, and in November 2015 they hosted 17 Syrian refugee families for Thanksgiving dinner in Chicago. The Athletics nominated Doolittle for the Branch Rickey Award in 2013-2014 and the Roberto Clemente Award in 2016.

During a stop in Philadelphia this week, Doolittle shared his thoughts on the furor swirling around athletes and the national anthem in a conversation with ESPN.com.

Were you surprised when you saw Bruce Maxwell take a knee in Oakland?

Sean Doolittle: "I was a little bit surprised, mainly because it was a young guy that did it -- a guy that still has so much to prove in this league and so much to lose at the same time. [It's harder] for a guy like that to put himself out there. I hope we get to a point whether people agree with him or not, or wherever they fall on the issue, they can respect somebody for standing up for what they believe in."

What did you learn about Maxwell during your time in Oakland?

SD: "He's a very thoughtful guy. He's really matured a lot as a person and a player over his last couple of years. He had some big league time and got to be around some really good veteran guys in that clubhouse who really helped his development. He has talent, and he's starting to mature and work really well with that pitching staff.

"Bruce is a super nuanced guy. We want to put people in boxes. Words like 'conservative' or 'liberal' or 'Republican' or 'Democrat' have become pejoratives that people use to define and use against other people now. We want to label them before we even get to know them."

There has been a lot of conversation about how NFL and NBA players have jumped into the political fray while baseball players have remained largely silent. Some people point to the racial makeup of MLB rosters or the game's established clubhouse culture. What do you think?

SD: "I have theories, but I don't know. It's touchy."

Does it strike you that the national anthem is becoming such a flash point for debate?

SD: "A lot of these questions are being posed to people for the first time, like, 'What does it mean to you to stand for the anthem?' I think if you asked 10 people, you might get 10 different answers. You might see one guy standing at attention and other people walking around the concourse buying food or whatever."

What does the playing of the national anthem mean to you personally?

SD: "I came from a military family, so there are a lot of things I think about when the anthem is playing. One thing that bothers me is the way that people use veterans and troops almost as a shield. They say that's the reason they stand and that veterans deserve to be honored and respected during the anthem. But where is that outrage in taking better care of veterans? The most recent statistics say that we still lose 20 veterans to suicide every day.

"If you want to have that conversation, if that's your reason for standing, then let's talk. Let's have a conversation about putting that into action, because they deserve a heck of a lot more than people standing at attention during the flag or giving them discounts on food or hotels.

"It's really nice that we honor them at games sometimes. They'll bring a veteran on the field and he'll get a standing ovation, and that's important. We're in the 16th or 17th year of this war [in Afghanistan], and it keeps a reminder that we are still a country at war. But we need to follow through on those thoughts and actions."

How are you involved personally?

SD: "My fiancée and I do a lot of work with veterans' issues. Earlier this year, we wrote an op-ed that ran in Sports Illustrated about some of the things we found regarding veterans being wrongly excluded from VA care at a time when they're experiencing a mental health crisis and a suicide epidemic the way they are now. We need to be figuring out ways to expand VA care to take better care of veterans.

"We've worked very closely with three big organizations. We've also gotten closely connected with people in and around D.C. When we were writing the op-ed, we talked to policy makers and policy groups about it. We've learned a lot about veterans' issues and we stay super informed about it. Anytime people use vets and the military as a political football or a prop, it's kind of bothersome.

"The VA works, it really does. For some of the negative press they've gotten in the past few years, when the veterans are able to access it, it really works and saves lives, because they're the ones that are really equipped to handle the unique needs that veterans have."

Do you think there's a distinction to be made between symbolism and action here?

SD: "I don't want it to be a hollow gesture. I think it's a very valid reason to stand for the anthem. But if people are going to point to veterans and use them as the reason, then let's follow through on that.

"There are a lot of veterans being left out. It takes more than standing for the anthem or 'God Bless America' to stand up for them in a [real] sense. As long as we have a volunteer-only military, a lot of the responsibility falls on the general public to make sure they're getting the

care they need when they're done with their service. The veterans raise these questions with Congress and policymakers, but it's going to take the general public to raise their voices in order to really move the needle."

Some people say that athletes who kneel are disrespecting veterans and their service. Others maintain that veterans have fought to give people the right to peacefully protest in such a manner. Can you understand both arguments?

SD: "I worry sometimes in this country that we conflate patriotism exclusively with love of the military and militarism and the strength of our armed forces. That's not the only way that you can be patriotic."

"People draw a direct line between the national anthem and the military, or patriotism and the military. But there are a lot of things that we're not doing for veterans."

Have you seen any positive changes since you've been doing advocacy work for veterans?

SD: "It's getting better. [Veterans Affairs] Secretary [David] Shulkin, who was appointed last year, is doing a good job. But it's almost like we have to capture some of the momentum so that we don't lose any of that progress. He said his priority is bringing down the suicide numbers and reducing that rate."

Can the current debate be a "teachable moment"?

SD: "I think it's important to realize that the players who are protesting aren't protesting the anthem. They're not protesting the flag. People kind of move the goalposts on them and try to tell them what they're protesting. But as they keep saying, that's not what they're protesting."

As someone who stands for the anthem, what's your response to athletes who kneel?

SD: "I think American democracy is strong enough to have that conversation. I think my patriotism is strong enough to not be offended when somebody takes a knee during the anthem. That's not something I take personally. It's something that makes me want to reach out to that person and have a conversation with them and say, 'Let's talk about some of these issues. Tell me about certain things that have caused you to take such a stand.'"

"I want to have these conversations with guys like Bruce Maxwell and guys in other leagues, and maybe someday we can get to a point where we give them a reason to stand, and they're proud to stand along the other guys that are standing."

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2. Veteran and Employee Experience

2.1 - FOX News: [Creators of lifesaving body armor, artificial pancreas among federal workers honored](#) (30 September, Joseph Weber, 32.5M online visitors/mo; New York, NY)

Marine Corps engineer Flora Jordan was honored this week at a Washington, black-tie gala for creating body armor that's nearly half the weight of older models yet equally protective.

While humbled for winning the 2017 Service to America Medal, Jordan admitted that her mind was already focused on next-generation armor that will better help soldiers in combat and keep them healthier.

"This is so humbling, especially among all the accomplishments being recognized here," Jordan, the youngest recipient of the award, formally known as the Samuel J. Heyman Service to America Medal, said Wednesday at the awards ceremony, inside the neoclassic Andrew W. Mellon Auditorium on Constitution Avenue.

The 28-year-old Jordan said she and others at Marine Corps Systems Command in Quantico, Va., are now working on integrating the award-winning vests with other soldier-gear like helmets and hydration packs "in a more holistic way," which she said will also help with back and shoulder problems.

The annual gala, in which hundreds of not-so-famous federal employees pay tribute to coworkers' vital-yet-frequently-unheralded efforts, was not without star power and laughter this year.

Award-winning writer Michael Lewis -- who's had several books turned into movies -- was among those who spoke at the ceremonies, known around the nation's capital as the "Sammies."

"This is way more efficient" than the Oscars, Lewis said in a nod to federal workers' pride in no-waste efficiency.

Joshua Van Eaton, a Justice Department attorney honored with EPA investigators Phillip Brooks and Bryon Bunker for their lead work in the 2016 Volkswagen emission case, thanked Robert Muller for his efforts in negotiating the landmark, \$17.4 billion settlement with the German automaker.

The case, in which the company rigged more than a half-million vehicles to evade pollution regulations, also led to billions more in civil and criminal penalties.

"It should be obvious why I'd want to stay in (former FBI Director) Mueller's good graces," Eaton said about Mueller, who now leads a Justice probe into whether Trump campaign officials colluded with Russia in the 2016 White House race.

"Our nation relies on dedicated public servants like those we honor here tonight," Max Stier, president and CEO of the nonprofit, nonpartisan Partnership for Public Service, which runs the awards program, said in joint statement with Tom Bernstein, the partnership's chairman.

This year's lifetime achievement award went to Dr. Tedd Ellerbrock from the Centers for Disease Control and Prevention.

Ellerbrock played a vital role in building, expanding and improving the U.S.-led program that provides medicine and assistance to 11 million people worldwide living with HIV/AIDS.

Like many who won awards, Ellerbrock thanked his wife and family for their support and acknowledge how their work forced them to miss so many dance recitals and youth soccer games.

Ellerbrock said about his wife, "Without Pamela, I wouldn't be here today. Thank you for your love and support."

The other 2017 winners were the FDA's Courtney Lias and Stayce Beck who paved the way for the first artificial pancreas device to receive agency approval, three years faster than expected, which has helped those living with Type 1 diabetes.

Timothy Camus, a Treasury Department inspector general, and the IRS Impersonation Scam Team won for leading a multi-agency investigation and public awareness campaign to stop a massive fraud that conned thousands of Americans into paying millions of dollars in bogus tax bills.

Alex Mahoney and the Middle East Crisis Humanitarian Response Team for leading the U.S. humanitarian relief effort in war-torn Syria and parts of Iraq -- delivering food, medicine, safe drinking water and other assistance to millions of victims.

Rory Cooper, a Department of Veterans Affairs researcher, received a Sammie for designing wheelchairs and other assistive technology equipment that has improved the mobility and quality of life for hundreds of thousands of disabled veterans and other Americans.

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2.2 - The Hill: [Trump's Cabinet and charter flights: What we know and don't know](#) (30 September, Nathaniel Weixel, 11.8M online visitors/mo; Washington, DC)

Health and Human Services Secretary Tom Price resigned Friday following a series of public rebukes from President Trump and GOP lawmakers over his repeated use of charter and military aircraft, at public expense, for official travel.

Price is far from the only Cabinet member to take private flights however, so his resignation isn't likely to stem the controversy.

Here's what we know, and what we don't know.

Who is involved?

There are at least four Cabinet secretaries under fire for their use of charter or military flights.

Price was the most extreme case, as his flights cost taxpayers about \$1 million, according to estimates by Politico.

The Treasury Department inspector general is reviewing department head Steven Mnuchin's use of a private jet in August, as well as why he requested a government plane to take him and his wife, Louise Linton, on their European honeymoon. Environmental Protection Agency Administrator Scott Pruitt has also been using private planes for government duties. The Washington Post reported on Wednesday that Pruitt's private flights have cost taxpayers more than \$58,000.

On Thursday, Politico and The Washington Post reported Interior Secretary Ryan Zinke took a \$12,000 charter flight aboard a plane owned by oil-and-gas executives.

They also reported on at least three other occasions of private jet travel since Zinke was confirmed, including to the Virgin Islands, before hurricanes Irma and Maria hit.

Veterans Affairs Secretary David Shulkin is also coming under scrutiny for combining personal travel in Europe with an official trip, all paid for with taxpayer money. While Shulkin flew commercial, the government paid for both he and his wife's flight and a per-diem for both their meals.

The trip also came less than two weeks after he signed a memo instructing top VA staffers to determine whether "employee travel in their organization is essential."

Apologizing might not be enough

Price apologized for his decision and offered to pay back tax payers for the cost of his seat on his private flights.

That wasn't enough to stem the controversy or the president's ire.

Zinke on Friday was more combative, telling an audience at the Heritage Foundation that the outrage was "a little B.S."

Mnuchin hasn't apologized either, and on Thursday he declined to promise that he would only ever fly commercial.

"I can promise the American taxpayer that the only time that I will be using mil air is when there are issues either for national security or we have to get to various different things where there's no other means," Mnuchin said on CBS "This Morning."

Price's pledge to pay back "his share of the travel" amounts to \$51,887.31. According to Politico, which broke the stories about his private flights, Price took at least 26 flights on private jets at an estimated cost to the taxpayers of over \$400,000.

On Thursday night, Politico reported that the White House approved flights on U.S. military aircraft to travel to Europe, Asia and Africa for official events, at a cost of more than \$500,000.

Congressional Republicans are taking notice.

Price's trips managed to earn bipartisan outrage.

Democrats were fuming, but Republicans also gave him a dressing down.

"[Everything] that happens around here is based on appearances. And if it just appears wrong, don't do it," Sen. Lisa Murkowski (R-Alaska) told reporters this week.

Sen. John Kennedy (R-La.) had harsher words.

“Taking these charter flights, playing the big shot on the taxpayer's dime when you can go by bus or train or regular commercial air, can't put lipstick on this pig,” Kennedy said Thursday on Fox News Channel's “America's Newsroom.”

More broadly, the charter flights by Cabinet members are also the subject of an investigation by the House Oversight Committee.

Judiciary Committee Chairman Chuck Grassley (R-Iowa) on Thursday urged Trump to curb the spending of Cabinet secretaries.

He called on Trump to “emphasize to cabinet secretaries the necessity of using reasonable and cost-effective modes of travel,” especially “considering the many travel options to and from Washington, D.C.”

Will the flights cost anyone else their jobs?

Trump was reportedly incensed at Price for being a distraction, and was annoyed the reports about Price's air travel have undercut his “swamp draining” image.

But there was also speculation that Trump blamed Price for the failure of Congress to repeal ObamaCare.

If tax reform suffers a similar fate, one couldn't blame Mnuchin for being worried.

On the other hand, Mnuchin is a confidante and friend to Trump. Price was seen as a loyalist to Vice President Pence, and lacked a more personal connection to Trump.

Trump has also been cleaning house at the VA, firing more than 500 employees since he took office. It's not clear yet how the latest scandal will impact Shulkin.

Zinke has already come under fire from Democrats, and his initial defense shows he may be painting the issue as a partisan attack, which doesn't necessarily reflect poorly on Trump.

Trump has also been trying to combat the image of a White House in chaos, and while the scandals have not gotten positive cable news coverage, more staff resignations or firings could be even worse.

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2.3 - Sun Herald: [Cruise-in to salute veterans goes back to its roots with return to Centennial Plaza](#) (30 September, Scott Hawkins, 858k online visitors/mo; Gulfport, MS)

One of the most meaningful and memorable events at Cruisin' The Coast each year is the Salute To Our Veterans cruise-ins.

“The whole purpose is to have the vets enjoy the cars,” said Woody Bailey, executive director of Cruisin' The Coast.

This year, the event, which features Cruisers converging on the location to honor veterans, will be held 10 a.m. to 2 p.m. Tuesday, Oct. 3, at Centennial Plaza, 200 E. Beach Blvd., Gulfport. In recent years, it has been held at the Biloxi VA facility.

“The change of venue is going back to its original roots,” Bailey said.

Prior to Hurricane Katrina, the event was held under the oaks at the old Veterans Affairs facility at Centennial Plaza, which is now Cruise Central, but after the storm damaged the property, organizers moved the veterans cruise-in to the Biloxi VA facility.

In the following years, construction and other issues forced the event to move around for a few years.

“The vets event started at the Gulfport VA property a number of years ago,” Bailey said, “to have the vets at the VA home in Gulfport enjoy Cruisin’ The Coast.”

Now the veterans are living in Gulfport’s new VA retirement facility near Centennial Plaza, so moving the event back to the original location makes sense. Bailey said veterans from both the Gulfport and Biloxi VA facilities will be bused to Cruise Central for the Tuesday, Oct. 3, Salute to Veterans event.

“The vets have served their country,” he said. “We want to honor that service and feel like this is a way Cruisin’ The Coast can help do that.”

This year’s Salute to Our Veterans event also will feature a celebrity appearance by Cristy Lee and the Crusin’ The Coast Feature car.

SALUTE TO OUR VETERANS

Where: Cruise Central, Centennial Plaza, 200 E. Beach Blvd., Gulfport

When: 10 a.m.-2 p.m. Tuesday, Oct. 3

The event will feature a celebrity appearance by Cristy Lee and an appearance of the Cruisin’ The Coast Feature Car

Cruisin’ The Coast

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2.4 - Herald-Mail Media: [Cruise-in unites community, veterans in common passion](#) (30 September, Richard Belisle, 158k online visitors/mo; Hagerstown, MD)

MARTINSBURG, W.Va. — The main parking lot at the VA Medical Center shined bright in paint and chrome from a hundred sport and muscle cars, street rods, vintage Detroit autos and trucks lined up for Saturday’s annual Country Roads Car Club Cruise-in.

This was the third year for the event.

It's stated goal, VA and club organizers said, is to bring the community and military veterans together in a common passion — the love of things automotive.

Veterans themselves judged the vehicles and chose the winners in about a dozen categories. The biggest trophy, the Director's Choice, was a 1978 Corvette, picked by Timothy J. Cooke, the medical center's director. He once owned a 1978 Corvette, according Mike McAleer, public affairs officer.

The cruise-in is hosted every year by the Jefferson County, W.Va., car club. Member Bill Crawford said the club has its headquarters in Harpers Ferry, W.Va. It hosts two shows a year — the one at the VA and one in Ranson, W.Va.

Among the vehicles getting attention from veterans and visitors was a vintage 1959 British-made Turner MK 1 sports racing car. It was brought to the cruise-in by David Thomas, president of High Performance Heroes of Clarksburg, W.Va.

Heroes is a group of race fans who help combat-wounded veterans become active in motorsports.

Thomas's wife, Ashley Thomas, said the organization restores and modifies vintage sports cars, including a 1962 Austin Healey Sprite and 1972 MG Midget. Two combat-wounded veterans, Liam Dwyer of Litchfield, Conn., and Patrick Brown of Chesapeake, Va., have benefitted from the group's help.

Dwyer lost his left leg from an improvised explosive device in Afghanistan in 2011. In 2013, through the efforts of High Performance Heroes, he won the Pittsburgh Vintage Grand Prix Group 2 in the Austin Healey Sprite.

Brown was able to drive the MG Midget because the mechanics at High Performance Heroes were able to convert a window crank from a Ford F-150 into an automatic clutch for the MG's manual transmission, Ashley Thomas said.

"We are the only ones doing vintage sports car racing with combat-wounded veterans," she said.

Jim Boyer of Kearneysville, W.Va., who was wounded in action in Korea, was at the VA showing off his 1959 Plymouth Fury. He said he had bought a brand new iceberg-white Fury with a yellow roof in 1959. He drove the car for years before he sold it. The one on display Saturday was purchased in Franklin, W.Va. It's owner had died and his widow was trying to sell it.

"It was just like my first one. It had the same color, same 318-cubic-inch motor and it only had 28,000 miles on it," he said. "I bought it for \$23,000. My first one cost, new, less than \$3,000. I didn't have to do anything to it. I only get it out for occasions like this."

Steve Hummer of Star Tannery, Va., has a similar story, but with an "all original" 1929 Ford Model A pickup truck. An Army Ranger, he was seriously wounded in 1968 during the Tet Offensive in Vietnam. Today, Hummer is a certified peer recovery specialist in a veteran-to-veteran program at the Hope Center at the Martinsburg VA.

Jocelyn Doyle of Boonsboro is a dental assistant at the VA. On Saturday she was one of a cadre of volunteers who transported veterans in wheelchairs from their rooms to the cruise-in to see the cars up close.

"I transported six of them today," she said. "I do this so I can give something back."

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2.5 - Little India: [Undersecretary Poonam Alaigh Caught Up in Veterans Affairs Travel Scandal](#) (30 September, 44k online visitors/mo; Torrington, CT)

Acting Undersecretary Poonam Alaigh and her husband accompanied Veterans Affairs chief David Shulkin and his wife on a 10-day trip to Europe in July this year, which is being criticized as a taxpayer paid holiday junket.

Shuklin and his entourage attended a Wimbledon tennis match, toured Westminster Abbey and took a cruise on the Thames, all while on an official visit for meetings with Danish and British officials.

Besides the Alaighs, Shulkin's travel team included his chief of staff, and another aide. They were accompanied by a team of six security personnel.

Controversial Europe Trip

Shulkin was visiting the continent for meetings on veterans' health issues, but he spent more than half the time in sightseeing and shopping, the Washington Post reported.

The report comes on the heels of the resignation of Tom Price, the Health and Human Services Secretary, who was forced to resign on Sept. 29 following allegations of taxpayer-funded air travel.

VA revealed on Sept. 29 that the federal government paid for the flights for Shulkin and his wife, Merle Bari. The government also provided per-diem reimbursement for their meals and other expenses.

The VA representative did not respond to the Washington Post on how Bari became eligible for reimbursements and taxpayer-funded airfare, saying that she was traveling on "approved invitational orders." The spokesperson also refused to reveal the flight fare and the total reimbursement amount. Under federal guidelines, Bari could have been eligible for per diem reimbursement of \$3,600.

Alaigh defended the trip, telling the newspaper it enabled valuable exchange of ideas with their British and Danish counterparts.

"Were there some breaks we got? Sure. But they were reasonable. They were not at the expense of what we had committed to do: representing our country and showing our commitment to veterans," Alaigh told the Washington Post.

A travel itinerary released by the Department of Veterans Affairs shows that Alaigh and her husband accompanied the secretary on a separate flight.

The Indian American physician is reported to have submitted her resignation for family reasons on Sept. 25, effective Oct 7, according to the Military Times . It reported that Alaigh, who assumed the post in February, said in a letter to staff: "I want you to know that it has been my greatest honor to serve (VA) Secretary (David) Shulkin, each one of you and all of our veterans.

"As I prepare to now leave Washington, I thank you sincerely for what you have helped us to accomplish, moving from being the country's largest integrated healthcare system into, truly, America's greatest healthcare system."

Her resignation, however, has not been publicly announced, and Alaigh made no reference to it in her interview with the Washington Post.

Alaigh is an internist, who completed her residency at the State University of New York in Stony Brook. She earlier served as national medical director for GlaxoSmithKline, was cofounder of the Atlantic Accountable Care Organization in New Jersey, and a senior advisor to the Under Secretary for Health.

The Military Times reported that Carolyn Clancy, the deputy undersecretary of health for organizational excellence, will assume her post next month.

VA Press Secretary Curt Cashour defended the trip, saying that the visit, including the trip to the Wimbledon game, was reviewed and approved by the ethics counsel. He added that Alaigh's husband paid his expenses for the trip.

"These were important trips with our allies to discuss best practices for taking care of veterans. The secretary has been transparent on his down-time activities that were similar to what he would have done with his family over a weekend in the U.S.," Cashour said.

Shulkin attended a conference in London on July 19 to discuss mental health issues with representatives of Britain, Canada, Australia and New Zealand, following meetings in Denmark from July 12-14.

During the trip, Shulkin and his team also visited Copenhagen's Christiansborg and Amalienborg, and London's Buckingham and Kensington.

Travel Scandals in Trump Administration

Many senior members of Congress, including two key Republicans, have expressed concerns over the travel scandals involving members of the Trump administration. House Oversight Committee Chairman Trey Gowdy and Democrat Rep. Elijah E. Cummings wrote to the White House that official travel should not be connected to personal use.

Sen. Charles E. Grassley, the Chairman of the Senate Judiciary Committee, wrote to Trump asking what steps the government has taken to "ensure Cabinet secretaries use the most fiscally responsible travel in accordance with the public trust they hold."

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2.6 - WOAY (ABC-50): [Beckley's Inaugural VAMC Veterans Art Show](#) (30 September, Daniella Hankey, Oak Hill, WV)

The Beckley VA Medical Center hosted its inaugural art show this Saturday at the Medical Center auditorium.

The Veteran's Council planned the art show as one of its projects. Using the tag line "healing through creativity", the art show features projects that have helped Veterans to heal. Nationwide, VA medical facilities use the creative arts as one form of rehabilitative treatment to help Veterans recover from and cope with physical and emotional disabilities.

"It helps our veterans heal through our PTSD, military trauma and whatever else we have gone through and we're having an art show displaying it," said Melissa Burnett, Vice President of the Veteran's Council.

Veterans submitted their pieces including paintings, models, wood crafts, needlework and more. The art submissions will be judged by fellow veterans who will vote for their favorite piece of art.

Vern Hughes, a Navy Veteran and volunteer at the Beckley VA, submitted five of his pieces for the show.

"I'm trying to help people through their healing a little bit and give them a place to display their artwork and hopefully this will become an annual event," said Vern Hughes, a Navy Veteran.

In the past, Hughes has given his handmade cards to patients, employees and visitors at the VA.

"One veteran that use to be upstairs, his roommate got a card from his granddaughter and he said, I've never gotten a home made card, so his birthday came around and I made him one and he was just so excited. I make about 150 cards and hand them out to veterans, visitors and patients," said Hughes.

Awards were presented for first, second and third place. Veterans were able to submit up to five pieces. Additionally, all winners of the show were encouraged to submit their pieces to the 2017 National Veterans Creative Arts Festival to be held later this year.

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3. Access to Healthcare

3.1 - Times Union: [What's the point of jailing this veteran?](#) (30 September, Chris Churchill, 1.5M online visitors/mo; Albany, NY)

Scott Gilligan had just turned 26. He was a guy from Cohoes and a Navy petty officer stationed in Puerto Rico. One day, he took a drive that would change his life.

Gilligan was stopped at a light when a man walked up to his car and stuck a gun in his face. A second armed man climbed into the back seat.

As Gilligan thought of his pregnant wife, the men ordered him to drive to an isolated section of rain forest. There, they savagely beat the soldier and left him for dead. He walked six hours to call for help.

That was on Good Friday in 1995.

Gilligan returned to civilian life in Cohoes soon after, but struggled despite keeping steady jobs. He drank too much. He got divorced. His two sons became men. He was often anxious or depressed, but he held it together.

Then, two years ago, everything fell apart.

He lost his job at the Von Roll factory in Rotterdam, which meant he lost his health insurance. He couldn't afford the prescriptions that made his life bearable.

So he drank more. He started smoking crack. He slid into addiction.

"It was the only way I could make it through the day," Gilligan told me. "I wasn't in my right mind."

Gilligan hit bottom on Jan. 22, 2016.

That was the day he broke into a friend's house and stole a TV, two iPads and a laptop. He was arrested within hours and immediately confessed to the crime.

The arrest was a blessing — the jolt that turned Gilligan around.

He devoted himself to treatment and got clean. Doctors at the VA hospital in Albany told him he had post-traumatic stress disorder from the attack in Puerto Rico. It was like a revelation, an explanation for so much of what he'd been feeling.

Gilligan has been sober for 17 months now. He works at Saratoga National Cemetery, where he digs and maintains the graves of veterans.

"We make sure they get the respect they deserve," he said. "It's like therapy to me."

Gilligan typically attends seven Alcoholics Anonymous meetings a week. When he rises to speak, the 48-year-old hopes he's a role model, especially for veterans. That's what he wants his life to be now. He wants to help.

But there's a problem.

Gilligan still faces a second-degree burglary charge. His trial starts Monday. If convicted, he could face at least three-and-a-half years in prison.

But why? What good will that really do? Doesn't the veteran deserve a break?

"None of this would have happened to him, nor would he be suffering the effects, but for volunteering to serve his country," Gary Horton, director of the Veterans Defense Program at the New York State Defenders Association, wrote in a letter supporting Gilligan.

"He deserves the consideration and leniency of the justice system."

That seems obvious. And hardly groundbreaking. Some New York counties have Veterans Courts to deal with precisely these scenarios — to recognize the special difficulties faced by military veterans and to give them the understanding they deserve.

Albany County doesn't have a veterans court, but Gilligan would seem an ideal candidate for its drug court. There, he could avoid prison time and continue his treatment under supervision.

A lesser burglary charge would also keep him out of prison.

But District Attorney David Soares has refused to cut Gilligan any slack. As of Friday afternoon, he had offered no deals that don't involve prison time. He has insisted on criminal charges that mandate a prison sentence if Gilligan is convicted.

That led Gilligan's exasperated attorney, Michael Feit, to take an unusual step: He asked the court to remove Soares' office from the case, arguing the district attorney has no valid reason to oppose treatment as an alternative to prison.

"Everything Mr. Gilligan has done shows that he should not be locked in a cage," Feit said.

Gilligan has no criminal record, save for a drunken-driving conviction in 1996. He was an exemplary soldier.

Albany County Judge William Carter was sympathetic.

"I'm very well aware of Mr. Gilligan's plight," he said during a recent hearing on Feit's request. "I'm very well aware about how hard he has worked in treatment. And I don't disagree that he is the poster child for a veterans court."

But Carter found no legal reason to remove Soares' office from the case.

"I can't do that any more than I can make them actually care about the things they profess to care about and put into action some of the words that they speak," said the judge, who has tangled with Soares before.

Soares' office declined to comment, so I can't say why the district attorney is taking so harsh a position. I can't comprehend why he would.

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3.2 - The Olympian: [How we can help improve the quality of life for military veterans](#) (30 September, Dr. Rachel Wood, 851k online visitors/mo; Olympia, WA)

There are many things that contribute to our quality of life here in Thurston County: where you live or work, what you eat for breakfast, or how much stress you have in your day-to-day life.

It's common sense that your health affects your quality of life, but it's also true that your quality of life can affect your health. To improve our quality of life, we can change what we're eating, where we're living, or even where we work. But for many, those changes are difficult; for others, such as our military veterans, there are unique hurdles that can be holding them back.

According to the National Homeless Veteran Coalition, nearly 200,000 American veterans face this reality every year. Military service members may have been away from home for long stretches of time. They may be dealing with Post-Traumatic Stress Disorder, pain or depression. There may be injuries (visible or not visible) they have to overcome. This is all on top of the stress of navigating health care, finances and family life.

But there are tools and programs in Thurston County that are designed to help veterans address these issues, and get the support they need.

Finding work can be a major hurdle for veterans, and one that affects all areas of their lives, including their health. Service members entering the job market after serving with distinction and honor and carrying out their missions regardless of the circumstances often find it difficult to translate their skillset into the civilian equivalent. Many feel they have to re-invent themselves. Their skills, although sharp, are hard to define to a new employer. They may need to find a new industry, learn new jargon, or even move to a new place. Worse, they may have to start at a near entry-level positions.

Transitioning out of the military can be the hardest mission that a service member will have to endure. In those circumstances, stress and depression may become issues, and veterans may feel alone and isolated. The stress it causes resonates through the entire family, straining relationships.

But there are numerous programs to help veterans make this transition as smooth as possible while maintaining their dignity in the process. While it's true that the civilian world lacks machine gunners and nuclear weapons technicians, many managers are seeking leadership, initiative and motivation in their workers. Luckily for us, there is a deluge of veterans with these intangible qualities seeking employment each day. Both veterans and civilian managers can benefit greatly by simply learning to speak a similar language.

There are tools, and people, that can help. Veterans looking to find a new job can use a "skills translator tool" to help reframe their experience in a way civilian employers will understand. Titles such as "Squad Leader" and "Section Chief" can be retooled to highlight leadership qualities, for example, and provide an understanding of the responsibilities that are embedded in those unfamiliar titles.

Among the resources:

National Center for PTSD: <https://www.ptsd.va.gov/public/types/war/index.asp>

U.S. Department of Veterans Affairs resource locator: <https://maketheconnection.net/resources>

Veterans Administration military skills translator: <https://www.vets.gov/employment/job-seekers/skills-translator>

Lacey Veterans Services Hub: <https://www.laceyveteranshub.org/>

Veterans have worked diligently for their country around the globe. With the right tools and resources, we can support veterans re-integrating to civilian society and help them attain the quality of life they are seeking.

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3.3 - Los Angeles Daily News: [L.A. veterans' health care has room to improve](#) (29 September, Editorial Board, 883k online visitors/mo; Woodland Hills, CA)

A Veterans Administration regional health care system is more than a corner of the federal bureaucracy. It's a promise to the men and women who served this country in the military. It's part of Americans' bargain with young people who sign up for duty.

You take care of us; we'll take care of you.

That's why it causes more than the usual disappointment in government to learn the VA health-care system in our area isn't as good as it could be.

The VA has released results from the rating system it uses to assess medical service delivery at its 140 service centers. The system assigns regional systems scores from 1 to a glistening 5. So, what score did the VA Greater Los Angeles Healthcare System receive?

That puts the L.A. VA in the bottom 10 percent of the nation's VA systems.

VA officials emphasize that a relatively low score like L.A.'s doesn't mean veterans don't get good care. Regions' scores are meant to compare one to the other. The goal is for low scorers to learn from high scorers — and improve.

Evidently, there's a considerable range of quality within one rating. According to the list on the VA website, although L.A. got a "1" this year, it actually has shown "large improvement" from the last time scores were assigned under the VA's Strategic Analytics for Improvement and Learning (SAIL) rating formula, which rates the systems on metrics used by the private sector and special metrics measuring access and quality of care.

Still, people in Greater L.A. should be sorry to see that medical service delivery isn't as good as it is in other places. Next door, the Long Beach Veterans Healthcare System rated a 3, while San Diego, San Francisco and Sacramento also got 3s. Among the nation's other big cities earning top-shelf 5s were Boston, Cleveland and Pittsburgh.

All American remember the scandal a few years ago when long delays for VA care were revealed.

That scandal led to Congress infusing the VA with funding, including billions for hires. An NPR report last January showed staffing additions have come inconsistently, and L.A. was among the systems getting less than needed.

VA officials here vow to continue their progress. We can see there's room for improvement.

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3.4 - La Crosse Tribune: [Thanks to VA for great service](#) (30 September, Eugene Smithart, 823k online visitors/mo; La Crosse, WI)

I recently retired from Trane after more than 40 years. As a former U.S. Marine who served in Vietnam, I was able to get coverage from the Veterans Administration to replace the health coverage Trane had provided for all those years.

With all I had heard about the Tomah VA, I didn't know what to expect in the way of quality of service I would receive.

Well, I am pleased to report that the service I have received has been nothing short of amazing from both the Tomah and La Crosse VA personnel.

In talking to a number of people, this reflects a remarkable turnaround in the past nine months and I want to thank everyone involved.

To everyone at the VA, thank you. Keep up your wonderful efforts.

Eugene Smithart, Onalaska

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3.5 - WHAM (ABC-13): [Groundwork underway for new VA clinic in Henrietta](#) (29 September, 817k online visitors/mo; Rochester, NY)

Henrietta, N.Y. - There will soon be a new location for local veterans to go for services and healthcare.

A ceremonial groundbreaking took place Friday afternoon in the drizzle for the new VA clinic on Calkins Road in Henrietta.

The 84,000-square-foot building will expand primary care services, along with mental health assessments and social work support.

The bigger facility will also have room for an eye clinic, women's healthcare and diagnostic imaging.

Carnegie Management and Development Corporation will construct the new facility and lease it to the VA for 20 years.

The new clinic should be fully constructed in the spring of 2019.

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3.6 - WSBT (CBS-22): [Local veterans say they're glad to see new VA clinic in Mishawaka officially open](#) (30 September, Cassidy Williams, 449k online visitors/day; Mishawaka, IN)

The new St. Joseph County VA Clinic in Mishawaka is officially open.

The 90,000 square foot facility offers a variety of services.

The \$38 million dollar project finished on time and on budget

Senator Joe Donnelly and Congresswoman Jackie Walorski were there to get a tour of the new facility.

They both see this is as just the start.

"This is just the beginning," said Walorski. "You know this isn't the end of taking care of veterans. This is the beginning of taking care of veterans in our district and throughout Michigan as well."

Dozens of veterans also came out to see it. The facility will serve almost 9,000.

Each veteran will save travel time for some procedures and exams.

The new Mishawaka facility offers more services than the old clinic in South Bend. Meaning they won't always need to leave this area.

George Proctor spent a large portion of his life serving in both the Marines and the Army.

"23 years, 9 months, and 18 days. I say 24 because that's close enough."

Despite his decades of service, George says he rarely used the benefits provided by the VA.

Living in Mishawaka, the services in Indianapolis or Fort Wayne were just too far away.

"I'm what you call a busted wing," Proctor said. "I broke up my back on third jump at Fort Bragg. It's just too far for me to drive and be comfortable." "

Now that is no longer a problem.

Proctor got his first look at the new facility in Mishawaka. Not only is it closer, but the city has added a bus stop to serve the clinic.

Mishawaka's Mayor also says plowing the road will be a priority in the winter.

Proctor already has ideas for how to use it.

"probably for prosthetics, orthopedics, dermatology, my eyes, whatever."

The facility can also be used as a place to socialize.

A coffee shop inside hopes to bring veterans together, and the socializing has already begun.

The veterans say they are happy to have it for themselves, and for the veterans yet to serve.

"I'm very glad to see it, because it is in my backyard."

Half of the services offered at the facility have already begun.

The final part -- urology and podiatry services -- are expected to open on Decemeber 11.

Address: 1540 Trinity Pl, Mishawaka, IN 46545

Phone: (574) 272-9000

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3.7 - The Post and Courier: [South Carolina veterans react sharply to Ken Burns Vietnam documentary](#) (30 September, Bo Petersen, 319k online visitors/mo; Charleston, SC)

Jerry Davis won't watch the Ken Burns' documentary on the Vietnam War, he tells you. The bayonet scar still plainly shows on his eye.

"I saw it 'real time' and I don't want to see what someone else thinks," said the 76-year-old Marine Corps veteran from West Ashley, who set up communications under fire on hilltops in Vietnam.

Chuck Blankin did watch.

"I just want to see somebody held accountable for what they turned their back on," said the 65-year-old Navy veteran from James Island, his gregarious smile gone grim. He had a river patrol boat blown out from under him.

Emotions flared and nightmares re-awoke for veterans across South Carolina as the 10-episode, public television special "The Vietnam War" finished last week.

Among the more than 130,000 veterans of the era still living in the state, many opted to ignore it. For the others who did watch, the broadcast was more than a documentation. It was an affirmation — reassuring or not — of what happened in front of their eyes.

"The vets have wanted to talk about it," said Sonya Campbell, director of the Columbia Vet Center, about the uptick in sessions in the show's aftermath.

The centers are an outreach, counseling and referral service for troubled veterans. The Charleston Vet Center put together round table sessions at some veterans' request so they could talk it out.

"It has brought up a lot of issues for them," said Director Emily Shannon.

"They're saying, 'This has validated a lot of what I've been saying and believing for years,'" said Curtis Lucas, a psychologist with the Myrtle Beach Vet Center.

But it's been difficult, Lucas acknowledged. A lot of the vets he works with bought the video set or taped the show, wanting to watch only as much as they could handle at a time.

Some veterans who watched came away with new insights about the divisive conflict. Much of the thrust of the PBS documentary is how U.S. leaders across multiple presidential administrations knew there was little chance of U.S. victory in Southeast Asia but kept pouring men and materials into the conflict.

"Why you were there, it made sense at the time," said Eugene E. Coakley, 72, of North Charleston, an Air Force veteran who did maintenance work on F-4 fighter jets launching from a base in Thailand.

"I learned some things I never heard about before," said Craig Burnette, 71, of Inman in the Upstate. He led an Army platoon into firefights against the Viet Cong and North Vietnam army.

"I was very angry. I was sad. I was frustrated. I saw all these people making political decisions (in contradiction to what people on the ground were telling them)," he said.

Burnette stopped watching episodes when American troops like his began to be featured. He had trouble falling asleep.

"I'm worried for the (reactions of) other vets and their families, plus the families with names on the Wall," he said, referring to the Vietnam Veterans Memorial on the National Mall in Washington, D.C., which lists the names of some 58,220 U.S. service people who died in the war.

An estimated 895 South Carolinians died in Vietnam.

During a recent interview, Davis and Blankin sat at a table in the American Legion Post 147 on James Island. The bar chatter quieted as they talk. Like a lot of combat veterans, they don't go to fireworks shows. Seemingly mundane things can set off memories that, as Davis said, many thought had been buried. Davis recoils from the smell of coconut. For Blankin, it's burning rubber.

When Davis' eight-man crew was attacked on a hilltop, he was gashed in the face as an enemy fighter leaped over him. He thought he had been butted by a rifle until it started to bleed.

"I pulled out my .45 pistol and shot him," he said.

Blankin commanded a "river rat" patrol boat through the jungle when a rocket-propelled grenade blew the hull apart under him, killing one of his seven-man crew.

"You don't know what's around the next bend. The banks are sprayed bare by Agent Orange. You know, you go into the Navy, you just don't think you're going to be doing things like that," he said.

Like a lot of others, both men struggled with post-traumatic stress disorder but have come to their own acceptances.

"Some things are just right there. They will always be right there," Davis said. "The only thing, you can't dwell on it. That was then. This is now. When we came back, we didn't call it going home. We called it going back to the real world."

At times, the television special irritated Blankin, he said. Jane Fonda (featured protesting in North Vietnam in support of the enemy during the war) and John Kerry (featured testifying to Congress about American atrocities after he returned from combat), "They just stick in my craw," he said.

Both veterans returned home on transports also carrying the caskets of other service people — Davis on a boat "with a hull full of bodies," Blankin on a C-130 plane with caskets set in the cargo hold the soldiers' seats lined.

"Everything that left had bodies on it," he said. "When I felt that plane come off the ground (in Vietnam), that was the best I'd felt in a long time."

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3.8 - South Bend Tribune: [Viewpoint: St. Joseph County clinic's grand opening fulfills a promise to our veterans](#) (29 September, Sen. Joe Donnelly (D-Ind.), 274k online visitors/mo; South Bend, IN)

When we care for our veterans, we both honor their service, and we reinforce our values.

Yet for too long, it was a struggle to provide veterans in our community convenient access to quality health care. Veterans from South Bend, Mishawaka, Elkhart, LaPorte and Plymouth have regularly had to make a two-hour trip to VA facilities in Chicago or Fort Wayne to see a doctor. Veterans, family members and their caregivers often have to fight traffic and bad weather to get the health care they earned through their service to our nation. For those veterans unable to drive themselves, making the trip often involved taking a Disabled Americans Veterans van all the way to Fort Wayne, possibly spending an entire day in transit, receiving care, and waiting hours for other DAV passengers to receive their care too.

For the last 10 years — in the U.S. House of Representatives and in the U.S. Senate — it has been my mission to work alongside veterans in north central Indiana to provide the finest VA care possible, and I am proud that today we will officially open the St. Joseph County VA Clinic.

And while the promise we are fulfilling today seems simple, the process was long and full of challenges. Alongside our local veterans, we began working on the clinic in 2007, holding roundtables and meetings to understand the specific needs of Hoosiers. Through each step of the decade-long process — gathering the facts necessary to make our case for a new VA clinic; securing VA approval, congressional authorizations, as well as funding; cutting through red tape to contract, permit, and build the new clinic; and even locating a Transpo bus stop at the clinic to accommodate local veterans and employees — our community stood up, answering the call to make good on our promise to provide access to quality health.

I want to recognize our entire community, the VA, veterans service officers and other veterans advocates, and local elected officials, for their persistence and tireless work that made the St. Joseph County VA Clinic a reality.

Today we officially open a new 89,000-square foot, state-of-the-art St. Joseph County VA Clinic that is expected to serve up to 13,000 area veterans. Our veterans will be able to receive a range of services from primary medical care, mental health care, audiology, radiology, physical therapy, podiatry, care for post-traumatic stress disorder, substance abuse counseling, traumatic brain injury care, tele-health, and many other services. Perhaps, more importantly, they will receive these services right here in north central Indiana.

Today's grand opening is a significant milestone. It's the culmination of the dedication and determination of the entire community, and it's an example of what we can accomplish when we work together. More importantly, it fulfills an important part of our promise to our veterans.

Joe Donnelly, D-Indiana, is a U.S. senator.

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3.9 - The Herald-Dispatch: [Look for these warning signs to help prevent suicide](#) (1 October, Debbie Brammer, 192k online visitors/mo; Huntington, WV)

Thirty-nine stones lay scattered beneath the leafy branches of a young maple tree. Each stone bears the name of a loved one who was lost to suicide. Billy, Rita, Scott are among the names painted on the stones, representing both male and female, young and old, because suicide has no respect for gender or age.

This Tree of Remembrance, planted on the lawn of the Huntington VA Medical Center (VAMC), stands as a solemn reminder of lives cut short and the families and friends who were left behind to grieve. The tree is not only a memorial, but it also supports the healing of the families and friends.

Suicide prevention is a top priority of the Department of Veterans Affairs. In a recent message to employees, Huntington VAMC Director Brian Nimmo pointed out that suicide is preventable. September was designated Suicide Prevention Month and now is a perfect opportunity to change the way the public thinks about suicide through education about warning signs

"The statistics are startling," Nimmo said. "An average of 20 veterans die from suicide each day, and 67 percent of those deaths were a result of firearm injuries. But, did you know only six of the 20 were users of VA health services." He encouraged staff, who encounter hundreds of veterans and their friends and family members each day, to not only reach out to educate the public but to make sure they know the warning signs, too.

The warning signs include significant changes in behavior or mood such as:

>> sleeping a lot more or a lot less.

>> quick to anger, more withdrawn.

>> drinking more or using drugs.

>> engaging in high risk behavior.

>> expressing feeling of hopelessness or saying loved ones would be better off without them around.

If these changes are noticed, encourage the veteran to contact the Veterans Crisis Line or make the contact yourself. The toll- free number is 1-800-273-8255, and press 1, or chat online at VeteransCrisisLine.net, or send a text to 838255.

The Huntington VA has two suicide prevention coordinators, Deanna Stump and Julie Brawn, who work to raise awareness of VA's resources and foster communication and education among veterans, community organizations and the public at large. They provide intensive case management for those identified as being at risk.

Unfortunately, VA and our suicide prevention coordinators cannot do it alone, we need the help of our communities. To learn more about suicide awareness and prevention go online to <http://www.VeteransCrisisLine.net/BeThere>, or <http://maketheconnection.net>.

Debbie Brammer is public affairs officer at the Huntington VA Medical Center.

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3.10 - FierceHealthcare: [VA proposed rule would override state licensing restrictions to expand access to telehealth](#) (29 September, Evan Sweeney, 140k online visitors/mo; Washington, DC)

The Department of Veterans Affairs has issued a proposed rule that would allow VA providers to treat patients in any state via telehealth, regardless of where they are licensed to practice.

The proposed rule would override state licensing restrictions that the agency says are limiting its telehealth program and allow VA physicians to treat patients anywhere in the country using the VA's telehealth technology.

That change is a critical part of the VA's "Anywhere to Anywhere VA Health Care" program, unveiled by VA Secretary David Shulkin, M.D., and President Donald Trump last month. During that announcement, Shulkin said he was working with the White House's Office of American Innovation and the Department of Justice to issue a new medical practice regulation to support telehealth initiatives.

According to the proposal, "many VA medical centers" have not expanded telehealth programs because of state laws, and "many physicians" refuse to practice telehealth out of fear they will jeopardize their medical license.

"As VA's telehealth program expands and successfully provides increased access to high quality healthcare to all beneficiaries, it is increasingly important for VA health care providers to be able to practice telehealth across State lines and within states free of restrictions imposed by State law or regulations, including conditions attached to their State licenses," the rule states.

Rather than lobby each state to remove licensure restrictions, the VA argues that preempting state law would allow the agency to quickly expand telehealth services.

“By allowing VA telehealth providers to more easily treat patients across state lines, we can ensure that recent advances in technology-enabled care reach the most deserved among us and spur better outcomes for the 20 million veterans in the VA system today,” Health IT Now Executive Director Joel White said in a statement supporting the regulatory change.

Currently, VA providers can waive state licensing requirements if both the physician and the patient are in a federally owned facility. But with the development of a new mobile app, the VA wants to reach veterans in their homes to expand access to mental health services and make it easier for those with limited mobility to get necessary medical care.

This week, behavioral health advocates came out in support of the VETS Act of 2017, which proposes similar regulatory changes. But the VA’s rulemaking process could move faster. The proposed rule will be open for comments for 30 days.

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3.11 - The Sun News: [VA hospitals must be fixed - now](#) (30 September, Stephen Sherwood, 140k online visitors/mo; Myrtle Beach, SC)

I have written all my senators and one congressman, and yet nothing changes with the VA hospital.

I had major neck surgery in July and was prescribed four different opiates for pain. Now I cannot get anyone to prescribe any of these opiates, so along with being in pain, I am withdrawing from the opiates cold turkey. I would be willing to bet that if you and all your staff looked into this situation, you would find that there are countless other veterans who are also receiving this unethical and immoral treatment from VA hospitals nationwide.

Please do something other than what you haven't been doing. I am begging you as a proud veteran and a resident of the great state of South Carolina that you immediately do more than send them a letter or a phone call - that you actually look into this terrible treatment that myself and countless other veterans continue to receive at the hands of the VA.

STEPHEN SHERWOOD, MYRTLE BEACH

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3.12 - The Joplin Globe: [Missouri's U.S. senators note bipartisan efforts](#) (29 September, Susan Redden, 76k online visitors/mo; Joplin, MO)

On the federal front, Missouri's U.S. Sen. Roy Blunt this week announced he and Sen. Richard Blumenthal had introduced bipartisan legislation to expand veterans' access to peer counseling specialists to better combat the risks of suicide and treat associated mental health conditions.

"Our nation has a responsibility to ensure our veterans have access to quality behavioral and mental health treatment," Blunt said. "Given their shared experiences, peer specialists are uniquely positioned to provide veterans the support they need in their recovery."

The Veteran Peer Act would establish peer specialists in patient aligned-care teams within the Veterans Affairs medical system to undertake veteran outreach, according to Blumenthal, a Democrat from Connecticut.

The Department of Veterans Affairs employs peer specialists to assist veterans in treatment for mental health and substance abuse disorders. The specialists support their fellow veterans and encourage recovery by helping them access veterans' health services and navigate the VA health care system and by teaching coping and positive behavior.

The VA was instructed by a 2012 executive order to hire and train 800 peer specialists by the end of 2013 to treat the estimated 1.5 million veterans needing mental health services.

Blunt's bill would expand veterans' access to the services by addressing current shortcomings that restrict specialists' participation in primary care services, along with the persistent stigma attached to seeking mental health treatment.

The measure would implement the program in 50 locations across the nation over a two-year period. It would also require consideration of rural and underserved areas when seeking locations.

Missouri's U.S. Sen. Claire McCaskill, a Democrat, on Thursday announced she had joined a GOP colleague to introduce what she described as "commonsense fixes" aimed at providing relief to some regional banks affected by burdensome requirements of the Dodd-Frank financial reform bill.

In a release, McCaskill said the proposed rules are aimed at small, regional banks to modify Dodd-Frank regulations that were never intended for banks that engage in ordinary consumer banking practices.

David Perdue, a Republican from Georgia, is co-sponsor of the measure. It serves as the Senate companion to a measure sponsored by U.S. Rep. Blaine Leutkemeyer, of Missouri, and passed in the House last year.

"When even some of the architects of Dodd-Frank agree the law is overly burdensome on regional banks, you know we've got a problem on our hands," McCaskill said. "This commonsense fix will untie the hands of our small regional banks and return to them to the flexibility to lend to Missouri customers who want to buy a house or start a business. I'm glad to join Congressman Leutkemeyer's efforts to help get this bill across the finish line in the Senate."

Perdue pointed out that Dodd-Frank overregulated regional banks by placing them in the same category as huge banks with a global reach, increasing their costs and limiting their ability to support their communities.

The legislation would lower the regulatory burden on regional banks by giving the Federal Reserve the flexibility to exempt them from certain Dodd-Frank rules that limit their lending

ability. Under the measure passed in the wake of the 2008 financial crisis, banks with assets over \$50 billion are subject to stronger regulations.

The proposed measure would relax rules for banks over the \$50 billion threshold if they are not designated as a Global Systemically Important Bank that, according to the Federal Reserve, could have an impact on international financial systems.

McCaskill said the threshold being applied to regional banks had been criticized by everyone from governors for the Federal Reserve to Barney Frank, the former lawmaker who authorized the legislation.

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3.13 - Daily Messenger: [Improvements reported at Veterans Crisis Line](#) (29 September, Julie Sherwood, 74k online visitors/mo; Canandaigua, NY)

The Veterans Crisis Line — which has been criticized for calls rolling to voicemail, dropped calls and veterans put on hold for long periods — received a glowing report Friday.

U.S. Reps. Chris Collins, R-Clarence and Phil Roe, a Republican from Tennessee who chairs the House Committee on Veterans Affairs, discussed improvements following a tour of the crisis center at the Canandaigua VA Medical Center.

“The biggest problem we’ve had is timely access to care, so this is basically the front porch to that,” said Roe, after seeing the crisis center that opened in 2007 and is now one of two centers at the forefront of the VA’s efforts to address the alarming rate of veteran suicide. The call centers, in Canandaigua and Atlanta, Georgia, answer phone calls, texts and online messages from veterans, military members and their families.

“It’s very disturbing to me, the number of veterans we are losing to suicide, and not just veterans but Americans,” said Roe, a Vietnam veteran and physician. “When you lose more men and women to suicide than combat, something needs to be done.”

Roe and Collins were pleased with what they saw and heard. A panel of VA staff involved with the Crisis Line in Building 37, where dispatchers work the center, discussed improvements with the congressmen. Among those: the Veterans Crisis Line averaged 2,300 calls in the month of September at both call centers. Of those, an average of 1.3 percent of calls (about 30 calls) rolled over to a backup center. When phone lines are busy, calls are routed to another contracted call center. In the past few days that percentage dropped to less than half a percent.

The crisis line is now answering calls, on average, in 7.5 seconds, with 99 percent of calls answered within 20 seconds.

“I am very impressed, it was a great tour,” said Collins, whose district covers much of Western New York and part of the Finger Lakes including Canandaigua. “Folks here care about our veterans, their dedication is clear,” he said.

The VA plans to open a third call center this fall on the VA campus in Topeka, Kansas.

About 200 responders work at the Atlanta facility, and 310 work at the Canandaigua center, according to a Sept. 14 report by the military publication Stars and Stripes. The Topeka facility will bring the number of employees staffing the veterans crisis line to 610.

During the press conference, the congressmen were also asked about a federal funding cut of millions of dollars for the Veterans Outreach Center in Rochester. At issue is a \$2.1 million grant that the VOC has received annually for the last six years that was not renewed for 2018. The VOC of Rochester was one of 36 previous recipients of the funds through the VA's Supportive Services for Veteran Families program that did not get renewed.

The center in Rochester helps veterans in seven local counties and their families find reliable housing. The lack of funds would scale back services, and a satellite office at the Veteran's Outreach Center in Buffalo could close with staff losing jobs or being reassigned.

Roe said he couldn't say why the funds were cut. Collins mentioned a possible "paperwork snafu." Collins said this is not a partisan issue and he was going to fix the problem, beginning that afternoon, working with others in Congress.

Need help?

— Call Veterans Crisis Line at 1-800-273-8255 and press 1 to talk to someone now.

— Text 838255 to get help now.

— Chat online at www.veteranscrisisline.net.

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3.14 - KXRM (FOX-21, Video, Updated): [VFW raises concerns over VA care](#) (30 September, Carly Moore, 60k online visitors/mo; Colorado Springs, CO)

A fallen service member has a group from the Veterans of Foreign Wars organization speaking out. Some members of the VFW are attributing his death to lack of care from the Colorado Springs Veterans Affairs hospital.

The widow of the service member was left overwhelmed and unprepared. She was concerned about her financial situation and was worried she would lose her house.

The VFW said it's extremely common for people to not have plans, to not know their benefits, and to not have documents on hand.

A small group of commanders at VFW Post 3917 turned it around.

Ray Belasco was a 20-year Vietnam veteran. He passed away at age 65, and some VFW members believe his death could have been avoided.

"It sound to me, people didn't really take him serious, didn't feel that he was really sick," said VFW Sr. Vice Commander Steve Kjonaas.

He went to the VA in Colorado Springs over the Labor Day holiday and was sent to an emergency room.

“Veterans have very unique diseases, illness and problems,” said Kjonaas. “That’s the difference between the Department of Veterans Affairs and any other civilian healthcare that you see.”

The VA facility in Colorado Springs doesn’t have an emergency room specifically for veterans. For that, they must go to Denver or to a local civilian emergency room.

“As with other outpatient clinics in the community, emergency services are not available at the PFC Floyd K Lindstrom VA Clinic in Colorado Springs,” the VA said in a statement. “We encourage anyone in an emergency situation to seek immediate treatment and care at their nearest emergency department, where appropriate services are available.”

After the emergency room released him, hospice care he was searching for wasn’t enough. He died just days later.

Belasco’s widow, Ute, was left with nothing: no money or plans for her husband’s funeral. She tried to sort things out, but was shut down without documentation.

“Once a service member dies, they cut off his pay,” said VFW Jr. Vice Commander Cindy Galvin. “If you don’t have the paperwork to go in and say, ‘Hey, I’m a spouse,’ then you don’t get the survivors pay.”

VFW members helped expedite the process. Something that could take one to three months was done in about two weeks.

“As a veteran myself, it makes me very happy to help,” said Galvin.

When Galvin was asked why she is also helping plan a funeral this Saturday, she said, “He’s a comrade and we never leave a vet behind.”

The American Legion Post 38 at 6685 Southmoor Drive in Fountain is hosting a memorial service starting at 11 a.m. Saturday. They want other former service members to come out and help support this fallen veteran.

Those close to Ute have released the following statement on her behalf:

Ute would like them to know about her being misquoted. She never said she was afraid nobody would show up for Ray’s funeral. Not a funeral, but to attend a memorial. She only reached out for help with this process, not for anything for her. She also wanted help with the way Ray was treated at Cheyenne Mountain Care Facility (Center) hospice provider. They showed extreme lack of care, compassion and dignity with his care. Ute wants to thank the Veterans of Foreign Wars for their help and all who have supported her and helped during this time.”

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3.15 - KXRM (FOX-21, Video): [Colorado Springs widow gives final salute to veteran husband who died suddenly](#) (30 September, Sarah Ferguson, 60k online visitors/mo; Colorado Springs, CO)

The widow of a fallen Service Member left overwhelmed after he suddenly died, is able to give her husband, a Vietnam Veteran, the honorary send-off he deserves.

His wife, Ute was shocked when her husband Ray Belasco suddenly passed away at 65-year's-old.

Recently a local Veterans of Foreign Wars group heard the widow's story, with Members attributing his death to a lack of care from the Colorado Springs Veterans Affairs hospital.

"When we found out that the funeral home wanted to hold the funeral in the parking lot we couldn't have that," said VFW Jr. Vice Commander Cindy Galvin.

Saying because Ute didn't have the proper documentation complete after Ray's death, she was turned away from any funeral plans.

Fortunately, VFW Post 3917 took matters into their own hands and set-up a memorial at the American Legion Post 38 in Fountain.

"So many valued people; so many honorable people from different walks of life, from different organizations, different motivations who come here to honor the veterans," said VFW Sr. Vice Commander Steve Kjonaas.

Prior to the memorial, VFW Post 3917 also helped Ute collect the benefits her husband deserves, while assisting her with filling out the proper documentation.

"They weren't asking for anything; they weren't expecting anything, they didn't beg for anything, they just are very grateful, they didn't realize we were going to do all of this," said Galvin.

If you'd like to read more about Ute's story and her concern with the Colorado Springs Veterans Affairs hospital, click here.

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3.16 - Finger Lakes Daily News: [VA Crisis Line Reports Improvements in Call Handling](#) (30 September, Joe Lasky, 53k online visitors/mo; Geneva, NY)

The Daily Messenger reports Congressman Chris Collins and Tennessee Representative Phil Roe toured the facility Friday, and reported that only 1.3% of calls are now rolling over to a backup center, with 99% of calls answered within 8 seconds.

The Crisis Line had come under fire in recent years for allowing as many as 30% of calls to go to backup centers.

The suicide hotline employs 310 at the Canandaigua center, with an additional 200 workers out of Atlanta, and an additional center in Topeka, Kansas set to go online later this fall.

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3.17 - Inquirer.net: [US lawmaker files bill for full benefits for Filipino WWII veterans](#) (29 September, 14k online visitors/mo; Daly City, CA)

WASHINGTON, DC – Congresswoman Jackie Speier (CA-14) introduced H.R. 3865, the Filipino Veterans Fairness Act of 2017 on Thursday, September 28.

During World War II, about 250,000 Filipinos volunteered to fight alongside U.S. troops. As citizens of a commonwealth of the United States before and during the war, Filipinos were legally American nationals.

With American nationality, they were promised all the benefits afforded to those serving in the U.S. Armed Forces. But in 1946, Congress stripped many Filipinos of the benefits that had been promised by President Franklin D. Roosevelt. Of veterans of the 66 countries allied with the United States during World War II, only Filipinos were denied benefits.

Speier's legislation eliminates the distinction between the Regular or "Old" Philippine Scouts and the other three groups of veterans—Commonwealth Army of the Philippines, Recognized Guerrilla Forces, and New Philippine Scouts. Widows and children of Filipino veterans would be eligible for Dependency and Indemnity Compensation just like any other veteran.

"This bill rights a shameful wrong created when Congress rescinded a promise to Filipino veterans of World War II over 70 years ago," Speier said. "I will not rest until these heroes, and their families, receive the benefits they need and deserve. If America won't live up to its honor and duty to our allies and friends we may find ourselves alone in our next hour of need."

The 2009 American Recovery and Reinvestment Act contained a provision that provided a lump sum payment of \$15,000 for Filipino veterans who are now U.S. citizens and \$9,000 for non-citizens. But there have been problems with the implementation of this payment program. To be eligible, a veteran has to be on the so-called "Missouri List," an Army roster of eligible veterans.

The Missouri List is incomplete. A 1973 fire destroyed 80 percent of the records for Army personnel from 1912 to 1960. As a result, over 17,000 Filipino veterans have had their claims denied. The Filipino Veterans Fairness Act directs the VA to take into account alternative military documentation to determine eligibility.

"The Recovery Act payments were a start, but our nation must bestow the full status it promised these veterans in wartime," Speier concluded. "Their average age is 90. Fewer than 15,000 are still alive today, and they are dying at a rate of over 10 a day. For these veterans and their loved ones the time to act is now."

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3.18 - Montgomery Herald: [VA awards grants to help at-risk Southern W.Va. vets, families](#) (29 September, 7k online visitors/mo; Montgomery, WV)

BECKLEY — Earlier this month, the Department of Veterans Affairs (VA) announced it has awarded \$343 million in grants to 288 nonprofit organizations to help low-income veterans and their families. More than \$2 million will go towards a community partner that assists veterans across the state, including southern West Virginia.

The grants were awarded under VA's Supportive Services for Veteran Families (SSVF) program.

In West Virginia, three SSVF programs received money from the \$343 million grants. One of them, West Virginia Community Action Partnerships, supports the entire state.

SSVF funding, which supports outreach, case management and other flexible assistance to rapidly re-house veterans who become homeless or to prevent veterans from becoming homeless. The funding helps the most economically vulnerable veterans avoid or exit homelessness.

In 2016, SSVF funding through WVCAP supported 589 veterans who were homeless or at-risk in West Virginia. As of July 31, 461 veterans had been helped, according to Leah Willis, SSVF coordinator for WVCAP.

"We are projecting to assist 600 veterans during the 2018 program year," Willis said.

"No veteran that served our country should be without a home or be facing that reality," said Stacy Vasquez, Beckley VAMC director and Army veteran. "Our homeless, health care and social work teams, along with community partners, successfully reduced the overall homeless Veteran rate in this region by more than 51 percent in 2016."

This year's recipients competed successfully for grants under a Dec. 7, 2016, Notice of Fund Availability. The funding will support SSVF services in fiscal 2018.

For additional information, please contact Public Affairs Officer Sara Yoke at 1-304-255-2121, ext. 4883 (office) or sara.yoke@va.gov

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6. Strategic Partnerships

6.1 - WFED (AM-1500): [Major changes coming to DoD's TRICARE system Jan. 1](#) (29 September, Jared Serbu, 831k online visitors/mo; Washington, DC)

The Defense Department published new rules Friday that will make significant changes to the health insurance system that serves military family members and retirees on Jan. 1, altering the structure and fees of benefit plans, and, according to Defense health officials, making care more accessible.

Most significantly, new beneficiaries will have to make an affirmative decision to enroll in the TRICARE system and will only be able to do so during an annual open enrollment period. The open enrollment schedule will be the same as the one used by the Federal Employee Health Benefits Program that serves civilian DoD employees: November and December of each year.

The policy differs substantially from the one in place today, in which TRICARE-eligible beneficiaries receive health benefits automatically. With a few exceptions, family members and retirees who do not sign up during the open enrollment period will lose coverage in TRICARE's "purchased care" market for the following year. They would still be able to seek care in military-run hospitals and clinics, but only on a space-available basis.

The change was one of several Defense health reforms Congress ordered as part of the 2017 Defense authorization bill, But Vice Adm. Raquel Bono, the director of the Defense Health Agency, said the move to open enrollment made sense from DHA's perspective as well.

"We need to make sure that we have as much information as possible in order to design our provider network," she told reporters on a conference call. "We wanted to also come as close as we could to what's happening in the commercial sector, and we're intent on being able to create some efficiencies in the administration of our health plans. We see this as one of the mechanisms to do that."

But officials said the open enrollment change will not have any meaningful effect on beneficiaries for another year; 2018 will be treated as a "transition year," and anyone who's covered by TRICARE as of Jan. 1, 2018 will be automatically enrolled in the plan that most closely matches the one that serves them today.

The plans are changing as well, effective Jan. 1. Also at the direction of Congress, DoD is merging the existing TRICARE Standard and Extra benefits — the department's fee-for-service options — into a single plan called TRICARE Select.

Like Standard and Extra, Select will let patients use any authorized medical provider, but cost shares are lower when beneficiaries see in-network providers. In most ways, it will operate like the plans it's replacing, but with changes to the ways in which patients pay out-of-pocket costs.

Currently, the cost shares are based on a percentage of TRICARE's negotiated costs with a network provider (or of that provider's "allowable costs" if they're out-of-network). Starting next year, patients will pay a fixed, per-visit rate for in-network providers that varies according to the type of medical care they're receiving.

For example, under Standard and Extra, a family member of an active-duty service member is responsible for 15 percent of the bill for an outpatient visit from an in-network doctor and 20 percent for an out-of-network doctor. The new Standard plan would charge a flat \$27 fee for an in-network provider. The fees for TRICARE-covered retirees are higher: the same visit would cost \$35.

“We thought this was something that would be a little more predictable and a little more patient-friendly, and we also thought it was an easier construct for our providers to use,” Bono said. “What we tried to do was take an average, so it should be close to what people are currently paying.”

Another change: The rules set a new requirement that TRICARE Select’s provider network cover enough geographic territory to provide services to at least 85 percent of its beneficiaries, up from just over 60 percent under the existing Standard and Extra plans.

The fee structure for TRICARE’s Prime plan, the managed care option that primarily serves areas with large concentrations of military members, remains largely unchanged, but the rule makes several changes that officials said were designed to improve access to care.

For instance, if TRICARE’s contractors don’t offer an appointment with a managed care provider within a timeframe that meets DoD’s access standards, the patient will be allowed to see an out-of-network provider without paying additional fees. The department says it will also waive some of its previous requirements that patients get referrals or pre-authorizations before patients visit specialty care providers or urgent care clinics, and treatments for obesity are specifically called out in the rule as covered care.

None of the changes are applicable to currently-serving military members, whose medical care remains a government obligation for as long as they continue to serve on active duty, but the fees for family members whose sponsors join the military after 2018 will be different from those that are currently serving, depending on which TRICARE plan they enroll in.

The changes to TRICARE’s health plans were only a few of the tweaks Congress made to the military health system as part of the 2017 Defense bill.

The rules DoD published on Friday nominally implement some of them, but Bono said the department will have to undertake more careful study before the other changes take effect.

Among those changes, Congress ordered DoD to treat expenses for telehealth in the same way it covers in-person visits, adjust the staffing in its military treatment facilities so that the health specialists the military employs more closely matches the medical expertise the military is likely to need in wartime environments, and to start creating “high-performance” treatment networks in pockets of the country that are underserved by DoD’s system by partnering with the Department of Veterans Affairs and private-sector hospital networks.

“The rule gives us an opportunity to implement some of these things, but it’s going to be an iterative process,” Bono said. “We will be looking specifically at where it makes the most sense to partner with the civilian health care systems that are in the particular areas where we have our beneficiaries. It’s part of our network development and it’s an opportunity to build partnerships. We’ll be evaluating it, and this is one of the things that the open enrollment requirement if going to help us with in terms of understanding where those opportunities might exist.”

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7. Supply Chain Modernization

8. Other

From: (b) (6)

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Subject: [EXTERNAL] 30 September Veterans Affairs Media Summary and News Clips

Date: Sat Sep 30 2017 04:23:03 CDT

Attachments: 170930_Veterans Affairs Media Summary and News Clips.docx
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Good morning,

Please find the attached Veterans Affairs Media Summary and News Clips.

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Veterans Affairs Media Summary and News Clips

30 September 2017

[1. Top Stories](#)

1.1 - The Washington Post (Video): [VA chief took in Wimbledon, river cruise on European work trip; wife's expenses covered by taxpayers](#) (29 September, Jack Gillum, Alex Horton, Drew Harwell and Lisa Rein, 43.9M online visitors/mo; Washington, DC)

Nearly three days into a trip to Europe this past July, Veterans Affairs Secretary David Shulkin had attended a Wimbledon championship tennis match, toured Westminster Abbey and taken a cruise on the Thames. The 10-day trip was not entirely a vacation. Shulkin was in Europe for meetings with Danish and British officials about veterans' health issues, so taxpayers picked up part of the tab.

[Hyperlink to Above](#)

1.2 - Reuters: [Under pressure from Trump, Price resigns as health secretary over private plane uproar](#) (29 September, Steve Holland, 43.6M online visitors/mo; New York, NY)

U.S. Health and Human Services Secretary Tom Price resigned under pressure from President Donald Trump on Friday in an uproar over Price's use of costly private charter planes for government business. His abrupt departure was announced an hour after Trump told reporters he was disappointed in Price's use of private aircraft and did not like the way it reflected on his administration.

[Hyperlink to Above](#)

1.3 - The New York Times: [Veterans Agency Seeks to Scrap Ethics Law on For-Profit Colleges](#) (29 September, Patricia Cohen, 29.8M online visitors/mo; New York, NY)

The Department of Veterans Affairs is pushing to suspend a 50-year-old ethics law that prevents employees from receiving money or owning a stake in for-profit colleges that pocket hundreds of millions of dollars in tuition paid through the G.I. Bill of Rights.

[Hyperlink to Above](#)

1.4 - U.S. News & World Report (AP): [Alaska VA Office Gets Mixed Report From Watchdog](#) (29 September, Becky Bohrer, 24M online visitors/mo; Washington, DC)

A government watchdog says the U.S. Department of Veterans Affairs regional office in Anchorage has made strides in processing claims but has work to do in other areas. The VA's inspector general said the accuracy of the claims processing it reviewed earlier this year was significantly better than a prior inspection in 2013.

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1.5 - Stars and Stripes: [VA publicizes Shulkin's travel schedule amid scrutiny over Cabinet spending](#) (29 September, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

The Department of Veterans Affairs made moves Friday to publicize Secretary David Shulkin's travel schedule, following scrutiny over the cost of government-funded travel by other Cabinet members. The VA announced it will post Shulkin's itineraries of international and domestic trips, as well as who accompanies him and whether he uses private or government aircraft.

[Hyperlink to Above](#)

1.6 - The Clarion-Ledger (Video): [Mississippi treating 11 Hurricane Maria victims, more coming](#)

(29 September, Anna Wolfe, 849k online visitors/mo; Jackson, MS)

So far, 11 hurricane victims from Puerto Rico and St. Croix have been transported to metro Jackson hospitals in the aftermath of Hurricanes Irma and Maria. The storms devastated Puerto Rico's hospitals, a majority of which are without electricity or fuel for generators and beginning to run out of oxygen and clean water.

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1.7 - The San Diego Union-Tribune: [Does a soldier's best friend belong in VA research labs? A fight at the heart of the veterans community](#)

(29 September, Jeanette Steele, 494k online visitors/mo; San Diego, CA)

America loves dogs, but many veterans have an extra bond after serving with canine units on the battlefield and increasingly depending on service dogs back at home. Now the U.S. Department of Veterans Affairs and some of the nation's largest veterans groups are in a scrap with a government watchdog organization and some in Congress over VA medical research programs that inflict harm on man's best friend in the name of science.

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[2. Veteran and Employee Experience](#)**2.1 - USA Today: [VA Secretary David Shulkin discloses official travel details](#)**

(29 September, Jessica Estepa, 36.7M online visitors/mo; McLean, VA)

Veterans Affairs Secretary David Shulkin announced Friday that his department would disclose details about his official travels, in an attempt to be transparent as the travels of other members of the administration come under scrutiny. The department will regularly update a page that includes any travels by private and government aircraft, as well as itineraries of official international and domestic trips.

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2.2 - ABC News: [VA secretary spent half of official London trip sightseeing](#)

(29 September, Luis Martinez, 24.1M online visitors/mo; New York, NY)

Veterans Affairs Secretary David Shulkin flew a commercial airline to London this past July to attend a veterans conference, but half his time there was spent on sightseeing and a stop at Wimbledon tennis tournament. Shulkin's wife's commercial travel costs were also paid for by the federal government because she was under "approved invitational orders"

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2.3 - Politico: [Who will replace Tom Price? A dozen names are circulating as possible successors](#)

(29 September, Joanne Kenen and Jennifer Haberkorn, 23.9M online visitors/mo; Arlington, VA)

The VA secretary is a Trump favorite, and the only cabinet nominee to be unanimously confirmed. However, Shulkin has come under criticism for combining leisure with business on his official travel — he attended a Wimbledon championship tennis match, toured Westminster Abbey and took a cruise on the Thames while meeting this summer with European officials about veterans' issues, The Washington Post reported Friday.

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2.4 - The Huffington Post: [Yet Another Trump Administration Official Took Questionable Liberties With Work Travel](#) (29 September, Mollie Reilly, 23M online visitors/mo; New York, NY)

Veterans Affairs Secretary David Shulkin used his downtime on a recent international trip for several leisure activities, including a tennis match and river cruise, The Washington Post reported Friday. According to the report, Shulkin spent roughly half of a 10-day trip to the U.K. and Denmark to sightsee, watch a high-profile Wimbledon match and take in other activities more typical of a vacation than a work trip.

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2.5 - The Hill: [Trump VA chief went sightseeing, shopping with wife on government trip: report](#) (29 September, Brandon Carter, 11.8M online visitors/mo; Washington, DC)

Veterans Affairs Secretary David Shulkin spent nearly half his time on a recent international trip sightseeing and shopping with his wife, according to The Washington Post. Shulkin traveled to Europe in July to attend a conference in London with representatives of several countries on veterans' health issues, as well as a series of meetings in Denmark.

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2.6 - Washington Examiner: [VA secretary saw Wimbledon match during taxpayer-funded trip to Europe: Report](#) (29 September, Melissa Quinn, 4.8M online visitors/mo; Washington, DC)

Secretary of Veterans Affairs David Shulkin and his wife, accompanied by other VA officials, attended a tennis match at Wimbledon, toured Westminster Abbey, and cruised the Thames River as part of a taxpayer-funded, 10-day work trip to Europe this summer, according to a report.

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2.7 - Pittsburgh Post-Gazette: [Pittsburgh VA nurse is finalist for national caregiver award](#) (29 September, Gary Rotstein, 4.8M online visitors/mo; Pittsburgh, PA)

A nurse for the VA Pittsburgh Healthcare System is one of six national finalists for an annual award given to a medical professional who shows an exemplary caregiving approach on the job. Victor Fagan, a licensed practical nurse from Butler, won recognition from among nearly 200 nominees who were submitted to the Boston-based Schwartz Center for Compassionate Healthcare.

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2.8 - PennLive (Video): [VA chief mixed business with pleasure at taxpayer expense: Media report](#) (29 September, Ivey DeJesus, 3.1M online visitors/mo; New Bloomfield, PA)

President Donald Trump's veterans affairs chief is the latest administration official in hot water for reportedly tapping into taxpayer money to pay for vacation outings and non-official business. Veterans Affairs Secretary David Shulkin in July took in a Wimbledon championship tennis match and a Thames River cruise on taxpayer money. That's according to a report published Friday by The Washington Post.

[Hyperlink to Above](#)

2.9 - Military Times: [Amid Cabinet controversies, VA promises to post secretary's travel details online](#) (29 September, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)
In response to the growing scandal of Cabinet officials using pricey private aircraft for business trips, Veterans Affairs officials announced Friday they will post details of all official travel by department Secretary David Shulkin online to provide transparency about his travels. "Veterans and taxpayers have a right to know about my official travel as secretary, and posting this information online for all to see will do just that," Shulkin said in a statement.

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2.10 - Providence Journal (The Enterprise): [Providence VA official relieved of duties amid allegations of racism, homophobia](#) (29 September, Paul Edward Parker, 1.2M online visitors/mo; Providence, RI)
A manager at the Veterans Affairs Regional Office in Providence has been relieved of his duties pending disciplinary action, following a complaint from a co-worker that he created a "toxic work atmosphere."

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2.11 - KATV (ABC-7, Video): [Troubles at the VA: Nurses speaking out about culture](#) (29 September, Elisabeth Armstrong, 448k online visitors/mo; Little Rock, AR)
Two former nurses who have filed EEO complaints against the CAVHS are speaking out about problems. In July, Channel 7 brought you this report out of the VA. In it, some thirty nurses filed a complaint against the hospital - alleging that under-staffing was impacting patient care.

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2.12 - WQAD (ABC-8, Video): [Moline man shocked after job training center for veterans shuts down](#) (29 September, Chris Minor, 450k online visitors/mo; Moline, IL)
A Moline, Illinois man is one of more than 300 veterans left in the dark after a job training school they paid for through the GI bill abruptly shut its doors. "Three weeks before graduation, we were told goodbye.

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2.13 - FedSmith: [VA to Begin Disclosing Agency Secretary's Official Travel](#) (29 September, Ian Smith, 277k online visitors/mo; Washington, DC)
The Department of Veterans Affairs announced today that it will begin publishing all of the agency secretary's official travel on its website. The lists include all official travel taken by Dr. David J. Shulkin since January 20, and the site will be updated within five days after the conclusion of each trip.

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2.14 - Leavenworth Times: [Sentencing continued for former VA physician assistant](#) (29 September, 46k online visitors/mo; Leavenworth, KS)
A former physician assistant who was convicted of sexually abusing patients at the Leavenworth veterans hospital will not be sentenced until November. Mark E. Wisner was scheduled to be

sentenced today in Leavenworth County District Court. But the sentencing and arguments for post trial motions have been continued until Nov. 3.

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2.15 - Pahrump Valley Times: [Plaques at Pahrump VA clinic recognize veterans of U.S. armed forces](#) (29 September, Jeffrey Meehan, 1k online visitors/day; Pahrump, NV)

A group of local veterans of the U.S. armed forces gathered to recognize the installation of several plaques at the Pahrump VA Community Based Outpatient Clinic in September. Each plaque bore the symbol of one of the five branches of the U.S. armed forces and another was hung for prisoners of war.

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[3. Access to Healthcare](#)

3.1 - WBBM (CBS-2, Video): [2 Investigators: Disabled Vets Face Tough Parking At VA Hospital](#) (29 September, Dave Savini, 27.5M online visitors/mo; Chicago, IL)

A major problem at Hines VA Medical Center: Some sick and wounded veterans are struggling to get to their medical appointments because of parking violators. CBS 2's Dave Savini has the story. James Dahan, a Marine Corps veteran, gets angry when fellow wounded vets struggle to find a parking spot.

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3.2 - The News & Observer: [Vietnam vet happy to be back in Durham's VA hospital, but for how long?](#) (29 September, Thomasi McDonald, 3.9M online visitors/mo; Raleigh, NC)

A Vietnam veteran and double-amputee said things are "perfect" now that he is back in Durham's Veterans Administration Medical Center, where he has lived for a little more than three years. But James Donald Francis, 69, said he's worried because VA officials have not told him or given him any documentation about how long he will be able to stay at the VA's Community Living Center.

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3.3 - Newsday (Video): [House vet chair Roe tours Northport VA after maintenance issues](#) (29 September, Martin C. Evans, 3.2M online visitors/mo; Melville, NY)

The head of the House Committee on Veterans Affairs came to Long Island for an up-close look at the troubled Northport VA Medical Center Thursday, saying the facility should "find the right size" to address maintenance problems straining its budget and impacting patient care.

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3.4 - Stars and Stripes: [Stage set in Congress for debate on Choice program reform](#) (29 September, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

The Department of Veterans Affairs estimated the funds that allow veterans to receive health care in the private sector will last until the end of the year – a projection that establishes a new deadline for when Congress needs to come up with a long-term solution for the Veterans Choice Program.

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3.5 - WNDU (NBC-16, Video): [New VA clinic in Mishawaka will 'quadruple services'](#) (29 September, Mark Peterson, 833k online visitors/mo; South Bend, IN)
Ribbon cutting ceremonies in Mishawaka on Friday marked the completion of a \$38 million medical clinic for veterans. About ten years ago, the Veterans Administration was first asked to study how often local vets had to travel long distances to get needed medical care. "I'll be able to come here for my eye appointments, I'll be able to come here for my hearing appointments, and those are all things I have to go to Fort Wayne for," said veteran Chuck Damp.

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3.6 - WNDU (NBC-16, Video): [Sen. Joe Donnelly on tax overhaul, health care and new VA clinic](#) (29 September, Jason Krug, 833k online visitors/mo; South Bend, IN)
President Donald Trump visited Indianapolis on Wednesday, pitching his tax overhaul plan. Traveling with the president from Washington D.C. that day was Sen. Joe Donnelly. A question some had is why the Democrat would travel on Air Force One with the Republican president.

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3.7 - WFLA (NBC-8, Video): [Veteran suicides, VA corruption focus of rally and protest](#) (29 September, Steve Andrews, 702k online visitors/mo; Tampa, FL)
In the United States, 22 veterans take their lives every day. In front of the Veterans Affairs office at Bay Pines, 22 mannequins stood to serve as a reminder of this American tragedy. Army veteran Mike Ford admits he's come close to ending his life. "Idea was to just go ahead and just kill yourself on V-A property right, maybe if they see, if maybe people like, wow, there's something really going on here," he told News Channel 8.

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3.8 - Modern Healthcare: [VA looks to ease telehealth regulations](#) (29 September, Rachel Z. Arndt, 460k online visitors/mo; Chicago, IL)
The Veterans Affairs Department proposed a rule Friday that would allow VA providers anywhere in the country to conduct telehealth visits with VA patients across state borders, regardless of state licensing.

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3.9 - KMVT (FOX-14, Video): [As Suicide Prevention Month comes to a close, the search continues for solutions to veteran suicide](#) (29 September, Peter Zampa, 71k online visitors/mo; Twin Falls, ID)
Suicide prevention month is highlighting how the U.S. Can better address the issue. A specific focus currently in Washington is a push to end veteran suicide. Senators are examining what is being done to help veterans in need, and what other efforts are necessary. One veteran says it is not easy to solve this tragic problem.

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3.10 - mHealth Intelligence: [New Rule Would Give VA Doctors National Telehealth Privileges](#) (29 September, Eric Wicklund, 53k online visitors/mo; Danvers, MA)

The Department of Veterans Affairs is moving forward with a plan to enable VA doctors to treat veterans through telehealth no matter where the doctor or patient are located, essentially overriding state laws.

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3.11 - WLTZ (NBC-38, WSB/ABC-2, Video): [Hospital Evacuees from Caribbean Arrive in Atlanta](#) (28 September, Nami Dockery, 44k online visitors/mo; Columbus, GA)

Hospital patients evacuated from the Caribbean due to hurricane Maria are finding refuge in Georgia. Doctors and nurses welcomed the patients after a plane carrying roughly 40 medical evacuees landed Wednesday night. It comes after the hurricane caused widespread power outages, including a loss of electricity at hospitals.

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3.12 - Marion Republican: [Bost 'not happy' with VA investigation; vows to look further into allegations at Marion VAMC](#) (29 September, Holly Lee, 14k online visitors/mo; Marion, IL)

The conclusion of a Veterans Affairs inquiry into allegations of nepotism, employee intimidation and why some patients died at the VA Medical Center in Marion leaves one southern Illinois congressman "not happy" with the answers and vowing further action.

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[4. Women Veterans](#)

4.1 - The Mercury: [Expo will focus on women entrepreneurs and female veterans](#) (29 September, Donna Rovins, 187k online visitors/mo; Pottstown, PA)

A unique expo highlighting women entrepreneurs and female veterans is scheduled for Saturday, Oct. 7, at Phoenixville Area Middle School. The 2017 Women Entrepreneur & Women Veteran Expo will give women from different business areas the opportunity to connect with each other to educate, share information and inspire other women to become business owners, according to organizer Dolores Winston, founder and CEO of Here to Apparel.

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4.2 - KSFY (ABC-13, Video): [Sioux Falls conference puts spotlight on women veterans](#) (29 September, 4k online visitors/day; Sioux Falls, SD)

The annual Women Veteran Conference was held Friday in Sioux Falls. The event was put on by the Sioux Falls VA. About 86 women veterans attended this year's event. Organizers said it is important to recognize women veterans and honor their service and sacrifice.

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[5. Appeals Modernization](#) – No Coverage

[6. Strategic Partnerships](#) – No Coverage

7. Supply Chain Modernization

7.1 - WFED (AM-1500): VA close to awarding Cerner contract for new EHR (29 September, Nicole Ogrysko, 831k online visitors/mo; Washington, DC)

The Veterans Affairs Department is preparing to award its contract with Cerner Corporation for a new electronic health record in the next month or so. The award comes after the department announced its decision abandon its own, existing Veterans Information Systems and Technology Architecture (VistA) and adopt MHS Genesis, the same EHR system that DoD is deploying.

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8. Other

8.1 - ABC News (AP): The Latest: John Kelly given authority over Cabinet travel (29 September, 24.1M online visitors/mo; New York, NY)

The secretary of the Department of Veterans Affairs says information about his official travel will be posted on the department's website. Secretary David Shulkin says he has not used private aircraft for official business, but has taken six trips on military aircraft. The trip details will include the type of aircraft, members of the traveling party and information about the events he was attending.

[Hyperlink to Above](#)

8.2 - ABC News (AP): A look at questions over Cabinet members' travel (29 September, 24.1M online visitors/mo; New York, NY)

Health and Human Services Secretary Tom Price has resigned amid controversy over his use of costly private charter flights on government business. But other Cabinet members are also facing congressional scrutiny over their travel. Interior Secretary Ryan Zinke dismissed the controversy over charters as "a little BS over travel," but he acknowledged taxpayers do have the right to know official travel costs.

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8.3 - The Washington Times (AP): Couple gets jail for keeping veteran's dead body in home (29 September, 10.8M online visitors/mo; Washington, DC)

An Ohio couple criminally charged for keeping a Vietnam veteran's decomposing body in their home for several months to steal his Social Security and veteran benefits have received six months in jail. The New Philadelphia Times Reporter reports 50-year-old Brian Sorohan and 46-year-old Stacy Sorohan also received two years' probation Thursday in Tuscarawas County.

[Hyperlink to Above](#)

1. Top Stories

1.1 - The Washington Post (Video): [VA chief took in Wimbledon, river cruise on European work trip; wife's expenses covered by taxpayers](#) (29 September, Jack Gillum, Alex Horton, Drew Harwell and Lisa Rein, 43.9M online visitors/mo; Washington, DC)

Nearly three days into a trip to Europe this past July, Veterans Affairs Secretary David Shulkin had attended a Wimbledon championship tennis match, toured Westminster Abbey and taken a cruise on the Thames.

The 10-day trip was not entirely a vacation. Shulkin was in Europe for meetings with Danish and British officials about veterans' health issues, so taxpayers picked up part of the tab.

Yet he and his wife spent about half their time sightseeing, including shopping and touring historic sites, according to an itinerary obtained by The Washington Post and confirmed by a U.S. official familiar with their activities.

The federal government paid for the flights for Shulkin and his wife, Merle Bari, and provided a per-diem reimbursement for their meals and other expenses, VA said Friday. An agency spokesman did not respond to questions about why Bari qualified for the reimbursements and taxpayer-funded airfare, other than to say she was traveling on "approved invitational orders" and had "temporary duty" travel expenses.

The agency also did not respond to questions about the cost of the flights and the total reimbursement. If Bari took the full per diem every day of the trip, she could have been reimbursed as much as \$3,600 under federal guidelines.

Trump administration Cabinet members have faced mounting scrutiny over their use of private and government jets in recent days, and Health and Human Services Secretary Tom Price resigned Friday amid criticism of his use of taxpayer-funded charter flights. Shulkin traveled on a commercial flight, though, and he was seated in coach on at least one leg.

The European visit, however, puts a focus on the mixing of business and leisure during these trips, which can come at considerable taxpayer expense. Shulkin's immediate predecessor, Robert McDonald, took no foreign work trips, according to a former VA official who spoke on the condition of anonymity.

Shulkin's six-person traveling party included his acting undersecretary of health and her husband, Shulkin's chief of staff and another aide, the itinerary says. They were accompanied by a security detail of as many as six people.

Shulkin's trip came less than two weeks after he signed a memo instructing top VA staffers to determine whether "employee travel in their organization is essential."

"I expect this will result in decreased employee travel and generate savings within the Department of Veterans Affairs," Shulkin wrote.

In response to questions from The Post, VA announced Friday that the agency will begin posting details of the secretary's travel online, including itineraries, and disclosing any use of government or private aircraft. That information had not previously been disclosed publicly.

All of Shulkin's activities on the European trip, including his attendance at Wimbledon, "were reviewed and approved by ethics counsel," VA press secretary Curt Cashour said in an emailed statement.

"These were important trips with our allies to discuss best practices for taking care of veterans," Cashour said. "The secretary has been transparent on his down-time activities that were similar to what he would have done with his family over a weekend in the U.S."

Cashour said the husband of Poonam Alaigh, the acting undersecretary for health, paid his own expenses.

In an interview Friday, Alaigh defended the trip as a "tremendous and valuable exchange of ideas" with British and Danish counterparts.

"Were there some breaks we got? Sure," she said. "But they were reasonable. They were not at the expense of what we had committed to do: representing our country and showing our commitment to veterans."

Alaigh said the delegation took an unplanned trip across the border to Sweden one evening.

Senior members of Congress, including two key Republicans, have expressed concerns about travel by officials in President Trump's Cabinet. The leaders of the House Oversight Committee, Chairman Trey Gowdy (R-S.C.) and Rep. Elijah E. Cummings (D-Md.), wrote to the White House this week to demand records on air travel for executive officials since Trump's inauguration, saying that official travel "by no means should include personal use."

Sen. Charles E. Grassley (R-Iowa), chairman of the Senate Judiciary Committee, also wrote Trump a letter Thursday asking what steps the administration has taken to "ensure Cabinet secretaries use the most fiscally responsible travel in accordance with the public trust they hold."

One ethics expert said the trip sends the wrong message to taxpayers, especially if spouses' expenses were paid by the government.

"That's kind of a long trip for the secretary to be gone," said Walter M. Shaub Jr., a vocal critic of the Trump administration who resigned in July as the federal government's top ethics watchdog. "The cost has got to be extravagant."

Shulkin was invited to attend a July 19 conference in London to discuss veterans' mental health issues with representatives of Britain, Canada, Australia and New Zealand. In past years, the VA secretary has attended the conference.

He also arranged to attend meetings in Denmark from July 12 to 14. Officials in Denmark said VA officials approached them about the meetings.

The bookend events left Shulkin with four days in between, according to his itinerary. He attended a ceremony one of those nights at which a British veteran of the war in Afghanistan was honored, and a meeting the next night at the British prime minister's residence.

Over the course of the trip, Shulkin and his entourage visited four palaces — Copenhagen's Christiansborg and Amalienborg and London's Buckingham and Kensington — and included times for walks, self-guided tours and photo stops.

On one calendar item, a canal tour of Copenhagen, the itinerary specifically noted the group “Will See Little Mermaid Statue,” one of the city’s most iconic public artworks. During the London visit, Shulkin and his wife shared a meal at a restaurant overlooking a tennis court with Victoria Gosling, a British leader of the Invictus Games, a sports tournament for wounded veterans. Gosling posted a photo of the gathering on Twitter.

“Great honour and a pleasure to host US Secretary of the VA and his lovely family,” Gosling wrote.

The Wimbledon event was one of the prized moments of the tennis year: In the women’s final, American Venus Williams would lose her chance at a sixth title to Spain’s Garbiñe Muguruza.

It is not clear whether the London invitation came before or after the scheduling of the events in Copenhagen, which included speaking with several Danish health-care executives at a luncheon organized by a Danish business group. A spokesman for one company in attendance, Leo Pharma, said the executives were asked by the Danish Foreign Affairs Ministry to attend.

In any event, the Copenhagen meetings occurred at a time the business group said was inconvenient, because it was a holiday period for Danes.

“It was quite difficult for us to accommodate,” said Kasper Ernest, a director at the Confederation of Danish Enterprise, noting that his group’s chief executive could not attend. “I was also on holiday.”

Shulkin’s relationship with Danish government leaders has grown over the past year, Danish officials said, and Denmark’s military had been heavily involved in the war in Afghanistan.

In a statement, the Danish Embassy in Washington said it has had “a close dialogue with the U.S. Department of Veterans Affairs for a couple of years based on the long-standing partnership between Denmark and the USA on global conflicts. Over this period, there has been a standing invitation to visit Denmark.”

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1.2 - Reuters: [Under pressure from Trump, Price resigns as health secretary over private plane uproar](#) (29 September, Steve Holland, 43.6M online visitors/mo; New York, NY)

WASHINGTON - U.S. Health and Human Services Secretary Tom Price resigned under pressure from President Donald Trump on Friday in an uproar over Price’s use of costly private charter planes for government business.

His abrupt departure was announced an hour after Trump told reporters he was disappointed in Price’s use of private aircraft and did not like the way it reflected on his administration.

“Secretary of Health and Human Services Thomas Price offered his resignation earlier today and the president accepted,” the White House said in a statement.

Trump named Don Wright to serve as acting secretary. Wright is currently the deputy assistant secretary for health and director of the office of disease prevention and health promotion.

"I'm not happy. OK? I'm not happy," Trump told reporters on the White House South Lawn.

Candidates to succeed Price included Seema Verma, who is administrator of the Centers for Medicare and Medicaid Services and who is close to Vice President Mike Pence, and Scott Gottlieb, a physician who serves as commissioner of the Food and Drug Administration, according to industry analysts.

Several sources saw Gottlieb as a clear front runner. They said he got along well with the White House and is viewed favourably there.

Price's resignation leaves Trump with a second Cabinet position to fill. He has yet to pick a secretary for homeland security after hiring former Secretary John Kelly as his White House chief of staff.

It was the latest blow to the Trump White House, which has struggled to get major legislative achievements passed by Congress and has been embroiled in one controversy after another since Trump took office in January.

Price, a former congressman, was instrumental in the Trump administration's policies aimed at undercutting Obamacare, as well as working with governors across the country to slowly begin unravelling parts of the law.

In a resignation letter, Price offered little in the way of contrition. He said he had been working to reform the U.S. healthcare system and reduce regulatory burdens, among other goals.

"I have spent forty years both as a doctor and public servant putting people first. I regret that the recent events have created a distraction from these important objectives," he said.

Trump, currently trying to sell his tax cut plan and oversee the federal response to devastation wreaked by three hurricanes, saw the Price drama as an unnecessary distraction and behind the scenes was telling aides "what was he thinking?," a source close to the president said.

Price promised on Thursday to repay the nearly \$52,000 cost of his seats on private charter flights. "The taxpayers won't pay a dime for my seat on those planes," Price said.

But that was not enough to satisfy Trump.

Trump told reporters that the "optics" of Price's travel were not good, since, as president he was trying to renegotiate U.S. contracts to get a better deal for taxpayers.

"Look, I think he's a very fine person. I certainly don't like the optics," Trump said.

Price had also been seen in the White House as having been ineffective in getting Congress to pass healthcare reform legislation, an effort that has fizzled on Capitol Hill.

Price was one of a handful of senior officials in Trump's administration put on the defensive over reports about their use of charter flights and government aircraft, sometimes for personal travel, when they could have flown commercial for less money.

The White House issued an order late on Friday saying use of private planes required approval from White House Chief of Staff John Kelly and that the commercial air system was appropriate even for very senior officials with few exceptions.

The Washington Post on Friday reported that Veterans Affairs Secretary David Shulkin attended a Wimbledon tennis match, toured Westminster Abbey and took a cruise on the Thames this summer during a 10-day trip to discuss veterans' health issues in Britain and Denmark.

Shulkin, who travelled on a commercial airline, was accompanied on the trip by his wife, whose airfare was paid for by the government and who received a per diem for meals, the Post said, noting that the Department of Veterans Affairs said she was travelling on "approved invitational orders."

His six-person travelling party included an acting undersecretary of health and her husband as well as two aides. They were accompanied by a security detail of as many as six people, the Post said.

Washington news media outlet Politico has reported that Price had taken at least two dozen private charter flights since May at a cost to U.S. taxpayers of more than \$400,000. Politico also reported he took approved military flights to Africa and Europe costing \$500,000.

Senior U.S. government officials travel frequently, but are generally expected to keep costs down by taking commercial flights or the train when possible.

Environmental Protection Agency Administrator Scott Pruitt and Treasury Secretary Steve Mnuchin have also been in the spotlight for their travel habits.

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1.3 - The New York Times: [Veterans Agency Seeks to Scrap Ethics Law on For-Profit Colleges](#) (29 September, Patricia Cohen, 29.8M online visitors/mo; New York, NY)

The Department of Veterans Affairs is pushing to suspend a 50-year-old ethics law that prevents employees from receiving money or owning a stake in for-profit colleges that pocket hundreds of millions of dollars in tuition paid through the G.I. Bill of Rights.

The agency says the conflict-of-interest law — enacted after scandals enveloped the for-profit education industry — is now redundant and outdated, with "illogical and unintended consequences" affecting employees who have no real conflict of interest, such as a V.A. doctor teaching a course at a school attended by veterans with educational benefits.

But veterans' groups and ethics experts reject those arguments and say the department is abandoning protections for veterans and taxpayers. They worry that the effort is part of a larger rollback of federal safeguards that were instituted before President Trump took office to combat abuses and fraud by for-profit colleges.

Several officials who worked in the for-profit college industry and had criticized the Obama-era crackdown as excessive, for example, have joined the Education Department, which administers and polices the federal student loan program and the industry.

The proposal to suspend the ethics law was published in the Federal Register in mid-September and is scheduled to take effect on Oct. 16, but no public hearings have been scheduled and no public comments have yet been submitted.

“It’s just reckless and sloppy,” said Walter M. Shaub Jr., a former director of the Office of Government Ethics, said of the agency’s action. He questioned why such a blanket exception for more than 330,000 agency employees should exist when the law allows waivers for individuals or even classes of individuals, like those teaching courses. Invoking the waiver also requires public hearings, he said.

Most troubling to Mr. Shaub, now senior counsel at the nonpartisan Campaign Legal Center, is that the move seems like an attempt by the executive branch to overrule the legislative branch. “They are saying the statute is unreasonable, but that’s not for them to say,” he said of agency officials.

Curtis Cashour, a V.A. spokesman, said officials had focused on the ethics law after the agency’s inspector general investigated complaints this year that two V.A. employees were teaching at a for-profit institution. There were no significant conflicts and a waiver was ultimately granted, he said, but the report led to worries among many employees about the impact of more rigorous enforcement.

“Our response was aimed at easing the concerns of numerous V.A. employees,” Mr. Cashour said in an email, adding that the ethics law had been superseded by subsequent conflict-of-interest statutes.

One concern of critics is that officials at the organization’s upper levels could be making decisions about a college in which they have a financial interest, like permitting a school with a record of abuses to recruit at military bases. Another is that people advising veterans about their educational benefits could steer students to a particular school because they were on the payroll.

“There’s no good that can come from allowing colleges to have unseemly financial entanglements with V.A. employees,” Carrie Wofford, director of Veterans Education Success, a nonprofit advocacy group. “Congress enacted a zero tolerance for financial conflicts of interest for V.A. employees precisely because Congress uncovered massive fraud by for-profit colleges targeting veterans.”

She added that “student veterans were already facing an aggressive rollback of their protections under the Trump administration’s Education Department.”

Two months ago, the Republican-led Senate Appropriations Committee issued a report during its debate over the military budget instructing the department to review the statute — but its concern was that the current rules “may be inadequate to identify conflicts of interest that can develop” because of gifts or expensive meals.

Veterans are particularly valuable as potential students: There are limits on the federal funds that for-profit schools can receive, but money from the G.I. Bill is not counted.

Even before last year's presidential election, some of the biggest veterans and military organizations were urging the department to better monitor for-profit colleges that were misleading veterans about the costs and benefits of enrolling, and violating legal and regulatory standards.

And a report issued in July by the director of the agency's Education Service found that financial issues involving tuition and fees were by far the leading complaint among students who had called the agency's G.I. Bill hotline since 2014.

Some ethics experts disagreed with the department's contention that other federal statutes made the ethics law unnecessary, saying the agency's rule sets a higher bar, requiring, for example, more public review.

Dozens of other agencies also have supplemental ethics rules that have been written to address potential problems specific to those agencies.

Senator Patty Murray, Democrat of Washington, and a longtime advocate for veterans, said she planned to look into the agency's decision. "I am deeply concerned the V.A. is opening the door for predatory for-profits to take advantage of men and women who have bravely served our country," she said.

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1.4 - U.S. News & World Report (AP): [Alaska VA Office Gets Mixed Report From Watchdog](#) (29 September, Becky Bohrer, 24M online visitors/mo; Washington, DC)

JUNEAU, Alaska — A government watchdog says the U.S. Department of Veterans Affairs regional office in Anchorage has made strides in processing claims but has work to do in other areas.

The VA's inspector general said the accuracy of the claims processing it reviewed earlier this year was significantly better than a prior inspection in 2013.

But it found delays in processing benefit reductions or discontinuations, resulting in about \$16,800 in overpayments for care, and inaccuracies in how staff entered claim information. The inspector general said such overpayments due to administrative errors aren't recoverable.

The watchdog recommended that the office prioritize the processing of benefit changes and improve oversight to ensure information is accurate when claims are established.

The VA, in responses included with the report, agreed with the findings and recommendations.

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1.5 - Stars and Stripes: [VA publicizes Shulkin's travel schedule amid scrutiny over Cabinet spending](#) (29 September, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

The Department of Veterans Affairs made moves Friday to publicize Secretary David Shulkin's travel schedule, following scrutiny over the cost of government-funded travel by other Cabinet members.

The VA announced it will post Shulkin's itineraries of international and domestic trips, as well as who accompanies him and whether he uses private or government aircraft. On Friday, the information was online at the VA's new "Secretary's Travel" page.

"Veterans and taxpayers have a right to know about my official travel as secretary, and posting this information online for all to see will do just that," Shulkin said in a prepared statement.

The announcement came two days after the House Oversight Committee initiated an investigation into the travel of President Donald Trump's administration.

Rep. Trey Gowdy, R-S.C., and Rep. Elijah Cummings, D-Md., leaders of the committee, sent letters Wednesday to the White House and 24 federal agencies, including the VA, asking for senior officials' travel details. The lawmakers cited federal law that official travel should be "expeditious" and "by no means should include personal use."

Gowdy and Cummings requested responses from each agency by 5 p.m. on Oct. 10.

In August, Treasury Secretary Steve Mnuchin used military aircraft to fly from New York City to Washington, D.C., costing about \$25,000, ABC News reported. The Treasury's Office of Inspector General is reviewing another of Mnuchin's trips, in which he used government aircraft to fly to Kentucky, where he spoke to business leaders and viewed the solar eclipse.

According to several reports, Mnuchin also requested to use a military jet to fly him and his wife, Louise Linton, to their European honeymoon. The request was later withdrawn.

Another cabinet member, Health and Human Services Secretary Tom Price, promised Thursday to repay about \$52,000 for his travel on private charter planes, which costs thousands of dollars more than commercial flights.

Interior Secretary Ryan Zinke took a charter plane to Montana and the Caribbean at a price of \$12,000, Politico reported. Multiple news outlets reported Scott Pruitt, who leads the Environmental Protection Agency, has taken at least four noncommercial flights since February, costing taxpayers more than \$58,000.

As of Friday afternoon, the VA posted Shulkin had taken five trips on Air Force 1 and Air Force 2, two of them to Texas to see damage caused by Hurricane Harvey. He also used a military aircraft last week for a trip to the Invictus Games in Toronto with First Lady Melania Trump. Shulkin has not used any private aircraft for official travel, according to information on the VA website.

According to one itinerary posted on the VA website Friday, Shulkin, his wife, Merle Bari, and other VA officials traveled July 11 to Denmark, where Shulkin was briefed on the Danish health care system for veterans, toured a veterans home and met the Danish ministers of defense and health. The group then traveled to London, where Shulkin and Bari spent July 15 at the Wimbledon tennis tournament with friends. On July 16, they visited Buckingham Palace, Kensington Palace, Westminster Abbey and took a cruise of the Thames River, followed by an

evening in Piccadilly Circus. Later during the week, Shulkin attended a conference in London on veterans issues.

The VA said it would update the site five days after the conclusion of every trip. The agency tied the move to other attempts at transparency since Shulkin took over as secretary. In July, the VA made public a list of employee terminations, demotions and suspensions, which is updated weekly.

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1.6 - The Clarion-Ledger (Video): [Mississippi treating 11 Hurricane Maria victims, more coming](#) (29 September, Anna Wolfe, 849k online visitors/mo; Jackson, MS)

So far, 11 hurricane victims from Puerto Rico and St. Croix have been transported to metro Jackson hospitals in the aftermath of Hurricanes Irma and Maria.

The storms devastated Puerto Rico's hospitals, a majority of which are without electricity or fuel for generators and beginning to run out of oxygen and clean water.

"You're talking about a hospital that has one week of oxygen left, one day of drinkable water. It's a level of devastation I don't think we could ever begin to imagine," said state Department of Health spokeswoman Liz Sharlot.

The Health Department has partnered with the G.V. "Sonny" Montgomery Veterans Affairs Medical Center, Air National Guard and the University of Mississippi Medical Center to accept patients at 13 local hospitals. UMMC is treating four patients, some of whom are children and infants.

On Sept. 22, the department set up a patient reception area — a federal coordinating center at the Jackson-Medgar Wiley Evers International Airport — where doctors and nurses from the VA are assessing each patient's needs, providing any emergency care, then transporting them to a local hospital. Ambulances are on standby.

The first patients arrived Monday. By Thursday night, they'd seen 11 patients with a range of conditions, including one high-risk pregnancy, a double amputee, one on a ventilator with respiratory failure and a neonatal intensive care unit patient.

"These are serious medical needs and high-risk patients," Sharlot said. "We're just grateful we're able to do what we can."

VA Medical Center Director Dr. David Walker, commander of the federal coordinating center, described the scene at the airport as stressful, but rewarding "knowing you're helping people at their most vulnerable."

"You never know what you're going to get until the plane doors open," Walker said.

The plane ride on the commercial air ambulance is between four and six hours, at which point a patient's condition can change.

One of Walker's staffers is from Puerto Rico and hasn't been able to speak with her family. She's volunteered to do any translation at the coordinating center.

The goal is to transfer patients back home when they've been stabilized, but considering the conditions in Puerto Rico, that hasn't happened yet. Walker said he only knows of patients leaving the hospitals to stay with relatives in the United States.

The Health Department expected more arrivals Friday. Shreveport, Atlanta and Columbia, South Carolina, are also receiving patients from Puerto Rico and the U.S. Virgin Islands.

"It's not over," Sharlot said. "I think this is going to be going on for a while."

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1.7 - The San Diego Union-Tribune: [Does a soldier's best friend belong in VA research labs? A fight at the heart of the veterans community](#) (29 September, Jeanette Steele, 494k online visitors/mo; San Diego, CA)

America loves dogs, but many veterans have an extra bond after serving with canine units on the battlefield and increasingly depending on service dogs back at home.

Now the U.S. Department of Veterans Affairs and some of the nation's largest veterans groups are in a scrap with a government watchdog organization and some in Congress over VA medical research programs that inflict harm on man's best friend in the name of science.

A VA investigation found problems at a Richmond, Virginia, program where researchers do heart surgery on dogs to study the development of cardiac abnormalities.

Techniques include inserting pacemakers and catheters into the hearts of dogs, destroying heart tissue and creating heart attacks by injecting liquid latex into an artery. At the end, dogs are killed and their tissues studied.

One of the reasons that dogs are considered good for these experiments is they are easy to train to run on a treadmill while their hearts are monitored.

As a result of botched procedures, one lead researcher was removed from the studies this spring and the VA tightened its research protocols at Richmond's Hunter Holmes McGuire VA Medical Center, one of at least three sites nationwide where the VA does invasive medical research on dogs.

Changes include additional reviews by the VA's chief veterinarian of proposed dog research, more stringent scientific scrutiny of VA funding requests involving dogs and increased frequency of site visits for VA programs that have canines, a VA official told The San Diego Union-Tribune.

These moves come atop questioning of research at the Los Angeles VA on narcoleptic Doberman pinschers. The approved protocol called for dosing dogs with antidepressants or methamphetamine, then killing them and studying how the drugs affect their brains.

Now, at the highest levels, the VA is battling to save its canine research programs, which have come under assault in Congress.

“Part of our mission is to push the envelope constantly in search of medical advancements that will help improve the lives of disabled veterans,” VA Secretary David Shulkin wrote in an opinion piece this month in USA Today.

“If this legislation passes ... it would stop potential VA canine research-related medical advancements that offer seriously disabled veterans the hope of a better future,” wrote Shulkin, a practicing physician.

A spending bill that unanimously passed the House in July would ban funding for two categories of invasive dog experimentation at the VA in the coming fiscal year.

Separately, the “PUPPERS Act” (Preventing Unkind and Painful Procedures and Experiments on Respected Species) would permanently ban money for invasive dog research by the VA.

Rep. Dave Brat, the Virginia Republican who sponsored the act, called the experiments in Richmond “horrific and inhumane” in a statement.

“These dog testing experiments at the VA are consuming limited taxpayer dollars, medical staff time and office space that could be better utilized to deliver health care for veterans,” Brat said.

But the VA has rallied an important chunk of the veterans community to its defense.

The American Legion, Iraq and Afghanistan Veterans of America and Vietnam Veterans of America have written letters to Congress in support of the VA’s canine research.

“There are many pet owners and animal lovers in the American Legion,” the legion’s statement said. “Sometimes animal research is needed for the greater good of protecting human life.”

The executive director of Paralyzed Veterans of America said he’d like to see Congress strike a balance on the issue.

“On one hand, understand and acknowledge the tremendous gains in medicine and treatment,” said Sherman Gillums Jr., in response to a query from the Union-Tribune. “On the other hand, if it is warranted, Congress should call for greater accountability and transparency to confront waste and deviation from humane protocols in scientific research funded by taxpayers.”

Dogs accounted for less than 0.05 percent of animals used in VA research in 2016, an official said. Almost all are mice or rats.

Not all veterans agree with the nation’s most established organizations.

“I’m not going to say canine research should or shouldn’t be done at all, I just don’t think the VA should do it,” said Ben Krause, creator of the contrarian website Disabledveterans.org. “VA has a hard enough time not withholding health care from veterans on a regular basis.”

A major player in this conflict is White Coat Waste Project, a four-year-old Washington, D.C. nonprofit group whose philosophy is a marriage of fiscal conservatism and animal protection

sentiment. The group offers \$1,000 rewards to whistleblowers with evidence of animal abuse or wasteful spending at VA dog labs.

Founded by a Republican strategist, the group argues that taxpayers are spending over \$15 billion a year on wasteful dog, cat, monkey and other animal experiments that are irrelevant, slow and expensive.

It was White Coat Waste's complaint in March that spurred the VA's investigation of the Richmond facility. The group filed Freedom of Information Act requests for records from the McGuire VA.

"We had known that the VA was one of the few agencies conducting painful experiments on dogs. And through our research into the details of those projects, we uncovered these series of violations at Richmond," said Justin Goodman, White Coat Waste's vice president.

According to Goodman, the VA has 79 sites that do animal experiments, but only three are doing "significantly painful" research on dogs.

Aside from Richmond, the others are Stokes Veterans Affairs Medical Center in Cleveland and Zablocki Veterans Affairs Medical Center in Milwaukee.

In Milwaukee, according to the watchdog group, the VA is using 150 dogs, including beagle puppies, for lung research that includes collapsing the dogs' lungs and dissecting their necks and heads.

"The use of dogs has been decreasing in the United States," Goodman said this week.

"Most people would probably be alarmed that, in 2017, there are still 60,000 dogs being used in experiments. I think that for many people, even one dog being used in an experiment that they are forced to pay for is too many," he said, adding that research outside of federal agencies is often funded by government grants.

One expert said the VA's research is not an anomaly in the biomedical industry.

"Work with dogs is happening all over the place," said Cindy Buckmaster, chairwoman of Americans for Medical Progress, a nonprofit group that advocates for the role of laboratory animals.

"Any time they are the optimal model, they are part of the study," said Buckmaster, also a Ph.D. at Baylor University College of Medicine.

She said researchers are required to give dogs pain medication during invasive procedures, just like in human surgeries, but the majority of animal subjects are eventually killed as part of the study.

"That's because the answers are in the tissues," Buckmaster said.

The VA argues that its animal research has saved lives and will save more in the future. It issued a list of past accomplishments: development of the cardiac pacemaker, the first liver transplant, the nicotine patch, the discovery of insulin and, most recently, the first FDA-approved artificial pancreas.

White Coat Waste disputes that list as ancient history, saying the artificial pancreas is the only 21st century accomplishment of the bunch.

A University of California San Diego pathology professor said experts are going to disagree about whether dog research, and animal research in general, is effective. Dr. Lawrence Hansen, who is involved with White Coat Waste, led a successful campaign nearly 15 years ago to end surgery on dogs as a mandatory part of the medical school's curriculum.

"We have created creatures that are hard-wired to love and trust us," Hansen said. "It is a betrayal to then turn around and keep them in cages, cut them up and kill them."

To him, it comes down to an ethical question: If dog research does work to expand science, is it worth it?

It's a question Congress may take up in the coming year, with the plight and opinions of America's veterans as added weight.

Current VA research using dogs

- Studying ways of preventing lung infections in people with spinal cord injuries because they are unable to cough effectively
- Developing glucose sensors that diabetic human patients can wear to allow continuous monitoring and insulin delivery
- Understanding and treating dysfunction in the brain circuits that control breathing
- Meeting a congressional mandate to establish scientific evidence as to whether service dogs reliably reduce the symptoms of post-traumatic stress disorder
- Gaining insights into narcolepsy through studies of a unique colony of naturally narcoleptic dogs
- Studies to develop novel treatments for human heart conditions like atrial fibrillation and heart failure

Source: VA

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2. Veteran and Employee Experience

2.1 - USA Today: [VA Secretary David Shulkin discloses official travel details](#) (29 September, Jessica Estepa, 36.7M online visitors/mo; McLean, VA)

Veterans Affairs Secretary David Shulkin announced Friday that his department would disclose details about his official travels, in an attempt to be transparent as the travels of other members of the administration come under scrutiny.

The department will regularly update a page that includes any travels by private and government aircraft, as well as itineraries of official international and domestic trips.

"Under this administration, VA is committed to becoming the most transparent organization in government, and I'm pleased to take another step in that direction with this move," Shulkin said in a statement. "Veterans and taxpayers have a right to know about my official travel as secretary, and posting this information online for all to see will do just that."

Shulkin's announcement comes as Health and Human Services Secretary Tom Price faces criticism for his own use of private planes for official business. Price has apologized for the chartered flights and vowed to put an end to the practice.

According to the VA, Shulkin has not yet taken any private aircraft for official business.

He has taken six domestic trips on government aircraft, four of which were on Air Force One.

He has also taken two international trips: a September trip to Toronto for the Invictus Games and another to Copenhagen and London. The Copenhagen and London trip included tours of palaces and a river cruise down the Thames.

The Washington Post reported that the VA's decision to start disclosing Shulkin's travels came after it obtained a copy of the Europe itinerary.

The Post reported that the department covered the airfare of and provided per diem for Shulkin's wife, Merle Bari. The agency told the Post that she was traveling on "approved invitational orders."

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2.2 - ABC News: [VA secretary spent half of official London trip sightseeing](#) (29 September, Luis Martinez, 24.1M online visitors/mo; New York, NY)

Veterans Affairs Secretary David Shulkin flew a commercial airline to London this past July to attend a veterans conference, but half his time there was spent on sightseeing and a stop at Wimbledon tennis tournament.

Shulkin's wife's commercial travel costs were also paid for by the federal government because she was under "approved invitational orders"

As questions have swirled about other Trump cabinet officials' use of government aircraft, the Department of Veterans Affairs has decided that in the interest of transparency it will post all of Shulkin's travel details on a VA website.

Those documents show Shulkin has flown six times on U.S. military aircraft. Four of the flights were on Air Force One as he accompanied President Trump, one was on Air Force Two accompanying Vice President Pence and a flight earlier this week accompanying the first lady to this week's Invictus Games in Toronto. Shulkin has never flown a private plane to travel for his official duties, according to a Veterans Affairs spokesman.

The Department also posted the itineraries of Shulkin's trip in mid-July to Denmark and the United Kingdom and earlier this week to Canada with first lady Melania Trump.

Shulkin and his delegation of six, including his wife Dr. Merle Bari, traveled commercial airlines to Copenhagen and London.

But that trip itinerary to Denmark and London has raised questions about the amount of time Shulkin spent sightseeing.

The itinerary shows that on July 12, the first day of his first three days in Copenhagen, Shulkin visited multiple tourist stops. The next two days were spent on meetings with Danish government and health care officials to discuss veterans issues.

The first half of the six-day stay in London was dedicated to sightseeing before his full participation in a two-day veterans summit.

Shulkin arrived in London on Saturday, July 15 and according to the itinerary he spent the afternoon at the "Wimbledon Tennis Tournament with Friends." That would have been the day of the Women's singles final.

He spent the next two days visiting notable tourist sites in London including Buckingham Palace, Kensington Palace, Westminster Abbey, St. Paul's Cathedral, the Tower of London and took a "Thames River cruise to Greenwich Pier/Followed by dinner/evening in Piccadilly Circus."

But from the afternoon of Wednesday, July 19, through Friday, July 21, Shulkin was immersed in full-day participation in the veterans conference.

"All activities on the itinerary were reviewed and approved by ethics counsel," said Curt Cashour, the VA Press Secretary.

Cashour said the rules permit government reimbursement for a spouse's "temporary duty" travel expenses.

According to a VA press release, the department is the first federal agency to make public the travel details of its top official. "The information will also include what VA staff and spouses accompany him on each trip, if any, but for security reasons, members of the Secretary's security detail will not be listed by name or number," said the release.

"Under this Administration, VA is committed to becoming the most transparent organization in government, and I'm pleased to take another step in that direction with this move," Secretary Shulkin said. "Veterans and taxpayers have a right to know about my official travel as Secretary, and posting this information online for all to see will do just that."

According to the release, Shulkin "pointed to the move as the fourth major step in long-sought transparency and accountability actions at VA." Previous actions include the VA's public listing of wait times and quality/satisfaction data at all VA medical centers, adverse employee actions and employee settlements.

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2.3 - Politico: [Who will replace Tom Price? A dozen names are circulating as possible successors](#) (29 September, Joanne Kenen and Jennifer Haberkorn, 23.9M online visitors/mo; Arlington, VA)

Tom Price hadn't even stepped down when the Washington policy world was buzzing about who was likely to replace him.

A dozen names are being talked about, including several belonging to those already serving in the administration. Of course, President Donald Trump often does the opposite of what insiders expect.

The rumored short-list includes former Sen. Judd Gregg (R-N.H.), who would sail through Senate confirmation but would probably be considered too moderate on Obamacare, to Dr. Mehmet Oz, a cardiothoracic surgeon known through his talk show. Other current or former members of Congress who could be considered include Rep. Fred Upton and former Rep. Dave Camp.

Here are a few others who may be in the mix:

[...]

David Shulkin: The VA secretary is a Trump favorite, and the only cabinet nominee to be unanimously confirmed. However, Shulkin has come under criticism for combining leisure with business on his official travel — he attended a Wimbledon championship tennis match, toured Westminster Abbey and took a cruise on the Thames while meeting this summer with European officials about veterans' issues, The Washington Post reported Friday. Shulkin did fly commercial but his wife's expenses were covered by taxpayers, according to the Post.

A physician and former health administrator, Shulkin is also the only member of Trump's cabinet who is a holdover from the Obama years; he served as the VA's undersecretary of health in that administration. Now he's trying to get the massive, scandal-plagued VA health care back on track to serve around 9 million Americans a year. He has made the agency's performance and improvement programs public and transparent. He still sees patients — in person and via telemedicine.

[...]

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2.4 - The Huffington Post: [Yet Another Trump Administration Official Took Questionable Liberties With Work Travel](#) (29 September, Mollie Reilly, 23M online visitors/mo; New York, NY)

Veterans Affairs Secretary David Shulkin used his downtime on a recent international trip for several leisure activities, including a tennis match and river cruise, The Washington Post reported Friday.

According to the report, Shulkin spent roughly half of a 10-day trip to the U.K. and Denmark to sightsee, watch a high-profile Wimbledon match and take in other activities more typical of a vacation than a work trip.

Shulkin flew commercial for the July trip, a notable difference from other officials who have recently come under scrutiny for opting to use charter or military planes for their travel. However, the government did pay for his wife's airfare as well as some of the cost of her meals while abroad.

Read the full report [here](#).

When asked for comment on the Post story and the agency's ethics review process, a Department of Veterans Affairs spokesman pointed to a Friday announcement that the agency will now make all of Shulkin's travel itineraries publicly available and will note what kind of aircraft he used on each trip.

The revelations about Shulkin, a holdover from President Barack Obama's Cabinet, are just the latest in a series of reports regarding Trump administration officials' conduct and financial choices while traveling on official business.

Health and Human Services Secretary Tom Price has received by far the most criticism for his use of private planes and military aircraft to travel both domestically and abroad. According to a series of reports in Politico, the secretary's travel has come at an expense of more than \$1 million to taxpayers.

On Thursday, after President Donald Trump said he was "not happy" with Price, the secretary announced he would no longer take private planes and vowed to reimburse taxpayers for the expenses he's incurred. However, he plans to pay just for "his seat" — or about \$50,000.

Interior Secretary Ryan Zinke has also faced criticism for chartering a plane to travel from Las Vegas to Montana, costing taxpayers more than \$12,000.

Environmental Protection Agency Administrator Scott Pruitt and Treasury Secretary Steven Mnuchin are also under scrutiny for similar travel expenses.

The White House has said it's looking into these expenses, and on Wednesday the House Oversight and Government Reform Committee announced it had requested information from 24 federal agencies on officials' travel.

"Under 5 U.S.C. § 5733, official travel on the part of federal employees must be 'by the most expeditious means of transportation practicable' and 'commensurate with the nature and purpose of the [employee's] duties,' and by no means should include personal use," reads a letter from the committee's leadership to the agencies.

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2.5 - The Hill: [Trump VA chief went sightseeing, shopping with wife on government trip: report](#) (29 September, Brandon Carter, 11.8M online visitors/mo; Washington, DC)

Veterans Affairs Secretary David Shulkin spent nearly half his time on a recent international trip sightseeing and shopping with his wife, according to The Washington Post.

Shulkin traveled to Europe in July to attend a conference in London with representatives of several countries on veterans' health issues, as well as a series of meetings in Denmark.

The VA chief's traveling party included his acting undersecretary of health and her husband, his chief of staff, another aide and a security detail, according to the Post.

Shulkin's wife, who also accompanied him on the trip, had her airfare paid for by the government because she was traveling on "approved invitational orders," a VA spokesperson told the Post. Shulkin's wife also received a per diem for her meals.

The newspaper reports Shulkin attended a Wimbledon tennis tournament match and visited multiple palaces in both London and Denmark. Shulkin also reportedly took a cruise on the River Thames in London during the trip.

Shulkin took commercial flights for the trip and sat in coach on at least one flight, according to the Post.

VA press secretary Curt Cashour told the Post that the entire itinerary for Shulkin's trip was "reviewed and approved by ethics counsel."

"These were important trips with our allies to discuss best practices for taking care of veterans," Cashour told the Post. "The secretary has been transparent on his downtime activities that were similar to what he would have done with his family over a weekend in the U.S."

In a statement Friday, the VA said it would begin making public a list of Shulkin's official travel, including trip itineraries and his use of private and government aircraft.

"Veterans and taxpayers have a right to know about my official travel as Secretary, and posting this information online for all to see will do just that," Shulkin, a holdover from the Obama administration who President Trump tapped for the top VA spot this year, said in the statement.

Other Trump administration officials have come under fire for their travel while in office.

Health and Human Services Secretary Tom Price has reportedly racked up over \$1 million in travel costs with his use of private and military planes since May. Price said Thursday he would reimburse taxpayers just under \$52,000 for charter jet travels he's used for government business.

President Trump said Wednesday he was "not happy" with Price's use of private planes and said "we'll see" when asked if he planned to fire Price.

Interior Secretary Ryan Zinke and Environmental Protection Agency Administrator Scott Pruitt have also come under scrutiny for their use of private aircraft for government business in recent days.

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2.6 - Washington Examiner: [VA secretary saw Wimbledon match during taxpayer-funded trip to Europe: Report](#) (29 September, Melissa Quinn, 4.8M online visitors/mo; Washington, DC)

Secretary of Veterans Affairs David Shulkin and his wife, accompanied by other VA officials, attended a tennis match at Wimbledon, toured Westminster Abbey, and cruised the Thames River as part of a taxpayer-funded, 10-day work trip to Europe this summer, according to a report.

Shulkin and a group of six people, including his wife, traveled to London and Denmark in July, where Shulkin met with Danish and British officials to discuss veterans' health issues, according to an itinerary of the trip obtained by the Washington Post. The VA secretary traveled in coach on a commercial flight during at least one part of the trip.

The VA secretary attended a conference in London on July 19, one previous secretaries have also attended, that included representatives from Britain, Canada, Australia and New Zealand. He also scheduled a series of meetings in Copenhagen, Denmark, that took place from July 12 to July 14.

On two nights between the official events in London and Copenhagen, Shulkin spent one at a ceremony where a British veteran who served in Afghanistan was honored, and another meeting with British Prime Minister Theresa May.

But during the day, Shulkin, his wife, Merle Bari, Acting Undersecretary For Health Poonam Alaigh, her husband, Shulkin's chief of staff, and another aide, as well as a security detail, saw the sights and shopped.

The government covered the cost of Bari's airfare and gave her a per diem for meals, the VA told the Washington Post. Bari, the agency said, was traveling on "approved invitational orders."

"These were important trips with our allies to discuss best practices for taking care of veterans," VA spokesman Curt Cashour told the Washington Post. "The secretary has been transparent on his down-time activities that were similar to what he would have done with his family over a weekend in the U.S."

It's unclear whether the government or Alaigh covered the expenses for Alaigh's husband.

According to the itinerary of the trip, Shulkin had no official business scheduled during the days in between his meetings in London and Copenhagen.

Rather, Shulkin and his group attended the women's final at Wimbledon, where Venus Williams lost to Garbine Muguruza.

The group also visited two palaces in London, Buckingham Palace and Kensington Palace, and two in Copenhagen, Christiansborg Palace and Amalienborg Palace.

Revelations of Shulkin's trip come as four of President Trump's Cabinet officials are under scrutiny for their use of private and government planes to travel.

Secretary of Health and Human Services Tom Price is facing calls for his resignation after it was revealed he's taken at least 24 trips aboard private jets, as well as trips on military aircraft, costing taxpayers more than \$1 million.

Treasury Secretary Steven Mnuchin's travel on government planes has also come under fire.

Both Price and Mnuchin are facing probes from the inspectors general at their respective agencies, and numerous congressional committees are requesting information on administration officials' travel.

Interior Secretary Ryan Zinke and EPA Administrator Scott Pruitt have also traveled via private or military aircraft.

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2.7 - Pittsburgh Post-Gazette: [Pittsburgh VA nurse is finalist for national caregiver award](#)
(29 September, Gary Rotstein, 4.8M online visitors/mo; Pittsburgh, PA)

A nurse for the VA Pittsburgh Healthcare System is one of six national finalists for an annual award given to a medical professional who shows an exemplary caregiving approach on the job.

Victor Fagan, a licensed practical nurse from Butler, won recognition from among nearly 200 nominees who were submitted to the Boston-based Schwartz Center for Compassionate Healthcare. It will announce the winner of its 2017 National Compassionate Caregiver of the Year Award at a dinner on Nov. 16.

Mr. Fagan has worked with veterans the past five years at the VA's primary care clinic on University Drive in Oakland. He was nominated for the Schwartz Center award by co-workers who noted the unusual level of compassion and respect he brings to his role of helping others.

Examples of his efforts that were cited included his purchasing shoes for a low-income veteran's child; connecting a homeless veteran to helpful resources; celebrating patients' milestones such as birthdays; working to develop a Wall of Heroes that will honor local vets; and encouraging his fellow staff to do their own similar good work.

"Victor is always thinking of others first and incorporates caring and respect into every interaction with the veterans for whom he provides care," Christin Durham, the VA Pittsburgh primary care nursing manager, wrote in endorsing Mr. Fagan for the award.

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2.8 - PennLive (Video): [VA chief mixed business with pleasure at taxpayer expense: Media report](#)
(29 September, Ivey DeJesus, 3.1M online visitors/mo; New Bloomfield, PA)

President Donald Trump's veterans affairs chief is the latest administration official in hot water for reportedly tapping into taxpayer money to pay for vacation outings and non-official business.

Veterans Affairs Secretary David Shulkin in July took in a Wimbledon championship tennis match and a Thames River cruise on taxpayer money. That's according to a report published Friday by The Washington Post.

Shulkin was in Europe for 10 days for meetings with Danish and British officials about veterans' health issues, but during that time, the Post reports, he and his wife spent about half their time sightseeing, including shopping and touring historic sites.

The Washington Post cited an itinerary obtained by the news outlet, and which was confirmed by a U.S. official familiar with it.

Shulkin last week visited the Harrisburg area, meeting with veterans at a local VFW to outline what he said was the right direction for the embattled agency. Shulkin said to veterans that accountability was one of his top priorities.

News of Shulkin's multi-purpose trip comes on the heels of that of Health and Human Services Secretary Tom Price, who is at the center of White House- approved trips outside the bounds of protocol. The Trump administration this spring and summer approved the use of military aircraft for multi-national trips by Price to Africa, Europe and Asia at a cost of more than \$500,000 to taxpayers.

The overseas trips bring the total cost to taxpayers of Price's travels to more than \$1 million since May, according to a POLITICO review.

Price this week pledged to reimburse the government for the cost of his own seat on his domestic trips using private aircraft -- reportedly around \$52,000 -- but that would not include the cost of the military flights, Politico reported.

Shulkin's six-person traveling party included his acting undersecretary of health and her husband, his chief of staff and another aide, the Post reports. A security detail of as many as six agents was assigned to the entourage.

The Post reported that the VA said that the government paid airfare for Merle Bari, Shulkin's wife, because she was traveling on "approved invitational orders." The government also provided a per diem for her meals, the agency said.

Wimbledon tickets for final matches can run into the thousands of dollars - as can a river cruise. Shulkin also toured Westminster Abbey. Those tickets run about £22 (sterling) or approximately \$30 a person.

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2.9 - Military Times: [Amid Cabinet controversies, VA promises to post secretary's travel details online](#) (29 September, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

WASHINGTON — In response to the growing scandal of Cabinet officials using pricey private aircraft for business trips, Veterans Affairs officials announced Friday they will post details of all official travel by department Secretary David Shulkin online to provide transparency about his travels.

“Veterans and taxpayers have a right to know about my official travel as secretary, and posting this information online for all to see will do just that,” Shulkin said in a statement.

The move comes one day after Health and Human Services Secretary Tom Price announced he would reimburse the government about \$52,000 for charter flights made in recent months for government duties, a sum that amounts to only a small portion of the flights' costs.

The White House announced Friday afternoon that Price resigned.

Reports of Price's charter flights have prompted congressional investigators to look into travel expenses for all of Trump's Cabinet.

The VA's announcement also comes on the same day as a Washington Post article that details a trip Shulkin and his wife took to Europe last summer that included government business but also sightseeing and other non-work activities.

The VA told the Post that the government paid for Shulkin's wife's airfare because she was traveling on “approved invitational orders.” The VA added that all of Shulkin's activities were reviewed and approved by ethics counsel. The couple flew commercial, including at least one leg in coach, according to the Post.

VA officials said Shulkin has not used any private aircraft for travel to date, but will list them on the department's website if he employs that option in the future.

In addition, the new site will list all use of government aircraft by the secretary, along with itineraries of all official trips. That information will be available within five days of any travel, starting in mid-October.

Officials will start posting some of those details on the VA's “Secretary Travel” site later today.

Shulkin has used government aircraft for transportation six times so far this year. Five of them were aboard Air Force One, accompanying the president to events.

The sixth was a recent trip to the Invictus Games in Toronto, where he traveled with first lady Melania Trump to see wounded U.S. troops and veterans participate in athletic competitions against teams from other countries.

Shulkin has made department transparency one of the key focuses of his department reform efforts. Earlier this year, the department began posting online information on medical center wait times, employee firings and workplace settlements.

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2.10 - Providence Journal (The Enterprise): [Providence VA official relieved of duties amid allegations of racism, homophobia](#) (29 September, Paul Edward Parker, 1.2M online visitors/mo; Providence, RI)

A manager at the Veterans Affairs Regional Office in Providence has been relieved of his duties pending disciplinary action, following a complaint from a co-worker that he created a “toxic work atmosphere.”

Stephen V. Pina, the Veterans Services Center manager, who also has been embroiled in controversy after a Facebook post suggesting that New England Patriots players who knelt during the national anthem on Sunday were dancing monkeys, is “no longer engaged in processing benefits claims,” according to Mark Ramos, a spokesman for the Providence VA office.

Ramos said that disciplinary action against Pina has been proposed and that, to afford due process rights, it can’t be imposed for 15 business days. Ramos said he was not aware of the nature of the proposed discipline. In the interim, Pina has been assigned to other job duties.

Peter Rogers, who was a human resources specialist at the Providence office, said he left for another government job two years ago due to insensitive remarks made at work by Pina.

“The work environment there is awful because of him,” said Rogers, who now works for the U.S. Department of Homeland Security.

Rogers said he is an openly gay veteran who served 23 years in the military, including a tour in Afghanistan as an air traffic controller for the Air Force.

The 44-year-old Virginia native said he recalled one moment when he was driving Pina and other colleagues to an event at a VFW in Warwick. Rogers claimed that Pina made homophobic remarks during the ride.

“He was pounding on the dashboard, yelling all kinds of obscenities and f-bombs,” said Rogers. “I was completely blown away by his behavior.”

Pina, who lives in Brockton, Massachusetts, landed in hot water this week after making a comment under a Facebook story about Patriots players who knelt during the national anthem on Sunday. In the post, Pina called the players “turds” and added, “dance monkey dance.”

Pina has since resigned from his position on the Brockton Parks and Recreation Commission, after Mayor Bill Carpenter called on him to do so. A Pop Warner football team, the Brockton Junior Boxers, said Pina had stepped down as a coach after the youth football league made a statement calling for him to do so.

Pina received a \$120,000 salary last year as manager of the Veterans Service Center, overseeing 157 government employees at the downtown office on Westminster Street.

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2.11 - KATV (ABC-7, Video): [Troubles at the VA: Nurses speaking out about culture](#) (29 September, Elisabeth Armstrong, 448k online visitors/mo; Little Rock, AR)

Two former nurses who have filed EEO complaints against the CAVHS are speaking out about problems. In July, Channel 7 brought you this report out of the VA. In it, some thirty nurses filed a complaint against the hospital - alleging that under-staffing was impacting patient care.

After that story aired, more than a dozen staffers reached out to the newsroom, saying that poor management, unsafe working conditions, even claims of harassment are behind the issue.

Lyn Gardner and Brandy Ballard: both former nurses at the VA, both saying there's something wrong with the Central Arkansas Veteran's Healthcare System. Lyn is a veteran who served in the military for six years, before pursuing her dream of becoming a nurse in the VA system.

But she says that dream, turned into a nightmare: "It actually upsets me to this day, talking about it, because it was very traumatic."

In her claim she alleges that she was subjected to a hostile work environment - dealing with screaming supervisors, limited equipment, and in one case, an issue where she passed out while assisting during surgery, and never received medical attention.

"I walked out of the unit, pretty much all on my own, receiving no treatment. And that's very upsetting. As a veteran, and as an employee of a facility that's supposed to care for veterans."

Lyn says, it's this culture that creates problems for patient care: "Not having the support from management, not being able to articulate issues, is scary, because you're dealing with people's lives." Adding, changes need to be made.

Brandy Ballard agrees. She has several veterans in her family, and credits the VA with providing her grandfather life-saving cancer treatment. But she says her family members are now expressing fear about the care they're receiving.

"Another family member, more recently, voiced his concerns to me about that very VA because he didn't feel he would get the treatment he deserved with stage 4 cancer," she explains.

She says the culture at the VA has truly taken a toll on her life, alleging that nurses are punished for speaking out about patient care: "It really has affected my family. I mean, a failed marriage as a result of this, just mental anguish, physical ailments as a result of the constant stress."

This is why she says she filed a complaint. And these nurses are not the only ones - two other staffers at the VA provided me with copies of their EEO complaints. None of these have been ruled on yet, as the EEO is currently investigating several of the claims.

So, Channel 7 dug into data out of the national VA Administration. It shows that Central Arkansas Veterans Healthcare System has one of the highest nurse turnover rates in the entire VA System. They're just under the 90th percentile.

But Medical Director Dr. Margie Scott, says this is not due to workplace harassment or discrimination: "Well if you look at our exit interviews, Elisabeth, for nurses who are leaving the workforce, the top number of nurses who are leaving is due to number one taking a higher level position, and advancement in position, or number two retiring... The third most common is actually to go back to school."

Channel 7 requested those numbers and the VA complied 47% of employees said they left for those reasons (along with "relocating with a spouse") during exit interviews. But KATV also took a look at employee satisfaction scores.

When it comes to employee satisfaction, the Little Rock VA comes in at 3.8 out of 5. Dr Scott breaks down this statistic, "Over 60% of our staff think this is not only a good, but a great place to work. There's always a spectrum in any survey of low scores and high scores, but a 3.8 out of 5 is an excellent score. It's not where we want to be - we always want to be higher - so we'll continue to work on that."

But a 3.8 is also around the 50th percentile - that means 50% of other VA facilities have higher employee satisfaction rates.

And when it comes to veterans' experience, in the four categories the VA looks at, Central Arkansas comes in near the bottom of each. When it comes to comprehensiveness of care, the system scores as one of the worst.

Channel 7's Elisabeth Armstrong asked, "I probably spoke to 15 or twenty people. and a number of them said, 'I'm a veteran or I have veterans in my family, and I would not take them to the Little Rock VA. Does that concern you?'"

Dr. Scott says, "Absolutely that concerns me, and I would love to talk to those individuals and hear what they have to say as far as ways we can improve our work environment."

Dr. Scott and Acting Deputing Medical Center Director Salena Wright-Brown say the VA is implementing several new ways for employees to make their voices heard: through listening sessions, surveys, a video blog, and being selected as an "Innovation Hub."

"I think that's the key," explains Dr. Wright-Brown. "To open those communication avenues, we reassure people that nothing is going to happen negative, only positive - only improvement for our veterans."

The VA has filled 102 of the 149 open nursing positions since our first piece aired in July. However, we do not have numbers on how many have left since that time.

The system held another job fair last Saturday.

*Correction: An earlier version of this story stated the job fair was this upcoming weekend. However, it was last weekend, and officials say it was successful.

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2.12 - WQAD (ABC-8, Video): [Moline man shocked after job training center for veterans shuts down](#) (29 September, Chris Minor, 450k online visitors/mo; Moline, IL)

GARLAND, Texas - A Moline, Illinois man is one of more than 300 veterans left in the dark after a job training school they paid for through the GI bill abruptly shut its doors.

"Three weeks before graduation, we were told goodbye. They sent a senior instructor around to each class and he just came in front of the school and said, 'I need everyone to pack your bags, the schools been officially shut down and everyone needs to vacate the premises' ," said Dallas Wild, who had enrolled in the career center after hitting dead ends looking for a decent paying job in the Quad Cities.

The Retail Ready Career Center catered to veterans interested in a career in heating and air conditioning.

"They called and offered us a \$23 dollar an hour job after we got out, guaranteed job placement," said Wild.

Tuition was \$21,000 for the six week program, which included food, lodging, and round-trip air-fare. Most tuition bills were paid through the GI bill.

The Department of Veterans Affairs is investigating the job training center for unknown reasons.

The owner John Davis, is seen on video telling the students that the investigation was launched after a former employee who embezzled money from a school fund went to authorities.

Wild says he had hoped to graduate so that he could find a better job in the Quad Cities, and is uncertain what happens next.

"I spent 30 minutes on the phone with the VA. It seems they don't want to hand out information because of the investigation. Everyone is in the dark. I plan on trying to find a local company that supports vets that will give me a shot," he said.

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2.13 - FedSmith: [VA to Begin Disclosing Agency Secretary's Official Travel](#) (29 September, Ian Smith, 277k online visitors/mo; Washington, DC)

The Department of Veterans Affairs announced today that it will begin publishing all of the agency secretary's official travel on its website.

The lists include all official travel taken by Dr. David J. Shulkin since January 20, and the site will be updated within five days after the conclusion of each trip.

The webpage (which will be available at <http://www.va.gov/opa/secvatravel>) will list the use of private and government aircraft by the Secretary, and also itineraries of international and domestic trips. The details on domestic trips will be added to the website by October 15.

The information posted will also include what VA staff and spouses accompany Shulkin on each trip, if any, but for security reasons, members of the Secretary's security detail will not be listed by name or number.

Shulkin notes that the VA is the first agency to make this kind of data public. The agency also recently began posting all disciplinary actions taken against agency employees on its website in an effort to spotlight actions the agency is taking to reform its culture.

“Under this Administration, VA is committed to becoming the most transparent organization in government, and I’m pleased to take another step in that direction with this move,” Secretary Shulkin said. “Veterans and taxpayers have a right to know about my official travel as Secretary, and posting this information online for all to see will do just that.”

Increased Scrutiny of Agency Officials’ Travels

The announcement from the VA comes right after an article appeared in the Washington Post that was critical of a recent trip that Shulkin took to Europe with several individuals, including his wife, that mixed business and pleasure, the latter part including shopping trips and a Wimbledon tennis match.

The investigation conducted by the Post noted that although all aspects of the trip were approved by the agency, the VA paid for the airfare and meal per diems for Shulkin’s wife. It noted, however, that Shulkin flew on a commercial aircraft with at least one leg of the trip in coach seating.

VA press secretary Curt Cashour told the Post, “These were important trips with our allies to discuss best practices for taking care of veterans. The secretary has been transparent on his down-time activities that were similar to what he would have done with his family over a weekend in the U.S.”

The Post takes at least some credit for the VA now disclosing details about the Secretary’s travel. “In response to questions from the Post, VA announced Friday that the agency will begin posting details of the secretary’s travel online, including itineraries, and disclosing any use of government or private aircraft. That information had not previously been disclosed publicly,” according to the Post article.

The VA’s announcement also comes after news that Health and Human Services Secretary Tom Price came under heavy criticism for trips he took using a private charter jet using taxpayer money. Price has said he will repay the Treasury for costs incurred from the trips and also resigned from his position as HHS Secretary over the situation.

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2.14 - Leavenworth Times: [Sentencing continued for former VA physician assistant](#) (29 September, 46k online visitors/mo; Leavenworth, KS)

A former physician assistant who was convicted of sexually abusing patients at the Leavenworth veterans hospital will not be sentenced until November.

Mark E. Wisner was scheduled to be sentenced today in Leavenworth County District Court. But the sentencing and arguments for post trial motions have been continued until Nov. 3.

Last month, a jury convicted Wisner of one felony count of aggravated sexual battery, one felony count of aggravated criminal sodomy and three misdemeanor charges of sexual battery. The crimes occurred between 2012 and 2014 while Wisner was working at the Eisenhower VA Medical Center.

The judge in the case had something come up, and he had to reschedule all of the cases that were on his docket for Friday, according to Assistant County Attorney Michael Jones.

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2.15 - Pahrump Valley Times: [Plaques at Pahrump VA clinic recognize veterans of U.S. armed forces](#) (29 September, Jeffrey Meehan, 1k online visitors/day; Pahrump, NV)

A group of local veterans of the U.S. armed forces gathered to recognize the installation of several plaques at the Pahrump VA Community Based Outpatient Clinic in September.

Each plaque bore the symbol of one of the five branches of the U.S. armed forces and another was hung for prisoners of war.

The group, led by U.S. Army veteran Bernie Cusimano, gathered at the Pahrump VA clinic at 220 Lola Lane on Sept. 22, 2017 to recognize the plaques being hung. Cusimano was joined by several other veterans who worked to see the plaques hung at the clinic.

"We started it, and I want to acknowledge all the people that started it and thank everybody," Cusimano said.

The group was also joined by Nye County Commissioner John Koenig, District II, former Nye County Commissioner Frank Carbone and Michelle Leavitt, executive assistant/business license tech for the town of Pahrump.

The symbols were hung behind the check-in area at the Pahrump VA clinic in order of the Army, Navy, Marines and the Air Force, from left to right, which is mandatory. The prisoners of war symbol sits on another wall adjacent to the other symbols.

Cusimano said it was the end of the long process.

It took nearly two years for the group to realize the end goal, he said.

Some of the original veterans involved in the process were Pahrump Veterans of Foreign Wars Commander Tom Vick, Cusimano and Kyler Samuel Escalera, just to mention a few.

The cost of the plaques was funded by the town of Pahrump, which cost roughly \$200 each or a total of \$1,200.

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3. Access to Healthcare

3.1 - WBBM (CBS-2, Video): [2 Investigators: Disabled Vets Face Tough Parking At VA Hospital](#) (29 September, Dave Savini, 27.5M online visitors/mo; Chicago, IL)

A major problem at Hines VA Medical Center: Some sick and wounded veterans are struggling to get to their medical appointments because of parking violators.

CBS 2's Dave Savini has the story.

James Dahan, a Marine Corps veteran, gets angry when fellow wounded vets struggle to find a parking spot.

"It's clearly a violation. They need to be ticketed," Dahan says of a vehicle illegally parked near the entrance to the VA.

He says seriously injured veterans going to the Edward Hines, Jr. VA Hospital in Maywood are forced to wheel or walk long distances. This is because parking spots for those with disabilities are taken by motorists not permitted to use them.

"That really ticks me off," Dahan says.

The 2 Investigators found plenty of examples of cars, without required placards in windows, snagging the handicapped-designated spots. Even the lot reserved for spinal cord injury victims had problems. Yet CBS 2 never saw a single ticket issued.

"Seeing veterans pushing from the back of the parking lot with a wheelchair or a walker, it's disgusting," Dahan says. "They deserve a lot better than that."

There is valet service, but those lines can be long and cause delays, he says.

"If you're 15 minutes late, they cancel your appointment," Dahan says.

CBS 2 also found numerous fire lane and loading zone violators, too.

Dahan injured his foot while serving in Iraq. He has had three surgeries and suffers from nerve damage. Because of his time using a wheelchair, Dahan says he can understand how difficult it can be when parking.

"Transferring in and out of a wheelchair takes a lot more than people can understand," he says.

The 2 Investigators found a vehicle parked next to a disabled spot, in a loading zone designed to help a person in a wheelchair get in and out of their vehicle.

"They do that all the time," one driver with disabilities says.

Dahan says Hines VA needs to better patrol the lots and ticket illegal parkers. He also said they need more spaces and could use a parking structure, similar to those found at other hospitals.

A spokesperson from Hines says they are now upgrading the spinal cord lot with new signs and new striping. They are also considering hiring more valet workers, along with opening an overflow lot for employees.

The hospital's full statement:

“At Hines VA Hospital we provide outpatient care to about 2,000 Veterans on an average week day and parking is often their first and last experience with the VA. With several construction projects underway, parking is stretched to its capacity, even with more than 250 handicap accessible parking spaces available. We have 76 accessible parking spaces in our dedicated lot for Spinal Cord Injury rehabilitation. We also offer free valet services to all of our patients.

We are monitoring the parking situation and have recently taken additional steps that include:

- * Making every attempt to complete clinic visits when patients are delayed because of parking
- * Opening an overflow gravel parking lot for employees to help ensure patients and visitors have access to the most convenient spaces
- * Adding signage that identifies where patients can find additional parking and promoting the availability of free valet parking for our patients and visitors
- * Working with our volunteers to provide more frequent shuttles for patients parking in more distant lots
- * Upgrading handicap parking in our Spinal Cord Injury parking lot (additional striping & signage)

We are considering additional valet staff as needed and looking at the possibility of adding another gravel lot on the north end of the campus.

As our construction projects continue to progress, we will continue to inform our patients of any impact on parking areas via on-site signage, direct mail, social media and face-to-face communications.”

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3.2 - The News & Observer: [Vietnam vet happy to be back in Durham's VA hospital, but for how long?](#) (29 September, Thomasi McDonald, 3.9M online visitors/mo; Raleigh, NC)

DURHAM - A Vietnam veteran and double-amputee said things are “perfect” now that he is back in Durham’s Veterans Administration Medical Center, where he has lived for a little more than three years.

But James Donald Francis, 69, said he’s worried because VA officials have not told him or given him any documentation about how long he will be able to stay at the VA’s Community Living Center.

“I haven’t signed anything,” he said. “I could be here for a good night’s sleep and the next morning they could put me out of here. I haven’t seen anything. I’m in limbo. That’s where I am.”

Francis spent two days this week staying in the lobby of the facility. He refused to leave when the VA told him he had to go to an assisted living facility.

Durham VA officials have not commented about where Francis will be staying in the future, except to say it probably won’t be at their facility.

A statement from the Durham VA on Friday afternoon said, "Prior to release, we provided Mr. Francis several assisted living options within the community, however, over time it became apparent that he did not feel comfortable with those choices and wished only to remain at Durham VA. Medical care and treatment is ever-changing and that transition at times can be very difficult for our patients. We will continue to work side-by-side with Mr. Francis to provide him the proper care he has earned and deserves while we search for a suitable follow-on solution that meets his health and social needs."

Francis lost his legs after he was stricken with Agent Orange-related diabetes while fighting in Vietnam.

Sharonda Pearson, a Durham VA spokeswoman, said Francis, who undergoes dialysis treatment three times a week at the VA hospital, no longer met the medical criteria for acute in-patient care. He was discharged Monday. Francis said he returned from dialysis that day to find the door to his room locked and his belongings stuffed in several bags.

Francis then camped out in his motorized wheelchair at the patient entrance from Monday until Wednesday. By late Wednesday afternoon, the VA had a change of heart and said he would be allowed to move back into the hospital's community-based living center, at least momentarily.

The combat veteran is currently living on the second floor of the Community Living Center.

"Everything is going fine right now, for the next five minutes," he said Thursday. "You know how things can change."

He said he has been able to assume the daily routine he had before his discharge Monday.

According to the U.S. Department of Veterans Affairs website, the Community Living Center resembles "home" as much as possible. There are activities for veterans of all ages and family friendly places for visiting. Veterans are invited to decorate their rooms, and pets are allowed to visit or live at the facility.

The website said veterans may stay for a short time or, in rare instances, for the rest of their life, while receiving a nursing home-level of care that includes help with activities of daily living such as bathing and getting dressed.

On Thursday, a nurse visited Francis' room, provided him with a bedpan and rolled him to the side so he could relieve himself. The nurse, after bathing and clothing him, hoisted Francis out of bed and into his wheelchair. He rolled into the bathroom to brush his teeth and shave before going to breakfast. He was given an insulin shot, and his blood sugar level was checked for the first time since Monday.

"I been listening to the blues, but mostly talking to people here who I hadn't seen. It's been pretty much a normal day," he said. "But once I go to the bathroom and come out, I don't know if my bags are going to be packed up or what."

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3.3 - Newsday (Video): [House vet chair Roe tours Northport VA after maintenance issues](#)
(29 September, Martin C. Evans, 3.2M online visitors/mo; Melville, NY)

The head of the House Committee on Veterans Affairs came to Long Island for an up-close look at the troubled Northport VA Medical Center Thursday, saying the facility should “find the right size” to address maintenance problems straining its budget and impacting patient care.

“That’s the challenge we have, is how to provide the most economic care because money is not infinite, it is finite and budgets are tight,” said Rep. Phil Roe (R-Tenn).

Roe said he decided to visit the medical center because of reports of serious problems with maintenance at the nearly 90-year-old facility.

Roe, a physician himself, said Northport would benefit from centralizing its operations into a few core buildings, as well as pushing more of its clinical operations into satellite facilities scattered across Long Island.

The lawmaker spent about three hours touring the Northport facility, which includes more than 70 buildings, including dozens that are mostly unused. Roe was accompanied by Reps. Thomas Suozzi, (D-Glen Cove) and Lee Zeldin, (R-Shirley), and Northport director Scott Guermonprez — all of whom said they could support the concept of consolidation.

Thursday’s congressional visit also came on the heels of two internal VA investigations which concluded that repeated lapses in the facility’s engineering department led to a host of problems at Northport.

Among those problems was the failure of an air-conditioning unit at Northport’s main hospital building, which forced a months-long closure of its surgical facility, and meant that veterans requiring emergency surgery had to seek treatment at VA hospitals in Manhattan or the Bronx.

The reports also concluded that the failings of the engineering department at Northport were a financial drain on a facility already struggling against recent budgetary shortfalls.

Northport has long been viewed with near reverential regard among the area’s roughly 140,000 veterans, who typically laud its medical care for its quality and availability.

But in the past two years, veteran leaders have expressed increasing alarm over the physical condition of the medical center.

Hutch DuBosque, president of the PTSD Veterans Association of Northport, whose members use the facility for self-care meetings, said mold caused by leaking roofs and frequently-flooded underground walkways has forced his group to move therapy sessions because of respiratory distress twice in the past three months.

“Our concern is the toxic environment,” said DuBosque. “A lot of us older guys have respiratory problems, and we can’t take this stuff.”

Guermonprez, a retired Air Force officer, came on as Northport’s new director in late June, expressed agreement that some of Northport’s maintenance problems could be mitigated by consolidating to fewer buildings.

Roe said he was encouraged that Guernonprez had initiated staffing changes in the leadership of Northport's engineering, nursing and medical staff.

"I think he is headed in the right direction," Roe said.

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3.4 - Stars and Stripes: [Stage set in Congress for debate on Choice program reform](#) (29 September, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

The Department of Veterans Affairs estimated the funds that allow veterans to receive health care in the private sector will last until the end of the year – a projection that establishes a new deadline for when Congress needs to come up with a long-term solution for the Veterans Choice Program.

President Donald Trump signed legislation Aug. 12 immediately providing \$2.1 billion for the Choice program to prevent a funding crisis. VA Secretary David Shulkin had told lawmakers in June that the account was quickly and unexpectedly running out of money because of increased demand. Now, the money – originally estimated to last until February 2018 – is again being spent faster than predicted.

Shulkin told reporters Wednesday that he's confident Choice funding will last at least through the end of the year and rebuked a report from The Associated Press that the program would run out of money as early as December. The VA is spending about \$280 million each month to send veterans into the private sector for health care, he said.

"It's a very, very hard program to do accurate financial projections," Shulkin said. "We've always said it's important that Congress needs to act this fall, this legislative session so we do not get into a funding crisis."

Sen. John McCain, R-Ariz., sent a letter to Shulkin on Wednesday asking for an accounting of the program, expressing concern about another unexpected shortfall. McCain helped create the Choice program in 2014 in response to the VA wait-time scandal that originated at the Phoenix VA hospital.

Tiffany Haverly, communications director for the House Committee on Veterans' Affairs and the group's chairman, Rep. Phil Roe, R-Tenn., said Roe's office is receiving regular updates on Choice program spending. At the same time, the House committee is working on legislation to reform how the VA balances private-sector care, Haverly said Friday.

"We are continuing to monitor the account and working to move legislation to reform VA's community care programs so veterans can continue accessing care should funding be expended sooner than expected," she said.

House and Senate lawmakers undertook reform efforts following complaints from veterans that the Choice program is complex and bureaucratic. Current rules allow veterans to seek care outside the VA only if they can't receive an appointment within 30 days or they live more than 40 miles from a VA facility.

Shulkin said Wednesday that in order to avoid another funding shortfall, he wants legislation passed before Congress leaves for Thanksgiving break in mid-November.

"I expect we will get this done," he said. "We are in close communication with Congress and the White House on this. No one wants to see us putting veterans at risk."

It's expected the House and Senate will introduce their versions of Choice program reform in the next few weeks.

Shulkin has devised his own proposal, which is under review by the White House Office of Management and Budget. An early discussion draft of Shulkin's proposal describes a performance-based system in which veterans would be allowed to seek private-sector health care if the quality of VA care in a certain area isn't up to par with other providers in that community.

The issue is likely to be subject to intense debate about whether the VA is sliding too far into the private sector.

When the legislation was introduced in the summer to provide \$2.1 billion to the Choice program, eight major veterans groups railed against it. Then, they successfully pushed for another \$1.8 billion to be included in the legislation for VA hiring and infrastructure. The coalition -- comprising AMVETS, Veterans of Foreign Wars, Disabled American Veterans, Iraq and Afghanistan Veterans of America and other groups -- viewed the original plan as prioritizing private-sector health care while neglecting VA services, and as setting a dangerous precedent.

In preparation for the Choice reform debate, groups on each side of the political divide have already started advocacy efforts.

VoteVets, a left-leaning political action committee, ran a \$400,000 ad campaign in September pleading with viewers to "Tell Congress, don't let Trump privatize my VA." The advertisement aired in Alaska, Florida, Kansas, Louisiana, Maine, Minnesota, Montana, Nevada, Ohio, South Dakota, Tennessee, Texas and West Virginia.

Concerned Veterans for America, a conservative veterans advocacy group in the Koch brothers' political network, is also speaking out. The group, which gained more influence since the presidential election, has lobbied to transfer VA oversight to a government-chartered nonprofit and expand veterans' private-sector health care options.

"The Trump Administration and Congress should not be dissuaded from keeping their campaign promises to offer veterans more health care choices by Washington special interests that want to preserve the status quo at the VA," said Dan Caldwell, the policy director for CVA. "There is no excuse for Congress not to put forward a VA choice reform plan that would give all veterans who use the VA the ability to access care in the private sector."

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3.5 - WNDU (NBC-16, Video): [New VA clinic in Mishawaka will 'quadruple services'](#) (29 September, Mark Peterson, 833k online visitors/mo; South Bend, IN)

Ribbon cutting ceremonies in Mishawaka on Friday marked the completion of a \$38 million medical clinic for veterans.

About ten years ago, the Veterans Administration was first asked to study how often local vets had to travel long distances to get needed medical care.

"I'll be able to come here for my eye appointments, I'll be able to come here for my hearing appointments, and those are all things I have to go to Fort Wayne for," said veteran Chuck Damp.

"So we have most every medical every medical service you could possibly think of," said Sen. Joseph Donnelly, (D) Indiana. "Mental health services, audiology, cardiology, so many things are here for our veterans."

"The services that are provided out of here really kind of quadruple what the services were available in Michiana before," added U.S. Rep. Jackie Walorski, ® Indiana's Second District.

The hope is, with all those additional medical services available closer to those who served, trips to the doctor will no longer be something local vets dread, and could become something they grow to love.

"They said this is our home, I mean, besides being home with their family, this is their second home, with their brothers and sisters who served together with them, meeting other veterans," said Sen. Donnelly.

Veteran Chuck Damp agrees: "It's going to be so much better than veterans having to travel, like I said, Fort Wayne, Indianapolis, Marion. It's right here, right in our neighborhood."

Sen. Donnelly noted how dramatically things have changed in the past ten years when the local VA clinic was housed on the south side of South Bend in a residential neighborhood, in a building no bigger than a house.

The new facility at 1540 Trinity Place has a coffee and sandwich shop tucked away near the front entrance. A spacious lobby has high ceilings with skylights.

"I talked to so many veterans, outside as we all came rushing in the door and you could hear the ooh's and the ah's and the excitement of something that's been promised for so long, it's taken years to actually make this happen," said Rep. Walorski.

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3.6 - WNDU (NBC-16, Video): [Sen. Joe Donnelly on tax overhaul, health care and new VA clinic](#) (29 September, Jason Krug, 833k online visitors/mo; South Bend, IN)

President Donald Trump visited Indianapolis on Wednesday, pitching his tax overhaul plan.

Traveling with the president from Washington D.C. that day was Sen. Joe Donnelly.

A question some had is why the Democrat would travel on Air Force One with the Republican president.

"He's the President of the United States and whether the president was President Bush or President Obama or President Trump, I try to show respect to the position," says Donnelly on 16 Morning News. "When I have a chance to come back to my home state and to be with everybody from Indiana and welcome the president, I try to do so."

When it comes to Trump's new tax plan, there is still a lot of details to be filled in according to Donnelly, but there a few things he is working to make sure happens.

"My focus has been on keeping jobs that are here, here, making sure we create more jobs and more opportunity and making sure that middle class families' paychecks get a little bit bigger."

Republicans moved their focus to a tax overhaul after failed attempts to repeal and replace the Affordable Care Act, the latest try falling apart earlier this week. Donnelly says it did not come as a surprise to him.

"It was a terrible bill that would have taken health care away from over 400,000 Hoosiers. But I've been working behind the scenes with about 31 other senators on some bipartisan legislation that we're trying to bring up next week that I think has a great chance of passage that'll stabilize our health care programs."

The Senator also briefly touched on the new VA clinic in Mishawaka, something that he has been working 10 years to help complete. It opened last Monday, but Friday is its grand opening.

"The reason it's such a great thing is because it helps our vets and they deserve everything."

The facility is opening in three phases over the next two months, and is expected to see over 8,500 veterans per year.

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3.7 - WFLA (NBC-8, Video): [Veteran suicides, VA corruption focus of rally and protest](#) (29 September, Steve Andrews, 702k online visitors/mo; Tampa, FL)

PINELLAS COUNTY, Fla. — In the United States, 22 veterans take their lives every day.

In front of the Veterans Affairs office at Bay Pines, 22 mannequins stood to serve as a reminder of this American tragedy.

Army veteran Mike Ford admits he's come close to ending his life.

"Idea was to just go ahead and just kill yourself on V-A property right, maybe if they see, if maybe people like, wow, there's something really going on here," he told News Channel 8.

Ford was diagnosed with post-traumatic stress disorder after serving in Grenada and claims he suffered physical and mental pain for years while struggling with the VA for treatment.

After waiting nine months for an appointment, Ford left his ailing father to drive across the state to finally see a doctor at the VA.

"I go there, oh you didn't get our message, we canceled your appointment," Ford recalled.

When Ford returned home, his father was gone.

"Wasting my time with the VA when I should've been with my father. He was my hero," he said.

"If I was going to kill myself, it was going to be out here," another veteran Keith Hansford said as he pointed to the grounds at Bay Pines.

Hansford also struggles with PTSD, and said sometimes he thinks he would welcome death. "My pain, my anxiety, my nightmares all of that will stop," Keith explained.

According to Hansford, harassment by Bay Pines Police administration while he worked there, pushed him to the brink.

Hansford has organized rallies condemning police corruption and promoting suicide awareness.

In August, we told you VA police removed signs promoting Keith's rally, which were placed on a state right of way. We helped him get them back.

Hansford believes without his wife, he'd be gone.

"I'm not stronger or weaker than the ones that have killed themselves. I just had the right help at the right time," said Keith. "The help they needed didn't come when they needed it."

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3.8 - Modern Healthcare: [VA looks to ease telehealth regulations](#) (29 September, Rachel Z. Arndt, 460k online visitors/mo; Chicago, IL)

The Veterans Affairs Department proposed a rule Friday that would allow VA providers anywhere in the country to conduct telehealth visits with VA patients across state borders, regardless of state licensing.

Giving patients access to providers across state lines is necessary for the VA to grow its telehealth program and increase the number of sites where the VA provides care, wrote Michael Shores, director of regulation policy and management in the VA secretary's office. This rule would amend VA medical regulations to do so. "Eliminating veteran suicide and providing access to mental health care is VA's number one clinical priority, and this proposed rulemaking would improve VA's ability to reach its most vulnerable beneficiaries," Shores wrote.

In fiscal 2016, VA providers saw 702,000 patients via telemedicine in 2.17 million episodes of care. Nearly half of those who received telemedicine care live in rural areas.

"By increasing VA's capabilities to provide telehealth services, VA would be able to expand these services," Shores wrote.

The rule would complement the VA's push to increase the use of technology in veterans' healthcare, an effort VA Secretary Dr. David Shulkin called "anywhere to anywhere VA healthcare" when President Donald Trump announced the initiative in August.

Right now, VA telehealth care is limited by state restrictions. If a physician were to see a patient via telemedicine in a state in which the physician is not licensed to practice, that physician could lose his or her credentials and be fined.

Under the proposed rule, physicians wouldn't be penalized for providing telemedicine outside the states where they're currently allowed to practice.

A federal rule is necessary to relax these restrictions because it would take too long for every state to nix the penalties, according to Shore.

"While the VA's rule is limited, in that it would apply only to VA providers and VA patients, it could be the first step towards a national medical practice licensing concept," said Nathaniel Lacktman, a healthcare lawyer with Foley and Lardner. "Overall, I predict providers will look upon this new rule favorably."

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3.9 - KMVT (FOX-14, Video): [As Suicide Prevention Month comes to a close, the search continues for solutions to veteran suicide](#) (29 September, Peter Zampa, 71k online visitors/mo; Twin Falls, ID)

WASHINGTON (Gray DC) -- Suicide prevention month is highlighting how the U.S. Can better address the issue. A specific focus currently in Washington is a push to end veteran suicide. Senators are examining what is being done to help veterans in need, and what other efforts are necessary.

One veteran says it is not easy to solve this tragic problem.

"There's such a stigma with mental health," said Kayda Keleher, Associate Director at Veterans of Foreign Wars.

20 veterans take their own lives every day. As Suicide Prevention Month comes to a close, Keleher says addressing mental health for all Americans is the right approach to getting these veterans the help they need.

"We have to get to a point where we better understand it, and we're definitely working on that," said Keleher.

She served in the Marine Corps for five years. It's an issue dear to her heart. She says great strides are being made in areas like telehealth, but there is much more work to be done, especially helping veterans in rural areas.

"It's important that we don't forget about the basics. The proven, empirically proven, necessities of face-to-face therapy options and just being there for one another as veterans," said Keleher.

The Senate Veterans' Affairs Committee held a hearing to look at what the VA is doing to combat veteran suicide. Senator Dan Sullivan (R-AK) sits on the committee and is currently in the Marine Corps reserves. He says as a country, we need to be able to get help to every veteran in the U.S.

"I lost one of my Marines to suicide, you know, after he reached out to me. It's a very hard issue," said Sullivan.

Sullivan says key parts of the hearing with VA Secretary David Shulkin were the ability to identify mental health issues and to reach veterans in remote areas who require help. Senator Joe Manchin (D-WV), who also sits on the committee, says the VA has a shortage in qualified mental health specialists.

"We need help. We need professionals. We need psychiatry help, we need to be able to get these people and give them the assistance they're needing," said Manchin.

The senators say implementing these new ideas will be key in saving lives. If you or someone you know is a veteran struggling with suicidal thoughts you can dial 1-800-273-8255 and press one.

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3.10 - mHealth Intelligence: [New Rule Would Give VA Doctors National Telehealth Privileges](#) (29 September, Eric Wicklund, 53k online visitors/mo; Danvers, MA)

The Department of Veterans Affairs is moving forward with a plan to enable VA doctors to treat veterans through telehealth no matter where the doctor or patient are located, essentially overriding state laws.

Officials said the 28-page proposed order, unveiled on Sept. 29 under the VA's Anywhere to Anywhere VA Health Care Initiative, aims to boost the number of veterans using telehealth and telemedicine to access needed healthcare services, especially mental health services. It would give VA doctors the authority to use telehealth and telemedicine to treat veterans regardless of state guidelines on originating sites or licensing requirements.

It also could be seen as a veiled criticism of the mishmash of state laws regulating telehealth and telemedicine, which often do more to curb new healthcare services than promote them.

"In an effort to furnish care to all beneficiaries and use its resources most efficiently, VA needs to operate its telehealth program with healthcare providers who will provide services via telehealth to beneficiaries in states in which they are not licensed, registered, certified, or located, or where they are not authorized to furnish care using telehealth," the proposed order states. "Currently, doing so may jeopardize these providers' credentials, including fines and imprisonment for unauthorized practice of medicine, because of conflicts between VA's need to provide telehealth across the VA system and some states' laws or licensure, registration, certification, or other requirements that restrict or limit the practice of telehealth. A number of states have already enacted legislation or regulations that restrict the practice of interstate telehealth, as discussed below in the Administrative Procedure Act section."

As a result, VA officials say, many VA centers aren't expanding their telehealth and telemedicine programs to non-federal locations, such as the patient's home or the doctor's home. And VA doctors are reluctant to take on telehealth for fear of running into conflicts with state laws.

"This proposed rulemaking would clarify that VA healthcare providers may exercise their authority to provide care through the use of telehealth, notwithstanding any state laws, rules, or licensure, registration, or certification requirements to the contrary," the proposed rule states. "In so doing, VA would exercise federal preemption of state licensure, registration, and certification laws, rules, regulations, or requirements to the extent such state laws conflict with the ability of VA healthcare providers to engage in the practice of telehealth while acting within the scope of their VA employment."

"Preemption would be the minimum necessary action for VA to furnish effectively telehealth services because it would be impractical for VA to lobby each state to remove its restrictions that impair VA's ability to furnish telehealth services to beneficiaries and then wait for the state to implement appropriate changes," the rule continues. "That process would delay the growth of telehealth services in VA, thereby delaying delivery of healthcare to beneficiaries. It would be costly and time-consuming for VA and would not guarantee a successful result."

According to the VA, some 702,000 veterans, or 12 percent of the country's veteran population, used telehealth or telemedicine in FY 2016, accounting for 2.17 million telehealth episodes. Of that group, 45 percent were living in rural communities.

"The data collected in FY 2016 demonstrates that telehealth, particularly in the mental health context, improves patient care and improves patient outcomes," the proposed order points out. "In FY 2016, there was a 31 percent decrease in VA hospital admissions for beneficiaries enrolled in the Home Telehealth monitoring program for non-institutional care needs and chronic care management. Also, beneficiaries who received mental health services through synchronous video telehealth in FY 2016 saw a reduction in the number of acute psychiatric VA bed days of care by 39 percent."

Other benefits, the VA said, include improvements to remote monitoring for veterans with limited mobility or difficulties traveling to a healthcare provider, and its use as an incentive to recruit more VA healthcare providers, thereby reducing a national shortage.

The proposal surfaced when VA Secretary David Shulkin unveiled the Anywhere to Anywhere VA Healthcare Initiative in August, in a ceremony attended by President Donald Trump. At that time he also announced the nationwide roll-out of the Veteran Appointment Request (VAR) app, which allows veterans to use their smartphone, tablet or computer to schedule or modify appointments at VA facilities.

"What we're really doing is, we're removing regulations that have prevented us from doing this," he said. "We're removing geography as a barrier so that we can speed up access to Veterans and really honor our commitment to them."

Shulkin garnered support from, among others, the American Telemedicine Association – which has scheduled him as a keynote speaker at its ATA Edge conference next week in Washington D.C. – and Sen. Joni Ernst (R-Iowa), whose bill, the Veterans E-Health & Telemedicine Support (VETS) Act of 2017, seeks to give VA doctors that same authority.

“The VA’s decision to allow veterans to access care from the comfort of, or closer to, their own homes is necessary to improving quality and timely care for the more than 200,000 veterans in Iowa, particularly those who are disabled or reside in rural communities,” Ernst, a National Guard veteran, said. “It is critical that we continue to create opportunities for veterans to receive the best care out there, including potentially life-saving mental healthcare. Improving the VA’s telehealth program is critical, and I am thrilled to see this common-sense measure will be put into action to benefit Iowans and veterans across the country.”

The industry trade group Health IT Now also supports the measure.

“This proposed rule will be instrumental in breaking down geographic barriers that, for too long, have prevented our nation’s heroes from accessing the care they need where they need it,” Joel White, the group’s executive director, said in a Sept. 29 blog post. “By allowing VA telehealth providers to more easily treat patients across state lines, we can ensure that recent advances in technology-enabled care reach the most deserved among us and spur better outcomes for the 20 million veterans in the VA system today.”

Supporters also say the success of such a program could help spur efforts to create a national licensing framework for healthcare providers, such as the Interstate Medical Licensure Compact for doctors and similar compacts for nurses and physical therapists. It might also spur state medical boards to collaborate more freely on national telehealth and telemedicine standards.

But the proposal may draw complaints from state officials and national physicians’ groups interested in preserving each state’s right to regulate telemedicine and telehealth inside its borders.

During Congressional deliberation last September on the National Defense Authorization Act for FY 2017, the American Medical Association and American Academy of Family Physicians lobbied against a telehealth benefit for the TRICARE program that would have designated the originating location for certain telehealth services to be the physician’s location, instead of the patient’s location. They argued the legislation would enable physicians treating military personnel and veterans to skip state licensing laws when treating patients via telehealth.

In a Sept. 1 letter to Congressional leaders, AAFP Board Chairman Robert L. Wergin, MD, warned that the Senate version of the bill “portends a troubling scenario under which state licensing boards will lack the authority to discipline physicians who are practicing medicine within that state’s borders.”

“While this language would indeed ease barriers that hinder the free flow of telehealth services, it also would undermine the existing system of medical licensure, under which each state governs the practice of medicine within its borders,” Wergin wrote. “Allowing physicians with a single license to treat TRICARE beneficiaries in any state via telemedicine would create episodes of medical care that the state in which the patient resides cannot readily regulate, if at all.”

The Defense bill was eventually passed without the telehealth provision.

The proposed order is scheduled to be published in the National Register on Monday, Oct. 2. The public comment period will last 30 days.

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3.11 - WLTZ (NBC-38, WSB/ABC-2, Video): [Hospital Evacuees from Caribbean Arrive in Atlanta](#) (28 September, Nami Dockery, 44k online visitors/mo; Columbus, GA)

Cobb County, GA – Hospital patients evacuated from the Caribbean due to hurricane Maria are finding refuge in Georgia.

Doctors and nurses welcomed the patients after a plane carrying roughly 40 medical evacuees landed Wednesday night.

It comes after the hurricane caused widespread power outages, including a loss of electricity at hospitals.

A VA Medical Center official says medics will triage the patients to ensure proper care.

Some evacuees will travel to Atlanta area hospitals, while others will stay in hotels.

Three flights carrying evacuees have landed so far, and more are expected over the next few days.

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3.12 - Marion Republican: [Bost 'not happy' with VA investigation; vows to look further into allegations at Marion VAMC](#) (29 September, Holly Lee, 14k online visitors/mo; Marion, IL)

The conclusion of a Veterans Affairs inquiry into allegations of nepotism, employee intimidation and why some patients died at the VA Medical Center in Marion leaves one southern Illinois congressman "not happy" with the answers and vowing further action.

Rep. Mike Bost (R-Murphysboro), vice chairman of the Oversight and Investigations subcommittee of the House Committee on Veterans Affairs, said he doesn't believe the VA's investigation into complaints at the Marion VA Hospital went far enough.

Bost received the VA's analysis Sept. 22, about two months after his initial inquiry. Neither he nor the VA has made the Sept. 22 report public, citing the privacy of individual veterans mentioned within.

Even so, Bost said, he was "really not happy with the response," especially the VA's explanation for the deaths associated with the 54-bed Community Living Center, the nursing home facility on the VA campus. He characterized the VA's overall answers as "vague," with no real plan for correcting issues going forward, and "almost like they aren't sure these issues are that big of a problem."

Neither the Department of Veterans Affairs nor the Marion VA responded to calls for comment on Bost's criticisms.

Bost said that for the most part, "the Marion VA does a good job and people like them." The Marion VA provides care to nearly 44,000 veterans annually in 27 southern Illinois counties, as well as eight counties in southwest Indiana and 17 in northwest Kentucky. It also operates 10 outpatient clinics around the region.

"We just need more answers than we are getting," Bost added. "The incidents we have been hearing about ... I think they need to be looked into more."

Bost said his first step will be to discuss his concerns with the VA report in a face-to-face meeting with VA Secretary David Shulkin. If he is not satisfied with those answers, he said, he and subcommittee Chairman Jack Bergman (R-Michigan) could proceed with a congressional hearing. There, the committee would call its own witnesses.

In July, Bost and Bergman wrote to Shulkin asking for information on specific allegations related to the Marion VA Hospital. They also questioned why the results of a 2016 employee "culture" survey at Marion, routinely done at all VA facilities every two years, was so dramatically worse than the one taken in 2014, specifically in the areas of patient safety and employee morale.

The allegations Bost and Bergman asked the VA to investigate include:

- Reported staff concerns about patient safety that either "disappeared" or did not make it up the chain to the VAMC director;
- Why the Veterans Integrated Service Network (VISN) did not fully investigate complaints from Marion VA employees, despite calls by the VA National Center for Patient Safety to do so;
- The deaths of 15 veterans since October 2016, either while they were patients in the Community Living Center or shortly after discharge, and whether inadequate care played a role in any of them;
- Reports of "retaliation, unprofessional conduct and bullying" toward employees by Marion leadership;
- That one Marion administrator is alleged to have hired his wife as an administrative officer for the surgery department.

Bost said he and Bergman are hoping to get their meeting with Shulkin within two weeks. If a congressional hearing follows, he said it would include ranking members of both parties.

"This is a huge concern," Bost said, adding the Marion VA is not the only one in the nation undergoing scrutiny at the moment. In May 2016, Bost sponsored a bipartisan House bill addressing the issue of VA medical centers operating without permanent directors -- an instability that makes it more difficult to implement long-term reforms affecting patient care. That bill, which passed the House unanimously, is now in the Senate.

"Continual uncertainty at the top of any organization is destructive, and it certainly makes it tougher to fix problems," he said.

The Marion VA has had three directors in about five years. That's not as big a turnaround as at some VA hospitals, Bost said, but not as consistent as he would like.

"I want to make sure that all of our VAs are operating at a certain level, and taking care of our veterans, our heroes," he said. "With the problems in the VA around the nation, we need a response. This is not the last chapter."

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4. Women Veterans

4.1 - The Mercury: [Expo will focus on women entrepreneurs and female veterans](#) (29 September, Donna Rovins, 187k online visitors/mo; Pottstown, PA)

Phoenixville >> A unique expo highlighting women entrepreneurs and female veterans is scheduled for Saturday, Oct. 7, at Phoenixville Area Middle School.

The 2017 Women Entrepreneur & Women Veteran Expo will give women from different business areas the opportunity to connect with each other to educate, share information and inspire other women to become business owners, according to organizer Dolores Winston, founder and CEO of Here to Apparel. The online shop specializes in sports attire and souvenirs that promote positive thinking, according to the company's website.

"We're bringing women entrepreneurs and women veterans together to spend the day connecting with each other and supporting each other," Winston said. "This is about sharing the knowledge to help another woman."

Winston said she had organized an entrepreneur expo in 2011. But this year's event is different because it focuses on women entrepreneurs and women veterans.

The expo will include panel discussions, the opportunity to visit with vendors promoting products and services, the chance to network with potential new customers and entertainment. At the end of the day, the group will name a woman entrepreneur of the year from the Phoenixville area. That award will be presented by state Rep. Warren Kampf, R-157th Dist.

"My dream is to bring women entrepreneurs together. On this day motivated women will share, educate, encourage, inspire, and rejuvenate us to bring out the best in ourselves," Winston said on the website for the event.

A highlight of the event, according to Winston, will be the presentation of two youth entrepreneurs: Jenna Swymelar, a fifth grade student at Renaissance Academy Charter School in Phoenixville and Jessica Meyers, a fifth grade student at Schuylkill Elementary School in Phoenixville.

Winston said the young entrepreneurs will present their businesses to the group. Swymelar has a business called Sweet Dream Pillows by Jenna, while Meyers' business is balloon creations.

Keynote speaker for the event will be Dr. Betty Moseley Brown, associate director, Center for Women Veterans at the Department of Veterans Affairs in Washington, D.C., and 19th president of the Women Marines Association.

"I met her at an event in Indiana, and when she heard what we were doing in bringing women entrepreneurs and women veterans together, she wanted to be part of it," Winston added.

Another speaker will be Jason Raia, executive vice president of the Freedoms Foundation of Valley Forge, a national educational non-profit that encourages "engaged, responsible citizenship," according to the organization's website. Winston said Raia will speak about the organization's youth outreach.

Two panel discussions will be held during the day. The first will feature six Phoenixville-area businesswomen, who will share stories about starting their own businesses.

The second panel discussion will focus on empowerment. Winston said the group of five women, "come from different areas of experiences and we'll share what we're doing and how we're empowering women," she said.

In addition to Kampf's presentation of the Woman Entrepreneur of the Year award, citations will be presented to the winner by state Sen. Andrew Dinniman, D-19th Dist., and U.S. Rep. Ryan Costello, R-6th Dist.

The event will be held from 2-7 p.m. Oct. 7 at the Phoenixville Area Middle School, 1000 Purple Pride Parkway in Phoenixville. Winston said more than 20 vendors have signed up to attend will attend the event. The 2017 Women Entrepreneur & Women Veteran Expo is free, and while registration is not required, people planning to attend can register at <https://weexpo.eventbrite.com>.

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4.2 - KSFY (ABC-13, Video): [Sioux Falls conference puts spotlight on women veterans](#) (29 September, 4k online visitors/day; Sioux Falls, SD)

The annual Women Veteran Conference was held Friday in Sioux Falls.

The event was put on by the Sioux Falls VA.

About 86 women veterans attended this year's event.

Organizers said it is important to recognize women veterans and honor their service and sacrifice.

"They tend to be invisible and under recognized by the general public, by VA staff, by other veterans, and so this is just a way to bring them into the spotlight and say 'thank you,'" Brenda Fredericks, Women Veteran program manager, said.

The event also featured artwork by women veterans. The artwork is traveling around to different VA centers throughout the country.

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5. Appeals Modernization

6. Strategic Partnerships

7. Supply Chain Modernization

7.1 - WFED (AM-1500): [VA close to awarding Cerner contract for new EHR](#) (29 September, Nicole Ogrysko, 831k online visitors/mo; Washington, DC)

The Veterans Affairs Department is preparing to award its contract with Cerner Corporation for a new electronic health record in the next month or so.

The award comes after the department announced its decision abandon its own, existing Veterans Information Systems and Technology Architecture (VistA) and adopt MHS Genesis, the same EHR system that DoD is deploying. All patient data will reside in one common Cerner Millennium system.

“We released to Congress, to you, a 30-day notice of award of a contract,” VA Secretary David Shulkin said of the EHR during Wednesday’s Senate Veterans Affairs Committee hearing. “We are keeping on the timeline that we talked about. We’re marching forward. We have the principles. I have some updates to share with you on the strategic IT plan, because I think we are making a lot of progress with that.”

Shulkin signed a “determination and findings” (D&F) form back in June, which grants special permission for VA to issue a direct solicitation to Cerner Corporation for the acquisition of MHS Genesis.

Initial discussions with Cerner were expected to take three to six months, Shulkin said when he announced his decision in early June.

Shulkin said part of the department’s IT strategic plan will include a sunset of 80 percent of VA’s current projects under development.

“By concentrating on some specific IT modernization initiatives, like [electronic health record modernization, financial management business transformation], etc., and leveraging cloud and digital platforms, the 80 percent reduction of ongoing development projects is expected to occur within 18 months, which is part of the overall IT modernization roadmap,” VA Press Secretary Curt Cashour wrote in an email.

VA will migrate or stop 240 out of 299 current projects, Cashour added.

A government source familiar with VA said the department is ending development on projects that aren’t going anywhere. The plan is shift those funds to the new EHR, the source said.

It’s still unclear just how much the new electronic health record will cost, but VA’s IT office faced a \$215 million budget cut in the president’s fiscal 2018 proposal.

Shulkin told lawmakers in May that he'd likely need to return to Congress to work with appropriators after he decides on the department's direction for a new EHR.

The EHR project is a massive undertaking for VA. The department has more than 100 versions of VistA. Those versions exist because VA hospitals largely had the freedom over the past 40 years to change the software to conform to the standards their leaders and doctors wanted to see, former VA IT executives have said.

The department has also outlined the broad principles it envisions it will need in a new EHR, in addition to the other tools and pieces it may need to complement the Cerner system.

"We haven't gotten to defining which specific tools they are yet, and how we're going to meet those needs," Shulkin said. "We've talked about the days of VA being a software developer are over, and we're going to be looking at off the shelf, current technologies. There's going to be a lot more definition on that."

This all comes as the VA's current chief information officer and acting assistant secretary for information and technology, Rob Thomas, announced his retirement next month.

Thomas, who has 35 years of federal experience, took on the CIO position in January, after Laverne Council left because of the change in administration.

VA has been struggling to fill the position since then. Shulkin said during a June budget hearing that a candidate for the CIO position withdrew his name but did not offer a more detailed expansion.

"I need help," Shulkin told reporters after Wednesday's hearing when asked about the leadership vacancies. "This is a big, complex organization. I need the best team possible. I need my nominees, all my political appointments to clear through the vetting process and then to go through their confirmation if it's required. And I need additional people from the private sector who want to come and serve their country to get in touch, because we need the A team on this."

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8. Other

8.1 - ABC News (AP): [The Latest: John Kelly given authority over Cabinet travel](#) (29 September, 24.1M online visitors/mo; New York, NY)

The Latest on Health and Human Services Secretary Tom Price's resignation from the Trump Cabinet (all times local):

7:45 p.m.

The White House is giving chief of staff John Kelly authority to sign off on government travel on government-owned, rented, leased or chartered aircraft.

The change comes after Tom Price resigned Friday as President Donald Trump's health secretary over his costly travel.

White House budget director Mick Mulvaney has issued the new guidance, reminding the heads of executive branch departments and agencies that they are public servants and that every penny they spend comes from taxpayers.

Mulvaney tells Cabinet secretaries and department heads to consider whether commercial travel would be a more appropriate use of public funds even when the guidelines allow for the use of government-owned or chartered aircraft.

Mulvaney says that just because something is legal doesn't make it right.

5:55 p.m.

The resignation of Tom Price as secretary of Health and Human Services is drawing partisan responses from Republican and Democratic lawmakers.

Price resigned Friday amid investigations into his costly travel on charter flights.

The Republican House speaker, Paul Ryan, is praising Price, saying that the former Georgia congressman and House Budget Committee chairman is a "good man."

The top House Democrat, Minority Leader Nancy Pelosi, says Price should never have become health secretary because the country needs someone in the job "who believes in health care for all Americans."

Pelosi says President Donald Trump should pick a replacement who will stop the administration's sabotage of health care programs.

Price has been a top Democratic target because he's been a point man in Trump administration efforts to scrap and undermine "Obamacare."

[...]

12:01 p.m.

The secretary of the Department of Veterans Affairs says information about his official travel will be posted on the department's website.

Secretary David Shulkin says he has not used private aircraft for official business, but has taken six trips on military aircraft.

The trip details will include the type of aircraft, members of the traveling party and information about the events he was attending.

His decision to post his travel information comes as Health and Human Services Secretary Tom Price finds his job in jeopardy over his use of costly charters. Price has said he would reimburse the U.S. Treasury nearly \$52,000 for the cost of his seat on the charter flights. He has not addressed the overall cost of the flights, which are estimated to cost hundreds of thousands of dollars.

[...]

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8.2 - ABC News (AP): [A look at questions over Cabinet members' travel](#) (29 September, 24.1M online visitors/mo; New York, NY)

Health and Human Services Secretary Tom Price has resigned amid controversy over his use of costly private charter flights on government business. But other Cabinet members are also facing congressional scrutiny over their travel.

Interior Secretary Ryan Zinke dismissed the controversy over charters as "a little BS over travel," but he acknowledged taxpayers do have the right to know official travel costs.

The Price controversy was a catalyst for the House Oversight and Government Reform Committee to launch a government-wide travel investigation. The panel is seeking detailed records from the White House and 24 departments and agencies on the use of government planes as well as private charters.

Here's a look at what other Cabinet members are saying:

—Interior's Zinke said he's taken three charter flights while in office, including a \$12,375 late-night trip from Las Vegas to his home state of Montana in June. Zinke said no commercial flight was available at the time he planned to fly for a speech to Western governors. He also went on a military flight with Agriculture Secretary Sonny Perdue to view wildfires in Montana. All of his travel was approved in advance by Interior's ethics officials "after extensive due diligence," Zinke said.

—Veterans Affairs Secretary David Shulkin said he has not used private aircraft for official business but has taken six trips on military aircraft. Information about his official travel will be posted on the department's website, he said.

—At the Treasury Department, the inspector general is investigating all requests for and use of government aircraft, including those by Secretary Steven Mnuchin, who came under fire for requesting a government aircraft to use on his honeymoon. The request was later withdrawn.

—The EPA said four non-commercial flights taken by Administrator Scott Pruitt were pre-approved by ethics lawyers. The agency's inspector general opened an inquiry last month into Pruitt's frequent taxpayer-funded travel on commercial planes. The Associated Press reported earlier this year that Pruitt often spends weekends at his Tulsa home.

— The Pentagon said Defense Secretary Jim Mattis has never requested or used charter aircraft. Mattis has reimbursed the government for the cost of some unofficial travel, but the Pentagon did not immediately provide the number of trips or the total costs repaid. The secretary of defense is required to travel on military aircraft wherever he goes so he can be in contact with the president and the chairman of the Joint Chiefs of Staff. Military planes carry the secure communications equipment required for classified calls and video teleconferences. In addition, the military flights of top defense leaders often double as training missions for Air Force crew.

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8.3 - The Washington Times (AP): [Couple gets jail for keeping veteran's dead body in home](#) (29 September, 10.8M online visitors/mo; Washington, DC)

NEW PHILADELPHIA, Ohio - An Ohio couple criminally charged for keeping a Vietnam veteran's decomposing body in their home for several months to steal his Social Security and veteran benefits have received six months in jail.

The New Philadelphia Times Reporter reports 50-year-old Brian Sorohan and 46-year-old Stacy Sorohan also received two years' probation Thursday in Tuscarawas County.

The Wainwright residents pleaded no contest to gross abuse of a corpse and theft in a plea agreement. The couple must pay \$1,300 in restitution to the Veterans Administration and \$4,100 to the Social Security Administration.

Seventy-one-year-old Robert Harris' body was found in the couple's home March 22. Authorities searched the home that day after relatives became concerned about Harris' well-being.

Attorneys for the couple said in court the Sorohans regretted what they did.

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Veterans Affairs Media Summary and News Clips

30 September 2017

[1. Top Stories](#)

1.1 - The Washington Post (Video): [VA chief took in Wimbledon, river cruise on European work trip; wife's expenses covered by taxpayers](#) (29 September, Jack Gillum, Alex Horton, Drew Harwell and Lisa Rein, 43.9M online visitors/mo; Washington, DC)

Nearly three days into a trip to Europe this past July, Veterans Affairs Secretary David Shulkin had attended a Wimbledon championship tennis match, toured Westminster Abbey and taken a cruise on the Thames. The 10-day trip was not entirely a vacation. Shulkin was in Europe for meetings with Danish and British officials about veterans' health issues, so taxpayers picked up part of the tab.

[Hyperlink to Above](#)

1.2 - Reuters: [Under pressure from Trump, Price resigns as health secretary over private plane uproar](#) (29 September, Steve Holland, 43.6M online visitors/mo; New York, NY)

U.S. Health and Human Services Secretary Tom Price resigned under pressure from President Donald Trump on Friday in an uproar over Price's use of costly private charter planes for government business. His abrupt departure was announced an hour after Trump told reporters he was disappointed in Price's use of private aircraft and did not like the way it reflected on his administration.

[Hyperlink to Above](#)

1.3 - The New York Times: [Veterans Agency Seeks to Scrap Ethics Law on For-Profit Colleges](#) (29 September, Patricia Cohen, 29.8M online visitors/mo; New York, NY)

The Department of Veterans Affairs is pushing to suspend a 50-year-old ethics law that prevents employees from receiving money or owning a stake in for-profit colleges that pocket hundreds of millions of dollars in tuition paid through the G.I. Bill of Rights.

[Hyperlink to Above](#)

1.4 - U.S. News & World Report (AP): [Alaska VA Office Gets Mixed Report From Watchdog](#) (29 September, Becky Bohrer, 24M online visitors/mo; Washington, DC)

A government watchdog says the U.S. Department of Veterans Affairs regional office in Anchorage has made strides in processing claims but has work to do in other areas. The VA's inspector general said the accuracy of the claims processing it reviewed earlier this year was significantly better than a prior inspection in 2013.

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1.5 - Stars and Stripes: [VA publicizes Shulkin's travel schedule amid scrutiny over Cabinet spending](#) (29 September, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

The Department of Veterans Affairs made moves Friday to publicize Secretary David Shulkin's travel schedule, following scrutiny over the cost of government-funded travel by other Cabinet members. The VA announced it will post Shulkin's itineraries of international and domestic trips, as well as who accompanies him and whether he uses private or government aircraft.

[Hyperlink to Above](#)

1.6 - The Clarion-Ledger (Video): [Mississippi treating 11 Hurricane Maria victims, more coming](#) (29 September, Anna Wolfe, 849k online visitors/mo; Jackson, MS)

So far, 11 hurricane victims from Puerto Rico and St. Croix have been transported to metro Jackson hospitals in the aftermath of Hurricanes Irma and Maria. The storms devastated Puerto Rico's hospitals, a majority of which are without electricity or fuel for generators and beginning to run out of oxygen and clean water.

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1.7 - The San Diego Union-Tribune: [Does a soldier's best friend belong in VA research labs? A fight at the heart of the veterans community](#) (29 September, Jeanette Steele, 494k online visitors/mo; San Diego, CA)

America loves dogs, but many veterans have an extra bond after serving with canine units on the battlefield and increasingly depending on service dogs back at home. Now the U.S. Department of Veterans Affairs and some of the nation's largest veterans groups are in a scrap with a government watchdog organization and some in Congress over VA medical research programs that inflict harm on man's best friend in the name of science.

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[2. Veteran and Employee Experience](#)

2.1 - USA Today: [VA Secretary David Shulkin discloses official travel details](#) (29 September, Jessica Estepa, 36.7M online visitors/mo; McLean, VA)

Veterans Affairs Secretary David Shulkin announced Friday that his department would disclose details about his official travels, in an attempt to be transparent as the travels of other members of the administration come under scrutiny. The department will regularly update a page that includes any travels by private and government aircraft, as well as itineraries of official international and domestic trips.

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2.2 - ABC News: [VA secretary spent half of official London trip sightseeing](#) (29 September, Luis Martinez, 24.1M online visitors/mo; New York, NY)

Veterans Affairs Secretary David Shulkin flew a commercial airline to London this past July to attend a veterans conference, but half his time there was spent on sightseeing and a stop at Wimbledon tennis tournament. Shulkin's wife's commercial travel costs were also paid for by the federal government because she was under "approved invitational orders"

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2.3 - Politico: [Who will replace Tom Price? A dozen names are circulating as possible successors](#) (29 September, Joanne Kenen and Jennifer Haberkorn, 23.9M online visitors/mo; Arlington, VA)

The VA secretary is a Trump favorite, and the only cabinet nominee to be unanimously confirmed. However, Shulkin has come under criticism for combining leisure with business on his official travel — he attended a Wimbledon championship tennis match, toured Westminster Abbey and took a cruise on the Thames while meeting this summer with European officials about veterans' issues, The Washington Post reported Friday.

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2.4 - The Huffington Post: [Yet Another Trump Administration Official Took Questionable Liberties With Work Travel](#) (29 September, Mollie Reilly, 23M online visitors/mo; New York, NY)

Veterans Affairs Secretary David Shulkin used his downtime on a recent international trip for several leisure activities, including a tennis match and river cruise, The Washington Post reported Friday. According to the report, Shulkin spent roughly half of a 10-day trip to the U.K. and Denmark to sightsee, watch a high-profile Wimbledon match and take in other activities more typical of a vacation than a work trip.

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2.5 - The Hill: [Trump VA chief went sightseeing, shopping with wife on government trip: report](#) (29 September, Brandon Carter, 11.8M online visitors/mo; Washington, DC)

Veterans Affairs Secretary David Shulkin spent nearly half his time on a recent international trip sightseeing and shopping with his wife, according to The Washington Post. Shulkin traveled to Europe in July to attend a conference in London with representatives of several countries on veterans' health issues, as well as a series of meetings in Denmark.

[Hyperlink to Above](#)

2.6 - Washington Examiner: [VA secretary saw Wimbledon match during taxpayer-funded trip to Europe: Report](#) (29 September, Melissa Quinn, 4.8M online visitors/mo; Washington, DC)

Secretary of Veterans Affairs David Shulkin and his wife, accompanied by other VA officials, attended a tennis match at Wimbledon, toured Westminster Abbey, and cruised the Thames River as part of a taxpayer-funded, 10-day work trip to Europe this summer, according to a report.

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2.7 - Pittsburgh Post-Gazette: [Pittsburgh VA nurse is finalist for national caregiver award](#) (29 September, Gary Rotstein, 4.8M online visitors/mo; Pittsburgh, PA)

A nurse for the VA Pittsburgh Healthcare System is one of six national finalists for an annual award given to a medical professional who shows an exemplary caregiving approach on the job. Victor Fagan, a licensed practical nurse from Butler, won recognition from among nearly 200 nominees who were submitted to the Boston-based Schwartz Center for Compassionate Healthcare.

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2.8 - PennLive (Video): [VA chief mixed business with pleasure at taxpayer expense: Media report](#) (29 September, Ivey DeJesus, 3.1M online visitors/mo; New Bloomfield, PA)

President Donald Trump's veterans affairs chief is the latest administration official in hot water for reportedly tapping into taxpayer money to pay for vacation outings and non-official business. Veterans Affairs Secretary David Shulkin in July took in a Wimbledon championship tennis match and a Thames River cruise on taxpayer money. That's according to a report published Friday by The Washington Post.

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2.9 - Military Times: [Amid Cabinet controversies, VA promises to post secretary's travel details online](#) (29 September, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

In response to the growing scandal of Cabinet officials using pricey private aircraft for business trips, Veterans Affairs officials announced Friday they will post details of all official travel by department Secretary David Shulkin online to provide transparency about his travels. "Veterans and taxpayers have a right to know about my official travel as secretary, and posting this information online for all to see will do just that," Shulkin said in a statement.

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2.10 - Providence Journal (The Enterprise): [Providence VA official relieved of duties amid allegations of racism, homophobia](#) (29 September, Paul Edward Parker, 1.2M online visitors/mo; Providence, RI)

A manager at the Veterans Affairs Regional Office in Providence has been relieved of his duties pending disciplinary action, following a complaint from a co-worker that he created a "toxic work atmosphere."

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2.11 - KATV (ABC-7, Video): [Troubles at the VA: Nurses speaking out about culture](#) (29 September, Elisabeth Armstrong, 448k online visitors/mo; Little Rock, AR)

Two former nurses who have filed EEO complaints against the CAVHS are speaking out about problems. In July, Channel 7 brought you this report out of the VA. In it, some thirty nurses filed a complaint against the hospital - alleging that under-staffing was impacting patient care.

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2.12 - WQAD (ABC-8, Video): [Moline man shocked after job training center for veterans shuts down](#) (29 September, Chris Minor, 450k online visitors/mo; Moline, IL)

A Moline, Illinois man is one of more than 300 veterans left in the dark after a job training school they paid for through the GI bill abruptly shut its doors. "Three weeks before graduation, we were told goodbye.

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2.13 - FedSmith: [VA to Begin Disclosing Agency Secretary's Official Travel](#) (29 September, Ian Smith, 277k online visitors/mo; Washington, DC)

The Department of Veterans Affairs announced today that it will begin publishing all of the agency secretary's official travel on its website. The lists include all official travel taken by Dr. David J. Shulkin since January 20, and the site will be updated within five days after the conclusion of each trip.

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2.14 - Leavenworth Times: [Sentencing continued for former VA physician assistant](#) (29 September, 46k online visitors/mo; Leavenworth, KS)

A former physician assistant who was convicted of sexually abusing patients at the Leavenworth veterans hospital will not be sentenced until November. Mark E. Wisner was scheduled to be

sentenced today in Leavenworth County District Court. But the sentencing and arguments for post trial motions have been continued until Nov. 3.

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2.15 - Pahrump Valley Times: [Plaques at Pahrump VA clinic recognize veterans of U.S. armed forces](#) (29 September, Jeffrey Meehan, 1k online visitors/day; Pahrump, NV)

A group of local veterans of the U.S. armed forces gathered to recognize the installation of several plaques at the Pahrump VA Community Based Outpatient Clinic in September. Each plaque bore the symbol of one of the five branches of the U.S. armed forces and another was hung for prisoners of war.

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[3. Access to Healthcare](#)

3.1 - WBBM (CBS-2, Video): [2 Investigators: Disabled Vets Face Tough Parking At VA Hospital](#) (29 September, Dave Savini, 27.5M online visitors/mo; Chicago, IL)

A major problem at Hines VA Medical Center: Some sick and wounded veterans are struggling to get to their medical appointments because of parking violators. CBS 2's Dave Savini has the story. James Dahan, a Marine Corps veteran, gets angry when fellow wounded vets struggle to find a parking spot.

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3.2 - The News & Observer: [Vietnam vet happy to be back in Durham's VA hospital, but for how long?](#) (29 September, Thomasi McDonald, 3.9M online visitors/mo; Raleigh, NC)

A Vietnam veteran and double-amputee said things are "perfect" now that he is back in Durham's Veterans Administration Medical Center, where he has lived for a little more than three years. But James Donald Francis, 69, said he's worried because VA officials have not told him or given him any documentation about how long he will be able to stay at the VA's Community Living Center.

[Hyperlink to Above](#)

3.3 - Newsday (Video): [House vet chair Roe tours Northport VA after maintenance issues](#) (29 September, Martin C. Evans, 3.2M online visitors/mo; Melville, NY)

The head of the House Committee on Veterans Affairs came to Long Island for an up-close look at the troubled Northport VA Medical Center Thursday, saying the facility should "find the right size" to address maintenance problems straining its budget and impacting patient care.

[Hyperlink to Above](#)

3.4 - Stars and Stripes: [Stage set in Congress for debate on Choice program reform](#) (29 September, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

The Department of Veterans Affairs estimated the funds that allow veterans to receive health care in the private sector will last until the end of the year – a projection that establishes a new deadline for when Congress needs to come up with a long-term solution for the Veterans Choice Program.

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3.5 - WNDU (NBC-16, Video): [New VA clinic in Mishawaka will 'quadruple services'](#) (29 September, Mark Peterson, 833k online visitors/mo; South Bend, IN)

Ribbon cutting ceremonies in Mishawaka on Friday marked the completion of a \$38 million medical clinic for veterans. About ten years ago, the Veterans Administration was first asked to study how often local vets had to travel long distances to get needed medical care. "I'll be able to come here for my eye appointments, I'll be able to come here for my hearing appointments, and those are all things I have to go to Fort Wayne for," said veteran Chuck Damp.

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3.6 - WNDU (NBC-16, Video): [Sen. Joe Donnelly on tax overhaul, health care and new VA clinic](#) (29 September, Jason Krug, 833k online visitors/mo; South Bend, IN)

President Donald Trump visited Indianapolis on Wednesday, pitching his tax overhaul plan. Traveling with the president from Washington D.C. that day was Sen. Joe Donnelly. A question some had is why the Democrat would travel on Air Force One with the Republican president.

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3.7 - WFLA (NBC-8, Video): [Veteran suicides, VA corruption focus of rally and protest](#) (29 September, Steve Andrews, 702k online visitors/mo; Tampa, FL)

In the United States, 22 veterans take their lives every day. In front of the Veterans Affairs office at Bay Pines, 22 mannequins stood to serve as a reminder of this American tragedy. Army veteran Mike Ford admits he's come close to ending his life. "Idea was to just go ahead and just kill yourself on V-A property right, maybe if they see, if maybe people like, wow, there's something really going on here," he told News Channel 8.

[Hyperlink to Above](#)

3.8 - Modern Healthcare: [VA looks to ease telehealth regulations](#) (29 September, Rachel Z. Arndt, 460k online visitors/mo; Chicago, IL)

The Veterans Affairs Department proposed a rule Friday that would allow VA providers anywhere in the country to conduct telehealth visits with VA patients across state borders, regardless of state licensing.

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3.9 - KMYT (FOX-14, Video): [As Suicide Prevention Month comes to a close, the search continues for solutions to veteran suicide](#) (29 September, Peter Zampa, 71k online visitors/mo; Twin Falls, ID)

Suicide prevention month is highlighting how the U.S. Can better address the issue. A specific focus currently in Washington is a push to end veteran suicide. Senators are examining what is being done to help veterans in need, and what other efforts are necessary. One veteran says it is not easy to solve this tragic problem.

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3.10 - mHealth Intelligence: [New Rule Would Give VA Doctors National Telehealth Privileges](#) (29 September, Eric Wicklund, 53k online visitors/mo; Danvers, MA)

The Department of Veterans Affairs is moving forward with a plan to enable VA doctors to treat veterans through telehealth no matter where the doctor or patient are located, essentially overriding state laws.

[Hyperlink to Above](#)

3.11 - WLTZ (NBC-38, WSB/ABC-2, Video): [Hospital Evacuees from Caribbean Arrive in Atlanta](#) (28 September, Nami Dockery, 44k online visitors/mo; Columbus, GA)

Hospital patients evacuated from the Caribbean due to hurricane Maria are finding refuge in Georgia. Doctors and nurses welcomed the patients after a plane carrying roughly 40 medical evacuees landed Wednesday night. It comes after the hurricane caused widespread power outages, including a loss of electricity at hospitals.

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3.12 - Marion Republican: [Bost 'not happy' with VA investigation; vows to look further into allegations at Marion VAMC](#) (29 September, Holly Lee, 14k online visitors/mo; Marion, IL)

The conclusion of a Veterans Affairs inquiry into allegations of nepotism, employee intimidation and why some patients died at the VA Medical Center in Marion leaves one southern Illinois congressman "not happy" with the answers and vowing further action.

[Hyperlink to Above](#)

[4. Women Veterans](#)

4.1 - The Mercury: [Expo will focus on women entrepreneurs and female veterans](#) (29 September, Donna Rovins, 187k online visitors/mo; Pottstown, PA)

A unique expo highlighting women entrepreneurs and female veterans is scheduled for Saturday, Oct. 7, at Phoenixville Area Middle School. The 2017 Women Entrepreneur & Women Veteran Expo will give women from different business areas the opportunity to connect with each other to educate, share information and inspire other women to become business owners, according to organizer Dolores Winston, founder and CEO of Here to Apparel.

[Hyperlink to Above](#)

4.2 - KSFY (ABC-13, Video): [Sioux Falls conference puts spotlight on women veterans](#) (29 September, 4k online visitors/day; Sioux Falls, SD)

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[Hyperlink to Above](#)

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[Hyperlink to Above](#)

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The 10-day trip was not entirely a vacation. Shulkin was in Europe for meetings with Danish and British officials about veterans' health issues, so taxpayers picked up part of the tab.

Yet he and his wife spent about half their time sightseeing, including shopping and touring historic sites, according to an itinerary obtained by The Washington Post and confirmed by a U.S. official familiar with their activities.

The federal government paid for the flights for Shulkin and his wife, Merle Bari, and provided a per-diem reimbursement for their meals and other expenses, VA said Friday. An agency spokesman did not respond to questions about why Bari qualified for the reimbursements and taxpayer-funded airfare, other than to say she was traveling on "approved invitational orders" and had "temporary duty" travel expenses.

The agency also did not respond to questions about the cost of the flights and the total reimbursement. If Bari took the full per diem every day of the trip, she could have been reimbursed as much as \$3,600 under federal guidelines.

Trump administration Cabinet members have faced mounting scrutiny over their use of private and government jets in recent days, and Health and Human Services Secretary Tom Price resigned Friday amid criticism of his use of taxpayer-funded charter flights. Shulkin traveled on a commercial flight, though, and he was seated in coach on at least one leg.

The European visit, however, puts a focus on the mixing of business and leisure during these trips, which can come at considerable taxpayer expense. Shulkin's immediate predecessor, Robert McDonald, took no foreign work trips, according to a former VA official who spoke on the condition of anonymity.

Shulkin's six-person traveling party included his acting undersecretary of health and her husband, Shulkin's chief of staff and another aide, the itinerary says. They were accompanied by a security detail of as many as six people.

Shulkin's trip came less than two weeks after he signed a memo instructing top VA staffers to determine whether "employee travel in their organization is essential."

"I expect this will result in decreased employee travel and generate savings within the Department of Veterans Affairs," Shulkin wrote.

In response to questions from The Post, VA announced Friday that the agency will begin posting details of the secretary's travel online, including itineraries, and disclosing any use of government or private aircraft. That information had not previously been disclosed publicly.

All of Shulkin's activities on the European trip, including his attendance at Wimbledon, "were reviewed and approved by ethics counsel," VA press secretary Curt Cashour said in an emailed statement.

"These were important trips with our allies to discuss best practices for taking care of veterans," Cashour said. "The secretary has been transparent on his down-time activities that were similar to what he would have done with his family over a weekend in the U.S."

Cashour said the husband of Poonam Alaigh, the acting undersecretary for health, paid his own expenses.

In an interview Friday, Alaigh defended the trip as a "tremendous and valuable exchange of ideas" with British and Danish counterparts.

"Were there some breaks we got? Sure," she said. "But they were reasonable. They were not at the expense of what we had committed to do: representing our country and showing our commitment to veterans."

Alaigh said the delegation took an unplanned trip across the border to Sweden one evening.

Senior members of Congress, including two key Republicans, have expressed concerns about travel by officials in President Trump's Cabinet. The leaders of the House Oversight Committee, Chairman Trey Gowdy (R-S.C.) and Rep. Elijah E. Cummings (D-Md.), wrote to the White House this week to demand records on air travel for executive officials since Trump's inauguration, saying that official travel "by no means should include personal use."

Sen. Charles E. Grassley (R-Iowa), chairman of the Senate Judiciary Committee, also wrote Trump a letter Thursday asking what steps the administration has taken to "ensure Cabinet secretaries use the most fiscally responsible travel in accordance with the public trust they hold."

One ethics expert said the trip sends the wrong message to taxpayers, especially if spouses' expenses were paid by the government.

"That's kind of a long trip for the secretary to be gone," said Walter M. Shaub Jr., a vocal critic of the Trump administration who resigned in July as the federal government's top ethics watchdog. "The cost has got to be extravagant."

Shulkin was invited to attend a July 19 conference in London to discuss veterans' mental health issues with representatives of Britain, Canada, Australia and New Zealand. In past years, the VA secretary has attended the conference.

He also arranged to attend meetings in Denmark from July 12 to 14. Officials in Denmark said VA officials approached them about the meetings.

The bookend events left Shulkin with four days in between, according to his itinerary. He attended a ceremony one of those nights at which a British veteran of the war in Afghanistan was honored, and a meeting the next night at the British prime minister's residence.

Over the course of the trip, Shulkin and his entourage visited four palaces — Copenhagen's Christiansborg and Amalienborg and London's Buckingham and Kensington — and included times for walks, self-guided tours and photo stops.

On one calendar item, a canal tour of Copenhagen, the itinerary specifically noted the group "Will See Little Mermaid Statue," one of the city's most iconic public artworks. During the London visit, Shulkin and his wife shared a meal at a restaurant overlooking a tennis court with Victoria Gosling, a British leader of the Invictus Games, a sports tournament for wounded veterans. Gosling posted a photo of the gathering on Twitter.

"Great honour and a pleasure to host US Secretary of the VA and his lovely family," Gosling wrote.

The Wimbledon event was one of the prized moments of the tennis year: In the women's final, American Venus Williams would lose her chance at a sixth title to Spain's Garbiñe Muguruza.

It is not clear whether the London invitation came before or after the scheduling of the events in Copenhagen, which included speaking with several Danish health-care executives at a luncheon organized by a Danish business group. A spokesman for one company in attendance, Leo Pharma, said the executives were asked by the Danish Foreign Affairs Ministry to attend.

In any event, the Copenhagen meetings occurred at a time the business group said was inconvenient, because it was a holiday period for Danes.

"It was quite difficult for us to accommodate," said Kasper Ernest, a director at the Confederation of Danish Enterprise, noting that his group's chief executive could not attend. "I was also on holiday."

Shulkin's relationship with Danish government leaders has grown over the past year, Danish officials said, and Denmark's military had been heavily involved in the war in Afghanistan.

In a statement, the Danish Embassy in Washington said it has had "a close dialogue with the U.S. Department of Veterans Affairs for a couple of years based on the long-standing partnership between Denmark and the USA on global conflicts. Over this period, there has been a standing invitation to visit Denmark."

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1.2 - Reuters: [Under pressure from Trump, Price resigns as health secretary over private plane uproar](#) (29 September, Steve Holland, 43.6M online visitors/mo; New York, NY)

WASHINGTON - U.S. Health and Human Services Secretary Tom Price resigned under pressure from President Donald Trump on Friday in an uproar over Price's use of costly private charter planes for government business.

His abrupt departure was announced an hour after Trump told reporters he was disappointed in Price's use of private aircraft and did not like the way it reflected on his administration.

“Secretary of Health and Human Services Thomas Price offered his resignation earlier today and the president accepted,” the White House said in a statement.

Trump named Don Wright to serve as acting secretary. Wright is currently the deputy assistant secretary for health and director of the office of disease prevention and health promotion.

“I’m not happy. OK? I’m not happy,” Trump told reporters on the White House South Lawn.

Candidates to succeed Price included Seema Verma, who is administrator of the Centers for Medicare and Medicaid Services and who is close to Vice President Mike Pence, and Scott Gottlieb, a physician who serves as commissioner of the Food and Drug Administration, according to industry analysts.

Several sources saw Gottlieb as a clear front runner. They said he got along well with the White House and is viewed favourably there.

Price’s resignation leaves Trump with a second Cabinet position to fill. He has yet to pick a secretary for homeland security after hiring former Secretary John Kelly as his White House chief of staff.

It was the latest blow to the Trump White House, which has struggled to get major legislative achievements passed by Congress and has been embroiled in one controversy after another since Trump took office in January.

Price, a former congressman, was instrumental in the Trump administration’s policies aimed at undercutting Obamacare, as well as working with governors across the country to slowly begin unravelling parts of the law.

In a resignation letter, Price offered little in the way of contrition. He said he had been working to reform the U.S. healthcare system and reduce regulatory burdens, among other goals.

“I have spent forty years both as a doctor and public servant putting people first. I regret that the recent events have created a distraction from these important objectives,” he said.

Trump, currently trying to sell his tax cut plan and oversee the federal response to devastation wreaked by three hurricanes, saw the Price drama as an unnecessary distraction and behind the scenes was telling aides “what was he thinking?,” a source close to the president said.

Price promised on Thursday to repay the nearly \$52,000 cost of his seats on private charter flights. “The taxpayers won’t pay a dime for my seat on those planes,” Price said.

But that was not enough to satisfy Trump.

Trump told reporters that the “optics” of Price’s travel were not good, since, as president he was trying to renegotiate U.S. contracts to get a better deal for taxpayers.

“Look, I think he’s a very fine person. I certainly don’t like the optics,” Trump said.

Price had also been seen in the White House as having been ineffective in getting Congress to pass healthcare reform legislation, an effort that has fizzled on Capitol Hill.

Price was one of a handful of senior officials in Trump's administration put on the defensive over reports about their use of charter flights and government aircraft, sometimes for personal travel, when they could have flown commercial for less money.

The White House issued an order late on Friday saying use of private planes required approval from White House Chief of Staff John Kelly and that the commercial air system was appropriate even for very senior officials with few exceptions.

The Washington Post on Friday reported that Veterans Affairs Secretary David Shulkin attended a Wimbledon tennis match, toured Westminster Abbey and took a cruise on the Thames this summer during a 10-day trip to discuss veterans' health issues in Britain and Denmark.

Shulkin, who travelled on a commercial airline, was accompanied on the trip by his wife, whose airfare was paid for by the government and who received a per diem for meals, the Post said, noting that the Department of Veterans Affairs said she was travelling on "approved invitational orders."

His six-person travelling party included an acting undersecretary of health and her husband as well as two aides. They were accompanied by a security detail of as many as six people, the Post said.

Washington news media outlet Politico has reported that Price had taken at least two dozen private charter flights since May at a cost to U.S. taxpayers of more than \$400,000. Politico also reported he took approved military flights to Africa and Europe costing \$500,000.

Senior U.S. government officials travel frequently, but are generally expected to keep costs down by taking commercial flights or the train when possible.

Environmental Protection Agency Administrator Scott Pruitt and Treasury Secretary Steve Mnuchin have also been in the spotlight for their travel habits.

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1.3 - The New York Times: [Veterans Agency Seeks to Scrap Ethics Law on For-Profit Colleges](#) (29 September, Patricia Cohen, 29.8M online visitors/mo; New York, NY)

The Department of Veterans Affairs is pushing to suspend a 50-year-old ethics law that prevents employees from receiving money or owning a stake in for-profit colleges that pocket hundreds of millions of dollars in tuition paid through the G.I. Bill of Rights.

The agency says the conflict-of-interest law — enacted after scandals enveloped the for-profit education industry — is now redundant and outdated, with "illogical and unintended consequences" affecting employees who have no real conflict of interest, such as a V.A. doctor teaching a course at a school attended by veterans with educational benefits.

But veterans' groups and ethics experts reject those arguments and say the department is abandoning protections for veterans and taxpayers. They worry that the effort is part of a larger rollback of federal safeguards that were instituted before President Trump took office to combat abuses and fraud by for-profit colleges.

Several officials who worked in the for-profit college industry and had criticized the Obama-era crackdown as excessive, for example, have joined the Education Department, which administers and polices the federal student loan program and the industry.

The proposal to suspend the ethics law was published in the Federal Register in mid-September and is scheduled to take effect on Oct. 16, but no public hearings have been scheduled and no public comments have yet been submitted.

“It’s just reckless and sloppy,” said Walter M. Shaub Jr., a former director of the Office of Government Ethics, said of the agency’s action. He questioned why such a blanket exception for more than 330,000 agency employees should exist when the law allows waivers for individuals or even classes of individuals, like those teaching courses. Invoking the waiver also requires public hearings, he said.

Most troubling to Mr. Shaub, now senior counsel at the nonpartisan Campaign Legal Center, is that the move seems like an attempt by the executive branch to overrule the legislative branch. “They are saying the statute is unreasonable, but that’s not for them to say,” he said of agency officials.

Curtis Cashour, a V.A. spokesman, said officials had focused on the ethics law after the agency’s inspector general investigated complaints this year that two V.A. employees were teaching at a for-profit institution. There were no significant conflicts and a waiver was ultimately granted, he said, but the report led to worries among many employees about the impact of more rigorous enforcement.

“Our response was aimed at easing the concerns of numerous V.A. employees,” Mr. Cashour said in an email, adding that the ethics law had been superseded by subsequent conflict-of-interest statutes.

One concern of critics is that officials at the organization’s upper levels could be making decisions about a college in which they have a financial interest, like permitting a school with a record of abuses to recruit at military bases. Another is that people advising veterans about their educational benefits could steer students to a particular school because they were on the payroll.

“There’s no good that can come from allowing colleges to have unseemly financial entanglements with V.A. employees,” Carrie Wofford, director of Veterans Education Success, a nonprofit advocacy group. “Congress enacted a zero tolerance for financial conflicts of interest for V.A. employees precisely because Congress uncovered massive fraud by for-profit colleges targeting veterans.”

She added that “student veterans were already facing an aggressive rollback of their protections under the Trump administration’s Education Department.”

Two months ago, the Republican-led Senate Appropriations Committee issued a report during its debate over the military budget instructing the department to review the statute — but its concern was that the current rules “may be inadequate to identify conflicts of interest that can develop” because of gifts or expensive meals.

Veterans are particularly valuable as potential students: There are limits on the federal funds that for-profit schools can receive, but money from the G.I. Bill is not counted.

Even before last year's presidential election, some of the biggest veterans and military organizations were urging the department to better monitor for-profit colleges that were misleading veterans about the costs and benefits of enrolling, and violating legal and regulatory standards.

And a report issued in July by the director of the agency's Education Service found that financial issues involving tuition and fees were by far the leading complaint among students who had called the agency's G.I. Bill hotline since 2014.

Some ethics experts disagreed with the department's contention that other federal statutes made the ethics law unnecessary, saying the agency's rule sets a higher bar, requiring, for example, more public review.

Dozens of other agencies also have supplemental ethics rules that have been written to address potential problems specific to those agencies.

Senator Patty Murray, Democrat of Washington, and a longtime advocate for veterans, said she planned to look into the agency's decision. "I am deeply concerned the V.A. is opening the door for predatory for-profits to take advantage of men and women who have bravely served our country," she said.

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1.4 - U.S. News & World Report (AP): [Alaska VA Office Gets Mixed Report From Watchdog](#) (29 September, Becky Bohrer, 24M online visitors/mo; Washington, DC)

JUNEAU, Alaska — A government watchdog says the U.S. Department of Veterans Affairs regional office in Anchorage has made strides in processing claims but has work to do in other areas.

The VA's inspector general said the accuracy of the claims processing it reviewed earlier this year was significantly better than a prior inspection in 2013.

But it found delays in processing benefit reductions or discontinuations, resulting in about \$16,800 in overpayments for care, and inaccuracies in how staff entered claim information. The inspector general said such overpayments due to administrative errors aren't recoverable.

The watchdog recommended that the office prioritize the processing of benefit changes and improve oversight to ensure information is accurate when claims are established.

The VA, in responses included with the report, agreed with the findings and recommendations.

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1.5 - Stars and Stripes: [VA publicizes Shulkin's travel schedule amid scrutiny over Cabinet spending](#) (29 September, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

The Department of Veterans Affairs made moves Friday to publicize Secretary David Shulkin's travel schedule, following scrutiny over the cost of government-funded travel by other Cabinet members.

The VA announced it will post Shulkin's itineraries of international and domestic trips, as well as who accompanies him and whether he uses private or government aircraft. On Friday, the information was online at the VA's new "Secretary's Travel" page.

"Veterans and taxpayers have a right to know about my official travel as secretary, and posting this information online for all to see will do just that," Shulkin said in a prepared statement.

The announcement came two days after the House Oversight Committee initiated an investigation into the travel of President Donald Trump's administration.

Rep. Trey Gowdy, R-S.C., and Rep. Elijah Cummings, D-Md., leaders of the committee, sent letters Wednesday to the White House and 24 federal agencies, including the VA, asking for senior officials' travel details. The lawmakers cited federal law that official travel should be "expeditious" and "by no means should include personal use."

Gowdy and Cummings requested responses from each agency by 5 p.m. on Oct. 10.

In August, Treasury Secretary Steve Mnuchin used military aircraft to fly from New York City to Washington, D.C., costing about \$25,000, ABC News reported. The Treasury's Office of Inspector General is reviewing another of Mnuchin's trips, in which he used government aircraft to fly to Kentucky, where he spoke to business leaders and viewed the solar eclipse.

According to several reports, Mnuchin also requested to use a military jet to fly him and his wife, Louise Linton, to their European honeymoon. The request was later withdrawn.

Another cabinet member, Health and Human Services Secretary Tom Price, promised Thursday to repay about \$52,000 for his travel on private charter planes, which costs thousands of dollars more than commercial flights.

Interior Secretary Ryan Zinke took a charter plane to Montana and the Caribbean at a price of \$12,000, Politico reported. Multiple news outlets reported Scott Pruitt, who leads the Environmental Protection Agency, has taken at least four noncommercial flights since February, costing taxpayers more than \$58,000.

As of Friday afternoon, the VA posted Shulkin had taken five trips on Air Force 1 and Air Force 2, two of them to Texas to see damage caused by Hurricane Harvey. He also used a military aircraft last week for a trip to the Invictus Games in Toronto with First Lady Melania Trump. Shulkin has not used any private aircraft for official travel, according to information on the VA website.

According to one itinerary posted on the VA website Friday, Shulkin, his wife, Merle Bari, and other VA officials traveled July 11 to Denmark, where Shulkin was briefed on the Danish health care system for veterans, toured a veterans home and met the Danish ministers of defense and health. The group then traveled to London, where Shulkin and Bari spent July 15 at the

Wimbledon tennis tournament with friends. On July 16, they visited Buckingham Palace, Kensington Palace, Westminster Abbey and took a cruise of the Thames River, followed by an evening in Piccadilly Circus. Later during the week, Shulkin attended a conference in London on veterans issues.

The VA said it would update the site five days after the conclusion of every trip. The agency tied the move to other attempts at transparency since Shulkin took over as secretary. In July, the VA made public a list of employee terminations, demotions and suspensions, which is updated weekly.

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1.6 - The Clarion-Ledger (Video): [Mississippi treating 11 Hurricane Maria victims, more coming](#) (29 September, Anna Wolfe, 849k online visitors/mo; Jackson, MS)

So far, 11 hurricane victims from Puerto Rico and St. Croix have been transported to metro Jackson hospitals in the aftermath of Hurricanes Irma and Maria.

The storms devastated Puerto Rico's hospitals, a majority of which are without electricity or fuel for generators and beginning to run out of oxygen and clean water.

"You're talking about a hospital that has one week of oxygen left, one day of drinkable water. It's a level of devastation I don't think we could ever begin to imagine," said state Department of Health spokeswoman Liz Sharlot.

The Health Department has partnered with the G.V. "Sonny" Montgomery Veterans Affairs Medical Center, Air National Guard and the University of Mississippi Medical Center to accept patients at 13 local hospitals. UMMC is treating four patients, some of whom are children and infants.

On Sept. 22, the department set up a patient reception area — a federal coordinating center at the Jackson-Medgar Wiley Evers International Airport — where doctors and nurses from the VA are assessing each patient's needs, providing any emergency care, then transporting them to a local hospital. Ambulances are on standby.

The first patients arrived Monday. By Thursday night, they'd seen 11 patients with a range of conditions, including one high-risk pregnancy, a double amputee, one on a ventilator with respiratory failure and a neonatal intensive care unit patient.

"These are serious medical needs and high-risk patients," Sharlot said. "We're just grateful we're able to do what we can."

VA Medical Center Director Dr. David Walker, commander of the federal coordinating center, described the scene at the airport as stressful, but rewarding "knowing you're helping people at their most vulnerable."

"You never know what you're going to get until the plane doors open," Walker said.

The plane ride on the commercial air ambulance is between four and six hours, at which point a patient's condition can change.

One of Walker's staffers is from Puerto Rico and hasn't been able to speak with her family. She's volunteered to do any translation at the coordinating center.

The goal is to transfer patients back home when they've been stabilized, but considering the conditions in Puerto Rico, that hasn't happened yet. Walker said he only knows of patients leaving the hospitals to stay with relatives in the United States.

The Health Department expected more arrivals Friday. Shreveport, Atlanta and Columbia, South Carolina, are also receiving patients from Puerto Rico and the U.S. Virgin Islands.

"It's not over," Sharlot said. "I think this is going to be going on for a while."

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1.7 - The San Diego Union-Tribune: [Does a soldier's best friend belong in VA research labs? A fight at the heart of the veterans community](#) (29 September, Jeanette Steele, 494k online visitors/mo; San Diego, CA)

America loves dogs, but many veterans have an extra bond after serving with canine units on the battlefield and increasingly depending on service dogs back at home.

Now the U.S. Department of Veterans Affairs and some of the nation's largest veterans groups are in a scrap with a government watchdog organization and some in Congress over VA medical research programs that inflict harm on man's best friend in the name of science.

A VA investigation found problems at a Richmond, Virginia, program where researchers do heart surgery on dogs to study the development of cardiac abnormalities.

Techniques include inserting pacemakers and catheters into the hearts of dogs, destroying heart tissue and creating heart attacks by injecting liquid latex into an artery. At the end, dogs are killed and their tissues studied.

One of the reasons that dogs are considered good for these experiments is they are easy to train to run on a treadmill while their hearts are monitored.

As a result of botched procedures, one lead researcher was removed from the studies this spring and the VA tightened its research protocols at Richmond's Hunter Holmes McGuire VA Medical Center, one of at least three sites nationwide where the VA does invasive medical research on dogs.

Changes include additional reviews by the VA's chief veterinarian of proposed dog research, more stringent scientific scrutiny of VA funding requests involving dogs and increased frequency of site visits for VA programs that have canines, a VA official told The San Diego Union-Tribune.

These moves come atop questioning of research at the Los Angeles VA on narcoleptic Doberman pinschers. The approved protocol called for dosing dogs with antidepressants or methamphetamine, then killing them and studying how the drugs affect their brains.

Now, at the highest levels, the VA is battling to save its canine research programs, which have come under assault in Congress.

“Part of our mission is to push the envelope constantly in search of medical advancements that will help improve the lives of disabled veterans,” VA Secretary David Shulkin wrote in an opinion piece this month in USA Today.

“If this legislation passes ... it would stop potential VA canine research-related medical advancements that offer seriously disabled veterans the hope of a better future,” wrote Shulkin, a practicing physician.

A spending bill that unanimously passed the House in July would ban funding for two categories of invasive dog experimentation at the VA in the coming fiscal year.

Separately, the “PUPPERS Act” (Preventing Unkind and Painful Procedures and Experiments on Respected Species) would permanently ban money for invasive dog research by the VA.

Rep. Dave Brat, the Virginia Republican who sponsored the act, called the experiments in Richmond “horrific and inhumane” in a statement.

“These dog testing experiments at the VA are consuming limited taxpayer dollars, medical staff time and office space that could be better utilized to deliver health care for veterans,” Brat said.

But the VA has rallied an important chunk of the veterans community to its defense.

The American Legion, Iraq and Afghanistan Veterans of America and Vietnam Veterans of America have written letters to Congress in support of the VA’s canine research.

“There are many pet owners and animal lovers in the American Legion,” the legion’s statement said. “Sometimes animal research is needed for the greater good of protecting human life.”

The executive director of Paralyzed Veterans of America said he’d like to see Congress strike a balance on the issue.

“On one hand, understand and acknowledge the tremendous gains in medicine and treatment,” said Sherman Gillums Jr., in response to a query from the Union-Tribune. “On the other hand, if it is warranted, Congress should call for greater accountability and transparency to confront waste and deviation from humane protocols in scientific research funded by taxpayers.”

Dogs accounted for less than 0.05 percent of animals used in VA research in 2016, an official said. Almost all are mice or rats.

Not all veterans agree with the nation’s most established organizations.

“I’m not going to say canine research should or shouldn’t be done at all, I just don’t think the VA should do it,” said Ben Krause, creator of the contrarian website Disabledveterans.org. “VA has a hard enough time not withholding health care from veterans on a regular basis.”

A major player in this conflict is White Coat Waste Project, a four-year-old Washington, D.C. nonprofit group whose philosophy is a marriage of fiscal conservatism and animal protection sentiment. The group offers \$1,000 rewards to whistleblowers with evidence of animal abuse or wasteful spending at VA dog labs.

Founded by a Republican strategist, the group argues that taxpayers are spending over \$15 billion a year on wasteful dog, cat, monkey and other animal experiments that are irrelevant, slow and expensive.

It was White Coat Waste's complaint in March that spurred the VA's investigation of the Richmond facility. The group filed Freedom of Information Act requests for records from the McGuire VA.

"We had known that the VA was one of the few agencies conducting painful experiments on dogs. And through our research into the details of those projects, we uncovered these series of violations at Richmond," said Justin Goodman, White Coat Waste's vice president.

According to Goodman, the VA has 79 sites that do animal experiments, but only three are doing "significantly painful" research on dogs.

Aside from Richmond, the others are Stokes Veterans Affairs Medical Center in Cleveland and Zablocki Veterans Affairs Medical Center in Milwaukee.

In Milwaukee, according to the watchdog group, the VA is using 150 dogs, including beagle puppies, for lung research that includes collapsing the dogs' lungs and dissecting their necks and heads.

"The use of dogs has been decreasing in the United States," Goodman said this week.

"Most people would probably be alarmed that, in 2017, there are still 60,000 dogs being used in experiments. I think that for many people, even one dog being used in an experiment that they are forced to pay for is too many," he said, adding that research outside of federal agencies is often funded by government grants.

One expert said the VA's research is not an anomaly in the biomedical industry.

"Work with dogs is happening all over the place," said Cindy Buckmaster, chairwoman of Americans for Medical Progress, a nonprofit group that advocates for the role of laboratory animals.

"Any time they are the optimal model, they are part of the study," said Buckmaster, also a Ph.D. at Baylor University College of Medicine.

She said researchers are required to give dogs pain medication during invasive procedures, just like in human surgeries, but the majority of animal subjects are eventually killed as part of the study.

"That's because the answers are in the tissues," Buckmaster said.

The VA argues that its animal research has saved lives and will save more in the future. It issued a list of past accomplishments: development of the cardiac pacemaker, the first liver transplant, the nicotine patch, the discovery of insulin and, most recently, the first FDA-approved artificial pancreas.

White Coat Waste disputes that list as ancient history, saying the artificial pancreas is the only 21st century accomplishment of the bunch.

A University of California San Diego pathology professor said experts are going to disagree about whether dog research, and animal research in general, is effective. Dr. Lawrence Hansen, who is involved with White Coat Waste, led a successful campaign nearly 15 years ago to end surgery on dogs as a mandatory part of the medical school's curriculum.

"We have created creatures that are hard-wired to love and trust us," Hansen said. "It is a betrayal to then turn around and keep them in cages, cut them up and kill them."

To him, it comes down to an ethical question: If dog research does work to expand science, is it worth it?

It's a question Congress may take up in the coming year, with the plight and opinions of America's veterans as added weight.

Current VA research using dogs

- Studying ways of preventing lung infections in people with spinal cord injuries because they are unable to cough effectively
- Developing glucose sensors that diabetic human patients can wear to allow continuous monitoring and insulin delivery
- Understanding and treating dysfunction in the brain circuits that control breathing
- Meeting a congressional mandate to establish scientific evidence as to whether service dogs reliably reduce the symptoms of post-traumatic stress disorder
- Gaining insights into narcolepsy through studies of a unique colony of naturally narcoleptic dogs
- Studies to develop novel treatments for human heart conditions like atrial fibrillation and heart failure

Source: VA

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2. Veteran and Employee Experience

2.1 - USA Today: [VA Secretary David Shulkin discloses official travel details](#) (29 September, Jessica Estepa, 36.7M online visitors/mo; McLean, VA)

Veterans Affairs Secretary David Shulkin announced Friday that his department would disclose details about his official travels, in an attempt to be transparent as the travels of other members of the administration come under scrutiny.

The department will regularly update a page that includes any travels by private and government aircraft, as well as itineraries of official international and domestic trips.

"Under this administration, VA is committed to becoming the most transparent organization in government, and I'm pleased to take another step in that direction with this move," Shulkin said in a statement. "Veterans and taxpayers have a right to know about my official travel as secretary, and posting this information online for all to see will do just that."

Shulkin's announcement comes as Health and Human Services Secretary Tom Price faces criticism for his own use of private planes for official business. Price has apologized for the chartered flights and vowed to put an end to the practice.

According to the VA, Shulkin has not yet taken any private aircraft for official business.

He has taken six domestic trips on government aircraft, four of which were on Air Force One.

He has also taken two international trips: a September trip to Toronto for the Invictus Games and another to Copenhagen and London. The Copenhagen and London trip included tours of palaces and a river cruise down the Thames.

The Washington Post reported that the VA's decision to start disclosing Shulkin's travels came after it obtained a copy of the Europe itinerary.

The Post reported that the department covered the airfare of and provided per diem for Shulkin's wife, Merle Bari. The agency told the Post that she was traveling on "approved invitational orders."

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2.2 - ABC News: [VA secretary spent half of official London trip sightseeing](#) (29 September, Luis Martinez, 24.1M online visitors/mo; New York, NY)

Veterans Affairs Secretary David Shulkin flew a commercial airline to London this past July to attend a veterans conference, but half his time there was spent on sightseeing and a stop at Wimbledon tennis tournament.

Shulkin's wife's commercial travel costs were also paid for by the federal government because she was under "approved invitational orders"

As questions have swirled about other Trump cabinet officials' use of government aircraft, the Department of Veterans Affairs has decided that in the interest of transparency it will post all of Shulkin's travel details on a VA website.

Those documents show Shulkin has flown six times on U.S. military aircraft. Four of the flights were on Air Force One as he accompanied President Trump, one was on Air Force Two accompanying Vice President Pence and a flight earlier this week accompanying the first lady to this week's Invictus Games in Toronto. Shulkin has never flown a private plane to travel for his official duties, according to a Veterans Affairs spokesman.

The Department also posted the itineraries of Shulkin's trip in mid-July to Denmark and the United Kingdom and earlier this week to Canada with first lady Melania Trump.

Shulkin and his delegation of six, including his wife Dr. Merle Bari, traveled commercial airlines to Copenhagen and London.

But that trip itinerary to Denmark and London has raised questions about the amount of time Shulkin spent sightseeing.

The itinerary shows that on July 12, the first day of his first three days in Copenhagen, Shulkin visited multiple tourist stops. The next two days were spent on meetings with Danish government and health care officials to discuss veterans issues.

The first half of the six-day stay in London was dedicated to sightseeing before his full participation in a two-day veterans summit.

Shulkin arrived in London on Saturday, July 15 and according to the itinerary he spent the afternoon at the "Wimbledon Tennis Tournament with Friends." That would have been the day of the Women's singles final.

He spent the next two days visiting notable tourist sites in London including Buckingham Palace, Kensington Palace, Westminster Abbey, St. Paul's Cathedral, the Tower of London and took a "Thames River cruise to Greenwich Pier/Followed by dinner/evening in Piccadilly Circus."

But from the afternoon of Wednesday, July 19, through Friday, July 21, Shulkin was immersed in full-day participation in the veterans conference.

"All activities on the itinerary were reviewed and approved by ethics counsel," said Curt Cashour, the VA Press Secretary.

Cashour said the rules permit government reimbursement for a spouse's "temporary duty" travel expenses.

According to a VA press release, the department is the first federal agency to make public the travel details of its top official. "The information will also include what VA staff and spouses accompany him on each trip, if any, but for security reasons, members of the Secretary's security detail will not be listed by name or number," said the release.

"Under this Administration, VA is committed to becoming the most transparent organization in government, and I'm pleased to take another step in that direction with this move," Secretary Shulkin said. "Veterans and taxpayers have a right to know about my official travel as Secretary, and posting this information online for all to see will do just that."

According to the release, Shulkin "pointed to the move as the fourth major step in long-sought transparency and accountability actions at VA." Previous actions include the VA's public listing of wait times and quality/satisfaction data at all VA medical centers, adverse employee actions and employee settlements.

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2.3 - Politico: [Who will replace Tom Price? A dozen names are circulating as possible successors](#) (29 September, Joanne Kenen and Jennifer Haberkorn, 23.9M online visitors/mo; Arlington, VA)

Tom Price hadn't even stepped down when the Washington policy world was buzzing about who was likely to replace him.

A dozen names are being talked about, including several belonging to those already serving in the administration. Of course, President Donald Trump often does the opposite of what insiders expect.

The rumored short-list includes former Sen. Judd Gregg (R-N.H.), who would sail through Senate confirmation but would probably be considered too moderate on Obamacare, to Dr. Mehmet Oz, a cardiothoracic surgeon known through his talk show. Other current or former members of Congress who could be considered include Rep. Fred Upton and former Rep. Dave Camp.

Here are a few others who may be in the mix:

[...]

David Shulkin: The VA secretary is a Trump favorite, and the only cabinet nominee to be unanimously confirmed. However, Shulkin has come under criticism for combining leisure with business on his official travel — he attended a Wimbledon championship tennis match, toured Westminster Abbey and took a cruise on the Thames while meeting this summer with European officials about veterans' issues, The Washington Post reported Friday. Shulkin did fly commercial but his wife's expenses were covered by taxpayers, according to the Post.

A physician and former health administrator, Shulkin is also the only member of Trump's cabinet who is a holdover from the Obama years; he served as the VA's undersecretary of health in that administration. Now he's trying to get the massive, scandal-plagued VA health care back on track to serve around 9 million Americans a year. He has made the agency's performance and improvement programs public and transparent. He still sees patients — in person and via telemedicine.

[...]

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2.4 - The Huffington Post: [Yet Another Trump Administration Official Took Questionable Liberties With Work Travel](#) (29 September, Mollie Reilly, 23M online visitors/mo; New York, NY)

Veterans Affairs Secretary David Shulkin used his downtime on a recent international trip for several leisure activities, including a tennis match and river cruise, The Washington Post reported Friday.

According to the report, Shulkin spent roughly half of a 10-day trip to the U.K. and Denmark to sightsee, watch a high-profile Wimbledon match and take in other activities more typical of a vacation than a work trip.

Shulkin flew commercial for the July trip, a notable difference from other officials who have recently come under scrutiny for opting to use charter or military planes for their travel. However, the government did pay for his wife's airfare as well as some of the cost of her meals while abroad.

Read the full report [here](#).

When asked for comment on the Post story and the agency's ethics review process, a Department of Veterans Affairs spokesman pointed to a Friday announcement that the agency will now make all of Shulkin's travel itineraries publicly available and will note what kind of aircraft he used on each trip.

The revelations about Shulkin, a holdover from President Barack Obama's Cabinet, are just the latest in a series of reports regarding Trump administration officials' conduct and financial choices while traveling on official business.

Health and Human Services Secretary Tom Price has received by far the most criticism for his use of private planes and military aircraft to travel both domestically and abroad. According to a series of reports in Politico, the secretary's travel has come at an expense of more than \$1 million to taxpayers.

On Thursday, after President Donald Trump said he was "not happy" with Price, the secretary announced he would no longer take private planes and vowed to reimburse taxpayers for the expenses he's incurred. However, he plans to pay just for "his seat" — or about \$50,000.

Interior Secretary Ryan Zinke has also faced criticism for chartering a plane to travel from Las Vegas to Montana, costing taxpayers more than \$12,000.

Environmental Protection Agency Administrator Scott Pruitt and Treasury Secretary Steven Mnuchin are also under scrutiny for similar travel expenses.

The White House has said it's looking into these expenses, and on Wednesday the House Oversight and Government Reform Committee announced it had requested information from 24 federal agencies on officials' travel.

"Under 5 U.S.C. § 5733, official travel on the part of federal employees must be 'by the most expeditious means of transportation practicable' and 'commensurate with the nature and purpose of the [employee's] duties,' and by no means should include personal use," reads a letter from the committee's leadership to the agencies.

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2.5 - The Hill: [Trump VA chief went sightseeing, shopping with wife on government trip: report](#) (29 September, Brandon Carter, 11.8M online visitors/mo; Washington, DC)

Veterans Affairs Secretary David Shulkin spent nearly half his time on a recent international trip sightseeing and shopping with his wife, according to The Washington Post.

Shulkin traveled to Europe in July to attend a conference in London with representatives of several countries on veterans' health issues, as well as a series of meetings in Denmark.

The VA chief's traveling party included his acting undersecretary of health and her husband, his chief of staff, another aide and a security detail, according to the Post.

Shulkin's wife, who also accompanied him on the trip, had her airfare paid for by the government because she was traveling on "approved invitational orders," a VA spokesperson told the Post. Shulkin's wife also received a per diem for her meals.

The newspaper reports Shulkin attended a Wimbledon tennis tournament match and visited multiple palaces in both London and Denmark. Shulkin also reportedly took a cruise on the River Thames in London during the trip.

Shulkin took commercial flights for the trip and sat in coach on at least one flight, according to the Post.

VA press secretary Curt Cashour told the Post that the entire itinerary for Shulkin's trip was "reviewed and approved by ethics counsel."

"These were important trips with our allies to discuss best practices for taking care of veterans," Cashour told the Post. "The secretary has been transparent on his downtime activities that were similar to what he would have done with his family over a weekend in the U.S."

In a statement Friday, the VA said it would begin making public a list of Shulkin's official travel, including trip itineraries and his use of private and government aircraft.

"Veterans and taxpayers have a right to know about my official travel as Secretary, and posting this information online for all to see will do just that," Shulkin, a holdover from the Obama administration who President Trump tapped for the top VA spot this year, said in the statement.

Other Trump administration officials have come under fire for their travel while in office.

Health and Human Services Secretary Tom Price has reportedly racked up over \$1 million in travel costs with his use of private and military planes since May. Price said Thursday he would reimburse taxpayers just under \$52,000 for charter jet travels he's used for government business.

President Trump said Wednesday he was "not happy" with Price's use of private planes and said "we'll see" when asked if he planned to fire Price.

Interior Secretary Ryan Zinke and Environmental Protection Agency Administrator Scott Pruitt have also come under scrutiny for their use of private aircraft for government business in recent days.

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2.6 - Washington Examiner: [VA secretary saw Wimbledon match during taxpayer-funded trip to Europe: Report](#) (29 September, Melissa Quinn, 4.8M online visitors/mo; Washington, DC)

Secretary of Veterans Affairs David Shulkin and his wife, accompanied by other VA officials, attended a tennis match at Wimbledon, toured Westminster Abbey, and cruised the Thames River as part of a taxpayer-funded, 10-day work trip to Europe this summer, according to a report.

Shulkin and a group of six people, including his wife, traveled to London and Denmark in July, where Shulkin met with Danish and British officials to discuss veterans' health issues, according to an itinerary of the trip obtained by the Washington Post. The VA secretary traveled in coach on a commercial flight during at least one part of the trip.

The VA secretary attended a conference in London on July 19, one previous secretaries have also attended, that included representatives from Britain, Canada, Australia and New Zealand. He also scheduled a series of meetings in Copenhagen, Denmark, that took place from July 12 to July 14.

On two nights between the official events in London and Copenhagen, Shulkin spent one at a ceremony where a British veteran who served in Afghanistan was honored, and another meeting with British Prime Minister Theresa May.

But during the day, Shulkin, his wife, Merle Bari, Acting Undersecretary For Health Poonam Alaigh, her husband, Shulkin's chief of staff, and another aide, as well as a security detail, saw the sights and shopped.

The government covered the cost of Bari's airfare and gave her a per diem for meals, the VA told the Washington Post. Bari, the agency said, was traveling on "approved invitational orders."

"These were important trips with our allies to discuss best practices for taking care of veterans," VA spokesman Curt Cashour told the Washington Post. "The secretary has been transparent on his down-time activities that were similar to what he would have done with his family over a weekend in the U.S."

It's unclear whether the government or Alaigh covered the expenses for Alaigh's husband.

According to the itinerary of the trip, Shulkin had no official business scheduled during the days in between his meetings in London and Copenhagen.

Rather, Shulkin and his group attended the women's final at Wimbledon, where Venus Williams lost to Garbine Muguruza.

The group also visited two palaces in London, Buckingham Palace and Kensington Palace, and two in Copenhagen, Christiansborg Palace and Amalienborg Palace.

Revelations of Shulkin's trip come as four of President Trump's Cabinet officials are under scrutiny for their use of private and government planes to travel.

Secretary of Health and Human Services Tom Price is facing calls for his resignation after it was revealed he's taken at least 24 trips aboard private jets, as well as trips on military aircraft, costing taxpayers more than \$1 million.

Treasury Secretary Steven Mnuchin's travel on government planes has also come under fire.

Both Price and Mnuchin are facing probes from the inspectors general at their respective agencies, and numerous congressional committees are requesting information on administration officials' travel.

Interior Secretary Ryan Zinke and EPA Administrator Scott Pruitt have also traveled via private or military aircraft.

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2.7 - Pittsburgh Post-Gazette: [Pittsburgh VA nurse is finalist for national caregiver award](#)
(29 September, Gary Rotstein, 4.8M online visitors/mo; Pittsburgh, PA)

A nurse for the VA Pittsburgh Healthcare System is one of six national finalists for an annual award given to a medical professional who shows an exemplary caregiving approach on the job.

Victor Fagan, a licensed practical nurse from Butler, won recognition from among nearly 200 nominees who were submitted to the Boston-based Schwartz Center for Compassionate Healthcare. It will announce the winner of its 2017 National Compassionate Caregiver of the Year Award at a dinner on Nov. 16.

Mr. Fagan has worked with veterans the past five years at the VA's primary care clinic on University Drive in Oakland. He was nominated for the Schwartz Center award by co-workers who noted the unusual level of compassion and respect he brings to his role of helping others.

Examples of his efforts that were cited included his purchasing shoes for a low-income veteran's child; connecting a homeless veteran to helpful resources; celebrating patients' milestones such as birthdays; working to develop a Wall of Heroes that will honor local vets; and encouraging his fellow staff to do their own similar good work.

"Victor is always thinking of others first and incorporates caring and respect into every interaction with the veterans for whom he provides care," Christin Durham, the VA Pittsburgh primary care nursing manager, wrote in endorsing Mr. Fagan for the award.

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2.8 - PennLive (Video): [VA chief mixed business with pleasure at taxpayer expense: Media report](#)
(29 September, Ivey DeJesus, 3.1M online visitors/mo; New Bloomfield, PA)

President Donald Trump's veterans affairs chief is the latest administration official in hot water for reportedly tapping into taxpayer money to pay for vacation outings and non-official business.

Veterans Affairs Secretary David Shulkin in July took in a Wimbledon championship tennis match and a Thames River cruise on taxpayer money. That's according to a report published Friday by The Washington Post.

Shulkin was in Europe for 10 days for meetings with Danish and British officials about veterans' health issues, but during that time, the Post reports, he and his wife spent about half their time sightseeing, including shopping and touring historic sites.

The Washington Post cited an itinerary obtained by the news outlet, and which was confirmed by a U.S. official familiar with it.

Shulkin last week visited the Harrisburg area, meeting with veterans at a local VFW to outline what he said was the right direction for the embattled agency. Shulkin said to veterans that accountability was one of his top priorities.

News of Shulkin's multi-purpose trip comes on the heels of that of Health and Human Services Secretary Tom Price, who is at the center of White House- approved trips outside the bounds of protocol. The Trump administration this spring and summer approved the use of military aircraft for multi-national trips by Price to Africa, Europe and Asia at a cost of more than \$500,000 to taxpayers.

The overseas trips bring the total cost to taxpayers of Price's travels to more than \$1 million since May, according to a POLITICO review.

Price this week pledged to reimburse the government for the cost of his own seat on his domestic trips using private aircraft -- reportedly around \$52,000 -- but that would not include the cost of the military flights, Politico reported.

Shulkin's six-person traveling party included his acting undersecretary of health and her husband, his chief of staff and another aide, the Post reports. A security detail of as many as six agents was assigned to the entourage.

The Post reported that the VA said that the government paid airfare for Merle Bari, Shulkin's wife, because she was traveling on "approved invitational orders." The government also provided a per diem for her meals, the agency said.

Wimbledon tickets for final matches can run into the thousands of dollars - as can a river cruise. Shulkin also toured Westminster Abbey. Those tickets run about £22 (sterling) or approximately \$30 a person.

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2.9 - Military Times: [Amid Cabinet controversies, VA promises to post secretary's travel details online](#) (29 September, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

WASHINGTON — In response to the growing scandal of Cabinet officials using pricey private aircraft for business trips, Veterans Affairs officials announced Friday they will post details of all official travel by department Secretary David Shulkin online to provide transparency about his travels.

“Veterans and taxpayers have a right to know about my official travel as secretary, and posting this information online for all to see will do just that,” Shulkin said in a statement.

The move comes one day after Health and Human Services Secretary Tom Price announced he would reimburse the government about \$52,000 for charter flights made in recent months for government duties, a sum that amounts to only a small portion of the flights' costs.

The White House announced Friday afternoon that Price resigned.

Reports of Price's charter flights have prompted congressional investigators to look into travel expenses for all of Trump's Cabinet.

The VA's announcement also comes on the same day as a Washington Post article that details a trip Shulkin and his wife took to Europe last summer that included government business but also sightseeing and other non-work activities.

The VA told the Post that the government paid for Shulkin's wife's airfare because she was traveling on “approved invitational orders.” The VA added that all of Shulkin's activities were reviewed and approved by ethics counsel. The couple flew commercial, including at least one leg in coach, according to the Post.

VA officials said Shulkin has not used any private aircraft for travel to date, but will list them on the department's website if he employs that option in the future.

In addition, the new site will list all use of government aircraft by the secretary, along with itineraries of all official trips. That information will be available within five days of any travel, starting in mid-October.

Officials will start posting some of those details on the VA's “Secretary Travel” site later today.

Shulkin has used government aircraft for transportation six times so far this year. Five of them were aboard Air Force One, accompanying the president to events.

The sixth was a recent trip to the Invictus Games in Toronto, where he traveled with first lady Melania Trump to see wounded U.S. troops and veterans participate in athletic competitions against teams from other countries.

Shulkin has made department transparency one of the key focuses of his department reform efforts. Earlier this year, the department began posting online information on medical center wait times, employee firings and workplace settlements.

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2.10 - Providence Journal (The Enterprise): [Providence VA official relieved of duties amid allegations of racism, homophobia](#) (29 September, Paul Edward Parker, 1.2M online visitors/mo; Providence, RI)

A manager at the Veterans Affairs Regional Office in Providence has been relieved of his duties pending disciplinary action, following a complaint from a co-worker that he created a “toxic work atmosphere.”

Stephen V. Pina, the Veterans Services Center manager, who also has been embroiled in controversy after a Facebook post suggesting that New England Patriots players who knelt during the national anthem on Sunday were dancing monkeys, is “no longer engaged in processing benefits claims,” according to Mark Ramos, a spokesman for the Providence VA office.

Ramos said that disciplinary action against Pina has been proposed and that, to afford due process rights, it can’t be imposed for 15 business days. Ramos said he was not aware of the nature of the proposed discipline. In the interim, Pina has been assigned to other job duties.

Peter Rogers, who was a human resources specialist at the Providence office, said he left for another government job two years ago due to insensitive remarks made at work by Pina.

“The work environment there is awful because of him,” said Rogers, who now works for the U.S. Department of Homeland Security.

Rogers said he is an openly gay veteran who served 23 years in the military, including a tour in Afghanistan as an air traffic controller for the Air Force.

The 44-year-old Virginia native said he recalled one moment when he was driving Pina and other colleagues to an event at a VFW in Warwick. Rogers claimed that Pina made homophobic remarks during the ride.

“He was pounding on the dashboard, yelling all kinds of obscenities and f-bombs,” said Rogers. “I was completely blown away by his behavior.”

Pina, who lives in Brockton, Massachusetts, landed in hot water this week after making a comment under a Facebook story about Patriots players who knelt during the national anthem on Sunday. In the post, Pina called the players “turds” and added, “dance monkey dance.”

Pina has since resigned from his position on the Brockton Parks and Recreation Commission, after Mayor Bill Carpenter called on him to do so. A Pop Warner football team, the Brockton Junior Boxers, said Pina had stepped down as a coach after the youth football league made a statement calling for him to do so.

Pina received a \$120,000 salary last year as manager of the Veterans Service Center, overseeing 157 government employees at the downtown office on Westminster Street.

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2.11 - KATV (ABC-7, Video): [Troubles at the VA: Nurses speaking out about culture](#) (29 September, Elisabeth Armstrong, 448k online visitors/mo; Little Rock, AR)

Two former nurses who have filed EEO complaints against the CAVHS are speaking out about problems. In July, Channel 7 brought you this report out of the VA. In it, some thirty nurses filed a complaint against the hospital - alleging that under-staffing was impacting patient care.

After that story aired, more than a dozen staffers reached out to the newsroom, saying that poor management, unsafe working conditions, even claims of harassment are behind the issue.

Lyn Gardner and Brandy Ballard: both former nurses at the VA, both saying there's something wrong with the Central Arkansas Veteran's Healthcare System. Lyn is a veteran who served in the military for six years, before pursuing her dream of becoming a nurse in the VA system.

But she says that dream, turned into a nightmare: "It actually upsets me to this day, talking about it, because it was very traumatic."

In her claim she alleges that she was subjected to a hostile work environment - dealing with screaming supervisors, limited equipment, and in one case, an issue where she passed out while assisting during surgery, and never received medical attention.

"I walked out of the unit, pretty much all on my own, receiving no treatment. And that's very upsetting. As a veteran, and as an employee of a facility that's supposed to care for veterans."

Lyn says, it's this culture that creates problems for patient care: "Not having the support from management, not being able to articulate issues, is scary, because you're dealing with people's lives." Adding, changes need to be made.

Brandy Ballard agrees. She has several veterans in her family, and credits the VA with providing her grandfather life-saving cancer treatment. But she says her family members are now expressing fear about the care they're receiving.

"Another family member, more recently, voiced his concerns to me about that very VA because he didn't feel he would get the treatment he deserved with stage 4 cancer," she explains.

She says the culture at the VA has truly taken a toll on her life, alleging that nurses are punished for speaking out about patient care: "It really has affected my family. I mean, a failed marriage as a result of this, just mental anguish, physical ailments as a result of the constant stress."

This is why she says she filed a complaint. And these nurses are not the only ones - two other staffers at the VA provided me with copies of their EEO complaints. None of these have been ruled on yet, as the EEO is currently investigating several of the claims.

So, Channel 7 dug into data out of the national VA Administration. It shows that Central Arkansas Veterans Healthcare System has one of the highest nurse turnover rates in the entire VA System. They're just under the 90th percentile.

But Medical Director Dr. Margie Scott, says this is not due to workplace harassment or discrimination: "Well if you look at our exit interviews, Elisabeth, for nurses who are leaving the workforce, the top number of nurses who are leaving is due to number one taking a higher level position, and advancement in position, or number two retiring... The third most common is actually to go back to school."

Channel 7 requested those numbers and the VA complied 47% of employees said they left for those reasons (along with "relocating with a spouse") during exit interviews. But KATV also took a look at employee satisfaction scores.

When it comes to employee satisfaction, the Little Rock VA comes in at 3.8 out of 5. Dr Scott breaks down this statistic, "Over 60% of our staff think this is not only a good, but a great place to work. There's always a spectrum in any survey of low scores and high scores, but a 3.8 out of 5 is an excellent score. It's not where we want to be - we always want to be higher - so we'll continue to work on that."

But a 3.8 is also around the 50th percentile - that means 50% of other VA facilities have higher employee satisfaction rates.

And when it comes to veterans' experience, in the four categories the VA looks at, Central Arkansas comes in near the bottom of each. When it comes to comprehensiveness of care, the system scores as one of the worst.

Channel 7's Elisabeth Armstrong asked, "I probably spoke to 15 or twenty people. and a number of them said, 'I'm a veteran or I have veterans in my family, and I would not take them to the Little Rock VA. Does that concern you?'"

Dr. Scott says, "Absolutely that concerns me, and I would love to talk to those individuals and hear what they have to say as far as ways we can improve our work environment."

Dr. Scott and Acting Deputing Medical Center Director Salena Wright-Brown say the VA is implementing several new ways for employees to make their voices heard: through listening sessions, surveys, a video blog, and being selected as an "Innovation Hub."

"I think that's the key," explains Dr. Wright-Brown. "To open those communication avenues, we reassure people that nothing is going to happen negative, only positive - only improvement for our veterans."

The VA has filled 102 of the 149 open nursing positions since our first piece aired in July. However, we do not have numbers on how many have left since that time.

The system held another job fair last Saturday.

*Correction: An earlier version of this story stated the job fair was this upcoming weekend. However, it was last weekend, and officials say it was successful.

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2.12 - WQAD (ABC-8, Video): [Moline man shocked after job training center for veterans shuts down](#) (29 September, Chris Minor, 450k online visitors/mo; Moline, IL)

GARLAND, Texas - A Moline, Illinois man is one of more than 300 veterans left in the dark after a job training school they paid for through the GI bill abruptly shut its doors.

"Three weeks before graduation, we were told goodbye. They sent a senior instructor around to each class and he just came in front of the school and said, 'I need everyone to pack your bags, the schools been officially shut down and everyone needs to vacate the premises' ," said Dallas Wild, who had enrolled in the career center after hitting dead ends looking for a decent paying job in the Quad Cities.

The Retail Ready Career Center catered to veterans interested in a career in heating and air conditioning.

"They called and offered us a \$23 dollar an hour job after we got out, guaranteed job placement," said Wild.

Tuition was \$21,000 for the six week program, which included food, lodging, and round-trip air-fare. Most tuition bills were paid through the GI bill.

The Department of Veterans Affairs is investigating the job training center for unknown reasons.

The owner John Davis, is seen on video telling the students that the investigation was launched after a former employee who embezzled money from a school fund went to authorities.

Wild says he had hoped to graduate so that he could find a better job in the Quad Cities, and is uncertain what happens next.

"I spent 30 minutes on the phone with the VA. It seems they don't want to hand out information because of the investigation. Everyone is in the dark. I plan on trying to find a local company that supports vets that will give me a shot," he said.

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2.13 - FedSmith: [VA to Begin Disclosing Agency Secretary's Official Travel](#) (29 September, Ian Smith, 277k online visitors/mo; Washington, DC)

The Department of Veterans Affairs announced today that it will begin publishing all of the agency secretary's official travel on its website.

The lists include all official travel taken by Dr. David J. Shulkin since January 20, and the site will be updated within five days after the conclusion of each trip.

The webpage (which will be available at <http://www.va.gov/opa/secvatravel>) will list the use of private and government aircraft by the Secretary, and also itineraries of international and domestic trips. The details on domestic trips will be added to the website by October 15.

The information posted will also include what VA staff and spouses accompany Shulkin on each trip, if any, but for security reasons, members of the Secretary's security detail will not be listed by name or number.

Shulkin notes that the VA is the first agency to make this kind of data public. The agency also recently began posting all disciplinary actions taken against agency employees on its website in an effort to spotlight actions the agency is taking to reform its culture.

“Under this Administration, VA is committed to becoming the most transparent organization in government, and I’m pleased to take another step in that direction with this move,” Secretary Shulkin said. “Veterans and taxpayers have a right to know about my official travel as Secretary, and posting this information online for all to see will do just that.”

Increased Scrutiny of Agency Officials’ Travels

The announcement from the VA comes right after an article appeared in the Washington Post that was critical of a recent trip that Shulkin took to Europe with several individuals, including his wife, that mixed business and pleasure, the latter part including shopping trips and a Wimbledon tennis match.

The investigation conducted by the Post noted that although all aspects of the trip were approved by the agency, the VA paid for the airfare and meal per diems for Shulkin’s wife. It noted, however, that Shulkin flew on a commercial aircraft with at least one leg of the trip in coach seating.

VA press secretary Curt Cashour told the Post, “These were important trips with our allies to discuss best practices for taking care of veterans. The secretary has been transparent on his down-time activities that were similar to what he would have done with his family over a weekend in the U.S.”

The Post takes at least some credit for the VA now disclosing details about the Secretary’s travel. “In response to questions from the Post, VA announced Friday that the agency will begin posting details of the secretary’s travel online, including itineraries, and disclosing any use of government or private aircraft. That information had not previously been disclosed publicly,” according to the Post article.

The VA’s announcement also comes after news that Health and Human Services Secretary Tom Price came under heavy criticism for trips he took using a private charter jet using taxpayer money. Price has said he will repay the Treasury for costs incurred from the trips and also resigned from his position as HHS Secretary over the situation.

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2.14 - Leavenworth Times: [Sentencing continued for former VA physician assistant](#) (29 September, 46k online visitors/mo; Leavenworth, KS)

A former physician assistant who was convicted of sexually abusing patients at the Leavenworth veterans hospital will not be sentenced until November.

Mark E. Wisner was scheduled to be sentenced today in Leavenworth County District Court. But the sentencing and arguments for post trial motions have been continued until Nov. 3.

Last month, a jury convicted Wisner of one felony count of aggravated sexual battery, one felony count of aggravated criminal sodomy and three misdemeanor charges of sexual battery. The crimes occurred between 2012 and 2014 while Wisner was working at the Eisenhower VA Medical Center.

The judge in the case had something come up, and he had to reschedule all of the cases that were on his docket for Friday, according to Assistant County Attorney Michael Jones.

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2.15 - Pahrump Valley Times: [Plaques at Pahrump VA clinic recognize veterans of U.S. armed forces](#) (29 September, Jeffrey Meehan, 1k online visitors/day; Pahrump, NV)

A group of local veterans of the U.S. armed forces gathered to recognize the installation of several plaques at the Pahrump VA Community Based Outpatient Clinic in September.

Each plaque bore the symbol of one of the five branches of the U.S. armed forces and another was hung for prisoners of war.

The group, led by U.S. Army veteran Bernie Cusimano, gathered at the Pahrump VA clinic at 220 Lola Lane on Sept. 22, 2017 to recognize the plaques being hung. Cusimano was joined by several other veterans who worked to see the plaques hung at the clinic.

"We started it, and I want to acknowledge all the people that started it and thank everybody," Cusimano said.

The group was also joined by Nye County Commissioner John Koenig, District II, former Nye County Commissioner Frank Carbone and Michelle Leavitt, executive assistant/business license tech for the town of Pahrump.

The symbols were hung behind the check-in area at the Pahrump VA clinic in order of the Army, Navy, Marines and the Air Force, from left to right, which is mandatory. The prisoners of war symbol sits on another wall adjacent to the other symbols.

Cusimano said it was the end of the long process.

It took nearly two years for the group to realize the end goal, he said.

Some of the original veterans involved in the process were Pahrump Veterans of Foreign Wars Commander Tom Vick, Cusimano and Kyler Samuel Escalera, just to mention a few.

The cost of the plaques was funded by the town of Pahrump, which cost roughly \$200 each or a total of \$1,200.

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3. Access to Healthcare

3.1 - WBBM (CBS-2, Video): [2 Investigators: Disabled Vets Face Tough Parking At VA Hospital](#) (29 September, Dave Savini, 27.5M online visitors/mo; Chicago, IL)

A major problem at Hines VA Medical Center: Some sick and wounded veterans are struggling to get to their medical appointments because of parking violators.

CBS 2's Dave Savini has the story.

James Dahan, a Marine Corps veteran, gets angry when fellow wounded vets struggle to find a parking spot.

"It's clearly a violation. They need to be ticketed," Dahan says of a vehicle illegally parked near the entrance to the VA.

He says seriously injured veterans going to the Edward Hines, Jr. VA Hospital in Maywood are forced to wheel or walk long distances. This is because parking spots for those with disabilities are taken by motorists not permitted to use them.

"That really ticks me off," Dahan says.

The 2 Investigators found plenty of examples of cars, without required placards in windows, snagging the handicapped-designated spots. Even the lot reserved for spinal cord injury victims had problems. Yet CBS 2 never saw a single ticket issued.

"Seeing veterans pushing from the back of the parking lot with a wheelchair or a walker, it's disgusting," Dahan says. "They deserve a lot better than that."

There is valet service, but those lines can be long and cause delays, he says.

"If you're 15 minutes late, they cancel your appointment," Dahan says.

CBS 2 also found numerous fire lane and loading zone violators, too.

Dahan injured his foot while serving in Iraq. He has had three surgeries and suffers from nerve damage. Because of his time using a wheelchair, Dahan says he can understand how difficult it can be when parking.

"Transferring in and out of a wheelchair takes a lot more than people can understand," he says.

The 2 Investigators found a vehicle parked next to a disabled spot, in a loading zone designed to help a person in a wheelchair get in and out of their vehicle.

"They do that all the time," one driver with disabilities says.

Dahan says Hines VA needs to better patrol the lots and ticket illegal parkers. He also said they need more spaces and could use a parking structure, similar to those found at other hospitals.

A spokesperson from Hines says they are now upgrading the spinal cord lot with new signs and new striping. They are also considering hiring more valet workers, along with opening an overflow lot for employees.

The hospital's full statement:

“At Hines VA Hospital we provide outpatient care to about 2,000 Veterans on an average week day and parking is often their first and last experience with the VA. With several construction projects underway, parking is stretched to its capacity, even with more than 250 handicap accessible parking spaces available. We have 76 accessible parking spaces in our dedicated lot for Spinal Cord Injury rehabilitation. We also offer free valet services to all of our patients.

We are monitoring the parking situation and have recently taken additional steps that include:

- * Making every attempt to complete clinic visits when patients are delayed because of parking
- * Opening an overflow gravel parking lot for employees to help ensure patients and visitors have access to the most convenient spaces
- * Adding signage that identifies where patients can find additional parking and promoting the availability of free valet parking for our patients and visitors
- * Working with our volunteers to provide more frequent shuttles for patients parking in more distant lots
- * Upgrading handicap parking in our Spinal Cord Injury parking lot (additional striping & signage)

We are considering additional valet staff as needed and looking at the possibility of adding another gravel lot on the north end of the campus.

As our construction projects continue to progress, we will continue to inform our patients of any impact on parking areas via on-site signage, direct mail, social media and face-to-face communications.”

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3.2 - The News & Observer: [Vietnam vet happy to be back in Durham's VA hospital, but for how long?](#) (29 September, Thomasi McDonald, 3.9M online visitors/mo; Raleigh, NC)

DURHAM - A Vietnam veteran and double-amputee said things are “perfect” now that he is back in Durham’s Veterans Administration Medical Center, where he has lived for a little more than three years.

But James Donald Francis, 69, said he’s worried because VA officials have not told him or given him any documentation about how long he will be able to stay at the VA’s Community Living Center.

“I haven’t signed anything,” he said. “I could be here for a good night’s sleep and the next morning they could put me out of here. I haven’t seen anything. I’m in limbo. That’s where I am.”

Francis spent two days this week staying in the lobby of the facility. He refused to leave when the VA told him he had to go to an assisted living facility.

Durham VA officials have not commented about where Francis will be staying in the future, except to say it probably won’t be at their facility.

A statement from the Durham VA on Friday afternoon said, "Prior to release, we provided Mr. Francis several assisted living options within the community, however, over time it became apparent that he did not feel comfortable with those choices and wished only to remain at Durham VA. Medical care and treatment is ever-changing and that transition at times can be very difficult for our patients. We will continue to work side-by-side with Mr. Francis to provide him the proper care he has earned and deserves while we search for a suitable follow-on solution that meets his health and social needs."

Francis lost his legs after he was stricken with Agent Orange-related diabetes while fighting in Vietnam.

Sharonda Pearson, a Durham VA spokeswoman, said Francis, who undergoes dialysis treatment three times a week at the VA hospital, no longer met the medical criteria for acute in-patient care. He was discharged Monday. Francis said he returned from dialysis that day to find the door to his room locked and his belongings stuffed in several bags.

Francis then camped out in his motorized wheelchair at the patient entrance from Monday until Wednesday. By late Wednesday afternoon, the VA had a change of heart and said he would be allowed to move back into the hospital's community-based living center, at least momentarily.

The combat veteran is currently living on the second floor of the Community Living Center.

"Everything is going fine right now, for the next five minutes," he said Thursday. "You know how things can change."

He said he has been able to assume the daily routine he had before his discharge Monday.

According to the U.S. Department of Veterans Affairs website, the Community Living Center resembles "home" as much as possible. There are activities for veterans of all ages and family friendly places for visiting. Veterans are invited to decorate their rooms, and pets are allowed to visit or live at the facility.

The website said veterans may stay for a short time or, in rare instances, for the rest of their life, while receiving a nursing home-level of care that includes help with activities of daily living such as bathing and getting dressed.

On Thursday, a nurse visited Francis' room, provided him with a bedpan and rolled him to the side so he could relieve himself. The nurse, after bathing and clothing him, hoisted Francis out of bed and into his wheelchair. He rolled into the bathroom to brush his teeth and shave before going to breakfast. He was given an insulin shot, and his blood sugar level was checked for the first time since Monday.

"I been listening to the blues, but mostly talking to people here who I hadn't seen. It's been pretty much a normal day," he said. "But once I go to the bathroom and come out, I don't know if my bags are going to be packed up or what."

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3.3 - Newsday (Video): [House vet chair Roe tours Northport VA after maintenance issues](#)
(29 September, Martin C. Evans, 3.2M online visitors/mo; Melville, NY)

The head of the House Committee on Veterans Affairs came to Long Island for an up-close look at the troubled Northport VA Medical Center Thursday, saying the facility should “find the right size” to address maintenance problems straining its budget and impacting patient care.

“That’s the challenge we have, is how to provide the most economic care because money is not infinite, it is finite and budgets are tight,” said Rep. Phil Roe (R-Tenn).

Roe said he decided to visit the medical center because of reports of serious problems with maintenance at the nearly 90-year-old facility.

Roe, a physician himself, said Northport would benefit from centralizing its operations into a few core buildings, as well as pushing more of its clinical operations into satellite facilities scattered across Long Island.

The lawmaker spent about three hours touring the Northport facility, which includes more than 70 buildings, including dozens that are mostly unused. Roe was accompanied by Reps. Thomas Suozzi, (D-Glen Cove) and Lee Zeldin, (R-Shirley), and Northport director Scott Guermonprez — all of whom said they could support the concept of consolidation.

Thursday’s congressional visit also came on the heels of two internal VA investigations which concluded that repeated lapses in the facility’s engineering department led to a host of problems at Northport.

Among those problems was the failure of an air-conditioning unit at Northport’s main hospital building, which forced a months-long closure of its surgical facility, and meant that veterans requiring emergency surgery had to seek treatment at VA hospitals in Manhattan or the Bronx.

The reports also concluded that the failings of the engineering department at Northport were a financial drain on a facility already struggling against recent budgetary shortfalls.

Northport has long been viewed with near reverential regard among the area’s roughly 140,000 veterans, who typically laud its medical care for its quality and availability.

But in the past two years, veteran leaders have expressed increasing alarm over the physical condition of the medical center.

Hutch DuBosque, president of the PTSD Veterans Association of Northport, whose members use the facility for self-care meetings, said mold caused by leaking roofs and frequently-flooded underground walkways has forced his group to move therapy sessions because of respiratory distress twice in the past three months.

“Our concern is the toxic environment,” said DuBosque. “A lot of us older guys have respiratory problems, and we can’t take this stuff.”

Guermonprez, a retired Air Force officer, came on as Northport’s new director in late June, expressed agreement that some of Northport’s maintenance problems could be mitigated by consolidating to fewer buildings.

Roe said he was encouraged that Guernonprez had initiated staffing changes in the leadership of Northport's engineering, nursing and medical staff.

"I think he is headed in the right direction," Roe said.

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3.4 - Stars and Stripes: [Stage set in Congress for debate on Choice program reform](#) (29 September, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

The Department of Veterans Affairs estimated the funds that allow veterans to receive health care in the private sector will last until the end of the year – a projection that establishes a new deadline for when Congress needs to come up with a long-term solution for the Veterans Choice Program.

President Donald Trump signed legislation Aug. 12 immediately providing \$2.1 billion for the Choice program to prevent a funding crisis. VA Secretary David Shulkin had told lawmakers in June that the account was quickly and unexpectedly running out of money because of increased demand. Now, the money – originally estimated to last until February 2018 – is again being spent faster than predicted.

Shulkin told reporters Wednesday that he's confident Choice funding will last at least through the end of the year and rebuked a report from The Associated Press that the program would run out of money as early as December. The VA is spending about \$280 million each month to send veterans into the private sector for health care, he said.

"It's a very, very hard program to do accurate financial projections," Shulkin said. "We've always said it's important that Congress needs to act this fall, this legislative session so we do not get into a funding crisis."

Sen. John McCain, R-Ariz., sent a letter to Shulkin on Wednesday asking for an accounting of the program, expressing concern about another unexpected shortfall. McCain helped create the Choice program in 2014 in response to the VA wait-time scandal that originated at the Phoenix VA hospital.

Tiffany Haverly, communications director for the House Committee on Veterans' Affairs and the group's chairman, Rep. Phil Roe, R-Tenn., said Roe's office is receiving regular updates on Choice program spending. At the same time, the House committee is working on legislation to reform how the VA balances private-sector care, Haverly said Friday.

"We are continuing to monitor the account and working to move legislation to reform VA's community care programs so veterans can continue accessing care should funding be expended sooner than expected," she said.

House and Senate lawmakers undertook reform efforts following complaints from veterans that the Choice program is complex and bureaucratic. Current rules allow veterans to seek care outside the VA only if they can't receive an appointment within 30 days or they live more than 40 miles from a VA facility.

Shulkin said Wednesday that in order to avoid another funding shortfall, he wants legislation passed before Congress leaves for Thanksgiving break in mid-November.

"I expect we will get this done," he said. "We are in close communication with Congress and the White House on this. No one wants to see us putting veterans at risk."

It's expected the House and Senate will introduce their versions of Choice program reform in the next few weeks.

Shulkin has devised his own proposal, which is under review by the White House Office of Management and Budget. An early discussion draft of Shulkin's proposal describes a performance-based system in which veterans would be allowed to seek private-sector health care if the quality of VA care in a certain area isn't up to par with other providers in that community.

The issue is likely to be subject to intense debate about whether the VA is sliding too far into the private sector.

When the legislation was introduced in the summer to provide \$2.1 billion to the Choice program, eight major veterans groups railed against it. Then, they successfully pushed for another \$1.8 billion to be included in the legislation for VA hiring and infrastructure. The coalition -- comprising AMVETS, Veterans of Foreign Wars, Disabled American Veterans, Iraq and Afghanistan Veterans of America and other groups -- viewed the original plan as prioritizing private-sector health care while neglecting VA services, and as setting a dangerous precedent.

In preparation for the Choice reform debate, groups on each side of the political divide have already started advocacy efforts.

VoteVets, a left-leaning political action committee, ran a \$400,000 ad campaign in September pleading with viewers to "Tell Congress, don't let Trump privatize my VA." The advertisement aired in Alaska, Florida, Kansas, Louisiana, Maine, Minnesota, Montana, Nevada, Ohio, South Dakota, Tennessee, Texas and West Virginia.

Concerned Veterans for America, a conservative veterans advocacy group in the Koch brothers' political network, is also speaking out. The group, which gained more influence since the presidential election, has lobbied to transfer VA oversight to a government-chartered nonprofit and expand veterans' private-sector health care options.

"The Trump Administration and Congress should not be dissuaded from keeping their campaign promises to offer veterans more health care choices by Washington special interests that want to preserve the status quo at the VA," said Dan Caldwell, the policy director for CVA. "There is no excuse for Congress not to put forward a VA choice reform plan that would give all veterans who use the VA the ability to access care in the private sector."

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3.5 - WNDU (NBC-16, Video): [New VA clinic in Mishawaka will 'quadruple services'](#) (29 September, Mark Peterson, 833k online visitors/mo; South Bend, IN)

Ribbon cutting ceremonies in Mishawaka on Friday marked the completion of a \$38 million medical clinic for veterans.

About ten years ago, the Veterans Administration was first asked to study how often local vets had to travel long distances to get needed medical care.

"I'll be able to come here for my eye appointments, I'll be able to come here for my hearing appointments, and those are all things I have to go to Fort Wayne for," said veteran Chuck Damp.

"So we have most every medical every medical service you could possibly think of," said Sen. Joseph Donnelly, (D) Indiana. "Mental health services, audiology, cardiology, so many things are here for our veterans."

"The services that are provided out of here really kind of quadruple what the services were available in Michiana before," added U.S. Rep. Jackie Walorski, ® Indiana's Second District.

The hope is, with all those additional medical services available closer to those who served, trips to the doctor will no longer be something local vets dread, and could become something they grow to love.

"They said this is our home, I mean, besides being home with their family, this is their second home, with their brothers and sisters who served together with them, meeting other veterans," said Sen. Donnelly.

Veteran Chuck Damp agrees: "It's going to be so much better than veterans having to travel, like I said, Fort Wayne, Indianapolis, Marion. It's right here, right in our neighborhood."

Sen. Donnelly noted how dramatically things have changed in the past ten years when the local VA clinic was housed on the south side of South Bend in a residential neighborhood, in a building no bigger than a house.

The new facility at 1540 Trinity Place has a coffee and sandwich shop tucked away near the front entrance. A spacious lobby has high ceilings with skylights.

"I talked to so many veterans, outside as we all came rushing in the door and you could hear the ooh's and the ah's and the excitement of something that's been promised for so long, it's taken years to actually make this happen," said Rep. Walorski.

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3.6 - WNDU (NBC-16, Video): [Sen. Joe Donnelly on tax overhaul, health care and new VA clinic](#) (29 September, Jason Krug, 833k online visitors/mo; South Bend, IN)

President Donald Trump visited Indianapolis on Wednesday, pitching his tax overhaul plan.

Traveling with the president from Washington D.C. that day was Sen. Joe Donnelly.

A question some had is why the Democrat would travel on Air Force One with the Republican president.

"He's the President of the United States and whether the president was President Bush or President Obama or President Trump, I try to show respect to the position," says Donnelly on 16 Morning News. "When I have a chance to come back to my home state and to be with everybody from Indiana and welcome the president, I try to do so."

When it comes to Trump's new tax plan, there is still a lot of details to be filled in according to Donnelly, but there a few things he is working to make sure happens.

"My focus has been on keeping jobs that are here, here, making sure we create more jobs and more opportunity and making sure that middle class families' paychecks get a little bit bigger."

Republicans moved their focus to a tax overhaul after failed attempts to repeal and replace the Affordable Care Act, the latest try falling apart earlier this week. Donnelly says it did not come as a surprise to him.

"It was a terrible bill that would have taken health care away from over 400,000 Hoosiers. But I've been working behind the scenes with about 31 other senators on some bipartisan legislation that we're trying to bring up next week that I think has a great chance of passage that'll stabilize our health care programs."

The Senator also briefly touched on the new VA clinic in Mishawaka, something that he has been working 10 years to help complete. It opened last Monday, but Friday is its grand opening.

"The reason it's such a great thing is because it helps our vets and they deserve everything."

The facility is opening in three phases over the next two months, and is expected to see over 8,500 veterans per year.

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3.7 - WFLA (NBC-8, Video): [Veteran suicides, VA corruption focus of rally and protest](#) (29 September, Steve Andrews, 702k online visitors/mo; Tampa, FL)

PINELLAS COUNTY, Fla. — In the United States, 22 veterans take their lives every day.

In front of the Veterans Affairs office at Bay Pines, 22 mannequins stood to serve as a reminder of this American tragedy.

Army veteran Mike Ford admits he's come close to ending his life.

"Idea was to just go ahead and just kill yourself on V-A property right, maybe if they see, if maybe people like, wow, there's something really going on here," he told News Channel 8.

Ford was diagnosed with post-traumatic stress disorder after serving in Grenada and claims he suffered physical and mental pain for years while struggling with the VA for treatment.

After waiting nine months for an appointment, Ford left his ailing father to drive across the state to finally see a doctor at the VA.

"I go there, oh you didn't get our message, we canceled your appointment," Ford recalled.

When Ford returned home, his father was gone.

"Wasting my time with the VA when I should've been with my father. He was my hero," he said.

"If I was going to kill myself, it was going to be out here," another veteran Keith Hansford said as he pointed to the grounds at Bay Pines.

Hansford also struggles with PTSD, and said sometimes he thinks he would welcome death. "My pain, my anxiety, my nightmares all of that will stop," Keith explained.

According to Hansford, harassment by Bay Pines Police administration while he worked there, pushed him to the brink.

Hansford has organized rallies condemning police corruption and promoting suicide awareness.

In August, we told you VA police removed signs promoting Keith's rally, which were placed on a state right of way. We helped him get them back.

Hansford believes without his wife, he'd be gone.

"I'm not stronger or weaker than the ones that have killed themselves. I just had the right help at the right time," said Keith. "The help they needed didn't come when they needed it."

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3.8 - Modern Healthcare: [VA looks to ease telehealth regulations](#) (29 September, Rachel Z. Arndt, 460k online visitors/mo; Chicago, IL)

The Veterans Affairs Department proposed a rule Friday that would allow VA providers anywhere in the country to conduct telehealth visits with VA patients across state borders, regardless of state licensing.

Giving patients access to providers across state lines is necessary for the VA to grow its telehealth program and increase the number of sites where the VA provides care, wrote Michael Shores, director of regulation policy and management in the VA secretary's office. This rule would amend VA medical regulations to do so. "Eliminating veteran suicide and providing access to mental health care is VA's number one clinical priority, and this proposed rulemaking would improve VA's ability to reach its most vulnerable beneficiaries," Shores wrote.

In fiscal 2016, VA providers saw 702,000 patients via telemedicine in 2.17 million episodes of care. Nearly half of those who received telemedicine care live in rural areas.

"By increasing VA's capabilities to provide telehealth services, VA would be able to expand these services," Shores wrote.

The rule would complement the VA's push to increase the use of technology in veterans' healthcare, an effort VA Secretary Dr. David Shulkin called "anywhere to anywhere VA healthcare" when President Donald Trump announced the initiative in August.

Right now, VA telehealth care is limited by state restrictions. If a physician were to see a patient via telemedicine in a state in which the physician is not licensed to practice, that physician could lose his or her credentials and be fined.

Under the proposed rule, physicians wouldn't be penalized for providing telemedicine outside the states where they're currently allowed to practice.

A federal rule is necessary to relax these restrictions because it would take too long for every state to nix the penalties, according to Shore.

"While the VA's rule is limited, in that it would apply only to VA providers and VA patients, it could be the first step towards a national medical practice licensing concept," said Nathaniel Lacktman, a healthcare lawyer with Foley and Lardner. "Overall, I predict providers will look upon this new rule favorably."

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3.9 - KMVT (FOX-14, Video): [As Suicide Prevention Month comes to a close, the search continues for solutions to veteran suicide](#) (29 September, Peter Zampa, 71k online visitors/mo; Twin Falls, ID)

WASHINGTON (Gray DC) -- Suicide prevention month is highlighting how the U.S. Can better address the issue. A specific focus currently in Washington is a push to end veteran suicide. Senators are examining what is being done to help veterans in need, and what other efforts are necessary.

One veteran says it is not easy to solve this tragic problem.

"There's such a stigma with mental health," said Kayda Keleher, Associate Director at Veterans of Foreign Wars.

20 veterans take their own lives every day. As Suicide Prevention Month comes to a close, Keleher says addressing mental health for all Americans is the right approach to getting these veterans the help they need.

"We have to get to a point where we better understand it, and we're definitely working on that," said Keleher.

She served in the Marine Corps for five years. It's an issue dear to her heart. She says great strides are being made in areas like telehealth, but there is much more work to be done, especially helping veterans in rural areas.

"It's important that we don't forget about the basics. The proven, empirically proven, necessities of face-to-face therapy options and just being there for one another as veterans," said Keleher.

The Senate Veterans' Affairs Committee held a hearing to look at what the VA is doing to combat veteran suicide. Senator Dan Sullivan (R-AK) sits on the committee and is currently in the Marine Corps reserves. He says as a country, we need to be able to get help to every veteran in the U.S.

"I lost one of my Marines to suicide, you know, after he reached out to me. It's a very hard issue," said Sullivan.

Sullivan says key parts of the hearing with VA Secretary David Shulkin were the ability to identify mental health issues and to reach veterans in remote areas who require help. Senator Joe Manchin (D-WV), who also sits on the committee, says the VA has a shortage in qualified mental health specialists.

"We need help. We need professionals. We need psychiatry help, we need to be able to get these people and give them the assistance they're needing," said Manchin.

The senators say implementing these new ideas will be key in saving lives. If you or someone you know is a veteran struggling with suicidal thoughts you can dial 1-800-273-8255 and press one.

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3.10 - mHealth Intelligence: [New Rule Would Give VA Doctors National Telehealth Privileges](#) (29 September, Eric Wicklund, 53k online visitors/mo; Danvers, MA)

The Department of Veterans Affairs is moving forward with a plan to enable VA doctors to treat veterans through telehealth no matter where the doctor or patient are located, essentially overriding state laws.

Officials said the 28-page proposed order, unveiled on Sept. 29 under the VA's Anywhere to Anywhere VA Health Care Initiative, aims to boost the number of veterans using telehealth and telemedicine to access needed healthcare services, especially mental health services. It would give VA doctors the authority to use telehealth and telemedicine to treat veterans regardless of state guidelines on originating sites or licensing requirements.

It also could be seen as a veiled criticism of the mishmash of state laws regulating telehealth and telemedicine, which often do more to curb new healthcare services than promote them.

"In an effort to furnish care to all beneficiaries and use its resources most efficiently, VA needs to operate its telehealth program with healthcare providers who will provide services via telehealth to beneficiaries in states in which they are not licensed, registered, certified, or located, or where they are not authorized to furnish care using telehealth," the proposed order states. "Currently, doing so may jeopardize these providers' credentials, including fines and imprisonment for unauthorized practice of medicine, because of conflicts between VA's need to provide telehealth across the VA system and some states' laws or licensure, registration, certification, or other requirements that restrict or limit the practice of telehealth. A number of states have already enacted legislation or regulations that restrict the practice of interstate telehealth, as discussed below in the Administrative Procedure Act section."

As a result, VA officials say, many VA centers aren't expanding their telehealth and telemedicine programs to non-federal locations, such as the patient's home or the doctor's home. And VA doctors are reluctant to take on telehealth for fear of running into conflicts with state laws.

"This proposed rulemaking would clarify that VA healthcare providers may exercise their authority to provide care through the use of telehealth, notwithstanding any state laws, rules, or licensure, registration, or certification requirements to the contrary," the proposed rule states. "In so doing, VA would exercise federal preemption of state licensure, registration, and certification laws, rules, regulations, or requirements to the extent such state laws conflict with the ability of VA healthcare providers to engage in the practice of telehealth while acting within the scope of their VA employment."

"Preemption would be the minimum necessary action for VA to furnish effectively telehealth services because it would be impractical for VA to lobby each state to remove its restrictions that impair VA's ability to furnish telehealth services to beneficiaries and then wait for the state to implement appropriate changes," the rule continues. "That process would delay the growth of telehealth services in VA, thereby delaying delivery of healthcare to beneficiaries. It would be costly and time-consuming for VA and would not guarantee a successful result."

According to the VA, some 702,000 veterans, or 12 percent of the country's veteran population, used telehealth or telemedicine in FY 2016, accounting for 2.17 million telehealth episodes. Of that group, 45 percent were living in rural communities.

"The data collected in FY 2016 demonstrates that telehealth, particularly in the mental health context, improves patient care and improves patient outcomes," the proposed order points out. "In FY 2016, there was a 31 percent decrease in VA hospital admissions for beneficiaries enrolled in the Home Telehealth monitoring program for non-institutional care needs and chronic care management. Also, beneficiaries who received mental health services through synchronous video telehealth in FY 2016 saw a reduction in the number of acute psychiatric VA bed days of care by 39 percent."

Other benefits, the VA said, include improvements to remote monitoring for veterans with limited mobility or difficulties traveling to a healthcare provider, and its use as an incentive to recruit more VA healthcare providers, thereby reducing a national shortage.

The proposal surfaced when VA Secretary David Shulkin unveiled the Anywhere to Anywhere VA Healthcare Initiative in August, in a ceremony attended by President Donald Trump. At that time he also announced the nationwide roll-out of the Veteran Appointment Request (VAR) app, which allows veterans to use their smartphone, tablet or computer to schedule or modify appointments at VA facilities.

"What we're really doing is, we're removing regulations that have prevented us from doing this," he said. "We're removing geography as a barrier so that we can speed up access to Veterans and really honor our commitment to them."

Shulkin garnered support from, among others, the American Telemedicine Association – which has scheduled him as a keynote speaker at its ATA Edge conference next week in Washington D.C. – and Sen. Joni Ernst (R-Iowa), whose bill, the Veterans E-Health & Telemedicine Support (VETS) Act of 2017, seeks to give VA doctors that same authority.

“The VA’s decision to allow veterans to access care from the comfort of, or closer to, their own homes is necessary to improving quality and timely care for the more than 200,000 veterans in Iowa, particularly those who are disabled or reside in rural communities,” Ernst, a National Guard veteran, said. “It is critical that we continue to create opportunities for veterans to receive the best care out there, including potentially life-saving mental healthcare. Improving the VA’s telehealth program is critical, and I am thrilled to see this common-sense measure will be put into action to benefit Iowans and veterans across the country.”

The industry trade group Health IT Now also supports the measure.

“This proposed rule will be instrumental in breaking down geographic barriers that, for too long, have prevented our nation’s heroes from accessing the care they need where they need it,” Joel White, the group’s executive director, said in a Sept. 29 blog post. “By allowing VA telehealth providers to more easily treat patients across state lines, we can ensure that recent advances in technology-enabled care reach the most deserved among us and spur better outcomes for the 20 million veterans in the VA system today.”

Supporters also say the success of such a program could help spur efforts to create a national licensing framework for healthcare providers, such as the Interstate Medical Licensure Compact for doctors and similar compacts for nurses and physical therapists. It might also spur state medical boards to collaborate more freely on national telehealth and telemedicine standards.

But the proposal may draw complaints from state officials and national physicians’ groups interested in preserving each state’s right to regulate telemedicine and telehealth inside its borders.

During Congressional deliberation last September on the National Defense Authorization Act for FY 2017, the American Medical Association and American Academy of Family Physicians lobbied against a telehealth benefit for the TRICARE program that would have designated the originating location for certain telehealth services to be the physician’s location, instead of the patient’s location. They argued the legislation would enable physicians treating military personnel and veterans to skip state licensing laws when treating patients via telehealth.

In a Sept. 1 letter to Congressional leaders, AAFP Board Chairman Robert L. Wergin, MD, warned that the Senate version of the bill “portends a troubling scenario under which state licensing boards will lack the authority to discipline physicians who are practicing medicine within that state’s borders.”

“While this language would indeed ease barriers that hinder the free flow of telehealth services, it also would undermine the existing system of medical licensure, under which each state governs the practice of medicine within its borders,” Wergin wrote. “Allowing physicians with a single license to treat TRICARE beneficiaries in any state via telemedicine would create episodes of medical care that the state in which the patient resides cannot readily regulate, if at all.”

The Defense bill was eventually passed without the telehealth provision.

The proposed order is scheduled to be published in the National Register on Monday, Oct. 2. The public comment period will last 30 days.

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3.11 - WLTZ (NBC-38, WSB/ABC-2, Video): [Hospital Evacuees from Caribbean Arrive in Atlanta](#) (28 September, Nami Dockery, 44k online visitors/mo; Columbus, GA)

Cobb County, GA – Hospital patients evacuated from the Caribbean due to hurricane Maria are finding refuge in Georgia.

Doctors and nurses welcomed the patients after a plane carrying roughly 40 medical evacuees landed Wednesday night.

It comes after the hurricane caused widespread power outages, including a loss of electricity at hospitals.

A VA Medical Center official says medics will triage the patients to ensure proper care.

Some evacuees will travel to Atlanta area hospitals, while others will stay in hotels.

Three flights carrying evacuees have landed so far, and more are expected over the next few days.

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3.12 - Marion Republican: [Bost 'not happy' with VA investigation; vows to look further into allegations at Marion VAMC](#) (29 September, Holly Lee, 14k online visitors/mo; Marion, IL)

The conclusion of a Veterans Affairs inquiry into allegations of nepotism, employee intimidation and why some patients died at the VA Medical Center in Marion leaves one southern Illinois congressman "not happy" with the answers and vowing further action.

Rep. Mike Bost (R-Murphysboro), vice chairman of the Oversight and Investigations subcommittee of the House Committee on Veterans Affairs, said he doesn't believe the VA's investigation into complaints at the Marion VA Hospital went far enough.

Bost received the VA's analysis Sept. 22, about two months after his initial inquiry. Neither he nor the VA has made the Sept. 22 report public, citing the privacy of individual veterans mentioned within.

Even so, Bost said, he was "really not happy with the response," especially the VA's explanation for the deaths associated with the 54-bed Community Living Center, the nursing home facility on the VA campus. He characterized the VA's overall answers as "vague," with no real plan for correcting issues going forward, and "almost like they aren't sure these issues are that big of a problem."

Neither the Department of Veterans Affairs nor the Marion VA responded to calls for comment on Bost's criticisms.

Bost said that for the most part, "the Marion VA does a good job and people like them." The Marion VA provides care to nearly 44,000 veterans annually in 27 southern Illinois counties, as well as eight counties in southwest Indiana and 17 in northwest Kentucky. It also operates 10 outpatient clinics around the region.

"We just need more answers than we are getting," Bost added. "The incidents we have been hearing about ... I think they need to be looked into more."

Bost said his first step will be to discuss his concerns with the VA report in a face-to-face meeting with VA Secretary David Shulkin. If he is not satisfied with those answers, he said, he and subcommittee Chairman Jack Bergman (R-Michigan) could proceed with a congressional hearing. There, the committee would call its own witnesses.

In July, Bost and Bergman wrote to Shulkin asking for information on specific allegations related to the Marion VA Hospital. They also questioned why the results of a 2016 employee "culture" survey at Marion, routinely done at all VA facilities every two years, was so dramatically worse than the one taken in 2014, specifically in the areas of patient safety and employee morale.

The allegations Bost and Bergman asked the VA to investigate include:

- Reported staff concerns about patient safety that either "disappeared" or did not make it up the chain to the VAMC director;
- Why the Veterans Integrated Service Network (VISN) did not fully investigate complaints from Marion VA employees, despite calls by the VA National Center for Patient Safety to do so;
- The deaths of 15 veterans since October 2016, either while they were patients in the Community Living Center or shortly after discharge, and whether inadequate care played a role in any of them;
- Reports of "retaliation, unprofessional conduct and bullying" toward employees by Marion leadership;
- That one Marion administrator is alleged to have hired his wife as an administrative officer for the surgery department.

Bost said he and Bergman are hoping to get their meeting with Shulkin within two weeks. If a congressional hearing follows, he said it would include ranking members of both parties.

"This is a huge concern," Bost said, adding the Marion VA is not the only one in the nation undergoing scrutiny at the moment. In May 2016, Bost sponsored a bipartisan House bill addressing the issue of VA medical centers operating without permanent directors -- an instability that makes it more difficult to implement long-term reforms affecting patient care. That bill, which passed the House unanimously, is now in the Senate.

"Continual uncertainty at the top of any organization is destructive, and it certainly makes it tougher to fix problems," he said.

The Marion VA has had three directors in about five years. That's not as big a turnaround as at some VA hospitals, Bost said, but not as consistent as he would like.

"I want to make sure that all of our VAs are operating at a certain level, and taking care of our veterans, our heroes," he said. "With the problems in the VA around the nation, we need a response. This is not the last chapter."

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4. Women Veterans

4.1 - The Mercury: [Expo will focus on women entrepreneurs and female veterans](#) (29 September, Donna Rovins, 187k online visitors/mo; Pottstown, PA)

Phoenixville >> A unique expo highlighting women entrepreneurs and female veterans is scheduled for Saturday, Oct. 7, at Phoenixville Area Middle School.

The 2017 Women Entrepreneur & Women Veteran Expo will give women from different business areas the opportunity to connect with each other to educate, share information and inspire other women to become business owners, according to organizer Dolores Winston, founder and CEO of Here to Apparel. The online shop specializes in sports attire and souvenirs that promote positive thinking, according to the company's website.

"We're bringing women entrepreneurs and women veterans together to spend the day connecting with each other and supporting each other," Winston said. "This is about sharing the knowledge to help another woman."

Winston said she had organized an entrepreneur expo in 2011. But this year's event is different because it focuses on women entrepreneurs and women veterans.

The expo will include panel discussions, the opportunity to visit with vendors promoting products and services, the chance to network with potential new customers and entertainment. At the end of the day, the group will name a woman entrepreneur of the year from the Phoenixville area. That award will be presented by state Rep. Warren Kampf, R-157th Dist.

"My dream is to bring women entrepreneurs together. On this day motivated women will share, educate, encourage, inspire, and rejuvenate us to bring out the best in ourselves," Winston said on the website for the event.

A highlight of the event, according to Winston, will be the presentation of two youth entrepreneurs: Jenna Swymelar, a fifth grade student at Renaissance Academy Charter School in Phoenixville and Jessica Meyers, a fifth grade student at Schuylkill Elementary School in Phoenixville.

Winston said the young entrepreneurs will present their businesses to the group. Swymelar has a business called Sweet Dream Pillows by Jenna, while Meyers' business is balloon creations.

Keynote speaker for the event will be Dr. Betty Moseley Brown, associate director, Center for Women Veterans at the Department of Veterans Affairs in Washington, D.C., and 19th president of the Women Marines Association.

"I met her at an event in Indiana, and when she heard what we were doing in bringing women entrepreneurs and women veterans together, she wanted to be part of it," Winston added.

Another speaker will be Jason Raia, executive vice president of the Freedoms Foundation of Valley Forge, a national educational non-profit that encourages "engaged, responsible citizenship," according to the organization's website. Winston said Raia will speak about the organization's youth outreach.

Two panel discussions will be held during the day. The first will feature six Phoenixville-area businesswomen, who will share stories about starting their own businesses.

The second panel discussion will focus on empowerment. Winston said the group of five women, "come from different areas of experiences and we'll share what we're doing and how we're empowering women," she said.

In addition to Kampf's presentation of the Woman Entrepreneur of the Year award, citations will be presented to the winner by state Sen. Andrew Dinniman, D-19th Dist., and U.S. Rep. Ryan Costello, R-6th Dist.

The event will be held from 2-7 p.m. Oct. 7 at the Phoenixville Area Middle School, 1000 Purple Pride Parkway in Phoenixville. Winston said more than 20 vendors have signed up to attend will attend the event. The 2017 Women Entrepreneur & Women Veteran Expo is free, and while registration is not required, people planning to attend can register at <https://weexpo.eventbrite.com>.

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4.2 - KSFY (ABC-13, Video): [Sioux Falls conference puts spotlight on women veterans](#) (29 September, 4k online visitors/day; Sioux Falls, SD)

The annual Women Veteran Conference was held Friday in Sioux Falls.

The event was put on by the Sioux Falls VA.

About 86 women veterans attended this year's event.

Organizers said it is important to recognize women veterans and honor their service and sacrifice.

"They tend to be invisible and under recognized by the general public, by VA staff, by other veterans, and so this is just a way to bring them into the spotlight and say 'thank you,'" Brenda Fredericks, Women Veteran program manager, said.

The event also featured artwork by women veterans. The artwork is traveling around to different VA centers throughout the country.

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5. Appeals Modernization

6. Strategic Partnerships

7. Supply Chain Modernization

7.1 - WFED (AM-1500): [VA close to awarding Cerner contract for new EHR](#) (29 September, Nicole Ogrysko, 831k online visitors/mo; Washington, DC)

The Veterans Affairs Department is preparing to award its contract with Cerner Corporation for a new electronic health record in the next month or so.

The award comes after the department announced its decision abandon its own, existing Veterans Information Systems and Technology Architecture (VistA) and adopt MHS Genesis, the same EHR system that DoD is deploying. All patient data will reside in one common Cerner Millennium system.

“We released to Congress, to you, a 30-day notice of award of a contract,” VA Secretary David Shulkin said of the EHR during Wednesday’s Senate Veterans Affairs Committee hearing. “We are keeping on the timeline that we talked about. We’re marching forward. We have the principles. I have some updates to share with you on the strategic IT plan, because I think we are making a lot of progress with that.”

Shulkin signed a “determination and findings” (D&F) form back in June, which grants special permission for VA to issue a direct solicitation to Cerner Corporation for the acquisition of MHS Genesis.

Initial discussions with Cerner were expected to take three to six months, Shulkin said when he announced his decision in early June.

Shulkin said part of the department’s IT strategic plan will include a sunset of 80 percent of VA’s current projects under development.

“By concentrating on some specific IT modernization initiatives, like [electronic health record modernization, financial management business transformation], etc., and leveraging cloud and digital platforms, the 80 percent reduction of ongoing development projects is expected to occur within 18 months, which is part of the overall IT modernization roadmap,” VA Press Secretary Curt Cashour wrote in an email.

VA will migrate or stop 240 out of 299 current projects, Cashour added.

A government source familiar with VA said the department is ending development on projects that aren’t going anywhere. The plan is shift those funds to the new EHR, the source said.

It’s still unclear just how much the new electronic health record will cost, but VA’s IT office faced a \$215 million budget cut in the president’s fiscal 2018 proposal.

Shulkin told lawmakers in May that he'd likely need to return to Congress to work with appropriators after he decides on the department's direction for a new EHR.

The EHR project is a massive undertaking for VA. The department has more than 100 versions of VistA. Those versions exist because VA hospitals largely had the freedom over the past 40 years to change the software to conform to the standards their leaders and doctors wanted to see, former VA IT executives have said.

The department has also outlined the broad principles it envisions it will need in a new EHR, in addition to the other tools and pieces it may need to complement the Cerner system.

"We haven't gotten to defining which specific tools they are yet, and how we're going to meet those needs," Shulkin said. "We've talked about the days of VA being a software developer are over, and we're going to be looking at off the shelf, current technologies. There's going to be a lot more definition on that."

This all comes as the VA's current chief information officer and acting assistant secretary for information and technology, Rob Thomas, announced his retirement next month.

Thomas, who has 35 years of federal experience, took on the CIO position in January, after Laverne Council left because of the change in administration.

VA has been struggling to fill the position since then. Shulkin said during a June budget hearing that a candidate for the CIO position withdrew his name but did not offer a more detailed expansion.

"I need help," Shulkin told reporters after Wednesday's hearing when asked about the leadership vacancies. "This is a big, complex organization. I need the best team possible. I need my nominees, all my political appointments to clear through the vetting process and then to go through their confirmation if it's required. And I need additional people from the private sector who want to come and serve their country to get in touch, because we need the A team on this."

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8. Other

8.1 - ABC News (AP): [The Latest: John Kelly given authority over Cabinet travel](#) (29 September, 24.1M online visitors/mo; New York, NY)

The Latest on Health and Human Services Secretary Tom Price's resignation from the Trump Cabinet (all times local):

7:45 p.m.

The White House is giving chief of staff John Kelly authority to sign off on government travel on government-owned, rented, leased or chartered aircraft.

The change comes after Tom Price resigned Friday as President Donald Trump's health secretary over his costly travel.

White House budget director Mick Mulvaney has issued the new guidance, reminding the heads of executive branch departments and agencies that they are public servants and that every penny they spend comes from taxpayers.

Mulvaney tells Cabinet secretaries and department heads to consider whether commercial travel would be a more appropriate use of public funds even when the guidelines allow for the use of government-owned or chartered aircraft.

Mulvaney says that just because something is legal doesn't make it right.

5:55 p.m.

The resignation of Tom Price as secretary of Health and Human Services is drawing partisan responses from Republican and Democratic lawmakers.

Price resigned Friday amid investigations into his costly travel on charter flights.

The Republican House speaker, Paul Ryan, is praising Price, saying that the former Georgia congressman and House Budget Committee chairman is a "good man."

The top House Democrat, Minority Leader Nancy Pelosi, says Price should never have become health secretary because the country needs someone in the job "who believes in health care for all Americans."

Pelosi says President Donald Trump should pick a replacement who will stop the administration's sabotage of health care programs.

Price has been a top Democratic target because he's been a point man in Trump administration efforts to scrap and undermine "Obamacare."

[...]

12:01 p.m.

The secretary of the Department of Veterans Affairs says information about his official travel will be posted on the department's website.

Secretary David Shulkin says he has not used private aircraft for official business, but has taken six trips on military aircraft.

The trip details will include the type of aircraft, members of the traveling party and information about the events he was attending.

His decision to post his travel information comes as Health and Human Services Secretary Tom Price finds his job in jeopardy over his use of costly charters. Price has said he would reimburse the U.S. Treasury nearly \$52,000 for the cost of his seat on the charter flights. He has not addressed the overall cost of the flights, which are estimated to cost hundreds of thousands of dollars.

[...]

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8.2 - ABC News (AP): [A look at questions over Cabinet members' travel](#) (29 September, 24.1M online visitors/mo; New York, NY)

Health and Human Services Secretary Tom Price has resigned amid controversy over his use of costly private charter flights on government business. But other Cabinet members are also facing congressional scrutiny over their travel.

Interior Secretary Ryan Zinke dismissed the controversy over charters as "a little BS over travel," but he acknowledged taxpayers do have the right to know official travel costs.

The Price controversy was a catalyst for the House Oversight and Government Reform Committee to launch a government-wide travel investigation. The panel is seeking detailed records from the White House and 24 departments and agencies on the use of government planes as well as private charters.

Here's a look at what other Cabinet members are saying:

—Interior's Zinke said he's taken three charter flights while in office, including a \$12,375 late-night trip from Las Vegas to his home state of Montana in June. Zinke said no commercial flight was available at the time he planned to fly for a speech to Western governors. He also went on a military flight with Agriculture Secretary Sonny Perdue to view wildfires in Montana. All of his travel was approved in advance by Interior's ethics officials "after extensive due diligence," Zinke said.

—Veterans Affairs Secretary David Shulkin said he has not used private aircraft for official business but has taken six trips on military aircraft. Information about his official travel will be posted on the department's website, he said.

—At the Treasury Department, the inspector general is investigating all requests for and use of government aircraft, including those by Secretary Steven Mnuchin, who came under fire for requesting a government aircraft to use on his honeymoon. The request was later withdrawn.

—The EPA said four non-commercial flights taken by Administrator Scott Pruitt were pre-approved by ethics lawyers. The agency's inspector general opened an inquiry last month into Pruitt's frequent taxpayer-funded travel on commercial planes. The Associated Press reported earlier this year that Pruitt often spends weekends at his Tulsa home.

— The Pentagon said Defense Secretary Jim Mattis has never requested or used charter aircraft. Mattis has reimbursed the government for the cost of some unofficial travel, but the Pentagon did not immediately provide the number of trips or the total costs repaid. The secretary of defense is required to travel on military aircraft wherever he goes so he can be in contact with the president and the chairman of the Joint Chiefs of Staff. Military planes carry the secure communications equipment required for classified calls and video teleconferences. In addition, the military flights of top defense leaders often double as training missions for Air Force crew.

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8.3 - The Washington Times (AP): [Couple gets jail for keeping veteran's dead body in home](#) (29 September, 10.8M online visitors/mo; Washington, DC)

NEW PHILADELPHIA, Ohio - An Ohio couple criminally charged for keeping a Vietnam veteran's decomposing body in their home for several months to steal his Social Security and veteran benefits have received six months in jail.

The New Philadelphia Times Reporter reports 50-year-old Brian Sorohan and 46-year-old Stacy Sorohan also received two years' probation Thursday in Tuscarawas County.

The Wainwright residents pleaded no contest to gross abuse of a corpse and theft in a plea agreement. The couple must pay \$1,300 in restitution to the Veterans Administration and \$4,100 to the Social Security Administration.

Seventy-one-year-old Robert Harris' body was found in the couple's home March 22. Authorities searched the home that day after relatives became concerned about Harris' well-being.

Attorneys for the couple said in court the Sorohans regretted what they did.

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From: (b) (6)

Cc:

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Subject: [EXTERNAL] 5 October Veterans Affairs Media Summary and News Clips

Date: Thu Oct 05 2017 04:17:20 CDT

Attachments: 171005_Veterans Affairs Media Summary and News Clips.docx
171005_Veterans Affairs Media Summary and News Clips.pdf

Good morning,

Please find the attached Veterans Affairs Media Summary and News Clips.

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Veterans Affairs Media Summary and News Clips

5 October 2017

[1. Top Stories](#)

1.1 - U.S. News & World Report (AP): [Unclean Floors, Kitchens Found at Colorado](#)

[Veterans Hospital](#) (4 October, Dan Elliott, 24M online visitors/mo; Washington, DC)
Dirty floors, unclean kitchens and dusty vents were found by inspectors who checked a veterans hospital in Denver and a small veterans clinic in southern Colorado, according to a government report. Made public Wednesday by the Veterans Affairs Department's inspector general, the report did not say whether the conditions caused any health problems for patients.

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1.2 - HuffPost: [VA Loan Program May Be Letting Veterans Down, A shortage of home appraisers is gumming up the works.](#)

(4 October, Ann Brenoff, 22.9M online visitors/mo; New York, NY)

One of the promises we make members of the military is that in exchange for their service, we promise to ease their transition back into civilian life when the time comes. For over seven decades, a major element of that deal has been the VA loans that veterans can use to buy a home.

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1.3 - The Hill: [House Dems boycott VA reform discussion over inclusion of right-leaning group: report](#)

(4 October, Ellen Mitchell, 11.8M online visitors/mo; Washington, DC)
House Democrats boycotted a veterans health care reform discussion Tuesday over the inclusion of an advocacy group with ties to Republican Party donors, Military Times reported. House Veterans' Affairs Committee Democrats would not attend the meeting because Concerned Veterans for America (CVA) would be there. Democrats accused the group of being more interested in political attacks than creating new policy.

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1.4 - Military.com: [VA Photo ID Cards for All Veterans Coming in November](#)

(4 October, Amy Bushatz, 9M online visitors/mo; San Francisco, CA)
All honorably discharged veterans of every era will be able to get a photo identification card from the Department of Veterans Affairs starting in November due to a law passed in 2015. The law, known as the Veterans Identification Card Act 2015, orders the VA to issue a hard-copy photo ID to any honorably discharged veteran who applies. The card must contain the veteran's name, photo and a non-Social Security identification number...

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1.5 - Stars and Stripes: ['Alzheimer's is a veterans' disease:' New group tries to improve support for vets with dementia](#)

(4 October, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

It was part of Taylor's motivation to help create VeteransAgainstAlzheimer's, which officially launched Tuesday. The group is partnering with the Department of Veterans Affairs and Veterans of Foreign Wars to increase funding for Alzheimer's research, boost support for caregivers and enroll more veterans who are affected by dementia into the VA.

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2. Veteran and Employee Experience

2.1 - The Hill: The VA's woes cannot be pinned on any singular administration (4 October, Rory E. Riley-Topping, 11.8M online visitors/mo; Washington, DC)
Actions express priorities. Unfortunately, for the nation's veterans, the current priorities of the U.S. Department of Veterans Affairs have not changed much in the Trump era. As much as blaming Trump's populist policies or rousing rhetoric is an easy answer for any problem currently facing the nation, in the interest of fairness, it is important to note that the VA's woes cannot be pinned on any singular administration or political party, including the Trump administration.

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2.2 - Dayton Daily News: Dayton VA gets primary care director; Lima clinic to open at new site (4 October, Barrie Barber, 1.1M online visitors/mo; Dayton, OH)
The Dayton VA Medical Center has appointed a former Air Force medical officer to director of primary care and a larger clinic will open next spring in Lima, the federal health agency said. Edward P. Syron, a medical administrator, will earn the \$120,900-a-year overseeing primary and home-based care outpatient services, the VA reported. He replaces Dr. Kavita Peddireddi, who served in the job temporarily until a permanent replacement was found.

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2.3 - Military Times: House Democrats boycott VA health event, complicating reform plans (4 October, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)
Plans to overhaul veterans health care this fall could be in jeopardy after House Democrats boycotted a supposedly friendly roundtable discussion on the issue Tuesday over the inclusion of a Republican-linked advocacy group they insist is more interested in political attacks than policy crafting. The controversy comes just a few weeks before House lawmakers are planning to fast-track new legislation surrounding outside care programs at the Department of Veterans Affairs...

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2.4 - The State Journal-Register: 'Unaccompanied' veterans honored at Camp Butler National Cemetery (4 October, 834k online visitors/mo; Springfield, IL)
Ten "unaccompanied" veterans were honored at Camp Butler National Cemetery on Tuesday. The veterans were recently buried at the cemetery but either had no relatives or no relatives who could travel to the cemetery at the time of burial. The twice-annual ceremony includes the presentation of colors, a ceremonial flag folding, rifle volley and the playing of "Taps" presented by the Sangamon County Interveterans Burial Detail.

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2.5 - New Hampshire Union Leader: VAMC volunteers recognized (4 October, 318k online visitors/mo; Manchester, NH)
The Manchester VA Medical Center recently held a volunteer recognition ceremony in honor of its 320 registered volunteers, who serve in more than 28 departments within the facility. The Medical Center's volunteers work directly with veterans as drivers, welcome ambassadors and

recreation aides to behind-the-scenes work in the warehouse, in the research department and in management.

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2.6 - The Augusta Chronicle: [Club Car donates new golf cart to help disabled at Charlie Norwood VA Medical Center](#) (4 October, Nefeteria Brewster, 240k online visitors/mo; Augusta, GA)

Club Car dedicated a 2017 golf cart, valued at more than \$16,000, to the Charlie Norwood VA Medical Center to help get disabled veterans from the parking lot to the front of the facility. Although the uptown medical center holds two rows of handicapped spaces around the facility, Fred Palmer, a Club Car spokesman, said the new golf cart can further help those who are unable to secure those spots.

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2.7 - WRDW (CBS-12, Video): [Solution to VA Uptown Parking Problem](#) (4 October, Celia Palermo, 914k online visitors/mo; North Augusta, SC)

The distance from the parking lot to the hospital doors can be pretty far depending on where you park. Veterans say they're sick of walking the distance. The VA says they know and they're fixing it. "A lot of us have difficulty walking...be it bad hips...bad knees...or bad ankles." He walks with a cane because he has arthritis. It's a price he paid, he says, for serving his country.

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2.8 - WTAJ (CBS-10): [New director at Altoona VA Hospital](#) (4 October, Charlotte Ames, 192k online visitors/mo; Altoona, PA)

The new director at Altoona's Van Zandt VA Medical Center says she hopes to increase the number of services available to area veterans. Currently, the facility doesn't provide specialty services such as cardiology and cancer treatment, so veterans must travel to Pittsburgh for treatment. Sigrid Andrew said her goal is to offer those services in Altoona through the use of telemedicine and visiting clinics.

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2.9 - Foster's Daily Democrat: [UNH veterans adaptive sports program receives federal grant](#) (4 October, 191k online visitors/mo; Dover, NH)

The University of New Hampshire's Northeast Passage Program will receive a \$172,974.49 grant from the Department of Veterans Affairs (VA) to support adaptive sports opportunities for veterans and servicemembers with disabilities, according to Congresswomen Carol Shea-Porter and Annie Kuster.

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2.10 - Altoona Mirror: [Van Zandt director makes debut, Andrew said she chose job because veterans seem happy, staff respectful](#) (5 October, William Kibler, 74k online visitors/mo; Altoona, PA)

After Sigrid Andrew applied to become director of the Van Zandt VA Medical Center, but before she was offered the job, she came here and sat in various lobbies and waiting rooms, observing interactions between employees and veterans. She noticed that the veterans seemed happy, that the employees were kind and that they were respectful of each other.

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2.11 - WAND (NBC-17, Video): [Camp Butler National Cemetery honors 10 unaccompanied veterans](#) (4 October, Meredith Hackler, 68k online visitors/mo; Decatur, IL)

The gloomy weather matched the somber tone 10 veterans were honored for their sacrifice to our country. "The unaccompanied honors veterans ceremony is a way we show respect to veterans that come to our cemetery without family members or without being accompanied by their loved ones," said Antonio Henderson, assistant director of Camp Butler National Cemetery.

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2.12 - KXRM (FOX-21, Video): [Veteran students speak out after Career Center shuts down](#) (3 October, Carly Moore, 58k online visitors/mo; Colorado Springs, CO)

Dozens of veterans are out of luck after a school they were attending for a technical degree has been shut down. The school in North Texas is called Retail Ready Career Center (RRCC) which focuses on giving veterans hands-on training and professional job placement assistance in the HVAC industry. Two Colorado Springs veterans were enrolled in the class and both of their stories are exactly the same.

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2.13 - The Daily News: [Staller retires from VA Medical Center](#) (4 October, 54k online visitors/mo; Iron Mountain, MI)

After 24 years of federal service, Patricia Staller of Iron Mountain has retired from the Oscar G. Johnson VA Medical Center. Staller was born and raised in Fort Atkinson, Wis., and is the daughter of Donald and Marie Peterson. She graduated from the University of Wisconsin-Milwaukee with a master's degree in social work.

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2.14 - FEDweek: [Improving Policy-Making at VA a Complex Task, GAO Finds](#) (4 October, 51k online visitors/mo; Glen Allen, VA)

The Veterans Health Administration, the largest arm of the VA, is encountering several difficulties as it attempts to improve its policy-making, GAO has said. Under a policy issued last year, directives and notices are now the sole documents for establishing national agency policy; other types of documents, such as program office memos, are considered guidance.

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2.15 - Journal Express: [Residents seek answers at VA town hall](#) (4 October, Pat Finan, 9.2k online visitors/mo; Knoxville, IA)

A town hall meeting about the Veterans Administration campus on Thursday, Sept. 28, focused not only on the site's future but on vets themselves. The quality of their health care drew nearly as much attention as the 170-acre site during the two-hour discussion among about 125 people at the Knoxville Performing Arts Center. Many participants sought details of the process by which the government rids itself of the property. Others were frustrated about depressed or suicidal military comrades.

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3. Access to Healthcare

3.1 - WDBJ (CBS-7): VA expanding use of tele-medicine to improve access for veterans (4 October, Joe Dashiell, 833k online visitors/mo; Roanoke, VA)

The VA Medical Center in Salem is expanding the use of tele-medicine, as a way to improve veterans' access to health care. Wednesday, a company that provides the technology to the Department of Veterans Affairs demonstrated some of the newest equipment in Salem. Lindsay Gill is the Facility Telehealth Coordinator at the Salem VA Medical Center.

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3.2 - The National Law Review: Department of Veterans Affairs Aims to Trump State Telemedicine Rules (4 October, 475k online visitors/mo; New York, NY)

The U.S. Department of Veterans Affairs ("VA") is taking a significant step towards expanding needed services to Veterans by proposing a rule to preempt state restrictions on telehealth. Most states currently restrict providers (including VA employees) from treating patients that are located in that state if the provider is not licensed there. As a result, the VA has had difficulty getting a sufficient number of providers to furnish services via telemedicine for fear that they will face discipline from those states for the unlicensed practice of medicine.

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3.3 - WCSH (NBC-6, Video): Lawsuit targets Togus VA for botched operations (4 October, Don Carrigan, 442k online visitors/mo; Portland, ME)

Six Maine military veterans are waiting for a federal judge in Portland to decide if they will be allowed to sue the Veterans Administration. Those veterans all say they had foot or ankle surgery at the Togus VA hospital, and that the doctor botched the operations. That doctor left in 2008, but the veterans say they still suffer pain and other problems.

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3.4 - WHAS (ABC-11, Video): Annual event offers one-stop shop for homeless (4 October, Sara Wagner, 439k online visitors/mo; Louisville, KY)

The latest numbers show more than 6,000 people are struggling with homelessness in Louisville. Wednesday, a group of people put their talents together to help drastically reduce those numbers. Homeless Connect is an annual event aiming to serve hundreds of homeless individuals by offering dozens of free resources.

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3.5 - KRGV (ABC-5, Video): Local Organizations Provide Options for Homeless Valley Veterans (4 October, Cecillia Gutierrez, 275k online visitors/mo; Weslaco, TX)

One homeless veteran is one too many. On any given night, 39,000 veterans in the U.S. find themselves without a permanent roof over their head, according to the U.S. Department of Housing and Urban Development. Clifford Briggs is one of those veterans. From looking at him you would never know he was homeless with his big smile, positive attitude and contagious laughter.

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3.6 - KRGV (ABC-5, Video): [Valley Vietnam Veteran Battles Diabetes Linked to Agent Orange Exposure](#) (4 October, Ryan Nelson, 275k online visitors/mo; Weslaco, TX)

Veterans who believe they are suffering from an illness linked to Agent Orange may have health care options through the VA. "One of the most important things that they need to do when they believe that they've been exposed to Agent Orange is to come by either the McAllen outpatient clinic or the Harlingen outpatient clinic," said VA Texas Valley Coastal Bend spokesperson Reynaldo Leal.

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3.7 - KOLO (ABC-8, Video): [Reno physician helps Veterans in Puerto Rico](#) (4 October, Terri Russell, 274k online visitors/mo; Reno, NV)

Under normal circumstances, Dr. Ivan Correa is the chief of staff at the Veterans Affairs Sierra Nevada Health Care System. He is also a Puerto Rican native, and decided to fly to the island to check on the status of his parents, after two devastating hurricanes hit the area. "They tell me they are ok. But ok is a relative term..."

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3.8 - KRIS (NBC-6, Video): [Mobile veterans services center touring county](#) (4 October, Roland Rodriguez, 197k online visitors/mo; Corpus Christi, TX)

With more than 30,000 veterans in Nueces County, the Veterans Affairs Office has come up with a way to make serving those who served our country a little easier by going mobile. The mobile unit will be traveling throughout the county over three days next week, and it's equipped to provide a variety of services to local veterans. This a great way to help veterans who live out in rural areas.

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3.9 - The Robesonian: [Battaglia's death latest proof of veterans' neglect](#) (4 October, Editorial Board, 72k online visitors/mo; Lumberton, NC)

It looks as if an SBI investigation will conclude that Kevin Anthony Battaglia, retired Army, just 33 years old, someone's son, and the father of three young children, died when he was struck by an officer's bullet during a standoff at his Parkton home on Sunday. But make no mistake: This was suicide by cop, and Battaglia is only the latest veteran of our Middle East wars to pick that poison after returning to this country a shattered self...

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3.10 - KXLH (CBS-25, MTN News, Video): [VA Montana hosts Fall Health Festival](#) (4 October, John Riley, 57k online visitors/mo; Helena, MT)

Over 550 Veterans received their Flu immunization today along with community members and V-A staff. VA Montana staff braved the cold temperatures outside to kick off the flu season with the annual Fall Health Festival and Drive Thru Flu Clinic. The shots were free for enrolled veterans and VA employees and the County Health Department were on hand to supply flu shots for a fee for everyone else.

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3.11 - HealthTech: [NHIT Week 2017: Technology Improves Care Options for Veterans - Telehealth and predictive analytics are among the tools being deployed more](#)

strategically by the VA, Secretary David Shulkin says. (4 October, Dan Bowman, 20k online visitors/mo; Vernon Hills, IL)

One day after publication of a rule that would let doctors at Department of Veterans Affairs facilities leverage telemedicine to provide care to patients anywhere, VA Secretary David Shulkin discussed his agency's goals for using technology moving forward.

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4. Women Veterans – No Coverage

5. Appeals Modernization – No Coverage

6. Strategic Partnerships

6.1 - WIBW (CBS-13, Video): Visually impaired veterans tour Kansas Statehouse (4 October, Deneysa Richard, 484k online visitors/mo; Topeka, KS)

The VA of Eastern Kansas sponsored an event on Tuesday that left a long lasting impact. The Topeka and Leavenworth VA campuses partnered with The Kansas State Capitol to host a tour for veterans who are visually impaired. Over 40 veterans were in attendance, some of who visited the Capitol for the first time.

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7. Supply Chain Modernization

7.1 - Washington Technology: B3 Group wins \$156M VA financial, program management order (4 October, Ross Wilkers, Vienna, VA)

Leesburg, Va.-based small business B3 Group has won a five-year, \$156 million task order for financial and program management services to the Veterans Affairs Department. The VA awarded the order under its potential 10-year, \$22.3 billion T4NG IT services contract vehicle. Work under this order supports software development lifecycle tasks for the VA's financial services center, B3 Group said Tuesday.

[Hyperlink to Above](#)

8. Other

8.1 - CNN: Investigations opened into Zinke's meeting with Golden Knights hockey team (4 October, Miranda Green, 29.7M online visitors/mo; Atlanta, GA)

The OSC probe is the sixth known investigation into travel by the administration's cabinet members. The most recent investigation opened was into Veterans Affairs Secretary David Shulkin's July business trip to London and Denmark, which included meetings with Danish and UK officials as well as a stop at Wimbledon.

[Hyperlink to Above](#)

8.2 - ABC News (Video): [Top Democrat questions Kellyanne Conway's air travel](#) (4

October, Benjamin Siegel, 24.1M online visitors/mo; New York, NY)

In addition to Price, Interior Secretary Ryan Zinke, Veterans Affairs Secretary David Shulkin and Treasury Secretary Steven Mnuchin have all come under fire for their use of government planes or private aircraft.

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8.3 - WRIC (ABC-8, Video): [Virginia taxpayers funding deadly dog experiments at McGuire VA Medical Center](#) (4 October, Kerri O'Brien, 477k online visitors/mo; Richmond, VA)

We've known for months that federal tax dollars have been funding the deadly dog experiments at McGuire VA Medical Center. Now, 8News has learned that Virginia has funded those canine experiments, and it has some lawmakers calling for an end to the contributions. Documents obtained through a Freedom of Information Act request show that the Commonwealth of Virginia contributed to the funding for the McGuire Medical Center's dog experiments.

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8.4 - Fayetteville Observer: [Veteran charged in Gray's Creek murder](#) (4 October, Drew Brooks, 439k online visitors/mo; Manchester, NH)

A spokesman for the Fayetteville VA Medical Center confirmed Wednesday that Vann works at the VA. He was hired at around the time he graduated from the Veterans Treatment Court, but the spokesman could not provide any other details. In 2016, he told The Fayetteville Observer that he had turned his life around with the help of the Veterans Treatment Court team...

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8.5 - CBS News Radio (ConnectingVets.com): [Mr. Secretary, why is the VA abusing dogs?](#)

(4 October, Jonathan Kaupanger, 23k online visitors/mo; New York, NY)

Puppies having holes drilled into their heads, then parts of their brains removed. Latex injected into puppies' coronary arteries before they're forced to run on treadmills until they have a heart attack. Dogs with severed spinal cords, invasive lung experiments... it's all just another day at the Department of Veterans Affairs.

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1. Top Stories

1.1 - U.S. News & World Report (AP): [Unclean Floors, Kitchens Found at Colorado Veterans Hospital](#) (4 October, Dan Elliott, 24M online visitors/mo; Washington, DC)

DENVER (AP) — Dirty floors, unclean kitchens and dusty vents were found by inspectors who checked a veterans hospital in Denver and a small veterans clinic in southern Colorado, according to a government report.

Made public Wednesday by the Veterans Affairs Department's inspector general, the report did not say whether the conditions caused any health problems for patients.

The report , dated Sept. 29, said a February inspection found cleanliness problems in eight patient care areas, two areas where instruments are sterilized and in some ice machines and refrigerators in kitchens.

It also said some ventilation grills and horizontal surfaces were dusty.

The report did not specify whether the problems were at the aging Denver hospital or a small outpatient clinic in Salida, Colorado, which inspectors also visited. Kristen Schabert, a spokeswoman for the VA's Denver-based Eastern Colorado Health Care System, said inspectors focused on the Denver hospital.

A new veterans medical center is under construction in suburban Aurora to replace the Denver facility and is expected to open next year. The February inspection did not include that facility.

In a written statement, the VA said plans are in place to address the problems the inspectors found.

The VA nationwide is under scrutiny over spending, long wait times for care and other problems.

Last month, The Associated Press reported the VA program that pays for veterans to get health care in the private sector could run out of money this year, despite getting \$2.1 billion in emergency funding in August. Another shortfall could force the VA to limit referrals to outside doctors, causing delays in medical care for hundreds of thousands of veterans.

In Colorado, the cost of the medical center being built outside Denver has nearly tripled to almost \$1.7 billion. That so infuriated lawmakers that they stripped the department of the authority to oversee large construction projects and put the Army Corps of Engineers in charge.

Other problems found in the February inspections in Colorado:

- Two doors in a mental health treatment facility were found unlocked and the alarms were not turned on.
- Inspectors found no record that some new employees were given required security training.
- Inspectors found no evidence that security personnel were compiling or analyzing data on violent or disruptive incidents.

-- Staff did not compile adequate reports on some patients who were transferred to other facilities, including whether the patients were stable enough to be moved and whether the new facility was told the patients' history, symptoms and test results.

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1.2 - HuffPost: [VA Loan Program May Be Letting Veterans Down, A shortage of home appraisers is gumming up the works.](#) (4 October, Ann Brenoff, 22.9M online visitors/mo; New York, NY)

One of the promises we make members of the military is that in exchange for their service, we promise to ease their transition back into civilian life when the time comes. For over seven decades, a major element of that deal has been the VA loans that veterans can use to buy a home.

These loans require no money down and can be obtained with much lower credit scores than other mortgages. But the much-vaunted program, which began under the GI Bill of 1944, has hit a snag.

The Mortgage Bankers Association recently warned the Department of Veterans Affairs that the program may be hurting the very vets it was designed to help.

Here's The Deal

Under the VA loan program, veterans can borrow up to \$417,000 — or \$625,000 in designated “high cost areas,” like parts of California — without putting any money down for a house that will be their principal residence. That's a good deal considering the median home value in the U.S. is currently \$200,700, according to Zillow.

Among the program's other attractions, there is no maximum debt ratio — meaning that the borrower's monthly mortgage payment can exceed the typical lender's restriction of no more than 28 percent of gross monthly income. There is no minimum credit score requirement either, while most other home mortgages require a credit score of at least 620 for conventional loans or 580 for most Federal Housing Administration loans. A VA loan can also be used to refinance an existing loan. And vets can get these loans more than once.

The VA home loan program is one of the key reasons that 79 percent of veterans own their own homes, compared with just 63 percent of the non-veteran population, according to Trulia.com.

But recent vets don't seem to be taking advantage of the program in large numbers. Just 36 percent said they had applied for a VA home loan in a 2014 survey of 2,000 members of Iraq and Afghanistan Veterans of America.

Pressured Not To Use VA Loans

Real estate agents have long complained that the VA's hurry-up-and-wait requirements when it comes to appraisals and inspections, associated red tape and extra hoops to jump through compared with conventional loan programs ultimately hurt veterans' efforts to purchase homes in a competitive market.

Now the Mortgage Bankers Association is highlighting the problem of delays in the appraisals that the VA requires. There is a shortage of available appraisers, which has led to longer wait times and missed contract deadlines.

Add the appraiser shortage to the fact that it's just faster and simpler to work with other buyers, and some home sellers and their agents shy away from dealing with VA loans. As a result, the mortgage bankers group said, veterans are under pressure to bypass the benefits of a VA loan and seek conventional financing instead.

Steve O'Connor, senior vice president of the Mortgage Bankers Association, laid out his group's concerns in a Sept. 5 letter to the executive director of the VA's Loan Guaranty Service, who oversees the loan program. He said that veterans often can't close a VA loan and are forced "to choose other loan programs to meet certain deadlines or face other adverse outcomes."

Finding alternate home funding means having to come up with as much as a 20 percent down payment, meeting tighter credit standards and walking away from a promised benefit they earned when they put their lives on the line for their country. A non-VA loan can also cost the veteran an additional "tens of thousands of dollars of interest payments over the life of the loan," O'Connor wrote.

The VA did not respond to questions emailed by HuffPost or make a spokesperson available for comment by publication time.

Appraisers Are Upset

While the Mortgage Bankers Association letter was sparked by anecdotal evidence provided by its members, the group is not the first to note the impact of changes to the appraisal industry — changes that have not set well with current appraisers and may have discouraged new ones from entering the field.

Almost 75 percent of the 2,248 appraisers surveyed in a 2017 study from the National Association of Realtors said they planned to leave or have already left the business because of greater regulation and an industry shift away from working directly for lenders to working for larger companies that manage groups of appraisers. These appraisal management companies take as much as 50 percent of what home buyers pay in appraisal fees.

The Dodd–Frank Wall Street reform law of 2010 put in place new federal guidelines that required banks to have a "firewall" between lenders and appraisers to avoid conflicts of interest. These appraisal management companies blossomed as the new middlemen, but the actual appraisers — the people who do the hands-on work — saw their pay cut. Appraisers also contend they're unfairly taking the blame when the companies "gouge" buyers with excessive fees, according to housing writer Kenneth R. Harney.

So appraisers are unhappy these days, and the assignments they most don't want to accept are those involving VA loans, according to the National Association of Realtors study. The double whammy of red tape and low compensation was the given reason.

To address the problem, the Mortgage Bankers Association offered a series of recommendations to the VA: use a virtual desktop appraiser to supplement the traditional

process of on-site visits, grant property inspection waivers, and lend its support to a proposal from the Appraisal Qualifications Board to reduce licensing requirements.

“The damaging impact to the veteran community is clear and the VA should act quickly,” the group wrote.

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1.3 - The Hill: [House Dems boycott VA reform discussion over inclusion of right-leaning group: report](#) (4 October, Ellen Mitchell, 11.8M online visitors/mo; Washington, DC)

House Democrats boycotted a veterans health care reform discussion Tuesday over the inclusion of an advocacy group with ties to Republican Party donors, Military Times reported.

House Veterans’ Affairs Committee Democrats would not attend the meeting because Concerned Veterans for America (CVA) would be there. Democrats accused the group of being more interested in political attacks than creating new policy.

CVA was one of 18 veterans groups invited to the event, including the American Legion, AMVETS, Iraq and Afghanistan Veterans of America and Wounded Warrior Project.

“The chairman has the right to invite any organization he pleases, but to pretend that CVA is anything other than a partisan organization that invests time and money into discrediting Democratic members of Congress, and specifically the ranking member of this committee, is disingenuous,” Griffin Anderson, press secretary for the committee’s Democrats, told Military Times.

“We will not pretend it is anything else.”

House lawmakers are looking to quickly move new legislation on outside care programs at the Department of Veterans Affairs (VA), including the Veterans Choice Program.

Under the three-year-old Choice program, the VA pays for veterans who live too far away from the nearest Veterans Health Administration (VHA) facility or need a quicker medical appointment to use private doctors and hospitals.

Critics of several proposals to replace the Choice program are afraid that will lead to privatizing the VA. Outsourcing veteran care to the private sector, they fear, will divert billions of dollars from VHA services to medical providers that can’t be as well supervised and that have limited experience caring for veterans.

VA Secretary David Shulkin has promised to replace the Choice program with the Coordinated Access and Rewarding Experiences program (CARE) to be revealed this month.

The closed roundtable discussion which Democrats refused to attend covered broad outlines of the upcoming proposals.

"It is disappointing that the Democrat members of the committee did not want to hear ideas on how to fix the VA from a group of veterans, including many patients of the VA and combat veterans like myself," said Dan Caldwell, the policy director for CVA.

A spokeswoman for House VA Committee Chairman Phil Roe (R-Tenn.) told Military Times that attendees for the event "were invited to participate because of their interest in and serious study of VA's community care programs. They were invited for that reason and that reason only."

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1.4 - Military.com: [VA Photo ID Cards for All Veterans Coming in November](#) (4 October, Amy Bushatz, 9M online visitors/mo; San Francisco, CA)

All honorably discharged veterans of every era will be able to get a photo identification card from the Department of Veterans Affairs starting in November due to a law passed in 2015.

The law, known as the Veterans Identification Card Act 2015, orders the VA to issue a hard-copy photo ID to any honorably discharged veteran who applies. The card must contain the veteran's name, photo and a non-Social Security identification number, the law states.

A VA official on Wednesday confirmed the cards are on track to be available nationwide starting in November. Veterans may apply for the card online, but a timeline for how long it will take to receive a card after application has not been finalized, the official said.

Although the law states that the VA may charge a fee for the card, the official said no fee is planned.

The change comes as the military exchange stores prepare to open online shopping to all honorably discharged veterans starting Nov. 11. Veterans who wish to use that new benefit must be verified through VetVerify.org.

Congress passed the ID law as a way to help veterans prove their service without showing a copy of their DD-214.

"Goods, services and promotional activities are often offered by public and private institutions to veterans who demonstrate proof of service in the military, but it is impractical for a veteran to always carry Department of Defense form DD-214 discharge papers to demonstrate such proof," the law states.

Some veterans already carry such proof of service.

Those who receive health care from the VA or have a disability rating can get a photo ID VA health card, also known as a Veteran Identification Card. Military retirees also hold an ID card issued by the Defense Department.

Veterans are also able to get a proof of service letter through the VA's ebenefits website. And some states will include a veteran designation on driver's licenses if requested.

Editor's Note: The fourth and fifth graphs have been updated with additional information from the VA.

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1.5 - Stars and Stripes: [‘Alzheimer’s is a veterans’ disease:’ New group tries to improve support for vets with dementia](#) (4 October, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

WASHINGTON — Shawn Taylor knows the strain that Alzheimer’s can put on a family.

Her grandmother developed Alzheimer’s in the early 1980s. Then, her grandfather was diagnosed with the disease. Then her mother and father.

At age 21, as an only child and grandchild, the deadly form of dementia forced Taylor to become a caregiver for the next 35 years.

“I understand the intense caregiver needs,” she said. “And as I watch my mother slip away -- unable to recognize me, unable to take care of her most basic needs -- I realized I needed to do more.”

It was part of Taylor’s motivation to help create VeteransAgainstAlzheimer’s, which officially launched Tuesday. The group is partnering with the Department of Veterans Affairs and Veterans of Foreign Wars to increase funding for Alzheimer’s research, boost support for caregivers and enroll more veterans who are affected by dementia into the VA.

Her decision to focus her attention on veterans -- a group disproportionately at risk for dementia -- was personal, too. Taylor’s grandfather, John Gavin, was an Army colonel and West Point graduate, and her father, Bernard Landau, is a retired lieutenant colonel and Vietnam War veteran.

The veterans-focused group is a new segment of UsAgainstAlzheimer’s, which lobbies to increase research for a cure. George Vradenburg, a cofounder of UsAgainstAlzheimer’s, described the organization as “small, feisty and fearless.”

“We’re learning far too often veterans are disproportionately affected by this disease and are at a greater risk for Alzheimer’s because of their war-related brain impairments,” Vradenburg said. “Alzheimer’s is a veterans’ disease.”

article continues below

Veterans are at higher risk for Alzheimer’s for several reasons, explained David Cifu, a researcher and traumatic brain injury specialist at the VA. There’s a higher prevalence of mental health disorders in the veterans community, he said, which creates more likelihood of developing dementia. According to a study in the Journal of the American Geriatrics Society, the risk of Alzheimer’s doubles for veterans with post-traumatic stress disorder.

Traumatic brain injury also increases the risk of dementia, and of developing it earlier in life, according to a 2014 study published by the American Academy of Neurology. Older veterans

with TBI are 60 percent more likely to develop dementia than other veterans, according to the study.

Iraq and Afghanistan veterans are at higher risk to develop Alzheimer's sometime in their lives because they've sustained more brain injuries, VeteransAgainstAlzheimer's wrote in a report Monday. Of all combat wounds in Iraq and Afghanistan, 22 percent were brain injuries – nearly double the brain injuries sustained during the Vietnam War.

"Now more than ever, we need to redouble our efforts," Cifu said.

One study published by the National Institute of Health estimates 420,000 veterans will have developed Alzheimer's between 2010 and 2020.

About 270,000 veterans with dementia are enrolled in the VA, Cifu said. The number enrolled in the VA represents only about 35 percent of the 774,000 veterans estimated to have dementia.

The VFW got involved in order to improve the numbers, said Ryan Gallucci, a director with the VFW. Some veterans and families don't realize they qualify for VA benefits, such as caregiver support, Gallucci said.

Others are barred from those services because of VA regulations. For instance, some caregiver benefits are available only to family members of veterans wounded post-9/11. There's legislation in Congress, H.R. 1472 and S. 591, that would expand the services to all veterans.

Karen Garner, who was a caregiver to her husband, Senior Master Sgt. Jim Garner, said she didn't qualify for VA assistance because of income restrictions. She said her husband, who died of Alzheimer's last year at age 52, was confused and hurt that the VA wouldn't provide help.

"With the low enrollment numbers in VA... we have to do better than this," Gallucci said. "This is where we can help make a difference."

Increasing funding for Alzheimer's research is also key, said Cifu. In 2016, the VA conducted 157 research projects on Alzheimer's disease across 44 locations, at a cost of \$30 million.

"This sounds like a lot, and it is, but we need to do even more," he said.

Cifu is part of a consortium of specialists at the VA and Defense Department starting a new study to find connections between brain injury and dementia, he said. The group is looking to get as many veterans and servicemembers involved as possible.

At age 56, Taylor is still a primary caregiver. Her mother is in the late stages of Alzheimer's, and her father was just diagnosed with the disease last fall.

Taylor is hoping improvements in research and support could help Vietnam War-era veterans such as her father -- who's now 87 and living in a nursing home -- as well as the potential surge of Iraq and Afghanistan veterans who could develop the disease in the next 20 to 30 years.

"What we want to do is start the conversation," Taylor said. "Nobody wants to talk about it, but we have to talk about it. It's happening, and what's ahead of us is going to be devastating."

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2. Veteran and Employee Experience

2.1 - The Hill: [The VA's woes cannot be pinned on any singular administration](#) (4 October, Rory E. Riley-Topping, 11.8M online visitors/mo; Washington, DC)

Actions express priorities. Unfortunately, for the nation's veterans, the current priorities of the U.S. Department of Veterans Affairs have not changed much in the Trump era.

As much as blaming Trump's populist policies or rousing rhetoric is an easy answer for any problem currently facing the nation, in the interest of fairness, it is important to note that the VA's woes cannot be pinned on any singular administration or political party, including the Trump administration.

Entrenched accountability issues such as those that are plaguing the VA take time to resolve. But, it appears that, thus far, the Trump administration may have over-promised and under-delivered.

Trump campaigned on a platform of overhauling the VA, and despite a robust legislative agenda aimed at following through on those campaign promises, the VA's priorities over the last several months have included gallivanting through Europe, defending questionable research programs, and delaying the release of a much-needed strategic plan on the future of the Veterans Choice program.

Wasting taxpayer funding seems to be at the route of many of the VA's problems. As explained by Avik Roy, a health care policy advisor and president of the Foundation for Research on Equal Opportunity, "[i]f you look at the budget of the VA and simply divide it by the number of people enrolled . . . there's more than enough money to fund veterans' healthcare. The problem is too much of the money is being spent not on veterans' healthcare, but on other institutional priorities."

The first institutional priority distracting top VA officials from veterans' healthcare relates to splurging on travel. Although VA Secretary David Shulkin's travel indiscretions pale in comparison to other members of the Trump cabinet, such as recently-resigned Health and Human Services Secretary Tom Price who spent over \$1 million of taxpayer funds on charter flights, a Washington Post investigation into Shulkin's travel revealed that, while veterans continued to struggle with the improved access to care promised by the Trump administration, he attended Wimbledon, toured Westminster Abbey, and took a cruise along the Thames at taxpayer expense. The VA's Office of the Inspector General is now conducting its own investigation into the propriety of these travel expenses.

The revelations regarding Shulkin's travel were particularly egregious in light of the fact that, less than two weeks prior, Shulkin signed a memo instructing VA staff to curtail travel in order to "generate savings" within the department. Ironically, the memo went on to state that providing clearly documented rationale on the necessity of official travel was required to promote "accountability in determining whether employee travel in their organization is essential."

Assuming that leadership starts from the top, Shulkin has failed to provide the type of leadership necessary to promote the type of accountability and cost savings that are essential to reforming the department he oversees.

The second institutional priority distracting the VA from veterans' healthcare is in regard to the department's controversial canine research program. Many in the veterans community found it bizarre that, during the month of September, which is National Suicide Prevention Awareness Month, the only public opinion authored by Shulkin for a major media outlet was an opinion piece defending this program in USA Today, while he remained relatively silent publicly on internal data released the same week on the high rates of veteran suicide in rural states and among female veterans, until the Senate Committee on Veterans' Affairs scheduled a hearing on the topic at the end of the month.

As noted by Ben Krause, disabled veteran and founder of the website Disabledveterans.org in a San Diego Tribune article discussing this topic, "I'm not going to say canine research should or shouldn't be done at all, I just don't think the VA should do it. VA has a hard enough time not withholding healthcare from veterans on a regular basis." If VA could redirect its zealotry in defending this program to providing better access to care, veterans would certainly be better off.

Finally, the third institutional priority distracting VA from veterans' healthcare is its inability to effectively implement the Veterans Choice Program. Although the Choice Program is relatively new, having been first signed in to law in 2014, VA has consistently struggled with the role of private sector care in conjunction with VA-care, with some equating the Choice Program with the demise of the department and full-scale privatization of the VA.

As VA continues to find a balance between its own existence and the role of private sector care, it nonetheless asked Congress for an emergency increase in funding for the program due to increased demand.

Despite legislation in August that provided the program with an additional \$2.1 billion in funding, the money continues to be spent faster than expected because of a combination of the popularity of the program and VA's inability to properly account for the money. As a result, VA has slowed down veterans' referrals for medical appointments outside the VA, thus causing additional delays in needed care.

In requesting additional funding, Shulkin acknowledged to a Senate subcommittee in charge of VA funding that "we do not want to see veterans impacted at all because of our inability to manage budgets." However, this is exactly what is continuing to happen.

As Sen. John McCain (R-Ariz.) said in a scolding to Shulkin in a letter dated Sept. 27

"On June 21 of this year, I joined several of my colleagues in writing to you to express our serious concerns about reports of financial mismanagement at the VA. We said at the time that it was essential, given the growing demand for care under the Choice program, that the VA immediately correct the failures that created such a serious shortfall. It appears as if you have not done so."

It should go without saying that VA's top priority should be veterans, but as the current administration's actions have demonstrated to date, this is not always the case. Only when the VA embraces a culture of veterans first, rather than entrenched bureaucracy first, can they

overcome the many institutional detriments distracting them from effectively using its taxpayer funded budget to provide veterans with first class care.

Rory E. Riley-Topping has dedicated her career to ensuring accountability within the Department of Veterans Affairs (VA) to care for our nation's veterans. She is the principal at Riley-Topping Consulting and has served in a legal capacity for the U.S. House of Representatives Committee on Veterans' Affairs, the National Veterans Legal Services Program, the U.S. Court of Appeals for Veterans Claims, and the Department of Veterans Affairs, and can be reached on Twitter @RileyTopping.

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2.2 - Dayton Daily News: [Dayton VA gets primary care director; Lima clinic to open at new site](#) (4 October, Barrie Barber, 1.1M online visitors/mo; Dayton, OH)

DAYTON - The Dayton VA Medical Center has appointed a former Air Force medical officer to director of primary care and a larger clinic will open next spring in Lima, the federal health agency said.

Edward P. Syron, a medical administrator, will earn the \$120,900-a-year overseeing primary and home-based care outpatient services, the VA reported. He replaces Dr. Kavita Peddireddi, who served in the job temporarily until a permanent replacement was found.

Syron, who joined the VA staff three years ago, was a former chief of non-VA care coordination and a group practice manager at the medical facility.

He's also an assistant adjunct professor in medicine at the Wright State University Boonshoft School of Medicine, according to the VA.

Next spring, a larger VA outpatient clinic is scheduled to open at 750 High St. in Lima. The renovated 9,750-square-foot leased facility will handle a growing patient case load that has risen 10.5 percent over two years, figures show.

The new facility will have about 100 more parking spaces than the current location at 1303 Bellfontaine Ave., the VA said.

The clinic has served about 4,200 veterans and counted more than 22,000 outpatient visits within the past year, the VA reported.

The VA also plans a \$1 million expansion of an outpatient clinic in Springfield, officials announced in August. Proposals to expand on site or move to a new location were due this December. The VA has targeted an opening in 2018.

The Dayton VA Medical Center has a more than \$425 million budget and employs about 2,100 employees at the medical center and four outpatient clinics in Lima, Middletown and Springfield, Ohio and Richmond, Indiana. The facilities treated about 39,300 patients in the past fiscal year, said spokesman Ted Froats.

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2.3 - Military Times: [House Democrats boycott VA health event, complicating reform plans](#) (4 October, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

WASHINGTON — Plans to overhaul veterans health care this fall could be in jeopardy after House Democrats boycotted a supposedly friendly roundtable discussion on the issue Tuesday over the inclusion of a Republican-linked advocacy group they insist is more interested in political attacks than policy crafting.

The controversy comes just a few weeks before House lawmakers are planning to fast-track new legislation surrounding outside care programs at the Department of Veterans Affairs, including the problematic Choice program.

The topic was already sensitive within the veterans community before the boycott, with concerns about shifting funding to private-sector physicians and the possibility of a slow dismantling of VA responsibilities.

But tensions grew this week when Democrats on the House Veterans' Affairs Committee refused to attend Tuesday's event because of the presence of Concerned Veterans for America, an advocacy group with ties to Republican Party donors.

"The chairman has the right to invite any organization he pleases, but to pretend that CVA is anything other than a partisan organization that invests time and money into discrediting Democratic members of Congress, and specifically the ranking member of this committee, is disingenuous," said Griffin Anderson, press secretary for the committee's Democrats.

"We will not pretend it is anything else."

CVA was one of 18 veterans groups invited to the event, a group that included the large legacy organizations such as the American Legion and AMVETS as well as newer organizations like Iraq and Afghanistan Veterans of America and Wounded Warrior Project.

Several VA officials also attended, including soon-to-be acting VA Undersecretary for Health Carolyn Clancy. Committee Chairman Rep. Phil Roe, R-Tenn., moderated the discussion.

Individuals in the closed roundtable characterized the discussion as largely non-eventful, covering broad outlines of the proposals to come. Dan Caldwell, policy director for CVA, criticized the Democratic members for turning it into a political issue.

"It is disappointing that the Democrat members of the committee did not want to hear ideas on how to fix the VA from a group of veterans, including many patients of the VA and combat veterans like myself," he said. "We have worked for years to develop comprehensive and bipartisan solutions to the VA's problems and appreciate that Chairman Roe invited us."

Tiffany Haverly, communications director for Roe, said attendees for the event "were invited to participate because of their interest in and serious study of VA's community care programs. They were invited for that reason and that reason only."

CVA is a controversial force within the veterans community. Earlier this year, the group ran ads in Minnesota blasting committee ranking member Rep. Tim Walz, D-Minn., for blocking VA reform proposals favored by Republicans, saying that he “let veterans down.”

Group officials have declined to release funding sources and trustee information for the group, but numerous news reports have linked the group to the Koch brothers network of conservative activist organizations. They’ve also enjoyed significantly better access to policy talks and events under President Donald Trump than they did under former President Barack Obama.

Unlike most veteran advocacy groups, CVA’s non-profit designation allows them to spend significant amounts on political or lobbying efforts. Haverly said committee precedent has included organizations like CVA in the Capitol Hill discussions.

Groups like IAVA and the Veterans of Foreign Wars have had similar lobbying arms in the past.

CVA’s main focus in recent years has been pushing for an expansion of outside care options for veterans. Officials there insist the current VA system is too overwhelmed and archaic to provide reliable, swift service for veterans’ medical needs, and have advocated for widespread changes to the system to allow more competition between VA hospitals and private-sector medical centers.

Some Democrats have labeled that approach a step toward privatizing the department. The health care reforms this fall are expected to center around the fight, balancing access issues with upgrades to the existing VA infrastructure.

VA Secretary David Shulkin has pushed for significant changes to the Choice program, including changing eligibility criteria to open the program to more veterans. He promised the replacement to the program — the Coordinated Access and Rewarding Experiences program, or Veterans CARE — is expected to be rolled out later this month.

In the meantime, House and Senate lawmakers have been meeting with veterans groups to try and work out potential challenges to those proposals early.

An extension of the Choice program was signed into law in August, but money for tens of thousands of veterans’ medical appointments outside the department is expected to run out by the end of the year, giving lawmakers a tight legislative timeline for reforms.

Whether the Democrats boycott in the House hurts that timeline — or leads to similar fights in the Senate, where Democrats there have voiced similar complaints about CVA — remains to be seen.

Haverly said Roe “remains committed to a bipartisan process for community care reform” despite the brewing fight. Griffin voiced similar optimism.

“The veterans committee is known for its bipartisanship, and while this invitation was a speedbump in that relationship, it is our hope we can get back on track so we can find a long-term solution to VA care in the community in the coming weeks,” he said.

CVA officials said they hope to remain heavily involved in the work as well. Public hearings on the issue are expected by the end of this month.

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2.4 - The State Journal-Register: [‘Unaccompanied’ veterans honored at Camp Butler National Cemetery](#) (4 October, 834k online visitors/mo; Springfield, IL)

Ten “unaccompanied” veterans were honored at Camp Butler National Cemetery on Tuesday.

The veterans were recently buried at the cemetery but either had no relatives or no relatives who could travel to the cemetery at the time of burial.

The twice-annual ceremony includes the presentation of colors, a ceremonial flag folding, rifle volley and the playing of “Taps” presented by the Sangamon County Interveterans Burial Detail.

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2.5 - New Hampshire Union Leader: [VAMC volunteers recognized](#) (4 October, 318k online visitors/mo; Manchester, NH)

The Manchester VA Medical Center recently held a volunteer recognition ceremony in honor of its 320 registered volunteers, who serve in more than 28 departments within the facility.

The Medical Center’s volunteers work directly with veterans as drivers, welcome ambassadors and recreation aides to behind-the-scenes work in the warehouse, in the research department and in management.

“Appreciating these volunteers is important to veterans and the staff, (who) are proud to work day in and day out with these selfless servants,” said Alfred Montoya, acting Medical Center director at the Manchester VA.

Madeline Dreusicke, a volunteer representing the VFW Auxiliary, was on the 2017 volunteer recognition ceremony planning committee and received an award herself for having worked 1,750 volunteer hours. When asked what drives her to give so much, she said, “Just because it is the right thing to do. They served us and we should serve them. They come home changed, and when they come to the (Manchester VA) they are in a safe zone, and I want to be a part of providing that. These brave men and women are always on my mind. Serving them is an honor.”

It is with a heavy heart that the Medical Center says goodbye to Richard Dobbyn, Charles Mesurvey Sr., Gerard Provencher and Preston Lawrance, who passed away within the past year.

“Richie, Charlie, Gerry and Preston made such a difference at the Medical Center,” said Debra Krinsky, chief of voluntary service at the VA. “They truly improved the lives of so many of the veterans we serve. We are better for having shared our lives with these wonderful men. They will forever be remembered as our family, and for their contribution to the wellness of the veterans we serve.”

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2.6 - The Augusta Chronicle: [Club Car donates new golf cart to help disabled at Charlie Norwood VA Medical Center](#) (4 October, Nefeteria Brewster, 240k online visitors/mo; Augusta, GA)

Club Car dedicated a 2017 golf cart, valued at more than \$16,000, to the Charlie Norwood VA Medical Center to help get disabled veterans from the parking lot to the front of the facility.

Although the uptown medical center holds two rows of handicapped spaces around the facility, Fred Palmer, a Club Car spokesman, said the new golf cart can further help those who are unable to secure those spots.

“Transportation on both campuses in downtown and here in uptown is very important to get around,” he said. “They have parking and then they have transportation needs within the campus so I just see this as a fulfillment in partnership with that.”

Bob Frasier, a Voluntary Service Chief for the medical center who received the key to the new cart Wednesday, said the unique valet service is effective immediately.

Phones will also be added to poles in the parking lot by the end of the year for visitors who plan to use the new door-to-door service, he said.

“We’re going to continue to monitor the parking situation here and take steps as needed to make it the best possible experience for our veterans when they get here,” Frasier said. “So what we’re hoping to do eventually is we’re going to add phones and we’re going to have a phone number for veterans and when they park they can actually call and identify their location and then we can have a car clerk meet them at their car and have door-to-door service that way.”

Asked how services will be maintained, Frasier said it would depend significantly on those who are willing to volunteer as drivers for up to four hours each week.

“That would help us out greatly,” he said. “This is a pretty big step for us so of course in order for us to continue to do this we’re going to need people volunteer their hours.”

Those interested in volunteering can visit the Charlie Norwood VA Medical Center website for more information.

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2.7 - WRDW (CBS-12, Video): [Solution to VA Uptown Parking Problem](#) (4 October, Celia Palermo, 914k online visitors/mo; North Augusta, SC)

The distance from the parking lot to the hospital doors can be pretty far depending on where you park.

Veterans say they’re sick of walking the distance. The VA says they know and they’re fixing it.

"A lot of us have difficulty walking...be it bad hips...bad knees...or bad ankles."

He walks with a cane because he has arthritis. It's a price he paid, he says, for serving his country.

He's a Vietnam War Veteran and he travels for miles to come here for his medical needs.

"This is the best facility for miles around."

Well, he loves the facility, but he doesn't love having to walk so far from his car just to get seen.

"You gotta struggle across, what? About two football fields?"

The VA and community leaders like Fred Palmer with Club Car are noticing.

"This uptown campus is quite the place...the parking looks like it could be challenging."

It is, but here's how they're helping you. Club Car and the VA teamed up to add another vehicle to their fleet, a golf cart. Except this one is dedicated to the busy and big parking lots at the VA Uptown Division, not the medical district.

"If someone does need a little extra help, our vehicle can provide that comfortably."

It'll take you from wherever you park to the front door of the facility, quite the trek.

"The distance from here to there, this is the short distance. That's about one football field. Then you gotta get inside and then you gotta walk upstairs."

But once the cart hits the streets...

"Anytime I can take pressure off the bone, I'll be riding. The driver won't have to be alone, I'll ride with him."

Officials say they hope to have the cart up and running as soon as possible so they can start helping people. But to do that, they say they need even more volunteers to drive the new cart, and others.

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2.8 - WTAJ (CBS-10): [New director at Altoona VA Hospital](#) (4 October, Charlotte Ames, 192k online visitors/mo; Altoona, PA)

Altoona, Blair County, Pa. - The new director at Altoona's Van Zandt VA Medical Center says she hopes to increase the number of services available to area veterans. Currently, the facility doesn't provide specialty services such as cardiology and cancer treatment, so veterans must travel to Pittsburgh for treatment.

Sigrid Andrew said her goal is to offer those services in Altoona through the use of telemedicine and visiting clinics.

"If we can establish clinics whether it be four hours a week, two days a week, bring that provider in from the Pittsburgh VA, we would like to do that as well. But we need to establish what our needs are here in Altoona," she explained.

Andrew said the chief of staff from the Pittsburgh VA Medical Center is in Altoona to assess which specialty services are needed. She said she's already requested iPads for exam rooms, so that telemedicine can be used for consults with specialists in Pittsburgh.

The director said her background as a nurse impacts how she makes decisions as an administrator.

"I think when you're dealing with the costs and the budget and when you have to make choices, being a nurse does allow you to fairly balance and to fairly assess what the needs really are, because, at the end of the day, the patient, the veteran, is at the center of all decisions and you will always weigh on the side of the patient," Andrew said.

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2.9 - Foster's Daily Democrat: [UNH veterans adaptive sports program receives federal grant](#) (4 October, 191k online visitors/mo; Dover, NH)

WASHINGTON, D.C. — The University of New Hampshire's Northeast Passage Program will receive a \$172,974.49 grant from the Department of Veterans Affairs (VA) to support adaptive sports opportunities for veterans and servicemembers with disabilities, according to Congresswomen Carol Shea-Porter and Annie Kuster.

"As a leader in the field of recreational therapy, UNH's Northeast Passage Program empowers military men and women who are living with disabilities, and today's grant will help them continue their important work," Shea-Porter said. "I have always been proud to support this excellent program. Congratulations to the staff and volunteers at Northeast Passage on this recognition of the important work they do for our servicemembers, veterans, and so many Granite Staters living with disabilities."

"Recreational therapy holds tremendous potential for our men and women who have served in uniform," said Kuster, a member of the House Committee on Veterans' Affairs. "The University of New Hampshire Northeast Passage Program supports veterans and servicemembers with disabilities who wish to pursue adaptive sports as a means of therapy. I'm proud of the work being done by UNH to support our veterans and servicemembers and will continue to advocate on behalf this important program."

"We are very pleased that the VA has once again recognized Northeast Passage as a leader in providing adaptive sports opportunities for veterans and servicemembers with disabilities," said Northeast Passage Director Jill Gravink. "Our programs enable veterans to come together and share their experiences with people with similar interests, building social networks where veterans and servicemembers can connect with each other and enjoy recreation with the same independence as their non-disabled peers."

Founded in 1990 as a non-profit organization, NEP merged with UNH in 2000 and specializes in recreational therapy (RT) and adaptive sports for children, adults, servicemembers, and veterans with disabilities. RT interventions help people with disabilities cope with the stress of their illness or disability and prepare individuals for managing their disabilities in order to achieve and maintain independence, productivity, health, and well-being.

In March, Shea-Porter and Kuster wrote to the House Appropriations Subcommittee on Military Construction and Veterans Affairs requesting increased funding for the Adaptive Sports Grant program. In their letter to appropriators, the Congresswomen requested that the committee include report language recommending \$10,000,000 for adaptive sports programs.

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2.10 - Altoona Mirror: [Van Zandt director makes debut, Andrew said she chose job because veterans seem happy, staff respectful](#) (5 October, William Kibler, 74k online visitors/mo; Altoona, PA)

After Sigrid Andrew applied to become director of the Van Zandt VA Medical Center, but before she was offered the job, she came here and sat in various lobbies and waiting rooms, observing interactions between employees and veterans.

She noticed that the veterans seemed happy, that the employees were kind and that they were respectful of each other.

It's a "buyer's market" in the VA for managerial posts, and Andrew had a choice about whether to come to Altoona.

She ended up coming here largely because of those observations, she said Wednesday at an introductory meeting with local media.

"It was the people of Altoona who lured me," she said.

A native of the Newark, Del., area who spent time as a child in Vermont, she also appreciated the region's four distinct seasons. "And you can't discount the mountains," she said.

Van Zandt territory — extending to DuBois, Johnstown, Huntingdon and State College — is also drivable, in contrast to some larger VA hospital territories where airplane flights are necessary, she added.

Andrew is coming to a hospital that hasn't had a permanent director for 20 months, following William Mills' departure for Memphis, and that has been roiled by accusations of whistleblower retaliation examined during recent hearings before the Merit System Protection Board — a quasi-judicial body that ensures federal employees are treated based on performance.

The whistleblowers testified about a poisonous atmosphere created because of their mandated reporting of what they said was the impairment from dementia of a doctor in their department.

Andrew intends to deal with those issues by moving "forward," she said.

"I'm hoping for a healing-type future," she said.

She hopes to establish good relationships with employees — and with veterans, the overall community and the media, she said.

Two employee meetings have already been held, said Andrew, who hadn't yet completed her third day on the job.

She plans to be "transparent, direct and open" and to tell the truth, she said.

She has a track record for that, she said — giving as evidence that at a facility where she worked, a union president called a counterpart at another facility — presumably where she was going to work — and said of Andrew, "You may not always like the decisions she makes, but you will always know what she stands for."

She stands for the veterans, she said.

One recurrent issue raised in Van Zandt town hall meetings in recent times has been what veterans say is a shortage of specialist services.

Some of those veterans remember when there were 200 acute beds at Van Zandt, said hospital spokeswoman Andrea Young. Now there are only 11 acute beds, she said, to go with 40 nursing home beds. Those old ways aren't coming back, Young said.

But, channeling Regional VA Director Michael Adelman, Andrew said there are modern ways to remedy the problem.

She plans to work with recently appointed Acting Chief of Staff Ali Sonel — who remains Chief of Staff at the Pittsburgh VA — to recruit doctors here and increase the number of telemedicine consultations from Pittsburgh, of visits to Altoona from specialists in Pittsburgh and of "fee-based" visits from private providers in this area to Van Zandt, as well as fee-based visits by veterans to those providers in their community settings.

Thanks to Sonel, it's already happening, Andrew said.

Sonel's position in Pittsburgh — his "connections" — can help make it all work, she said.

To make it work well, however, the hospital will do a market analysis to identify how those changes can serve the needs of 26,000 veterans on the hospital's roster, she said.

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2.11 - WAND (NBC-17, Video): [Camp Butler National Cemetery honors 10 unaccompanied veterans](#) (4 October, Meredith Hackler, 68k online visitors/mo; Decatur, IL)

SPRINGFIELD, Ill. (WAND)-The gloomy weather matched the somber tone 10 veterans were honored for their sacrifice to our country.

"The unaccompanied honors veterans ceremony is a way we show respect to veterans that come to our cemetery without family members or without being accompanied by their loved ones," said Antonio Henderson, assistant director of Camp Butler National Cemetery.

A 21-gun salute, and the playing of tap, pays homage to those who were lost.

"We are honoring and respecting the selfless service that the veterans gave to our nation," added Henderson.

"Every veteran should have a ceremony like this and for whatever reason many don't get that opportunity," said Sam Montalbano with the Inter Veterans Burial Detail.

Many of those who took part in the ceremony are veterans themselves.

"I'm a veteran as well," added Henderson. "I feel that it is also my duty and responsibility to give back for those who have laid the ultimate sacrifice,"

"It's giving back for all the things that they do while they are in the service," says Montalbano. "So, it's a good feeling for me personally."

While there's nothing we can do to bring them back, those involved say they hope the lost are always remembered.

"We are their brothers and sisters. It's our responsibility to let them know that they are not alone on their final salute," added Henderson.

The next unaccompanied veteran's ceremony will be held on April 5th, 2018 and Camp Butler National Cemetery.

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2.12 - KXRM (FOX-21, Video): [Veteran students speak out after Career Center shuts down](#)
(3 October, Carly Moore, 58k online visitors/mo; Colorado Springs, CO)

Dozens of veterans are out of luck after a school they were attending for a technical degree has been shut down.

The school in North Texas is called Retail Ready Career Center (RRCC) which focuses on giving veterans hands-on training and professional job placement assistance in the HVAC industry.

Two Colorado Springs veterans were enrolled in the class and both of their stories are exactly the same. The Career Center approached them about the HVAC program and just about a week ago, without much notice the school was shut down and now their futures are uncertain.

One of those vets was Steve Pattillo who says two weeks ago his future career looked totally different after signing up for a 6-week certification class at RRCC.

"They convinced everyone to quit their jobs. I had a good paying job, at the time, they promised me something better. So, I moved my family here," said Pattillo, an Army veteran.

On September 20, students were abruptly told the school was closed for the day and to go home but class would resume the next day.

"I did feel a little bit weird I felt a little uneasy because, it's my families life basically in that schools hand," said Pattillo.

Then on that Friday, September 22, students say the school's president, John Davis, made an announcement to the group saying the Department of Veterans Affairs was investigating the school. This information left another classmate and Colorado Springs veteran, Charles Autry, with even more questions.

"[He] Basically assured us this was nothing more than an administrative review, that the school was in no danger of closing," said Autry, a Navy veteran.

Davis went on to say an employee had been fired for stealing \$20,000 of scholarship funds and the school illegally had too many student veterans.

"Less than a week later, we were in class doing some lecture lessons. In the middle of that, we had some school officials, come in and interrupt the class session and say 'you had 5 minutes to get your stuff and get off the property'," said Autry.

With no other answers, these two veterans along with more than 300 other students were sent home without their certificate or money back.

Right now both fathers want the same thing.

"I hope myself and other veterans are restored what they are owed," said Autry.

"I'd basically like to see every body get back out on their feet and recuperate from what the school's done to them and I'd like to prevent veterans from going through this again," said Pattillo.

Autry is reaching out to Congressman Doug Lamborn's office to see if they could help. They said the following in response:

"Congressman Lamborn's office routinely helps veterans in our community. We have heard from one veteran about this school and are currently awaiting paperwork that will allow us to advocate on his behalf."

The school was thought to be violating the 85/15 rule, meaning that only 85 percent of the student body can use their GI bill to pay for tuition; the other 15 percent had to be non-service members or fund the program themselves. Davis said it turns out 98 percent of the people enrolled were former service members.

Pattillo and Autry did use \$21,000 and 9 months of their VA benefits. They're concerned what will happen next.

“Basically what the VA has told us, or told me, is that it’s up in the air if we’ll have our benefits restored, fully or partially restored, as it stand right now we are out 9 months of our benefits,” Autry said.

“They said that’s a big maybe and they are not 100 percent sure, so it’s basically a big waiting game for all the veterans involved if we get anything back or not,” Pattillo said.

FOX21 attempted to reach out to the Career Center, but no one answered the phone or returned the voicemail. The veterans said most of their classmates are also joining in on a class action lawsuit.

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2.13 - The Daily News: [Staller retires from VA Medical Center](#) (4 October, 54k online visitors/mo; Iron Mountain, MI)

IRON MOUNTAIN — After 24 years of federal service, Patricia Staller of Iron Mountain has retired from the Oscar G. Johnson VA Medical Center.

Staller was born and raised in Fort Atkinson, Wis., and is the daughter of Donald and Marie Peterson. She graduated from the University of Wisconsin-Milwaukee with a master’s degree in social work.

After completing her graduate work at the Milwaukee VA Medical Center, Staller started her career at the Waco VA Medical Center in Texas. She later worked at the Central Texas VA Health Care System in Temple, Texas, and then transferred to the Iron Mountain VA Medical Center in 2001.

During her tenure in Texas, Staller worked in many medical areas and piloted the first Patient Orientation Program to help new veterans and their families coming into the VA. At the Iron Mountain VA, she worked in various clinical social work areas, including acute care, student education, low vision and ethics. Most recently, she served as social worker for geriatric and extended care in the medical center’s Community Living Center.

Staller has been involved in many local theater productions, and she is a member of Zonta and the local chapter of Toastmasters of the Northwoods.

She is a widow and has one son, Curtis Staller; a daughter-in-law, Olga; and a granddaughter, Natasha, residing in Round Rock, Texas.

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2.14 - FEDweek: [Improving Policy-Making at VA a Complex Task, GAO Finds](#) (4 October, 51k online visitors/mo; Glen Allen, VA)

The Veterans Health Administration, the largest arm of the VA, is encountering several difficulties as it attempts to improve its policy-making, GAO has said.

Under a policy issued last year, directives and notices are now the sole documents for establishing national agency policy; other types of documents, such as program office memos, are considered guidance. VHA is reviewing about 800 existing national policy documents to eliminate those that no longer meet its new definitions, and to rescind or recertify those that are outdated, GAO said.

However, it found that “VHA is not planning to review guidance documents, such as program office memos and standard operating procedures, to assess whether they align with its updated directive, because there is no central repository for these documents and it would be too resource intensive to locate all of them.”

“Further, GAO’s review found—contrary to VHA’s updated directive—that program offices are continuing to use memos to issue policy. The continued use of program office memos to establish national policy undermines VHA’s efforts to improve its policy management,” it said.

It added that program offices do not track or consistently disseminate the guidance documents they issue. And while the VHA has process for making national policy documents accessible to its medical centers and the veterans integrated service networks that oversee those centers, it lacks a process for making guidance documents accessible at the local level. The result is that “VHA lacks assurance that staff receive and follow the same guidance, as intended.”

Nor does the VHA routinely collect information on local challenges in complying with national policies—such as resource constraints and undefined time frames—or on waivers of those requirements that program offices can approve “on an ad hoc basis.”

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2.15 - Journal Express: [Residents seek answers at VA town hall](#) (4 October, Pat Finan, 9.2k online visitors/mo; Knoxville, IA)

KNOXVILLE - A town hall meeting about the Veterans Administration campus on Thursday, Sept. 28, focused not only on the site’s future but on vets themselves. The quality of their health care drew nearly as much attention as the 170-acre site during the two-hour discussion among about 125 people at the Knoxville Performing Arts Center.

Many participants sought details of the process by which the government rids itself of the property. Others were frustrated about depressed or suicidal military comrades. Still more expressed worries about their own health, or about the eyesore they fear the campus will become.

The VA sent three people to the stage, mostly to discuss patient care. Gail Graham, medical director for the VA’s Central Iowa Health Care System, touted its new outpatient clinic at 1607 N. Lincoln St. While she accepted accountability for moldy, deteriorating buildings at the old site, she eventually drew the line.

“I’m in the business of delivering health care, not in the business of maintaining buildings,” Graham said.

The government won't sink money into the upkeep or the teardown of the buildings, officials said. Its main interest is getting the most money it can from the property and returning it to productive use, they said.

Those jobs fall to the General Services Administration, the real estate arm of the federal government. Jennifer Mollenshott, branch chief of the VA's Fort Worth, Texas, office, is in charge of the process for the next year or so.

Mollenshott said the VA is completing a review of the property and its potential, which she expects to see by the end of 2017. When GSA gets that report, a process of screenings is launched. Government agencies can express interest in the property, though that's not likely, she said. Other screenings include a look at the site's suitability to serve homeless people.

In similar situations, the process usually leads to the land being sold as-is, Mollenshott said. While many in the audience expressed eagerness for action, their waiting will continue as the process plays out through 2018.

"If all goes well, soup to nuts, you're looking at about a year," Mollenshott said.

The government's appraisal process considers what it calls "the highest and best use" for the property as well as local market conditions as it determines fair market value, Mollenshott said. The results of that appraisal will not be available to the public, she added.

Mollenshott tried to dispel concerns that potential buyers won't be interested in land that's dotted with large, dilapidated buildings.

"Trust me, I have seen a lot worse, and we still make a lot of money," she said.

Knoxville resident Park Woodle asked whether the site could be split into smaller parcels, contrary to what Knoxville has been told in the past. He mentioned several parts of the property that hold potential for housing or other uses. Such splits likely will be part of the marketing strategy, Mollenshott responded.

Would the city get a chance to get some parcels? Would it have to pay for them? Those were Knoxville resident Mike Lane's questions. Mollenshott and Mayor Brian Hatch both had answers.

The city and other government entities get dibs earlier in the screening process, Mollenshott said, though it would have to pay fair market price. Hatch said Knoxville might be interested in getting some of the land, while expressing wariness about the burden such a move could bring.

"We're like to have some control of that situation so that we can get something in there that's good for the community," he said.

With five days to reflect on takeaways from the two-hour meeting, Hatch described himself Tuesday as hopeful but cautious, given the history of the campus. The town hall was a good step, he said, and city and federal officials will continue to meet regularly.

"There were no real surprises," Hatch said. "I was hoping we would know what direction GSA was thinking of going. I think that once we have a better direction from GSA on selling the

property, we can then begin to formulate a little better strategy for the community to move forward.”

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3. Access to Healthcare

3.1 - WDBJ (CBS-7): [VA expanding use of tele-medicine to improve access for veterans](#) (4 October, Joe Dashiell, 833k online visitors/mo; Roanoke, VA)

The VA Medical Center in Salem is expanding the use of tele-medicine, as a way to improve veterans' access to health care.

Wednesday, a company that provides the technology to the Department of Veterans Affairs demonstrated some of the newest equipment in Salem.

Lindsay Gill is the Facility Telehealth Coordinator at the Salem VA Medical Center.

"It means improved access," Gill told WDBJ7. "It allows our veterans to be seen at a distance, so they don't have to travel to the Salem VA. A lot of our veterans live hours away and this will allow them to seek care closer to home, but from the Salem Medical Center so it's really exciting."

A new program that will let veterans consult with health professionals from their homes should be coming on line in the next year.

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3.2 - The National Law Review: [Department of Veterans Affairs Aims to Trump State Telemedicine Rules](#) (4 October, 475k online visitors/mo; New York, NY)

The U.S. Department of Veterans Affairs ("VA") is taking a significant step towards expanding needed services to Veterans by proposing a rule to preempt state restrictions on telehealth.

Most states currently restrict providers (including VA employees) from treating patients that are located in that state if the provider is not licensed there. As a result, the VA has had difficulty getting a sufficient number of providers to furnish services via telemedicine for fear that they will face discipline from those states for the unlicensed practice of medicine.

The VA has a real need for expanding its telemedicine capabilities as many of its patients are located in rural and underserved areas. The VA's top clinical priority is mental health, and having more robust telemedicine capabilities could help improve timeliness of treatment (a reputational sore spot for the VA). The VA could also use telemedicine to reach more people in need that may not otherwise seek help. The rule would allow the VA to more evenly distribute care by hiring providers in urban areas where there is larger pool and have them treat in rural areas (via telemedicine).

Not everyone is happy about the proposed rule, however. Organizations such as the American Medical Association oppose the rule as undermining each state's ability to govern the practice of medicine within its borders. The concern is that states would have no ability to regulate their citizens' care under this new framework.

While this rule is limited only to VA patients and providers, the hope is that other federal agencies or even states will follow the VA's lead. Given the importance of increasing access to care and the advances in the delivery of care via telemedicine, it might be time for states to reexamine their restrictive approach to professional licensure.

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3.3 - WCSH (NBC-6, Video): [Lawsuit targets Togus VA for botched operations](#) (4 October, Don Carrigan, 442k online visitors/mo; Portland, ME)

AUGUSTA, Maine (NEWS CENTER) — Six Maine military veterans are waiting for a federal judge in Portland to decide if they will be allowed to sue the Veterans Administration.

Those veterans all say they had foot or ankle surgery at the Togus VA hospital, and that the doctor botched the operations. That doctor left in 2008, but the veterans say they still suffer pain and other problems.

Army veteran Steve Turner of Topsham isn't involved in the lawsuit but said Wednesday he also suffered at the hands of the same doctor.

Turner told NEWS CENTER his foot was operated on in early 2008 because of injuries sustained during his 13 years in the Army. He said there were problems soon after the first surgery and the doctor did a second operation. He said the foot then became badly infected and swollen and that only an emergency operation by a different doctor saved his foot.

Turner said it still causes him pain. He said the VA contacted him in 2010 and arranged a meeting, at which time it apologized, and blamed the doctor.

"They were very apologetic about what happened to me," he said, "and went step by step what [the doctor's] discrepancies were during surgery, what he should have done., and not done."

VA officials on Wednesday would not answer questions about the situation, referring all inquiries to the U.S. attorney's office.

In 2014, NEWS CENTER reported on a similar case involving a Hampden man, who said he had also suffered pain and continuing problems because of a failed ankle surgery by the same doctor. At that time, VA Togus director Ryan Lilly confirmed it had been dealing with a number of foot and ankle surgeries that had turned out badly.

Lilly said the staff had been alerted to the problems by patients, had contacted the doctor's patients to apologize and offer to pay for whatever further care was required.

Lilly was asked how many patients suffered problems. "We're talking less than 100," he replied at that time.

Neither the VA nor the U.S. Attorney would say Thursday how many total patients were affected.

Steve Turner said he does not blame the VA, but blames the doctor, and would "like to sue him personally," if he could.

Lawyers knowledgeable about the case told NEWS CENTER the doctor cannot be sued personally because he was working for the VA at the time.

That doctor is believed to be living in the New York City area, where an internet search showed he has been working at a medical practice. A receptionist at that practice said Wednesday the doctor no longer worked there.

The lawsuits by the six veterans are aimed at the VA, seeking permission to sue the government even though Maine's statute of limitations has expired. Lawyers said oral arguments are scheduled for later this month and a ruling could come this fall.

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3.4 - WHAS (ABC-11, Video): [Annual event offers one-stop shop for homeless](#) (4 October, Sara Wagner, 439k online visitors/mo; Louisville, KY)

The latest numbers show more than 6,000 people are struggling with homelessness in Louisville. Wednesday, a group of people put their talents together to help drastically reduce those numbers. Homeless Connect is an annual event aiming to serve hundreds of homeless individuals by offering dozens of free resources.

The Salvation Army is no stranger to helping those in need. Inside the building, you'll find many stories of service and success, with plenty of new chapters being added at Wednesday's event.

"It's a lot of work to do, and it can't be done by one agency. It's got to be done by everybody in a group effort. It's got to be done by a community," Salvation Army Commander Major Roy Williams said.

More than 80 partners came together to help those who need it most.

"There's one thing they need and they come here and they say, oh, I didn't know that was there. They get that and they start lifting themselves up out of poverty," Williams said.

The organizations offered everything from IDs to eye and ear exams to haircuts and clothes. There were selfless acts at every corner, even feet washing.

"You can tell a lot about a person's health by washing their feet and then they can direct them to the medical center," Williams said.

Acts like that help to wipe away some of the struggle and stereotypes that come with homelessness.

"It's not all about people who just want to sit outside and lay around all day. There's homeless that want to help themselves every day," Williams said.

Organizers said this event has the ability to reach many who won't seek it otherwise.

"A lot of people don't feel safe in the shelter, particularly veterans who may have had trauma," Healthcare for Homeless Veterans supervisor Jamie Watts said.

Having everything set up in a one-stop shop makes a major difference when you're used to anything but convenience.

"Anybody who has ever been homeless or been at the point where you're almost homeless knows you spend a lot of time waiting in lines, being in waiting rooms, and getting on a waiting list. So, our hope is that today you can get a lot of that done in one place and get moving faster toward getting a place of your own," Coalition for Homeless Executive Director Natalie Harris said.

Veteran Jack Jones knows that all too well.

"I've been homeless off and on for several years, but at this time, I've been homeless for about three months," Jones said.

Thanks to the VA, Jones has housing now and is getting ready to work again.

"I signed up for a library card so I can learn computers. I don't know computers yet, but they're going to teach me," Jones said.

Homelessness can take away so much, but these acts of kindness can help life get back on track.

"It's amazing what they do and so far, I haven't met a negative person yet," Jones said.

Organizers said the number of homeless has consistently dropped every year in Louisville for the last five years. They expect to serve around 600 people at this year's event and hope that number continues to go down each and every year, eventually eliminating the need for the event altogether.

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3.5 - KRGV (ABC-5, Video): [Local Organizations Provide Options for Homeless Valley Veterans](#) (4 October, Cecillia Gutierrez, 275k online visitors/mo; Weslaco, TX)

HARLINGEN – One homeless veteran is one too many. On any given night, 39,000 veterans in the U.S. find themselves without a permanent roof over their head, according to the U.S. Department of Housing and Urban Development.

Clifford Briggs is one of those veterans. From looking at him you would never know he was homeless with his big smile, positive attitude and contagious laughter.

Briggs comes from a military family, but now the ex-Navy firefighter goes to work during the day and sleeps at Loaves and Fishes in Harlingen.

"I moved down from Portland and it didn't work out too well, so I ended up at Loaves and Fishes. It's just a place to lay your head, stay out the weather at night to sleep," he said.

Briggs said he doesn't let life's unexpected turns get the best of him.

CHANNEL 5 NEWS spoke to Tommy Martinez, the Loaves and Fishes director of Family Emergency Assistance, to see if homeless veterans in their shelter are seen often.

"It ranges. Sometimes we have one to two homeless veterans in a month during the summer months or maybe even December we might have maybe three to four homeless veterans in our shelter at one point." Felix Rodriguez, a veteran service officer with the Hidalgo County Veterans Service.

He explained to us why veterans are more likely to face homelessness.

"Well, many of these veterans that are having issues with finding a place to stay, a home are coming back with issues that civilians don't have to deal with," he said. "And some of these issues and conditions run the gamut between post-traumatic stress disorder, traumatic brain injury, depressive disorders and other conditions secondary to that."

He said there are several ways you can help a homeless veteran.

"My first advice to them is to call the VA homeless hotline, it's a HUD hotline," he said.

Rodriguez added other ways to help homeless veterans are through Family Endeavors and other organizations.

You can contact the VA Homeless Hotline at 877-424-3838. For a full list of resources click [here](#).

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3.6 - KRGV (ABC-5, Video): [Valley Vietnam Veteran Battles Diabetes Linked to Agent Orange Exposure](#) (4 October, Ryan Nelson, 275k online visitors/mo; Weslaco, TX)

PHARR – Vietnam veteran Gabriel Avendano said a part of him will always remain overseas.

"What can I tell you? We never come back," said Avendano, "but I'm here."

Avendano is one of the 2.6 million U.S. military personnel possibly exposed to Agent Orange from January 1965 to April 1970.

"They just flew it through the C-130's and they killed a lot of the jungle," said Avendano.

He was formally diagnosed with diabetes in the year 2000. He said he may have lived with the disease for many years before the discovery was made.

"I have to inject my body twice a day," said Avendano, "in the morning and at night."

Diabetes is one of the many diseases considered a presumptive illness by Veterans Affairs.

These are diseases presumed to be linked to Agent Orange exposure, or a Veteran's qualified military service. Veterans do not have to prove these illnesses were spawned by their military service.

The long list of diseases includes several forms of cancer.

Veterans who believe they are suffering from an illness linked to Agent Orange may have health care options through the VA.

"One of the most important things that they need to do when they believe that they've been exposed to Agent Orange is to come by either the McAllen outpatient clinic or the Harlingen outpatient clinic," said VA Texas Valley Coastal Bend spokesperson Reynaldo Leal.

By taking their DD FORM 214 and driver's license to an outpatient clinic, they can begin to explore these options.

"Once we register them as Agent Orange exposed veterans, they'll be given an assessment. They'll be scheduled for an assessment and they'll be input into the Agent Orange registry," said Leal.

These veterans may also qualify for benefits such as disability compensation.

"They can go to any number of veterans service officers, they can go through the county, the state with the Texas Veterans Commission," said Leal.

"Keep going and they'll help you," said Avendano. "You got to keep on going. You have to keep on going to the centers and they will sooner or later help you."

Avendano also urges veterans to consume a healthy, balanced diet.

A complete list of presumed diseases linked to Agent Orange exposure can be found at the U.S. Department of Veterans Affairs website.

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3.7 - KOLO (ABC-8, Video): [Reno physician helps Veterans in Puerto Rico](#) (4 October, Terri Russell, 274k online visitors/mo; Reno, NV)

RENO, (Nev) KOLO Under normal circumstances, Dr. Ivan Correa is the chief of staff at the Veterans Affairs Sierra Nevada Health Care System.

He is also a Puerto Rican native, and decided to fly to the island to check on the status of his parents, after two devastating hurricanes hit the area.

"They tell me they are ok. But ok is a relative term. You know ok is that they are alive, and that they are being able to eat some food, and that they go to bed, they wake up in the morning. It is not that everything is fine," says Dr. Correa.

But as a physician locally, taking care of vets, Dr. Correa says he couldn't help but answer the call to attend to veterans on the island both at a Veterans home of 100 patients, and other veterans who for now cannot leave their homes because of the massive damage around the island.

"476 Veterans. We have either laid eyes in a vast majority of them we have laid eyes, but almost to 90% of those.... going house to house and seeing individuals that are already set up with the VA and depend upon us to provide primary care at home. It's called home based primary care," says Dr. Correa.

Fuel is tough to come by, he says the Veteran's Hospital is running off of generators, but it is in a limited capacity.

While he feels good about the care given to veterans during these tough times, he is also surprisingly optimistic about the civilians on the island as well,

"They are going to be able to get over this, and being able to see that there is a bright future for Puerto Rico," says Dr. Correa.

He'll be headed home early next week.

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3.8 - KRIS (NBC-6, Video): [Mobile veterans services center touring county](#) (4 October, Roland Rodriguez, 197k online visitors/mo; Corpus Christi, TX)

With more than 30,000 veterans in Nueces County, the Veterans Affairs Office has come up with a way to make serving those who served our country a little easier by going mobile.

The mobile unit will be traveling throughout the county over three days next week, and it's equipped to provide a variety of services to local veterans.

This a great way to help veterans who live out in rural areas.

The Nueces County Veterans Services will have mobile centers in rural areas three times in the month of October.

Mobile veteran centers will be at:

October 11: VFW Post 3837, 12030 Leopard Street in Corpus Christi, TX

October 12: Driscoll Community Center, 200 East 6th Street in Driscoll, TX

October 13: VFW Post 8932, 702 Jester in Flour Bluff

Representatives will be available 10 a.m. to 2 p.m.

If you're a veteran, and you're going to school or working, this is an opportunity where the Nueces County Veterans Services comes to your area, and you don't have to drive all the way to Corpus Christi office to get help.

The VA Texas Valley Coastal Bend Health Care system, along with the Nueces County Veterans Services will reach out and provide counseling for individual readjustment, bereavement, marital and family issues, employment and career guidance and military sexual trauma (not all locations).

There will be representatives on hand for benefits assistance and referral, substance abuse assistance and referral and community education.

Specific health care, disability, pension, burial and survivors benefit information will be given by the U.S. Department of Veterans Affairs.

For more information, call county veteran services at 361-888-0820.

Many Veterans who rely on VA for their health care live in remote areas. Our nation's rural and highly rural Veteran population is large and dispersed. It is also racially, ethnically, and culturally diverse. Providing comprehensive, high-quality health care to these Veterans is a challenge.

VA's Office of Rural Health (ORH), created in 2007, strives to eliminate the barriers between rural Veterans and the services they have earned and deserve, thus improving Veterans' health and well-being by increasing access to care.

According to ORH, 5.2 million Veterans live in rural communities across the United States, and more than 32.9 million rural Veterans rely on VA for their health care. Veterans are more likely to live in rural areas than Americans who did not serve in the military. While 18 percent of Americans live in rural areas, 23 percent a quarter of Veterans do.

More than half (57 percent) of rural Veterans enrolled in VA health care are 65 years old or older. In addition, 6 percent are women; 9 percent report being members of racial and ethnic minorities; and nearly 435,000 are Veterans of our recent conflicts in Iraq and Afghanistan. About 44 percent of rural Veterans have one or more service-related disabilities.

Rural Veterans have lower than average household incomes than other Veterans; they often face long driving distances to access quality health care; and there are fewer health care providers and nurses per capita in rural areas.

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3.9 - The Robesonian: [Battaglia's death latest proof of veterans' neglect](#) (4 October, Editorial Board, 72k online visitors/mo; Lumberton, NC)

It looks as if an SBI investigation will conclude that Kevin Anthony Battaglia, retired Army, just 33 years old, someone's son, and the father of three young children, died when he was struck by an officer's bullet during a standoff at his Parkton home on Sunday.

But make no mistake: This was suicide by cop, and Battaglia is only the latest veteran of our Middle East wars to pick that poison after returning to this country a shattered self, unable to deny his demons. In a very real sense, it was all of us who pulled the trigger that sent the bullet hurtling that would take Battaglia's life, ending his suffering, but robbing him of so much that life could have offered.

A mix of family, neighbors and Army buddies portrayed Battaglia as a respectful guy who was struggling to assimilate back into society after seeing duty overseas. He had multiple brushes with the law, some minor, but also a serious brawl in a bar that sent him to prison. He was facing two DWI charges in Cumberland County, so it's clear that alcohol was his medication of choice.

Battaglia was medically retired, presumably for a bad back, and he claimed to have been suffering from post traumatic stress disorder, PTSD, that is so prevalent among veterans who experience first hand the horror of war. PTSD was first ascribed to Vietnam War veterans, and now the word is universally recognized.

We were told that Battaglia was frustrated by the Department of Veterans Affairs, believing he wasn't receiving the kind of care he needed and deserved. The VA's problems have been well-documented in recent years, so it's easy to believe Battaglia's gripe was legitimate.

Those who knew him saw his behavior deteriorating in recent weeks, and it could be seen on Facebook where his religious leanings were becoming cult-like. The American flag, Bible and weapons were prominent there — and in recent days he took to wearing camouflage.

There have been many studies concerning the number of veterans with PTSD, and one by RAND in 2014 found at least 20 percent of the 2.7 million Americans who served in Iraq or Afghanistan suffered with it or depression — and half never seek any treatment. That many more were suffering with traumatic brain injury, and about 7 percent both PTSD and TBI.

Those numbers are most likely low.

Last year a study for the Department of Veteran Affairs found that about 20 veterans commit suicide a day in this country. pushing the number to almost 7,500 a year.

So the evidence is overwhelming that this country continues to send its young people to war, and when they return we are ill-equipped to provide the care they deserve.

Often, as with Battaglia, the problems are apparent. But no one could stop this train wreck no matter how leisurely its pace. Friends, especially fellow military, apparently tried — and that included trying to talk him out of the house on the day he died.

Somehow, somehow, this country has to do better for those who step forward and put themselves in harm's way to preserve the ways of life and liberties that the rest of us enjoy.

It's too late for Battaglia, but his death, which was explosive and public, can be given greater meaning should it move the needle at all in the direction of better care for our veterans.

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3.10 - KXLH (CBS-25, MTN News, Video): [VA Montana hosts Fall Health Festival](#) (4 October, John Riley, 57k online visitors/mo; Helena, MT)

Over 550 Veterans received their Flu immunization today along with community members and V-A staff.

VA Montana staff braved the cold temperatures outside to kick off the flu season with the annual Fall Health Festival and Drive Thru Flu Clinic.

The shots were free for enrolled veterans and VA employees and the County Health Department were on hand to supply flu shots for a fee for everyone else.

People 65 years and older, young children, and people with certain health conditions are at higher risk for serious flu complications.

Each year around 200,000 people are hospitalized and around 32,000 people die from Influenza.

The best way to prevent the flu is by getting vaccinated each year.

Veterans attending the event said that they love the ease of the clinic considering they didn't even have to leave their vehicles.

"I've never had to wait long," said veteran Louie Stiles, "When I was doing it privately getting these private shots they'd just take a lot of time, this doesn't."

If you are an enrolled veteran and missed the clinic you can still get your shot at the VA medical Center.

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3.11 - HealthTech: [NHIT Week 2017: Technology Improves Care Options for Veterans - Telehealth and predictive analytics are among the tools being deployed more strategically by the VA, Secretary David Shulkin says.](#) (4 October, Dan Bowman, 20k online visitors/mo; Vernon Hills, IL)

One day after publication of a rule that would let doctors at Department of Veterans Affairs facilities leverage telemedicine to provide care to patients anywhere, VA Secretary David Shulkin discussed his agency's goals for using technology moving forward.

Speaking Tuesday at the American Telemedicine Association's Edge 2017 Fall Forum in Washington, D.C., Shulkin outlined five priorities for "fixing" the VA: greater patient choice, systems modernization, improved service timeliness, world-class foundational service and suicide prevention.

"Our mission is to take care of those who serve the country," Shulkin said.

Expanding Telehealth to Improve Access

Telehealth is a big part of the agency's plans for remedying its timeliness and access issues, Shulkin said.

"This is a strategy that VA is growing and investing in and believes is essential to solving this priority of timeliness of services," Shulkin said.

Its new initiative centers on allowing veterans to receive care wherever they are, as long as they have access to an internet connection. Individuals can access provider services on any device in any location, Shulkin said. However, he also noted that moving ahead was less of a technology challenge and more of a legal and regulatory issue.

"Very conservative interpretations interpreted current law as saying that we needed to provide telehealth services from one VA facility to another, which just didn't make a lot of sense to me," Shulkin said. "I was making my patients drive 80 miles from their home to a VA facility waiting room so they could get into an exam room to see me using telehealth; it just didn't make any sense."

The rule change will allow innovators within the agency to do a lot more with its technology now that all VA doctors will be able to take advantage, Shulkin said. To aid in the expansion, in August, the agency announced it would start a nationwide rollout of its VA Video Connect app, which allows providers and patients to connect via live video on a computer, smartphone or tablet.

The American Medical Association offered early praise for the rule, with Dr. Jack Resneck Jr., chairman-elect of the AMA's Board of Trustees, saying in a statement that the VA "has a unique federally controlled healthcare system with essential safeguards" that can ensure high care quality for patients.

Using Analytics for Suicide Prevention

Shulkin also noted that the VA is deploying Big Data and predictive analytics technology to try to proactively identify veterans who may be at risk for suicide.

"This is an American public health crisis, not just a VA crisis," he said. "The number of Americans committing suicide each year is growing, but among veterans it's growing even more."

Access to care through the VA stems such rates, Shulkin said. Over the last 15 years, the rate of veterans committing suicide has gone up 5.4 percent for those accessing VA care; for veterans who don't use the VA, the suicide rate has gone up 38.4 percent. In particular, for female veterans who accessed the VA for care over the last 15 years, the suicide rate decreased 2.6 percent, but increased 81.6 percent for those not using the VA.

"We are really trying to outreach to veterans to let them know that they have options and that treatment works," Shulkin said.

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4. Women Veterans

5. Appeals Modernization

6. Strategic Partnerships

6.1 - WIBW (CBS-13, Video): [Visually impaired veterans tour Kansas Statehouse](#) (4 October, Deneysa Richard, 484k online visitors/mo; Topeka, KS)

The VA of Eastern Kansas sponsored an event on Tuesday that left a long lasting impact.

The Topeka and Leavenworth VA campuses partnered with The Kansas State Capitol to host a tour for veterans who are visually impaired.

Over 40 veterans were in attendance, some of who visited the Capitol for the first time.

"I'm glad to be here," veteran Keith Sese said, "It's the first time I've been at the Capitol, and I have been here since 1982."

The event aimed towards promoting the inclusion of individuals of all abilities in recreational activities.

"With the support of the staff that is here today and their family members, we're going to be able to get them through the tour and to be able to be a part of it, even if they don't have much sight, at least they are here with everybody and just take part in something in the community," said VA Visual Impairment Services Team Coordinator, Dawn Clouse.

Veterans who attended the event also learned about the Kansas Commission for Veteran Affairs, as well as the state and federal benefits available to veterans who are visually impaired.

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7. Supply Chain Modernization

7.1 - Washington Technology: [B3 Group wins \\$156M VA financial, program management order](#) (4 October, Ross Wilkers, Vienna, VA)

Leesburg, Va.-based small business B3 Group has won a five-year, \$156 million task order for financial and program management services to the Veterans Affairs Department.

The VA awarded the order under its potential 10-year, \$22.3 billion T4NG IT services contract vehicle. Work under this order supports software development lifecycle tasks for the VA's financial services center, B3 Group said Tuesday.

Only service-disabled, veteran-owned small businesses were eligible for this order and the VA received four offers, according to Deltek.

B3 Group's teammates for the order include AdaptiveStack Consulting, First-Tek, Grant Thornton, ISC, Longview International Technology Solutions, Rios Partners and Vets Inc.

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8. Other

8.1 - CNN: [Investigations opened into Zinke's meeting with Golden Knights hockey team](#)
(4 October, Miranda Green, 29.7M online visitors/mo; Atlanta, GA)

Washington (CNN)A summer visit that Interior Secretary Ryan Zinke made to the Vegas Golden Knights hockey team is now under two investigations by federal watchdogs.

The Interior Department's inspector general has added concerns about Zinke's meeting with the new NHL team and use of a private jet from Las Vegas to an investigation it opened Friday looking into the secretary's travel, an IG spokesperson confirmed to CNN Wednesday.

The Office of Special Counsel has also opened a Hatch Act investigation into Zinke's meeting with the hockey team.

Zinke met with players on the hockey team at a hotel across the street from their practice facility June 26, a Golden Knights spokesman said.

The meeting was added to the IG probe at the behest of Democratic Reps. Raul Grijalva and Donald McEachin. Grijalva criticized Zinke's need to hire a chartered plane to return home to Montana following the Nevada meeting as well as the purpose of the meeting itself.

"Claims that the secretary's full schedule required the use of chartered aircraft deserve scrutiny. It appears as though Secretary Zinke and his staff could have taken a commercial flight from Las Vegas to Montana if he did not attend the motivational speech to the hockey team owned by his friend and campaign donor, Bill Foley," read Grijalva's letter.

The OSC probe came after a complaint filed by the government watchdog group, Campaign for Accountability and was first reported by Reuters.

An OSC spokesperson told the watchdog group that the Hatch complaint had been "received" and they will "open a case file to address this matter."

An Interior Department spokesperson told CNN that Zinke's late night private flight to Montana from the Nevada meeting cost taxpayers \$12,375. The spokesperson maintained that the flight was booked after no suitable commercial alternative was available and was approved by the Interior's ethics office.

Zinke's meeting with the Vegas Golden Knights is also being scrutinized since it is owned by someone Zinke called "a major donor" when he was running for Congress in 2014.

Bill Foley, a billionaire businessman and owner of the Golden Knights, is also board chairman of Fidelity National Financial Inc. FEC filings show that Foley was responsible for heavily bankrolling Zinke's first congressional campaign in Montana. He personally donated \$2,600 in 2013 and again 2014 -- the maximum contribution amount.

Fidelity donated \$154,823 to Zinke between the years of 2013 and 2018. Fidelity also owns Chicago Title Services, which donated 23,900 to Zinke.

The OSC probe is the sixth known investigation into travel by the administration's cabinet members.

The most recent investigation opened was into Veterans Affairs Secretary David Shulkin's July business trip to London and Denmark, which included meetings with Danish and UK officials as well as a stop at Wimbledon.

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8.2 - ABC News (Video): [Top Democrat questions Kellyanne Conway's air travel](#) (4 October, Benjamin Siegel, 24.1M online visitors/mo; New York, NY)

The top Democrat on the House Oversight Committee is raising questions about White House counselor Kellyanne Conway's air travel, and asking for proof that former Health and Human Services Secretary Tom Price has paid for his seats on controversial private flights.

In a letter to Conway obtained by ABC News, Rep. Elijah Cummings, D-Maryland, has asked Conway for information on all private, non-commercial and military flights she has taken.

Conway, who is the first White House official to be questioned regarding air travel, is coming under scrutiny after Price resigned Friday, and after reporting from Politico revealed that she joined Price on several chartered flights for events across the country.

"Despite the fact that you joined Secretary Price on several of these flights, you have not made any similar public statements indicating whether your own actions were appropriate, whether you will continue to take such flights at taxpayer expense in the future, or whether you plan to personally repay the taxpayers for the cost of your seats on these flights," Cummings wrote.

A White House official told ABC News in response to questions about Conway's travel: "Agencies are responsible for arranging appropriate transportation for their own events. Members of the President's Cabinet occasionally invite relevant White House staff for official travel for events promoting the President's agenda. When White House staff are invited, their travel plans are planned and secured by the inviting agency."

In addition to Price, Interior Secretary Ryan Zinke, Veterans Affairs Secretary David Shulkin and Treasury Secretary Steven Mnuchin have all come under fire for their use of government planes or private aircraft.

The White House is taking steps to crack down on travel and use of private charters in the administration instead of commercial air travel. John Kelly, the White House chief of staff, will

now sign off on all government and chartered air travel by agency leaders, according to a memo released by White House budget director Mick Mulvaney Friday.

“Every penny we spend comes from the taxpayer. We thus owe it to the taxpayer to work as hard managing that money wisely as the taxpayer must do to earn it in the first place,” he wrote.

On Friday, Price said in a statement that he plans to write a personal check to the Treasury for the expense of his travel.

According to a person familiar with the former secretary’s travel, Price’s seats on all the flights cost \$51,877.31. But Price’s total travel has cost the government an estimated \$400,000 in chartered aircraft expenses, according to Politico.

ABC News has reached out repeatedly to the Treasury Department and HHS asking if Price has actually written the promised check. A Treasury Department spokesman declined to reveal that information, citing privacy concerns, while HHS has declined to comment.

On Wednesday Cummings also sent a letter to Mnuchin and acting HHS Secretary Don Wright asking for proof of Price’s pledge: a copy of his check reimbursing the government.

ABC’s Justin Fishel and Katherine Faulders contributed to this report.

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8.3 - WRIC (ABC-8, Video): [Virginia taxpayers funding deadly dog experiments at McGuire VA Medical Center](#) (4 October, Kerri O’Brien, 477k online visitors/mo; Richmond, VA)

We’ve known for months that federal tax dollars have been funding the deadly dog experiments at McGuire VA Medical Center. Now, 8News has learned that Virginia has funded those canine experiments, and it has some lawmakers calling for an end to the contributions.

Documents obtained through a Freedom of Information Act request show that the Commonwealth of Virginia contributed to the funding for the McGuire Medical Center’s dog experiments.

The information had been originally redacted but was recently disclosed after watchdog group White Coat Project sued to have the information disclosed.

“We cannot do this, we just can’t,” Virginia State Senator Bill Stanley said.

Sen. Stanley said he was appalled by the experiments, which have involved at least 39 dogs having pacemakers surgically implanted as part of a heart disease study. All of the dogs involved are eventually euthanized.

“I was truly shocked when I learned state funds, state taxpayer money is going to the cruel and inhumane treatment of dogs all in the name of science,” Stanley said.

8News dug further and confirmed that lawmakers allocate money from Virginia’s General Fund each year to the Center for Innovative Technology.

CIT then decides what research projects to fund.

In 2016, CIT awarded McGuire and Dr. Alex Tan nearly \$100,000 for dog research. Dr. Tan is the same doctor that a review committee called “reckless” and responsible for several botched surgeries resulting in dog’s deaths.

We shared what we found with lawmakers.

Stanley said he had no idea that this block grant was being used to conduct deadly tests on dogs.

“We can find better ways in 2017 to find the information that they need to make the lives of our veterans and other people better,” Sen. Stanley said.

The VA argues that dogs are only used in studies when rodents cannot provide the information needed. Other supporters say canine research has and can lead to future medical breakthroughs.

8News spoke with Sherman Gillums, Jr., the Executive Director of Paralyzed Veterans of America. He said the sacrifices involved in animal research are worth it.

“The chance we are taking though, by stopping animal research is you will in effect impact our ability to find new treatments for not just human beings, but animals,” Gillums said.

Still, Sen. Stanley and Sen. Glen Sturtevant have fired off a letter to the governor expressing “opposition to the commonwealth’s role in the funding.” They describe it as “abusive and wasteful.”

They demand to know how much total taxpayer money has been provided for the research, and what action the Commonwealth has taken to address violations at McGuire, including those botched surgeries.

Sen. Stanley tells 8News he has already drafted legislation that would ban the use of Virginia taxpayer money for any research projects that harm dogs.

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8.4 - Fayetteville Observer: [Veteran charged in Gray’s Creek murder](#) (4 October, Drew Brooks, 439k online visitors/mo; Manchester, NH)

Air Force veteran, once praised for turning life around, is charged with first-degree murder after fatal shooting in Gray’s Creek

When Garrett Jordan Vann was last in a Cumberland County courtroom, the Air Force veteran was being celebrated for turning his life around.

Once homeless, estranged from his family, battling substance abuse and facing several felony charges, Vann appeared to have excelled under the strict regimen of the county's Veterans Treatment Court.

He was the court's first graduate during a ceremony in April 2016, earning praise from local judges, Veterans Affairs officials and others.

But a little more than a year later, Vann, 32, of the 300 block of Southern Comfort Drive in Parkton, was led into a courtroom under very different circumstances.

At the Cumberland County Detention Center, Vann made his first appearance on charges related to the killing of a Fayetteville man Tuesday night. Vann is charged with first-degree murder and shooting into an occupied vehicle, according to the Cumberland County Sheriff's Office.

He is accused of firing a 12-gauge shotgun into a Chevrolet Impala. Jason Ray Tyner, 40, of Fayetteville, was struck in the head and killed, an arrest warrant said.

Vann was initially charged with second-degree murder, but that charge was dismissed during his first appearance hearing Wednesday afternoon. Vann reportedly was served with the warrants for the newer charges just before appearing in court.

The Sheriff's Office has not issued any details about the incident that happened about 8 p.m. on the 3400 block of Nash Road, off Butler Nursery Road in the Gray's Creek community.

On Wednesday, family members of both Vann and Tyner filled one side of the small courtroom in the detention center. When Assistant District Attorney Robby Hicks announced that the second-degree murder charge was being dropped, there were gasps from some.

"Oh my God," one person said softly while another spoke a bit louder saying, "Thank you."

However, that was before they were told that Vann was being charged with first-degree murder.

Vann is being held without bail.

A 2004 graduate of Gray's Creek High, Vann enlisted in the Air Force in 2007 and served for about three years.

A spokesman for the Fayetteville VA Medical Center confirmed Wednesday that Vann works at the VA. He was hired at around the time he graduated from the Veterans Treatment Court, but the spokesman could not provide any other details.

In 2016, he told The Fayetteville Observer that he had turned his life around with the help of the Veterans Treatment Court team, which includes a judge, lawyers, law enforcement, substance abuse and mental health providers and a team of volunteer mentors.

A year earlier, the veteran who spent two tours in Afghanistan said he was at a low point in his life. But he said he regained control with the help of the court, which holds veterans charged with nonviolent crimes to strict standards, with regular court dates and drug tests.

In exchange, those who graduate can see their cases dismissed.

The Cumberland County veterans court was the second of its kind in North Carolina, following a similar court in Harnett County. Today, there are at least four such courts in the state.

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8.5 - CBS News Radio (ConnectingVets.com): [Mr. Secretary, why is the VA abusing dogs?](#)
(4 October, Jonathan Kaupanger, 23k online visitors/mo; New York, NY)

Puppies having holes drilled into their heads, then parts of their brains removed. Latex injected into puppies' coronary arteries before they're forced to run on treadmills until they have a heart attack. Dogs with severed spinal cords, invasive lung experiments... it's all just another day at the Department of Veterans Affairs.

Each year taxpayers fund between \$15 to \$20 billion worth of animal experiments. What part of that number belongs to the VA is hard to say because Veterans Affairs refuses to report the amount it spends on these type of tests. With over 9,000 projects listed in the Federal Register database, not one has the costs associated with the project listed.

ConnectingVets reached out to the VA with our questions, but as of publishing this article, they have refused to respond. Even with the agency's new "transparency," catchphrase, it's almost impossible to find out what exactly is going on with dog tests at the VA. The only thing coming from the VA on the subject is that they will look into how these tests are being done.

"It's unclear to me," said Justin Goodman, White Coat Waste Project's Vice President for Advocacy and Public Policy. "They say they're going to improve the oversight process for dogs in particular. I know they haven't communicated to Congress what that looks like."

It's not clear that Veterans Affairs even knows what this looks like either. At every turn, VA obfuscates reality and even makes outright lies about this subject.

"It is important to note that almost 100 percent of the animals involved in VA research are mice or rats," said Dr. Michael Fallon, VA's Chief Veterinary Medical Officer, said in a statement recently. "Studies involving larger animals such as canines are rare exceptions; canines accounted for fewer than 0.05 percent of animals used in VA research in 2016."

He went on to say, "At VA we have a duty to do everything in our power to develop new treatments to help restore some of what veterans have lost on the battlefield. One of the most effective ways for VA to discover new treatments for diseases that affect veterans and non-veterans alike is the continuation of responsible animal research."

Fallon also said that VA's animal research program "sets the standard for accountability and transparency both inside and outside the government." I'm going to come back to this point in a minute, but first, you need to understand how animal tests – specifically testing on dogs – are categorized.

Dogs that are kept in a lab, maybe used for breeding but not used for tests, these are category B experiments. Category C would be anything that is non-invasive, a pinprick maybe, but nothing painful. Experiments with category D testing are painful, but relief is given to the dogs.

Category E tests are where dogs are under maximum pain and distress but are given nothing to reduce the pain.

Dr. Fallon's comment about accountability and transparency are just simply ridiculous. The VA doesn't publish anything at all on this, so if this is the "standard for accountability and transparency," it's not a good one. Now, his comment that dogs make up "fewer than 0.05 percent of animals used in VA" is technically true.

Last year there were about 60,000 dogs used in US labs, 0.05 percent of that is around 300, but what the VA doesn't tell us is that it's the ONLY government agency conducting category E tests on dogs.

One of the places conducting these painful tests is the Louis Stokes VA Medical Center in Cleveland, Ohio. Earlier this year, Cleveland announced that five of the dogs they were using in tests had been adopted out after the experiments were complete. Two of these dogs were able to find a home, but the VA gets real shady at this point. These two dogs were only marked for adoption the day a Freedom of Information request was made about the projects. Then, the same day reporters were told about the five adoptions, three of these dogs, it was later found out, had been killed.

This was admitted by the VA only after the facts were made public.

The burden is on the VA to prove veterans are getting something out of these tests, but they are simply quiet on the subject. Take for example the latex injected into puppies experiment. This has been going on for an estimated 20 years. Papers published on this don't even use the word veteran.

"If there's something that is truly valuable and might be promising, let the private sector fund it," said Goodman. "A private company isn't going to run dogs on treadmills for 20 years and not get anything to show for it."

Last month, VA Secretary Dr. David Shulkin wrote an opinion piece about the VA's dog testing programs. In it he discussed many life-changing medical advancements that are due to canine research. He also explains why dogs are used in biomedical research as well. These excuses worked before, but now that we're in the 21st Century, the excuses might explain why the VA is the least advanced federal agency when it comes to biomedical research.

To this, I have four words: Organ on a Chip.

Using this technology, tests can be simulated on the lung, heart, kidney, and arteries. Besides the cruelty factor of animal testing, using dogs often adds to the length of tests and can be expensive. The National Institute of Health estimates that 95 percent of drugs and treatments that pass animal tests fail when done on humans. This makes me wonder if this is the reason why VA refuses to follow the Federal Funding Accountability and Transparency Act.

New legislation has been introduced this year to stop Government funds from being spent on painful dog experiments. The Preventing Unkind and Painful Procedures and Experiments on Respected Species or PUPPERS Act, if signed into law, would only apply to D and E type animal experiments and would essentially stop the U.S. Government from paying to abuse animals.

Secretary Shulkin ends his opinion piece by saying, “The Senate should take a stand and preserve humane and carefully supervised canine research at VA.” Please, Mr. Secretary, can you first explain to your country what’s exactly going on with this research and how much it’s costing us?

And to paraphrase Janet Jackson, what exactly has this done for veterans, lately?

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Veterans Affairs Media Summary and News Clips

5 October 2017

[1. Top Stories](#)

1.1 - U.S. News & World Report (AP): [Unclean Floors, Kitchens Found at Colorado](#)

[Veterans Hospital](#) (4 October, Dan Elliott, 24M online visitors/mo; Washington, DC)
Dirty floors, unclean kitchens and dusty vents were found by inspectors who checked a veterans hospital in Denver and a small veterans clinic in southern Colorado, according to a government report. Made public Wednesday by the Veterans Affairs Department's inspector general, the report did not say whether the conditions caused any health problems for patients.

[Hyperlink to Above](#)

1.2 - HuffPost: [VA Loan Program May Be Letting Veterans Down, A shortage of home appraisers is gumming up the works.](#) (4 October, Ann Brenoff, 22.9M online visitors/mo; New York, NY)

One of the promises we make members of the military is that in exchange for their service, we promise to ease their transition back into civilian life when the time comes. For over seven decades, a major element of that deal has been the VA loans that veterans can use to buy a home.

[Hyperlink to Above](#)

1.3 - The Hill: [House Dems boycott VA reform discussion over inclusion of right-leaning group: report](#) (4 October, Ellen Mitchell, 11.8M online visitors/mo; Washington, DC)

House Democrats boycotted a veterans health care reform discussion Tuesday over the inclusion of an advocacy group with ties to Republican Party donors, Military Times reported. House Veterans' Affairs Committee Democrats would not attend the meeting because Concerned Veterans for America (CVA) would be there. Democrats accused the group of being more interested in political attacks than creating new policy.

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1.4 - Military.com: [VA Photo ID Cards for All Veterans Coming in November](#) (4 October, Amy Bushatz, 9M online visitors/mo; San Francisco, CA)

All honorably discharged veterans of every era will be able to get a photo identification card from the Department of Veterans Affairs starting in November due to a law passed in 2015. The law, known as the Veterans Identification Card Act 2015, orders the VA to issue a hard-copy photo ID to any honorably discharged veteran who applies. The card must contain the veteran's name, photo and a non-Social Security identification number...

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1.5 - Stars and Stripes: ['Alzheimer's is a veterans' disease:' New group tries to improve support for vets with dementia](#) (4 October, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

It was part of Taylor's motivation to help create VeteransAgainstAlzheimer's, which officially launched Tuesday. The group is partnering with the Department of Veterans Affairs and Veterans of Foreign Wars to increase funding for Alzheimer's research, boost support for caregivers and enroll more veterans who are affected by dementia into the VA.

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2. Veteran and Employee Experience

2.1 - The Hill: [The VA's woes cannot be pinned on any singular administration](#) (4 October, Rory E. Riley-Topping, 11.8M online visitors/mo; Washington, DC)

Actions express priorities. Unfortunately, for the nation's veterans, the current priorities of the U.S. Department of Veterans Affairs have not changed much in the Trump era. As much as blaming Trump's populist policies or rousing rhetoric is an easy answer for any problem currently facing the nation, in the interest of fairness, it is important to note that the VA's woes cannot be pinned on any singular administration or political party, including the Trump administration.

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2.2 - Dayton Daily News: [Dayton VA gets primary care director; Lima clinic to open at new site](#) (4 October, Barrie Barber, 1.1M online visitors/mo; Dayton, OH)

The Dayton VA Medical Center has appointed a former Air Force medical officer to director of primary care and a larger clinic will open next spring in Lima, the federal health agency said. Edward P. Syron, a medical administrator, will earn the \$120,900-a-year overseeing primary and home-based care outpatient services, the VA reported. He replaces Dr. Kavita Peddireddi, who served in the job temporarily until a permanent replacement was found.

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2.3 - Military Times: [House Democrats boycott VA health event, complicating reform plans](#) (4 October, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

Plans to overhaul veterans health care this fall could be in jeopardy after House Democrats boycotted a supposedly friendly roundtable discussion on the issue Tuesday over the inclusion of a Republican-linked advocacy group they insist is more interested in political attacks than policy crafting. The controversy comes just a few weeks before House lawmakers are planning to fast-track new legislation surrounding outside care programs at the Department of Veterans Affairs...

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2.4 - The State Journal-Register: ['Unaccompanied' veterans honored at Camp Butler National Cemetery](#) (4 October, 834k online visitors/mo; Springfield, IL)

Ten "unaccompanied" veterans were honored at Camp Butler National Cemetery on Tuesday. The veterans were recently buried at the cemetery but either had no relatives or no relatives who could travel to the cemetery at the time of burial. The twice-annual ceremony includes the presentation of colors, a ceremonial flag folding, rifle volley and the playing of "Taps" presented by the Sangamon County Interveterans Burial Detail.

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2.5 - New Hampshire Union Leader: [VAMC volunteers recognized](#) (4 October, 318k online visitors/mo; Manchester, NH)

The Manchester VA Medical Center recently held a volunteer recognition ceremony in honor of its 320 registered volunteers, who serve in more than 28 departments within the facility. The Medical Center's volunteers work directly with veterans as drivers, welcome ambassadors and

recreation aides to behind-the-scenes work in the warehouse, in the research department and in management.

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2.6 - The Augusta Chronicle: [Club Car donates new golf cart to help disabled at Charlie Norwood VA Medical Center](#) (4 October, Nefeteria Brewster, 240k online visitors/mo; Augusta, GA)

Club Car dedicated a 2017 golf cart, valued at more than \$16,000, to the Charlie Norwood VA Medical Center to help get disabled veterans from the parking lot to the front of the facility. Although the uptown medical center holds two rows of handicapped spaces around the facility, Fred Palmer, a Club Car spokesman, said the new golf cart can further help those who are unable to secure those spots.

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2.7 - WRDW (CBS-12, Video): [Solution to VA Uptown Parking Problem](#) (4 October, Celia Palermo, 914k online visitors/mo; North Augusta, SC)

The distance from the parking lot to the hospital doors can be pretty far depending on where you park. Veterans say they're sick of walking the distance. The VA says they know and they're fixing it. "A lot of us have difficulty walking...be it bad hips...bad knees...or bad ankles." He walks with a cane because he has arthritis. It's a price he paid, he says, for serving his country.

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2.8 - WTAJ (CBS-10): [New director at Altoona VA Hospital](#) (4 October, Charlotte Ames, 192k online visitors/mo; Altoona, PA)

The new director at Altoona's Van Zandt VA Medical Center says she hopes to increase the number of services available to area veterans. Currently, the facility doesn't provide specialty services such as cardiology and cancer treatment, so veterans must travel to Pittsburgh for treatment. Sigrid Andrew said her goal is to offer those services in Altoona through the use of telemedicine and visiting clinics.

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2.9 - Foster's Daily Democrat: [UNH veterans adaptive sports program receives federal grant](#) (4 October, 191k online visitors/mo; Dover, NH)

The University of New Hampshire's Northeast Passage Program will receive a \$172,974.49 grant from the Department of Veterans Affairs (VA) to support adaptive sports opportunities for veterans and servicemembers with disabilities, according to Congresswomen Carol Shea-Porter and Annie Kuster.

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2.10 - Altoona Mirror: [Van Zandt director makes debut, Andrew said she chose job because veterans seem happy, staff respectful](#) (5 October, William Kibler, 74k online visitors/mo; Altoona, PA)

After Sigrid Andrew applied to become director of the Van Zandt VA Medical Center, but before she was offered the job, she came here and sat in various lobbies and waiting rooms, observing interactions between employees and veterans. She noticed that the veterans seemed happy, that the employees were kind and that they were respectful of each other.

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2.11 - WAND (NBC-17, Video): [Camp Butler National Cemetery honors 10 unaccompanied veterans](#) (4 October, Meredith Hackler, 68k online visitors/mo; Decatur, IL)

The gloomy weather matched the somber tone 10 veterans were honored for their sacrifice to our country. "The unaccompanied honors veterans ceremony is a way we show respect to veterans that come to our cemetery without family members or without being accompanied by their loved ones," said Antonio Henderson, assistant director of Camp Butler National Cemetery.

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2.12 - KXRM (FOX-21, Video): [Veteran students speak out after Career Center shuts down](#) (3 October, Carly Moore, 58k online visitors/mo; Colorado Springs, CO)

Dozens of veterans are out of luck after a school they were attending for a technical degree has been shut down. The school in North Texas is called Retail Ready Career Center (RRCC) which focuses on giving veterans hands-on training and professional job placement assistance in the HVAC industry. Two Colorado Springs veterans were enrolled in the class and both of their stories are exactly the same.

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2.13 - The Daily News: [Staller retires from VA Medical Center](#) (4 October, 54k online visitors/mo; Iron Mountain, MI)

After 24 years of federal service, Patricia Staller of Iron Mountain has retired from the Oscar G. Johnson VA Medical Center. Staller was born and raised in Fort Atkinson, Wis., and is the daughter of Donald and Marie Peterson. She graduated from the University of Wisconsin-Milwaukee with a master's degree in social work.

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2.14 - FEDweek: [Improving Policy-Making at VA a Complex Task, GAO Finds](#) (4 October, 51k online visitors/mo; Glen Allen, VA)

The Veterans Health Administration, the largest arm of the VA, is encountering several difficulties as it attempts to improve its policy-making, GAO has said. Under a policy issued last year, directives and notices are now the sole documents for establishing national agency policy; other types of documents, such as program office memos, are considered guidance.

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2.15 - Journal Express: [Residents seek answers at VA town hall](#) (4 October, Pat Finan, 9.2k online visitors/mo; Knoxville, IA)

A town hall meeting about the Veterans Administration campus on Thursday, Sept. 28, focused not only on the site's future but on vets themselves. The quality of their health care drew nearly as much attention as the 170-acre site during the two-hour discussion among about 125 people at the Knoxville Performing Arts Center. Many participants sought details of the process by which the government rids itself of the property. Others were frustrated about depressed or suicidal military comrades.

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3. Access to Healthcare

3.1 - WDBJ (CBS-7): VA expanding use of tele-medicine to improve access for veterans (4 October, Joe Dashiell, 833k online visitors/mo; Roanoke, VA)

The VA Medical Center in Salem is expanding the use of tele-medicine, as a way to improve veterans' access to health care. Wednesday, a company that provides the technology to the Department of Veterans Affairs demonstrated some of the newest equipment in Salem. Lindsay Gill is the Facility Telehealth Coordinator at the Salem VA Medical Center.

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3.2 - The National Law Review: Department of Veterans Affairs Aims to Trump State Telemedicine Rules (4 October, 475k online visitors/mo; New York, NY)

The U.S. Department of Veterans Affairs ("VA") is taking a significant step towards expanding needed services to Veterans by proposing a rule to preempt state restrictions on telehealth. Most states currently restrict providers (including VA employees) from treating patients that are located in that state if the provider is not licensed there. As a result, the VA has had difficulty getting a sufficient number of providers to furnish services via telemedicine for fear that they will face discipline from those states for the unlicensed practice of medicine.

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3.3 - WCSH (NBC-6, Video): Lawsuit targets Togus VA for botched operations (4 October, Don Carrigan, 442k online visitors/mo; Portland, ME)

Six Maine military veterans are waiting for a federal judge in Portland to decide if they will be allowed to sue the Veterans Administration. Those veterans all say they had foot or ankle surgery at the Togus VA hospital, and that the doctor botched the operations. That doctor left in 2008, but the veterans say they still suffer pain and other problems.

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3.4 - WHAS (ABC-11, Video): Annual event offers one-stop shop for homeless (4 October, Sara Wagner, 439k online visitors/mo; Louisville, KY)

The latest numbers show more than 6,000 people are struggling with homelessness in Louisville. Wednesday, a group of people put their talents together to help drastically reduce those numbers. Homeless Connect is an annual event aiming to serve hundreds of homeless individuals by offering dozens of free resources.

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3.5 - KRGV (ABC-5, Video): Local Organizations Provide Options for Homeless Valley Veterans (4 October, Cecilia Gutierrez, 275k online visitors/mo; Weslaco, TX)

One homeless veteran is one too many. On any given night, 39,000 veterans in the U.S. find themselves without a permanent roof over their head, according to the U.S. Department of Housing and Urban Development. Clifford Briggs is one of those veterans. From looking at him you would never know he was homeless with his big smile, positive attitude and contagious laughter.

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3.6 - KRGV (ABC-5, Video): [Valley Vietnam Veteran Battles Diabetes Linked to Agent Orange Exposure](#) (4 October, Ryan Nelson, 275k online visitors/mo; Weslaco, TX)

Veterans who believe they are suffering from an illness linked to Agent Orange may have health care options through the VA. "One of the most important things that they need to do when they believe that they've been exposed to Agent Orange is to come by either the McAllen outpatient clinic or the Harlingen outpatient clinic," said VA Texas Valley Coastal Bend spokesperson Reynaldo Leal.

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3.7 - KOLO (ABC-8, Video): [Reno physician helps Veterans in Puerto Rico](#) (4 October, Terri Russell, 274k online visitors/mo; Reno, NV)

Under normal circumstances, Dr. Ivan Correa is the chief of staff at the Veterans Affairs Sierra Nevada Health Care System. He is also a Puerto Rican native, and decided to fly to the island to check on the status of his parents, after two devastating hurricanes hit the area. "They tell me they are ok. But ok is a relative term..."

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3.8 - KRIS (NBC-6, Video): [Mobile veterans services center touring county](#) (4 October, Roland Rodriguez, 197k online visitors/mo; Corpus Christi, TX)

With more than 30,000 veterans in Nueces County, the Veterans Affairs Office has come up with a way to make serving those who served our country a little easier by going mobile. The mobile unit will be traveling throughout the county over three days next week, and it's equipped to provide a variety of services to local veterans. This a great way to help veterans who live out in rural areas.

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3.9 - The Robesonian: [Battaglia's death latest proof of veterans' neglect](#) (4 October, Editorial Board, 72k online visitors/mo; Lumberton, NC)

It looks as if an SBI investigation will conclude that Kevin Anthony Battaglia, retired Army, just 33 years old, someone's son, and the father of three young children, died when he was struck by an officer's bullet during a standoff at his Parkton home on Sunday. But make no mistake: This was suicide by cop, and Battaglia is only the latest veteran of our Middle East wars to pick that poison after returning to this country a shattered self...

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3.10 - KXLH (CBS-25, MTN News, Video): [VA Montana hosts Fall Health Festival](#) (4 October, John Riley, 57k online visitors/mo; Helena, MT)

Over 550 Veterans received their Flu immunization today along with community members and V-A staff. VA Montana staff braved the cold temperatures outside to kick off the flu season with the annual Fall Health Festival and Drive Thru Flu Clinic. The shots were free for enrolled veterans and VA employees and the County Health Department were on hand to supply flu shots for a fee for everyone else.

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3.11 - HealthTech: [NHIT Week 2017: Technology Improves Care Options for Veterans - Telehealth and predictive analytics are among the tools being deployed more](#)

strategically by the VA, Secretary David Shulkin says. (4 October, Dan Bowman, 20k online visitors/mo; Vernon Hills, IL)

One day after publication of a rule that would let doctors at Department of Veterans Affairs facilities leverage telemedicine to provide care to patients anywhere, VA Secretary David Shulkin discussed his agency's goals for using technology moving forward.

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4. Women Veterans – No Coverage

5. Appeals Modernization – No Coverage

6. Strategic Partnerships

6.1 - WIBW (CBS-13, Video): Visually impaired veterans tour Kansas Statehouse (4 October, Deneysa Richard, 484k online visitors/mo; Topeka, KS)

The VA of Eastern Kansas sponsored an event on Tuesday that left a long lasting impact. The Topeka and Leavenworth VA campuses partnered with The Kansas State Capitol to host a tour for veterans who are visually impaired. Over 40 veterans were in attendance, some of who visited the Capitol for the first time.

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7. Supply Chain Modernization

7.1 - Washington Technology: B3 Group wins \$156M VA financial, program management order (4 October, Ross Wilkers, Vienna, VA)

Leesburg, Va.-based small business B3 Group has won a five-year, \$156 million task order for financial and program management services to the Veterans Affairs Department. The VA awarded the order under its potential 10-year, \$22.3 billion T4NG IT services contract vehicle. Work under this order supports software development lifecycle tasks for the VA's financial services center, B3 Group said Tuesday.

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8. Other

8.1 - CNN: Investigations opened into Zinke's meeting with Golden Knights hockey team (4 October, Miranda Green, 29.7M online visitors/mo; Atlanta, GA)

The OSC probe is the sixth known investigation into travel by the administration's cabinet members. The most recent investigation opened was into Veterans Affairs Secretary David Shulkin's July business trip to London and Denmark, which included meetings with Danish and UK officials as well as a stop at Wimbledon.

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8.2 - ABC News (Video): [Top Democrat questions Kellyanne Conway's air travel](#) (4

October, Benjamin Siegel, 24.1M online visitors/mo; New York, NY)

In addition to Price, Interior Secretary Ryan Zinke, Veterans Affairs Secretary David Shulkin and Treasury Secretary Steven Mnuchin have all come under fire for their use of government planes or private aircraft.

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8.3 - WRIC (ABC-8, Video): [Virginia taxpayers funding deadly dog experiments at McGuire VA Medical Center](#) (4 October, Kerri O'Brien, 477k online visitors/mo; Richmond, VA)

We've known for months that federal tax dollars have been funding the deadly dog experiments at McGuire VA Medical Center. Now, 8News has learned that Virginia has funded those canine experiments, and it has some lawmakers calling for an end to the contributions. Documents obtained through a Freedom of Information Act request show that the Commonwealth of Virginia contributed to the funding for the McGuire Medical Center's dog experiments.

[Hyperlink to Above](#)

8.4 - Fayetteville Observer: [Veteran charged in Gray's Creek murder](#) (4 October, Drew Brooks, 439k online visitors/mo; Manchester, NH)

A spokesman for the Fayetteville VA Medical Center confirmed Wednesday that Vann works at the VA. He was hired at around the time he graduated from the Veterans Treatment Court, but the spokesman could not provide any other details. In 2016, he told The Fayetteville Observer that he had turned his life around with the help of the Veterans Treatment Court team...

[Hyperlink to Above](#)

8.5 - CBS News Radio (ConnectingVets.com): [Mr. Secretary, why is the VA abusing dogs?](#) (4 October, Jonathan Kaupanger, 23k online visitors/mo; New York, NY)

Puppies having holes drilled into their heads, then parts of their brains removed. Latex injected into puppies' coronary arteries before they're forced to run on treadmills until they have a heart attack. Dogs with severed spinal cords, invasive lung experiments... it's all just another day at the Department of Veterans Affairs.

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1. Top Stories

1.1 - U.S. News & World Report (AP): [Unclean Floors, Kitchens Found at Colorado Veterans Hospital](#) (4 October, Dan Elliott, 24M online visitors/mo; Washington, DC)

DENVER (AP) — Dirty floors, unclean kitchens and dusty vents were found by inspectors who checked a veterans hospital in Denver and a small veterans clinic in southern Colorado, according to a government report.

Made public Wednesday by the Veterans Affairs Department's inspector general, the report did not say whether the conditions caused any health problems for patients.

The report, dated Sept. 29, said a February inspection found cleanliness problems in eight patient care areas, two areas where instruments are sterilized and in some ice machines and refrigerators in kitchens.

It also said some ventilation grills and horizontal surfaces were dusty.

The report did not specify whether the problems were at the aging Denver hospital or a small outpatient clinic in Salida, Colorado, which inspectors also visited. Kristen Schabert, a spokeswoman for the VA's Denver-based Eastern Colorado Health Care System, said inspectors focused on the Denver hospital.

A new veterans medical center is under construction in suburban Aurora to replace the Denver facility and is expected to open next year. The February inspection did not include that facility.

In a written statement, the VA said plans are in place to address the problems the inspectors found.

The VA nationwide is under scrutiny over spending, long wait times for care and other problems.

Last month, The Associated Press reported the VA program that pays for veterans to get health care in the private sector could run out of money this year, despite getting \$2.1 billion in emergency funding in August. Another shortfall could force the VA to limit referrals to outside doctors, causing delays in medical care for hundreds of thousands of veterans.

In Colorado, the cost of the medical center being built outside Denver has nearly tripled to almost \$1.7 billion. That so infuriated lawmakers that they stripped the department of the authority to oversee large construction projects and put the Army Corps of Engineers in charge.

Other problems found in the February inspections in Colorado:

- Two doors in a mental health treatment facility were found unlocked and the alarms were not turned on.
- Inspectors found no record that some new employees were given required security training.
- Inspectors found no evidence that security personnel were compiling or analyzing data on violent or disruptive incidents.

-- Staff did not compile adequate reports on some patients who were transferred to other facilities, including whether the patients were stable enough to be moved and whether the new facility was told the patients' history, symptoms and test results.

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1.2 - HuffPost: [VA Loan Program May Be Letting Veterans Down, A shortage of home appraisers is gumming up the works.](#) (4 October, Ann Brenoff, 22.9M online visitors/mo; New York, NY)

One of the promises we make members of the military is that in exchange for their service, we promise to ease their transition back into civilian life when the time comes. For over seven decades, a major element of that deal has been the VA loans that veterans can use to buy a home.

These loans require no money down and can be obtained with much lower credit scores than other mortgages. But the much-vaunted program, which began under the GI Bill of 1944, has hit a snag.

The Mortgage Bankers Association recently warned the Department of Veterans Affairs that the program may be hurting the very vets it was designed to help.

Here's The Deal

Under the VA loan program, veterans can borrow up to \$417,000 — or \$625,000 in designated “high cost areas,” like parts of California — without putting any money down for a house that will be their principal residence. That's a good deal considering the median home value in the U.S. is currently \$200,700, according to Zillow.

Among the program's other attractions, there is no maximum debt ratio — meaning that the borrower's monthly mortgage payment can exceed the typical lender's restriction of no more than 28 percent of gross monthly income. There is no minimum credit score requirement either, while most other home mortgages require a credit score of at least 620 for conventional loans or 580 for most Federal Housing Administration loans. A VA loan can also be used to refinance an existing loan. And vets can get these loans more than once.

The VA home loan program is one of the key reasons that 79 percent of veterans own their own homes, compared with just 63 percent of the non-veteran population, according to Trulia.com.

But recent vets don't seem to be taking advantage of the program in large numbers. Just 36 percent said they had applied for a VA home loan in a 2014 survey of 2,000 members of Iraq and Afghanistan Veterans of America.

Pressured Not To Use VA Loans

Real estate agents have long complained that the VA's hurry-up-and-wait requirements when it comes to appraisals and inspections, associated red tape and extra hoops to jump through compared with conventional loan programs ultimately hurt veterans' efforts to purchase homes in a competitive market.

Now the Mortgage Bankers Association is highlighting the problem of delays in the appraisals that the VA requires. There is a shortage of available appraisers, which has led to longer wait times and missed contract deadlines.

Add the appraiser shortage to the fact that it's just faster and simpler to work with other buyers, and some home sellers and their agents shy away from dealing with VA loans. As a result, the mortgage bankers group said, veterans are under pressure to bypass the benefits of a VA loan and seek conventional financing instead.

Steve O'Connor, senior vice president of the Mortgage Bankers Association, laid out his group's concerns in a Sept. 5 letter to the executive director of the VA's Loan Guaranty Service, who oversees the loan program. He said that veterans often can't close a VA loan and are forced "to choose other loan programs to meet certain deadlines or face other adverse outcomes."

Finding alternate home funding means having to come up with as much as a 20 percent down payment, meeting tighter credit standards and walking away from a promised benefit they earned when they put their lives on the line for their country. A non-VA loan can also cost the veteran an additional "tens of thousands of dollars of interest payments over the life of the loan," O'Connor wrote.

The VA did not respond to questions emailed by HuffPost or make a spokesperson available for comment by publication time.

Appraisers Are Upset

While the Mortgage Bankers Association letter was sparked by anecdotal evidence provided by its members, the group is not the first to note the impact of changes to the appraisal industry — changes that have not set well with current appraisers and may have discouraged new ones from entering the field.

Almost 75 percent of the 2,248 appraisers surveyed in a 2017 study from the National Association of Realtors said they planned to leave or have already left the business because of greater regulation and an industry shift away from working directly for lenders to working for larger companies that manage groups of appraisers. These appraisal management companies take as much as 50 percent of what home buyers pay in appraisal fees.

The Dodd–Frank Wall Street reform law of 2010 put in place new federal guidelines that required banks to have a "firewall" between lenders and appraisers to avoid conflicts of interest. These appraisal management companies blossomed as the new middlemen, but the actual appraisers — the people who do the hands-on work — saw their pay cut. Appraisers also contend they're unfairly taking the blame when the companies "gouge" buyers with excessive fees, according to housing writer Kenneth R. Harney.

So appraisers are unhappy these days, and the assignments they most don't want to accept are those involving VA loans, according to the National Association of Realtors study. The double whammy of red tape and low compensation was the given reason.

To address the problem, the Mortgage Bankers Association offered a series of recommendations to the VA: use a virtual desktop appraiser to supplement the traditional

process of on-site visits, grant property inspection waivers, and lend its support to a proposal from the Appraisal Qualifications Board to reduce licensing requirements.

“The damaging impact to the veteran community is clear and the VA should act quickly,” the group wrote.

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1.3 - The Hill: [House Dems boycott VA reform discussion over inclusion of right-leaning group: report](#) (4 October, Ellen Mitchell, 11.8M online visitors/mo; Washington, DC)

House Democrats boycotted a veterans health care reform discussion Tuesday over the inclusion of an advocacy group with ties to Republican Party donors, Military Times reported.

House Veterans’ Affairs Committee Democrats would not attend the meeting because Concerned Veterans for America (CVA) would be there. Democrats accused the group of being more interested in political attacks than creating new policy.

CVA was one of 18 veterans groups invited to the event, including the American Legion, AMVETS, Iraq and Afghanistan Veterans of America and Wounded Warrior Project.

“The chairman has the right to invite any organization he pleases, but to pretend that CVA is anything other than a partisan organization that invests time and money into discrediting Democratic members of Congress, and specifically the ranking member of this committee, is disingenuous,” Griffin Anderson, press secretary for the committee’s Democrats, told Military Times.

“We will not pretend it is anything else.”

House lawmakers are looking to quickly move new legislation on outside care programs at the Department of Veterans Affairs (VA), including the Veterans Choice Program.

Under the three-year-old Choice program, the VA pays for veterans who live too far away from the nearest Veterans Health Administration (VHA) facility or need a quicker medical appointment to use private doctors and hospitals.

Critics of several proposals to replace the Choice program are afraid that will lead to privatizing the VA. Outsourcing veteran care to the private sector, they fear, will divert billions of dollars from VHA services to medical providers that can’t be as well supervised and that have limited experience caring for veterans.

VA Secretary David Shulkin has promised to replace the Choice program with the Coordinated Access and Rewarding Experiences program (CARE) to be revealed this month.

The closed roundtable discussion which Democrats refused to attend covered broad outlines of the upcoming proposals.

"It is disappointing that the Democrat members of the committee did not want to hear ideas on how to fix the VA from a group of veterans, including many patients of the VA and combat veterans like myself," said Dan Caldwell, the policy director for CVA.

A spokeswoman for House VA Committee Chairman Phil Roe (R-Tenn.) told Military Times that attendees for the event "were invited to participate because of their interest in and serious study of VA's community care programs. They were invited for that reason and that reason only."

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1.4 - Military.com: [VA Photo ID Cards for All Veterans Coming in November](#) (4 October, Amy Bushatz, 9M online visitors/mo; San Francisco, CA)

All honorably discharged veterans of every era will be able to get a photo identification card from the Department of Veterans Affairs starting in November due to a law passed in 2015.

The law, known as the Veterans Identification Card Act 2015, orders the VA to issue a hard-copy photo ID to any honorably discharged veteran who applies. The card must contain the veteran's name, photo and a non-Social Security identification number, the law states.

A VA official on Wednesday confirmed the cards are on track to be available nationwide starting in November. Veterans may apply for the card online, but a timeline for how long it will take to receive a card after application has not been finalized, the official said.

Although the law states that the VA may charge a fee for the card, the official said no fee is planned.

The change comes as the military exchange stores prepare to open online shopping to all honorably discharged veterans starting Nov. 11. Veterans who wish to use that new benefit must be verified through VetVerify.org.

Congress passed the ID law as a way to help veterans prove their service without showing a copy of their DD-214.

"Goods, services and promotional activities are often offered by public and private institutions to veterans who demonstrate proof of service in the military, but it is impractical for a veteran to always carry Department of Defense form DD-214 discharge papers to demonstrate such proof," the law states.

Some veterans already carry such proof of service.

Those who receive health care from the VA or have a disability rating can get a photo ID VA health card, also known as a Veteran Identification Card. Military retirees also hold an ID card issued by the Defense Department.

Veterans are also able to get a proof of service letter through the VA's ebenefits website. And some states will include a veteran designation on driver's licenses if requested.

Editor's Note: The fourth and fifth graphs have been updated with additional information from the VA.

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1.5 - Stars and Stripes: [‘Alzheimer’s is a veterans’ disease:’ New group tries to improve support for vets with dementia](#) (4 October, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

WASHINGTON — Shawn Taylor knows the strain that Alzheimer’s can put on a family.

Her grandmother developed Alzheimer’s in the early 1980s. Then, her grandfather was diagnosed with the disease. Then her mother and father.

At age 21, as an only child and grandchild, the deadly form of dementia forced Taylor to become a caregiver for the next 35 years.

“I understand the intense caregiver needs,” she said. “And as I watch my mother slip away -- unable to recognize me, unable to take care of her most basic needs -- I realized I needed to do more.”

It was part of Taylor’s motivation to help create VeteransAgainstAlzheimer’s, which officially launched Tuesday. The group is partnering with the Department of Veterans Affairs and Veterans of Foreign Wars to increase funding for Alzheimer’s research, boost support for caregivers and enroll more veterans who are affected by dementia into the VA.

Her decision to focus her attention on veterans -- a group disproportionately at risk for dementia -- was personal, too. Taylor’s grandfather, John Gavin, was an Army colonel and West Point graduate, and her father, Bernard Landau, is a retired lieutenant colonel and Vietnam War veteran.

The veterans-focused group is a new segment of UsAgainstAlzheimer’s, which lobbies to increase research for a cure. George Vradenburg, a cofounder of UsAgainstAlzheimer’s, described the organization as “small, feisty and fearless.”

“We’re learning far too often veterans are disproportionately affected by this disease and are at a greater risk for Alzheimer’s because of their war-related brain impairments,” Vradenburg said. “Alzheimer’s is a veterans’ disease.”

article continues below

Veterans are at higher risk for Alzheimer’s for several reasons, explained David Cifu, a researcher and traumatic brain injury specialist at the VA. There’s a higher prevalence of mental health disorders in the veterans community, he said, which creates more likelihood of developing dementia. According to a study in the Journal of the American Geriatrics Society, the risk of Alzheimer’s doubles for veterans with post-traumatic stress disorder.

Traumatic brain injury also increases the risk of dementia, and of developing it earlier in life, according to a 2014 study published by the American Academy of Neurology. Older veterans

with TBI are 60 percent more likely to develop dementia than other veterans, according to the study.

Iraq and Afghanistan veterans are at higher risk to develop Alzheimer's sometime in their lives because they've sustained more brain injuries, VeteransAgainstAlzheimer's wrote in a report Monday. Of all combat wounds in Iraq and Afghanistan, 22 percent were brain injuries – nearly double the brain injuries sustained during the Vietnam War.

"Now more than ever, we need to redouble our efforts," Cifu said.

One study published by the National Institute of Health estimates 420,000 veterans will have developed Alzheimer's between 2010 and 2020.

About 270,000 veterans with dementia are enrolled in the VA, Cifu said. The number enrolled in the VA represents only about 35 percent of the 774,000 veterans estimated to have dementia.

The VFW got involved in order to improve the numbers, said Ryan Gallucci, a director with the VFW. Some veterans and families don't realize they qualify for VA benefits, such as caregiver support, Gallucci said.

Others are barred from those services because of VA regulations. For instance, some caregiver benefits are available only to family members of veterans wounded post-9/11. There's legislation in Congress, H.R. 1472 and S. 591, that would expand the services to all veterans.

Karen Garner, who was a caregiver to her husband, Senior Master Sgt. Jim Garner, said she didn't qualify for VA assistance because of income restrictions. She said her husband, who died of Alzheimer's last year at age 52, was confused and hurt that the VA wouldn't provide help.

"With the low enrollment numbers in VA... we have to do better than this," Gallucci said. "This is where we can help make a difference."

Increasing funding for Alzheimer's research is also key, said Cifu. In 2016, the VA conducted 157 research projects on Alzheimer's disease across 44 locations, at a cost of \$30 million.

"This sounds like a lot, and it is, but we need to do even more," he said.

Cifu is part of a consortium of specialists at the VA and Defense Department starting a new study to find connections between brain injury and dementia, he said. The group is looking to get as many veterans and servicemembers involved as possible.

At age 56, Taylor is still a primary caregiver. Her mother is in the late stages of Alzheimer's, and her father was just diagnosed with the disease last fall.

Taylor is hoping improvements in research and support could help Vietnam War-era veterans such as her father -- who's now 87 and living in a nursing home -- as well as the potential surge of Iraq and Afghanistan veterans who could develop the disease in the next 20 to 30 years.

"What we want to do is start the conversation," Taylor said. "Nobody wants to talk about it, but we have to talk about it. It's happening, and what's ahead of us is going to be devastating."

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2. Veteran and Employee Experience

2.1 - The Hill: [The VA's woes cannot be pinned on any singular administration](#) (4 October, Rory E. Riley-Topping, 11.8M online visitors/mo; Washington, DC)

Actions express priorities. Unfortunately, for the nation's veterans, the current priorities of the U.S. Department of Veterans Affairs have not changed much in the Trump era.

As much as blaming Trump's populist policies or rousing rhetoric is an easy answer for any problem currently facing the nation, in the interest of fairness, it is important to note that the VA's woes cannot be pinned on any singular administration or political party, including the Trump administration.

Entrenched accountability issues such as those that are plaguing the VA take time to resolve. But, it appears that, thus far, the Trump administration may have over-promised and under-delivered.

Trump campaigned on a platform of overhauling the VA, and despite a robust legislative agenda aimed at following through on those campaign promises, the VA's priorities over the last several months have included gallivanting through Europe, defending questionable research programs, and delaying the release of a much-needed strategic plan on the future of the Veterans Choice program.

Wasting taxpayer funding seems to be at the route of many of the VA's problems. As explained by Avik Roy, a health care policy advisor and president of the Foundation for Research on Equal Opportunity, "[i]f you look at the budget of the VA and simply divide it by the number of people enrolled . . . there's more than enough money to fund veterans' healthcare. The problem is too much of the money is being spent not on veterans' healthcare, but on other institutional priorities."

The first institutional priority distracting top VA officials from veterans' healthcare relates to splurging on travel. Although VA Secretary David Shulkin's travel indiscretions pale in comparison to other members of the Trump cabinet, such as recently-resigned Health and Human Services Secretary Tom Price who spent over \$1 million of taxpayer funds on charter flights, a Washington Post investigation into Shulkin's travel revealed that, while veterans continued to struggle with the improved access to care promised by the Trump administration, he attended Wimbledon, toured Westminster Abbey, and took a cruise along the Thames at taxpayer expense. The VA's Office of the Inspector General is now conducting its own investigation into the propriety of these travel expenses.

The revelations regarding Shulkin's travel were particularly egregious in light of the fact that, less than two weeks prior, Shulkin signed a memo instructing VA staff to curtail travel in order to "generate savings" within the department. Ironically, the memo went on to state that providing clearly documented rationale on the necessity of official travel was required to promote "accountability in determining whether employee travel in their organization is essential."

Assuming that leadership starts from the top, Shulkin has failed to provide the type of leadership necessary to promote the type of accountability and cost savings that are essential to reforming the department he oversees.

The second institutional priority distracting the VA from veterans' healthcare is in regard to the department's controversial canine research program. Many in the veterans community found it bizarre that, during the month of September, which is National Suicide Prevention Awareness Month, the only public opinion authored by Shulkin for a major media outlet was an opinion piece defending this program in USA Today, while he remained relatively silent publicly on internal data released the same week on the high rates of veteran suicide in rural states and among female veterans, until the Senate Committee on Veterans' Affairs scheduled a hearing on the topic at the end of the month.

As noted by Ben Krause, disabled veteran and founder of the website Disabledveterans.org in a San Diego Tribune article discussing this topic, "I'm not going to say canine research should or shouldn't be done at all, I just don't think the VA should do it. VA has a hard enough time not withholding healthcare from veterans on a regular basis." If VA could redirect its zealotry in defending this program to providing better access to care, veterans would certainly be better off.

Finally, the third institutional priority distracting VA from veterans' healthcare is its inability to effectively implement the Veterans Choice Program. Although the Choice Program is relatively new, having been first signed in to law in 2014, VA has consistently struggled with the role of private sector care in conjunction with VA-care, with some equating the Choice Program with the demise of the department and full-scale privatization of the VA.

As VA continues to find a balance between its own existence and the role of private sector care, it nonetheless asked Congress for an emergency increase in funding for the program due to increased demand.

Despite legislation in August that provided the program with an additional \$2.1 billion in funding, the money continues to be spent faster than expected because of a combination of the popularity of the program and VA's inability to properly account for the money. As a result, VA has slowed down veterans' referrals for medical appointments outside the VA, thus causing additional delays in needed care.

In requesting additional funding, Shulkin acknowledged to a Senate subcommittee in charge of VA funding that "we do not want to see veterans impacted at all because of our inability to manage budgets." However, this is exactly what is continuing to happen.

As Sen. John McCain (R-Ariz.) said in a scolding to Shulkin in a letter dated Sept. 27

"On June 21 of this year, I joined several of my colleagues in writing to you to express our serious concerns about reports of financial mismanagement at the VA. We said at the time that it was essential, given the growing demand for care under the Choice program, that the VA immediately correct the failures that created such a serious shortfall. It appears as if you have not done so."

It should go without saying that VA's top priority should be veterans, but as the current administration's actions have demonstrated to date, this is not always the case. Only when the VA embraces a culture of veterans first, rather than entrenched bureaucracy first, can they

overcome the many institutional detriments distracting them from effectively using its taxpayer funded budget to provide veterans with first class care.

Rory E. Riley-Topping has dedicated her career to ensuring accountability within the Department of Veterans Affairs (VA) to care for our nation's veterans. She is the principal at Riley-Topping Consulting and has served in a legal capacity for the U.S. House of Representatives Committee on Veterans' Affairs, the National Veterans Legal Services Program, the U.S. Court of Appeals for Veterans Claims, and the Department of Veterans Affairs, and can be reached on Twitter @RileyTopping.

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2.2 - Dayton Daily News: [Dayton VA gets primary care director; Lima clinic to open at new site](#) (4 October, Barrie Barber, 1.1M online visitors/mo; Dayton, OH)

DAYTON - The Dayton VA Medical Center has appointed a former Air Force medical officer to director of primary care and a larger clinic will open next spring in Lima, the federal health agency said.

Edward P. Syron, a medical administrator, will earn the \$120,900-a-year overseeing primary and home-based care outpatient services, the VA reported. He replaces Dr. Kavita Peddireddi, who served in the job temporarily until a permanent replacement was found.

Syron, who joined the VA staff three years ago, was a former chief of non-VA care coordination and a group practice manager at the medical facility.

He's also an assistant adjunct professor in medicine at the Wright State University Boonshoft School of Medicine, according to the VA.

Next spring, a larger VA outpatient clinic is scheduled to open at 750 High St. in Lima. The renovated 9,750-square-foot leased facility will handle a growing patient case load that has risen 10.5 percent over two years, figures show.

The new facility will have about 100 more parking spaces than the current location at 1303 Bellfontaine Ave., the VA said.

The clinic has served about 4,200 veterans and counted more than 22,000 outpatient visits within the past year, the VA reported.

The VA also plans a \$1 million expansion of an outpatient clinic in Springfield, officials announced in August. Proposals to expand on site or move to a new location were due this December. The VA has targeted an opening in 2018.

The Dayton VA Medical Center has a more than \$425 million budget and employs about 2,100 employees at the medical center and four outpatient clinics in Lima, Middletown and Springfield, Ohio and Richmond, Indiana. The facilities treated about 39,300 patients in the past fiscal year, said spokesman Ted Froats.

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2.3 - Military Times: [House Democrats boycott VA health event, complicating reform plans](#) (4 October, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

WASHINGTON — Plans to overhaul veterans health care this fall could be in jeopardy after House Democrats boycotted a supposedly friendly roundtable discussion on the issue Tuesday over the inclusion of a Republican-linked advocacy group they insist is more interested in political attacks than policy crafting.

The controversy comes just a few weeks before House lawmakers are planning to fast-track new legislation surrounding outside care programs at the Department of Veterans Affairs, including the problematic Choice program.

The topic was already sensitive within the veterans community before the boycott, with concerns about shifting funding to private-sector physicians and the possibility of a slow dismantling of VA responsibilities.

But tensions grew this week when Democrats on the House Veterans' Affairs Committee refused to attend Tuesday's event because of the presence of Concerned Veterans for America, an advocacy group with ties to Republican Party donors.

"The chairman has the right to invite any organization he pleases, but to pretend that CVA is anything other than a partisan organization that invests time and money into discrediting Democratic members of Congress, and specifically the ranking member of this committee, is disingenuous," said Griffin Anderson, press secretary for the committee's Democrats.

"We will not pretend it is anything else."

CVA was one of 18 veterans groups invited to the event, a group that included the large legacy organizations such as the American Legion and AMVETS as well as newer organizations like Iraq and Afghanistan Veterans of America and Wounded Warrior Project.

Several VA officials also attended, including soon-to-be acting VA Undersecretary for Health Carolyn Clancy. Committee Chairman Rep. Phil Roe, R-Tenn., moderated the discussion.

Individuals in the closed roundtable characterized the discussion as largely non-eventful, covering broad outlines of the proposals to come. Dan Caldwell, policy director for CVA, criticized the Democratic members for turning it into a political issue.

"It is disappointing that the Democrat members of the committee did not want to hear ideas on how to fix the VA from a group of veterans, including many patients of the VA and combat veterans like myself," he said. "We have worked for years to develop comprehensive and bipartisan solutions to the VA's problems and appreciate that Chairman Roe invited us."

Tiffany Haverly, communications director for Roe, said attendees for the event "were invited to participate because of their interest in and serious study of VA's community care programs. They were invited for that reason and that reason only."

CVA is a controversial force within the veterans community. Earlier this year, the group ran ads in Minnesota blasting committee ranking member Rep. Tim Walz, D-Minn., for blocking VA reform proposals favored by Republicans, saying that he “let veterans down.”

Group officials have declined to release funding sources and trustee information for the group, but numerous news reports have linked the group to the Koch brothers network of conservative activist organizations. They’ve also enjoyed significantly better access to policy talks and events under President Donald Trump than they did under former President Barack Obama.

Unlike most veteran advocacy groups, CVA’s non-profit designation allows them to spend significant amounts on political or lobbying efforts. Haverly said committee precedent has included organizations like CVA in the Capitol Hill discussions.

Groups like IAVA and the Veterans of Foreign Wars have had similar lobbying arms in the past.

CVA’s main focus in recent years has been pushing for an expansion of outside care options for veterans. Officials there insist the current VA system is too overwhelmed and archaic to provide reliable, swift service for veterans’ medical needs, and have advocated for widespread changes to the system to allow more competition between VA hospitals and private-sector medical centers.

Some Democrats have labeled that approach a step toward privatizing the department. The health care reforms this fall are expected to center around the fight, balancing access issues with upgrades to the existing VA infrastructure.

VA Secretary David Shulkin has pushed for significant changes to the Choice program, including changing eligibility criteria to open the program to more veterans. He promised the replacement to the program — the Coordinated Access and Rewarding Experiences program, or Veterans CARE — is expected to be rolled out later this month.

In the meantime, House and Senate lawmakers have been meeting with veterans groups to try and work out potential challenges to those proposals early.

An extension of the Choice program was signed into law in August, but money for tens of thousands of veterans’ medical appointments outside the department is expected to run out by the end of the year, giving lawmakers a tight legislative timeline for reforms.

Whether the Democrats boycott in the House hurts that timeline — or leads to similar fights in the Senate, where Democrats there have voiced similar complaints about CVA — remains to be seen.

Haverly said Roe “remains committed to a bipartisan process for community care reform” despite the brewing fight. Griffin voiced similar optimism.

“The veterans committee is known for its bipartisanship, and while this invitation was a speedbump in that relationship, it is our hope we can get back on track so we can find a long-term solution to VA care in the community in the coming weeks,” he said.

CVA officials said they hope to remain heavily involved in the work as well. Public hearings on the issue are expected by the end of this month.

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2.4 - The State Journal-Register: [‘Unaccompanied’ veterans honored at Camp Butler National Cemetery](#) (4 October, 834k online visitors/mo; Springfield, IL)

Ten “unaccompanied” veterans were honored at Camp Butler National Cemetery on Tuesday.

The veterans were recently buried at the cemetery but either had no relatives or no relatives who could travel to the cemetery at the time of burial.

The twice-annual ceremony includes the presentation of colors, a ceremonial flag folding, rifle volley and the playing of “Taps” presented by the Sangamon County Interveterans Burial Detail.

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2.5 - New Hampshire Union Leader: [VAMC volunteers recognized](#) (4 October, 318k online visitors/mo; Manchester, NH)

The Manchester VA Medical Center recently held a volunteer recognition ceremony in honor of its 320 registered volunteers, who serve in more than 28 departments within the facility.

The Medical Center’s volunteers work directly with veterans as drivers, welcome ambassadors and recreation aides to behind-the-scenes work in the warehouse, in the research department and in management.

“Appreciating these volunteers is important to veterans and the staff, (who) are proud to work day in and day out with these selfless servants,” said Alfred Montoya, acting Medical Center director at the Manchester VA.

Madeline Dreusicke, a volunteer representing the VFW Auxiliary, was on the 2017 volunteer recognition ceremony planning committee and received an award herself for having worked 1,750 volunteer hours. When asked what drives her to give so much, she said, “Just because it is the right thing to do. They served us and we should serve them. They come home changed, and when they come to the (Manchester VA) they are in a safe zone, and I want to be a part of providing that. These brave men and women are always on my mind. Serving them is an honor.”

It is with a heavy heart that the Medical Center says goodbye to Richard Dobbyn, Charles Meserve Sr., Gerard Provencher and Preston Lawrance, who passed away within the past year.

“Richie, Charlie, Gerry and Preston made such a difference at the Medical Center,” said Debra Krinsky, chief of voluntary service at the VA. “They truly improved the lives of so many of the veterans we serve. We are better for having shared our lives with these wonderful men. They will forever be remembered as our family, and for their contribution to the wellness of the veterans we serve.”

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2.6 - The Augusta Chronicle: [Club Car donates new golf cart to help disabled at Charlie Norwood VA Medical Center](#) (4 October, Nefeteria Brewster, 240k online visitors/mo; Augusta, GA)

Club Car dedicated a 2017 golf cart, valued at more than \$16,000, to the Charlie Norwood VA Medical Center to help get disabled veterans from the parking lot to the front of the facility.

Although the uptown medical center holds two rows of handicapped spaces around the facility, Fred Palmer, a Club Car spokesman, said the new golf cart can further help those who are unable to secure those spots.

"Transportation on both campuses in downtown and here in uptown is very important to get around," he said. "They have parking and then they have transportation needs within the campus so I just see this as a fulfillment in partnership with that."

Bob Frasier, a Voluntary Service Chief for the medical center who received the key to the new cart Wednesday, said the unique valet service is effective immediately.

Phones will also be added to poles in the parking lot by the end of the year for visitors who plan to use the new door-to-door service, he said.

"We're going to continue to monitor the parking situation here and take steps as needed to make it the best possible experience for our veterans when they get here," Frasier said. "So what we're hoping to do eventually is we're going to add phones and we're going to have a phone number for veterans and when they park they can actually call and identify their location and then we can have a car clerk meet them at their car and have door-to-door service that way."

Asked how services will be maintained, Frasier said it would depend significantly on those who are willing to volunteer as drivers for up to four hours each week.

"That would help us out greatly," he said. "This is a pretty big step for us so of course in order for us to continue to do this we're going to need people volunteer their hours."

Those interested in volunteering can visit the Charlie Norwood VA Medical Center website for more information.

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2.7 - WRDW (CBS-12, Video): [Solution to VA Uptown Parking Problem](#) (4 October, Celia Palermo, 914k online visitors/mo; North Augusta, SC)

The distance from the parking lot to the hospital doors can be pretty far depending on where you park.

Veterans say they're sick of walking the distance. The VA says they know and they're fixing it.

"A lot of us have difficulty walking...be it bad hips...bad knees...or bad ankles."

He walks with a cane because he has arthritis. It's a price he paid, he says, for serving his country.

He's a Vietnam War Veteran and he travels for miles to come here for his medical needs.

"This is the best facility for miles around."

Well, he loves the facility, but he doesn't love having to walk so far from his car just to get seen.

"You gotta struggle across, what? About two football fields?"

The VA and community leaders like Fred Palmer with Club Car are noticing.

"This uptown campus is quite the place...the parking looks like it could be challenging."

It is, but here's how they're helping you. Club Car and the VA teamed up to add another vehicle to their fleet, a golf cart. Except this one is dedicated to the busy and big parking lots at the VA Uptown Division, not the medical district.

"If someone does need a little extra help, our vehicle can provide that comfortably."

It'll take you from wherever you park to the front door of the facility, quite the trek.

"The distance from here to there, this is the short distance. That's about one football field. Then you gotta get inside and then you gotta walk upstairs."

But once the cart hits the streets...

"Anytime I can take pressure off the bone, I'll be riding. The driver won't have to be alone, I'll ride with him."

Officials say they hope to have the cart up and running as soon as possible so they can start helping people. But to do that, they say they need even more volunteers to drive the new cart, and others.

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2.8 - WTAJ (CBS-10): [New director at Altoona VA Hospital](#) (4 October, Charlotte Ames, 192k online visitors/mo; Altoona, PA)

Altoona, Blair County, Pa. - The new director at Altoona's Van Zandt VA Medical Center says she hopes to increase the number of services available to area veterans. Currently, the facility doesn't provide specialty services such as cardiology and cancer treatment, so veterans must travel to Pittsburgh for treatment.

Sigrid Andrew said her goal is to offer those services in Altoona through the use of telemedicine and visiting clinics.

"If we can establish clinics whether it be four hours a week, two days a week, bring that provider in from the Pittsburgh VA, we would like to do that as well. But we need to establish what our needs are here in Altoona," she explained.

Andrew said the chief of staff from the Pittsburgh VA Medical Center is in Altoona to assess which specialty services are needed. She said she's already requested iPads for exam rooms, so that telemedicine can be used for consults with specialists in Pittsburgh.

The director said her background as a nurse impacts how she makes decisions as an administrator.

"I think when you're dealing with the costs and the budget and when you have to make choices, being a nurse does allow you to fairly balance and to fairly assess what the needs really are, because, at the end of the day, the patient, the veteran, is at the center of all decisions and you will always weigh on the side of the patient," Andrew said.

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2.9 - Foster's Daily Democrat: [UNH veterans adaptive sports program receives federal grant](#) (4 October, 191k online visitors/mo; Dover, NH)

WASHINGTON, D.C. — The University of New Hampshire's Northeast Passage Program will receive a \$172,974.49 grant from the Department of Veterans Affairs (VA) to support adaptive sports opportunities for veterans and servicemembers with disabilities, according to Congresswomen Carol Shea-Porter and Annie Kuster.

"As a leader in the field of recreational therapy, UNH's Northeast Passage Program empowers military men and women who are living with disabilities, and today's grant will help them continue their important work," Shea-Porter said. "I have always been proud to support this excellent program. Congratulations to the staff and volunteers at Northeast Passage on this recognition of the important work they do for our servicemembers, veterans, and so many Granite Staters living with disabilities."

"Recreational therapy holds tremendous potential for our men and women who have served in uniform," said Kuster, a member of the House Committee on Veterans' Affairs. "The University of New Hampshire Northeast Passage Program supports veterans and servicemembers with disabilities who wish to pursue adaptive sports as a means of therapy. I'm proud of the work being done by UNH to support our veterans and servicemembers and will continue to advocate on behalf this important program."

"We are very pleased that the VA has once again recognized Northeast Passage as a leader in providing adaptive sports opportunities for veterans and servicemembers with disabilities," said Northeast Passage Director Jill Gravink. "Our programs enable veterans to come together and share their experiences with people with similar interests, building social networks where veterans and servicemembers can connect with each other and enjoy recreation with the same independence as their non-disabled peers."

Founded in 1990 as a non-profit organization, NEP merged with UNH in 2000 and specializes in recreational therapy (RT) and adaptive sports for children, adults, servicemembers, and veterans with disabilities. RT interventions help people with disabilities cope with the stress of their illness or disability and prepare individuals for managing their disabilities in order to achieve and maintain independence, productivity, health, and well-being.

In March, Shea-Porter and Kuster wrote to the House Appropriations Subcommittee on Military Construction and Veterans Affairs requesting increased funding for the Adaptive Sports Grant program. In their letter to appropriators, the Congresswomen requested that the committee include report language recommending \$10,000,000 for adaptive sports programs.

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2.10 - Altoona Mirror: [Van Zandt director makes debut, Andrew said she chose job because veterans seem happy, staff respectful](#) (5 October, William Kibler, 74k online visitors/mo; Altoona, PA)

After Sigrid Andrew applied to become director of the Van Zandt VA Medical Center, but before she was offered the job, she came here and sat in various lobbies and waiting rooms, observing interactions between employees and veterans.

She noticed that the veterans seemed happy, that the employees were kind and that they were respectful of each other.

It's a "buyer's market" in the VA for managerial posts, and Andrew had a choice about whether to come to Altoona.

She ended up coming here largely because of those observations, she said Wednesday at an introductory meeting with local media.

"It was the people of Altoona who lured me," she said.

A native of the Newark, Del., area who spent time as a child in Vermont, she also appreciated the region's four distinct seasons. "And you can't discount the mountains," she said.

Van Zandt territory — extending to DuBois, Johnstown, Huntingdon and State College — is also drivable, in contrast to some larger VA hospital territories where airplane flights are necessary, she added.

Andrew is coming to a hospital that hasn't had a permanent director for 20 months, following William Mills' departure for Memphis, and that has been roiled by accusations of whistleblower retaliation examined during recent hearings before the Merit System Protection Board — a quasi-judicial body that ensures federal employees are treated based on performance.

The whistleblowers testified about a poisonous atmosphere created because of their mandated reporting of what they said was the impairment from dementia of a doctor in their department.

Andrew intends to deal with those issues by moving "forward," she said.

“I’m hoping for a healing-type future,” she said.

She hopes to establish good relationships with employees — and with veterans, the overall community and the media, she said.

Two employee meetings have already been held, said Andrew, who hadn’t yet completed her third day on the job.

She plans to be “transparent, direct and open” and to tell the truth, she said.

She has a track record for that, she said — giving as evidence that at a facility where she worked, a union president called a counterpart at another facility — presumably where she was going to work — and said of Andrew, “You may not always like the decisions she makes, but you will always know what she stands for.”

She stands for the veterans, she said.

One recurrent issue raised in Van Zandt town hall meetings in recent times has been what veterans say is a shortage of specialist services.

Some of those veterans remember when there were 200 acute beds at Van Zandt, said hospital spokeswoman Andrea Young. Now there are only 11 acute beds, she said, to go with 40 nursing home beds. Those old ways aren’t coming back, Young said.

But, channeling Regional VA Director Michael Adelman, Andrew said there are modern ways to remedy the problem.

She plans to work with recently appointed Acting Chief of Staff Ali Sonel — who remains Chief of Staff at the Pittsburgh VA — to recruit doctors here and increase the number of telemedicine consultations from Pittsburgh, of visits to Altoona from specialists in Pittsburgh and of “fee-based” visits from private providers in this area to Van Zandt, as well as fee-based visits by veterans to those providers in their community settings.

Thanks to Sonel, it’s already happening, Andrew said.

Sonel’s position in Pittsburgh — his “connections” — can help make it all work, she said.

To make it work well, however, the hospital will do a market analysis to identify how those changes can serve the needs of 26,000 veterans on the hospital’s roster, she said.

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2.11 - WAND (NBC-17, Video): [Camp Butler National Cemetery honors 10 unaccompanied veterans](#) (4 October, Meredith Hackler, 68k online visitors/mo; Decatur, IL)

SPRINGFIELD, Ill. (WAND)-The gloomy weather matched the somber tone 10 veterans were honored for their sacrifice to our country.

"The unaccompanied honors veterans ceremony is a way we show respect to veterans that come to our cemetery without family members or without being accompanied by their loved ones," said Antonio Henderson, assistant director of Camp Butler National Cemetery.

A 21-gun salute, and the playing of tap, pays homage to those who were lost.

"We are honoring and respecting the selfless service that the veterans gave to our nation," added Henderson.

"Every veteran should have a ceremony like this and for whatever reason many don't get that opportunity," said Sam Montalbano with the Inter Veterans Burial Detail.

Many of those who took part in the ceremony are veterans themselves.

"I'm a veteran as well," added Henderson. "I feel that it is also my duty and responsibility to give back for those who have laid the ultimate sacrifice,"

"It's giving back for all the things that they do while they are in the service," says Montalbano. "So, it's a good feeling for me personally."

While there's nothing we can do to bring them back, those involved say they hope the lost are always remembered.

"We are their brothers and sisters. It's our responsibility to let them know that they are not alone on their final salute," added Henderson.

The next unaccompanied veteran's ceremony will be held on April 5th, 2018 and Camp Butler National Cemetery.

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2.12 - KXRM (FOX-21, Video): [Veteran students speak out after Career Center shuts down](#)
(3 October, Carly Moore, 58k online visitors/mo; Colorado Springs, CO)

Dozens of veterans are out of luck after a school they were attending for a technical degree has been shut down.

The school in North Texas is called Retail Ready Career Center (RRCC) which focuses on giving veterans hands-on training and professional job placement assistance in the HVAC industry.

Two Colorado Springs veterans were enrolled in the class and both of their stories are exactly the same. The Career Center approached them about the HVAC program and just about a week ago, without much notice the school was shut down and now their futures are uncertain.

One of those vets was Steve Pattillo who says two weeks ago his future career looked totally different after signing up for a 6-week certification class at RRCC.

"They convinced everyone to quit their jobs. I had a good paying job, at the time, they promised me something better. So, I moved my family here," said Pattillo, an Army veteran.

On September 20, students were abruptly told the school was closed for the day and to go home but class would resume the next day.

"I did feel a little bit weird I felt a little uneasy because, it's my families life basically in that schools hand," said Pattillo.

Then on that Friday, September 22, students say the school's president, John Davis, made an announcement to the group saying the Department of Veterans Affairs was investigating the school. This information left another classmate and Colorado Springs veteran, Charles Autry, with even more questions.

"[He] Basically assured us this was nothing more than an administrative review, that the school was in no danger of closing," said Autry, a Navy veteran.

Davis went on to say an employee had been fired for stealing \$20,000 of scholarship funds and the school illegally had too many student veterans.

"Less than a week later, we were in class doing some lecture lessons. In the middle of that, we had some school officials, come in and interrupt the class session and say 'you had 5 minutes to get your stuff and get off the property'," said Autry.

With no other answers, these two veterans along with more than 300 other students were sent home without their certificate or money back.

Right now both fathers want the same thing.

"I hope myself and other veterans are restored what they are owed," said Autry.

"I'd basically like to see every body get back out on their feet and recuperate from what the school's done to them and I'd like to prevent veterans from going through this again," said Pattillo.

Autry is reaching out to Congressman Doug Lamborn's office to see if they could help. They said the following in response:

"Congressman Lamborn's office routinely helps veterans in our community. We have heard from one veteran about this school and are currently awaiting paperwork that will allow us to advocate on his behalf."

The school was thought to be violating the 85/15 rule, meaning that only 85 percent of the student body can use their GI bill to pay for tuition; the other 15 percent had to be non-service members or fund the program themselves. Davis said it turns out 98 percent of the people enrolled were former service members.

Pattillo and Autry did use \$21,000 and 9 months of their VA benefits. They're concerned what will happen next.

“Basically what the VA has told us, or told me, is that it’s up in the air if we’ll have our benefits restored, fully or partially restored, as it stand right now we are out 9 months of our benefits,” Autry said.

“They said that’s a big maybe and they are not 100 percent sure, so it’s basically a big waiting game for all the veterans involved if we get anything back or not,” Pattillo said.

FOX21 attempted to reach out to the Career Center, but no one answered the phone or returned the voicemail. The veterans said most of their classmates are also joining in on a class action lawsuit.

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2.13 - The Daily News: [Staller retires from VA Medical Center](#) (4 October, 54k online visitors/mo; Iron Mountain, MI)

IRON MOUNTAIN — After 24 years of federal service, Patricia Staller of Iron Mountain has retired from the Oscar G. Johnson VA Medical Center.

Staller was born and raised in Fort Atkinson, Wis., and is the daughter of Donald and Marie Peterson. She graduated from the University of Wisconsin-Milwaukee with a master’s degree in social work.

After completing her graduate work at the Milwaukee VA Medical Center, Staller started her career at the Waco VA Medical Center in Texas. She later worked at the Central Texas VA Health Care System in Temple, Texas, and then transferred to the Iron Mountain VA Medical Center in 2001.

During her tenure in Texas, Staller worked in many medical areas and piloted the first Patient Orientation Program to help new veterans and their families coming into the VA. At the Iron Mountain VA, she worked in various clinical social work areas, including acute care, student education, low vision and ethics. Most recently, she served as social worker for geriatric and extended care in the medical center’s Community Living Center.

Staller has been involved in many local theater productions, and she is a member of Zonta and the local chapter of Toastmasters of the Northwoods.

She is a widow and has one son, Curtis Staller; a daughter-in-law, Olga; and a granddaughter, Natasha, residing in Round Rock, Texas.

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2.14 - FEDweek: [Improving Policy-Making at VA a Complex Task, GAO Finds](#) (4 October, 51k online visitors/mo; Glen Allen, VA)

The Veterans Health Administration, the largest arm of the VA, is encountering several difficulties as it attempts to improve its policy-making, GAO has said.

Under a policy issued last year, directives and notices are now the sole documents for establishing national agency policy; other types of documents, such as program office memos, are considered guidance. VHA is reviewing about 800 existing national policy documents to eliminate those that no longer meet its new definitions, and to rescind or recertify those that are outdated, GAO said.

However, it found that “VHA is not planning to review guidance documents, such as program office memos and standard operating procedures, to assess whether they align with its updated directive, because there is no central repository for these documents and it would be too resource intensive to locate all of them.”

“Further, GAO’s review found—contrary to VHA’s updated directive—that program offices are continuing to use memos to issue policy. The continued use of program office memos to establish national policy undermines VHA’s efforts to improve its policy management,” it said.

It added that program offices do not track or consistently disseminate the guidance documents they issue. And while the VHA has process for making national policy documents accessible to its medical centers and the veterans integrated service networks that oversee those centers, it lacks a process for making guidance documents accessible at the local level. The result is that “VHA lacks assurance that staff receive and follow the same guidance, as intended.”

Nor does the VHA routinely collect information on local challenges in complying with national policies—such as resource constraints and undefined time frames—or on waivers of those requirements that program offices can approve “on an ad hoc basis.”

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2.15 - Journal Express: [Residents seek answers at VA town hall](#) (4 October, Pat Finan, 9.2k online visitors/mo; Knoxville, IA)

KNOXVILLE - A town hall meeting about the Veterans Administration campus on Thursday, Sept. 28, focused not only on the site’s future but on vets themselves. The quality of their health care drew nearly as much attention as the 170-acre site during the two-hour discussion among about 125 people at the Knoxville Performing Arts Center.

Many participants sought details of the process by which the government rids itself of the property. Others were frustrated about depressed or suicidal military comrades. Still more expressed worries about their own health, or about the eyesore they fear the campus will become.

The VA sent three people to the stage, mostly to discuss patient care. Gail Graham, medical director for the VA’s Central Iowa Health Care System, touted its new outpatient clinic at 1607 N. Lincoln St. While she accepted accountability for moldy, deteriorating buildings at the old site, she eventually drew the line.

“I’m in the business of delivering health care, not in the business of maintaining buildings,” Graham said.

The government won't sink money into the upkeep or the teardown of the buildings, officials said. Its main interest is getting the most money it can from the property and returning it to productive use, they said.

Those jobs fall to the General Services Administration, the real estate arm of the federal government. Jennifer Mollenshott, branch chief of the VA's Fort Worth, Texas, office, is in charge of the process for the next year or so.

Mollenshott said the VA is completing a review of the property and its potential, which she expects to see by the end of 2017. When GSA gets that report, a process of screenings is launched. Government agencies can express interest in the property, though that's not likely, she said. Other screenings include a look at the site's suitability to serve homeless people.

In similar situations, the process usually leads to the land being sold as-is, Mollenshott said. While many in the audience expressed eagerness for action, their waiting will continue as the process plays out through 2018.

"If all goes well, soup to nuts, you're looking at about a year," Mollenshott said.

The government's appraisal process considers what it calls "the highest and best use" for the property as well as local market conditions as it determines fair market value, Mollenshott said. The results of that appraisal will not be available to the public, she added.

Mollenshott tried to dispel concerns that potential buyers won't be interested in land that's dotted with large, dilapidated buildings.

"Trust me, I have seen a lot worse, and we still make a lot of money," she said.

Knoxville resident Park Woodle asked whether the site could be split into smaller parcels, contrary to what Knoxville has been told in the past. He mentioned several parts of the property that hold potential for housing or other uses. Such splits likely will be part of the marketing strategy, Mollenshott responded.

Would the city get a chance to get some parcels? Would it have to pay for them? Those were Knoxville resident Mike Lane's questions. Mollenshott and Mayor Brian Hatch both had answers.

The city and other government entities get dibs earlier in the screening process, Mollenshott said, though it would have to pay fair market price. Hatch said Knoxville might be interested in getting some of the land, while expressing wariness about the burden such a move could bring.

"We're like to have some control of that situation so that we can get something in there that's good for the community," he said.

With five days to reflect on takeaways from the two-hour meeting, Hatch described himself Tuesday as hopeful but cautious, given the history of the campus. The town hall was a good step, he said, and city and federal officials will continue to meet regularly.

"There were no real surprises," Hatch said. "I was hoping we would know what direction GSA was thinking of going. I think that once we have a better direction from GSA on selling the

property, we can then begin to formulate a little better strategy for the community to move forward.”

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3. Access to Healthcare

3.1 - WDBJ (CBS-7): [VA expanding use of tele-medicine to improve access for veterans](#) (4 October, Joe Dashiell, 833k online visitors/mo; Roanoke, VA)

The VA Medical Center in Salem is expanding the use of tele-medicine, as a way to improve veterans' access to health care.

Wednesday, a company that provides the technology to the Department of Veterans Affairs demonstrated some of the newest equipment in Salem.

Lindsay Gill is the Facility Telehealth Coordinator at the Salem VA Medical Center.

"It means improved access," Gill told WDBJ7. "It allows our veterans to be seen at a distance, so they don't have to travel to the Salem VA. A lot of our veterans live hours away and this will allow them to seek care closer to home, but from the Salem Medical Center so it's really exciting."

A new program that will let veterans consult with health professionals from their homes should be coming on line in the next year.

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3.2 - The National Law Review: [Department of Veterans Affairs Aims to Trump State Telemedicine Rules](#) (4 October, 475k online visitors/mo; New York, NY)

The U.S. Department of Veterans Affairs ("VA") is taking a significant step towards expanding needed services to Veterans by proposing a rule to preempt state restrictions on telehealth.

Most states currently restrict providers (including VA employees) from treating patients that are located in that state if the provider is not licensed there. As a result, the VA has had difficulty getting a sufficient number of providers to furnish services via telemedicine for fear that they will face discipline from those states for the unlicensed practice of medicine.

The VA has a real need for expanding its telemedicine capabilities as many of its patients are located in rural and underserved areas. The VA's top clinical priority is mental health, and having more robust telemedicine capabilities could help improve timeliness of treatment (a reputational sore spot for the VA). The VA could also use telemedicine to reach more people in need that may not otherwise seek help. The rule would allow the VA to more evenly distribute care by hiring providers in urban areas where there is larger pool and have them treat in rural areas (via telemedicine).

Not everyone is happy about the proposed rule, however. Organizations such as the American Medical Association oppose the rule as undermining each state's ability to govern the practice of medicine within its borders. The concern is that states would have no ability to regulate their citizens' care under this new framework.

While this rule is limited only to VA patients and providers, the hope is that other federal agencies or even states will follow the VA's lead. Given the importance of increasing access to care and the advances in the delivery of care via telemedicine, it might be time for states to reexamine their restrictive approach to professional licensure.

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3.3 - WCSH (NBC-6, Video): [Lawsuit targets Togus VA for botched operations](#) (4 October, Don Carrigan, 442k online visitors/mo; Portland, ME)

AUGUSTA, Maine (NEWS CENTER) — Six Maine military veterans are waiting for a federal judge in Portland to decide if they will be allowed to sue the Veterans Administration.

Those veterans all say they had foot or ankle surgery at the Togus VA hospital, and that the doctor botched the operations. That doctor left in 2008, but the veterans say they still suffer pain and other problems.

Army veteran Steve Turner of Topsham isn't involved in the lawsuit but said Wednesday he also suffered at the hands of the same doctor.

Turner told NEWS CENTER his foot was operated on in early 2008 because of injuries sustained during his 13 years in the Army. He said there were problems soon after the first surgery and the doctor did a second operation. He said the foot then became badly infected and swollen and that only an emergency operation by a different doctor saved his foot.

Turner said it still causes him pain. He said the VA contacted him in 2010 and arranged a meeting, at which time it apologized, and blamed the doctor.

"They were very apologetic about what happened to me," he said, "and went step by step what [the doctor's] discrepancies were during surgery, what he should have done., and not done."

VA officials on Wednesday would not answer questions about the situation, referring all inquiries to the U.S. attorney's office.

In 2014, NEWS CENTER reported on a similar case involving a Hampden man, who said he had also suffered pain and continuing problems because of a failed ankle surgery by the same doctor. At that time, VA Togus director Ryan Lilly confirmed it had been dealing with a number of foot and ankle surgeries that had turned out badly.

Lilly said the staff had been alerted to the problems by patients, had contacted the doctor's patients to apologize and offer to pay for whatever further care was required.

Lilly was asked how many patients suffered problems. "We're talking less than 100," he replied at that time.

Neither the VA nor the U.S. Attorney would say Thursday how many total patients were affected.

Steve Turner said he does not blame the VA, but blames the doctor, and would "like to sue him personally," if he could.

Lawyers knowledgeable about the case told NEWS CENTER the doctor cannot be sued personally because he was working for the VA at the time.

That doctor is believed to be living in the New York City area, where an internet search showed he has been working at a medical practice. A receptionist at that practice said Wednesday the doctor no longer worked there.

The lawsuits by the six veterans are aimed at the VA, seeking permission to sue the government even though Maine's statute of limitations has expired. Lawyers said oral arguments are scheduled for later this month and a ruling could come this fall.

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3.4 - WHAS (ABC-11, Video): [Annual event offers one-stop shop for homeless](#) (4 October, Sara Wagner, 439k online visitors/mo; Louisville, KY)

The latest numbers show more than 6,000 people are struggling with homelessness in Louisville. Wednesday, a group of people put their talents together to help drastically reduce those numbers. Homeless Connect is an annual event aiming to serve hundreds of homeless individuals by offering dozens of free resources.

The Salvation Army is no stranger to helping those in need. Inside the building, you'll find many stories of service and success, with plenty of new chapters being added at Wednesday's event.

"It's a lot of work to do, and it can't be done by one agency. It's got to be done by everybody in a group effort. It's got to be done by a community," Salvation Army Commander Major Roy Williams said.

More than 80 partners came together to help those who need it most.

"There's one thing they need and they come here and they say, oh, I didn't know that was there. They get that and they start lifting themselves up out of poverty," Williams said.

The organizations offered everything from IDs to eye and ear exams to haircuts and clothes. There were selfless acts at every corner, even feet washing.

"You can tell a lot about a person's health by washing their feet and then they can direct them to the medical center," Williams said.

Acts like that help to wipe away some of the struggle and stereotypes that come with homelessness.

"It's not all about people who just want to sit outside and lay around all day. There's homeless that want to help themselves every day," Williams said.

Organizers said this event has the ability to reach many who won't seek it otherwise.

"A lot of people don't feel safe in the shelter, particularly veterans who may have had trauma," Healthcare for Homeless Veterans supervisor Jamie Watts said.

Having everything set up in a one-stop shop makes a major difference when you're used to anything but convenience.

"Anybody who has ever been homeless or been at the point where you're almost homeless knows you spend a lot of time waiting in lines, being in waiting rooms, and getting on a waiting list. So, our hope is that today you can get a lot of that done in one place and get moving faster toward getting a place of your own," Coalition for Homeless Executive Director Natalie Harris said.

Veteran Jack Jones knows that all too well.

"I've been homeless off and on for several years, but at this time, I've been homeless for about three months," Jones said.

Thanks to the VA, Jones has housing now and is getting ready to work again.

"I signed up for a library card so I can learn computers. I don't know computers yet, but they're going to teach me," Jones said.

Homelessness can take away so much, but these acts of kindness can help life get back on track.

"It's amazing what they do and so far, I haven't met a negative person yet," Jones said.

Organizers said the number of homeless has consistently dropped every year in Louisville for the last five years. They expect to serve around 600 people at this year's event and hope that number continues to go down each and every year, eventually eliminating the need for the event altogether.

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3.5 - KRGV (ABC-5, Video): [Local Organizations Provide Options for Homeless Valley Veterans](#) (4 October, Cecillia Gutierrez, 275k online visitors/mo; Weslaco, TX)

HARLINGEN – One homeless veteran is one too many. On any given night, 39,000 veterans in the U.S. find themselves without a permanent roof over their head, according to the U.S. Department of Housing and Urban Development.

Clifford Briggs is one of those veterans. From looking at him you would never know he was homeless with his big smile, positive attitude and contagious laughter.

Briggs comes from a military family, but now the ex-Navy firefighter goes to work during the day and sleeps at Loaves and Fishes in Harlingen.

"I moved down from Portland and it didn't work out too well, so I ended up at Loaves and Fishes. It's just a place to lay your head, stay out the weather at night to sleep," he said.

Briggs said he doesn't let life's unexpected turns get the best of him.

CHANNEL 5 NEWS spoke to Tommy Martinez, the Loaves and Fishes director of Family Emergency Assistance, to see if homeless veterans in their shelter are seen often.

"It ranges. Sometimes we have one to two homeless veterans in a month during the summer months or maybe even December we might have maybe three to four homeless veterans in our shelter at one point." Felix Rodriguez, a veteran service officer with the Hidalgo County Veterans Service.

He explained to us why veterans are more likely to face homelessness.

"Well, many of these veterans that are having issues with finding a place to stay, a home are coming back with issues that civilians don't have to deal with," he said. "And some of these issues and conditions run the gamut between post-traumatic stress disorder, traumatic brain injury, depressive disorders and other conditions secondary to that."

He said there are several ways you can help a homeless veteran.

"My first advice to them is to call the VA homeless hotline, it's a HUD hotline," he said.

Rodriguez added other ways to help homeless veterans are through Family Endeavors and other organizations.

You can contact the VA Homeless Hotline at 877-424-3838. For a full list of resources click [here](#).

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3.6 - KRGV (ABC-5, Video): [Valley Vietnam Veteran Battles Diabetes Linked to Agent Orange Exposure](#) (4 October, Ryan Nelson, 275k online visitors/mo; Weslaco, TX)

PHARR – Vietnam veteran Gabriel Avendano said a part of him will always remain overseas.

"What can I tell you? We never come back," said Avendano, "but I'm here."

Avendano is one of the 2.6 million U.S. military personnel possibly exposed to Agent Orange from January 1965 to April 1970.

"They just flew it through the C-130's and they killed a lot of the jungle," said Avendano.

He was formally diagnosed with diabetes in the year 2000. He said he may have lived with the disease for many years before the discovery was made.

"I have to inject my body twice a day," said Avendano, "in the morning and at night."

Diabetes is one of the many diseases considered a presumptive illness by Veterans Affairs.

These are diseases presumed to be linked to Agent Orange exposure, or a Veteran's qualified military service. Veterans do not have to prove these illnesses were spawned by their military service.

The long list of diseases includes several forms of cancer.

Veterans who believe they are suffering from an illness linked to Agent Orange may have health care options through the VA.

"One of the most important things that they need to do when they believe that they've been exposed to Agent Orange is to come by either the McAllen outpatient clinic or the Harlingen outpatient clinic," said VA Texas Valley Coastal Bend spokesperson Reynaldo Leal.

By taking their DD FORM 214 and driver's license to an outpatient clinic, they can begin to explore these options.

"Once we register them as Agent Orange exposed veterans, they'll be given an assessment. They'll be scheduled for an assessment and they'll be input into the Agent Orange registry," said Leal.

These veterans may also qualify for benefits such as disability compensation.

"They can go to any number of veterans service officers, they can go through the county, the state with the Texas Veterans Commission," said Leal.

"Keep going and they'll help you," said Avendano. "You got to keep on going. You have to keep on going to the centers and they will sooner or later help you."

Avendano also urges veterans to consume a healthy, balanced diet.

A complete list of presumed diseases linked to Agent Orange exposure can be found at the U.S. Department of Veterans Affairs website.

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3.7 - KOLO (ABC-8, Video): [Reno physician helps Veterans in Puerto Rico](#) (4 October, Terri Russell, 274k online visitors/mo; Reno, NV)

RENO, (Nev) KOLO Under normal circumstances, Dr. Ivan Correa is the chief of staff at the Veterans Affairs Sierra Nevada Health Care System.

He is also a Puerto Rican native, and decided to fly to the island to check on the status of his parents, after two devastating hurricanes hit the area.

"They tell me they are ok. But ok is a relative term. You know ok is that they are alive, and that they are being able to eat some food, and that they go to bed, they wake up in the morning. It is not that everything is fine," says Dr. Correa.

But as a physician locally, taking care of vets, Dr. Correa says he couldn't help but answer the call to attend to veterans on the island both at a Veterans home of 100 patients, and other veterans who for now cannot leave their homes because of the massive damage around the island.

"476 Veterans. We have either laid eyes in a vast majority of them we have laid eyes, but almost to 90% of those.... going house to house and seeing individuals that are already set up with the VA and depend upon us to provide primary care at home. It's called home based primary care," says Dr. Correa.

Fuel is tough to come by, he says the Veteran's Hospital is running off of generators, but it is in a limited capacity.

While he feels good about the care given to veterans during these tough times, he is also surprisingly optimistic about the civilians on the island as well,

"They are going to be able to get over this, and being able to see that there is a bright future for Puerto Rico," says Dr. Correa.

He'll be headed home early next week.

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3.8 - KRIS (NBC-6, Video): [Mobile veterans services center touring county](#) (4 October, Roland Rodriguez, 197k online visitors/mo; Corpus Christi, TX)

With more than 30,000 veterans in Nueces County, the Veterans Affairs Office has come up with a way to make serving those who served our country a little easier by going mobile.

The mobile unit will be traveling throughout the county over three days next week, and it's equipped to provide a variety of services to local veterans.

This a great way to help veterans who live out in rural areas.

The Nueces County Veterans Services will have mobile centers in rural areas three times in the month of October.

Mobile veteran centers will be at:

October 11: VFW Post 3837, 12030 Leopard Street in Corpus Christi, TX

October 12: Driscoll Community Center, 200 East 6th Street in Driscoll, TX

October 13: VFW Post 8932, 702 Jester in Flour Bluff

Representatives will be available 10 a.m. to 2 p.m.

If you're a veteran, and you're going to school or working, this is an opportunity where the Nueces County Veterans Services comes to your area, and you don't have to drive all the way to Corpus Christi office to get help.

The VA Texas Valley Coastal Bend Health Care system, along with the Nueces County Veterans Services will reach out and provide counseling for individual readjustment, bereavement, marital and family issues, employment and career guidance and military sexual trauma (not all locations).

There will be representatives on hand for benefits assistance and referral, substance abuse assistance and referral and community education.

Specific health care, disability, pension, burial and survivors benefit information will be given by the U.S. Department of Veterans Affairs.

For more information, call county veteran services at 361-888-0820.

Many Veterans who rely on VA for their health care live in remote areas. Our nation's rural and highly rural Veteran population is large and dispersed. It is also racially, ethnically, and culturally diverse. Providing comprehensive, high-quality health care to these Veterans is a challenge.

VA's Office of Rural Health (ORH), created in 2007, strives to eliminate the barriers between rural Veterans and the services they have earned and deserve, thus improving Veterans' health and well-being by increasing access to care.

According to ORH, 5.2 million Veterans live in rural communities across the United States, and more than 32.9 million rural Veterans rely on VA for their health care. Veterans are more likely to live in rural areas than Americans who did not serve in the military. While 18 percent of Americans live in rural areas, 23 percent a quarter of Veterans do.

More than half (57 percent) of rural Veterans enrolled in VA health care are 65 years old or older. In addition, 6 percent are women; 9 percent report being members of racial and ethnic minorities; and nearly 435,000 are Veterans of our recent conflicts in Iraq and Afghanistan. About 44 percent of rural Veterans have one or more service-related disabilities.

Rural Veterans have lower than average household incomes than other Veterans; they often face long driving distances to access quality health care; and there are fewer health care providers and nurses per capita in rural areas.

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3.9 - The Robesonian: [Battaglia's death latest proof of veterans' neglect](#) (4 October, Editorial Board, 72k online visitors/mo; Lumberton, NC)

It looks as if an SBI investigation will conclude that Kevin Anthony Battaglia, retired Army, just 33 years old, someone's son, and the father of three young children, died when he was struck by an officer's bullet during a standoff at his Parkton home on Sunday.

But make no mistake: This was suicide by cop, and Battaglia is only the latest veteran of our Middle East wars to pick that poison after returning to this country a shattered self, unable to deny his demons. In a very real sense, it was all of us who pulled the trigger that sent the bullet hurtling that would take Battaglia's life, ending his suffering, but robbing him of so much that life could have offered.

A mix of family, neighbors and Army buddies portrayed Battaglia as a respectful guy who was struggling to assimilate back into society after seeing duty overseas. He had multiple brushes with the law, some minor, but also a serious brawl in a bar that sent him to prison. He was facing two DWI charges in Cumberland County, so it's clear that alcohol was his medication of choice.

Battaglia was medically retired, presumably for a bad back, and he claimed to have been suffering from post traumatic stress disorder, PTSD, that is so prevalent among veterans who experience first hand the horror of war. PTSD was first ascribed to Vietnam War veterans, and now the word is universally recognized.

We were told that Battaglia was frustrated by the Department of Veterans Affairs, believing he wasn't receiving the kind of care he needed and deserved. The VA's problems have been well-documented in recent years, so it's easy to believe Battaglia's gripe was legitimate.

Those who knew him saw his behavior deteriorating in recent weeks, and it could be seen on Facebook where his religious leanings were becoming cult-like. The American flag, Bible and weapons were prominent there — and in recent days he took to wearing camouflage.

There have been many studies concerning the number of veterans with PTSD, and one by RAND in 2014 found at least 20 percent of the 2.7 million Americans who served in Iraq or Afghanistan suffered with it or depression — and half never seek any treatment. That many more were suffering with traumatic brain injury, and about 7 percent both PTSD and TBI.

Those numbers are most likely low.

Last year a study for the Department of Veteran Affairs found that about 20 veterans commit suicide a day in this country. pushing the number to almost 7,500 a year.

So the evidence is overwhelming that this country continues to send its young people to war, and when they return we are ill-equipped to provide the care they deserve.

Often, as with Battaglia, the problems are apparent. But no one could stop this train wreck no matter how leisurely its pace. Friends, especially fellow military, apparently tried — and that included trying to talk him out of the house on the day he died.

Somehow, someday, this country has to do better for those who step forward and put themselves in harm's way to preserve the ways of life and liberties that the rest of us enjoy.

It's too late for Battaglia, but his death, which was explosive and public, can be given greater meaning should it move the needle at all in the direction of better care for our veterans.

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3.10 - KXLH (CBS-25, MTN News, Video): [VA Montana hosts Fall Health Festival](#) (4 October, John Riley, 57k online visitors/mo; Helena, MT)

Over 550 Veterans received their Flu immunization today along with community members and V-A staff.

VA Montana staff braved the cold temperatures outside to kick off the flu season with the annual Fall Health Festival and Drive Thru Flu Clinic.

The shots were free for enrolled veterans and VA employees and the County Health Department were on hand to supply flu shots for a fee for everyone else.

People 65 years and older, young children, and people with certain health conditions are at higher risk for serious flu complications.

Each year around 200,000 people are hospitalized and around 32,000 people die from Influenza.

The best way to prevent the flu is by getting vaccinated each year.

Veterans attending the event said that they love the ease of the clinic considering they didn't even have to leave their vehicles.

"I've never had to wait long," said veteran Louie Stiles, "When I was doing it privately getting these private shots they'd just take a lot of time, this doesn't."

If you are an enrolled veteran and missed the clinic you can still get your shot at the VA medical Center.

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3.11 - HealthTech: [NHIT Week 2017: Technology Improves Care Options for Veterans - Telehealth and predictive analytics are among the tools being deployed more strategically by the VA, Secretary David Shulkin says.](#) (4 October, Dan Bowman, 20k online visitors/mo; Vernon Hills, IL)

One day after publication of a rule that would let doctors at Department of Veterans Affairs facilities leverage telemedicine to provide care to patients anywhere, VA Secretary David Shulkin discussed his agency's goals for using technology moving forward.

Speaking Tuesday at the American Telemedicine Association's Edge 2017 Fall Forum in Washington, D.C., Shulkin outlined five priorities for "fixing" the VA: greater patient choice, systems modernization, improved service timeliness, world-class foundational service and suicide prevention.

"Our mission is to take care of those who serve the country," Shulkin said.

Expanding Telehealth to Improve Access

Telehealth is a big part of the agency's plans for remedying its timeliness and access issues, Shulkin said.

"This is a strategy that VA is growing and investing in and believes is essential to solving this priority of timeliness of services," Shulkin said.

Its new initiative centers on allowing veterans to receive care wherever they are, as long as they have access to an internet connection. Individuals can access provider services on any device in any location, Shulkin said. However, he also noted that moving ahead was less of a technology challenge and more of a legal and regulatory issue.

"Very conservative interpretations interpreted current law as saying that we needed to provide telehealth services from one VA facility to another, which just didn't make a lot of sense to me," Shulkin said. "I was making my patients drive 80 miles from their home to a VA facility waiting room so they could get into an exam room to see me using telehealth; it just didn't make any sense."

The rule change will allow innovators within the agency to do a lot more with its technology now that all VA doctors will be able to take advantage, Shulkin said. To aid in the expansion, in August, the agency announced it would start a nationwide rollout of its VA Video Connect app, which allows providers and patients to connect via live video on a computer, smartphone or tablet.

The American Medical Association offered early praise for the rule, with Dr. Jack Resneck Jr., chairman-elect of the AMA's Board of Trustees, saying in a statement that the VA "has a unique federally controlled healthcare system with essential safeguards" that can ensure high care quality for patients.

Using Analytics for Suicide Prevention

Shulkin also noted that the VA is deploying Big Data and predictive analytics technology to try to proactively identify veterans who may be at risk for suicide.

"This is an American public health crisis, not just a VA crisis," he said. "The number of Americans committing suicide each year is growing, but among veterans it's growing even more."

Access to care through the VA stems such rates, Shulkin said. Over the last 15 years, the rate of veterans committing suicide has gone up 5.4 percent for those accessing VA care; for veterans who don't use the VA, the suicide rate has gone up 38.4 percent. In particular, for female veterans who accessed the VA for care over the last 15 years, the suicide rate decreased 2.6 percent, but increased 81.6 percent for those not using the VA.

"We are really trying to outreach to veterans to let them know that they have options and that treatment works," Shulkin said.

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4. Women Veterans

5. Appeals Modernization

6. Strategic Partnerships

6.1 - WIBW (CBS-13, Video): [Visually impaired veterans tour Kansas Statehouse](#) (4 October, Deneysa Richard, 484k online visitors/mo; Topeka, KS)

The VA of Eastern Kansas sponsored an event on Tuesday that left a long lasting impact.

The Topeka and Leavenworth VA campuses partnered with The Kansas State Capitol to host a tour for veterans who are visually impaired.

Over 40 veterans were in attendance, some of who visited the Capitol for the first time.

"I'm glad to be here," veteran Keith Sese said, "It's the first time I've been at the Capitol, and I have been here since 1982."

The event aimed towards promoting the inclusion of individuals of all abilities in recreational activities.

"With the support of the staff that is here today and their family members, we're going to be able to get them through the tour and to be able to be a part of it, even if they don't have much sight, at least they are here with everybody and just take part in something in the community," said VA Visual Impairment Services Team Coordinator, Dawn Clouse.

Veterans who attended the event also learned about the Kansas Commission for Veteran Affairs, as well as the state and federal benefits available to veterans who are visually impaired.

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7. Supply Chain Modernization

7.1 - Washington Technology: [B3 Group wins \\$156M VA financial, program management order](#) (4 October, Ross Wilkers, Vienna, VA)

Leesburg, Va.-based small business B3 Group has won a five-year, \$156 million task order for financial and program management services to the Veterans Affairs Department.

The VA awarded the order under its potential 10-year, \$22.3 billion T4NG IT services contract vehicle. Work under this order supports software development lifecycle tasks for the VA's financial services center, B3 Group said Tuesday.

Only service-disabled, veteran-owned small businesses were eligible for this order and the VA received four offers, according to Deltek.

B3 Group's teammates for the order include AdapctiveStack Consulting, First-Tek, Grant Thornton, ISC, Longview International Technology Solutions, Rios Partners and Vets Inc.

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8. Other

8.1 - CNN: [Investigations opened into Zinke's meeting with Golden Knights hockey team](#)
(4 October, Miranda Green, 29.7M online visitors/mo; Atlanta, GA)

Washington (CNN)A summer visit that Interior Secretary Ryan Zinke made to the Vegas Golden Knights hockey team is now under two investigations by federal watchdogs.

The Interior Department's inspector general has added concerns about Zinke's meeting with the new NHL team and use of a private jet from Las Vegas to an investigation it opened Friday looking into the secretary's travel, an IG spokesperson confirmed to CNN Wednesday.

The Office of Special Counsel has also opened a Hatch Act investigation into Zinke's meeting with the hockey team.

Zinke met with players on the hockey team at a hotel across the street from their practice facility June 26, a Golden Knights spokesman said.

The meeting was added to the IG probe at the behest of Democratic Reps. Raul Grijalva and Donald McEachin. Grijalva criticized Zinke's need to hire a chartered plane to return home to Montana following the Nevada meeting as well as the purpose of the meeting itself.

"Claims that the secretary's full schedule required the use of chartered aircraft deserve scrutiny. It appears as though Secretary Zinke and his staff could have taken a commercial flight from Las Vegas to Montana if he did not attend the motivational speech to the hockey team owned by his friend and campaign donor, Bill Foley," read Grijalva's letter.

The OSC probe came after a complaint filed by the government watchdog group, Campaign for Accountability and was first reported by Reuters.

An OSC spokesperson told the watchdog group that the Hatch complaint had been "received" and they will "open a case file to address this matter."

An Interior Department spokesperson told CNN that Zinke's late night private flight to Montana from the Nevada meeting cost taxpayers \$12,375. The spokesperson maintained that the flight was booked after no suitable commercial alternative was available and was approved by the Interior's ethics office.

Zinke's meeting with the Vegas Golden Knights is also being scrutinized since it is owned by someone Zinke called "a major donor" when he was running for Congress in 2014.

Bill Foley, a billionaire businessman and owner of the Golden Knights, is also board chairman of Fidelity National Financial Inc. FEC filings show that Foley was responsible for heavily bankrolling Zinke's first congressional campaign in Montana. He personally donated \$2,600 in 2013 and again 2014 -- the maximum contribution amount.

Fidelity donated \$154,823 to Zinke between the years of 2013 and 2018. Fidelity also owns Chicago Title Services, which donated 23,900 to Zinke.

The OSC probe is the sixth known investigation into travel by the administration's cabinet members.

The most recent investigation opened was into Veterans Affairs Secretary David Shulkin's July business trip to London and Denmark, which included meetings with Danish and UK officials as well as a stop at Wimbledon.

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8.2 - ABC News (Video): [Top Democrat questions Kellyanne Conway's air travel](#) (4 October, Benjamin Siegel, 24.1M online visitors/mo; New York, NY)

The top Democrat on the House Oversight Committee is raising questions about White House counselor Kellyanne Conway's air travel, and asking for proof that former Health and Human Services Secretary Tom Price has paid for his seats on controversial private flights.

In a letter to Conway obtained by ABC News, Rep. Elijah Cummings, D-Maryland, has asked Conway for information on all private, non-commercial and military flights she has taken.

Conway, who is the first White House official to be questioned regarding air travel, is coming under scrutiny after Price resigned Friday, and after reporting from Politico revealed that she joined Price on several chartered flights for events across the country.

"Despite the fact that you joined Secretary Price on several of these flights, you have not made any similar public statements indicating whether your own actions were appropriate, whether you will continue to take such flights at taxpayer expense in the future, or whether you plan to personally repay the taxpayers for the cost of your seats on these flights," Cummings wrote.

A White House official told ABC News in response to questions about Conway's travel: "Agencies are responsible for arranging appropriate transportation for their own events. Members of the President's Cabinet occasionally invite relevant White House staff for official travel for events promoting the President's agenda. When White House staff are invited, their travel plans are planned and secured by the inviting agency."

In addition to Price, Interior Secretary Ryan Zinke, Veterans Affairs Secretary David Shulkin and Treasury Secretary Steven Mnuchin have all come under fire for their use of government planes or private aircraft.

The White House is taking steps to crack down on travel and use of private charters in the administration instead of commercial air travel. John Kelly, the White House chief of staff, will

now sign off on all government and chartered air travel by agency leaders, according to a memo released by White House budget director Mick Mulvaney Friday.

“Every penny we spend comes from the taxpayer. We thus owe it to the taxpayer to work as hard managing that money wisely as the taxpayer must do to earn it in the first place,” he wrote.

On Friday, Price said in a statement that he plans to write a personal check to the Treasury for the expense of his travel.

According to a person familiar with the former secretary's travel, Price's seats on all the flights cost \$51,877.31. But Price's total travel has cost the government an estimated \$400,000 in chartered aircraft expenses, according to Politico.

ABC News has reached out repeatedly to the Treasury Department and HHS asking if Price has actually written the promised check. A Treasury Department spokesman declined to reveal that information, citing privacy concerns, while HHS has declined to comment.

On Wednesday Cummings also sent a letter to Mnuchin and acting HHS Secretary Don Wright asking for proof of Price's pledge: a copy of his check reimbursing the government.

ABC's Justin Fishel and Katherine Faulders contributed to this report.

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8.3 - WRIC (ABC-8, Video): [Virginia taxpayers funding deadly dog experiments at McGuire VA Medical Center](#) (4 October, Kerri O'Brien, 477k online visitors/mo; Richmond, VA)

We've known for months that federal tax dollars have been funding the deadly dog experiments at McGuire VA Medical Center. Now, 8News has learned that Virginia has funded those canine experiments, and it has some lawmakers calling for an end to the contributions.

Documents obtained through a Freedom of Information Act request show that the Commonwealth of Virginia contributed to the funding for the McGuire Medical Center's dog experiments.

The information had been originally redacted but was recently disclosed after watchdog group White Coat Project sued to have the information disclosed.

“We cannot do this, we just can't,” Virginia State Senator Bill Stanley said.

Sen. Stanley said he was appalled by the experiments, which have involved at least 39 dogs having pacemakers surgically implanted as part of a heart disease study. All of the dogs involved are eventually euthanized.

“I was truly shocked when I learned state funds, state taxpayer money is going to the cruel and inhumane treatment of dogs all in the name of science,” Stanley said.

8News dug further and confirmed that lawmakers allocate money from Virginia's General Fund each year to the Center for Innovative Technology.

CIT then decides what research projects to fund.

In 2016, CIT awarded McGuire and Dr. Alex Tan nearly \$100,000 for dog research. Dr. Tan is the same doctor that a review committee called “reckless” and responsible for several botched surgeries resulting in dog’s deaths.

We shared what we found with lawmakers.

Stanley said he had no idea that this block grant was being used to conduct deadly tests on dogs.

“We can find better ways in 2017 to find the information that they need to make the lives of our veterans and other people better,” Sen. Stanley said.

The VA argues that dogs are only used in studies when rodents cannot provide the information needed. Other supporters say canine research has and can lead to future medical breakthroughs.

8News spoke with Sherman Gillums, Jr., the Executive Director of Paralyzed Veterans of America. He said the sacrifices involved in animal research are worth it.

“The chance we are taking though, by stopping animal research is you will in effect impact our ability to find new treatments for not just human beings, but animals,” Gillums said.

Still, Sen. Stanley and Sen. Glen Sturtevant have fired off a letter to the governor expressing “opposition to the commonwealth’s role in the funding.” They describe it as “abusive and wasteful.”

They demand to know how much total taxpayer money has been provided for the research, and what action the Commonwealth has taken to address violations at McGuire, including those botched surgeries.

Sen. Stanley tells 8News he has already drafted legislation that would ban the use of Virginia taxpayer money for any research projects that harm dogs.

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8.4 - Fayetteville Observer: [Veteran charged in Gray’s Creek murder](#) (4 October, Drew Brooks, 439k online visitors/mo; Manchester, NH)

Air Force veteran, once praised for turning life around, is charged with first-degree murder after fatal shooting in Gray’s Creek

When Garrett Jordan Vann was last in a Cumberland County courtroom, the Air Force veteran was being celebrated for turning his life around.

Once homeless, estranged from his family, battling substance abuse and facing several felony charges, Vann appeared to have excelled under the strict regimen of the county's Veterans Treatment Court.

He was the court's first graduate during a ceremony in April 2016, earning praise from local judges, Veterans Affairs officials and others.

But a little more than a year later, Vann, 32, of the 300 block of Southern Comfort Drive in Parkton, was led into a courtroom under very different circumstances.

At the Cumberland County Detention Center, Vann made his first appearance on charges related to the killing of a Fayetteville man Tuesday night. Vann is charged with first-degree murder and shooting into an occupied vehicle, according to the Cumberland County Sheriff's Office.

He is accused of firing a 12-gauge shotgun into a Chevrolet Impala. Jason Ray Tyner, 40, of Fayetteville, was struck in the head and killed, an arrest warrant said.

Vann was initially charged with second-degree murder, but that charge was dismissed during his first appearance hearing Wednesday afternoon. Vann reportedly was served with the warrants for the newer charges just before appearing in court.

The Sheriff's Office has not issued any details about the incident that happened about 8 p.m. on the 3400 block of Nash Road, off Butler Nursery Road in the Gray's Creek community.

On Wednesday, family members of both Vann and Tyner filled one side of the small courtroom in the detention center. When Assistant District Attorney Robby Hicks announced that the second-degree murder charge was being dropped, there were gasps from some.

"Oh my God," one person said softly while another spoke a bit louder saying, "Thank you."

However, that was before they were told that Vann was being charged with first-degree murder.

Vann is being held without bail.

A 2004 graduate of Gray's Creek High, Vann enlisted in the Air Force in 2007 and served for about three years.

A spokesman for the Fayetteville VA Medical Center confirmed Wednesday that Vann works at the VA. He was hired at around the time he graduated from the Veterans Treatment Court, but the spokesman could not provide any other details.

In 2016, he told The Fayetteville Observer that he had turned his life around with the help of the Veterans Treatment Court team, which includes a judge, lawyers, law enforcement, substance abuse and mental health providers and a team of volunteer mentors.

A year earlier, the veteran who spent two tours in Afghanistan said he was at a low point in his life. But he said he regained control with the help of the court, which holds veterans charged with nonviolent crimes to strict standards, with regular court dates and drug tests.

In exchange, those who graduate can see their cases dismissed.

The Cumberland County veterans court was the second of its kind in North Carolina, following a similar court in Harnett County. Today, there are at least four such courts in the state.

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8.5 - CBS News Radio (ConnectingVets.com): [Mr. Secretary, why is the VA abusing dogs?](#) (4 October, Jonathan Kaupanger, 23k online visitors/mo; New York, NY)

Puppies having holes drilled into their heads, then parts of their brains removed. Latex injected into puppies' coronary arteries before they're forced to run on treadmills until they have a heart attack. Dogs with severed spinal cords, invasive lung experiments... it's all just another day at the Department of Veterans Affairs.

Each year taxpayers fund between \$15 to \$20 billion worth of animal experiments. What part of that number belongs to the VA is hard to say because Veterans Affairs refuses to report the amount it spends on these type of tests. With over 9,000 projects listed in the Federal Register database, not one has the costs associated with the project listed.

ConnectingVets reached out to the VA with our questions, but as of publishing this article, they have refused to respond. Even with the agency's new "transparency," catchphrase, it's almost impossible to find out what exactly is going on with dog tests at the VA. The only thing coming from the VA on the subject is that they will look into how these tests are being done.

"It's unclear to me," said Justin Goodman, White Coat Waste Project's Vice President for Advocacy and Public Policy. "They say they're going to improve the oversight process for dogs in particular. I know they haven't communicated to Congress what that looks like."

It's not clear that Veterans Affairs even knows what this looks like either. At every turn, VA obfuscates reality and even makes outright lies about this subject.

"It is important to note that almost 100 percent of the animals involved in VA research are mice or rats," said Dr. Michael Fallon, VA's Chief Veterinary Medical Officer, said in a statement recently. "Studies involving larger animals such as canines are rare exceptions; canines accounted for fewer than 0.05 percent of animals used in VA research in 2016."

He went on to say, "At VA we have a duty to do everything in our power to develop new treatments to help restore some of what veterans have lost on the battlefield. One of the most effective ways for VA to discover new treatments for diseases that affect veterans and non-veterans alike is the continuation of responsible animal research."

Fallon also said that VA's animal research program "sets the standard for accountability and transparency both inside and outside the government." I'm going to come back to this point in a minute, but first, you need to understand how animal tests – specifically testing on dogs – are categorized.

Dogs that are kept in a lab, maybe used for breeding but not used for tests, these are category B experiments. Category C would be anything that is non-invasive, a pinprick maybe, but nothing painful. Experiments with category D testing are painful, but relief is given to the dogs.

Category E tests are where dogs are under maximum pain and distress but are given nothing to reduce the pain.

Dr. Fallon's comment about accountability and transparency are just simply ridiculous. The VA doesn't publish anything at all on this, so if this is the "standard for accountability and transparency," it's not a good one. Now, his comment that dogs make up "fewer than 0.05 percent of animals used in VA" is technically true.

Last year there were about 60,000 dogs used in US labs, 0.05 percent of that is around 300, but what the VA doesn't tell us is that it's the ONLY government agency conducting category E tests on dogs.

One of the places conducting these painful tests is the Louis Stokes VA Medical Center in Cleveland, Ohio. Earlier this year, Cleveland announced that five of the dogs they were using in tests had been adopted out after the experiments were complete. Two of these dogs were able to find a home, but the VA gets real shady at this point. These two dogs were only marked for adoption the day a Freedom of Information request was made about the projects. Then, the same day reporters were told about the five adoptions, three of these dogs, it was later found out, had been killed.

This was admitted by the VA only after the facts were made public.

The burden is on the VA to prove veterans are getting something out of these tests, but they are simply quiet on the subject. Take for example the latex injected into puppies experiment. This has been going on for an estimated 20 years. Papers published on this don't even use the word veteran.

"If there's something that is truly valuable and might be promising, let the private sector fund it," said Goodman. "A private company isn't going to run dogs on treadmills for 20 years and not get anything to show for it."

Last month, VA Secretary Dr. David Shulkin wrote an opinion piece about the VA's dog testing programs. In it he discussed many life-changing medical advancements that are due to canine research. He also explains why dogs are used in biomedical research as well. These excuses worked before, but now that we're in the 21st Century, the excuses might explain why the VA is the least advanced federal agency when it comes to biomedical research.

To this, I have four words: Organ on a Chip.

Using this technology, tests can be simulated on the lung, heart, kidney, and arteries. Besides the cruelty factor of animal testing, using dogs often adds to the length of tests and can be expensive. The National Institute of Health estimates that 95 percent of drugs and treatments that pass animal tests fail when done on humans. This makes me wonder if this is the reason why VA refuses to follow the Federal Funding Accountability and Transparency Act.

New legislation has been introduced this year to stop Government funds from being spent on painful dog experiments. The Preventing Unkind and Painful Procedures and Experiments on Respected Species or PUPPERS Act, if signed into law, would only apply to D and E type animal experiments and would essentially stop the U.S. Government from paying to abuse animals.

Secretary Shulkin ends his opinion piece by saying, “The Senate should take a stand and preserve humane and carefully supervised canine research at VA.” Please, Mr. Secretary, can you first explain to your country what’s exactly going on with this research and how much it’s costing us?

And to paraphrase Janet Jackson, what exactly has this done for veterans, lately?

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From: (b) (6)

Cc:

Bcc:

Subject: [EXTERNAL] 13 October Veterans Affairs Media Summary and News Clips

Date: Fri Oct 13 2017 04:16:33 CDT

Attachments: 171013_Veterans Affairs Media Summary and News Clips.docx
171013_Veterans Affairs Media Summary and News Clips.pdf

Good morning,

Please find the attached Veterans Affairs Media Summary and News Clips.

Document ID: 0.7.10678.168065-000001

Owner: (b) (6) >

Filename: 171013_Veterans Affairs Media Summary and News Clips.docx

Last Modified: Fri Oct 13 04:16:33 CDT 2017



Veterans Affairs Media Summary and News Clips

13 October 2017

1. Top Stories

1.1 - USA Today (Video): VA vows changes on bad health care providers, lawmakers take action after USA TODAY investigation (12 October, Donovan Slack, 37M online visitors/mo; McLean, VA)

The Department of Veterans Affairs is pledging to overhaul its reporting policies for bad medical workers and a group of lawmakers is introducing legislation following a USA TODAY investigation that found the VA has routinely concealed shoddy care and staff mistakes. VA Secretary David Shulkin directed agency officials to expand a nearly 30-year-old policy that limited what medical providers the agency would report to a national database created by Congress...

[Hyperlink to Above](#)

1.2 - U.S. News & World Report (AP): Congress OKs Expanded Protections for Federal Whistleblowers (12 October, Hope Yen, 24M online visitors/mo; Washington, DC)

Congress voted Thursday to boost the protection of federal whistleblowers from retaliation, part of a bid to uncover bad behavior at the Department of Veterans Affairs and other government agencies. The House easily cleared the bill, 420-0. It now goes to President Donald Trump for his signature, having previously passed the Senate in May.

[Hyperlink to Above](#)

1.3 - U.S. News & World Report (AP): Ex-Head of Tomah VA Allowed to Resign, Given Settlement (12 October, 24M online visitors/mo; Washington, DC)

The former head of the Tomah VA Medical Center was allowed to resign and given a settlement after allegations that painkillers were being overprescribed to patients. Mario DeSanctis was fired from the hospital in 2015. But a USA Today investigation found he fought his dismissal and reached a deal in which he was allowed to resign. He and his attorney were paid \$163,000.

[Hyperlink to Above](#)

1.4 - Reuters: Virtual interviewer prods veterans to reveal post-traumatic stress (12 October, Ronnie Cohen, 43.6M online visitors/mo; New York, NY)

Talking – to a computer-generated interviewer named Ellie – appears to free soldiers and veterans who served in war zones to disclose symptoms of post-traumatic stress, a new study finds. Warriors and veterans were up to three times more likely to reveal symptoms of post-traumatic stress to Ellie, the virtual chatbot, than on an official military survey called the post-deployment health assessment...

[Hyperlink to Above](#)

1.5 - The Washington Post: Virginia lawmakers say late VA payments jeopardize veterans' care (12 October, Jenna Portnoy, 43.9M online visitors/mo; Washington, DC)

Members of Congress from Virginia say chronic late payments from the Department of Veterans Affairs to doctors are jeopardizing care for the state's aging veteran population. The state's two senators and 11 House members urged VA administrators to fix a system that can leave health-care providers waiting more than four months for payments they should have received within 30 days. The delays can damage credit, they said.

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1.6 - The Washington Post: [‘This is frightening’: Noxious gas has sickened VA workers for two years, with few solutions](#) (12 October, Alex Horton, 43.9M online visitors/mo;

Washington, DC)

Staff and patients at a D.C. medical facility for homeless military veterans have endured noxious gas exposure for nearly two years as top hospital administrators, though aware of the problem, have failed to remedy it, according to interviews with staff and documents obtained by The Washington Post. At least eight clinical workers at the Department of Veterans Affairs Community Resource and Referral Center have tested positive for elevated levels of carbon monoxide...

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1.7 - The Denver Post: [Dozens of surgeries at Denver VA hospital put off because of doctor shortage, Too few anesthesiologists and competitive market to blame, VA says](#)

(12 October, David Migoya, 4.8M online visitors/mo; Denver, CO)

A shortage of anesthesiologists at Denver’s veterans hospital – despite salary offers reaching as high as \$400,000 a year – has forced a delay in dozens of surgeries just months after the institution was tagged with some of the nation’s worst waiting lists for care. Though the hospital employs eight anesthesiologists and eight nurse anesthetists, they’re short of the complement needed to meet surgery demands that run about 380 operations a month, a spokeswoman said...

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1.8 - Military Times: [Lawmakers take first steps toward a BRAC for VA facilities](#) (12

October, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

House lawmakers took the first steps Thursday toward shutting down hundreds of Veterans Affairs facilities through a process similar to military base closure rounds, saying the move is critical to keep the department from wasting millions of dollars on underused, aging buildings. But some of the largest veterans groups said they have serious concerns with the proposal, saying it’s ripe for abuse and could tempt VA officials to outsource more veterans’ medical care to private-sector physicians.

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1.9 - Stars and Stripes (Military Update): [VA, Congress crawl toward ending abuse of vet pensioners](#) (12 October, Tom Philpott, 1.5M online visitors/mo; Washington, DC)

In 2012, the Government Accountability Office found more than 200 financial planning firms and estate law offices enticing veterans or their survivors into costly annuities or irrevocable trusts intended to hide or reallocate their assets so they qualify for VA pensions that the claimants wouldn’t be eligible for otherwise. Since then, the Department of Veterans Affairs and Congress have been crawling toward actions to stop the abusive practices...

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1.10 - Public Radio International (Audio): [Meet the women combing through Puerto Rico, searching for veterans in need](#) (12 October, Jasmine Garsd, 1.2M online visitors/mo;

Minneapolis, MN)

Lind, an occupational therapist for the VA Caribbean Healthcare System in San Juan, goes to the door, asking, "Are there any veterans here?" Every day since the hurricane hit, she and her team have been roaming from shelter to shelter, looking for veterans who need medical attention. There are somewhere around 75,000 US Army veterans living in Puerto Rico. Most served during the Vietnam War. After Hurricane Maria, many are now living in shelters.

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2. Veteran and Employee Experience

2.1 - The Washington Post (PowerPost, Video): [House to vote on bill requiring discipline for officials who retaliate against whistleblowers](#) (12 October, Eric Yoder, 43.9M online visitors/mo; Washington, DC)

Federal agencies would be required to discipline officials who retaliate against whistleblowing employees, and to fire them on their second offense, under a bill up for a House vote Thursday. The bill, approved by the Senate in May, is one of many arising from the disclosures starting in 2014 of falsified patient records at the Department of Veterans Affairs.

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2.2 - U.S. News & World Report (AP): [Alaska Veterans Affairs System to Add 100 Staff Members](#) (13 October, 24M online visitors/mo; Washington, DC)

The Alaska Veterans Affairs system has announced it's adding 100 staff members. KTVA-TV reported Wednesday that Dr. Timothy Ballard said the staff is being added in response to negative reviews from both patients and staff. Ballard said the new positions are focused on mental health care and support functions. The 100 new jobs boost the system's number of staff to 650 at a cost of \$6 million.

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2.3 - Atlanta Journal-Constitution: [Roswell getting \\$21K for veterans adaptive sports](#) (12 October, David Ibata, 11.9M online visitors/mo; Atlanta, GA)

Roswell has agreed to accept \$21,080 from the federal government to purchase equipment and hire instructors for new VA Wheelchair Softball and Adaptive Cycling programs for disabled veterans. The City Council approved a resolution accepting the FY 201 Adaptive Sports Grant from the U.S. Department of Veterans Affairs. The grant does not require local matching funds, according to a staff report to the council.

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2.4 - The Hill: [New whistleblower protections head to Trump's desk](#) (12 October, Cristina Marcos, 11.8M online visitors/mo; Washington, DC)

The House unanimously cleared legislation on Thursday to ensure protections for federal employees who disclose government waste, fraud and abuse. Passed 420-0, the measure would train federal workers so they understand their protections, as well as enhance penalties for supervisors who retaliate against whistleblowers. The bill is named after Chris Kirkpatrick, a psychologist was fired from a Department of Veterans Affairs (VA) medical center after raising concerns about patients' medications.

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2.5 - Bangor Daily News: [‘Dangerous surgeon’ at Togus allegedly made mistakes in 88 cases, but VA kept it quiet](#) (12 October, 1.2M online visitors/mo; Bangor, ME)

An explosive USA Today investigation into medical mistakes allegedly made under the watch of the U.S. Department of Veterans Affairs highlighted what the newspaper described as one particularly egregious case in Maine. According to the report, podiatrist Thomas Franchini allegedly made mistakes in 88 cases while working at the Togus VA Medical Center near Augusta, the nation’s oldest veterans’ hospital.

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2.6 - WFED (AM-1500, Audio): [House passes bill to give TSP participants more withdrawal options](#) (12 October, Eric White, 831k online visitors/mo; Washington, DC)

The Veterans Affairs Department stepped back a proposal to suspend a 50-year-old ethics law. The law, first passed in 1966, requires VA to fire any employee who also works for a school whose students receive VA benefits. The department had planned to completely stop enforcing that requirement by next Monday, since some of its employees also work as adjunct professors at for-profit colleges.

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2.7 - La Crosse Tribune: [House approves whistleblower bill named for former Tomah VA doc](#) (12 October, 822k online visitors/mo; La Crosse, WI)

The U.S. House passed a federal whistle blower protection bill Thursday named for a former VA psychologist who questioned over-medication of patients at the Tomah VA Medical Center. The Dr. Chris Kirkpatrick Whistleblower Protection Act is designed to protect federal employees who come forward with allegations of waste, fraud and abuse and to set minimum disciplinary measures for supervisors found guilty of retaliation.

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2.8 - WLOS (ABC-13, Video): [Protesters at Asheville VA say being understaffed is dangerous](#) (12 October, 480k online visitors/mo; Asheville, NC)

Veterans Affairs employees held a rally outside Asheville's Charles George VA Medical Center on Thursday to protest working conditions. Protesters said low staffing levels are creating risks to patient safety and a hazardous work environment. They said Congress has failed to fill open positions, putting veterans' health care at risk.

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2.9 - HousingWire: [Ginnie Mae, VA launch task force to look into lenders targeting veterans for quick refinances - Comes on the heels of Ginnie Mae opening investigation](#) (12 October, Ben Lane, 438k online visitors/mo; Irving, TX)

Roughly one month ago, Ginnie Mae announced that it was launching an investigation into mortgage lenders that were aggressively targeting servicemembers and military veterans for quick and potentially risky refinances of their mortgages. The investigation came on the heels of a letter from Sen. Elizabeth Warren, D-Massachusetts, who cited a report from the Consumer Financial Protection Bureau, which covered complaints received from veterans about Department of Veterans Affairs mortgage refinancing.

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2.10 - Citizen-Times: [Disappointed VA employees voice concerns, lack of staffing and support](#) (12 October, Alexandria Bordas, 318k online visitors/mo; Asheville, NC)

Ralliers gathered at Charles George VA Medical Center on Thursday afternoon to express disappointment in the 49,000 vacant staff positions nationwide, which veterans' supporters said are affecting local VA branches. Months of delays in appointments, overworked employees and lack of internal support can no longer be ignored, said Brandy Morris, executive vice president of the local American Federation of Government Employees labor union in Asheville.

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2.11 - WEAU (NBC-13, Video): [House members pass Whistleblower Protection Bill](#) (12

October, Ruth Wendlandt, 276k online visitors/mo; Eau Claire, WI)

In a bi-partisan vote, House members unanimously passed Representative Sean Duffy's Whistleblower Protection Bill. The Dr. Chris Kirkpatrick Whistleblower Protection Act ensures no one is retaliated against for coming forward with concerns about waste, fraud, and abuse at the veteran affairs. It also requires the VA to come up with a plan to restrict unauthorized employee access to medical files.

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2.12 - Parkersburg News & Sentinel: [Outrageous: VA culprit deserves more than a lecture](#)

(13 October, Editorial Board, 187k online visitors/mo; Parkersburg, WV)

How should a Department of Veterans Affairs manager who defrauded the government, took chances with veterans' health care, then devised a coverup be punished? Readers probably have their own ideas about that. But according to the federal government, the answer is ... counseling.

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2.13 - WAGM (FOX-8): [After Report Shows VA's Failure to Disclose Medical Malpractice at Togus, Rep. Poliquin Acts to Make Changes](#) (12 October, 35k online visitors/mo; Presque

Isle, ME)

Congressman Bruce Poliquin, along with House Conference Chair Cathy McMorris Rodgers (WA-05) and House Veterans Affairs Committee Chairman Phil Roe (TN-01), today introduced the Ethical Patient Care for Veterans Act of 2017. This legislation requires Department of Veterans Affairs (VA) medical professionals to report directly to state licensing boards if they witness unacceptable or unethical behavior from other medical professionals at the VA.

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2.14 - WAGM (FOX-8): [Rep. Poliquin's Bill to Ensure VA Headstones For Veterans' Families Buried in Cemeteries Advances in the House](#) (12 October, 35k online visitors/mo;

Presque Isle, ME)

Today, Congressman Bruce Poliquin had his Veterans bill pass out of committee with unanimous, bipartisan support. Congressman Poliquin's legislation would ensure that Veterans' family members who are buried at tribal Veterans cemeteries—such as the Houlton Band of Maliseet Indians Tribal Veterans Cemetery in Aroostook County—are provided government furnished headstones...

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2.15 - KOB (NBC-5, Video): [Oregon politician concerned about Roseburg VA medical facility](#) (12 October, 27k online visitors/mo; Medford, OR)

An Oregon congressman is asking the U.S. Department of Veterans Affairs to address "substandard management" at the Roseburg VA hospital. Congressman Peter DeFazio (D-OR 4th District) said the VA Roseburg Health Care System (VARHS) is a source of concern for constituents, who complained to the governor about the lack of effective and accountable management.

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2.16 - The M Report: [Ginnie Mae and VA Create Refinance Loan Task Force](#) (12 October, Nicole Casperson, 20k online visitors/mo; Dallas, TX)

Ginnie Mae and the Department of Veterans Affairs (VA) recently announced the shaping of the "Joint Ginnie Mae – VA Refinance Loan Task Force," in an effort to address loan churning and repeated refinancing issues. Specifically, the task force is set to focus on examining critical issues, important data, and lender behaviors related to refinancing loans. In addition, the task force will "determine what program and policy changes should be made by the agencies..."

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2.17 - KSNW (NBC-3): [Kansas nurse in Puerto Rico to help Hurricane Maria victims](#) (12 October, 9.1k online visitors/day; Wichita, KS)

A Cheney nurse is in Puerto Rico helping victims of Hurricane Maria. Linda Sue Bayless is a provider at the Robert J. Dole VA Medical Center. As part of the VA's Disaster Emergency Medical Personnel Program System, she signed on to deploy where she was needed most. Bayless left October 4 and is due back on the 18.

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[3. Access to Healthcare](#)**3.1 - Newsweek (Video): [PTSD Treatment: How Ai Is Helping Veterans With Post-Traumatic Stress Disorder](#)** (12 October, Joseph Frankel, 9.4M online visitors/mo; New York, NY)

The Institute for Creative Technologies at USC got lots of buzz for its original research, and introducing the world to Ellie, a digital diagnostic tool that strongly resembles, but cannot replace a human therapist. Ellie, an avatar of a woman in a cardigan with olive-toned skin and a soothing voice, listens to the people who come to her, and does what any human sounding board does. She listens to the content of their speech, and scans their facial expressions, tone, and voice, for cues that hint at meanings beyond speech.

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3.2 - KTVU (FOX-2): [Services available for veterans at Napa Valley College evacuation center](#) (12 October, 2.1M online visitors/mo; Oakland, CA)

The Vet Center, a subsidiary of the U.S. Department of Veterans Affairs, deployed personnel today to the wildfire evacuation center at Napa Valley College from Concord and Fairfield to provide mental health services and paperwork assistance for any displaced veterans. They were

at the shelter today with a trailer set up for three separate counseling sessions to be conducted simultaneously.

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3.3 - The Gazette: [Mayor, nonprofits plead for Colorado Springs landlords to help homeless vets](#) (12 October, Jakob Rodgers, 870k online visitors/mo; Colorado Springs, CO)

The vouchers include a caseworker for each veteran who can help them find jobs, access health care and, if need be, find addiction treatment. "We want to help you have success," said Erika Huelskamp, who coordinates the VA's local voucher program. "We are just a phone call away. We're here for you, just as much as that veteran."

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3.4 - Daily Press: [Virginia lawmakers cite payment delays in veterans health program](#) (12 October, Hugh Lessig, 863k online visitors/mo; Newport News, VA)

The Department of Veterans Affairs owes Virginia health care providers millions of dollars for services provided to veterans who sought treatment outside the VA system, says the state's congressional delegation, who want the VA to pay its bills. At issue is Veterans Choice, a popular but controversial program that allows former service members to seek care in the community if they have to wait too long for an appointment or live too far from a Veterans' Affairs facility.

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3.5 - KLTU (ABC-7, Video): [Veteran says medications from VA repeatedly lost in the mail](#) (12 October, Sophia Constantine, 837k online visitors/mo; Tyler, TX)

An East Texas woman who is a military veteran of over fifteen years is struggling after her medications have been misplaced in the mail twice over the past six months. Jill Morehouse receives mail order prescriptions from the VA once a month. Each time, a 240-count bottle of Vicodin. Over the past six months, she says two of those prescriptions never arrived.

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3.6 - The Daily Reporter: [VA Clinic to stay in Spirit Lake](#) (12 October, Seth Boyes, 45k online visitors/mo; Spencer, IA)

Anticipation had been building as to where the Sioux Falls Veterans Affairs Medical Center would place its new clinic. Several locations in the region were considered, but Director Darwin Goodspeed with the Sioux Falls VA Health Care System announced Thursday a new clinic will be built in Spirit Lake, near the intersection of Highway 9 and Royal Avenue, just west of the Great Lakes Mall.

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3.7 - BeyondChron: [New VA Privatization Threat To Vets](#) (12 October, Suzanne Gordon, 39k online visitors/mo; San Francisco, CA)

On Thursday October 5th, the American Federation of Government Employees (AFGE) the union that represents federal employees, held a briefing on the threat to privatize the Veterans Health Administration (VHA), on Capitol Hill in Washington, D.C. Veterans, VHA caregivers, and policy analysts warned Congressional staff and the media on the cost to veterans if more and more VHA care was outsourced to the private sector.

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3.8 - The Laughlin Nevada Times: [VA clinic expands services](#) (12 October, Jennifer Denevan, 300 online visitors/mo; Bullhead City, AZ)

The MCPO Jesse Dean VA Clinic is getting some help in providing services to local veterans. The clinic will be expanding services via telemedicine to help ensure veterans are getting the care they need. Some services were recently expanded and more times offered and more services are coming at the end of the year. The big difference comes in expanding the number of slots available for care to be given.

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3.9 - Northeastern Public Radio: [Young Meets With VA Officials To Discuss Veteran Wait Times](#) (12 October, Jill Sheridan, 900 online visitors/day; Fort Wayne, IN)

U.S. Sen. Todd Young (R-Ind.) met with federal Veterans Administration officials to discuss the long waits many veterans face to have claims processed, and says he wants to work directly with the office to make significant changes. Young says the amount of time veterans have to wait for a claim to be processed is around two years and appeals take even longer.

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[4. Women Veterans](#)

ABC News: [Women vets pose for pin-up calendar to raise money for fellow vets' health care](#) (12 October, Joi-Marie McKenzie, 24.1M online visitors/mo; New York, NY)

The calendar, which serves as a fundraiser to help veterans' hospitals and health care programs, was started in 2006 by Gina Elise. Her grandfather served in World War II. "At the time, there were many stories in the news about our troops coming back from Iraq, needing medical care that I felt so strongly that I wanted to do something to support our troops and veterans," she told ABC News.

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[5. Appeals Modernization – No Coverage](#)

[6. Strategic Partnerships](#)

6.1 - Lake County News-Sun: [Durbin: Lovell Center ideal 'test case' for sharing health records between VA, active-duty personnel](#) (12 October, Yadira Sanchez Olson, 41k online visitors/mo; Chicago, IL)

U.S. Sen. Dick Durbin met with physicians of the Captain James A. Lovell Federal Health Care Center Thursday to hear what challenges they face while caring for the nearly 67,000 veterans and active-duty military men and women, along with the families of active-duty personnel. Although his visit to the North Chicago facility was brief, physicians quickly conveyed to Durbin the need for the facility to streamline its technology systems...

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7. Supply Chain Modernization

7.1 - Stars and Stripes: BRAC for VA: Lawmakers search for ways to reduce the number of VA facilities (12 October, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

The House Committee on Veterans' Affairs on Thursday initiated what could be a long and politically arduous process to get rid of aging and underused Department of Veterans Affairs facilities nationwide. Committee Chairman Rep. Phil Roe, R-Tenn., and Rep. Tim Walz, D-Minn., the ranking Democrat, presented a draft bill that would create an 11-member, paid commission to recommend which facilities to close and where the VA should invest.

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7.2 - Government Executive: Lawmakers Debate Bringing BRAC to VA Health Care Facilities (12 October, Eric Katz, 852k online visitors/mo; Washington, DC)

House lawmakers are pushing for the Veterans Affairs Department to go through a process to close down or realign underutilized medical facilities, similar to the Base Realignment and Closure process at the Defense Department. The measure would require the VA secretary to assess the department's current capacity to provide health care in each of its networks and ultimately recommend facilities to close, modernize or realign.

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8. Other

8.1 - Stars and Stripes: Lawmakers consider pushing VA to sell Pershing Hall, its 5-star Paris hotel (12 October, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

There's an effort underway in Congress to have the Department of Veterans Affairs sell an 18th century building it owns in Paris that's leased as a five-star boutique hotel and spa. Members of the House Committee on Veterans' Affairs voiced support Thursday for a bill authorizing the sale of Pershing Hall, which was established as a World War I memorial by the American Legion in 1928 and transferred to the VA in 1991.

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1. Top Stories

1.1 - USA Today (Video): [VA vows changes on bad health care providers, lawmakers take action after USA TODAY investigation](#) (12 October, Donovan Slack, 37M online visitors/mo; McLean, VA)

WASHINGTON — The Department of Veterans Affairs is pledging to overhaul its reporting policies for bad medical workers and a group of lawmakers is introducing legislation following a USA TODAY investigation that found the VA has routinely concealed shoddy care and staff mistakes.

VA Secretary David Shulkin directed agency officials to expand a nearly 30-year-old policy that limited what medical providers the agency would report to a national database created by Congress to prevent problem medical workers from crossing state lines to escape their pasts and keep practicing.

The agency will report all clinicians going forward, VA Press Secretary Curt Cashour said. Shulkin also asked staff to re-write 12-year-old guidelines for reporting them to state licensing boards in an effort to speed up the process.

“Under Secretary Shulkin, VA’s new direction is to hold employees accountable and to be transparent with our findings and actions,” Cashour said.

The legislation from Rep. Cathy McMorris Rogers, R-Wash., Rep. Phil Roe, R-Tenn., and Rep. Bruce Poliquin, R-Maine, would require VA doctors themselves to report directly to state licensing boards within five days of witnessing unacceptable behavior from fellow doctors.

“These newest reports out of the VA are deeply troubling,” McMorris Rodgers said. “This bill will help reform the culture at the VA by holding bad actors accountable and keeping them from continuing these mistakes at the VA or elsewhere.”

The USA TODAY investigation found the VA has frequently failed to ensure its hospitals reported problem health care providers to state licensing boards. Such reports can be delayed by years. The investigation also found the VA policy on reporting to the national database left out thousands of providers. The agency previously reported only physicians and dentists — no nurses, physicians’ assistants, or podiatrists.

The VA determined one podiatrist at its hospital in Maine harmed 88 veterans, including a woman who after two failed ankle surgeries chose to have her leg amputated rather than endure the pain. Still, the agency didn’t report the foot doctor to the database under its previous policy, and took two years to report him to state licensing boards.

In other cases, USA TODAY found VA hospitals signed secret settlement deals with dozens of doctors, nurses and other health care workers that included promises to conceal serious mistakes — from inappropriate relationships and breakdowns in supervision to dangerous medical errors — even after forcing them out of the VA.

Roe, chairman of the House Veterans Affairs Committee, said the committee has “long been concerned about VA’s settlement agreements, and even held a hearing on the topic last year.”

“The findings of the USA TODAY investigation are intolerable,” he said. “Malfeasance within the department will not be ignored, and it certainly cannot be rewarded and hidden from state licensing boards. As a physician, I find this deeply troubling.”

In response to USA TODAY’s findings, Shulkin directed that any future settlement agreements worth more than \$5,000 be approved by top VA officials in Washington. Previously, local and regional officials made decisions on the deals, which can cut short potentially costly employee challenges of VA disciplinary actions.

On Wednesday, the agency also said it planned to post publicly for the first time data on settlements that are approved. The first tranche of data shows that since President Trump took office in January, the VA has struck agreements with at least 160 employees involving payouts totaling \$4.2 million.

Poliquin said Thursday that USA TODAY’s findings were “appalling” and singled out the revelations about the podiatrist at the Togus VA hospital on the outskirts of Augusta, Maine.

“Our Maine veterans depend on their services at Togus and other VA facilities across our State for critical care, and it is absolutely unacceptable for them to ever be subjected to this kind of medical malpractice,” he said.

At least six patients of the podiatrist, Thomas Franchini, are suing the federal government over the care they received. Despite the VA taking years to tell patients about its findings on his surgeries, the government has argued their claims should be dismissed because they were filed after the three-year deadline for medical negligence claims in Maine. Oral arguments in the case are scheduled October 25.

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1.2 - U.S. News & World Report (AP): [Congress OKs Expanded Protections for Federal Whistleblowers](#) (12 October, Hope Yen, 24M online visitors/mo; Washington, DC)

WASHINGTON (AP) — Congress voted Thursday to boost the protection of federal whistleblowers from retaliation, part of a bid to uncover bad behavior at the Department of Veterans Affairs and other government agencies.

The House easily cleared the bill, 420-0. It now goes to President Donald Trump for his signature, having previously passed the Senate in May.

The measure would extend whistleblower protections to federal employees who are in probationary periods and provide training to ensure workers know their rights. It also establishes minimum disciplinary standards for supervisors who retaliate against employees for seeking to disclose wrongdoing.

The legislation, introduced by Sen. Ron Johnson, R-Wis., is named after Dr. Chris Kirkpatrick, a psychologist at the VA Medical Center in Tomah, Wisconsin. Kirkpatrick committed suicide in 2009 on the day he was fired by VA for questioning the over-medication of veterans. A VA investigation later found Kirkpatrick’s concerns had been warranted.

House Speaker Paul Ryan, R-Wis., said the legislation provides much-needed protections to whistleblowers. "No one who stands up for our veterans should be marginalized, let alone targeted and fired," he said.

The bill also would require the VA to put together a plan within six months to prevent supervisors from improperly accessing an employee's medical files in retaliation.

VA Secretary David Shulkin has pledged to bring greater accountability to the government's second largest agency, which provides medical care to millions of veterans. In July, Shulkin began posting employee disciplinary actions and announced that he would require approval by a senior official of any settlement with a VA employee over the amount of \$5,000, citing unnecessary payments to bad employees. A month later, he ordered a review to expand VA reporting requirements for bad workers.

During the 2016 campaign, Trump described the VA as the "most corrupt," promising to "protect and promote honest employees" at VA who expose wrongdoing.

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1.3 - U.S. News & World Report (AP): [Ex-Head of Tomah VA Allowed to Resign, Given Settlement](#) (12 October, 24M online visitors/mo; Washington, DC)

TOMAH, Wis. (AP) — The former head of the Tomah VA Medical Center was allowed to resign and given a settlement after allegations that painkillers were being overprescribed to patients.

Mario DeSanctis was fired from the hospital in 2015. But a USA Today investigation found he fought his dismissal and reached a deal in which he was allowed to resign. He and his attorney were paid \$163,000.

The Tomah VA hospital was rocked in January 2015 by reports of inappropriate dosages of narcotic pain killers and retaliation against employees who questioned the practice.

DeSanctis did not return a phone message left by The Associated Press on Thursday.

Jason Simcakoski was a Marine who died in 2014 from a fatal combination of drugs. His widow, Heather Simcakoski, told the La Crosse Tribune the settlement was "really disappointing."

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1.4 - Reuters: [Virtual interviewer prods veterans to reveal post-traumatic stress](#) (12 October, Ronnie Cohen, 43.6M online visitors/mo; New York, NY)

Talking – to a computer-generated interviewer named Ellie – appears to free soldiers and veterans who served in war zones to disclose symptoms of post-traumatic stress, a new study finds.

Warriors and veterans were up to three times more likely to reveal symptoms of post-traumatic stress to Ellie, the virtual chatbot, than on an official military survey called the post-deployment health assessment (PDHA), even after being assured the assessment would remain anonymous, researchers report in *Frontiers in Robotics and AI*.

“We believe this could be of value to veterans,” said study leader Gale Lucas, a research psychologist at the University of Southern California’s Institute for Creative Technologies in Los Angeles. “Having a conversation, even if it’s with a computer, would help them open up and really realize they might be having some issues.”

Recognizing psychological battle wounds is a necessary first step toward healing them.

As many as one in five recent combat veterans develops post-traumatic stress disorder (PTSD), an overactive fear memory that triggers disturbing thoughts, feelings and dreams, according to the U.S. Department of Veterans Affairs.

Stigma around mental health problems frequently prevents soldiers and veterans from admitting symptoms or seeking help, Lucas said in a phone interview.

“Allowing PTSD to go untreated can potentially have disastrous consequences, including suicide attempts,” she said.

Since 2004, suicide rates among active U.S. Army personnel have been rising, but the military’s current PDHA assessment identifies only one in seven soldiers who are considering suicide, previous research has shown.

In an effort to identify early signs of psychological scars, Lucas would like for Ellie, who was developed with U.S. Department of Defense grant money, to be available in kiosks set up in Veterans Administration hospitals throughout the nation.

Ellie starts the conversation with simple questions, such as, ‘Where are you from originally?’ and ‘What do you like to do to relax?’ to develop rapport with soldiers and veterans, Lucas said. Then she asks if they have nightmares, feel on guard or experience other telltale signs of PTSD.

“She’s very nonjudgmental, supportive,” Lucas said.

“We’re not trying to make virtual-agent therapists. She’s not giving treatment. All she’s doing is having a conversation, having them think and open up about the mental health symptoms they might have,” she said.

Prior research has shown that establishing rapport and ensuring anonymity are key to war veterans’ admitting that they are experiencing emotional wounds.

But veterans are hesitant to discuss their psychological suffering with other people, Lucas said.

“If they are talking to a human, they feel judged,” she said. “People feel more comfortable opening up to a computer than a human.”

In two studies, Lucas and her team found that Ellie’s questions prompted soldiers and veterans to open up and reveal more of their mental health needs.

In the first, researchers tested 29 active-duty Colorado National Guard service members returning from Afghanistan.

One of every four service members reported post-traumatic stress symptoms on the official PDHA, and one of three reported symptoms when the questionnaire was made anonymous. In conversations with Ellie, far more – three of four – reported symptoms.

In a second study of 132 active-duty service members and veterans, participants were more than twice as likely to report PTSD symptoms to Ellie than on an anonymous survey.

Alan Peterson, a clinical psychologist and professor at the University of Texas Health Science Center in San Antonio, said fear that service members could lose their jobs often impedes their reporting of psychological symptoms.

“In reality, there can be negative career consequences associated with reporting certain symptoms and behaviors,” said Peterson, who was not involved with the study. “This can be especially true for individuals seeking treatment for conditions such as PTSD, if they are not successfully treated into remission and subsequently determined to be fully fit for military duty.”

Making successful treatments available to soldiers would go a long way to reducing the stigma of seeking psychological help, he said.

“Veterans go through a lot for our country, and I really believe that we should take care of them, not just their physical scars, but their mental scars,” Lucas said.

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1.5 - The Washington Post: [Virginia lawmakers say late VA payments jeopardize veterans' care](#) (12 October, Jenna Portnoy, 43.9M online visitors/mo; Washington, DC)

Members of Congress from Virginia say chronic late payments from the Department of Veterans Affairs to doctors are jeopardizing care for the state's aging veteran population.

The state's two senators and 11 House members urged VA administrators to fix a system that can leave health-care providers waiting more than four months for payments they should have received within 30 days. The delays can damage credit, they said.

Congress created the Veterans Choice program in 2014 in response to a scandal exposing excessively long wait times at a Phoenix VA hospital that also had been a problem nationwide.

The program is intended to relieve pressure on VA hospitals by allowing veterans to receive care from private providers if they cannot book an appointment at their local VA facility within 30 days or access a facility within 40 miles of their home.

Since its inception, Veterans Choice has been hobbled by administrative errors, including tens of millions of dollars in overpayments, according to findings of the VA Office of the Inspector General.

“With many health care providers reporting accounts receivable in the millions of dollars, the level of late payments is unacceptable,” the Virginia delegation wrote in an Oct. 3 letter to Secretary of Veterans Affairs David Shulkin.

Rep. Rob Wittman (R-Va.) said Congress requires VA to pay bills in a timely manner.

“Everyone else in society has to do that,” he said in an interview. “If this program is going to work properly, then these bills need to be paid on time.”

Wittman, chairman of the House Armed Services subcommittee on sea power and projection forces, said he has talked to the committee chairman, Rep. Phil Roe (R-Tenn.), about calling Shulkin to testify if VA doesn’t reconcile outstanding bills soon. Virginia is home to 733,000 veterans.

“This is the law,” he said. “This is what you’re supposed to be doing. Why isn’t it getting done?”

VA spokeswoman Paula Paige said in a statement, “VA appreciates the lawmakers’ concerns and will respond to them directly.”

She referred specific questions to a May speech by Shulkin in which he said it takes more than 30 days to process 20 percent of VA claims from 25,000 providers nationwide. An additional \$50 million in charges are older than six months. He blamed the backlog in part on paperwork delays.

The latest stories and details on the 2017 Virginia general election and race for governor. Community care is handled through several federal programs, making it “too complex, and it’s confusing veterans and our employees alike,” he said.

Riverside Health System in eastern Virginia reported that 45 percent of claims totaling \$2 million went unpaid for more than 120 days. Private insurance companies as well as Medicare and Medicaid take about 60 days, said Mark Duncan, Riverside’s lobbyist.

Riverside considers it an honor to care for veterans, but “we need to have the tools the resources to provide that type of service to these folks over the long term,” Duncan said in an interview. “They’ve more than earned that service.”

The letter details a case relayed by the office of Rep. Barbara Comstock (R), who represents Northern Virginia, in which a veteran was denied dentures because VA failed to pay a private provider \$203,000. Comstock’s spokesman said the case has been resolved.

Veterans Choice allows veterans to avoid inconvenient travel to VA facilities in Martinsburg, W.Va., or the District, but VA “must get its house in order,” Comstock said in a statement.

In August, Congress approved \$2.1 billion in emergency funding intended to shore up the program until February.

Last month, Sen. John McCain (R-Ariz.), chairman of the Senate Armed Services Committee, wrote a letter to Shulkin demanding a full accounting of Veterans Choice spending after the Associated Press reported that the program could face another shortfall before the end of the year.

“We said at the time that it was essential, given the growing demand for care under the Choice program, that the VA immediately correct the failures that created such a serious shortfall,” McCain wrote. “It appears as if you have not done so.”

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1.6 - The Washington Post: [‘This is frightening’: Noxious gas has sickened VA workers for two years, with few solutions](#) (12 October, Alex Horton, 43.9M online visitors/mo; Washington, DC)

Staff and patients at a D.C. medical facility for homeless military veterans have endured noxious gas exposure for nearly two years as top hospital administrators, though aware of the problem, have failed to remedy it, according to interviews with staff and documents obtained by The Washington Post.

At least eight clinical workers at the Department of Veterans Affairs Community Resource and Referral Center have tested positive for elevated levels of carbon monoxide, a March internal email said, describing a potentially dangerous condition that restricts oxygen circulation. As many as 30 employees, desperate to avoid further exposure, have sought reassignment or permission to work remotely.

One doctor resigned in protest after VA leaders were unable to produce solutions, clinic staffers said.

“Many of my colleagues, including myself, have experienced some type of illness while working in the CRRC,” one staffer wrote in an August email responding to a VA health official who appeared to play down symptoms of concerned workers. The most recent incident was Oct. 4, staffers said.

The Post reviewed dozens of emails and records, and conducted numerous interviews with clinical workers and others familiar with the problem. What emerged is an unsettling glimpse of VA’s struggle to mitigate a potentially significant health hazard, and raises questions about the agency’s ability to fulfill the promises it has made to improve accountability. The troubled agency was identified early on by President Trump as being in dire need of sweeping reform.

VA spokesman Curt Cashour said the hospital’s leadership “took aggressive steps to look into the problem” once complaints began to circulate. Tests conducted by VA health officials and the local fire department and gas company, among others, “discovered no leaks, hazardous fumes or health risks,” he said, adding that officials continue to monitor the situation.

But those who work at the facility say those tests may not have been performed quickly enough, before the gas dissipated, or if the contractors brought in to conduct them knew which gases to evaluate.

On a given day, the facility is staffed with about 40 employees who serve dozens of patients, all homeless and at-risk veterans who seek care at the clinic. The incidents — numbering in the dozens since winter 2015 — have occurred intermittently and without warning.

Though it remains unclear what's causing the issue, the clinic's staff members have speculated that it could be anything from vehicle exhaust entering the building's heating system intake valves to sewer gas surfacing through sinks and drains. They've reported a range of symptoms, including intense headaches, rashes, stinging eyes, nausea and others — all of which are consistent with sewer gas exposure, as defined by the Centers for Disease Control and Prevention.

Administrators have not only allowed the problem to fester, they have also ordered clinicians back into the building, staffers say.

"I felt devalued. It was like our health wasn't important and our concerns weren't heard," one staffer told The Post, saying morale cratered among those tasked with what they call a rewarding yet grueling effort to help homeless veterans find housing along with primary and mental health care. Those familiar with the facility's troubles spoke on the condition of anonymity, citing their fear of reprisal.

The Community Resource and Referral Center, off Rhode Island Avenue NE, is part of the Washington DC VA Medical Center, the sprawling federal agency's self-proclaimed "flagship" facility. Its acting director, Lawrence B. Connell, has known about the problems there since June, according to emails exchanged among staff. At least two incidents have occurred since then — with 19 verified in all since late 2015, according to partial records obtained by The Post and data provided by the D.C. fire department.

Local firefighters responded to four such calls between February and November 2016. The last time was Nov. 30. One day later, a clinic safety official notified staff that, in the future, they should refrain from pulling a fire alarm if they encounter "noxious fumes" and to alert Washington Gas instead.

A spokesman for the utility company said no gas leak was found.

Connell "has been briefed regularly on these complaints and has been personally involved in the comprehensive, multipronged response involving respected investigators from both inside and outside VA," said Cashour, VA's spokesman. He was a senior adviser to VA Secretary David Shulkin before becoming the medical center's acting director this past summer. Connell accepted the job after his predecessor, Brian A. Hawkins, was removed after an internal investigation found patients receiving treatment at the facility had been endangered by "the highest levels of chaos" created by managerial ineptitude, a VA inspector general's report concluded.

One months-long email chain exchanged among several clinicians reveals a problem so persistent that it had become banal. "Just wanted everyone to know the gas smell is back," a staffer wrote Feb. 21. Another chimed in nine minutes later: "We smell something also in our area." Two hours later a third staffer wrote, "Haven't smelled it in a couple hours but I do have a bad headache."

Two days later, on Feb. 23, a mental health clinician said she briefed then-director Hawkins on the issue, saying unspecified repairs were made.

Hawkins could not be reached for comment.

On March 30, the emails resumed, when the gas smell returned, and again on May 17, when a social worker reported smelling vehicle exhaust.

Nine days later, after another incident, one staff member wrote, "I can only say this is frightening."

Hawkins was gone by then, but the problem was inherited by his successor.

"I raised the issue with Mr. Connell and the staff . . . this morning again," a senior staffer told colleagues on June 10, a day after yet another incident.

It is unclear how many clinic staffers and veterans have been exposed to the gas or what, if any, permanent afflictions they may carry. Staffers say their symptoms seem to improve when they are away from the clinic. The documents don't indicate anyone's current medical status, including the eight who tested positive for carbon monoxide.

One staffer said the patients are thought to be less at risk because they come for appointments and then leave, though they may not make the connection between potential symptoms and their visit to the clinic.

Staff members, however, can inhale the gas for hours on end.

VA safety officials and senior leaders, discussing the issue internally, say they've tried to resolve the problem. They point to numerous air tests for carbon monoxide, carbon dioxide and other gases as indication of their effort.

Two outdoor pipes were adjusted after some speculated that vehicle exhaust was to blame. Access to a dumpster was blocked. Building contractors even dumped water into drains to flush any sewer gas. An environmental liaison for the building's owner, Lincoln Property Company, acknowledged in December that sewer gas was a contributing factor that had been resolved.

A senior VA official visited Oct. 4, when the most recent gas exposure occurred, but it is unclear whether he experienced the problem firsthand.

Staffers at the clinic point to Todd Williams, one of two acting assistant directors of the main VA hospital who report to Connell, alleging that he too has played down the problem.

On Aug. 12, he said in an email that relocating dumpsters and blocking off two parking spots near an intake pipe would "further mitigate risk associated" with vehicle exhaust circulating in the building. "Given these efforts," he wrote, "do we have a timeline for relocation of providers back to CRRC?"

Cashour declined to address questions about Williams's role in resolving the issue.

Williams does not work at the clinic. Leadership on site has been more sympathetic, staffers say. For instance, a nursing manager advised staff to seek doctor's notes if they feared contact with the gas would adversely impact their health, emails show.

Staffers asked for health officials to conduct an epidemiological analysis of symptoms and exposure rates over time.

VA said they completed assessments and found no link between the clinic and health concerns.

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1.7 - The Denver Post: [Dozens of surgeries at Denver VA hospital put off because of doctor shortage, Too few anesthesiologists and competitive market to blame, VA says](#)
(12 October, David Migoya, 4.8M online visitors/mo; Denver, CO)

A shortage of anesthesiologists at Denver's veterans hospital – despite salary offers reaching as high as \$400,000 a year – has forced a delay in dozens of surgeries just months after the institution was tagged with some of the nation's worst waiting lists for care.

Though the hospital employs eight anesthesiologists and eight nurse anesthetists, they're short of the complement needed to meet surgery demands that run about 380 operations a month, a spokeswoman said, noting some staff has left for other jobs as well as taken paternity and maternity leaves.

"Currently we have had approximately 65 to 90 nonemergent surgeries rescheduled or postponed due to a shortage of anesthesiology staff," VA spokeswoman Kristen Schabert said. She offered no examples.

VA data show the average wait time for new-patient surgical appointments at the facilities that make up the Eastern Colorado Health Care System during the 2017 fiscal year that ended Sept. 30 is about 21.6 days, which is slightly better than the national average of 22.7 days. The average wait time at just the Denver facility is 18.6 days.

VA's waiting time in fiscal 2017 for surgery for established patients is 9.5 days, longer than the national average of 5.8 days, according to the VA. It is 8.3 days at the Denver facility.

The latest situation was first reported by FOX-31 News, and it's an extension of a problem that's plagued the Denver facility since the summer.

In July, The Denver Post reported that wait times for primary care medical appointments at veterans facilities in eastern Colorado and the Denver area were among the worst in the nation, and that Front Range veterans have seen little improvement in the three years since a national scandal erupted over the problem.

Colorado congressmen assailed the agency for its continued — and worsening — issues over veteran care, especially after the VA battled other controversies such as the massive delays and cost overruns in constructing a new \$1.7 billion facility in Aurora, which is expected to open in the spring.

Officials of VA's Eastern Colorado Health Care System at the time said critical shortages in medical personnel – including the doctors and nurses that are at the root of the surgery delays faced today – made it difficult to keep up with the growing demand Colorado has seen from an increasing veteran population.

Sometimes, chief of staff Dr. Ellen Mangione said, veterans would rather wait for a familiar face at the VA than be seen more immediately by a doctor outside the system, even when given the choice to do so.

The eastern system had a 16 percent vacancy rate — there were 336 physicians — during the summer crisis, even though it was offering some primary care doctors as much as \$200,000 a year in salary and additional training. Schabert did not immediately have current vacancy figures.

“Our leadership has been supportive and we were able to up our salary offerings to remain competitive,” Schabert said of the search for anesthesiology professionals, “but ... Denver is a competitive market.”

Until hires are made, the eastern system is contracting with temporary outside physicians, known as a “locum,” to fill the gaps, Schabert said.

And the eastern system is no longer among the nation’s worst waiting periods for an appointment to see a primary care physician, VA data show, although it still ranks high with an 11-day average compared with a 4.8-day national average.

It’s been replaced by the VA health care system in Grand Junction, where the average wait for a primary care visit is 18 days, data show. That system is nearly one-tenth the size of Denver’s.

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1.8 - Military Times: [Lawmakers take first steps toward a BRAC for VA facilities](#) (12 October, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

WASHINGTON — House lawmakers took the first steps Thursday toward shutting down hundreds of Veterans Affairs facilities through a process similar to military base closure rounds, saying the move is critical to keep the department from wasting millions of dollars on underused, aging buildings.

But some of the largest veterans groups said they have serious concerns with the proposal, saying it’s ripe for abuse and could tempt VA officials to outsource more veterans’ medical care to private-sector physicians.

Even supporters admitted the plan will be a difficult sell on Capitol Hill.

“This bill is bold, transformative and controversial,” said Rep. Phil Roe, R-Tenn., chairman of the House Veterans’ Affairs Committee. “Moving forward with it will require a significant amount of political courage and, let’s face it, members of Congress are not known for that.”

At issue are the roughly 6,300 facilities owned VA spread across the country. Department officials have said more than 57 percent of those locations are more than 50 years old, and hundreds of others provide little value to veterans care or department management.

VA Secretary David Shulkin in June announced plans to close at least 430 vacant or mostly vacant buildings over the next year, a move that is expected to save about \$7 million annually.

But he also has pushed for further authorities to close other locations, to better match department resources with future needs.

The VA base-closure-style plan — dubbed the Asset and Infrastructure Review Commission — would establish an eleven-member outside panel to recommend facility closings and resource shifts based on facility needs criteria to be established by the VA secretary.

That would involve an in-depth review of VA real estate and health care strategies, complete with public hearings. The final commission recommendations would need to be approved by the president. Congress would have 45 days to override the White House decision if they disagree with the planned closings and moves.

Much like the military base closing commissions, the set-up is designed to separate facility closing choices from political whims. Roe and committee ranking member Rep. Tim Walz, D-Minn., said the commission could also recommend setting up new facilities in underserved areas, using savings from other closings to pay for the new sites.

But veterans groups who testified before Roe's committee on Thursday said they have serious concerns that an outside panel could focus on savings instead of seeking the best care options for veterans, creating major problems for a system already dealing with wait time and access challenges.

Carl Blake, associate executive director at Paralyzed Veterans of America, said his group could support the idea "assuming the intent is to right-size the VA and not simply use this opportunity to reduce the footprint of VA for the purpose of fulfilling a promise for greater community care access and cutting spending."

Officials from Disabled American Veterans said they support a full review of the department's national footprint but aren't convinced the base-closing commission is the right path for that discussion. Officials from the American Legion said their group would not support the plan unless veterans groups had the opportunity to veto recommendations they deem harmful to veterans care.

But even without those concerns, any federal facility closing process faces a difficult path in Congress. Defense Department officials have been petitioning lawmakers for five years to hold another military base closing round, only to have the proposal rebuffed annually.

Government Accountability Office researchers said the last five BRAC rounds have produced nearly \$12 billion in annual federal savings. But the last round conducted in 2005 still has not recouped its original costs, which has lead many in Congress to question the value of such cutbacks.

Roe insisted this plan is different, because the focus isn't on generating savings but instead better preparing the department to respond to veterans needs. The proposal for now is only draft legislation, but he said he hopes to move forward on the issue in coming weeks.

Veterans groups said they would continue to work on the issue with lawmakers but emphasized their skepticism.

Acting VA Deputy Under Secretary for Health for Policy Regan Crump said department officials are not backing the idea of an outside asset commission yet, but do support “the need for more flexibility” with VA facilities.

As the congressional debate continues, VA officials are reviewing another 784 non-vacant but underused facilities to determine if they can close or restructure them in coming months.

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1.9 - Stars and Stripes (Military Update): [VA, Congress crawl toward ending abuse of vet pensioners](#) (12 October, Tom Philpott, 1.5M online visitors/mo; Washington, DC)

In 2012, the Government Accountability Office found more than 200 financial planning firms and estate law offices enticing veterans or their survivors into costly annuities or irrevocable trusts intended to hide or reallocate their assets so they qualify for VA pensions that the claimants wouldn't be eligible for otherwise.

Since then, the Department of Veterans Affairs and Congress have been crawling toward actions to stop the abusive practices, which twist the intent of the pension benefit in ways to help some veterans, put others in financial binds, and generate fees or profits or streams of residents for the schemers.

The crawl toward reform continues. The VA is still working on a draft rule first released for public comment in January 2015. Final publication of the “Net Worth, Asset Transfers and Income Exclusions for Needs-Based Benefits” rule was expected this past summer. However, it remains “in VA’s internal concurrence process,” a VA spokesman said Wednesday.

Meanwhile, the House veterans’ affairs subcommittee on disability assistance and memorial affairs held a first-ever hearing last month on legislation to address financial abuses of the pension program. The Veterans Care Financial Protection Act (now HR 3122) was first introduced in 2014.

The VA pension program exists to help veterans in financial distress if they served at least a day of wartime service, at least 90 consecutive days on active duty and earned an honorable or a general discharge. To be eligible for the basic VA pension, veterans also must have only modest annual incomes or none at all.

They can qualify for more VA financial help, however, if they are disabled and unable to leave their homes unassisted, or they have unmet daily living needs or they face exorbitant medical, assisted care or nursing home costs. The additional financial help is called the VA Aid and Attendance benefit.

“It’s an absolute lifeline for veterans who have significant health problems,” John Katz, the American Legion’s assistant director for pensions at the VA regional office in Philadelphia, told me late last year. “Many people who laid their lives on the line for their country are incapable today of taking care of themselves without housebound benefits or Aid and Attendance, in addition to the nonservice-connected [VA] pension. For them there’s no other way they’d survive.”

About 303,000 wartime veterans and 220,000 survivors draw VA pension benefits. Veteran advocates believe thousands more would qualify if they knew the program existed and applied. What has raised the profile of pensions recently, however, have been the reports of abuse and target marketing by unscrupulous financial planners, lawyers or even care facilities seeking vets who are ill or elderly.

The pension is a needs-based benefit with need determined using thresholds on annual incomes and on assets or net worth. For example, a wartime vet with no dependents can qualify for all or a portion of the basic pension benefit if he or she has income, including Social Security, less than \$12,907 annually. If income is \$10,000, for example, the benefit would be calculated by the maximum annual pension rate of \$12,907 minus \$10,000, for a total of \$2,907 annually.

However, the pension benefit is unique in that it allows veterans to apply medical expenses to offset income calculations and raise the benefit. Even higher amounts are payable if the veteran or surviving spouse is housebound, and more Aid and Attendance dollars are available if claimants need help with daily activities.

A married veteran needing Aid and Attendance can qualify for at least some pension monthly if his or her income doesn't exceed \$25,525. A survivor's pension is smaller but also based on need with consideration too of medical expenses.

The other threshold to determine eligibility is net worth. If assets other than primary residence and vehicle exceed \$80,000, then VA can't assume eligibility without a closer determination. Again, medical-related expenses can be critical. For example, if a veteran with assets totaling \$100,000 moves into an assisted-living facility that costs \$5,000 a month, a VA service officer could determine the asset threshold quickly will be reached and can find the veteran eligible for pension.

Veterans and survivors who believe they might qualify should contact the veterans' service office for their county to fill out required forms. More program information can be found online at: benefits.va.gov/PENSION/index.asp.

A key purpose of regulatory reforms aimed at VA pension benefits is to ensure they are used by low-income veterans or those facing exorbitant medical expenses they can't pay, rather than as a tool to preserve family wealth.

One provision in VA's draft rule would impose a three-year look-back provision on assets to discourage new claimants from hiding assets. Other changes would reset the asset ceiling to the higher and "brighter line" used by Medicaid, and more clearly define medical expenses that can reduce income calculations. The new rule would not leave the threshold on assets open to interpretation as it is now.

Legislative reforms, which show signs of life, take a different approach. As Rep. Matthew Cartwright, D-Pa., testified last month on behalf of his bill, HR 3122, his measure would direct the VA and other federal agencies to work with state officials and outside experts to establish state and federal standards to end "dishonest, predatory or otherwise unlawful practices" that target VA aid and attendance dollars.

"Unscrupulous actors are increasingly exploiting this assistance program by preying on our older veterans' vulnerability," to waste federal dollars and turn "this well-deserved benefit into a financial nightmare for those who can least afford it," said Cartwright.

Some charge veterans “a non-existent application fee to obtain the benefit,” he added. Others collect “consultation fees” with “promises to expedite the application process. Yet another scam is an offer to help veterans qualify for the benefit even when their net worth is too high to qualify.”

In this way, Cartwright explained, financial planners gain control of the veteran’s assets and “move them into an irrevocable trust or annuity, which the elderly veterans often cannot access for many years.”

Increasingly, he said, retirement homes are recruiting veteran residents with promises that they will qualify for VA aid and attendance to cover cost of the home.

“If the A&A claim is later denied, however, the nursing home then demands back payment from the veteran. This is a practice that leaves vulnerable elderly veterans with the undesirable choice of draining their own remaining assets or giving up their new home,” Cartwright said.

He first introduced his bill on learning of companion legislation in the Senate (now S. 1198) from Sen. Elizabeth Warren, D-Mass. The bill now has bipartisan support in the subcommittee. Witnesses for VA and veteran service organizations expressed support. Cartwright promised some changes to reflect concerns from the GAO that it shouldn’t be given a role in establishing the new protection standards given its existing responsibilities for reviewing how the standards are implemented.

With no costs attached, the bill is expected to clear the subcommittee this fall. Full committee action and passage by the House isn’t expected this year.

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1.10 - Public Radio International (Audio): [Meet the women combing through Puerto Rico, searching for veterans in need](#) (12 October, Jasmine Garsd, 1.2M online visitors/mo; Minneapolis, MN)

It’s early in the morning, and the entire city of San Juan, Puerto Rico, seems to be gazing at the sky with concern. It looks like rain but the island just can’t handle any more flooding.

On the highway, under the dark, heavy clouds, a small car makes its way through traffic. In it are four women, Ghislaine Rivera, Mia Lind, Janine Smalley and Katie Blanker, with whom I’m spending the day — it’s Oct. 5.

Our first stop? A school that’s been turned into a hurricane shelter.

Lind, an occupational therapist for the VA Caribbean Healthcare System in San Juan, goes to the door, asking, “Are there any veterans here?”

Every day since the hurricane hit, she and her team have been roaming from shelter to shelter, looking for veterans who need medical attention.

There are somewhere around 75,000 US Army veterans living in Puerto Rico. Most served during the Vietnam War. After Hurricane Maria, many are now living in shelters. Thousands, overall, have been displaced by the storm, and the shelters are packed.

At the school, a supervisor answers: Yes, there's a veteran here.

The VA team finds 70-year-old Luis Torres lying in bed. His dress shirt is wide open and his baseball cap is flipped backward. His bed is surrounded by piles of clothing and some bags of food.

The Air Force veteran was honorably discharged; he has his military ID, but the other paperwork was lost in the storm. "My house ... it disappeared," he says, breaking down in tears.

His teenage son, Andrew Torres, who is also staying here, pulls out his phone to show us pictures of what's left of their house. It's like the roof and the walls were just plucked out. On the second floor, a toilet stands alone in the open.

Janine Smalley takes Luis Torres's vitals. His blood pressure is 130 over 80, so that's "perfect," she says, asking, "Do you take any meds?" Smalley is the VA team's registered nurse and Disaster Emergency Medical Personnel trained by the Federal Emergency Management Agency. She's here from Cleveland, Ohio. She volunteered to come help. She says when she saw what was happening in Puerto Rico, she asked to be sent here.

Meanwhile, Katie Blanker, who also volunteered for this assignment, brings Torres toothbrushes, heating pads and food. Blanker is from Stevens Point, Wisconsin. She's a social worker with the VA and a veteran herself.

Katie Blanker is working in Puerto Rico as a social worker with the VA. She's also a veteran. She's originally from Stevens Point, Wisconsin. Credit: Jasmine Garsd/PRI
Torres cheers up. "Where's the T-bone steak?" he jokes. At least for a few minutes, the mood has lightened up.

Lind says that she, too, had been thinking about steak, just the day before. There is a meat shortage on the island. "I really want to have a meal for my kids that includes beef. That was my goal. To get my kids not canned food. When you have chaos like this, the only right you have is to stay alive. You stay alive, and you survive," she says.

Lind fights back tears. The others from her team hug her. Then she smiles and announces the next neighborhood they're heading to: "Let's go to Rio Grande!"

Let's go "before we're all crying. I was hoping to wait till noon to cry again," Smalley says.

The next shelter is even more packed than the last one.

"May we come in and ask if anyone is a vet?" Lind asks.

A man says there aren't any vets there.

Lind asks the man how he knows.

The man bristles, saying, "I can't force them to talk to you."

Lind thanks him, and the team leaves. Later on, in the parking lot, Lind tells me she suspects some shelters just don't want the VA team coming in. She and her colleagues represent the federal government. And they have to report it if a hurricane shelter isn't providing enough food and water. Or if it's overcrowded.

A lot of these shelters are just repurposed schools, places for people to lie down and rest, with no running water or electricity. This is the new normal. Which is why the last shelter we go to takes us a little by surprise.

The team walks right in. There's a radio blasting pop music. There are kids painting murals. And then there's Benny Molina.

The residents cheer his name as he sits down for a checkup by nurse Smalley. Molina, 61, is a veteran — "National Guard in Riverdale, New Jersey. Specialized in tanks. Driving the tanks," he says.

"Benny that's perfect!" interrupts Smalley. Benny's blood pressure is normal. He jokingly offers to do pushups — in a while — he just had a big meal. The room erupts in laughter.

Ghislaine Rivera, a social worker, asks him what happened to his home. It's gone. Benny lost everything he owned to the storm. The team offers to give him aid packages, with basic supplies, but he refuses. "Right now, we have food and everything ... but some other people are sleeping on the street and they have nothing to eat."

As he fills out his paperwork, Smalley and Blanker take a quick break in the shade. They are red from the heat and visibly tired. They've come a long way, from Ohio and Wisconsin. But, they say, this is a responsibility they have. All of us do.

"We don't know them all, but we owe them all," says Smalley.

"All of the veterans we're here for served for the United States," says Blanker. "This is Americans helping Americans. These veterans were stationed in the US, went to war with the US. I think that's the thing that people forget."

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2. Veteran and Employee Experience

2.1 - The Washington Post (PowerPost, Video): [House to vote on bill requiring discipline for officials who retaliate against whistleblowers](#) (12 October, Eric Yoder, 43.9M online visitors/mo; Washington, DC)

Federal agencies would be required to discipline officials who retaliate against whistleblowing employees, and to fire them on their second offense, under a bill up for a House vote Thursday.

The bill, approved by the Senate in May, is one of many arising from the disclosures starting in 2014 of falsified patient records at the Department of Veterans Affairs. The revelations drew a surge of complaints from lower-level employees who said they had suffered workplace reprisal

from managers for pointing out the problems and that managers were not being held accountable for violating the legal protections for whistleblowers.

“While retaliation at the VA has captured the public’s attention most recently, retaliation against whistleblowers is not confined to any one agency,” a Senate report on the bill says, adding that mandatory discipline is designed to “ensure accountability throughout the Federal Government.”

The bill would require at least a three-day suspension of a federal official found to have committed retaliation by an internal government legal process or by a federal judge and firing for a second offense. The time to contest a notice of proposed discipline would be shortened from 30 to 14 days, but once the firing became final, regular appeal rights would apply.

Congress last year enacted a similar requirement applying only to VA officials who retaliate against employees who disclose fraud, waste or misconduct, with at least a 12-day suspension for a first offense and firing for a second. This year, a law shortening and restricting appeal rights for VA employees was enacted, and on Wednesday the House passed a measure somewhat widening whistleblower protections.

The measure requiring firing for retaliation would create an exception to the general rule that agencies have wide discretion over disciplining their employees. Currently, mandatory firing also applies at the Internal Revenue Service under a long-standing policy known as the “10 deadly sins” involving abuse of authority.

The George W. Bush administration attempted to impose mandatory discipline for certain types of misconduct as part of alternative personnel policies at the departments of Defense and Homeland Security, but neither took effect in the face of lawsuits and opposition from Congress.

Also, under the latest bill, agencies would have to give priority to a request for a transfer on behalf of an employee — including one still in a probationary period — who alleges retaliation; it would be an act of retaliation for an agency official to access the employee’s medical records following a disclosure; and more training on whistleblower rights would be required for new employees and for supervisors.

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2.2 - U.S. News & World Report (AP): [Alaska Veterans Affairs System to Add 100 Staff Members](#) (13 October, 24M online visitors/mo; Washington, DC)

ANCHORAGE, Alaska (AP) — The Alaska Veterans Affairs system has announced it's adding 100 staff members.

KTVA-TV reported Wednesday that Dr. Timothy Ballard said the staff is being added in response to negative reviews from both patients and staff.

Ballard said the new positions are focused on mental health care and support functions. The 100 new jobs boost the system's number of staff to 650 at a cost of \$6 million.

Ballard said money to pay the new workers is being repurposed from other places in the budget.

He said the system is also increasing the speed at which it fills vacancies, bringing the wait time down from six months to six weeks.

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2.3 - Atlanta Journal-Constitution: [Roswell getting \\$21K for veterans adaptive sports](#) (12 October, David Ibata, 11.9M online visitors/mo; Atlanta, GA)

Roswell has agreed to accept \$21,080 from the federal government to purchase equipment and hire instructors for new VA Wheelchair Softball and Adaptive Cycling programs for disabled veterans.

The City Council approved a resolution accepting the FY 201 Adaptive Sports Grant from the U.S. Department of Veterans Affairs. The grant does not require local matching funds, according to a staff report to the council.

The Roswell Recreation, Parks, Historic and Cultural Affairs Department will be responsible for the adaptive sports program.

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2.4 - The Hill: [New whistleblower protections head to Trump's desk](#) (12 October, Cristina Marcos, 11.8M online visitors/mo; Washington, DC)

The House unanimously cleared legislation on Thursday to ensure protections for federal employees who disclose government waste, fraud and abuse.

Passed 420-0, the measure would train federal workers so they understand their protections, as well as enhance penalties for supervisors who retaliate against whistleblowers.

The bill is named after Chris Kirkpatrick, a psychologist was fired from a Department of Veterans Affairs (VA) medical center after raising concerns about patients' medications. He committed suicide on the day he was dismissed.

The bill also orders the VA to create a plan for preventing unauthorized access to employee medical records and conduct outreach to employees about mental-health services.

The Senate passed the legislation, authored by Senate Homeland Security and Governmental Affairs Committee Chairman Ron Johnson (R-Wis.), in May. It now heads to President Trump's desk for his signature.

"Future whistleblowers who take a risk to expose wrongdoing and waste in the federal government deserve the respect and support of our nation. I urge the president to quickly sign these important reforms into law," Johnson said in a statement.

Before final passage, House Democrats offered a procedural motion to amend the bill by extending protections to federal workers who reveal wrongdoing by an agency head or political appointee violating rules or regulations regarding travel.

Democrats offered the motion in light of Tom Price's resignation as secretary of Health and Human Services in September after Politico revealed his extensive use of private jets, instead of commercial alternatives, at taxpayers' expense. Politico estimated Price's travel costs at possibly more than \$1 million.

"The resources invested to agencies to fulfill their missions of serving Americans should not be abused or frivolously flaunted for personal gain or convenience," said Rep. Tom O'Halleran (D-Ariz.), who offered the motion.

Rep. Rod Blum (R-Iowa) did not disagree with the substance of the proposal offered by Democrats, but urged swift passage of the underlying whistleblower legislation so Trump could sign it into law as soon as possible.

"Let's not let one good bill get in the way of another," Blum said.

The motion failed along party lines, as is typical in the House when it comes to procedural votes.

The House also passed two noncontroversial bills by voice vote on Wednesday to protect and encourage whistleblowers.

One measure, authored by Rep. Chuck Fleischmann (R-Tenn.), would allow federal agencies to pay up to \$20,000 in cash rewards to workers who report waste. The other, sponsored by Rep. Steve Russell (R-Okla.), would allow whistleblowers outside the intelligence community to disclose classified information to supervisors in their chain of command.

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2.5 - Bangor Daily News: [‘Dangerous surgeon’ at Togus allegedly made mistakes in 88 cases, but VA kept it quiet](#) (12 October, 1.2M online visitors/mo; Bangor, ME)

An explosive USA Today investigation into medical mistakes allegedly made under the watch of the U.S. Department of Veterans Affairs highlighted what the newspaper described as one particularly egregious case in Maine.

According to the report, podiatrist Thomas Franchini allegedly made mistakes in 88 cases while working at the Togus VA Medical Center near Augusta, the nation's oldest veterans' hospital.

"We found that he was a dangerous surgeon," former hospital official Robert Sampson said during a deposition in a federal lawsuit against the department, according to the newspaper.

U.S. Rep. Bruce Poliquin, R-Maine, described the case as "unacceptable behavior" and called the situation "nothing short of appalling" in a Thursday statement.

USA Today's report describes myriad examples: Franchini allegedly drilled the wrong screw into the bone of one patient, severed a tendon in another, conducted unnecessary surgeries and twice failed to properly fuse a woman's ankle, for instance.

Instead of being fired, the newspaper's investigation found, the department didn't report him as a problem doctor or fire him, but rather allowed him to quietly resign and open a private practice in another state.

The Franchini case was revealed as part of an investigation that uncovered about 230 secret settlement deals in which VA officials quietly cut ties with problem doctors and other medical staff across the country, allegedly promising to conceal serious mistakes and allow many of the personnel in question to go into the private sector with unblemished records.

Franchini, who was reportedly placed on leave by the VA in 2010 and resigned soon thereafter, told USA Today he never got to respond to the department's findings that he'd made serious mistakes, and that his attorney submitted two outside reviews that contradicted those findings.

He also said he has performed many surgeries since leaving the VA without complications.

"If I was so bad, I would be bad all the time," he told USA Today.

Six veterans are now suing the VA accusing the agency of fraudulently concealing Franchini's mistakes.

In response to the report, Poliquin, who represents Maine's 2nd congressional district, announced Thursday he is joining fellow Reps. Cathy McMorris Rodgers of Washington and Phil Roe of Tennessee to introduce a bill that would force agency officials to report to state licensing boards if they discover "unacceptable or unethical behavior from other medical professionals at the VA."

"Our Maine veterans depend on their services at Togus and other VA facilities across our state for critical care, and it is absolutely unacceptable for them to ever be subjected to medical malpractice," Poliquin said in a statement. "We must have accountability at the VA, to ensure our veterans are always getting the best care possible, and I am proud to be working on the Veterans Affairs' Committee to do that."

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2.6 - WFED (AM-1500, Audio): [House passes bill to give TSP participants more withdrawal options](#) (12 October, Eric White, 831k online visitors/mo; Washington, DC)

[...]

The Veterans Affairs Department stepped back a proposal to suspend a 50-year-old ethics law. The law, first passed in 1966, requires VA to fire any employee who also works for a school whose students receive VA benefits. The department had planned to completely stop enforcing that requirement by next Monday, since some of its employees also work as adjunct professors at for-profit colleges. But it abruptly walked back the regulatory change on Wednesday after

complaints from veterans groups who said the waivers should only be granted on a case-by-case basis. (Federal News Radio)

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2.7 - La Crosse Tribune: [House approves whistleblower bill named for former Tomah VA doc](#) (12 October, 822k online visitors/mo; La Crosse, WI)

The U.S. House passed a federal whistle blower protection bill Thursday named for a former VA psychologist who questioned over-medication of patients at the Tomah VA Medical Center.

The Dr. Chris Kirkpatrick Whistleblower Protection Act is designed to protect federal employees who come forward with allegations of waste, fraud and abuse and to set minimum disciplinary measures for supervisors found guilty of retaliation.

The bill also requires the VA to put together a plan to prevent supervisors from improperly accessing an employee's medical files in retaliation.

Kirkpatrick killed himself in 2009 the same day he was fired after questioning over-medication practices at the Tomah VA, which earned the nickname "Candy Land" because doctors there prescribed such high doses of opiates. Investigations later blamed those prescription practices for the deaths of at least two veterans.

U.S. Rep. Ron Kind, whose district includes the Tomah VA, spoke on the House floor in favor of the bill.

"Dr. Kirkpatrick was dedicated to improving the lives (of) and serving our nation's veterans," Kind said. "The bill before us today will honor the memory of Dr. Kirkpatrick by helping to make sure no one will have to go through what he did."

The bill, introduced by Sen. Ron Johnson, passed the House unanimously and now heads to President's desk.

Johnson, a Wisconsin Republican, said the passage brings the nation "

one step closer to better protecting federal whistleblowers and providing better health care to the finest among us – our veterans."

VA Secretary David Shulkin has pledged to bring greater accountability to the government's second largest agency, which provides medical care to millions of veterans. In July, Shulkin began posting employee disciplinary actions and announced that he would require approval by a senior official of any settlement with a VA employee over the amount of \$5,000, citing unnecessary payments to bad employees. A month later, he ordered a review to expand VA reporting requirements for bad workers.

During the 2016 campaign, Trump described the VA as the "most corrupt," promising to "protect and promote honest employees" at the VA who expose wrongdoing.

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2.8 - WLOS (ABC-13, Video): [Protesters at Asheville VA say being understaffed is dangerous](#) (12 October, 480k online visitors/mo; Asheville, NC)

ASHEVILLE, N.C. (WLOS) — Veterans Affairs employees held a rally outside Asheville's Charles George VA Medical Center on Thursday to protest working conditions.

Protesters said low staffing levels are creating risks to patient safety and a hazardous work environment. They said Congress has failed to fill open positions, putting veterans' health care at risk.

"We're trying to get the word out and let Congress know that we're here to support these veterans," Brandee Morris, of AFGE Local 446, said.

Protestors said there are nearly 50,000 open positions at VA centers across the country, and there's no plan in place to fill them.

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2.9 - HousingWire: [Ginnie Mae, VA launch task force to look into lenders targeting veterans for quick refinances - Comes on the heels of Ginnie Mae opening investigation](#) (12 October, Ben Lane, 438k online visitors/mo; Irving, TX)

Roughly one month ago, Ginnie Mae announced that it was launching an investigation into mortgage lenders that were aggressively targeting servicemembers and military veterans for quick and potentially risky refinances of their mortgages.

The investigation came on the heels of a letter from Sen. Elizabeth Warren, D-Massachusetts, who cited a report from the Consumer Financial Protection Bureau, which covered complaints received from veterans about Department of Veterans Affairs mortgage refinancing.

Warren's letter claimed that there may be lenders "aggressively and misleadingly marketing the refinancing of mortgages backed by the Department of Veterans Affairs, generating fees for themselves at the expense of veterans and American taxpayers."

Now, Ginnie Mae and the VA are launching a task force to "address mortgage refinancing issues" surrounding VA loans.

The task force, which is called the "Joint Ginnie Mae – VA Refinance Loan Task Force," will focus on "examining critical issues, important data and lender behaviors related to refinancing loans and will determine what program and policy changes should be made by the agencies to ensure these loans do not pose an undue risk or burden to Veterans or the American taxpayer."

But more specifically, the agencies say that the task force will review the "aggressive and misleading refinancing" marketing practices of certain lenders, and will address "loan churning and repeated refinancing."

Loan churning is the practice of convincing an existing borrower to refinance their mortgage.

When announcing the investigation, Michael Bright, the acting president and chief operations officer of Ginnie Mae, said that the market for VA loans that is “somewhat saturated with lenders and brokers making dozens of calls and sending dozens of letters to veterans” trying to get them to refinance their mortgages.

And now, Ginnie Mae and the VA are working to address the issue.

“Both agencies agree that VA and Ginnie Mae programs work best when they are used by market participants in ways that provide a benefit to Veteran borrowers and, ultimately, lower Veterans’ costs,” Ginnie Mae said in an announcement.

According to Ginnie Mae, the task force has already started its work by examining data and information to “ensure loans provide a net tangible benefit to Veteran-borrowers, and consider establishing time frames regarding recoupment of fees associated with refinancing loans.”

Ginnie Mae said that the task force will also examine the impact of “establishing stronger seasoning requirements for VA-guaranteed loans that are securitized into Ginnie Mae Mortgage Backed Security pools.”

Additionally, Ginnie Mae said the task force will work to “ensure Veterans understand the costs and benefits of refinancing, and ensure robust borrower outreach and education programs are augmented for this purpose.”

The agencies also plan to arrange “joint discussions with individual lenders whose demonstrated origination practices may negatively affect Veteran borrowers or increase program costs and risks.”

The agencies also say that the task force will continue its work until “concrete solutions” are found that will “eliminate lender behavior that is unhelpful to Veterans and harmful to the American taxpayer.”

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2.10 - Citizen-Times: [Disappointed VA employees voice concerns, lack of staffing and support](#) (12 October, Alexandria Bordas, 318k online visitors/mo; Asheville, NC)

OTEEN - Ralliers gathered at Charles George VA Medical Center on Thursday afternoon to express disappointment in the 49,000 vacant staff positions nationwide, which veterans’ supporters said are affecting local VA branches.

Months of delays in appointments, overworked employees and lack of internal support can no longer be ignored, said Brandy Morris, executive vice president of the local American Federation of Government Employees labor union in Asheville.

“Veterans want to come to the VA and not be sent to private doctors because it will take us over a month to treat them,” said Morris, who has worked for the VA for 17 years.

Ralliers also said they were upset with the Trump administration's recent decisions in regards to veteran care.

In August, Trump signed a \$3.9 billion funding bill to save the nearly bankrupt Choice Program, which is a temporary benefit that allows eligible veterans to receive health care in their communities rather than waiting for a VA appointment or traveling to a VA facility, according to the Department of Veterans Affairs.

The Choice Program was created in 2014 after numerous reports revealed an alarming rate of cover-ups in veteran wait times at a handful of VA hospitals across the nation.

This summer, it was determined the Choice Program would no longer be able to offer the temporary benefit because it was running out of money.

Originally, the proposed bill was smaller and would solely fund the Choice Program, without an additional \$1.8 billion for hiring and clinics.

Backlash from veterans organizations, who said the bill prioritized privatized care as opposed to buffing up VA staff, led to the revised \$3.9 billion bill, which Trump signed in August, according to Stars and Stripes. The money is expected to keep the Choice Program afloat for six more months.

But, despite the new bill, there is still dissatisfaction among VA employees.

Paul Stone, a veteran who works at the VA as an electrician, was not inspired by the surge of support for the Choice Program under the Trump administration.

"If veterans had a choice, they would rather see their doctors here, but they don't have a choice so they are forced to see someone else," said Stone, who was holding a sign that said "I Love My VA".

Torre White comes from a family of servicemen and women. She works as a program support assistant with geriatrics at the VA.

It took her months to get hired, despite hundreds of job vacancies posted online, she said.

"There are plenty of openings, but why aren't people getting hired?" she asked. "With so many people applying and wanting jobs, it shouldn't take that long, and now our veterans are not able to get immediate care because of that."

These issues also bother Kay Murray, who has worked as a nurse at the VA for 8 years.

The VA can provide services in-house without the Choice Program if it had the right staffing, she said.

One of Murray's biggest concerns is veteran patients with mental health needs.

A lot of veterans come to the VA because they can trust their doctors, many of whom are veterans, which many not be the case if they go elsewhere, she said.

"The VA is home to veterans, their family, and they come to us wearing their buttons, hats and t-shirts," Murray said. "Half of our employees are veterans too, this is where all of them should be treated."

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2.11 - WEAU (NBC-13, Video): [House members pass Whistleblower Protection Bill](#) (12 October, Ruth Wendlandt, 276k online visitors/mo; Eau Claire, WI)

Washington, D.C. (WEAU) In a bi-partisan vote, House members unanimously passed Representative Sean Duffy's Whistleblower Protection Bill.

The Dr. Chris Kirkpatrick Whistleblower Protection Act ensures no one is retaliated against for coming forward with concerns about waste, fraud, and abuse at the veteran affairs. It also requires the VA to come up with a plan to restrict unauthorized employee access to medical files.

The bill is named after a Wisconsin doctor who worked at the Tomah VA Medical Center, and was fired after he questioned the over-medication of veterans. On the day of his firing, Dr. Kirkpatrick committed suicide.

Representative Ron Kind says he's happy the bill received support from across the aisle. Kind says, "We need people who are working with our veterans who feel confident and safe to come forward when they see things that aren't working the way they're supposed to, when veterans aren't getting the treatment they need, and they deserve, without fear of retaliation without fear of being retired."

Representative Duffy says, "This legislation strengthens protections for patriots-for those who are trying to do the right thing, for those who care about veterans and their safety."

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2.12 - Parkersburg News & Sentinel: [Outrageous: VA culprit deserves more than a lecture](#) (13 October, Editorial Board, 187k online visitors/mo; Parkersburg, WV)

How should a Department of Veterans Affairs manager who defrauded the government, took chances with veterans' health care, then devised a coverup be punished? Readers probably have their own ideas about that.

But according to the federal government, the answer is ... counseling.

One of U.S. Rep. David McKinley's constituents reported to him last year that something was wrong at the Louis A. Johnson VA Medical Center in Clarksburg. McKinley represents much of our area; and many veterans in our region rely on the VA hospital in Clarksburg.

McKinley went straight to the VA. The U.S. Office of Special Counsel, which also had been contacted by a whistleblower from the hospital, looked into the matter.

Investigators found that during a seven-year period, a manager at the hospital engineered a scheme whereby patient data was “intentionally manipulated” at the facility. The purpose was to make it appear at least some veterans were not kept waiting for care as long as actually was the case. In addition, the volume of patient visits was inflated.

Part of the scheme involved nurses being pressured to place patients in unofficial “clinics,” rather than record them as emergency department visits.

Whether any veterans were harmed by the manager’s actions was not reported by the Office of Special Counsel. Obviously, that should be checked.

One ramification of the misconduct was that 602 veterans were charged incorrect co-payments. That cost the VA \$21,070.

However, according to the Office of Special Counsel, the VA “is currently determining how to recoup lost payments.” In other words, the bureaucrats are looking into how they can go back to the 602 veterans and tell them they owe Uncle Sam money.

What about the culprit? According to the Office of Special Counsel, “the VA counseled the manager responsible ...”

That’s it. No punishment, just a good talking to.

We sometimes refer to the bureaucracy in Washington as “the swamp.” That may be a disservice to the snapping turtles, cottonmouth snakes, alligators and quicksand of the real thing.

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2.13 - WAGM (FOX-8): [After Report Shows VA’s Failure to Disclose Medical Malpractice at Togus, Rep. Poliquin Acts to Make Changes](#) (12 October, 35k online visitors/mo; Presque Isle, ME)

Congressman Bruce Poliquin, along with House Conference Chair Cathy McMorris Rodgers (WA-05) and House Veterans Affairs Committee Chairman Phil Roe (TN-01), today introduced the Ethical Patient Care for Veterans Act of 2017. This legislation requires Department of Veterans Affairs (VA) medical professionals to report directly to state licensing boards if they witness unacceptable or unethical behavior from other medical professionals at the VA. The legislation is in response to the alarming USA Today article out yesterday that revealed the VA failed to disclose bad medical practitioners to the public, risking the public’s exposure to these bad actors.

One of the most notorious offenders was Thomas Franchini, a practitioner at Togus who had committed malpractice in 88 separate cases, according to the VA’s conclusions.

“These most recent reports are nothing short of appalling,” said Congressman Poliquin. “Our Maine Veterans depend on their services at Togus and other VA facilities across our State for critical care, and it is absolutely unacceptable for them to ever be subjected to medical

malpractice. We must have accountability at the VA, to ensure our Veterans are always getting the best care possible, and I am proud to be working on the Veterans Affairs' Committee to do that. I'm now pleased to work with Chairwoman McMorris Rodgers and Chairman Roe to help prevent this unacceptable behavior from occurring again."

"These newest reports out of the VA are deeply troubling," said Chair McMorris Rodgers. "Our veterans deserve the best care imaginable, but as we've seen, far too often that's not the case. This bill will help reform the culture at the VA by holding bad actors accountable and keeping them from continuing these mistakes at the VA or elsewhere. We should be rolling out the red carpet to our nation's heroes in Eastern Washington and around the country, and that starts with ensuring that the best and brightest are at the VA caring for our veterans."

"The findings of the USA Today investigation are intolerable," said Chairman Roe. "The committee has long been concerned about VA's settlement agreements, and even held a hearing on the topic last year. While I can appreciate VA's recent decision to more closely vet settlement agreements, malfeasance within the department will not be ignored. It certainly cannot be rewarded and hidden from state licensing boards. As a physician, I find this deeply troubling, and I thank Reps. McMorris Rodgers and Poliquin for their leadership on this issue."

NOTE: Currently, if the VA receives a report of substandard health care practices, it takes at least 100 days to decide whether to refer the matter to a state licensing board. This legislation will require timely reporting to state licensing boards so there is proper notice of these serious allegations.

As reported by USA Today, "the VA — the nation's largest employer of health care workers — has for years concealed mistakes and misdeeds by staff members entrusted with the care of veterans." The article lays out a number of cases where doctors provided poor, unethical, or irresponsible care, and faced zero medical licensing reviews.

By requiring malpractice to be reported to state licensing boards, this legislation ensures that if poor care happens, doctors and clinicians will no longer be shielded by the VA and could face consequences just like they do in private practice.

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2.14 - WAGM (FOX-8): [Rep. Poliquin's Bill to Ensure VA Headstones For Veterans' Families Buried in Cemeteries Advances in the House](#) (12 October, 35k online visitors/mo; Presque Isle, ME)

Today, Congressman Bruce Poliquin had his Veterans bill pass out of committee with unanimous, bipartisan support.

Congressman Poliquin's legislation would ensure that Veterans' family members who are buried at tribal Veterans cemeteries—such as the Houlton Band of Maliseet Indians Tribal Veterans Cemetery in Aroostook County—are provided government furnished headstones, the same treatment as those buried at national and state Veterans cemeteries.

Congressman Poliquin, who represents the Houlton Band of Maliseet Indians and their Tribal Veterans Cemetery in Aroostook County, released the following statement:

“Our Veterans, who served and sacrificed for our Nation and who are now laid to rest in tribal Veterans cemeteries, should have the honor of being buried with their families and all should have access to headstones commemorating their sacrifices,” said Congressman Poliquin. “I’m proud to represent the Houlton Band of Maliseet Indians, who created the first Tribal Veterans Cemetery not only in Maine, but on the entire East Coast. It is a great honor to serve them and to push forward this commonsense fix so all our Veterans and their families can be properly honored when they are laid to rest. I’m extremely pleased to have the unanimous support of my Republican and Democratic colleagues on the Veterans’ Affairs Committee for this commonsense legislation, and I will continue to push this important bill through Congress and onto the President’s desk.”

Clarissa Sabattis, Chief of the Houlton Band of Maliseet Indians, said when the bill was introduced, “The Houlton Band of Maliseet Indians is honored to have the first Tribal Veterans Cemetery, East of the Mississippi. We all know that when a loved one serves in the military, especially when deployed overseas, that the family serves as well. Spouses take on the additional duties and stresses of taking care of their homes, being single parents, raising and comforting their children in times of great stress and ensuring our veterans have a home to return to. Congressman Poliquin’s Bill honors the families and acknowledges the sacrifices made by those who stay behind by providing headstones for the spouses and children of veterans who are buried in tribal cemeteries.”

Under current law, government furnished headstones are only available to Veterans’ eligible spouses and dependents buried in national and state Veterans cemeteries. This bill would authorize the Department of Veterans Affairs (VA) to provide headstones and markers to eligible spouses and dependents interred at tribal Veterans cemeteries.

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2.15 - KOB (NBC-5, Video): [Oregon politician concerned about Roseburg VA medical facility](#) (12 October, 27k online visitors/mo; Medford, OR)

Washington, D.C. – An Oregon congressman is asking the U.S. Department of Veterans Affairs to address “substandard management” at the Roseburg VA hospital.

Congressman Peter DeFazio (D-OR 4th District) said the VA Roseburg Health Care System (VARHS) is a source of concern for constituents, who complained to the governor about the lack of effective and accountable management.

DeFazio claims nothing has changed at VARHS despite repeated outreach with VA leadership, including a direct appeal to VA Secretary David Shulkin last week.

“Poor management has resulted in degraded patient care and difficulty in recruiting and retaining talented medical professionals to help Oregon’s veterans. It’s outrageous that in addition to delays and government bureaucracy veteran care is being hampered by management issues,” Rep. DeFazio said. “Doctors, nurses, and other VA employees are putting their careers on the line to improve the system, risking potential retaliation from the same inadequate leadership. The status quo is entirely unacceptable, and it is time for the VA to stop passing the buck and take immediate action. Our veterans deserve better.”

Rep. DeFazio voiced his concerns while speaking in support of the Dr. Chris Kirkpatrick Whistleblower Protection Act. The legislation would create harsher penalties for those who retaliate against whistleblowers.

According to DeFazio's office, in 2015 35% of whistleblower complaints came from VA employees.

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2.16 - The M Report: [Ginnie Mae and VA Create Refinance Loan Task Force](#) (12 October, Nicole Casperson, 20k online visitors/mo; Dallas, TX)

Ginnie Mae and the Department of Veterans Affairs (VA) recently announced the shaping of the "Joint Ginnie Mae – VA Refinance Loan Task Force," in an effort to address loan churning and repeated refinancing issues.

Specifically, the task force is set to focus on examining critical issues, important data, and lender behaviors related to refinancing loans. In addition, the task force will "determine what program and policy changes should be made by the agencies" as a way to ensure these loans do not pose an "undue risk or burden to Veterans or the American taxpayer."

According to the enterprise, this task force has begun its efforts in two ways. First, by examining data and information to ensure loans provide a "net tangible benefit" to Veteran-borrowers. Second, the task force is considering to establishing time frames regarding "recoupment of fees associated with refinancing loans."

The purpose of the task force is to also determine the effects if implementing stronger seasoning requirements for VA-guaranteed loans that are securitized into Ginnie Mae Mortgage Backed Security pools, according to Ginnie Mae's release.

Furthermore, the task force will "work to ensure Veterans understand the costs and benefits of refinancing, and ensure robust borrower outreach and education programs are augmented for this purpose."

Last year, the Consumer Financial Protection Bureau revealed a snapshot of service member complaints and issues related to VA mortgage refinancing. In light of these issues, the task force will examine aggressive and misleading refinancing propositions.

The release notes that Ginnie Mae and the VA will continue to work together until concrete solutions have been implemented to eliminate lender behavior that is unhelpful to Veterans and harmful to the American taxpayer.

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2.17 - KSNW (NBC-3): [Kansas nurse in Puerto Rico to help Hurricane Maria victims](#) (12 October, 9.1k online visitors/day; Wichita, KS)

A Cheney nurse is in Puerto Rico helping victims of Hurricane Maria. Linda Sue Bayless is a provider at the Robert J. Dole VA Medical Center.

As part of the VA's Disaster Emergency Medical Personnel Program System, she signed on to deploy where she was needed most. Bayless left October 4 and is due back on the 18.

Her husband, Greg, says she is now living in a tent and has had no hot water since she arrived. He describes her as working side by side with FEMA, the Red Cross, and Homeland Security. "She is an honorable woman," He said. "She wants to help. She is patriotic. She has been a caregiver her entire life. She wanted to volunteer."

He describes his wife's conditions as "difficult" and she is currently working nights on the 7 p.m. to 7 a.m. shift.

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3. Access to Healthcare

3.1 - Newsweek (Video): [PTSD Treatment: How Ai Is Helping Veterans With Post-Traumatic Stress Disorder](#) (12 October, Joseph Frankel, 9.4M online visitors/mo; New York, NY)

There is a real appeal to shouting into the void: the ubiquity of Google search as confessional, the popularity of PostSecret, the draw of confiding in a trusted friend with the hope verging on understanding that our secrets won't be shared all point to this. A group of researchers from the University of Southern California, with funding from the DARPA wing of the Department of Defense, believe that desire might drive a preference among veterans with PTSD to anonymously discuss their symptoms with a computerized avatar.

They found that the service members who volunteered for the study disclosed more symptoms of PTSD when speaking with a computerized "virtual human" than when filling out a symptoms checklist on the military's Post Deployment Health Assessment (PDHA). They also reported more symptoms even when filling out a completely anonymized version of the PDHA. The idea, the researchers suggest, is that people are more willing to disclose their symptoms when they know the data is anonymous.

It's unclear if that will fly in real life. Whether the program will truly help veterans remains to be seen. And its implementation raises questions about medical ethics and the stigma around mental-health in the military and culture at large.

The Institute for Creative Technologies at USC got lots of buzz for its original research, and introducing the world to Ellie, a digital diagnostic tool that strongly resembles, but cannot replace a human therapist. Ellie, an avatar of a woman in a cardigan with olive-toned skin and a soothing voice, listens to the people who come to her, and does what any human sounding board does. She listens to the content of their speech, and scans their facial expressions, tone, and voice, for cues that hint at meanings beyond speech. Ellie's design was decided upon by the research group's art team. As for how Ellie sounds, "she has a very comforting voice," Lucas told Newsweek.

(Unlike a human, of course, this kind of reading is made explicit enough to show in a video.)

Based off their results, Lucas says, the researchers believe that for veterans with PTSD, Ellie combines the best of both worlds: her warm demeanor and sympathetic responses establish the kind of rapport that a therapist would create, and the knowledge that she's not actually a person, and crucially, that she's not built into a chain of reporting, mean you can say whatever you want. This builds off past research this same team did, in which participants more intensely expressed feelings of sadness and reported lower rates of fear when going through a health screening with a virtual human rather than one they were led to believe was controlled by an actual human.

The way Lucas envisions it, Ellie is an economical and efficient solution. "All you need is a webcam, a laptop, and a microphone." She imagines Ellies existing in a kind of kiosk that can be tucked into a local VA. "I know it sounds creepy to put it in a closet, but you could put it in a closet."

And at least one psychiatrist thinks Ellie has potential. "This technology has amazing potential to drill down into the elements of rapport, and whether it differs by patient characteristics; something that is not possible with real life therapists or clinicians. A simple example is whether the sex and age of the avatar alters the effect," says Joseph Hayes, a psychiatrist at University College London.

However, Hayes believes the anonymity that drives the study's result might be impossible in real life. The participants in the study may feel more comfortable disclosing to Ellie because, unlike with the PDHA, which soldiers know will go on their permanent health record, what they say to Ellie will not. But if Ellie were really integrated into a care center, it's hard to imagine that the data she collects wouldn't also be accessible by treating clinicians.

"For an intervention to be possible ultimately, the disclosure would have to be shared with the same commanding officers who have traditionally received the results of the service members PDHA, and entered into their military health record. Once this is made explicit, would disclosure reduce to levels seen previously?" Hayes wrote. "If so, it is a culture change (reducing public stigma—within the military and more broadly) which is truly going to impact on disclosure and provision of appropriate treatment," Hayes wrote.

Lucas and her colleagues have been thinking about this problem, and she's optimistic they can work out a solution. She maintains that since the research is being implemented within the department of defense, it's under different rules than treatments marketed to civilians.

The way Lucas envisions it, even in real life, a session with Ellie can stay fully anonymous. A veteran can go in, talk with 'her', and at the end of the session Ellie can suggest they follow up with a clinician if the person needs further treatment. But, Lucas hopes, that choice will be up to the patient.

With one big exception.

If a therapist or doctor learns of a person's intent to harm or kill, among other acts, they are compelled to break confidentiality and intervene. But Ellie, Lucas maintains, can't be mandated to report these things because she isn't human. Lucas's ideal solution is that, if a veteran comes to Ellie expressing thoughts of self-harm, the program would send out a red flag of sorts to a human clinician who would then be compelled to act.

It has yet to be determined whether that approach is legally, ethically, or practically feasible.

Even if it is feasible, there are still many other problems to tackle when it comes to PTSD in veterans, Hayes says.

"As a clinician, I'd want to know that this technology could effectively detect cases of PTSD, rather than just increasing disclosure of less severe, potentially non-diagnostic, responses to trauma. The bottleneck is not necessarily in the shortage of resources for diagnosis, but a shortage in the resources to deliver effective evidence-based care following diagnosis," Hayes wrote. And while AI technologies that do exactly that are being developed and tested, he thinks it's a long ways away before they can take over that work.

And help is needed.

"Veterans account for 20% of suicides in the US," Hayes said. "Better support systems, beyond the brief provision of therapy may help reduce this shocking statistic."

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3.2 - KTVU (FOX-2): [Services available for veterans at Napa Valley College evacuation center](#) (12 October, 2.1M online visitors/mo; Oakland, CA)

NAPA, Calif. (BCN) - The Vet Center, a subsidiary of the U.S. Department of Veterans Affairs, deployed personnel today to the wildfire evacuation center at Napa Valley College from Concord and Fairfield to provide mental health services and paperwork assistance for any displaced veterans.

They were at the shelter today with a trailer set up for three separate counseling sessions to be conducted simultaneously.

"Say you're having a panic attack," readjustment counselor Lori Shepherd said. "You come in here and have a counseling session."

Shepherd said the smoke, smells and sight of burnt buildings can be stressful for veterans who served in Iraq, Afghanistan or other war zones.

"It can definitely be triggering," said Joseph Moglia, a veteran of the U.S. Marine Corps who served in Iraq.

Shepherd and Moglia are available at Napa Valley College for any veterans who have been displaced by the North Bay wildfires and are in need of assistance. They can be reached at (925) 433-3407.

They've also set up an area with seating and a television for veterans at the shelter who just want to spend time with other veterans.

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3.3 - The Gazette: [Mayor, nonprofits plead for Colorado Springs landlords to help homeless vets](#) (12 October, Jakob Rodgers, 870k online visitors/mo; Colorado Springs, CO)

Colorado Springs landlords reportedly are spurning federal housing vouchers in favor of renting to higher-paying tenants, thwarting efforts to help homeless veterans get off the streets, city officials and nonprofits say.

Mayor John Suthers, the National League of Cities and local advocates for the homeless called on landlords Thursday to accept the vouchers from veterans needing a place to live rather than taking advantage of the hot rental market.

Suthers stressed that local landlords hold the key to effectively ending veteran homelessness - a goal that has eluded the city for years.

"They're private businesses, they're there to make money and they don't have to engage in this," Suthers said. "But we're just trying to impress upon them that it's part of being a citizen of the community."

As an example, Suthers mentioned one homeless veteran who got a job while using his voucher - allowing him to pay more for rent.

"We're hoping they'll (landlords) see the long view that helping house people is in their interest as well as the community's," Suthers said.

Their message highlighted the latest in a series of meetings at the Apartment Association of Southern Colorado's offices, which seek to woo hesitant property owners.

As Colorado Springs' affordable housing crunch has worsened, rents have climbed to record territory, fed by Colorado's bustling economy and an influx of newcomers seeking cheaper housing outside the Denver Metro area.

In spring and early summer, the city's average monthly rate - not including utilities - was \$986 for a one-bedroom apartment and \$1,523 for a three-bedroom unit.

But the VA's vouchers are capped. For someone here without an income, they are from \$751 a month for a one-bedroom apartment and \$1,355 a month for a three-bedroom unit. Importantly, while those rates can rise with a person's income, they must include the cost of utilities.

That's kept landlords and property owners away, acknowledged Laura Nelson, the apartment association's executive director.

The plight of veterans seeking housing is "truly sad," said Carmen Azzopardi, vice president of multifamily property services for Griffis/Blessing.

Her company was among a few touted by the association as being more open to accepting vouchers.

But Azzopardi said many landlords feel hamstrung by the program's red tape. Many also fear violating the Fair Housing Act by prioritizing veterans above others, and accepting them at reduced rates.

"How can we help, when it's almost like our hands are tied on being able to help?" Azzopardi said.

Elisha Harig-Blaine, principal housing associate of the National League of Cities, disputed that notion.

"I can definitely tell you - it does not violate fair housing," Harig-Blaine said.

Homeless advocates also stressed a willingness to work with landlords and address any issues that arise, including landlords' concerns about renting to vets with felony convictions or past evictions.

The vouchers include a caseworker for each veteran who can help them find jobs, access health care and, if need be, find addiction treatment.

"We want to help you have success," said Erika Huelskamp, who coordinates the VA's local voucher program. "We are just a phone call away. We're here for you, just as much as that veteran."

Fifteen individuals and 13 families are searching for landlords willing to accept their Department of Veterans Affairs vouchers, said Huelskamp.

That's only a fraction of the homeless veterans in need of apartments here, and an even smaller portion of the city's overall homeless community.

People who haven't served in the military also face similar problems using different vouchers, nonprofit leaders say.

The pleas come as Colorado Springs tries to join the growing list of cities that have effectively ended homelessness among veterans.

The goal is to ensure no veterans are forced to live on the streets, and that their homelessness is brief, rare and nonrecurring.

A coalition led by Rocky Mountain Human Services almost succeeded in eliminating veteran homelessness in 2015 by creating an intensely-data driven program unlike anything ever seen in the Pikes Peak region.

Volunteers found people living on the streets. The nonprofit's employees helped them apply for VA benefits and seek housing.

But two main barriers - the city's severe lack of shelter space and affordable housing - kept the coalition from meeting its goal.

One impediment has since been eased.

The opening of Springs Rescue Mission's new shelter in November 2016 helped more people find beds indoors. The facility has routinely accommodated between 260 and 300 people a night.

But the other - a dearth of affordable housing - has only worsened.

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3.4 - Daily Press: [Virginia lawmakers cite payment delays in veterans health program](#) (12 October, Hugh Lessig, 863k online visitors/mo; Newport News, VA)

The Department of Veterans Affairs owes Virginia health care providers millions of dollars for services provided to veterans who sought treatment outside the VA system, says the state's congressional delegation, who want the VA to pay its bills.

At issue is Veterans Choice, a popular but controversial program that allows former service members to seek care in the community if they have to wait too long for an appointment or live too far from a Veterans' Affairs facility.

The 13-member Virginia delegation sent a letter to VA Secretary David Shulkin on Oct. 3 that states "the level of late payments is unacceptable" and adds, "We urge you to fix this problem and immediately develop a long-term solution aimed at ensuring that payments are made within 30 days of receiving an invoice."

Riverside Health Systems reported that 227 of 504 claims under Veterans Choice, totaling more than \$2 million, have languished more than 120 days without payment, the letter states.

Mark Duncan, Riverside's director of government relations, said, "VA related claims have taken an average of 177 days to be paid, or 3.5 times longer than the average of all third-party payers."

In one case, Riverside was reimbursed 961 days — more than 2 ½ years — after a veteran's discharge. Duncan said.

Carilion Clinic, with facilities in Roanoke, Danville, Martinsville and elsewhere, has seen its money owed go from \$28 million to \$58 million over the past year, the letter states. Late payments also hit Wellmont Health System and Lewis-Gale Hospital in southwestern Virginia.

A single dental facility in Northern Virginia is owed \$203,000.

"The situation has gotten so dire that a veteran who had used this facility to get VA-approved dentures ultimately had them withheld due to the Veteran Affairs medical center non-payment," the letter states.

Rep. Rob Wittman, R-Westmoreland, who released a copy of the letter with a news release, said the problem has been brewing across Virginia for months. Lawmakers and hospitals tried to resolve it without writing directly to Shulkin, but that now appears to be the only recourse, he said.

“The whole system needs to be looked at,” Wittman said. “Payments and access and appointments, they’re all related. It’s about people not going through another layer of bureaucracy. This needs to be flattened and simplified so people can quickly get an appointment and providers and quickly be paid.”

The letter points out that health care providers in Virginia “are now evaluating whether they can continue to provide services to veterans under the Choice program.”

Peter Glagola, a spokesman for Riverside, said the system wants to serve veterans, calling it “an honored duty.” But it also wants to be reimbursed in a timely manner. Since 2015 about 3,000 veterans have received care through Riverside via Veterans Choice.

“We want to come up with a solution,” he said. “That’s the key.”

A related problem concerns duplicate payments to third-party providers, the subject of a September report from the VA Inspector General. The IG’s office said it has identified tens of millions of dollars in overpayments across the program. The office is currently auditing Veterans Choice. The congressional letter said these problems could have been avoided through better training and communication.

VA hospitals have struggled to deal with the workload caused by Veterans Choice. In March, officials at Hampton VA Medical Center said they had more than doubled the staff to coordinate non-VA care. Veterans Choice also made the work more complex, they said, because it required coordination with a third party to refer patients outside the VA system, and that required a lot of back-and-forth communication.

VA officials in Washington had no comment Thursday on the congressional delegation letter.

In August 2017, President Donald Trump signed the VA Choice and Quality Employment Act of 2017 which authorized \$2.1 billion in additional funds for Veterans Choice. VA officials said it reflected the agency’s long-term commitment to the program, but the \$2.1 billion was seen as a short-term solution.

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3.5 - KLTV (ABC-7, Video): [Veteran says medications from VA repeatedly lost in the mail](#) (12 October, Sophia Constantine, 837k online visitors/mo; Tyler, TX)

An East Texas woman who is a military veteran of over fifteen years is struggling after her medications have been misplaced in the mail twice over the past six months.

Jill Morehouse receives mail order prescriptions from the VA once a month. Each time, a 240-count bottle of Vicodin. Over the past six months, she says two of those prescriptions never arrived.

The first time, she thought it was an honest mistake, lost somewhere at the post office. “But when the same thing happened twice, to the same medication...” she started to believe the medication was being stolen.

Morehouse says she filed a police report both times and contacted her postmaster at the United States Postal services, but says she was told there was nothing they could do.

We reached out to the USPS and Twana Barber, the Regional Communications Specialist provided us with a statement saying in part, “The Postal Service strives to provide exceptional service to our customers with every delivery, and the vast majority of mail reaches its destination on time, safely and securely. In extremely rare occasions, a package may fail to reach its destination or get damaged in processing. We certainly apologize to this customer for any inconvenience they may have experienced and we are committed to working with them until the matter is resolved to their satisfaction.

Following our story, the USPS has reached out to Morehouse to formally apologize.

According to Morehouse, the VA replaced her medication both times. She also tells us her packages have tracking numbers and require a signature upon arrival.

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3.6 - The Daily Reporter: [VA Clinic to stay in Spirit Lake](#) (12 October, Seth Boyes, 45k online visitors/mo; Spencer, IA)

SPIRIT LAKE — Anticipation had been building as to where the Sioux Falls Veterans Affairs Medical Center would place its new clinic. Several locations in the region were considered, but Director Darwin Goodspeed with the Sioux Falls VA Health Care System announced Thursday a new clinic will be built in Spirit Lake, near the intersection of Highway 9 and Royal Avenue, just west of the Great Lakes Mall. The announcement was part of the public meeting circuit Goodspeed conducts each quarter.

Ann Miller, Dickinson County Veterans Affairs director, said the new clinic will be under the umbrella of the Sioux Falls Medical Center, as the current clinic is, making Goodspeed the clinic's director. She said Goodspeed is director of several clinics in both Iowa and South Dakota.

Miller said both she and the clinic staff were unaware Spirit Lake had been chosen for the clinic until Goodspeed's announcement.

“I think it's very exciting,” Miller said. “The whole staff at the clinic, you could tell they're very excited about the new facility.”

The current clinic has effectively reached its capacity, according to Miller.

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3.7 - BeyondChron: [New VA Privatization Threat To Vets](#) (12 October, Suzanne Gordon, 39k online visitors/mo; San Francisco, CA)

On Thursday October 5th, the American Federation of Government Employees (AFGE) the union that represents federal employees, held a briefing on the threat to privatize the Veterans Health Administration (VHA), on Capitol Hill in Washington, D.C. Veterans, VHA caregivers, and policy analysts warned Congressional staff and the media on the cost to veterans if more and more VHA care was outsourced to the private sector.

Representatives Julia Brownley (D, CA-26), Mark Takano (D. CA-41) and Anthony Brown (D MD-04) spoke before the panel began, and pledged their support for the VHA and opposition to privatization. Senator Bernie Sanders was supposed to appear but was forced to cancel because of a conflict.

Joe Flynn, AFGE's Treasurer, introduced the panel and Jackie Maffucci, Research Director Iraq and Afghanistan Veterans of America, was its moderator. The first speaker was clinical psychologist Thomas Kirchberg, representing the Association of VA Psychologist Leaders (AVAPL). Kirchberg warned of current efforts to outsource the Compensation and Pension (Comp & Pen) exams that the VHA conducts when veterans make claims for eligibility for VA services, compensation for service connected problems, and pensions.

VA psychologists and medical staff— experts who understand the complex conditions and problems from which veterans suffer — have traditionally conducted these exams. Now, in the name of easing the backlog of claims at the chronically underfunded and understaffed VHA, they are being farmed out to for-profit firms who have little expertise in veterans' health problems and may not conduct comprehensive examinations of veterans.

In an impassioned plea, Kirchberg explained that, "When I sit with a Veteran who has never had the opportunity to tell his or her story he or she may break down and begin weeping, lost in the past, embarrassed, and wanting to get up and leave."

His own voice breaking as he spoke, he said, "I'm able to sit with them and help them so they can regain composure and then in an unhurried way either walk them to a clinic for a warm handoff to a mental health provider or talk with them knowledgeably about a referral. These comp and pen exams are often the first face of the VA for Veterans. The compensation and pension exam should not be a bureaucratic checklist. It's a critical encounter requiring deep knowledge and compassion."

Adrian Atizado, Deputy National Legislative Director for the Disabled American Veterans (DAV), also spoke to the group and raised their concerns about and opposition to privatization. Kathleen Pachomski, President of AFGE Local 3930, and a Registered Nurse at the Memphis VA Medical Center, spoke eloquently about her commitment to deliver high quality care to veterans. Pachomski is also a veteran herself and receives care at the VHA. "I would not get care anywhere else," she stated.

Eric Young, AFGE Council of Prison Locals President, spoke not only as a federal employee opposed to privatization and the denial of due process rights to federal employees but as a Navy veteran.

"I joined the Army and served abroad during Operation Desert Storm.... Frankly, I wouldn't be sitting here today talking to all of you if it wasn't for the VA. Had it not been for the care I received after I got home I would be dead today and that's a fact!" he said.

“If you would have looked at me during that time, you’d have never known how sick I was,” he continued. “To the outside world I looked like a young, healthy soldier returning home, but inside my body was tearing itself up. My blood pressure was sky high, almost at stroke level, and my kidneys were failing.

“Even though I couldn’t understand why this was happening to me, my VA primary care team made sure I was taking the steps I needed to recover. My nurse practitioner literally mothered me through my recovery. She made sure that I went to my appointments and took my medicine. And when I didn’t she chewed me out. The relationship that I developed with my VA healthcare team was more than transactional. It was personal. They didn’t just provide care – they actually cared.”

Finally I spoke about the salami strategy of privatization that I have described in a document entitled Ten Ways to Privatize and Kill the VHA. I concluded my remarks by holding up a bumper sticker produced by the San Francisco based group Fighting for Veterans Health Care (FFVHC).

The bumper sticker asks the public to join to “Save Our VA” “I am not a veteran, “ I told the group. “But I consider the VHA my VA as well as veterans’. I pay for it as a taxpayer. I benefit from its research, teaching and models of clinical care. It is my VA, Our VA, even if we are not veterans. Congress,” Please, Save Our VA.”

The panelists supported Bernie Sanders “Strengthening Veterans Health Care Act of 2017 would allocate \$5 billion to the VA to hire more doctors, nurses and other medical professionals to fill these vacancies and ensure that veterans continue to get the best care in a timely manner.”

They also supported a bill put forward by Representative Anthony Brown. — The VA Staffing and Vacancies Transparency Act of 2017 would require the Secretary of the U.S. Department of Veterans Affairs (VA) to post the number of job vacancies at the VA and report to Congress on what steps the Department is taking to reach full staffing capacity.

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3.8 - The Laughlin Nevada Times: [VA clinic expands services](#) (12 October, Jennifer Denevan, 300 online visitors/mo; Bullhead City, AZ)

The MCPO Jesse Dean VA Clinic is getting some help in providing services to local veterans. The clinic will be expanding services via telemedicine to help ensure veterans are getting the care they need. Some services were recently expanded and more times offered and more services are coming at the end of the year. The big difference comes in expanding the number of slots available for care to be given.

Dr. Monica Rawlinson-Maynor said the clinic will be offering more services for primary care through the telehealth program beginning Oct. 23. The clinic will have three providers that will provide for primary care via telehealth, she continued.

The clinic currently offers services such as teleaudiology, telemental health and telepain, she said. There will be more services coming in soon and an expansion of how often services are offered will soon be available.

She said the clinic currently offers laboratory services, immunizations and do simple procedures such a toenail care and ear care. If patients need help with their glucometer they can get that at the clinic, she added.

Rawlinson-Maynor said staff is aware of the difficulty for veterans to get care due to distance when it comes to having to drive to Las Vegas. This will account for increased access to care to veterans for specialty care, she continued.

Dr. Lowryanne Vick, a nurse practitioner who focuses on telehealth, said starting Oct. 23 there will be more slots available per day and more days per week. The telecardiology should be available starting in December and the telemental health will also be available by December if not sooner, she added.

Some of the services already available at the clinic include teleretinal and it provides eye exams for patients with diabetes. There is teledermatology and that allows for a patient to get care in relation to any skin issues and there is psychiatry and psychology through telehealth, Vick said.

The clinic has a telepain clinic which is run by a pain specialist, Vick said. There is telekinesiology, or TK, and that helps veterans who are in need of assistive devices such as a cane or walker. An evaluation can be done at the local clinic and the device is ordered and sent to the Laughlin clinic. That recently started, she added.

Teleaudiology, as mentioned by Rawlinson-Maynor, can't do screenings as of yet, but patients who've already been screened can still get help such as receiving hearing aids, Vick said. Adjustments can also be performed.

Vick said there is the teleVCamp and that helps patients with cognitive and memory impairment. Those are in place and in the near future, there will be telecardiology and will enhance the mental health services, she continued.

There is a program call VA Video Connect and that program allows patients can access healthcare services from home or out in the community and they use either a smart phone, tablet or desktop computer and the Internet to do a video conference with a provider, Vick said. That can be a challenge with patients who don't have those devices but they can come to the clinic for that care, she added.

Telemedicine is definitely different, but there are strategies the provider can use to help make the visit more personal, Vick said. Little strategies such as how they position themselves in front of the camera and there is a nurse with the patient to help with the personal touch as needed, she continued.

Rawlinson-Maynor said it helps patients to be paired up with a consistent provider, which they will be at the Jesse Dean Clinic. The more patients interact with their provider via telehealth, the more comfortable they will become, she continued.

The schedule is teleretinal is available at 9 a.m., 10 a.m. and 1 p.m. Thursdays and at 1 p.m. Fridays. Teledermatology is available on Mondays at 8 and 8:30 a.m. and Thursdays at 3:30 p.m.

Telepsychiatry is available Tuesdays and Thursdays from 8 a.m. to 2 p.m. Telepain is offered on Wednesdays from 8 a.m. to noon.

Telekinesiotherapy is on Tuesdays from 8 a.m. to noon. The V Camp is on Tuesdays at 9 a.m. and Fridays at 1:30 p.m.

Telepsychology is offered on Tuesdays at 2 and 3 p.m. and on Thursdays from 8 a.m. to noon. Teleaudiology is offered on Mondays from 1 to 4 p.m.

Teleprimary care will be all day Monday, Tuesday and Friday starting Oct. 23. There isn't a set start date for telecardiology but it's anticipated it will be offered on Fridays for half a day.

Vick said the big thing is to expand and offer more times to help provide care because the population is steadily growing in the area.

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3.9 - Northeastern Public Radio: [Young Meets With VA Officials To Discuss Veteran Wait Times](#) (12 October, Jill Sheridan, 900 online visitors/day; Fort Wayne, IN)

U.S. Sen. Todd Young (R-Ind.) met with federal Veterans Administration officials to discuss the long waits many veterans face to have claims processed, and says he wants to work directly with the office to make significant changes.

Young says the amount of time veterans have to wait for a claim to be processed is around two years and appeals take even longer.

"One veteran that we discussed today has been on appeal for almost 10 years," he says.

After sitting down with regional VA leaders Thursday, he says that case has finally been resolved but that it shouldn't take a lawmaker's intervention to help get a claim processed. Young says a new federal law may help.

"There is new legislation in place to help these government employees better serve our veterans, that legislation will finally be implemented early next year," Young says.

Young says the problems stem from personnel issues and outdated management processes.

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4. Women Veterans

4.1 - ABC News: [Women vets pose for pin-up calendar to raise money for fellow vets' health care](#) (12 October, Joi-Marie McKenzie, 24.1M online visitors/mo; New York, NY)

Nearly two dozen female veterans traded in their uniforms for sky-high heels in an effort to cheer up their fellow veterans -- and more importantly, raise money to provide financial assistance for veterans' health care needs.

Twenty-one veterans, serving a total of 145 years in all branches of the military, posed for Pin-Up for Vets 2018 calendar. The 1940s-style calendar features a weapons' instructor, a surgery technician, an intelligence officer and a military vehicle operator, among others.

The calendar, which serves as a fundraiser to help veterans' hospitals and health care programs, was started in 2006 by Gina Elise. Her grandfather served in World War II.

"At the time, there were many stories in the news about our troops coming back from Iraq, needing medical care that I felt so strongly that I wanted to do something to support our troops and veterans," she told ABC News.

Elise, 35, was inspired to create a pin-up style calendar because "pin-ups were really a symbol of hope to support troops and veterans."

Jennifer Marshall, who served in the Navy for five years, is part of the 2018 calendar.

"It was wonderful," Marshall said of the photo shoot, held on Hofer Ranch in Ontario, California, over three days last summer.

The veteran said the shoot was made even more special because she could bond with fellow service women.

She continued, "And speaking for the other ladies, everyone has expressed how much it means to them to recapture our femininity, give back to the community and have that long-lasting friendship with other veterans."

Since 2006, the calendars have raised nearly \$60,000 for veteran hospitals to purchase new equipment as well as provide financial assistance for veterans. It's also help fund the non-profit organizations' "50-State VA Hospital Tour," where they hand-deliver many of the calendars to vets.

"Some of these veteran patients are in the hospital for weeks and months and they won't have any visitors," Elise said of why she began visiting hospitals. "It's essential to let our nation's heroes know how much we value them."

"I feel it is my duty ... my responsibility to extend a helping hand to my fellow veteran. "Undoubtedly, there are a lot of people living in this world who are in need of care, time, and attention," United States Marine Corps veteran Tess Rutherford, who is featured in the 2018 calendar, said in a statement. "But for me, I feel it is my duty ... my responsibility to extend a helping hand to my fellow veteran."

Marshall, who is now an actress living in Los Angeles, agreed. She was initially hesitant to be part of the calendar, but after being involved in Pin-Up for Vets since 2015, she is now one of the organization's most active volunteers, visiting a veterans hospital every six weeks.

"Because they mean so much," she explained. "The visits that break my heart are when veterans tell us that we are their first visitor. That is so upsetting to me. It kind of reminds us why these non-profits that go into hospitals ... are so important."

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5. Appeals Modernization

6. Strategic Partnerships

6.1 - Lake County News-Sun: [Durbin: Lovell Center ideal 'test case' for sharing health records between VA, active-duty personnel](#) (12 October, Yadira Sanchez Olson, 41k online visitors/mo; Chicago, IL)

U.S. Sen. Dick Durbin met with physicians of the Captain James A. Lovell Federal Health Care Center Thursday to hear what challenges they face while caring for the nearly 67,000 veterans and active-duty military men and women, along with the families of active-duty personnel.

Although his visit to the North Chicago facility was brief, physicians quickly conveyed to Durbin the need for the facility to streamline its technology systems, in order to more efficiently share information between the Department of Defense and the Department of Veterans Affairs.

Durbin, D-Ill., spoke with administrators and a handful of doctors from a variety of departments that included geriatrics, pediatrics, radiology, family medicine, mental health and primary care. They all agreed that communication between the two departments' technology systems takes up time and presents hiccups in things like billing.

In June, U.S. Secretary of Veterans Affairs David J. Shulkin announced that to improve patient safety and care, the VA would be adopting the same Electronic Health Records (EHR) system as the Department of Defense.

On Thursday, Lovell staff asked Durbin to help make the facility the first to make the changeover, hopefully resulting in all patient data residing in one common system to enable seamless care between the departments, officials said.

Physicians told Durbin Lovell would be the perfect test tube to try the new integration, because it is a first-of-its-kind health care center that combines the two departments and integrates medical care.

During Durbin's visit, administration and staff praised the unique facility for its quality care, which they said attracts patients from across the nation with its reputation. But they were forthcoming with its hurdles, too, which they described as mainly centering on technology.

Durbin told them he sympathizes. "The federal government is way too slow at evolving on every level of technology," he said.

At the roundtable discussion Thursday, Lt. Cmdr. Eric Shafer, a Navy cardiologist, expressed his frustration with the current systems, saying his daily work often has him navigating through six different electronic health record systems to get his patient information.

After listening to the doctors, Durbin asked how he could help.

"Let us be your Petri dish," said Navy surgeon Capt. Paul Roach. "It has to be the same system to get standardization across the board from recruit to veteran."

Durbin also toured some parts of the facility Thursday, and before he left he assured the staff that their frustration with the technology was of high priority.

"I'm going to push to make Lovell the test case, because it really does bring under one roof the two different agencies," Durbin said, adding that it will not happen overnight and will be a unique challenge to get right.

Lovell spokesperson Julie Ewart said when the health care center was established, each department had invested in distinct and separate health-record systems. Further, Lovell was originally created as a five-year demonstration project, which did not support adoption of one department's electronic system over the other.

"Instead, several measures were implemented that allow the two EHR systems to 'talk' to each other, enabling Lovell to be a functional medical center without fully resolving the issues associated with operating two EHR systems," Ewart said. "We look forward to the possibility of a new single EHR that will be seamlessly integrated across the VA and the (Department of Defense)."

Other issues brought up at the discussion was more training on policy and procedure for those coming in from different areas in either the VA or DoD.

Yadira Sanchez Olson is a freelance reporter for the News-Sun.

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7. Supply Chain Modernization

7.1 - Stars and Stripes: [BRAC for VA: Lawmakers search for ways to reduce the number of VA facilities](#) (12 October, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

WASHINGTON — The House Committee on Veterans' Affairs on Thursday initiated what could be a long and politically arduous process to get rid of aging and underused Department of Veterans Affairs facilities nationwide.

Committee Chairman Rep. Phil Roe, R-Tenn., and Rep. Tim Walz, D-Minn., the ranking Democrat, presented a draft bill that would create an 11-member, paid commission to recommend which facilities to close and where the VA should invest. While major veterans service organizations applauded efforts to "right-size" the VA, they opposed the commission-style process, comparing it to the Defense Department's unpopular Base Realignment and Closure program.

There are also concerns that divesting facilities could create gaps in access to VA medical care, causing the department to send more veterans into the private sector.

Roe conceded the proposal, called the Asset Infrastructure Review Act – or AIR – would take “a significant amount of political courage.” The bill is still in its early stages, he said, and would likely change.

“It is an understatement to say the deck is stacked against the AIR Act,” Roe said. “This bill is bold, transformative and controversial. That said, veterans, VSOs and VA employees, and taxpayers alike, deserve more from each of us and to recognize how serious the problem before us is. If there’s any committee in Washington, D.C., that has the political courage to do what is necessary, it’s this one.”

VA Secretary David Shulkin said during a “State of the VA” address in May that dealing with bad infrastructure is one of his top priorities. About 57 percent of the thousands of VA facilities nationwide are more than 50 years old.

The VA is in the process of disposing of or finding another use for 430 vacant or nearly vacant buildings. The department is also reviewing another 784 buildings that are still in use. Regan Crump, a VA assistant deputy undersecretary for health, said Thursday that process would take about 18 months.

Crump said the VA wasn’t certain there was a need for a commission like what’s proposed in the AIR Act but that the agency would need “legislative flexibility” to support its infrastructure review.

The idea to divest VA facilities isn’t new. It’s been proposed by veterans service organization, the Government Accountability Office and the Commission on Care, which was established under former President Barack Obama to broadly examine the future of VA health care.

“We would recognize this as a necessary evil,” said Carl Blake, associate executive editor of Paralyzed Veterans of America. “I don’t know anyone who was involved in BRAC who didn’t think BRAC was in some form evil, and yet it’s probably a necessary process. We don’t oppose what you’re trying to do, but we don’t believe a commission is the right way forward.”

Nearly everyone involved in the hearing stated the importance of involving local veterans when a VA facility is recommended for closure. The draft bill calls for public field hearings.

The bill also requires Shulkin to publish in the Federal Register by Jan. 15 the criteria to be used in choosing which facilities to close, modernize or realign. Veterans advocates warned against the speedy deadline.

Louis Celli, a director with the American Legion, called Thursday’s discussion a first step to “get the conversation started.” Like other organizations, the Legion is against the idea of a commission, which Celli said could be susceptible to corruption.

Walz said Democrats and Republicans on the committee would be working together on the proposal.

“We are working side by side in this, but it’s a journey – and it’s a tough one,” he said. “There’s probably not any more difficult thing in the realm of veterans and veterans’ issues than this topic. We have to get this right.”

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7.2 - Government Executive: [Lawmakers Debate Bringing BRAC to VA Health Care Facilities](#) (12 October, Eric Katz, 852k online visitors/mo; Washington, DC)

House lawmakers are pushing for the Veterans Affairs Department to go through a process to close down or realign underutilized medical facilities, similar to the Base Realignment and Closure process at the Defense Department.

The measure would require the VA secretary to assess the department’s current capacity to provide health care in each of its networks and ultimately recommend facilities to close, modernize or realign. The secretary would by November 2018 pass those suggestions along to a presidentially-appointed, Senate-confirmed commission. That panel would submit its recommendations on to the president the following year, who would then have two weeks to approve of the plan in full, in part or reject it altogether. Congress would then have 45 days to vote down the plan or it would automatically go into effect.

The VA secretary would first have to post guidance on the Federal Register for the metrics by which he would determine whether facilities were underutilized. The secretary must consider whether a site is meeting VA standards, the cost savings from a closure, when those savings would occur, if it would harm VA’s ability to carry out its mission, and input from local stakeholders. The Asset and Infrastructure Review Commission would have 11 members, with each party in Congress suggesting four and the president choosing the rest. The members would have to reach certain qualifications, such as one with experience managing a large, private sector health care system and another with experience in capital asset management in the federal government.

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If the president and Congress allowed the commission’s recommendations to move forward, then VA would have three years to implement or begin planning for the closures and modernizations. The bill would require the department to provide “outplacement assistance” to all employees at facilities slated for closure.

At a House Veterans’ Affairs Committee hearing Thursday, lawmakers acknowledged the political difficulty in moving the Asset and Infrastructure Review (AIR) Act forward.

“The deck is stacked against the AIR Act,” said Rep. Phil Roe, R-Tenn., who chairs the committee and authored the draft legislation. “This bill is bold, transformative and controversial. Moving forward will require a significant amount of political courage and let’s face it, members are not known specifically for that.”

Democrats on the panel acknowledged Congress must do something to address VA’s excess and misaligned medical facilities, but expressed some reservations about applying a BRAC process to VA. Rep. Tim Walz, D-Minn, the committee’s ranking Democrat, called it a “top

priority” to give VA more authority to assess and ultimately realign department resources. He was concerned about the emphasis on cost savings, an overly ambitious timeline and the power entrusted to the president. Many of the 1,400 buildings VA has already identified for closure are vacant—fewer than 20 currently provide medical services to veterans, Walz said—meaning the low-hanging fruit will not deliver much in the way of savings.

Veterans service organizations at the hearings voiced similar apprehensions while supporting the larger goal. Any savings, they said, should be reinvested back into the VA system.

“We do not believe the BRAC-like model is the most appropriate way to address capital asset needs,” said Joy Ilem, national legislative director for Disabled American Veterans. She said DAV supports making VA “more nimble,” but added Congress should not move forward with an asset closure plan before first determining the future of the Veterans Choice Program and the role of private care in the department’s health care delivery. She added VA should not close any facility before it opens an alternative building or it establishes a private facility partnership.

Roe said the committee will take up legislation addressing the future of the choice program, which gives veterans struggling to receive care or living more than 40 miles from the closest VA facility, access to private care on the VA’s dime, in three weeks. The pairing of the AIR Act to the new choice bill will enable the committee to identify savings while injecting new VA spending on health care.

Regan Crump, VA’s assistant deputy under secretary for health for policy and planning, said VA is currently assessing its current and future needs for veterans. Achieving its goals, he said, may require “significant capital investments” to accompany the closures of underused facilities.

While some disagreements persist, Walz pledged to work with his Republican counterparts to advance some form of the legislation.

“We are working side by side in this, but it’s a journey,” Walz said, later emphasizing the pressing-nature of the issue. “Time is not on our side. This is one of those things that must be dealt with, it cannot be kicked the can down the road. But among that, it must be done right. We’re not going to get another bite at this thing.”

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8. Other

8.1 - Stars and Stripes: [Lawmakers consider pushing VA to sell Pershing Hall, its 5-star Paris hotel](#) (12 October, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

WASHINGTON — There’s an effort underway in Congress to have the Department of Veterans Affairs sell an 18th century building it owns in Paris that’s leased as a five-star boutique hotel and spa.

Members of the House Committee on Veterans’ Affairs voiced support Thursday for a bill authorizing the sale of Pershing Hall, which was established as a World War I memorial by the American Legion in 1928 and transferred to the VA in 1991. The Legion is asking the property remain under ownership of the federal government for posterity.

“While Pershing Hall is probably a terrific hotel, it makes no sense that the VA keeps a luxury hotel in Paris on its books,” said Rep. Mike Coffman, R-Colo. “The VA needs to focus its time and resources on its core mission: taking care of our nation’s veterans.”

Coffman introduced the legislation, HR 2773, authorizing VA Secretary David Shulkin to sell the property on the condition that whoever buys it agrees to preserve its architecture. The money from the sale and any historical memorabilia inside would be given to the American Battle Monuments Commission, which is responsible for maintaining American military cemeteries, monuments and memorials.

Louis Celli, a director of the American Legion who testified Thursday, said the property has “deeply personal meaning” to the organization.

Above the building’s entrance is the Legion’s wreath and star emblem, in stone and iron. At one time, it was full of fine art, furnishings, plaques and other memorabilia with some tie to WWI. After the VA took over the building, the items were placed in multiple storage areas in the United States and France.

The American Legion got its start in Paris in 1919, created by members of the American Expeditionary Force in WWI. The Legion purchased the property, which had been a townhouse, to recognize the American Expeditionary Forces and Gen. John Pershing and maintain the Legion’s presence in Paris.

Since management was transferred to the VA, the Legion has been disappointed with what’s happened with the building, Celli said.

The group thought it would remain a memorial and space for U.S. veterans in Paris to go for VA aid. Instead, the VA signed a 99-year lease in 1998 with a private French firm that operates the hotel and spa.

Coffman criticized the lease, calling it a bad deal that significantly decreases the property’s market value. Without the lease, the appraised value is about \$82 million, according to the Legion. If the building is sold and the new owner is required to honor the lease, its value could drop to about \$8 million.

The Legion asked that the property be kept under federal control until the lease is complete in 2097.

“We are displeased as to how VA decided to use the building but also understand that America, its people, and the need for memorials and VA assistance will be around in 99 years once the lease is terminated,” Celli said. “Selling this in a fire sale is the wrong thing to do.”

But Republicans and Democrats on the House committee said the VA “should not be in the business of managing hotels.”

Rep. Phil Roe, R-Tenn., chairman of the House committee, said he was uncertain what to do and needed to think about the issue.

“I think we need to be sensitive and aware of that history,” he said.

Coffman previously attempted to have the VA sell Pershing Hall in 2015 to help pay for cost overruns at the under-construction VA hospital in Aurora, Colo., but the legislation stalled.

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Veterans Affairs Media Summary and News Clips

13 October 2017

1. Top Stories

1.1 - USA Today (Video): [VA vows changes on bad health care providers, lawmakers take action after USA TODAY investigation](#) (12 October, Donovan Slack, 37M online visitors/mo; McLean, VA)

The Department of Veterans Affairs is pledging to overhaul its reporting policies for bad medical workers and a group of lawmakers is introducing legislation following a USA TODAY investigation that found the VA has routinely concealed shoddy care and staff mistakes. VA Secretary David Shulkin directed agency officials to expand a nearly 30-year-old policy that limited what medical providers the agency would report to a national database created by Congress...

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1.2 - U.S. News & World Report (AP): [Congress OKs Expanded Protections for Federal Whistleblowers](#) (12 October, Hope Yen, 24M online visitors/mo; Washington, DC)

Congress voted Thursday to boost the protection of federal whistleblowers from retaliation, part of a bid to uncover bad behavior at the Department of Veterans Affairs and other government agencies. The House easily cleared the bill, 420-0. It now goes to President Donald Trump for his signature, having previously passed the Senate in May.

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1.3 - U.S. News & World Report (AP): [Ex-Head of Tomah VA Allowed to Resign, Given Settlement](#) (12 October, 24M online visitors/mo; Washington, DC)

The former head of the Tomah VA Medical Center was allowed to resign and given a settlement after allegations that painkillers were being overprescribed to patients. Mario DeSanctis was fired from the hospital in 2015. But a USA Today investigation found he fought his dismissal and reached a deal in which he was allowed to resign. He and his attorney were paid \$163,000.

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1.4 - Reuters: [Virtual interviewer prods veterans to reveal post-traumatic stress](#) (12 October, Ronnie Cohen, 43.6M online visitors/mo; New York, NY)

Talking – to a computer-generated interviewer named Ellie – appears to free soldiers and veterans who served in war zones to disclose symptoms of post-traumatic stress, a new study finds. Warriors and veterans were up to three times more likely to reveal symptoms of post-traumatic stress to Ellie, the virtual chatbot, than on an official military survey called the post-deployment health assessment...

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1.5 - The Washington Post: [Virginia lawmakers say late VA payments jeopardize veterans' care](#) (12 October, Jenna Portnoy, 43.9M online visitors/mo; Washington, DC)

Members of Congress from Virginia say chronic late payments from the Department of Veterans Affairs to doctors are jeopardizing care for the state's aging veteran population. The state's two senators and 11 House members urged VA administrators to fix a system that can leave health-care providers waiting more than four months for payments they should have received within 30 days. The delays can damage credit, they said.

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1.6 - The Washington Post: [‘This is frightening’: Noxious gas has sickened VA workers for two years, with few solutions](#) (12 October, Alex Horton, 43.9M online visitors/mo;

Washington, DC)

Staff and patients at a D.C. medical facility for homeless military veterans have endured noxious gas exposure for nearly two years as top hospital administrators, though aware of the problem, have failed to remedy it, according to interviews with staff and documents obtained by The Washington Post. At least eight clinical workers at the Department of Veterans Affairs Community Resource and Referral Center have tested positive for elevated levels of carbon monoxide...

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1.7 - The Denver Post: [Dozens of surgeries at Denver VA hospital put off because of doctor shortage, Too few anesthesiologists and competitive market to blame, VA says](#) (12 October, David Migoya, 4.8M online visitors/mo; Denver, CO)

A shortage of anesthesiologists at Denver’s veterans hospital – despite salary offers reaching as high as \$400,000 a year – has forced a delay in dozens of surgeries just months after the institution was tagged with some of the nation’s worst waiting lists for care. Though the hospital employs eight anesthesiologists and eight nurse anesthetists, they’re short of the complement needed to meet surgery demands that run about 380 operations a month, a spokeswoman said...

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1.8 - Military Times: [Lawmakers take first steps toward a BRAC for VA facilities](#) (12

October, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

House lawmakers took the first steps Thursday toward shutting down hundreds of Veterans Affairs facilities through a process similar to military base closure rounds, saying the move is critical to keep the department from wasting millions of dollars on underused, aging buildings. But some of the largest veterans groups said they have serious concerns with the proposal, saying it’s ripe for abuse and could tempt VA officials to outsource more veterans’ medical care to private-sector physicians.

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1.9 - Stars and Stripes (Military Update): [VA, Congress crawl toward ending abuse of vet pensioners](#) (12 October, Tom Philpott, 1.5M online visitors/mo; Washington, DC)

In 2012, the Government Accountability Office found more than 200 financial planning firms and estate law offices enticing veterans or their survivors into costly annuities or irrevocable trusts intended to hide or reallocate their assets so they qualify for VA pensions that the claimants wouldn’t be eligible for otherwise. Since then, the Department of Veterans Affairs and Congress have been crawling toward actions to stop the abusive practices...

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1.10 - Public Radio International (Audio): [Meet the women combing through Puerto Rico, searching for veterans in need](#) (12 October, Jasmine Garsd, 1.2M online visitors/mo;

Minneapolis, MN)

Lind, an occupational therapist for the VA Caribbean Healthcare System in San Juan, goes to the door, asking, "Are there any veterans here?" Every day since the hurricane hit, she and her team have been roaming from shelter to shelter, looking for veterans who need medical attention. There are somewhere around 75,000 US Army veterans living in Puerto Rico. Most served during the Vietnam War. After Hurricane Maria, many are now living in shelters.

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2. Veteran and Employee Experience

2.1 - The Washington Post (PowerPost, Video): [House to vote on bill requiring discipline for officials who retaliate against whistleblowers](#) (12 October, Eric Yoder, 43.9M online visitors/mo; Washington, DC)

Federal agencies would be required to discipline officials who retaliate against whistleblowing employees, and to fire them on their second offense, under a bill up for a House vote Thursday. The bill, approved by the Senate in May, is one of many arising from the disclosures starting in 2014 of falsified patient records at the Department of Veterans Affairs.

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2.2 - U.S. News & World Report (AP): [Alaska Veterans Affairs System to Add 100 Staff Members](#) (13 October, 24M online visitors/mo; Washington, DC)

The Alaska Veterans Affairs system has announced it's adding 100 staff members. KTVA-TV reported Wednesday that Dr. Timothy Ballard said the staff is being added in response to negative reviews from both patients and staff. Ballard said the new positions are focused on mental health care and support functions. The 100 new jobs boost the system's number of staff to 650 at a cost of \$6 million.

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2.3 - Atlanta Journal-Constitution: [Roswell getting \\$21K for veterans adaptive sports](#) (12 October, David Ibata, 11.9M online visitors/mo; Atlanta, GA)

Roswell has agreed to accept \$21,080 from the federal government to purchase equipment and hire instructors for new VA Wheelchair Softball and Adaptive Cycling programs for disabled veterans. The City Council approved a resolution accepting the FY 201 Adaptive Sports Grant from the U.S. Department of Veterans Affairs. The grant does not require local matching funds, according to a staff report to the council.

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2.4 - The Hill: [New whistleblower protections head to Trump's desk](#) (12 October, Cristina Marcos, 11.8M online visitors/mo; Washington, DC)

The House unanimously cleared legislation on Thursday to ensure protections for federal employees who disclose government waste, fraud and abuse. Passed 420-0, the measure would train federal workers so they understand their protections, as well as enhance penalties for supervisors who retaliate against whistleblowers. The bill is named after Chris Kirkpatrick, a psychologist was fired from a Department of Veterans Affairs (VA) medical center after raising concerns about patients' medications.

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2.5 - Bangor Daily News: [‘Dangerous surgeon’ at Togus allegedly made mistakes in 88 cases, but VA kept it quiet](#) (12 October, 1.2M online visitors/mo; Bangor, ME)

An explosive USA Today investigation into medical mistakes allegedly made under the watch of the U.S. Department of Veterans Affairs highlighted what the newspaper described as one particularly egregious case in Maine. According to the report, podiatrist Thomas Franchini allegedly made mistakes in 88 cases while working at the Togus VA Medical Center near Augusta, the nation’s oldest veterans’ hospital.

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2.6 - WFED (AM-1500, Audio): [House passes bill to give TSP participants more withdrawal options](#) (12 October, Eric White, 831k online visitors/mo; Washington, DC)

The Veterans Affairs Department stepped back a proposal to suspend a 50-year-old ethics law. The law, first passed in 1966, requires VA to fire any employee who also works for a school whose students receive VA benefits. The department had planned to completely stop enforcing that requirement by next Monday, since some of its employees also work as adjunct professors at for-profit colleges.

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2.7 - La Crosse Tribune: [House approves whistleblower bill named for former Tomah VA doc](#) (12 October, 822k online visitors/mo; La Crosse, WI)

The U.S. House passed a federal whistle blower protection bill Thursday named for a former VA psychologist who questioned over-medication of patients at the Tomah VA Medical Center. The Dr. Chris Kirkpatrick Whistleblower Protection Act is designed to protect federal employees who come forward with allegations of waste, fraud and abuse and to set minimum disciplinary measures for supervisors found guilty of retaliation.

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2.8 - WLOS (ABC-13, Video): [Protesters at Asheville VA say being understaffed is dangerous](#) (12 October, 480k online visitors/mo; Asheville, NC)

Veterans Affairs employees held a rally outside Asheville’s Charles George VA Medical Center on Thursday to protest working conditions. Protesters said low staffing levels are creating risks to patient safety and a hazardous work environment. They said Congress has failed to fill open positions, putting veterans’ health care at risk.

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2.9 - HousingWire: [Ginnie Mae, VA launch task force to look into lenders targeting veterans for quick refinances - Comes on the heels of Ginnie Mae opening investigation](#) (12 October, Ben Lane, 438k online visitors/mo; Irving, TX)

Roughly one month ago, Ginnie Mae announced that it was launching an investigation into mortgage lenders that were aggressively targeting servicemembers and military veterans for quick and potentially risky refinances of their mortgages. The investigation came on the heels of a letter from Sen. Elizabeth Warren, D-Massachusetts, who cited a report from the Consumer Financial Protection Bureau, which covered complaints received from veterans about Department of Veterans Affairs mortgage refinancing.

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2.10 - Citizen-Times: [Disappointed VA employees voice concerns, lack of staffing and support](#) (12 October, Alexandria Bordas, 318k online visitors/mo; Asheville, NC)

Ralliers gathered at Charles George VA Medical Center on Thursday afternoon to express disappointment in the 49,000 vacant staff positions nationwide, which veterans' supporters said are affecting local VA branches. Months of delays in appointments, overworked employees and lack of internal support can no longer be ignored, said Brandy Morris, executive vice president of the local American Federation of Government Employees labor union in Asheville.

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2.11 - WEAU (NBC-13, Video): [House members pass Whistleblower Protection Bill](#) (12 October, Ruth Wendlandt, 276k online visitors/mo; Eau Claire, WI)

In a bi-partisan vote, House members unanimously passed Representative Sean Duffy's Whistleblower Protection Bill. The Dr. Chris Kirkpatrick Whistleblower Protection Act ensures no one is retaliated against for coming forward with concerns about waste, fraud, and abuse at the veteran affairs. It also requires the VA to come up with a plan to restrict unauthorized employee access to medical files.

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2.12 - Parkersburg News & Sentinel: [Outrageous: VA culprit deserves more than a lecture](#) (13 October, Editorial Board, 187k online visitors/mo; Parkersburg, WV)

How should a Department of Veterans Affairs manager who defrauded the government, took chances with veterans' health care, then devised a coverup be punished? Readers probably have their own ideas about that. But according to the federal government, the answer is ... counseling.

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2.13 - WAGM (FOX-8): [After Report Shows VA's Failure to Disclose Medical Malpractice at Togus, Rep. Poliquin Acts to Make Changes](#) (12 October, 35k online visitors/mo; Presque Isle, ME)

Congressman Bruce Poliquin, along with House Conference Chair Cathy McMorris Rodgers (WA-05) and House Veterans Affairs Committee Chairman Phil Roe (TN-01), today introduced the Ethical Patient Care for Veterans Act of 2017. This legislation requires Department of Veterans Affairs (VA) medical professionals to report directly to state licensing boards if they witness unacceptable or unethical behavior from other medical professionals at the VA.

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2.14 - WAGM (FOX-8): [Rep. Poliquin's Bill to Ensure VA Headstones For Veterans' Families Buried in Cemeteries Advances in the House](#) (12 October, 35k online visitors/mo; Presque Isle, ME)

Today, Congressman Bruce Poliquin had his Veterans bill pass out of committee with unanimous, bipartisan support. Congressman Poliquin's legislation would ensure that Veterans' family members who are buried at tribal Veterans cemeteries—such as the Houlton Band of Maliseet Indians Tribal Veterans Cemetery in Aroostook County—are provided government furnished headstones...

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2.15 - KOB (NBC-5, Video): [Oregon politician concerned about Roseburg VA medical facility](#) (12 October, 27k online visitors/mo; Medford, OR)

An Oregon congressman is asking the U.S. Department of Veterans Affairs to address "substandard management" at the Roseburg VA hospital. Congressman Peter DeFazio (D-OR 4th District) said the VA Roseburg Health Care System (VARHS) is a source of concern for constituents, who complained to the governor about the lack of effective and accountable management.

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2.16 - The M Report: [Ginnie Mae and VA Create Refinance Loan Task Force](#) (12 October, Nicole Casperson, 20k online visitors/mo; Dallas, TX)

Ginnie Mae and the Department of Veterans Affairs (VA) recently announced the shaping of the "Joint Ginnie Mae – VA Refinance Loan Task Force," in an effort to address loan churning and repeated refinancing issues. Specifically, the task force is set to focus on examining critical issues, important data, and lender behaviors related to refinancing loans. In addition, the task force will "determine what program and policy changes should be made by the agencies..."

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2.17 - KSNW (NBC-3): [Kansas nurse in Puerto Rico to help Hurricane Maria victims](#) (12 October, 9.1k online visitors/day; Wichita, KS)

A Cheney nurse is in Puerto Rico helping victims of Hurricane Maria. Linda Sue Bayless is a provider at the Robert J. Dole VA Medical Center. As part of the VA's Disaster Emergency Medical Personnel Program System, she signed on to deploy where she was needed most. Bayless left October 4 and is due back on the 18.

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[3. Access to Healthcare](#)

3.1 - Newsweek (Video): [PTSD Treatment: How Ai Is Helping Veterans With Post-Traumatic Stress Disorder](#) (12 October, Joseph Frankel, 9.4M online visitors/mo; New York, NY)

The Institute for Creative Technologies at USC got lots of buzz for its original research, and introducing the world to Ellie, a digital diagnostic tool that strongly resembles, but cannot replace a human therapist. Ellie, an avatar of a woman in a cardigan with olive-toned skin and a soothing voice, listens to the people who come to her, and does what any human sounding board does. She listens to the content of their speech, and scans their facial expressions, tone, and voice, for cues that hint at meanings beyond speech.

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3.2 - KTVU (FOX-2): [Services available for veterans at Napa Valley College evacuation center](#) (12 October, 2.1M online visitors/mo; Oakland, CA)

The Vet Center, a subsidiary of the U.S. Department of Veterans Affairs, deployed personnel today to the wildfire evacuation center at Napa Valley College from Concord and Fairfield to provide mental health services and paperwork assistance for any displaced veterans. They

were at the shelter today with a trailer set up for three separate counseling sessions to be conducted simultaneously.

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3.3 - The Gazette: [Mayor, nonprofits plead for Colorado Springs landlords to help homeless vets](#) (12 October, Jakob Rodgers, 870k online visitors/mo; Colorado Springs, CO)
The vouchers include a caseworker for each veteran who can help them find jobs, access health care and, if need be, find addiction treatment. "We want to help you have success," said Erika Huelskamp, who coordinates the VA's local voucher program. "We are just a phone call away. We're here for you, just as much as that veteran."

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3.4 - Daily Press: [Virginia lawmakers cite payment delays in veterans health program](#) (12 October, Hugh Lessig, 863k online visitors/mo; Newport News, VA)
The Department of Veterans Affairs owes Virginia health care providers millions of dollars for services provided to veterans who sought treatment outside the VA system, says the state's congressional delegation, who want the VA to pay its bills. At issue is Veterans Choice, a popular but controversial program that allows former service members to seek care in the community if they have to wait too long for an appointment or live too far from a Veterans' Affairs facility.

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3.5 - KLTU (ABC-7, Video): [Veteran says medications from VA repeatedly lost in the mail](#) (12 October, Sophia Constantine, 837k online visitors/mo; Tyler, TX)
An East Texas woman who is a military veteran of over fifteen years is struggling after her medications have been misplaced in the mail twice over the past six months. Jill Morehouse receives mail order prescriptions from the VA once a month. Each time, a 240-count bottle of Vicodin. Over the past six months, she says two of those prescriptions never arrived.

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3.6 - The Daily Reporter: [VA Clinic to stay in Spirit Lake](#) (12 October, Seth Boyes, 45k online visitors/mo; Spencer, IA)
Anticipation had been building as to where the Sioux Falls Veterans Affairs Medical Center would place its new clinic. Several locations in the region were considered, but Director Darwin Goodspeed with the Sioux Falls VA Health Care System announced Thursday a new clinic will be built in Spirit Lake, near the intersection of Highway 9 and Royal Avenue, just west of the Great Lakes Mall.

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3.7 - BeyondChron: [New VA Privatization Threat To Vets](#) (12 October, Suzanne Gordon, 39k online visitors/mo; San Francisco, CA)
On Thursday October 5th, the American Federation of Government Employees (AFGE) the union that represents federal employees, held a briefing on the threat to privatize the Veterans Health Administration (VHA), on Capitol Hill in Washington, D.C. Veterans, VHA caregivers, and policy analysts warned Congressional staff and the media on the cost to veterans if more and more VHA care was outsourced to the private sector.

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3.8 - The Laughlin Nevada Times: [VA clinic expands services](#) (12 October, Jennifer Denevan, 300 online visitors/mo; Bullhead City, AZ)

The MCPO Jesse Dean VA Clinic is getting some help in providing services to local veterans. The clinic will be expanding services via telemedicine to help ensure veterans are getting the care they need. Some services were recently expanded and more times offered and more services are coming at the end of the year. The big difference comes in expanding the number of slots available for care to be given.

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3.9 - Northeastern Public Radio: [Young Meets With VA Officials To Discuss Veteran Wait Times](#) (12 October, Jill Sheridan, 900 online visitors/day; Fort Wayne, IN)

U.S. Sen. Todd Young (R-Ind.) met with federal Veterans Administration officials to discuss the long waits many veterans face to have claims processed, and says he wants to work directly with the office to make significant changes. Young says the amount of time veterans have to wait for a claim to be processed is around two years and appeals take even longer.

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[4. Women Veterans](#)

ABC News: [Women vets pose for pin-up calendar to raise money for fellow vets' health care](#) (12 October, Joi-Marie McKenzie, 24.1M online visitors/mo; New York, NY)

The calendar, which serves as a fundraiser to help veterans' hospitals and health care programs, was started in 2006 by Gina Elise. Her grandfather served in World War II. "At the time, there were many stories in the news about our troops coming back from Iraq, needing medical care that I felt so strongly that I wanted to do something to support our troops and veterans," she told ABC News.

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[5. Appeals Modernization](#) – No Coverage

[6. Strategic Partnerships](#)

6.1 - Lake County News-Sun: [Durbin: Lovell Center ideal 'test case' for sharing health records between VA, active-duty personnel](#) (12 October, Yadira Sanchez Olson, 41k online visitors/mo; Chicago, IL)

U.S. Sen. Dick Durbin met with physicians of the Captain James A. Lovell Federal Health Care Center Thursday to hear what challenges they face while caring for the nearly 67,000 veterans and active-duty military men and women, along with the families of active-duty personnel. Although his visit to the North Chicago facility was brief, physicians quickly conveyed to Durbin the need for the facility to streamline its technology systems...

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7. Supply Chain Modernization

7.1 - Stars and Stripes: BRAC for VA: Lawmakers search for ways to reduce the number of VA facilities (12 October, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

The House Committee on Veterans' Affairs on Thursday initiated what could be a long and politically arduous process to get rid of aging and underused Department of Veterans Affairs facilities nationwide. Committee Chairman Rep. Phil Roe, R-Tenn., and Rep. Tim Walz, D-Minn., the ranking Democrat, presented a draft bill that would create an 11-member, paid commission to recommend which facilities to close and where the VA should invest.

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7.2 - Government Executive: Lawmakers Debate Bringing BRAC to VA Health Care Facilities (12 October, Eric Katz, 852k online visitors/mo; Washington, DC)

House lawmakers are pushing for the Veterans Affairs Department to go through a process to close down or realign underutilized medical facilities, similar to the Base Realignment and Closure process at the Defense Department. The measure would require the VA secretary to assess the department's current capacity to provide health care in each of its networks and ultimately recommend facilities to close, modernize or realign.

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8. Other

8.1 - Stars and Stripes: Lawmakers consider pushing VA to sell Pershing Hall, its 5-star Paris hotel (12 October, Nikki Wentling, 1.5M online visitors/mo; Washington, DC)

There's an effort underway in Congress to have the Department of Veterans Affairs sell an 18th century building it owns in Paris that's leased as a five-star boutique hotel and spa. Members of the House Committee on Veterans' Affairs voiced support Thursday for a bill authorizing the sale of Pershing Hall, which was established as a World War I memorial by the American Legion in 1928 and transferred to the VA in 1991.

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1. Top Stories

1.1 - USA Today (Video): [VA vows changes on bad health care providers, lawmakers take action after USA TODAY investigation](#) (12 October, Donovan Slack, 37M online visitors/mo; McLean, VA)

WASHINGTON — The Department of Veterans Affairs is pledging to overhaul its reporting policies for bad medical workers and a group of lawmakers is introducing legislation following a USA TODAY investigation that found the VA has routinely concealed shoddy care and staff mistakes.

VA Secretary David Shulkin directed agency officials to expand a nearly 30-year-old policy that limited what medical providers the agency would report to a national database created by Congress to prevent problem medical workers from crossing state lines to escape their pasts and keep practicing.

The agency will report all clinicians going forward, VA Press Secretary Curt Cashour said. Shulkin also asked staff to re-write 12-year-old guidelines for reporting them to state licensing boards in an effort to speed up the process.

“Under Secretary Shulkin, VA’s new direction is to hold employees accountable and to be transparent with our findings and actions,” Cashour said.

The legislation from Rep. Cathy McMorris Rogers, R-Wash., Rep. Phil Roe, R-Tenn., and Rep. Bruce Poliquin, R-Maine, would require VA doctors themselves to report directly to state licensing boards within five days of witnessing unacceptable behavior from fellow doctors.

“These newest reports out of the VA are deeply troubling,” McMorris Rodgers said. “This bill will help reform the culture at the VA by holding bad actors accountable and keeping them from continuing these mistakes at the VA or elsewhere.”

The USA TODAY investigation found the VA has frequently failed to ensure its hospitals reported problem health care providers to state licensing boards. Such reports can be delayed by years. The investigation also found the VA policy on reporting to the national database left out thousands of providers. The agency previously reported only physicians and dentists — no nurses, physicians’ assistants, or podiatrists.

The VA determined one podiatrist at its hospital in Maine harmed 88 veterans, including a woman who after two failed ankle surgeries chose to have her leg amputated rather than endure the pain. Still, the agency didn’t report the foot doctor to the database under its previous policy, and took two years to report him to state licensing boards.

In other cases, USA TODAY found VA hospitals signed secret settlement deals with dozens of doctors, nurses and other health care workers that included promises to conceal serious mistakes — from inappropriate relationships and breakdowns in supervision to dangerous medical errors — even after forcing them out of the VA.

Roe, chairman of the House Veterans Affairs Committee, said the committee has “long been concerned about VA’s settlement agreements, and even held a hearing on the topic last year.”

“The findings of the USA TODAY investigation are intolerable,” he said. “Malfeasance within the department will not be ignored, and it certainly cannot be rewarded and hidden from state licensing boards. As a physician, I find this deeply troubling.”

In response to USA TODAY’s findings, Shulkin directed that any future settlement agreements worth more than \$5,000 be approved by top VA officials in Washington. Previously, local and regional officials made decisions on the deals, which can cut short potentially costly employee challenges of VA disciplinary actions.

On Wednesday, the agency also said it planned to post publicly for the first time data on settlements that are approved. The first tranche of data shows that since President Trump took office in January, the VA has struck agreements with at least 160 employees involving payouts totaling \$4.2 million.

Poliquin said Thursday that USA TODAY’s findings were “appalling” and singled out the revelations about the podiatrist at the Togus VA hospital on the outskirts of Augusta, Maine.

“Our Maine veterans depend on their services at Togus and other VA facilities across our State for critical care, and it is absolutely unacceptable for them to ever be subjected to this kind of medical malpractice,” he said.

At least six patients of the podiatrist, Thomas Franchini, are suing the federal government over the care they received. Despite the VA taking years to tell patients about its findings on his surgeries, the government has argued their claims should be dismissed because they were filed after the three-year deadline for medical negligence claims in Maine. Oral arguments in the case are scheduled October 25.

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1.2 - U.S. News & World Report (AP): [Congress OKs Expanded Protections for Federal Whistleblowers](#) (12 October, Hope Yen, 24M online visitors/mo; Washington, DC)

WASHINGTON (AP) — Congress voted Thursday to boost the protection of federal whistleblowers from retaliation, part of a bid to uncover bad behavior at the Department of Veterans Affairs and other government agencies.

The House easily cleared the bill, 420-0. It now goes to President Donald Trump for his signature, having previously passed the Senate in May.

The measure would extend whistleblower protections to federal employees who are in probationary periods and provide training to ensure workers know their rights. It also establishes minimum disciplinary standards for supervisors who retaliate against employees for seeking to disclose wrongdoing.

The legislation, introduced by Sen. Ron Johnson, R-Wis., is named after Dr. Chris Kirkpatrick, a psychologist at the VA Medical Center in Tomah, Wisconsin. Kirkpatrick committed suicide in 2009 on the day he was fired by VA for questioning the over-medication of veterans. A VA investigation later found Kirkpatrick’s concerns had been warranted.

House Speaker Paul Ryan, R-Wis., said the legislation provides much-needed protections to whistleblowers. "No one who stands up for our veterans should be marginalized, let alone targeted and fired," he said.

The bill also would require the VA to put together a plan within six months to prevent supervisors from improperly accessing an employee's medical files in retaliation.

VA Secretary David Shulkin has pledged to bring greater accountability to the government's second largest agency, which provides medical care to millions of veterans. In July, Shulkin began posting employee disciplinary actions and announced that he would require approval by a senior official of any settlement with a VA employee over the amount of \$5,000, citing unnecessary payments to bad employees. A month later, he ordered a review to expand VA reporting requirements for bad workers.

During the 2016 campaign, Trump described the VA as the "most corrupt," promising to "protect and promote honest employees" at VA who expose wrongdoing.

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1.3 - U.S. News & World Report (AP): [Ex-Head of Tomah VA Allowed to Resign, Given Settlement](#) (12 October, 24M online visitors/mo; Washington, DC)

TOMAH, Wis. (AP) — The former head of the Tomah VA Medical Center was allowed to resign and given a settlement after allegations that painkillers were being overprescribed to patients.

Mario DeSanctis was fired from the hospital in 2015. But a USA Today investigation found he fought his dismissal and reached a deal in which he was allowed to resign. He and his attorney were paid \$163,000.

The Tomah VA hospital was rocked in January 2015 by reports of inappropriate dosages of narcotic pain killers and retaliation against employees who questioned the practice.

DeSanctis did not return a phone message left by The Associated Press on Thursday.

Jason Simcakoski was a Marine who died in 2014 from a fatal combination of drugs. His widow, Heather Simcakoski, told the La Crosse Tribune the settlement was "really disappointing."

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1.4 - Reuters: [Virtual interviewer prods veterans to reveal post-traumatic stress](#) (12 October, Ronnie Cohen, 43.6M online visitors/mo; New York, NY)

Talking – to a computer-generated interviewer named Ellie – appears to free soldiers and veterans who served in war zones to disclose symptoms of post-traumatic stress, a new study finds.

Warriors and veterans were up to three times more likely to reveal symptoms of post-traumatic stress to Ellie, the virtual chatbot, than on an official military survey called the post-deployment health assessment (PDHA), even after being assured the assessment would remain anonymous, researchers report in *Frontiers in Robotics and AI*.

“We believe this could be of value to veterans,” said study leader Gale Lucas, a research psychologist at the University of Southern California’s Institute for Creative Technologies in Los Angeles. “Having a conversation, even if it’s with a computer, would help them open up and really realize they might be having some issues.”

Recognizing psychological battle wounds is a necessary first step toward healing them.

As many as one in five recent combat veterans develops post-traumatic stress disorder (PTSD), an overactive fear memory that triggers disturbing thoughts, feelings and dreams, according to the U.S. Department of Veterans Affairs.

Stigma around mental health problems frequently prevents soldiers and veterans from admitting symptoms or seeking help, Lucas said in a phone interview.

“Allowing PTSD to go untreated can potentially have disastrous consequences, including suicide attempts,” she said.

Since 2004, suicide rates among active U.S. Army personnel have been rising, but the military’s current PDHA assessment identifies only one in seven soldiers who are considering suicide, previous research has shown.

In an effort to identify early signs of psychological scars, Lucas would like for Ellie, who was developed with U.S. Department of Defense grant money, to be available in kiosks set up in Veterans Administration hospitals throughout the nation.

Ellie starts the conversation with simple questions, such as, ‘Where are you from originally?’ and ‘What do you like to do to relax?’ to develop rapport with soldiers and veterans, Lucas said. Then she asks if they have nightmares, feel on guard or experience other telltale signs of PTSD.

“She’s very nonjudgmental, supportive,” Lucas said.

“We’re not trying to make virtual-agent therapists. She’s not giving treatment. All she’s doing is having a conversation, having them think and open up about the mental health symptoms they might have,” she said.

Prior research has shown that establishing rapport and ensuring anonymity are key to war veterans’ admitting that they are experiencing emotional wounds.

But veterans are hesitant to discuss their psychological suffering with other people, Lucas said.

“If they are talking to a human, they feel judged,” she said. “People feel more comfortable opening up to a computer than a human.”

In two studies, Lucas and her team found that Ellie’s questions prompted soldiers and veterans to open up and reveal more of their mental health needs.

In the first, researchers tested 29 active-duty Colorado National Guard service members returning from Afghanistan.

One of every four service members reported post-traumatic stress symptoms on the official PDHA, and one of three reported symptoms when the questionnaire was made anonymous. In conversations with Ellie, far more – three of four – reported symptoms.

In a second study of 132 active-duty service members and veterans, participants were more than twice as likely to report PTSD symptoms to Ellie than on an anonymous survey.

Alan Peterson, a clinical psychologist and professor at the University of Texas Health Science Center in San Antonio, said fear that service members could lose their jobs often impedes their reporting of psychological symptoms.

“In reality, there can be negative career consequences associated with reporting certain symptoms and behaviors,” said Peterson, who was not involved with the study. “This can be especially true for individuals seeking treatment for conditions such as PTSD, if they are not successfully treated into remission and subsequently determined to be fully fit for military duty.”

Making successful treatments available to soldiers would go a long way to reducing the stigma of seeking psychological help, he said.

“Veterans go through a lot for our country, and I really believe that we should take care of them, not just their physical scars, but their mental scars,” Lucas said.

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1.5 - The Washington Post: [Virginia lawmakers say late VA payments jeopardize veterans' care](#) (12 October, Jenna Portnoy, 43.9M online visitors/mo; Washington, DC)

Members of Congress from Virginia say chronic late payments from the Department of Veterans Affairs to doctors are jeopardizing care for the state's aging veteran population.

The state's two senators and 11 House members urged VA administrators to fix a system that can leave health-care providers waiting more than four months for payments they should have received within 30 days. The delays can damage credit, they said.

Congress created the Veterans Choice program in 2014 in response to a scandal exposing excessively long wait times at a Phoenix VA hospital that also had been a problem nationwide.

The program is intended to relieve pressure on VA hospitals by allowing veterans to receive care from private providers if they cannot book an appointment at their local VA facility within 30 days or access a facility within 40 miles of their home.

Since its inception, Veterans Choice has been hobbled by administrative errors, including tens of millions of dollars in overpayments, according to findings of the VA Office of the Inspector General.

“With many health care providers reporting accounts receivable in the millions of dollars, the level of late payments is unacceptable,” the Virginia delegation wrote in an Oct. 3 letter to Secretary of Veterans Affairs David Shulkin.

Rep. Rob Wittman (R-Va.) said Congress requires VA to pay bills in a timely manner.

“Everyone else in society has to do that,” he said in an interview. “If this program is going to work properly, then these bills need to be paid on time.”

Wittman, chairman of the House Armed Services subcommittee on sea power and projection forces, said he has talked to the committee chairman, Rep. Phil Roe (R-Tenn.), about calling Shulkin to testify if VA doesn’t reconcile outstanding bills soon. Virginia is home to 733,000 veterans.

“This is the law,” he said. “This is what you’re supposed to be doing. Why isn’t it getting done?”

VA spokeswoman Paula Paige said in a statement, “VA appreciates the lawmakers’ concerns and will respond to them directly.”

She referred specific questions to a May speech by Shulkin in which he said it takes more than 30 days to process 20 percent of VA claims from 25,000 providers nationwide. An additional \$50 million in charges are older than six months. He blamed the backlog in part on paperwork delays.

The latest stories and details on the 2017 Virginia general election and race for governor. Community care is handled through several federal programs, making it “too complex, and it’s confusing veterans and our employees alike,” he said.

Riverside Health System in eastern Virginia reported that 45 percent of claims totaling \$2 million went unpaid for more than 120 days. Private insurance companies as well as Medicare and Medicaid take about 60 days, said Mark Duncan, Riverside’s lobbyist.

Riverside considers it an honor to care for veterans, but “we need to have the tools the resources to provide that type of service to these folks over the long term,” Duncan said in an interview. “They’ve more than earned that service.”

The letter details a case relayed by the office of Rep. Barbara Comstock (R), who represents Northern Virginia, in which a veteran was denied dentures because VA failed to pay a private provider \$203,000. Comstock’s spokesman said the case has been resolved.

Veterans Choice allows veterans to avoid inconvenient travel to VA facilities in Martinsburg, W.Va., or the District, but VA “must get its house in order,” Comstock said in a statement.

In August, Congress approved \$2.1 billion in emergency funding intended to shore up the program until February.

Last month, Sen. John McCain (R-Ariz.), chairman of the Senate Armed Services Committee, wrote a letter to Shulkin demanding a full accounting of Veterans Choice spending after the Associated Press reported that the program could face another shortfall before the end of the year.

“We said at the time that it was essential, given the growing demand for care under the Choice program, that the VA immediately correct the failures that created such a serious shortfall,” McCain wrote. “It appears as if you have not done so.”

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1.6 - The Washington Post: [‘This is frightening’: Noxious gas has sickened VA workers for two years, with few solutions](#) (12 October, Alex Horton, 43.9M online visitors/mo; Washington, DC)

Staff and patients at a D.C. medical facility for homeless military veterans have endured noxious gas exposure for nearly two years as top hospital administrators, though aware of the problem, have failed to remedy it, according to interviews with staff and documents obtained by The Washington Post.

At least eight clinical workers at the Department of Veterans Affairs Community Resource and Referral Center have tested positive for elevated levels of carbon monoxide, a March internal email said, describing a potentially dangerous condition that restricts oxygen circulation. As many as 30 employees, desperate to avoid further exposure, have sought reassignment or permission to work remotely.

One doctor resigned in protest after VA leaders were unable to produce solutions, clinic staffers said.

“Many of my colleagues, including myself, have experienced some type of illness while working in the CRRC,” one staffer wrote in an August email responding to a VA health official who appeared to play down symptoms of concerned workers. The most recent incident was Oct. 4, staffers said.

The Post reviewed dozens of emails and records, and conducted numerous interviews with clinical workers and others familiar with the problem. What emerged is an unsettling glimpse of VA’s struggle to mitigate a potentially significant health hazard, and raises questions about the agency’s ability to fulfill the promises it has made to improve accountability. The troubled agency was identified early on by President Trump as being in dire need of sweeping reform.

VA spokesman Curt Cashour said the hospital’s leadership “took aggressive steps to look into the problem” once complaints began to circulate. Tests conducted by VA health officials and the local fire department and gas company, among others, “discovered no leaks, hazardous fumes or health risks,” he said, adding that officials continue to monitor the situation.

But those who work at the facility say those tests may not have been performed quickly enough, before the gas dissipated, or if the contractors brought in to conduct them knew which gases to evaluate.

On a given day, the facility is staffed with about 40 employees who serve dozens of patients, all homeless and at-risk veterans who seek care at the clinic. The incidents — numbering in the dozens since winter 2015 — have occurred intermittently and without warning.

Though it remains unclear what's causing the issue, the clinic's staff members have speculated that it could be anything from vehicle exhaust entering the building's heating system intake valves to sewer gas surfacing through sinks and drains. They've reported a range of symptoms, including intense headaches, rashes, stinging eyes, nausea and others — all of which are consistent with sewer gas exposure, as defined by the Centers for Disease Control and Prevention.

Administrators have not only allowed the problem to fester, they have also ordered clinicians back into the building, staffers say.

"I felt devalued. It was like our health wasn't important and our concerns weren't heard," one staffer told The Post, saying morale cratered among those tasked with what they call a rewarding yet grueling effort to help homeless veterans find housing along with primary and mental health care. Those familiar with the facility's troubles spoke on the condition of anonymity, citing their fear of reprisal.

The Community Resource and Referral Center, off Rhode Island Avenue NE, is part of the Washington DC VA Medical Center, the sprawling federal agency's self-proclaimed "flagship" facility. Its acting director, Lawrence B. Connell, has known about the problems there since June, according to emails exchanged among staff. At least two incidents have occurred since then — with 19 verified in all since late 2015, according to partial records obtained by The Post and data provided by the D.C. fire department.

Local firefighters responded to four such calls between February and November 2016. The last time was Nov. 30. One day later, a clinic safety official notified staff that, in the future, they should refrain from pulling a fire alarm if they encounter "noxious fumes" and to alert Washington Gas instead.

A spokesman for the utility company said no gas leak was found.

Connell "has been briefed regularly on these complaints and has been personally involved in the comprehensive, multipronged response involving respected investigators from both inside and outside VA," said Cashour, VA's spokesman. He was a senior adviser to VA Secretary David Shulkin before becoming the medical center's acting director this past summer. Connell accepted the job after his predecessor, Brian A. Hawkins, was removed after an internal investigation found patients receiving treatment at the facility had been endangered by "the highest levels of chaos" created by managerial ineptitude, a VA inspector general's report concluded.

One months-long email chain exchanged among several clinicians reveals a problem so persistent that it had become banal. "Just wanted everyone to know the gas smell is back," a staffer wrote Feb. 21. Another chimed in nine minutes later: "We smell something also in our area." Two hours later a third staffer wrote, "Haven't smelled it in a couple hours but I do have a bad headache."

Two days later, on Feb. 23, a mental health clinician said she briefed then-director Hawkins on the issue, saying unspecified repairs were made.

Hawkins could not be reached for comment.

On March 30, the emails resumed, when the gas smell returned, and again on May 17, when a social worker reported smelling vehicle exhaust.

Nine days later, after another incident, one staff member wrote, "I can only say this is frightening."

Hawkins was gone by then, but the problem was inherited by his successor.

"I raised the issue with Mr. Connell and the staff . . . this morning again," a senior staffer told colleagues on June 10, a day after yet another incident.

It is unclear how many clinic staffers and veterans have been exposed to the gas or what, if any, permanent afflictions they may carry. Staffers say their symptoms seem to improve when they are away from the clinic. The documents don't indicate anyone's current medical status, including the eight who tested positive for carbon monoxide.

One staffer said the patients are thought to be less at risk because they come for appointments and then leave, though they may not make the connection between potential symptoms and their visit to the clinic.

Staff members, however, can inhale the gas for hours on end.

VA safety officials and senior leaders, discussing the issue internally, say they've tried to resolve the problem. They point to numerous air tests for carbon monoxide, carbon dioxide and other gases as indication of their effort.

Two outdoor pipes were adjusted after some speculated that vehicle exhaust was to blame. Access to a dumpster was blocked. Building contractors even dumped water into drains to flush any sewer gas. An environmental liaison for the building's owner, Lincoln Property Company, acknowledged in December that sewer gas was a contributing factor that had been resolved.

A senior VA official visited Oct. 4, when the most recent gas exposure occurred, but it is unclear whether he experienced the problem firsthand.

Staffers at the clinic point to Todd Williams, one of two acting assistant directors of the main VA hospital who report to Connell, alleging that he too has played down the problem.

On Aug. 12, he said in an email that relocating dumpsters and blocking off two parking spots near an intake pipe would "further mitigate risk associated" with vehicle exhaust circulating in the building. "Given these efforts," he wrote, "do we have a timeline for relocation of providers back to CRRC?"

Cashour declined to address questions about Williams's role in resolving the issue.

Williams does not work at the clinic. Leadership on site has been more sympathetic, staffers say. For instance, a nursing manager advised staff to seek doctor's notes if they feared contact with the gas would adversely impact their health, emails show.

Staffers asked for health officials to conduct an epidemiological analysis of symptoms and exposure rates over time.

VA said they completed assessments and found no link between the clinic and health concerns.

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1.7 - The Denver Post: [Dozens of surgeries at Denver VA hospital put off because of doctor shortage, Too few anesthesiologists and competitive market to blame, VA says](#)
(12 October, David Migoya, 4.8M online visitors/mo; Denver, CO)

A shortage of anesthesiologists at Denver's veterans hospital – despite salary offers reaching as high as \$400,000 a year – has forced a delay in dozens of surgeries just months after the institution was tagged with some of the nation's worst waiting lists for care.

Though the hospital employs eight anesthesiologists and eight nurse anesthetists, they're short of the complement needed to meet surgery demands that run about 380 operations a month, a spokeswoman said, noting some staff has left for other jobs as well as taken paternity and maternity leaves.

"Currently we have had approximately 65 to 90 nonemergent surgeries rescheduled or postponed due to a shortage of anesthesiology staff," VA spokeswoman Kristen Schabert said. She offered no examples.

VA data show the average wait time for new-patient surgical appointments at the facilities that make up the Eastern Colorado Health Care System during the 2017 fiscal year that ended Sept. 30 is about 21.6 days, which is slightly better than the national average of 22.7 days. The average wait time at just the Denver facility is 18.6 days.

VA's waiting time in fiscal 2017 for surgery for established patients is 9.5 days, longer than the national average of 5.8 days, according to the VA. It is 8.3 days at the Denver facility.

The latest situation was first reported by FOX-31 News, and it's an extension of a problem that's plagued the Denver facility since the summer.

In July, The Denver Post reported that wait times for primary care medical appointments at veterans facilities in eastern Colorado and the Denver area were among the worst in the nation, and that Front Range veterans have seen little improvement in the three years since a national scandal erupted over the problem.

Colorado congressmen assailed the agency for its continued — and worsening — issues over veteran care, especially after the VA battled other controversies such as the massive delays and cost overruns in constructing a new \$1.7 billion facility in Aurora, which is expected to open in the spring.

Officials of VA's Eastern Colorado Health Care System at the time said critical shortages in medical personnel – including the doctors and nurses that are at the root of the surgery delays faced today – made it difficult to keep up with the growing demand Colorado has seen from an increasing veteran population.

Sometimes, chief of staff Dr. Ellen Mangione said, veterans would rather wait for a familiar face at the VA than be seen more immediately by a doctor outside the system, even when given the choice to do so.

The eastern system had a 16 percent vacancy rate — there were 336 physicians — during the summer crisis, even though it was offering some primary care doctors as much as \$200,000 a year in salary and additional training. Schabert did not immediately have current vacancy figures.

“Our leadership has been supportive and we were able to up our salary offerings to remain competitive,” Schabert said of the search for anesthesiology professionals, “but ... Denver is a competitive market.”

Until hires are made, the eastern system is contracting with temporary outside physicians, known as a “locum,” to fill the gaps, Schabert said.

And the eastern system is no longer among the nation’s worst waiting periods for an appointment to see a primary care physician, VA data show, although it still ranks high with an 11-day average compared with a 4.8-day national average.

It’s been replaced by the VA health care system in Grand Junction, where the average wait for a primary care visit is 18 days, data show. That system is nearly one-tenth the size of Denver’s.

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1.8 - Military Times: [Lawmakers take first steps toward a BRAC for VA facilities](#) (12 October, Leo Shane III, 2.1M online visitors/mo; Springfield, VA)

WASHINGTON — House lawmakers took the first steps Thursday toward shutting down hundreds of Veterans Affairs facilities through a process similar to military base closure rounds, saying the move is critical to keep the department from wasting millions of dollars on underused, aging buildings.

But some of the largest veterans groups said they have serious concerns with the proposal, saying it’s ripe for abuse and could tempt VA officials to outsource more veterans’ medical care to private-sector physicians.

Even supporters admitted the plan will be a difficult sell on Capitol Hill.

“This bill is bold, transformative and controversial,” said Rep. Phil Roe, R-Tenn., chairman of the House Veterans’ Affairs Committee. “Moving forward with it will require a significant amount of political courage and, let’s face it, members of Congress are not known for that.”

At issue are the roughly 6,300 facilities owned VA spread across the country. Department officials have said more than 57 percent of those locations are more than 50 years old, and hundreds of others provide little value to veterans care or department management.

VA Secretary David Shulkin in June announced plans to close at least 430 vacant or mostly vacant buildings over the next year, a move that is expected to save about \$7 million annually.

But he also has pushed for further authorities to close other locations, to better match department resources with future needs.

The VA base-closure-style plan — dubbed the Asset and Infrastructure Review Commission — would establish an eleven-member outside panel to recommend facility closings and resource shifts based on facility needs criteria to be established by the VA secretary.

That would involve an in-depth review of VA real estate and health care strategies, complete with public hearings. The final commission recommendations would need to be approved by the president. Congress would have 45 days to override the White House decision if they disagree with the planned closings and moves.

Much like the military base closing commissions, the set-up is designed to separate facility closing choices from political whims. Roe and committee ranking member Rep. Tim Walz, D-Minn., said the commission could also recommend setting up new facilities in underserved areas, using savings from other closings to pay for the new sites.

But veterans groups who testified before Roe's committee on Thursday said they have serious concerns that an outside panel could focus on savings instead of seeking the best care options for veterans, creating major problems for a system already dealing with wait time and access challenges.

Carl Blake, associate executive director at Paralyzed Veterans of America, said his group could support the idea "assuming the intent is to right-size the VA and not simply use this opportunity to reduce the footprint of VA for the purpose of fulfilling a promise for greater community care access and cutting spending."

Officials from Disabled American Veterans said they support a full review of the department's national footprint but aren't convinced the base-closing commission is the right path for that discussion. Officials from the American Legion said their group would not support the plan unless veterans groups had the opportunity to veto recommendations they deem harmful to veterans care.

But even without those concerns, any federal facility closing process faces a difficult path in Congress. Defense Department officials have been petitioning lawmakers for five years to hold another military base closing round, only to have the proposal rebuffed annually.

Government Accountability Office researchers said the last five BRAC rounds have produced nearly \$12 billion in annual federal savings. But the last round conducted in 2005 still has not recouped its original costs, which has lead many in Congress to question the value of such cutbacks.

Roe insisted this plan is different, because the focus isn't on generating savings but instead better preparing the department to respond to veterans needs. The proposal for now is only draft legislation, but he said he hopes to move forward on the issue in coming weeks.

Veterans groups said they would continue to work on the issue with lawmakers but emphasized their skepticism.

Acting VA Deputy Under Secretary for Health for Policy Regan Crump said department officials are not backing the idea of an outside asset commission yet, but do support “the need for more flexibility” with VA facilities.

As the congressional debate continues, VA officials are reviewing another 784 non-vacant but underused facilities to determine if they can close or restructure them in coming months.

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1.9 - Stars and Stripes (Military Update): [VA, Congress crawl toward ending abuse of vet pensioners](#) (12 October, Tom Philpott, 1.5M online visitors/mo; Washington, DC)

In 2012, the Government Accountability Office found more than 200 financial planning firms and estate law offices enticing veterans or their survivors into costly annuities or irrevocable trusts intended to hide or reallocate their assets so they qualify for VA pensions that the claimants wouldn't be eligible for otherwise.

Since then, the Department of Veterans Affairs and Congress have been crawling toward actions to stop the abusive practices, which twist the intent of the pension benefit in ways to help some veterans, put others in financial binds, and generate fees or profits or streams of residents for the schemers.

The crawl toward reform continues. The VA is still working on a draft rule first released for public comment in January 2015. Final publication of the “Net Worth, Asset Transfers and Income Exclusions for Needs-Based Benefits” rule was expected this past summer. However, it remains “in VA’s internal concurrence process,” a VA spokesman said Wednesday.

Meanwhile, the House veterans’ affairs subcommittee on disability assistance and memorial affairs held a first-ever hearing last month on legislation to address financial abuses of the pension program. The Veterans Care Financial Protection Act (now HR 3122) was first introduced in 2014.

The VA pension program exists to help veterans in financial distress if they served at least a day of wartime service, at least 90 consecutive days on active duty and earned an honorable or a general discharge. To be eligible for the basic VA pension, veterans also must have only modest annual incomes or none at all.

They can qualify for more VA financial help, however, if they are disabled and unable to leave their homes unassisted, or they have unmet daily living needs or they face exorbitant medical, assisted care or nursing home costs. The additional financial help is called the VA Aid and Attendance benefit.

“It’s an absolute lifeline for veterans who have significant health problems,” John Katz, the American Legion’s assistant director for pensions at the VA regional office in Philadelphia, told me late last year. “Many people who laid their lives on the line for their country are incapable today of taking care of themselves without housebound benefits or Aid and Attendance, in addition to the nonservice-connected [VA] pension. For them there’s no other way they’d survive.”

About 303,000 wartime veterans and 220,000 survivors draw VA pension benefits. Veteran advocates believe thousands more would qualify if they knew the program existed and applied. What has raised the profile of pensions recently, however, have been the reports of abuse and target marketing by unscrupulous financial planners, lawyers or even care facilities seeking vets who are ill or elderly.

The pension is a needs-based benefit with need determined using thresholds on annual incomes and on assets or net worth. For example, a wartime vet with no dependents can qualify for all or a portion of the basic pension benefit if he or she has income, including Social Security, less than \$12,907 annually. If income is \$10,000, for example, the benefit would be calculated by the maximum annual pension rate of \$12,907 minus \$10,000, for a total of \$2,907 annually.

However, the pension benefit is unique in that it allows veterans to apply medical expenses to offset income calculations and raise the benefit. Even higher amounts are payable if the veteran or surviving spouse is housebound, and more Aid and Attendance dollars are available if claimants need help with daily activities.

A married veteran needing Aid and Attendance can qualify for at least some pension monthly if his or her income doesn't exceed \$25,525. A survivor's pension is smaller but also based on need with consideration too of medical expenses.

The other threshold to determine eligibility is net worth. If assets other than primary residence and vehicle exceed \$80,000, then VA can't assume eligibility without a closer determination. Again, medical-related expenses can be critical. For example, if a veteran with assets totaling \$100,000 moves into an assisted-living facility that costs \$5,000 a month, a VA service officer could determine the asset threshold quickly will be reached and can find the veteran eligible for pension.

Veterans and survivors who believe they might qualify should contact the veterans' service office for their county to fill out required forms. More program information can be found online at: benefits.va.gov/PENSION/index.asp.

A key purpose of regulatory reforms aimed at VA pension benefits is to ensure they are used by low-income veterans or those facing exorbitant medical expenses they can't pay, rather than as a tool to preserve family wealth.

One provision in VA's draft rule would impose a three-year look-back provision on assets to discourage new claimants from hiding assets. Other changes would reset the asset ceiling to the higher and "brighter line" used by Medicaid, and more clearly define medical expenses that can reduce income calculations. The new rule would not leave the threshold on assets open to interpretation as it is now.

Legislative reforms, which show signs of life, take a different approach. As Rep. Matthew Cartwright, D-Pa., testified last month on behalf of his bill, HR 3122, his measure would direct the VA and other federal agencies to work with state officials and outside experts to establish state and federal standards to end "dishonest, predatory or otherwise unlawful practices" that target VA aid and attendance dollars.

"Unscrupulous actors are increasingly exploiting this assistance program by preying on our older veterans' vulnerability," to waste federal dollars and turn "this well-deserved benefit into a financial nightmare for those who can least afford it," said Cartwright.

Some charge veterans “a non-existent application fee to obtain the benefit,” he added. Others collect “consultation fees” with “promises to expedite the application process. Yet another scam is an offer to help veterans qualify for the benefit even when their net worth is too high to qualify.”

In this way, Cartwright explained, financial planners gain control of the veteran’s assets and “move them into an irrevocable trust or annuity, which the elderly veterans often cannot access for many years.”

Increasingly, he said, retirement homes are recruiting veteran residents with promises that they will qualify for VA aid and attendance to cover cost of the home.

“If the A&A claim is later denied, however, the nursing home then demands back payment from the veteran. This is a practice that leaves vulnerable elderly veterans with the undesirable choice of draining their own remaining assets or giving up their new home,” Cartwright said.

He first introduced his bill on learning of companion legislation in the Senate (now S. 1198) from Sen. Elizabeth Warren, D-Mass. The bill now has bipartisan support in the subcommittee. Witnesses for VA and veteran service organizations expressed support. Cartwright promised some changes to reflect concerns from the GAO that it shouldn’t be given a role in establishing the new protection standards given its existing responsibilities for reviewing how the standards are implemented.

With no costs attached, the bill is expected to clear the subcommittee this fall. Full committee action and passage by the House isn’t expected this year.

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1.10 - Public Radio International (Audio): [Meet the women combing through Puerto Rico, searching for veterans in need](#) (12 October, Jasmine Garsd, 1.2M online visitors/mo; Minneapolis, MN)

It’s early in the morning, and the entire city of San Juan, Puerto Rico, seems to be gazing at the sky with concern. It looks like rain but the island just can’t handle any more flooding.

On the highway, under the dark, heavy clouds, a small car makes its way through traffic. In it are four women, Ghislaine Rivera, Mia Lind, Janine Smalley and Katie Blanker, with whom I’m spending the day — it’s Oct. 5.

Our first stop? A school that’s been turned into a hurricane shelter.

Lind, an occupational therapist for the VA Caribbean Healthcare System in San Juan, goes to the door, asking, “Are there any veterans here?”

Every day since the hurricane hit, she and her team have been roaming from shelter to shelter, looking for veterans who need medical attention.

There are somewhere around 75,000 US Army veterans living in Puerto Rico. Most served during the Vietnam War. After Hurricane Maria, many are now living in shelters. Thousands, overall, have been displaced by the storm, and the shelters are packed.

At the school, a supervisor answers: Yes, there's a veteran here.

The VA team finds 70-year-old Luis Torres lying in bed. His dress shirt is wide open and his baseball cap is flipped backward. His bed is surrounded by piles of clothing and some bags of food.

The Air Force veteran was honorably discharged; he has his military ID, but the other paperwork was lost in the storm. "My house ... it disappeared," he says, breaking down in tears.

His teenage son, Andrew Torres, who is also staying here, pulls out his phone to show us pictures of what's left of their house. It's like the roof and the walls were just plucked out. On the second floor, a toilet stands alone in the open.

Janine Smalley takes Luis Torres's vitals. His blood pressure is 130 over 80, so that's "perfect," she says, asking, "Do you take any meds?" Smalley is the VA team's registered nurse and Disaster Emergency Medical Personnel trained by the Federal Emergency Management Agency. She's here from Cleveland, Ohio. She volunteered to come help. She says when she saw what was happening in Puerto Rico, she asked to be sent here.

Meanwhile, Katie Blanker, who also volunteered for this assignment, brings Torres toothbrushes, heating pads and food. Blanker is from Stevens Point, Wisconsin. She's a social worker with the VA and a veteran herself.

Katie Blanker is working in Puerto Rico as a social worker with the VA. She's also a veteran. She's originally from Stevens Point, Wisconsin. Credit: Jasmine Garsd/PRI
Torres cheers up. "Where's the T-bone steak?" he jokes. At least for a few minutes, the mood has lightened up.

Lind says that she, too, had been thinking about steak, just the day before. There is a meat shortage on the island. "I really want to have a meal for my kids that includes beef. That was my goal. To get my kids not canned food. When you have chaos like this, the only right you have is to stay alive. You stay alive, and you survive," she says.

Lind fights back tears. The others from her team hug her. Then she smiles and announces the next neighborhood they're heading to: "Let's go to Rio Grande!"

Let's go "before we're all crying. I was hoping to wait till noon to cry again," Smalley says.

The next shelter is even more packed than the last one.

"May we come in and ask if anyone is a vet?" Lind asks.

A man says there aren't any vets there.

Lind asks the man how he knows.

The man bristles, saying, "I can't force them to talk to you."

Lind thanks him, and the team leaves. Later on, in the parking lot, Lind tells me she suspects some shelters just don't want the VA team coming in. She and her colleagues represent the federal government. And they have to report it if a hurricane shelter isn't providing enough food and water. Or if it's overcrowded.

A lot of these shelters are just repurposed schools, places for people to lie down and rest, with no running water or electricity. This is the new normal. Which is why the last shelter we go to takes us a little by surprise.

The team walks right in. There's a radio blasting pop music. There are kids painting murals. And then there's Benny Molina.

The residents cheer his name as he sits down for a checkup by nurse Smalley. Molina, 61, is a veteran — "National Guard in Riverdale, New Jersey. Specialized in tanks. Driving the tanks," he says.

"Benny that's perfect!" interrupts Smalley. Benny's blood pressure is normal. He jokingly offers to do pushups — in a while — he just had a big meal. The room erupts in laughter.

Ghislaine Rivera, a social worker, asks him what happened to his home. It's gone. Benny lost everything he owned to the storm. The team offers to give him aid packages, with basic supplies, but he refuses. "Right now, we have food and everything ... but some other people are sleeping on the street and they have nothing to eat."

As he fills out his paperwork, Smalley and Blanker take a quick break in the shade. They are red from the heat and visibly tired. They've come a long way, from Ohio and Wisconsin. But, they say, this is a responsibility they have. All of us do.

"We don't know them all, but we owe them all," says Smalley.

"All of the veterans we're here for served for the United States," says Blanker. "This is Americans helping Americans. These veterans were stationed in the US, went to war with the US. I think that's the thing that people forget."

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2. Veteran and Employee Experience

2.1 - The Washington Post (PowerPost, Video): [House to vote on bill requiring discipline for officials who retaliate against whistleblowers](#) (12 October, Eric Yoder, 43.9M online visitors/mo; Washington, DC)

Federal agencies would be required to discipline officials who retaliate against whistleblowing employees, and to fire them on their second offense, under a bill up for a House vote Thursday.

The bill, approved by the Senate in May, is one of many arising from the disclosures starting in 2014 of falsified patient records at the Department of Veterans Affairs. The revelations drew a surge of complaints from lower-level employees who said they had suffered workplace reprisal

from managers for pointing out the problems and that managers were not being held accountable for violating the legal protections for whistleblowers.

“While retaliation at the VA has captured the public’s attention most recently, retaliation against whistleblowers is not confined to any one agency,” a Senate report on the bill says, adding that mandatory discipline is designed to “ensure accountability throughout the Federal Government.”

The bill would require at least a three-day suspension of a federal official found to have committed retaliation by an internal government legal process or by a federal judge and firing for a second offense. The time to contest a notice of proposed discipline would be shortened from 30 to 14 days, but once the firing became final, regular appeal rights would apply.

Congress last year enacted a similar requirement applying only to VA officials who retaliate against employees who disclose fraud, waste or misconduct, with at least a 12-day suspension for a first offense and firing for a second. This year, a law shortening and restricting appeal rights for VA employees was enacted, and on Wednesday the House passed a measure somewhat widening whistleblower protections.

The measure requiring firing for retaliation would create an exception to the general rule that agencies have wide discretion over disciplining their employees. Currently, mandatory firing also applies at the Internal Revenue Service under a long-standing policy known as the “10 deadly sins” involving abuse of authority.

The George W. Bush administration attempted to impose mandatory discipline for certain types of misconduct as part of alternative personnel policies at the departments of Defense and Homeland Security, but neither took effect in the face of lawsuits and opposition from Congress.

Also, under the latest bill, agencies would have to give priority to a request for a transfer on behalf of an employee — including one still in a probationary period — who alleges retaliation; it would be an act of retaliation for an agency official to access the employee’s medical records following a disclosure; and more training on whistleblower rights would be required for new employees and for supervisors.

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2.2 - U.S. News & World Report (AP): [Alaska Veterans Affairs System to Add 100 Staff Members](#) (13 October, 24M online visitors/mo; Washington, DC)

ANCHORAGE, Alaska (AP) — The Alaska Veterans Affairs system has announced it's adding 100 staff members.

KTVA-TV reported Wednesday that Dr. Timothy Ballard said the staff is being added in response to negative reviews from both patients and staff.

Ballard said the new positions are focused on mental health care and support functions. The 100 new jobs boost the system's number of staff to 650 at a cost of \$6 million.

Ballard said money to pay the new workers is being repurposed from other places in the budget.

He said the system is also increasing the speed at which it fills vacancies, bringing the wait time down from six months to six weeks.

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2.3 - Atlanta Journal-Constitution: [Roswell getting \\$21K for veterans adaptive sports](#) (12 October, David Ibata, 11.9M online visitors/mo; Atlanta, GA)

Roswell has agreed to accept \$21,080 from the federal government to purchase equipment and hire instructors for new VA Wheelchair Softball and Adaptive Cycling programs for disabled veterans.

The City Council approved a resolution accepting the FY 201 Adaptive Sports Grant from the U.S. Department of Veterans Affairs. The grant does not require local matching funds, according to a staff report to the council.

The Roswell Recreation, Parks, Historic and Cultural Affairs Department will be responsible for the adaptive sports program.

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2.4 - The Hill: [New whistleblower protections head to Trump's desk](#) (12 October, Cristina Marcos, 11.8M online visitors/mo; Washington, DC)

The House unanimously cleared legislation on Thursday to ensure protections for federal employees who disclose government waste, fraud and abuse.

Passed 420-0, the measure would train federal workers so they understand their protections, as well as enhance penalties for supervisors who retaliate against whistleblowers.

The bill is named after Chris Kirkpatrick, a psychologist was fired from a Department of Veterans Affairs (VA) medical center after raising concerns about patients' medications. He committed suicide on the day he was dismissed.

The bill also orders the VA to create a plan for preventing unauthorized access to employee medical records and conduct outreach to employees about mental-health services.

The Senate passed the legislation, authored by Senate Homeland Security and Governmental Affairs Committee Chairman Ron Johnson (R-Wis.), in May. It now heads to President Trump's desk for his signature.

"Future whistleblowers who take a risk to expose wrongdoing and waste in the federal government deserve the respect and support of our nation. I urge the president to quickly sign these important reforms into law," Johnson said in a statement.

Before final passage, House Democrats offered a procedural motion to amend the bill by extending protections to federal workers who reveal wrongdoing by an agency head or political appointee violating rules or regulations regarding travel.

Democrats offered the motion in light of Tom Price's resignation as secretary of Health and Human Services in September after Politico revealed his extensive use of private jets, instead of commercial alternatives, at taxpayers' expense. Politico estimated Price's travel costs at possibly more than \$1 million.

"The resources invested to agencies to fulfill their missions of serving Americans should not be abused or frivolously flaunted for personal gain or convenience," said Rep. Tom O'Halleran (D-Ariz.), who offered the motion.

Rep. Rod Blum (R-Iowa) did not disagree with the substance of the proposal offered by Democrats, but urged swift passage of the underlying whistleblower legislation so Trump could sign it into law as soon as possible.

"Let's not let one good bill get in the way of another," Blum said.

The motion failed along party lines, as is typical in the House when it comes to procedural votes.

The House also passed two noncontroversial bills by voice vote on Wednesday to protect and encourage whistleblowers.

One measure, authored by Rep. Chuck Fleischmann (R-Tenn.), would allow federal agencies to pay up to \$20,000 in cash rewards to workers who report waste. The other, sponsored by Rep. Steve Russell (R-Okla.), would allow whistleblowers outside the intelligence community to disclose classified information to supervisors in their chain of command.

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2.5 - Bangor Daily News: [‘Dangerous surgeon’ at Togus allegedly made mistakes in 88 cases, but VA kept it quiet](#) (12 October, 1.2M online visitors/mo; Bangor, ME)

An explosive USA Today investigation into medical mistakes allegedly made under the watch of the U.S. Department of Veterans Affairs highlighted what the newspaper described as one particularly egregious case in Maine.

According to the report, podiatrist Thomas Franchini allegedly made mistakes in 88 cases while working at the Togus VA Medical Center near Augusta, the nation's oldest veterans' hospital.

"We found that he was a dangerous surgeon," former hospital official Robert Sampson said during a deposition in a federal lawsuit against the department, according to the newspaper.

U.S. Rep. Bruce Poliquin, R-Maine, described the case as "unacceptable behavior" and called the situation "nothing short of appalling" in a Thursday statement.

USA Today's report describes myriad examples: Franchini allegedly drilled the wrong screw into the bone of one patient, severed a tendon in another, conducted unnecessary surgeries and twice failed to properly fuse a woman's ankle, for instance.

Instead of being fired, the newspaper's investigation found, the department didn't report him as a problem doctor or fire him, but rather allowed him to quietly resign and open a private practice in another state.

The Franchini case was revealed as part of an investigation that uncovered about 230 secret settlement deals in which VA officials quietly cut ties with problem doctors and other medical staff across the country, allegedly promising to conceal serious mistakes and allow many of the personnel in question to go into the private sector with unblemished records.

Franchini, who was reportedly placed on leave by the VA in 2010 and resigned soon thereafter, told USA Today he never got to respond to the department's findings that he'd made serious mistakes, and that his attorney submitted two outside reviews that contradicted those findings.

He also said he has performed many surgeries since leaving the VA without complications.

"If I was so bad, I would be bad all the time," he told USA Today.

Six veterans are now suing the VA accusing the agency of fraudulently concealing Franchini's mistakes.

In response to the report, Poliquin, who represents Maine's 2nd congressional district, announced Thursday he is joining fellow Reps. Cathy McMorris Rodgers of Washington and Phil Roe of Tennessee to introduce a bill that would force agency officials to report to state licensing boards if they discover "unacceptable or unethical behavior from other medical professionals at the VA."

"Our Maine veterans depend on their services at Togus and other VA facilities across our state for critical care, and it is absolutely unacceptable for them to ever be subjected to medical malpractice," Poliquin said in a statement. "We must have accountability at the VA, to ensure our veterans are always getting the best care possible, and I am proud to be working on the Veterans Affairs' Committee to do that."

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2.6 - WFED (AM-1500, Audio): [House passes bill to give TSP participants more withdrawal options](#) (12 October, Eric White, 831k online visitors/mo; Washington, DC)

[...]

The Veterans Affairs Department stepped back a proposal to suspend a 50-year-old ethics law. The law, first passed in 1966, requires VA to fire any employee who also works for a school whose students receive VA benefits. The department had planned to completely stop enforcing that requirement by next Monday, since some of its employees also work as adjunct professors at for-profit colleges. But it abruptly walked back the regulatory change on Wednesday after

complaints from veterans groups who said the waivers should only be granted on a case-by-case basis. (Federal News Radio)

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2.7 - La Crosse Tribune: [House approves whistleblower bill named for former Tomah VA doc](#) (12 October, 822k online visitors/mo; La Crosse, WI)

The U.S. House passed a federal whistle blower protection bill Thursday named for a former VA psychologist who questioned over-medication of patients at the Tomah VA Medical Center.

The Dr. Chris Kirkpatrick Whistleblower Protection Act is designed to protect federal employees who come forward with allegations of waste, fraud and abuse and to set minimum disciplinary measures for supervisors found guilty of retaliation.

The bill also requires the VA to put together a plan to prevent supervisors from improperly accessing an employee's medical files in retaliation.

Kirkpatrick killed himself in 2009 the same day he was fired after questioning over-medication practices at the Tomah VA, which earned the nickname "Candy Land" because doctors there prescribed such high doses of opiates. Investigations later blamed those prescription practices for the deaths of at least two veterans.

U.S. Rep. Ron Kind, whose district includes the Tomah VA, spoke on the House floor in favor of the bill.

"Dr. Kirkpatrick was dedicated to improving the lives (of) and serving our nation's veterans," Kind said. "The bill before us today will honor the memory of Dr. Kirkpatrick by helping to make sure no one will have to go through what he did."

The bill, introduced by Sen. Ron Johnson, passed the House unanimously and now heads to President's desk.

Johnson, a Wisconsin Republican, said the passage brings the nation "

one step closer to better protecting federal whistleblowers and providing better health care to the finest among us – our veterans."

VA Secretary David Shulkin has pledged to bring greater accountability to the government's second largest agency, which provides medical care to millions of veterans. In July, Shulkin began posting employee disciplinary actions and announced that he would require approval by a senior official of any settlement with a VA employee over the amount of \$5,000, citing unnecessary payments to bad employees. A month later, he ordered a review to expand VA reporting requirements for bad workers.

During the 2016 campaign, Trump described the VA as the "most corrupt," promising to "protect and promote honest employees" at the VA who expose wrongdoing.

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2.8 - WLOS (ABC-13, Video): [Protesters at Asheville VA say being understaffed is dangerous](#) (12 October, 480k online visitors/mo; Asheville, NC)

ASHEVILLE, N.C. (WLOS) — Veterans Affairs employees held a rally outside Asheville's Charles George VA Medical Center on Thursday to protest working conditions.

Protesters said low staffing levels are creating risks to patient safety and a hazardous work environment. They said Congress has failed to fill open positions, putting veterans' health care at risk.

"We're trying to get the word out and let Congress know that we're here to support these veterans," Brandee Morris, of AFGE Local 446, said.

Protestors said there are nearly 50,000 open positions at VA centers across the country, and there's no plan in place to fill them.

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2.9 - HousingWire: [Ginnie Mae, VA launch task force to look into lenders targeting veterans for quick refinances - Comes on the heels of Ginnie Mae opening investigation](#) (12 October, Ben Lane, 438k online visitors/mo; Irving, TX)

Roughly one month ago, Ginnie Mae announced that it was launching an investigation into mortgage lenders that were aggressively targeting servicemembers and military veterans for quick and potentially risky refinances of their mortgages.

The investigation came on the heels of a letter from Sen. Elizabeth Warren, D-Massachusetts, who cited a report from the Consumer Financial Protection Bureau, which covered complaints received from veterans about Department of Veterans Affairs mortgage refinancing.

Warren's letter claimed that there may be lenders "aggressively and misleadingly marketing the refinancing of mortgages backed by the Department of Veterans Affairs, generating fees for themselves at the expense of veterans and American taxpayers."

Now, Ginnie Mae and the VA are launching a task force to "address mortgage refinancing issues" surrounding VA loans.

The task force, which is called the "Joint Ginnie Mae – VA Refinance Loan Task Force," will focus on "examining critical issues, important data and lender behaviors related to refinancing loans and will determine what program and policy changes should be made by the agencies to ensure these loans do not pose an undue risk or burden to Veterans or the American taxpayer."

But more specifically, the agencies say that the task force will review the "aggressive and misleading refinancing" marketing practices of certain lenders, and will address "loan churning and repeated refinancing."

Loan churning is the practice of convincing an existing borrower to refinance their mortgage.

When announcing the investigation, Michael Bright, the acting president and chief operations officer of Ginnie Mae, said that the market for VA loans that is “somewhat saturated with lenders and brokers making dozens of calls and sending dozens of letters to veterans” trying to get them to refinance their mortgages.

And now, Ginnie Mae and the VA are working to address the issue.

“Both agencies agree that VA and Ginnie Mae programs work best when they are used by market participants in ways that provide a benefit to Veteran borrowers and, ultimately, lower Veterans’ costs,” Ginnie Mae said in an announcement.

According to Ginnie Mae, the task force has already started its work by examining data and information to “ensure loans provide a net tangible benefit to Veteran-borrowers, and consider establishing time frames regarding recoupment of fees associated with refinancing loans.”

Ginnie Mae said that the task force will also examine the impact of “establishing stronger seasoning requirements for VA-guaranteed loans that are securitized into Ginnie Mae Mortgage Backed Security pools.”

Additionally, Ginnie Mae said the task force will work to “ensure Veterans understand the costs and benefits of refinancing, and ensure robust borrower outreach and education programs are augmented for this purpose.”

The agencies also plan to arrange “joint discussions with individual lenders whose demonstrated origination practices may negatively affect Veteran borrowers or increase program costs and risks.”

The agencies also say that the task force will continue its work until “concrete solutions” are found that will “eliminate lender behavior that is unhelpful to Veterans and harmful to the American taxpayer.”

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2.10 - Citizen-Times: [Disappointed VA employees voice concerns, lack of staffing and support](#) (12 October, Alexandria Bordas, 318k online visitors/mo; Asheville, NC)

OTEEN - Ralliers gathered at Charles George VA Medical Center on Thursday afternoon to express disappointment in the 49,000 vacant staff positions nationwide, which veterans' supporters said are affecting local VA branches.

Months of delays in appointments, overworked employees and lack of internal support can no longer be ignored, said Brandy Morris, executive vice president of the local American Federation of Government Employees labor union in Asheville.

"Veterans want to come to the VA and not be sent to private doctors because it will take us over a month to treat them," said Morris, who has worked for the VA for 17 years.

Ralliers also said they were upset with the Trump administration's recent decisions in regards to veteran care.

In August, Trump signed a \$3.9 billion funding bill to save the nearly bankrupt Choice Program, which is a temporary benefit that allows eligible veterans to receive health care in their communities rather than waiting for a VA appointment or traveling to a VA facility, according to the Department of Veterans Affairs.

The Choice Program was created in 2014 after numerous reports revealed an alarming rate of cover-ups in veteran wait times at a handful of VA hospitals across the nation.

This summer, it was determined the Choice Program would no longer be able to offer the temporary benefit because it was running out of money.

Originally, the proposed bill was smaller and would solely fund the Choice Program, without an additional \$1.8 billion for hiring and clinics.

Backlash from veterans organizations, who said the bill prioritized privatized care as opposed to buffing up VA staff, led to the revised \$3.9 billion bill, which Trump signed in August, according to Stars and Stripes. The money is expected to keep the Choice Program afloat for six more months.

But, despite the new bill, there is still dissatisfaction among VA employees.

Paul Stone, a veteran who works at the VA as an electrician, was not inspired by the surge of support for the Choice Program under the Trump administration.

"If veterans had a choice, they would rather see their doctors here, but they don't have a choice so they are forced to see someone else," said Stone, who was holding a sign that said "I Love My VA".

Torre White comes from a family of servicemen and women. She works as a program support assistant with geriatrics at the VA.

It took her months to get hired, despite hundreds of job vacancies posted online, she said.

"There are plenty of openings, but why aren't people getting hired?" she asked. "With so many people applying and wanting jobs, it shouldn't take that long, and now our veterans are not able to get immediate care because of that."

These issues also bother Kay Murray, who has worked as a nurse at the VA for 8 years.

The VA can provide services in-house without the Choice Program if it had the right staffing, she said.

One of Murray's biggest concerns is veteran patients with mental health needs.

A lot of veterans come to the VA because they can trust their doctors, many of whom are veterans, which many not be the case if they go elsewhere, she said.

"The VA is home to veterans, their family, and they come to us wearing their buttons, hats and t-shirts," Murray said. "Half of our employees are veterans too, this is where all of them should be treated."

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2.11 - WEAU (NBC-13, Video): [House members pass Whistleblower Protection Bill](#) (12 October, Ruth Wendlandt, 276k online visitors/mo; Eau Claire, WI)

Washington, D.C. (WEAU) In a bi-partisan vote, House members unanimously passed Representative Sean Duffy's Whistleblower Protection Bill.

The Dr. Chris Kirkpatrick Whistleblower Protection Act ensures no one is retaliated against for coming forward with concerns about waste, fraud, and abuse at the veteran affairs. It also requires the VA to come up with a plan to restrict unauthorized employee access to medical files.

The bill is named after a Wisconsin doctor who worked at the Tomah VA Medical Center, and was fired after he questioned the over-medication of veterans. On the day of his firing, Dr. Kirkpatrick committed suicide.

Representative Ron Kind says he's happy the bill received support from across the aisle. Kind says, "We need people who are working with our veterans who feel confident and safe to come forward when they see things that aren't working the way they're supposed to, when veterans aren't getting the treatment they need, and they deserve, without fear of retaliation without fear of being retired."

Representative Duffy says, "This legislation strengthens protections for patriots-for those who are trying to do the right thing, for those who care about veterans and their safety."

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2.12 - Parkersburg News & Sentinel: [Outrageous: VA culprit deserves more than a lecture](#) (13 October, Editorial Board, 187k online visitors/mo; Parkersburg, WV)

How should a Department of Veterans Affairs manager who defrauded the government, took chances with veterans' health care, then devised a coverup be punished? Readers probably have their own ideas about that.

But according to the federal government, the answer is ... counseling.

One of U.S. Rep. David McKinley's constituents reported to him last year that something was wrong at the Louis A. Johnson VA Medical Center in Clarksburg. McKinley represents much of our area; and many veterans in our region rely on the VA hospital in Clarksburg.

McKinley went straight to the VA. The U.S. Office of Special Counsel, which also had been contacted by a whistleblower from the hospital, looked into the matter.

Investigators found that during a seven-year period, a manager at the hospital engineered a scheme whereby patient data was “intentionally manipulated” at the facility. The purpose was to make it appear at least some veterans were not kept waiting for care as long as actually was the case. In addition, the volume of patient visits was inflated.

Part of the scheme involved nurses being pressured to place patients in unofficial “clinics,” rather than record them as emergency department visits.

Whether any veterans were harmed by the manager’s actions was not reported by the Office of Special Counsel. Obviously, that should be checked.

One ramification of the misconduct was that 602 veterans were charged incorrect co-payments. That cost the VA \$21,070.

However, according to the Office of Special Counsel, the VA “is currently determining how to recoup lost payments.” In other words, the bureaucrats are looking into how they can go back to the 602 veterans and tell them they owe Uncle Sam money.

What about the culprit? According to the Office of Special Counsel, “the VA counseled the manager responsible ...”

That’s it. No punishment, just a good talking to.

We sometimes refer to the bureaucracy in Washington as “the swamp.” That may be a disservice to the snapping turtles, cottonmouth snakes, alligators and quicksand of the real thing.

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2.13 - WAGM (FOX-8): [After Report Shows VA’s Failure to Disclose Medical Malpractice at Togus, Rep. Poliquin Acts to Make Changes](#) (12 October, 35k online visitors/mo; Presque Isle, ME)

Congressman Bruce Poliquin, along with House Conference Chair Cathy McMorris Rodgers (WA-05) and House Veterans Affairs Committee Chairman Phil Roe (TN-01), today introduced the Ethical Patient Care for Veterans Act of 2017. This legislation requires Department of Veterans Affairs (VA) medical professionals to report directly to state licensing boards if they witness unacceptable or unethical behavior from other medical professionals at the VA. The legislation is in response to the alarming USA Today article out yesterday that revealed the VA failed to disclose bad medical practitioners to the public, risking the public’s exposure to these bad actors.

One of the most notorious offenders was Thomas Franchini, a practitioner at Togus who had committed malpractice in 88 separate cases, according to the VA’s conclusions.

“These most recent reports are nothing short of appalling,” said Congressman Poliquin. “Our Maine Veterans depend on their services at Togus and other VA facilities across our State for critical care, and it is absolutely unacceptable for them to ever be subjected to medical

malpractice. We must have accountability at the VA, to ensure our Veterans are always getting the best care possible, and I am proud to be working on the Veterans Affairs' Committee to do that. I'm now pleased to work with Chairwoman McMorris Rodgers and Chairman Roe to help prevent this unacceptable behavior from occurring again."

"These newest reports out of the VA are deeply troubling," said Chair McMorris Rodgers. "Our veterans deserve the best care imaginable, but as we've seen, far too often that's not the case. This bill will help reform the culture at the VA by holding bad actors accountable and keeping them from continuing these mistakes at the VA or elsewhere. We should be rolling out the red carpet to our nation's heroes in Eastern Washington and around the country, and that starts with ensuring that the best and brightest are at the VA caring for our veterans."

"The findings of the USA Today investigation are intolerable," said Chairman Roe. "The committee has long been concerned about VA's settlement agreements, and even held a hearing on the topic last year. While I can appreciate VA's recent decision to more closely vet settlement agreements, malfeasance within the department will not be ignored. It certainly cannot be rewarded and hidden from state licensing boards. As a physician, I find this deeply troubling, and I thank Reps. McMorris Rodgers and Poliquin for their leadership on this issue."

NOTE: Currently, if the VA receives a report of substandard health care practices, it takes at least 100 days to decide whether to refer the matter to a state licensing board. This legislation will require timely reporting to state licensing boards so there is proper notice of these serious allegations.

As reported by USA Today, "the VA — the nation's largest employer of health care workers — has for years concealed mistakes and misdeeds by staff members entrusted with the care of veterans." The article lays out a number of cases where doctors provided poor, unethical, or irresponsible care, and faced zero medical licensing reviews.

By requiring malpractice to be reported to state licensing boards, this legislation ensures that if poor care happens, doctors and clinicians will no longer be shielded by the VA and could face consequences just like they do in private practice.

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2.14 - WAGM (FOX-8): [Rep. Poliquin's Bill to Ensure VA Headstones For Veterans' Families Buried in Cemeteries Advances in the House](#) (12 October, 35k online visitors/mo; Presque Isle, ME)

Today, Congressman Bruce Poliquin had his Veterans bill pass out of committee with unanimous, bipartisan support.

Congressman Poliquin's legislation would ensure that Veterans' family members who are buried at tribal Veterans cemeteries—such as the Houlton Band of Maliseet Indians Tribal Veterans Cemetery in Aroostook County—are provided government furnished headstones, the same treatment as those buried at national and state Veterans cemeteries.

Congressman Poliquin, who represents the Houlton Band of Maliseet Indians and their Tribal Veterans Cemetery in Aroostook County, released the following statement:

“Our Veterans, who served and sacrificed for our Nation and who are now laid to rest in tribal Veterans cemeteries, should have the honor of being buried with their families and all should have access to headstones commemorating their sacrifices,” said Congressman Poliquin. “I’m proud to represent the Houlton Band of Maliseet Indians, who created the first Tribal Veterans Cemetery not only in Maine, but on the entire East Coast. It is a great honor to serve them and to push forward this commonsense fix so all our Veterans and their families can be properly honored when they are laid to rest. I’m extremely pleased to have the unanimous support of my Republican and Democratic colleagues on the Veterans’ Affairs Committee for this commonsense legislation, and I will continue to push this important bill through Congress and onto the President’s desk.”

Clarissa Sabattis, Chief of the Houlton Band of Maliseet Indians, said when the bill was introduced, “The Houlton Band of Maliseet Indians is honored to have the first Tribal Veterans Cemetery, East of the Mississippi. We all know that when a loved one serves in the military, especially when deployed overseas, that the family serves as well. Spouses take on the additional duties and stresses of taking care of their homes, being single parents, raising and comforting their children in times of great stress and ensuring our veterans have a home to return to. Congressman Poliquin’s Bill honors the families and acknowledges the sacrifices made by those who stay behind by providing headstones for the spouses and children of veterans who are buried in tribal cemeteries.”

Under current law, government furnished headstones are only available to Veterans’ eligible spouses and dependents buried in national and state Veterans cemeteries. This bill would authorize the Department of Veterans Affairs (VA) to provide headstones and markers to eligible spouses and dependents interred at tribal Veterans cemeteries.

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2.15 - KOB (NBC-5, Video): [Oregon politician concerned about Roseburg VA medical facility](#) (12 October, 27k online visitors/mo; Medford, OR)

Washington, D.C. – An Oregon congressman is asking the U.S. Department of Veterans Affairs to address “substandard management” at the Roseburg VA hospital.

Congressman Peter DeFazio (D-OR 4th District) said the VA Roseburg Health Care System (VARHS) is a source of concern for constituents, who complained to the governor about the lack of effective and accountable management.

DeFazio claims nothing has changed at VARHS despite repeated outreach with VA leadership, including a direct appeal to VA Secretary David Shulkin last week.

“Poor management has resulted in degraded patient care and difficulty in recruiting and retaining talented medical professionals to help Oregon’s veterans. It’s outrageous that in addition to delays and government bureaucracy veteran care is being hampered by management issues,” Rep. DeFazio said. “Doctors, nurses, and other VA employees are putting their careers on the line to improve the system, risking potential retaliation from the same inadequate leadership. The status quo is entirely unacceptable, and it is time for the VA to stop passing the buck and take immediate action. Our veterans deserve better.”

Rep. DeFazio voiced his concerns while speaking in support of the Dr. Chris Kirkpatrick Whistleblower Protection Act. The legislation would create harsher penalties for those who retaliate against whistleblowers.

According to DeFazio's office, in 2015 35% of whistleblower complaints came from VA employees.

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2.16 - The M Report: [Ginnie Mae and VA Create Refinance Loan Task Force](#) (12 October, Nicole Casperson, 20k online visitors/mo; Dallas, TX)

Ginnie Mae and the Department of Veterans Affairs (VA) recently announced the shaping of the "Joint Ginnie Mae – VA Refinance Loan Task Force," in an effort to address loan churning and repeated refinancing issues.

Specifically, the task force is set to focus on examining critical issues, important data, and lender behaviors related to refinancing loans. In addition, the task force will "determine what program and policy changes should be made by the agencies" as a way to ensure these loans do not pose an "undue risk or burden to Veterans or the American taxpayer."

According to the enterprise, this task force has begun its efforts in two ways. First, by examining data and information to ensure loans provide a "net tangible benefit" to Veteran-borrowers. Second, the task force is considering to establishing time frames regarding "recoupment of fees associated with refinancing loans."

The purpose of the task force is to also determine the effects if implementing stronger seasoning requirements for VA-guaranteed loans that are securitized into Ginnie Mae Mortgage Backed Security pools, according to Ginnie Mae's release.

Furthermore, the task force will "work to ensure Veterans understand the costs and benefits of refinancing, and ensure robust borrower outreach and education programs are augmented for this purpose."

Last year, the Consumer Financial Protection Bureau revealed a snapshot of service member complaints and issues related to VA mortgage refinancing. In light of these issues, the task force will examine aggressive and misleading refinancing propositions.

The release notes that Ginnie Mae and the VA will continue to work together until concrete solutions have been implemented to eliminate lender behavior that is unhelpful to Veterans and harmful to the American taxpayer.

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2.17 - KSNW (NBC-3): [Kansas nurse in Puerto Rico to help Hurricane Maria victims](#) (12 October, 9.1k online visitors/day; Wichita, KS)

A Cheney nurse is in Puerto Rico helping victims of Hurricane Maria. Linda Sue Bayless is a provider at the Robert J. Dole VA Medical Center.

As part of the VA's Disaster Emergency Medical Personnel Program System, she signed on to deploy where she was needed most. Bayless left October 4 and is due back on the 18.

Her husband, Greg, says she is now living in a tent and has had no hot water since she arrived. He describes her as working side by side with FEMA, the Red Cross, and Homeland Security. "She is an honorable woman," He said. "She wants to help. She is patriotic. She has been a caregiver her entire life. She wanted to volunteer."

He describes his wife's conditions as "difficult" and she is currently working nights on the 7 p.m. to 7 a.m. shift.

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3. Access to Healthcare

3.1 - Newsweek (Video): [PTSD Treatment: How Ai Is Helping Veterans With Post-Traumatic Stress Disorder](#) (12 October, Joseph Frankel, 9.4M online visitors/mo; New York, NY)

There is a real appeal to shouting into the void: the ubiquity of Google search as confessional, the popularity of PostSecret, the draw of confiding in a trusted friend with the hope verging on understanding that our secrets won't be shared all point to this. A group of researchers from the University of Southern California, with funding from the DARPA wing of the Department of Defense, believe that desire might drive a preference among veterans with PTSD to anonymously discuss their symptoms with a computerized avatar.

They found that the service members who volunteered for the study disclosed more symptoms of PTSD when speaking with a computerized "virtual human" than when filling out a symptoms checklist on the military's Post Deployment Health Assessment (PDHA). They also reported more symptoms even when filling out a completely anonymized version of the PDHA. The idea, the researchers suggest, is that people are more willing to disclose their symptoms when they know the data is anonymous.

It's unclear if that will fly in real life. Whether the program will truly help veterans remains to be seen. And its implementation raises questions about medical ethics and the stigma around mental-health in the military and culture at large.

The Institute for Creative Technologies at USC got lots of buzz for its original research, and introducing the world to Ellie, a digital diagnostic tool that strongly resembles, but cannot replace a human therapist. Ellie, an avatar of a woman in a cardigan with olive-toned skin and a soothing voice, listens to the people who come to her, and does what any human sounding board does. She listens to the content of their speech, and scans their facial expressions, tone, and voice, for cues that hint at meanings beyond speech. Ellie's design was decided upon by the research group's art team. As for how Ellie sounds, "she has a very comforting voice," Lucas told Newsweek.

(Unlike a human, of course, this kind of reading is made explicit enough to show in a video.)

Based off their results, Lucas says, the researchers believe that for veterans with PTSD, Ellie combines the best of both worlds: her warm demeanor and sympathetic responses establish the kind of rapport that a therapist would create, and the knowledge that she's not actually a person, and crucially, that she's not built into a chain of reporting, mean you can say whatever you want. This builds off past research this same team did, in which participants more intensely expressed feelings of sadness and reported lower rates of fear when going through a health screening with a virtual human rather than one they were led to believe was controlled by an actual human.

The way Lucas envisions it, Ellie is an economical and efficient solution. "All you need is a webcam, a laptop, and a microphone." She imagines Ellies existing in a kind of kiosk that can be tucked into a local VA. "I know it sounds creepy to put it in a closet, but you could put it in a closet."

And at least one psychiatrist thinks Ellie has potential. "This technology has amazing potential to drill down into the elements of rapport, and whether it differs by patient characteristics; something that is not possible with real life therapists or clinicians. A simple example is whether the sex and age of the avatar alters the effect," says Joseph Hayes, a psychiatrist at University College London.

However, Hayes believes the anonymity that drives the study's result might be impossible in real life. The participants in the study may feel more comfortable disclosing to Ellie because, unlike with the PDHA, which soldiers know will go on their permanent health record, what they say to Ellie will not. But If Ellie were really integrated into a care center, it's hard to imagine that the data she collects wouldn't also be accessible by treating clinicians.

"For an intervention to be possible ultimately, the disclosure would have to be shared with the same commanding officers who have traditionally received the results of the service members PDHA, and entered into their military health record. Once this is made explicit, would disclosure reduce to levels seen previously?" Hayes wrote. "If so, it is a culture change (reducing public stigma—within the military and more broadly) which is truly going to impact on disclosure and provision of appropriate treatment," Hayes wrote.

Lucas and her colleagues have been thinking about this problem, and she's optimistic they can work out a solution. She maintains that since the research is being implemented within the department of defense, it's under different rules than treatments marketed to civilians.

The way Lucas envisions it, even in real life, a session with Ellie can stay fully anonymous. A veteran can go in, talk with 'her', and at the end of the session Ellie can suggest they follow up with a clinician if the person needs further treatment. But, Lucas hopes, that choice will be up to the patient.

With one big exception.

If a therapist or doctor learns of a person's intent to harm or kill, among other acts, they are compelled to break confidentiality and intervene. But Ellie, Lucas maintains, can't be mandated to report these things because she isn't human. Lucas's ideal solution is that, if a veteran comes to Ellie expressing thoughts of self-harm, the program would send out a red flag of sorts to a human clinician who would then be compelled to act.

It has yet to be determined whether that approach is legally, ethically, or practically feasible.

Even if it is feasible, there are still many other problems to tackle when it comes to PTSD in veterans, Hayes says.

"As a clinician, I'd want to know that this technology could effectively detect cases of PTSD, rather than just increasing disclosure of less severe, potentially non-diagnostic, responses to trauma. The bottleneck is not necessarily in the shortage of resources for diagnosis, but a shortage in the resources to deliver effective evidence-based care following diagnosis," Hayes wrote. And while AI technologies that do exactly that are being developed and tested, he thinks it's a long ways away before they can take over that work.

And help is needed.

"Veterans account for 20% of suicides in the US," Hayes said. "Better support systems, beyond the brief provision of therapy may help reduce this shocking statistic."

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3.2 - KTVU (FOX-2): [Services available for veterans at Napa Valley College evacuation center](#) (12 October, 2.1M online visitors/mo; Oakland, CA)

NAPA, Calif. (BCN) - The Vet Center, a subsidiary of the U.S. Department of Veterans Affairs, deployed personnel today to the wildfire evacuation center at Napa Valley College from Concord and Fairfield to provide mental health services and paperwork assistance for any displaced veterans.

They were at the shelter today with a trailer set up for three separate counseling sessions to be conducted simultaneously.

"Say you're having a panic attack," readjustment counselor Lori Shepherd said. "You come in here and have a counseling session."

Shepherd said the smoke, smells and sight of burnt buildings can be stressful for veterans who served in Iraq, Afghanistan or other war zones.

"It can definitely be triggering," said Joseph Moglia, a veteran of the U.S. Marine Corps who served in Iraq.

Shepherd and Moglia are available at Napa Valley College for any veterans who have been displaced by the North Bay wildfires and are in need of assistance. They can be reached at (925) 433-3407.

They've also set up an area with seating and a television for veterans at the shelter who just want to spend time with other veterans.

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3.3 - The Gazette: [Mayor, nonprofits plead for Colorado Springs landlords to help homeless vets](#) (12 October, Jakob Rodgers, 870k online visitors/mo; Colorado Springs, CO)

Colorado Springs landlords reportedly are spurning federal housing vouchers in favor of renting to higher-paying tenants, thwarting efforts to help homeless veterans get off the streets, city officials and nonprofits say.

Mayor John Suthers, the National League of Cities and local advocates for the homeless called on landlords Thursday to accept the vouchers from veterans needing a place to live rather than taking advantage of the hot rental market.

Suthers stressed that local landlords hold the key to effectively ending veteran homelessness - a goal that has eluded the city for years.

"They're private businesses, they're there to make money and they don't have to engage in this," Suthers said. "But we're just trying to impress upon them that it's part of being a citizen of the community."

As an example, Suthers mentioned one homeless veteran who got a job while using his voucher - allowing him to pay more for rent.

"We're hoping they'll (landlords) see the long view that helping house people is in their interest as well as the community's," Suthers said.

Their message highlighted the latest in a series of meetings at the Apartment Association of Southern Colorado's offices, which seek to woo hesitant property owners.

As Colorado Springs' affordable housing crunch has worsened, rents have climbed to record territory, fed by Colorado's bustling economy and an influx of newcomers seeking cheaper housing outside the Denver Metro area.

In spring and early summer, the city's average monthly rate - not including utilities - was \$986 for a one-bedroom apartment and \$1,523 for a three-bedroom unit.

But the VA's vouchers are capped. For someone here without an income, they are from \$751 a month for a one-bedroom apartment and \$1,355 a month for a three-bedroom unit. Importantly, while those rates can rise with a person's income, they must include the cost of utilities.

That's kept landlords and property owners away, acknowledged Laura Nelson, the apartment association's executive director.

The plight of veterans seeking housing is "truly sad," said Carmen Azzopardi, vice president of multifamily property services for Griffis/Blessing.

Her company was among a few touted by the association as being more open to accepting vouchers.

But Azzopardi said many landlords feel hamstrung by the program's red tape. Many also fear violating the Fair Housing Act by prioritizing veterans above others, and accepting them at reduced rates.

"How can we help, when it's almost like our hands are tied on being able to help?" Azzopardi said.

Elisha Harig-Blaine, principal housing associate of the National League of Cities, disputed that notion.

"I can definitely tell you - it does not violate fair housing," Harig-Blaine said.

Homeless advocates also stressed a willingness to work with landlords and address any issues that arise, including landlords' concerns about renting to vets with felony convictions or past evictions.

The vouchers include a caseworker for each veteran who can help them find jobs, access health care and, if need be, find addiction treatment.

"We want to help you have success," said Erika Huelskamp, who coordinates the VA's local voucher program. "We are just a phone call away. We're here for you, just as much as that veteran."

Fifteen individuals and 13 families are searching for landlords willing to accept their Department of Veterans Affairs vouchers, said Huelskamp.

That's only a fraction of the homeless veterans in need of apartments here, and an even smaller portion of the city's overall homeless community.

People who haven't served in the military also face similar problems using different vouchers, nonprofit leaders say.

The pleas come as Colorado Springs tries to join the growing list of cities that have effectively ended homelessness among veterans.

The goal is to ensure no veterans are forced to live on the streets, and that their homelessness is brief, rare and nonrecurring.

A coalition led by Rocky Mountain Human Services almost succeeded in eliminating veteran homelessness in 2015 by creating an intensely-data driven program unlike anything ever seen in the Pikes Peak region.

Volunteers found people living on the streets. The nonprofit's employees helped them apply for VA benefits and seek housing.

But two main barriers - the city's severe lack of shelter space and affordable housing - kept the coalition from meeting its goal.

One impediment has since been eased.